

**Welcome To The  
ANNUAL END STAGE RENAL DISEASE (ESRD) FACILITY QUESTIONNAIRE FOR CALENDAR YEAR 2015**

The purpose of this survey instrument is to collect, on an annual basis, individual ESRD facility data. The HFSRB appreciates your time in responding to this important survey. Please be advised that every effort is being taken to keep this task simple, user friendly and pertinent to HFSRB's purpose. This survey is being administered under the authority of the Illinois Health Facilities Planning Act [20 ILCS 3960/]. Failure to respond may result in sanctions including the following:

"A person subject to this Act who fails to provide information requested by the State Board or Agency within 30 days of a formal written request shall be fined an amount not to exceed \$1,000 plus an additional \$1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or Agency." [20 ILCS 3960/14.1(b)(6)]

**The completed survey must be electronically submitted by 5PM on Friday, March 4, 2016.**

**Facilities failing to submit this survey by the stated deadline will be reported to HFSRB for its consideration of the imposition of sanctions as mandated by the Act. There will be no exceptions or extensions.**

Please note that this survey is divided into two parts:

**PART I**

Collects utilization data pertaining to each licensed facility.

The requested information **MUST BE REPORTED FOR the CALENDAR YEAR 2015**

**PART II**

Collects financial and capital expenditure data pertaining to each licensed facility.

The requested information **MUST BE REPORTED FOR the MOST RECENT AUDITED FISCAL YEAR**

If you experience any problems or have questions concerning this survey, please check the **[help] links and definitions** provided. If problems continue, contact this office via e-mail at [dph.facilitysurvey@illinois.gov](mailto:dph.facilitysurvey@illinois.gov) or by telephone at 217-782-3516.

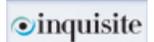
Again, thank you for your cooperation.

Click the button marked '**Next**' at the bottom of this page to begin the survey.

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**SURVEY**  
**INSTRUCTIONS**

There are 3 buttons at the bottom of each survey page:

'Back' returns you to the previous survey page.

'Next' takes you to the the next page of the survey.

'Save' saves work in progress **if you need to stop before finishing.**

**NOTE: YOU DO NOT NEED TO SAVE AFTER EACH PAGE. SAVE THE FORM ONLY IF YOU ARE FORCED TO STOP BEFORE COMPLETING.** Validation rules have been set up for some items; if your responses do not meet the validation rules, or if you have not filled in some required fields, you will not be allowed to proceed to the next page.

**IMPORTANT**

If you save your work, the unfinished survey is stored on our server with a new, random address. You will be prompted to set a **bookmark or Favorite in your web browser**. **YOU MUST DO THIS; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT.** The link provided in your e-mail notice **WILL NOT** access the saved form. **When you are ready to continue, use the bookmark or favorite to open the form.** You will be returned to the place where you left off.

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Please review the information below and provide any missing information.

Medicare ID	<input type="text"/>	Health Service Area	<input type="text"/>	
ESRD Facility Name	<input type="text"/>		County	<input type="text"/>
Facility Address	<input type="text"/>			
City	<input type="text"/>	IL	Zipcode	<input type="text"/>
Federal Employer Identification Number (FEIN)	<input type="text"/>			

**ESRD STATION INFORMATION**

Number of <b>AUTHORIZED ESRD</b> Stations as of December 31, 2014	<input type="text" value="0"/>
Number of <b>AUTHORIZED ESRD</b> Stations as of December 31, 2015	<input type="text" value="0"/>
Number of ESRD stations <b>certified by CMS</b> as of December 31, 2014	<input type="text" value="0"/>
Number of ESRD stations <b>certified by CMS</b> as of December 31, 2015	<input type="text" value="0"/>



**ANNUAL END STAGE RENAL DISEASE (ESRD) FACILITY QUESTIONNAIRE**

**PART I**

**1. PHYSICAL SET UP OF STATIONS**

- a. The **peak** number of **authorized stations** operated during **Calendar Year 2015**.
- b. The number of **authorized stations** that were set up and staffed during **Oct 1 - Oct 7, 2015**.
- c. The number of authorized **isolation stations** set up during **Oct 1 - Oct 7, 2015**   
(For item b and c, for this year's survey, provide best estimate)

**2. FACILITY UTILIZATION**

- a. Number of chronic in-center hemodialysis treatments done in the **Calendar Year 2015**.
- b. Average time spent per treatment (in minutes)
- c. List the number of missed **treatments** (not patients) or "no shows".
- d. How many shifts does your facility operate per day?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shifts	<input type="text" value="0"/>						

- e. Indicate if your facility operates Incenter-Nocturnal Dialysis.  YES  NO

- f. List your number of normal scheduled hours of operation during the week of Oct 1 - Oct 7, 2015.

	October 1	October 2	October 3	October 4	October 5	October 6	October 7
Hours	<input type="text" value="0"/>						
	THU	FRI	SAT	SUN	MON	TUE	WED

- g. List the number of patients treated during the week of Oct 1 - Oct 7, 2015.

	October 1	October 2	October 3	October 4	October 5	October 6	October 7
Patients	<input type="text" value="0"/>						
	THU	FRI	SAT	SUN	MON	TUE	WED

**(If the center operated fourth shift in the above given week (October 1-7), please include those hours of operation and patients served respectively) and note in the comments section (page 13) that a fourth shift is included.**



**3. PATIENT INFORMATION - DO NOT INCLUDE ACUTE PATIENTS**

- a. Enter the number of **ALL** patients receiving chronic in-center hemodialysis at the **beginning** of the survey year (**as of 1/1/2015**)
- b. Enter the number of **ALL** patients receiving chronic in-center hemodialysis **at the end** of the **survey year (as of 12/31/2015)**.
- c. Enter the total number of **unduplicated** patients who received chronic in-center hemodialysis treatment for **calendar year 2015** (include new patients, transients, losses and additions of patients)

**Of the patients who began or ended treatment at your facility during 2015, please list patients by reason for beginning or ending treatment:**

- d. *PATIENT ADDITIONS DURING 2015:*
  - i. List the number of new patients to the facility (includes transfers into the facility)
  - ii. List the number of all transient patients
  - iii. List the number of patients who restarted in-center haemodialysis.
  - iv. List the number of patients who returned after transplantation
  
- e. *PATIENT LOSSES DURING 2015:*
  - i. List the number of patients with recovered kidney function.
  - ii. List the number of patients who left due to kidney transplant (transplant recipients).
  - iii. List the number of patients who were transferred out (including transients).
  - iv. List the number of patients who have voluntarily discontinued dialysis (not transferred or transplant)
  - v. List the number of patients who are lost to follow-up.
  - vi. List the number of patients who ceased dialysis due to death.



**4. FACILITY OWNERSHIP AND ADMINISTRATION**

a. Legal entity that **operates and owns** the ESRD facility

b. Indicate the type of ownership for your ESRD facility (choose only one)

**FOR PROFIT**

**GOVERNMENTAL**

**NOT FOR PROFIT**

For Profit Corporation

County

Church-Related

Limited Partnership

City

Other Not for Profit Corporation (Not Church Related)

Limited Liability Partnership

Township

Other Not-for-Profit (specify below)

Limited Liability Company

Hospital District

Other For Profit (specify below)

Other Governmental (specify below)

Other Ownership Type

c. Please report the name of the Medical Director of your ESRD facility:

**MEDICAL DIRECTOR NAME**

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**4. FACILITY OWNERSHIP AND ADMINISTRATION (continued)**

d. Indicate the legal entity/entities that own(s) the building/structure in which ESRD facility is located. Include the name, address and zip code (include 5-digit Zip Code plus 4-digit extension)

Building Owner(s)	Address	City	State	Zip Code

e. Provide the name and relational interest of all organizations or entities that are legally, financially or otherwise related to the licensee (e.g., parent, subsidiary, affiliate, management agreement etc.)

NAME	RELATIONSHIP	TYPE OF INTEREST



**5. FACILITY ADMINISTRATION AND STAFFING**

a. Please indicate the number of hours in a work week for a **full time employee** of your facility

b. Please indicate the number of FTEs (Full Time Equivalents) working at your facility **during the first pay period of December 2015.**

The total line (in green) is automatically calculated as you enter data.

PERSONNEL	FULL-TIME EQUIVALENTS
Registered Nurse(s)	<input type="text" value="0"/>
Dialysis Technician(s)	<input type="text" value="0"/>
Dietician(s)	<input type="text" value="0"/>
Social Worker(s)	<input type="text" value="0"/>
LPNs	<input type="text" value="0"/>
Other Health Professionals	<input type="text" value="0"/>
Other Non-Health Professionals	<input type="text" value="0"/>
<b>Total of Personnel FTEs</b>	<b>0</b>

If you reported any other health or non-health professionals in the table above, please provide a brief explanation:



**6. UTILIZATION BY PATIENT RACIAL GROUP and ETHNICITY**

Report the total number of patients by their age, racial group and ethnicity who received treatment within the ESRD facility for **Calendar Year 2015**. **Totals in green are automatically generated.**

AGE TOTAL in Section 1 **must agree** with the RACIAL TOTAL in Section 2 and **also** with the ETHNIC TOTAL in Section 3. **TOTAL PATIENTS** reported in **each section** must equal the number of patients reported in Question 3c. on page 4 (**0**).

SECTION 1: AGE GROUPS	Male	Female	SECTION 2: RACIAL GROUPS	Patients Receiving Treatment	SECTION 3: ETHNIC GROUPS	Patients Receiving Treatment
Under 14	<input type="text" value="0"/>	<input type="text" value="0"/>		<input type="text" value="0"/>		<input type="text" value="0"/>
15 - 44	<input type="text" value="0"/>	<input type="text" value="0"/>	Asian	<input type="text" value="0"/>	Hispanic or Latino	<input type="text" value="0"/>
45 - 64	<input type="text" value="0"/>	<input type="text" value="0"/>	American Indian/Native Alaskan	<input type="text" value="0"/>	Not Hispanic or Latino	<input type="text" value="0"/>
65 - 74	<input type="text" value="0"/>	<input type="text" value="0"/>	Black/African American	<input type="text" value="0"/>	Ethnicity Unknown	<input type="text" value="0"/>
75 +	<input type="text" value="0"/>	<input type="text" value="0"/>	Native Hawaiian/Pacific Islander	<input type="text" value="0"/>		
	<b>0</b>	<b>0</b>	White	<input type="text" value="0"/>		
			Race Unknown	<input type="text" value="0"/>		
<b>AGE TOTAL</b>	<b>0</b>		<b>RACIAL TOTAL</b>	<b>0</b>	<b>ETHNIC TOTAL</b>	<b>0</b>



**7. PATIENTS SERVED DURING CALENDAR YEAR 2015 BY SOURCE OF PAYMENT**

**NOTE:** Report each patient **only once** by their **primary source** of payment. If a person is covered under two or more different payor sources, the patient must be counted under the category that covers major part of their bill (usually 50% or higher).  
 TOTAL PATIENTS reported under this question must equal the TOTAL PATIENTS (0) reported in Question 3c. on Page 4.

	Medicare	Medicaid	Private Insurance	Charity Care	Private Payment	Other Public	<b>TOTAL PATIENTS</b>
Patients Served	0	0	0	0	0	0	<b>0</b>

**"Charity care"** means care provided by a health care facility for which the provider does not expect to receive payment from a patient or a third party payer [20 ILCS 3960 Section 3]. Charity care eligibility is based on financial need. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid and /or other federal State, local indigent health care programs.

In reporting charity care patients the reporting entity must report the number of patients based on cost, not charges per CMS 2552-96 Worksheet C, Part 1, PPS inpatient ratios, by determining the party responsible for most of the cost of the services. A Charity care patient is one where charity care discounts (per facility policy) represent more than 50% of the cost of the services and the charity care discounts are greater than the reimbursed costs.

As per AICPA guidelines, determination of charity care can be made at any time during the entire process, although it is preferred to be done when the patients presents himself for the care.

**"Private Payment"** includes money from a private account (for example, a medical savings account) and any government funding made out and paid to the resident which is then transferred to the facility to pay for services. It also includes all the Self pay payments.

**"Other Public"** includes all forms of direct public payment excluding Medicare and Medicaid.DHS and veterans' administration funds and other funds paid directly to a facility should be recorded here.



**ANNUAL END STAGE RENAL DISEASE (ESRD) FACILITY QUESTIONNAIRE**

**PART II  
FINANCIAL & CAPITAL EXPENDITURES DATA**

The data requested in this section are authorized pursuant to the Illinois Health Facilities Planning Act [20 ILCS 3960/5.3]

The Financial Section of the survey will be reported based on **YOUR MOST RECENT AUDITED FISCAL YEAR**. If you have any problems related to this Financial Data section, please contact this office by e-mail to [dph.facilitysurvey@illinois.gov](mailto:dph.facilitysurvey@illinois.gov) or telephone at 217/782-3516.

The information reported must be taken from your **MOST RECENT ANNUAL FINANCIAL STATEMENTS** which includes your income statement and balance sheet. Allowable financial statements include **AUDITED FINANCIAL STATEMENTS, REVIEW OR COMPILATION FINANCIAL STATEMENTS,** or **TAX RETURN** for the **MOST RECENT AUDITED FISCAL YEAR AVAILABLE**.

Indicate the Starting and Ending Dates of your **MOST RECENT AUDITED FISCAL YEAR** (mm/dd/yyyy)

**Starting Date:**  **Ending Date:**

Use the drop-down arrow to select the source of your financial information:

**Source of Reported Financial Data:**



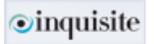


**A. CAPITAL EXPENDITURES**

i. Report the **TOTAL** of **ALL** Capital Expenditures for **YOUR MOST RECENT AUDITED FISCAL YEAR**:

ii. Provide the following information for **ONLY** projects/capital expenditures **IN EXCESS OF \$336,330** obligated by or on behalf of the health care facility for **YOUR REPORTED FISCAL YEAR** ([Help](#)):

	Description of Project/ Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if HFSRB reviewed)
1.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
2.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
3.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
4.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
5.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
6.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
7.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
8.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
9.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>
10.	<input type="text"/>	<input type="text" value="0"/>	<input type="text"/>	<input type="text"/>



**B. LONG-TERM DEBT**

Provide the amount of long-term debt indebtedness (including current maturities) incurred by or on behalf of the health care facility as reported in the facility's audited financial statements for your reported **MOST RECENT AUDITED FISCAL YEAR**. If the facility does not have its own financial statements, indicate the amount of debt that is allocated to the facility by the controlling entity.

LONG-TERM DEBT FOR REPORTED FISCAL YEAR (\$)

**C. PROVIDE THE NET REVENUES DURING YOUR REPORTED FISCAL YEAR BY PAYOR SOURCE**

	Medicare	Medicaid	Private Insurance	Private Payment	Other Public	Total Net Revenue
Net Revenue (\$)	<input type="text" value="0"/>	0				

**"Private Payment"** includes money from a private account (for example, a medical savings account) and any government funding made out and paid to the resident which is then transferred to the facility to pay for services. It also includes all Self pay payments.

**"Other Public"** includes all forms of direct public payment excluding Medicare and Medicaid. DHS and veterans' administration funds and other funds paid directly to a facility should be recorded here.

**D. ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE PATIENTS DURING YOUR REPORTED FISCAL YEAR**

Actual Cost of Services Provided to Charity Care Patients (\$)  Dollar Value

Actual cost of services provided to charity care patients. Include the dollar amount spent by the facility to care for the charity care inpatients and outpatients. As per AICPA guidelines, determination of charity care can be made at any time during the entire process, although it is preferred to be done when the patients presents himself for care.

**"Charity Care"** is defined as care for which the provider does not expect to receive payment from the patient or a third party payor. Charity care eligibility is based on financial need. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other Federal, State, or local indigent health care programs . In reporting charity care, the reporting entity must report the actual **cost** of services provided and not the actual **charges** for the services.



**Please provide the following information for the individual responsible for the preparation of this questionnaire:**

Contact Person Name	<input type="text"/>
Contact Person Job Title	<input type="text"/>
Contact Person Email Address	<input type="text"/>

**Enter the Name and Job Title of the Administrator of this facility, and the date, in the spaces provided:**

Administrator's Name	<input type="text"/>
Administrator's Title	<input type="text"/>
Date of Submission (MM/DD/YYYY)	<input type="text"/>

**THANK YOU FOR COMPLETING THE ON-LINE ESRD QUESTIONNAIRE.**  
**If you have any comments on the survey, please enter them in the space below.**



**CERTIFICATION OF SURVEY DATA**

**Pursuant to the Illinois Health Facilities Planning Act [20 ILCS 3960/13], the State Board requires "all the health facilities operating in the state to provide such reasonable reports at such times and containing such information as is needed" by the Board to carry out the purposes and provisions of this Act. By completing this section, the named individual is certifying that he/she has read the foregoing document, that he/she is authorized to make this certification on behalf of this facility, and that the information contained in this report is accurate, truthful and complete to the best of his/her knowledge and belief. Please note that the State Board will be relying on the information contained in this document as being truthful and accurate information. Any misrepresentation will be considered material.**

I certify that the information in this report is accurate, truthful and complete to the best of my knowledge.

<b>Person Certifying</b>	<input type="text"/>
<b>Job Title</b>	<input type="text"/>
<b>Certification Date</b> (mm/dd/yyyy)	<input type="text"/>

Click on the 'Next' button to proceed to the Finalization page. You will be instructed in the final steps in submitting your survey data.



**Thank You for Completing the Annual End Stage Renal Dialysis (ESRD) Facility Survey.**

**We Strongly Recommend You Print Out Each Page of This Form with Your Answers for Future Reference.**

**Once You Have Submitted This Form, No Further Access or Changes Are Allowed.  
Be Sure to Verify Your Answers Before Clicking on the 'SUBMIT FORM' Button.**

*When you have reviewed and printed your responses, click the 'SUBMIT FORM' button to submit your completed questionnaire.  
You will be routed to a Confirmation Message on the Internet.  
You will also be able to get a dated receipt for your records.*

**If you have any problems or questions, contact this office  
by phone at 217-782-3516 or by email to [dph.facilitysurvey@illinois.gov](mailto:dph.facilitysurvey@illinois.gov)**

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SUBMIT FORM

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## ESRD DEFINITIONS

TERM	DEFINITION	PAGE/COMMENTS
END STAGE RENAL DISEASE	The stage of renal impairment that appears irreversible and permanent and that requires a regular course of dialysis or kidney transplantation to maintain life.	According to Adm Rule 210 ILCS 62
END STAGE RENAL DIALYSIS FACILITY (ESRD FACILITY)	A freestanding facility or a unit within an existing health care facility that furnishes In-Center Chronic Hemodialysis treatment and other routine dialysis services to end stage renal disease patients. Such types of services may include: self-dialysis, training in self-dialysis, dialysis performed by trained professional staff, and chronic maintenance dialysis, including peritoneal dialysis. <b>For our purposes of this survey, we are only interested in the in-center chronic hemodialysis treatment regimen, patients etc.</b>	Adm Rule <u>[210 ILCS 62]</u>
DIALYSIS	Process in which dissolved substances are removed from a person's body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis which are recognized in classical practice are hemodialysis and peritoneal dialysis. For this survey, we capture data that is related only to in-center chronic hemodialysis.	General <u>210 ILCS 62/5</u>
ACUTE DIALYSIS	Dialysis given on an in-patient basis to patients suffering from (presumably reversible) acute renal failure, or to patients with chronic renal failure with serious complications. <b>This is not covered within this questionnaire.</b>	General
CHRONIC RENAL DIALYSIS	Dialysis performed on a regular long-term basis to patients with chronic irreversible renal failure. <b>Maintenance or preparation of a patient for kidney transplantation or post-operative period in case of organ rejection does not constitute chronic renal dialysis.</b>	General
HEMODIALYSIS	Type of dialysis that involves use of an artificial kidney through which blood is circulated on one side of the semi permeable membrane. The accumulated toxic products diffuse out of the blood into the dialysate bath solution	General
RENAL DIALYSIS FACILITY	Free standing facility or unit within an existing health care facility that furnishes routine chronic dialysis service(s) to chronic renal dialysis patients. Services include Self-care dialysis, training in-self dialysis, dialysis performed by trained professional staff and chronic maintenance dialysis which may include peritoneal dialysis.	General
IN-CENTER HEMODIALYSIS	A category of service that is provided in an end stage renal disease facility licensed by the State of Illinois and/or certified by the Centers for Medicare and Medicaid Services.	Adm Rule <u>[210 ILCS 62]</u>

IN-CENTER HEMODIALYSIS TREATMENT	A regimen of hemodialysis received by a patient usually three times a week, lasting three to five hours.	General Page 3
STATION	A medically appropriate bed or unit capable of performing dialysis in a given center at any particular time	General
UNDUPLICATED PATIENTS	Count the number of patients treated in the facility in the reporting period only once. For example if a person gets treatment (dialysis) done more than 4 times in a month, that will be counted as one person and not four.	General
AUTHORIZED ESRD STATIONS	Number of ESRD Stations recognized (approved) and licensed for operation by Illinois Department of Public Health (IDPH). These two fields will be pre-populated by the agency (as of Dec 31, 2005 and Dec 31 2006)	Page 2 (these fields will be pre-populated)
CERTIFIED CMS STATIONS	Number of ESRD Stations recognized (approved) and licensed for reimbursement of services by Center for Medicare and Medicaid Services (CMS). Ideally this number should be equal to IDPH CON (Certificate of Need) Authorized Stations but <b>not greater</b> than IDPH CON Stations if not less. Please fill these two fields (as of Dec 31, 2005 and Dec 31 2006)	Page 2
AUTHORIZED PEAK STATIONS	Indicate the highest number of authorized (CON) stations operated in any day for that given reporting survey year. This number cannot exceed the Authorized stations.	Page 3
SET UP & STAFFED OPERATING STATIONS (Oct 1- Oct 7)	For the given week (Oct 1- Oct 7), indicate the number of authorized stations in-operation that were set up & staffed and utilized for in-center hemodialysis. This number cannot exceed the CON stations. <b>It is the highest number of stations operated for that given week not a sum of stations for that entire week, but the highest number for that given week.</b>	Page 3
ISOLATION STATIONS	Enter the number of licensed authorized stations that are certified by CMS and approved by IDPH but used only as "Isolation stations" i.e., used for certain patients with unusual conditions and are always kept separate, in spite of surge circumstances.	Page 3
AVERAGE TIME SPENT PER TREATMENT	It is the time spent per person per station for in center chronic hemodialysis procedure. Also <b>include the time that involves clean up and set up of the station but not the time required for the preparation of the patient.</b> On average it is 3-4 hrs/treatment.	Page 3
MISSED TREATMENTS/ NO SHOWS	A station allocated for a patient is unfilled and/or unused because of late arrival or the person did not show up for his/her dialysis appointment is defined as "no show" or missed treatment.	Page 3
IN-CENTER NOCTURNAL DIALYSIS	Is defined as hemodialysis that takes place within the center while the patient is sleeping for approximately 8 hours.	Page 3



RESTARTED IN-CENTER HAEMODIALYSIS (Additions)	This is the count of patients who had temporarily recovered kidney function and had discontinued dialysis or had been lost to follow –up but restarted routine in-center dialysis during the survey period.	Page 4 (3d iii)
KIDNEY TRANSPLANTATION	Is a category of service that involves the surgical replacement of a nonfunctioning human kidney with a donor kidney in order to restore renal function to the patient.	General
RETURNED AFTER TRANSPLANTATION (Additions to the facility)	Do not include dialysis patients who are post transplant and are waiting for their graft to function. Enter the number of patients who are returned to in-center dialysis during the survey period after transplant failure.	Page 4 (3d iv)
RECOVERED KIDNEY FUNCTION (Losses to the facility)	Patients who have recovered function of their native kidneys and ceased in center haemodialysis during the survey period.	Page 4 (3e i)
TRANSPLANT RECIPIENT (Losses to the facility)	Enter the number of patients who received kidney transplant during the survey period. Do not include patients who returned to in center hemodialysis during survey period after a transplant failure.	Page 4 (3e ii)
PATIENTS TRANSFERRED OUT (Losses to the facility)	List the number of in center haemodialysis patients who permanently ( <b>left the facility for more than 30 days</b> ) transferred to another dialysis facility for their ongoing dialysis during the survey period. Their responsibility is longer this borne by this facility.	Page 4 (3e iii)
DISCONTINUED DIALYSIS (Losses to the facility)	Enter the patients who have <b>voluntarily</b> discontinued dialysis where the underlying reason is not death or transplant or transfer to another facility.	Page 4 (3e iv)
LOST TO FOLLOW-UP (Losses to the facility)	List the patients who have been dialyzing in-center but left dialysis during the survey period, and whose current status is unknown. Do not include patients who are voluntarily discontinued in-center haemodialysis.	Page 4 (3e v)
DEATHS (Losses to the facility)	Enter the number of in-center hemodialysis patients who died during survey period. These patients must have been on in-center hemodialysis regimen at the time of death.	Page 4 (3e vi)
LEGAL ENTITY THAT OWNS THE BUILDING/STRUCTURE	Indicate the property owner name and address information that is responsible for the physical structure of the ESRD facility. It could be same person who owns the ESRD facility or could have been different if the physical plant is located in a rented building.	Page 5
FULL TIME EQUIVALENT (FTE)	A Full Time Equivalent is defined as a position with at least 32 hours employment per week.	Page 7
MEDICAL DIRECTOR	Medical direction of the facility shall be vested in a physician who has completed a board-approved training program in nephrology and has at least 12 months experience providing care to patients receiving dialysis.	Page 2

REGISTERED NURSE (RN)	The nurse responsible for nursing services in the unit shall be a registered nurse (RN) who meets the practice requirements of the State of Illinois and has at least 12 months experience in providing nursing care to patients on maintenance dialysis.	Page 7
DIALYSIS TECHNICIAN	Individual who is not a registered nurse or physician and who provides dialysis care under the supervision of a registered nurse or physician. [210 ILCS 62/5]. This individual shall meet all applicable State of Illinois requirements	Page 7 <u>210 ILCS 62/5</u>
DIETICIAN	This individual shall be a registered dietitian with the Commission on Dietetic Registration, meet the practice requirements of the State of Illinois and have a minimum of one year of professional work experience in clinical nutrition as a registered dietitian	Page 7
SOCIAL WORKER	The Staff with LCSW, MSW, BSW or other professional social work degrees.	Page 7
CHARITY CARE	" <b>Charity Care</b> " is defined as care for which the provider does not expect to receive payment from the patient or a third party payor. Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other Federal, State, or local indigent health care programs, eligibility for which is based on financial need. In reporting charity care, the reporting entity must report the actual cost of services provided, based on the total cost to charge ratio derived from the hospital's Medicare cost report (CMS 2552-96 Worksheet C, Part 1 PPS Inpatient Ratios), and not the actual charges for the services	CMS 2552-96 Worksheet C, Part 1 PPS  Page 9
PATIENTS SERVED BY PAYMENT SOURCE	Include number of in center chronic haemodialysis patients served by their payment type. This number should equal the number of patients treated by Race-Ethnic and Age/Gender specific totals, which in turn should equal the total number of unduplicated patients treated within the facility for that survey period (Page 4, 3c)	Page 9  Payment sources are defined within the questionnaire.
ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE PATIENTS	Include the dollar amount spent by the facility to care for the charity care inpatients and outpatients. <b>Medicare Cost to Charge Ratio</b> dollar value should be used while figuring this amount.	Actual cost of service to be reported.  Page 12
REVENUE BY PAYMENT SOURCE	Include the amount of <b>net revenue</b> collected by the facility during the fiscal year 2006 for the inpatients and outpatients served by the payment type	Revenue to be listed  Page 12

## **FINANCIAL DEFINITIONS**

1. **ON BEHALF OF HEALTH CARE FACILITY:** Any transactions undertaken by the facility or by any other entity other than the facility which results in constitution or modification of the facility and directly or indirectly results in the facility billing or receiving reimbursement, or in participating or assuming responsibility for the retirement of debt or the provision of any services associated with the transaction.
2. **CAPITAL EXPENDITURE:** Any expenditure : (A) made by or on behalf of a health care facility .....and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part... and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made... and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value. For purposes of this report, expenditures which have a cost below \$231,750 may be aggregated.
3. **CONSTRUCTION OR MODIFICATION:** The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment of service for diagnostic or therapeutic purpose or for facility administration or operation, or any capital expenditures made by or on behalf of a health care facility.
4. **METHOD OF FINANCING:** The source of funds required to undertake the project or capital expenditure. Forms of financing include equity (cash and securities), lease, mortgages, general obligation bonds, revenue bonds, appropriations and gifts/donations/bequests.
5. **OBLIGATED AMOUNT:** The amount that an entity is required either by law or contract to meet from their resources. OR The commitment of funds directly or indirectly through the execution of construction or other contracts, purchase order, lease agreements of other means for any construction or modification project. NOTE: Funds obligated in a given year should not be carried forward to subsequent years due to phased or periodic payouts. For example, a facility signs a \$10 million contract in 1998 for construction of a new bed tower. Construction takes approximately three years with payments being made to the contractor during 1998, 1999 and 2000. The entire \$10 million would be listed once as an obligation for 1998 and would not be listed in subsequent years.
6. **PROJECT:** Any proposed construction or modification of a health care facility or any proposed acquisition of equipment undertaken by or on behalf of a health care facility regardless of whether or not the transaction required a certificate of need. Components of construction or modification, which are interdependent, must be grouped together for reporting purposes. Interdependence occurs when components of construction or modification are architecturally and/or programmatically interrelated to the extent that undertaking one of more of the components compels the other components to be undertaken. If components of construction or modification are undertaken by means of a

- single construction contract, those components must be grouped together. Projects involving acquisition of equipment, which are linked with construction for the provision of a service cannot be segmented. When a project or any component of a project is to be accomplished by lease, donation, gift or any other means, the fair market value or dollar value, which would have been required for purchase, construction or acquisition, is considered a capital expenditure.
7. GROSS REVENUE: Gross charges for the provision of health care services excluding charity care (Source: AICPA). Amounts initially charged to the patient before deductions for contractual discounts, bad debts, and charity care. These are the amounts initially shown on the patient's bill.
  8. NET REVENUE: Gross revenue less provision for contractual adjustments from third party payors (Source: AICPA). Amounts expected to be received from patients and third-party sources after deductions for contractual discounts and charity care, bad debts, and other administrative write-offs.
  9. CURRENT RATIO:  $\text{Current Assets} / \text{Current Liabilities}$ .
  10. NET MARGIN PERCENTAGE:  $\text{Net Income} / \text{Net Operating Revenue}$
  11. PERCENT DEBT TO TOTAL CAPITALIZATION:  $\text{Long Term Debt} / \text{Long term debt and unrestricted Fund Balance} \times 100$
  12. PROJECTED DEBT SERVICE COVERAGE:  $\text{Net Income} + \text{Depreciation} + \text{Interest} + \text{Amortization} / \text{Principle} + \text{Interest}$
  13. DAYS CASH ON HAND:  $\text{Cash and Investments} + \text{Board Designated Funds} / \text{Operating Expenses} + \text{Depreciation Expense} / 365$
  14. CUSHION RATIO:  $\text{Cash and Investments} + \text{Board Designated Funds} / \text{Maximum Annual Debt Service}$ .
  15. DEBT PER BED:  $\text{Long Term Debt} / \text{Number of Beds}$ .
  16. CHARITY CARE:  $\text{Charity Care} / \text{Gross Revenue}$ .
  17. AVERAGE AGE OF PLANT:  $\text{Accumulated Depreciation} / \text{Depreciation Expense}$ .
  18. CAPITAL EXPENSE AS PERCENT OF TOTAL EXPENSE:  $\text{Depreciation} + \text{Interest} + \text{Amortization} / \text{Total Expense}$ .
  19. CAPITAL COST:  $\text{Depreciation} + \text{Interest} + \text{Amortization}$ .