Long-Term Care Facility Questionnaire for 2015

This is a formal request by IHFSRB for full, complete and accurate information as stated herein. This request is made under the authority of the Health Facilities Planning Act [20ILCS 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 State Agency within 30 days of a formal written request shall be fined an amount not to exceed $1,000 for each 30-day period, or fraction thereof, that the information is not received by the State Board or State Agency." [20 ILCS 3960/14.1(b)(6)]

This questionnaire is divided into the following sections:

Section I

Information on your facility and facility utilization

This Section Must be Reported for Calendar Year 2015

Section II

Financial and Capital Expenditures data for your facility

This Section Must be Reported for the Most Recent Fiscal Year Available to You

Section III

Immunization for Influenza and Pneumonia

This questionnaire must be completed and submitted by April 1, 2016.

There will be no exceptions or extensions.

Facilities failing to submit this questionnaire within the required time frame will be reported to the Illinois Health Facilities and Services Review Board for its consideration of the imposition of sanctions mandated by the Act.

Please contact this office with any questions or concerns related to this survey. You may contact us by e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Long-Term Care Facility Questionnaire for 2015

INSTRUCTIONS FOR COMPLETING QUESTIONNAIRE

NOTE:
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.

Navigating and Saving:
There are 3 buttons at the bottom of each survey page except the last one.
'Next' takes you to the next page of the survey
'Back' returns you to the previous survey page.
'Save' saves work in progress if you need to stop before finishing.

YOU DO NOT NEED TO SAVE AFTER EACH PAGE.
ONLY SAVE IF YOU NEED TO STOP BEFORE COMPLETING THE SURVEY.

IMPORTANT:
When 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 our web browser.
YOU MUST DO THIS; YOU CANNOT ACCESS YOUR SAVED FORM WITHOUT IT.
The link provided in your e-mail WILL NOT access the saved form, only a blank survey. 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.

Saving the form also allows you to send the link created to another person, if needed. Since the link is to a file saved on our survey system, all the other person needs is the link to access the saved form.

The Submit form button on the last page transmits your survey responses to our database.
Once the survey has been submitted, no further access or changes are allowed.
If you find that you have submitted the form with incomplete or incorrect information, contact this office immediately.

Thank you for your cooperation.
Please contact this office by telephone at 217/782-3516
or by Email to DPH.FacilitySurvey@illinois.gov with any questions.

Long-Term Care Facility Questionnaire for 2015

This survey has been customized for your facility based on information in the IDPH databases.
Please verify the information on this page, making corrections and supplying missing information.

Facility Information

Facility Name

Facility Address

Facility City **Facility Zip Code**

, IL

Federal Employer Identification Number (FEIN)

Licensed Beds - 12/31/2015 <Definitions>

Licensed Beds shown here for information. Do not change.

Long-Term Care Facility Questionnaire for 2015

Section I - Facility and Utilization Data

Please read the instructions for each question for clarification to understand the nature of the information requested. All numeric fields are pre-filled with zeroes. Do not delete zeroes and leave fields blank. There are a number of values in green. These are calculated from your entered data. Validation rules are included to assist you in entering accurate and consistent data throughout the questionnaire. If entered values do not conform to the validation rules, please check and verify your entries.
SOME QUESTIONS ARE NOT REQUIRED OF ALL FACILITIES.

Question 2 - Indicate conditions that prevent admission to your facility. Check all that apply. At least one box must be checked. Please note that if None (No Restrictions) is checked, no other boxes should be checked. <Definitions>

- ☐ **Aggressive/Anti-Social**
- ☐ **Chronic Alcoholism**
- ☐ **Developmentally Disabled**
- ☐ **Drug Addiction**
- ☐ **Medicaid Recipient**
- ☐ **Medicare Recipient**
- ☐ **Mental Illness**
- ☐ **Non-Ambulatory**
- ☐ **Non-Mobile**
- ☐ **Other Government Recipient***
- ☐ **Under 65 Years of Age**
- ☐ **Unable to Self-Medicate**
- ☐ **Ventilator Dependency**
- ☐ **Infectious Disease Requiring Isolation**
- ☐ **Other Restrictions**
- ☐ **None (No Restrictions)**

* **'Other Government Recipient'** includes individuals whose primary source of payment is Veterans Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, or other government-sponsored programs.

If your facility ownership requires a Registered Agent with the Illinois Secretary of State, indicate the name, address and telephone number of this person or company (must be an Illinois resident or company).

Name of Registered Agent:	
Address of Registered Agent	
City. State and Zip Code (plus Four):	
Telephone Number:	

Long-Term Care Facility Questionnaire for 2015

Section I

Question 3 - Please report the number of Full-Time Equivalent Employees (FTEs), paid directly by your facility. DO NOT report the number of hours worked. Use the first pay period in December 2015 to account for your employees.

Due to the broad range of services provided in LTC facilities, we are leaving the definition of 'Other Healthcare Personnel' broad enough to include all categories of healthcare staff not covered in the six listed major categories of personnel.

The TOTAL STAFF line in green is automatically generated.

EMPLOYMENT CATEGORIES	FULL TIME EQUIVALENTS (FTEs)
Administrators	0
Physicians	0
Director of Nursing	0
Registered Nurses	0
LPNs	0
Certified Aides	0
Other Health Personnel	0
Other Non-Health Personnel	0
Total Staff	**0**

Please indicate the number of hours in the work week for a full-time employee: 0

Long-Term Care Facility Questionnaire for 2015

Section I

Question 4 - Resident Information for December 31, 2015 unless otherwise noted

All items in green are automatically calculated.

Beds	ICF/DD
1.Licensed Beds - 12/31/2015	16
2.Peak Beds Set Up - 2015*	0
3.Peak Beds Occupied - 2015*	0
4.Beds Set Up for Use - 12/31/2015	0
5.Beds Occupied - 12/31/2015	0

*** PEAK BEDS SET UP is the highest number of beds setup and staffed for use at any time during the year.**
PEAK BEDS OCCUPIED is the highest number of beds in use at any time during the year.
AVAILABLE BEDS will be calculated as "Licensed Beds less Beds Occupied on December 31, 2015." [20 ILCS 3960/13]

Males	
6. Under 18	0
7. 18 - 44	0
8. 45 - 59	0
9. 60 - 64	0
10. 65 - 74	0
11. 75 - 84	0
12. 85 & Over	0
13. Total Males	**0**

Females	
14. Under 18	0
15. 18 - 44	0
16. 45 - 59	0
17. 60 - 64	0
18. 65 - 74	0
19. 75 - 84	0
20. 85 & Over	0
21. Total Females	**0**
22. Total Residents	**0**

Patient Days for 2015 **Patient day values are based on daily resident counts for CALENDAR YEAR 2015.**

23. Medicare Patient Days	n/a
24. Medicaid Patient Days	0
25. Other Public Pay Patient Days	0
26. Private Insurance Patient Days	0
27. Private Pay Patient Days	0
28. Charity Care* Patient Days	0
29. Total All Patient Days	**0**

Room Rates	
30. Private Room Rate	0
31. Shared Room Rate	0

Racial Group **Each resident in your facility on the last day of the year should be accounted for and counted only once.**

32.Asian	0
33.Amer. Indian/Nat. Alaskan	0

34.Black/African American	0
35.Hawaiian/Pacific Islander	0
36.White	0
37.Race Unknown	0
38.Total All Races	**0**

Ethnicity **Each resident in your facility on the last day of the year should be accounted for and counted only once.**

39.Hispanic or Latino	0
40.Not Hispanic or Latino	0
41.Ethnicity Unknown	0
42.Total All Ethnicity	**0**

Primary Payment Source*

43.Medicare	n/a
44.Medicaid	0
45.Other Public	0
46.Private Insurance	0
47.Private Pay	0
48.Charity Care	0
49.Total Residents	**0**

***Any resident whose primary source of payment comes from MMAI program should be included in 'MEDICARE'.**
Any resident whose primary source of payment comes from Managed Care Public Aid should be included in 'MEDICAID'.
'OTHER PUBLIC' includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
'PRIVATE PAY' includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.
'INSURANCE' refers to payment made through private insurance policies.
***"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3]* 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.**

Long-Term Care Facility Questionnaire for 2015

Section I

Question 5 - Admissions and Discharges during the Calendar Year 2015.

Short-Term discharges to the hospital for Acute or Sub-Acute Care or releases to visit friends and relatives by residents who are expected to return to the facility are not to be counted as discharges or re-admissions. Count only those residents initially admitted and those permanently discharged from your facility. A resident who has been permanently discharged and later re-enters the facility may be counted as a new admission.

Fields in green are automatically calculated.

A. Residents on the January 1, 2015. 0

Indicate the number of residents in your facility at the BEGINNING of the day on January 1, 2015 on Line A. The resident count should be the same as the resident count your facility reported to the Department for December 31, 2014, on last year's LTC questionnaire.

B. Total Admissions DURING Calendar Year 2015. 0

Indicate the total number of residents your facility admitted during 2015.

C. Total Discharges DURING Calendar Year 2015. 0

Indicate the total number of residents your facility discharged during 2015. Remember, this value is final discharges only, not administrative discharges of any type.

D. Residents on the December 31, 2015. **0**

The residents in line D must equal the Beds Occupied on line 5 of Page 6.

Reported Beds Occupied - December 31, 2015 (from line 5 on page 6) **0**

Long-Term Care Facility Questionnaire for 2015
Section I

This Question on Resident Diagnoses is not required for ICF DD and SNF 22 facilities.

Question 6 - Primary Diagnosis of Residents on DECEMBER 31, 2015.

Reported Beds Occupied - December 31, 2015 **0**

Question 7 - Residents on December 31, 2015, whose Diagnosis included Mental Illness.

Report the number of residents in your facility on December 31, 2015, whose diagnosis included Mental Illness (ICD-9 CODE 293-297.300). Include any residents reported with Primary Diagnosis of Mental Illness in Question 7, and any other residents with a diagnosis of Mental Illness in addition to their Primary Diagnosis.

Residents with Diagnosis of Mental Illness 0

Question 8 - Residents on December 31, 2015, who were Identified Offenders*

Report the number of residents in your facility on December 31, 2015, who were categorized as 'Identified Offenders*.

Residents who were Identified Offenders* 0

*** Any resident so identified through a criminal history background check as required by the Nursing Home Care Act (210 ILCS 45/2-201.5) paragraphs b and c.**

Click 'Next' to proceed to Section II - Financial and Capital Expenditures Data

Long-Term Care Facility Questionnaire for 2015

Section II - Financial & Capital Expenditures Data

The Data Requested by This Questionnaire are Authorized Pursuant to the Illinois Health Facilities Planning Act [20 ILCS 3960/5.3]

Financial and Capital Expenditures data for your facility must be reported for the Most Recent Fiscal Year Available to You. These Dollar Amounts are Found in Your Most Recent Annual Financial Statements Which Include Your Income Statement and Balance Sheet.

"Financial Statements" are Defined as Audited Financial Statements, Review or Compilation Financial Statements, or Tax Return for the Most Recent Fiscal Year Available to You.

If you have any problems providing the data requested, please contact this office by e-mail at DPH.FacilitySurvey@illinois.gov, or by telephone at 217-782-3516.

Indicate the Starting and Ending Dates of your Fiscal Year (mm/dd/yyyy)

Starting Date

Ending Date

Source Used for Financial Data

Long-Term Care Facility Questionnaire for 2015
Section II

A. CAPITAL EXPENDITURES

Report the TOTAL of ALL Capital Expenditures for your reported Fiscal Year:

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR 0

Provide the following information for any individual project / capital expenditure IN EXCESS OF $336,330 obligated by or on behalf of the health care facility for your reported Fiscal Year (click the link below the table for definitions of terms). If you need to report additional expenditures, please send a listing with the requested information to DPH.FacilitySurvey@illinois.gov:

	Description of Project / Capital Expenditure	Amount Obligated	Method of Financing	CON Project Number (if HFSRB reviewed)
1.		0		
2.		0		
3.		0		
4,		0		
5.		0		
6.		0		
7.		0		
8.		0		
9.		0		
10.		0		

<Definitions>

Long-Term Care Facility Questionnaire for 2015
Section II

B. NET REVENUES BY PAYMENT SOURCE FOR YOUR REPORTED FISCAL YEAR

If you reported patients for a given payment source on lines 43 through 48 on Page 6, you should have revenues to report here for that payment source. If this is not the case, please give a brief explanation in the comments box on Page 14.

	Fiscal Year Net Revenues	Reported Patients
Medicare	0	0
Medicaid	0	0
Other Public Pay*	0	0
Private Insurance*	0	0
Private Payment*	0	0
Total Net Revenues	0	

*** Any revenues from MMAI program should be included in 'MEDICARE'.**
Any revenues from Managed Care Public Aid should be included in 'MEDICAID'.
'OTHER PUBLIC PAY' includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.
'PRIVATE INSURANCE' refers to payment made through private insurance policies.
'PRIVATE PAYMENT' includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

C. ACTUAL COST OF CHARITY CARE SERVICES PROVIDED IN YOUR REPORTED FISCAL YEAR

"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3]
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.

	Amount
Actual Cost of Services Provided to Charity Care Residents in Reported Fiscal Year	0

Long-Term Care Facility Questionnaire for 2015

Section III - Influenza/Pneumonia Vaccinations

The Immunization Section of the Illinois Department of Public Health requests that you provide the following information regarding the immunization policies and immunization status of your staff and residents in regards to influenza and pneumococcal pneumonia. Thank you.

	Yes	No
Does your facility have a written policy for administering influenza vaccine to RESIDENTS?	○	○
Does your facility have a written policy for administering pneumococcal vaccine to RESIDENTS?	○	○
Does your facility have a written policy for vaccinating STAFF MEMBERS against influenza?	○	○
Does your facility have a written policy for vaccinating STAFF MEMBERS against pneumococcal pneumonia?	○	○
Does your facility have a written policy for use of amantadine and/or rimantadine during an influenza outbreak?	○	○

	Number Receiving Inluenza Vaccine	Number NOT Receiving Influenza Vaccine	Totals
Record the number of RESIDENTS who received influenza vaccine during the time period from October, 2015 through January, 2016.	0	0	0

	Number Receiving Pneumococal Vaccine	Number NOT Receiving Pneumococal Vaccine	
Record the number of CURRENT RESIDENTS who have received a pneumococcal vaccine in the years 2010 through 2015.	0	0	0

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Long-Term Care Facility Questionnaire for 2015

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

Contact Person Name	
Contact Person Job Title	
Contact Person Telephone	
Contact Person E-Mail Address	

Please provide the following information for the Facility Administrator/CEO of the facility:

Administrator's Name	
Administrator's Title	
Administrator Telephone	
Administrator E-Mail Address	

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

Long-Term Care Facility Questionnaire for 2015

CERTIFICATION OF SURVEY DATA

Pursuant to the Health Facilities Planning Act (20 ILCS 3960/13), the State Board requires "all 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 misrepresentations will be considered material.

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

Person Certifying

Job Title

Certification Date

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

Once You Have Submitted This Form by Clicking on 'SUBMIT FORM' Below, No Further Access or Changes are Possible, So Be Sure to Verify Your Answers.

When You Have Reviewed and Printed Your Responses, Click the 'SUBMIT FORM' Button to Send Your Completed Form to Our Server. You Will be Routed to a Confirmation Page.

If You Have Any Problems, Please Contact This Office Immediately By Phone at 217-782-3516 or By Email to DPH.FacilitySurvey@illinois.gov

Term	Definition	Comments
Admissions	Number of patients accepted for service during a 12 month period.	According to Administrative rule 1100.220
Charity 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 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, not the actual charges for the services.	Actual cost of service to be reported.
Continuing Care Retirement Community	"Continuing Care Retirement Community" provides a continuum of care for a geriatric population that includes independent living and/or congregate housing (such as unlicensed apartments, high rises for the elderly and retirement villages and related health and social services); licensed supportive living, sheltered care or assisted living; and a licensed nursing care facility.	

	The housing complex shall be on the same site as the health facility component of the project.	
Life Care Facility	“Life Care Facility” is an organization that has written authorization from IDPH to administer a place or places in which the provider undertakes to provide a resident with nursing services, medical services or personal care services, in addition to maintenance services for a term in excess of one year or for life, pursuant to a life care contract. The term also means a place or places in which a provider undertakes to provide such services to a non-resident.	
Patient Days	"Patient Days" means the total number of days of service provided to patients in a facility over a 12-month period. Patient days of care are counted as beds occupied at the time the daily census is counted.	According to Administrative Rule 1100.220
Peak bed set up and staffed	Maximum number of beds the facility considers appropriate to place in patient rooms taking into account patient care requirements and ability to perform the regular functions of patient care required for patients	According to Administrative rule 1100.220

Peak Beds Occupied	Indicate your facility's maximum number of patients in at any one time during the reporting calendar year.	Measures the facility's peak utilization.
Revenue by payment source a. Private Pay b. Other Public Source of Financial Data Used	Include the amount of **net revenue** of the facility during the fiscal year for patients served by the payment type. Private pay 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. DMH/DD and veterans' administration funds and other funds paid directly to a facility should be recorded here. Indicate the source from which the financial information has been taken. The sources include audited financial statements, review or compilation of financial statements or tax return for most recent fiscal year.	

Financial/Capital Expenditures 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.

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. **OBLIGATION**: 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 $2 million contract in 2011 for construction of a new bed wing. Construction takes approximately three years with payments being made to the contractor during 2011, 2012 and 2013. The entire $2 million would be listed once as an obligation for 2011 and would not be listed in subsequent years.

6. **PROJECT**: Any proposed construction of 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. **NET REVENUE**: Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).