

**THE 2008
ANNUAL LONG-TERM CARE FACILITY QUESTIONNAIRE**

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PREFACE TO THE 2008 ANNUAL LONG-TERM CARE FACILITY QUESTIONNAIRE

The Annual Long-Term Care Facility Questionnaire (LTCQ) is administered by the Division of Health Systems Development, Office of Policy, Planning and Statistics, of the Illinois Department of Public Health under the authority of the Illinois Health Facilities Planning Act (20 ILCS 3960/). This survey is conducted on an annual basis and its results are published in the form of the Annual Long-Term Care Facility Profiles and other reports, posted on the website: <http://www.idph.state.il.us/about/hfpb.htm>.

Overview and Time Frame

The questionnaire is administered electronically by email or regular mail to all long term care facilities in the state of Illinois licensed under the Nursing Home Licensing Act. For the data submitted electronically, for the submittal to be complete a signature page must be received, signed the Administrator of the facility attesting that, to the best of his or her knowledge, the "...data contained in the questionnaire are true and accurate."

Email contacts were tested prior to the original submittal of the survey. The questionnaire was sent by email or regular mail to all long term care facilities on March 13, 2009 as a formal request for information, with a due date of April 24, 2009 (6 weeks for completion). Facilities that did not return their questionnaires or signature pages by May 11, 2009 received a certified letter informing them that they had been put on our non-compliance list and that referrals would be made to the Health Facilities Planning Board for the issuance of fine, for those facilities who did not submit their complete questionnaires by June 11, 2009. There were no facilities from whom either the survey or the signature page was not received within this time frame to be later issued Notices of Intent to Fine, as authorized under the Act.

Differences from Previous LTCQs to 2008 LTCQs

This year's survey collects occupancy for patient days in an expanded format. In past surveys patient days were collected for Medicare, Medicaid and Other patient days. For 2008 the breakout for patient days is Medicare, Medicaid, Other Public Pay, Private Insurance, Private Pay and Charity Care patient days.

Validation and Compilation of Data

Once submitted, the questionnaires are checked for data irregularities in regards to low occupancy rates, room rates, staffing and matching of patients on the last day of the year. Facilities with irregularity in room rates, staffing and matching numbers for patients automatically received calls from staff. Low occupancy rates (anything less than 65 percent) are checked against the previous year profile to see if it is a trend. If not, the facility is then called by staff to verify the total patient days for the calendar year.

Summary reports are run to make sure data matches in the appropriate places and averages for any data are in acceptable ranges. If not, suspect data is identified and either verified or corrected by the appropriate facility.

Data for patient days is for the entire calendar year. Staffing numbers are for all full time equivalent employee positions for the first pay period of December. All patient demographic information is for residents in the facility on December 31, 2008

Financial Data In the LTCQ (Fiscal Year)

Detailed financial information for each LTC is available on their individual profiles. The profiles indicate “Net Revenue by Payor Source” (Medicaid, Medicare, Private Pay, Other Public and Private Insurance). Charity Care expense is also listed for their population.

Questions may be addressed to:

Data Section
Division of Health Systems Development
525 W. Jefferson St., 2nd Floor
Springfield, IL 62761
Or email: IHFPB_data@idph.state.il.us

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008

This is a formal request by IDPH 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 the 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 3 parts:

Part I
Information on your facility and facility utilization
THIS PART MUST BE REPORTED FOR CALENDAR YEAR 2008

Part II
Financial and Capital Expenditures data for your facility
THIS PART MUST BE REPORTED FOR THE MOST RECENT FISCAL YEAR AVAILABLE TO YOU

Part III
Immunization for Influenza and Pneumonia

Signature Certification Page

The Long Term Care Questionnaire must be completed and submitted by April 24, 2009.

Facilities failing to submit this questionnaire within the required time frame will be reported to the Illinois Health Facilities Planning 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.

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008

Welcome to the IDPH Electronic Long Term Care Facility Questionnaire.
INSTRUCTIONS FOR COMPLETING THIS SURVEY

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.

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

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 the database on our system. **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.**

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008

This survey has been customized for your facility based on information in the IDPH databases. **Please verify the information on this page. If the facility shown IS NOT CORRECT, do NOT correct the values shown.** Please contact the Health Facilities Planning Board as soon as possible to obtain the correct survey.

Facility Information

Facility Name [\[Help\]](#)

Facility Address

Facility City , IL Facility Zip Code
Licensed
Beds [\[Help\]](#)
Lic. Beds shown here for information. Do not change.

Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008
Part I - Facility and Utilization Data

Please read the instructions for each question for clarification to understand the nature of the necessary response. All numeric fields are pre-filled with zeroes. As appropriate, complete all questions with required data. Validation rules are included to assist you in entering accurate and consistent data throughout the Questionnaire. All row and columns asking for entry of a total value are compared to the sum of the row and/or column. If entered values do not conform to the validation rules, please verify and enter the correct values.

Question 1a - 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. [\[Help\]](#)

- | | |
|---|---|
| <input type="checkbox"/> Aggressive/Anti-Social | <input type="checkbox"/> Non-Mobile |
| <input type="checkbox"/> Chronic Alcoholism | <input type="checkbox"/> Other Government Recipient* |
| <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> Under 65 Years of Age |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Unable to Self-Medicare |
| <input type="checkbox"/> Medicaid Recipient | <input type="checkbox"/> Ventilator Dependency |
| <input type="checkbox"/> Medicare Recipient | <input type="checkbox"/> Infectious Disease Requiring Isolation |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Other Restrictions |
| <input type="checkbox"/> Non-Ambulatory | <input type="checkbox"/> 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.

Question 1b - 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:

Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008
Part I - Facility and Utilization Data

Question II - 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 2008 to account for your employees.

Due to the broad range of services provided in LTC facilities, IDPH is 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.

EMPLOYMENT CATEGORIES	FULL TIME EQUIVALENTS (FTEs)
Administrators	<input type="text" value="0"/>
Physicians	<input type="text" value="0"/>
Director of Nursing	<input type="text" value="0"/>
Registered Nurses	<input type="text" value="0"/>
LPNs	<input type="text" value="0"/>
Certified Aides	<input type="text" value="0"/>
Other Health Personnel	<input type="text" value="0"/>
Other Non-Health Personnel	<input type="text" value="0"/>
Totals	<input type="text" value="0"/>

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

**Illinois Department of Public Health (IDPH)
 Long-Term Care Facility Questionnaire for 2008
 Part I - Facility and Utilization Data**

**Question III - Resident and patient day information - Multiple License
 Information for December 31, 2008**

Beds	1. Nursing Care	2. Sheltered	3. Total	
1. Licensed Beds - 12/31/2008	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
2. Peak Beds Set Up*	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
3. Peak Beds Occupied*	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
4. Beds Set Up - 12/31/2008	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
5. Beds Occupied - 12/31/2008	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	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, 2008" [20 ILCS 3960/13]

Males

6. Under 18	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
7. 18 - 44	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
8. 45 - 59	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
9. 60 - 64	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
10. 65 - 74	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
11. 75 - 84	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
12. 85 & Over	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
13. Total Males	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	

Females

14. Under 18	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
15. 18 - 44	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
16. 45 - 59	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
17. 60 - 64	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
18. 65 - 74	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
19. 75 - 84	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
20. 85 & Over	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
21. Total Females	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	
22. Total Residents	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	

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	1. Nursing Care	2. Sheltered	3. Total
Patient Days			
<i>Patient day values should be based on resident count for CALENDAR YEAR 2008.</i>			
23. Medicare Patient Days	<input type="text" value="0"/>	n/a	<input type="text" value="0"/>
24. Medicaid Patient Days	<input type="text" value="0"/>	n/a	<input type="text" value="0"/>
25. Other Public Pay Patient Days	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
26. Private Insurance Patient Days	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
27. Private Pay Patient Days	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
28. Charity Care* Patient Days	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
29. Total All Patient Days	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Room Rates			
30. Private Room Rate	<input type="text" value="0"/>	<input type="text" value="0"/>	n/a
31. Shared Room Rate	<input type="text" value="0"/>	<input type="text" value="0"/>	n/a
Racial Group			
<i>Each resident in your facility on the last day of the year should be accounted for and counted only once.</i>			
32. Asian	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
33. Amer. Indian/Nat. Alaskan	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
34. Black/African American	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
35. Hawaiian/Pacific Islander	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
36. White	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
37. Race Unknown	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
38. Total All Races	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Ethnicity			
<i>Each resident in your facility on the last day of the year should be accounted for and counted only once.</i>			
39. Hispanic or Latino	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
40. Not Hispanic or Latino	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
41. Ethnicity Unknown	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
42. Total All Ethnicity	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

Primary Payment Source*	1. Nursing Care	2. Sheltered	3. Total
43. Medicare	<input type="text" value="0"/>	n/a	<input type="text" value="0"/>
44. Medicaid	<input type="text" value="0"/>	n/a	<input type="text" value="0"/>
45. Other Public	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
46. Private Insurance	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
47. Private Pay	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
48. Charity Care	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
49. Total Residents	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

"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.

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Illinois Department of Public Health (IDPH) Long-Term Care Facility Questionnaire for 2008 Part I - Facility and Utilization Data

Question IV - Admissions and discharges during the Calendar Year 2008.

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.

A. Residents on the FIRST DAY of the 2008.

Indicate the number of residents in your facility at the BEGINNING of the day on January 1st 2008 on Line A. The resident count should be the same as the resident count your facility reported to the Department on December 31st 2007.

B. Total Admissions DURING Calendar Year 2008.

Indicate the total number of residents your facility admitted during 2008 on Line B.

C. Total Discharges DURING Calendar Year 2008.

Indicate the total number of residents your facility discharged during 2008 on Line C. Remember, this value is final discharges only, not administrative discharges of any type.

D. Residents on the LAST DAY of 2008.

Indicate the total number of residents your facility had on December 31st 2008. The sum of Lines A + B, minus Line C must equal Line D. The total number of residents recorded on Line D MUST NOT EXCEED the total number of licensed beds your facility has reported on Line 1 of QUESTION III. The total residents reported on line D must equal the total residents reported in Question IV and Question III, Lines 20a, 33, 37 and 44.

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**Illinois Department of Public Health (IDPH)
 Long-Term Care Facility Questionnaire for 2008
 Part I - Facility and Utilization Data**

Question V - Primary diagnosis of residents on the DECEMBER 31, 2008.

Report the number of residents in your facility at the END OF THE LAST DAY OF 2008 by their PRIMARY diagnosis. COUNT ALL RESIDENTS - COUNT EACH RESIDENT ONLY ONCE. The primary diagnosis of a resident is the MAJOR health problem for which a resident is receiving care. Alongside each diagnostic group is the range of International Classification of Diseases codes contained within the particular diagnostic group. Use only the classifications listed -- If a diagnosis does not fit into a listed classification include it in OTHER MEDICAL CONDITIONS.

NOTE: ALZHEIMER'S DISEASE -- For the purpose of this questionnaire only -- ALL RESIDENTS with a PRIMARY diagnosis of ALZHEIMER'S DISEASE are to be placed in the ICD-9 CODE 290.1 & 331.0.

ICD-9 CM Numbers	Primary Diagnosis	Number of Residents
140-239	Neoplasms	<input type="text" value="0"/>
240-279	Endocrine/Metabolic Disorders	<input type="text" value="0"/>
280-289	Blood Disorders	<input type="text" value="0"/>
290.1 & 331.0	Alzheimer's Disease (All with Primary Diagnosis of Alzheimer's)	<input type="text" value="0"/>
293-297,300	Mental Illness (Does not include Alzheimer's Disease)	<input type="text" value="0"/>
299,315-319	Developmental Disabilities (Does not include Alzheimer's Disease)	<input type="text" value="0"/>
320-389	Nervous System Disorders (Does not include Alzheimer's Disease)	<input type="text" value="0"/>
390-459	Circulatory System Disorders	<input type="text" value="0"/>
460-519	Respiratory System Disorders	<input type="text" value="0"/>
520-579	Digestive System Disorders	<input type="text" value="0"/>
580-629	Genitourinary System Disorders	<input type="text" value="0"/>
680-709	Skin Disorders	<input type="text" value="0"/>
710-739	Musculo-Skeletal Disorders	<input type="text" value="0"/>
800-999	Injuries and Poisonings	<input type="text" value="0"/>
	Other Medical Conditions	<input type="text" value="0"/>
	Non-Medical Conditions	<input type="text" value="0"/>
	Total Residents	<input type="text" value="0"/>

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

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Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008
Part 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]

We have made fundamental changes in the way we are collecting the data, intended to make responses easier and the data more accurate. Part II - Financial and Capital Expenditures data for your facility **MUST BE REPORTED 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**.

THESE DOLLAR AMOUNTS ARE FOUND IN YOUR MOST RECENT ANNUAL FINANCIAL STATEMENTS WHICH INCLUDES YOUR INCOME STATEMENT 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.

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

Starting Ending

Source of Financial Data Used

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**Illinois Department of Public Health (IDPH)
 Long-Term Care Facility Questionnaire for 2008
 Part II - Financial & Capital Expenditures Data**

A. CAPITAL EXPENDITURES

Provide the following information for all projects / capital expenditures **IN EXCESS OF \$247,200** 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):

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

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Report the **TOTAL** of ALL Capital Expenditures for your reported Fiscal Year (include expenditures below \$247,200):

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR
 (including those below \$247,200)

**Illinois Department of Public Health (IDPH)
 Long-Term Care Facility Questionnaire for 2008
 Part II - Financial & Capital Expenditures Data**

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

	Fiscal Year Net Revenues
Medicare	0
Medicaid	0
Other Public Pay*	0
Private Insurance*	0
Private Payment*	0
TOTAL NET REVENUES FOR REPORTED FISCAL YEAR	0

* '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

**Illinois Department of Public Health (IDPH)
 Long-Term Care Facility Questionnaire for 2008
 Part 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?	<input type="radio"/>	<input type="radio"/>
Does your facility have a written policy for administering pneumococcal vaccine to RESIDENTS?	<input type="radio"/>	<input type="radio"/>
Does your facility have a written policy for vaccinating STAFF MEMBERS against influenza?	<input type="radio"/>	<input type="radio"/>
Does your facility have a written policy for vaccinating STAFF MEMBERS against pneumococcal pneumonia?	<input type="radio"/>	<input type="radio"/>
Does your facility have a written policy for use of amantadine and/or rimantadine during an influenza outbreak?	<input type="radio"/>	<input type="radio"/>

	Number Receiving Influenza Vaccine	Number NOT Receiving Influenza Vaccine
Record the number of RESIDENTS who received influenza vaccine during the time period from October, 2008 through February, 2009	0	0

	Number Receiving Pneumococcal Vaccine	Number NOT Receiving Pneumococcal Vaccine
Record the number of CURRENT RESIDENTS who have received a pneumococcal vaccine in the years 2003 through 2008	0	0

**Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008**

Please provide the following contact 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 Telephone	<input type="text"/>
Contact Person E-Mail Address	<input type="text"/>

Provide the Name and Job Title of the Facility Administrator, and the date in the spaces provided:

Administrator's Name	<input type="text"/>
Administrator's Title	<input type="text"/>
Administrator Telephone	<input type="text"/>
Administrator E-Mail Address	<input type="text"/>
Date of Submission (MM/DD/YYYY format)	<input type="text"/>

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

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**Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2008**

THIS PAGE MUST BE PRINTED OUT, COMPLETED AND SIGNED BY THE FACILITY ADMINISTRATOR, DATED AND RETURNED TO THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH BEFORE YOUR QUESTIONNAIRE WILL BE CONSIDERED COMPLETE.

, IL

I certify that I have reviewed our submittal of the Illinois Department of Public Health Long-Term Care Questionnaire for 2008, and that to the best of my knowledge and belief the data contained in the questionnaire are true and accurate.

Printed Name

Printed Job Title

Signature

Date

Once signed you may
Mail, Fax or Email the completed and signed page to:
Division of Health Systems Development
Illinois Department of Public Health
2nd Floor
525 West Jefferson
Springfield, Illinois 62761
Fax# 217-785-4308
Email: DPH.FacilitySurvey@illinois.gov

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WE STRONGLY RECOMMEND THAT YOU PRINT OUT EACH PAGE OF THIS FORM WITH YOUR ANSWERS FOR FUTURE REFERENCE.

ONCE YOU HAVE SUBMITTED THE FORM, NO FURTHER ACCESS OR CHANGES ARE POSSIBLE.

YOU CANNOT RETRACT OR CHANGE A SUBMITTED FORM, SO 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 SEND YOUR COMPLETED QUESTIONNAIRE BACK TO OUR OFFICE. YOU WILL BE ROUTED TO A CONFIRMATION PAGE.

IF YOU HAVE ANY PROBLEMS, PLEASE CONTACT THIS OFFICE IMMEDIATELY AT 217-782-3516 OR BY EMAIL AT DPH.FACILITYSURVEY@ILLINOIS.GOV

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EXPENSE OF CHARITY CARE – WORKSHEET

Please print a copy of this worksheet to use in calculating expense of charity care.

EXAMPLE:

Total Net Patient Revenue	\$ 2,000,000
Total Operating Expenses less bad debt expense	\$ 1,800,000
Expenses (Costs) to Revenues (Charges)	
$\$1,800,000/\$2,000,000 = 90\%$ Ratio	
Total Patient Revenue written off for	
Charity care	\$ 100,000
Ratio	X .90
Total cost of charity care	\$ 90,000

WORKSHEET FOR YOUR FACILITY:

Total Net Patient Revenue	\$ _____
Total Operating Expenses less bad debt expense	\$ _____
Expenses (Costs) to Revenues (Charges)	
_____ / _____ = ____% Ratio	
Total Patient Revenue written off for	
Charity care	\$ _____
Ratio	X ____
Total cost of charity care	\$ _____

Term	Definitions	Reference
Authorized/Licensed Bed Count (CON)	Number of beds by category of service recognized and licensed by Illinois Department of Public Health.	According to Administrative rule 1100.220
Admissions	Number of patients accepted for inpatient service during a 12 month period.	According to Administrative rule 1100.220
Adult cardiac catheterization	Cardiac catheterization of patients 15 years of age and older	According to Administrative rule 1110.1320
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. Medicare Cost to Charge Ratio dollar value should be used while figuring this amount.	Actual cost of service to be reported.
Beds set up and staffed on a particular day.	Number of beds/stations set up and staffed on a particular day	Measures the hospital utilization on a given random day.
By or on behalf of a Health Care facility	By or on behalf of a Health Care facility Any transactions undertaken by the facility or by any other entity other than the facility which results in construction 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.	
Cardiac Labs	Includes labs that are dedicated as well as non dedicated cardiac labs for diagnostic, interventional and electrophysiology procedures. Total cardiac labs will be more than or equal to the sum of dedicated cardiac labs.	
Cardiovascular Intervention or treatment	All interventional cardiac procedures performed on a patient during one session in the laboratory (one patient visit equals one intervention regardless of number of procedures performed).	
Capital Expenditure	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 thereof 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 or facilities or a transfer of equipment or facilities at fair market value.	
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, and not the actual charges for the services.	
Construction or Modification	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 or 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 . . .	
Diagnostic Cardiac Catheterization (DCC)	Performance of Catheterization procedures associated with determining the blockage of blood vessels and the diagnosis of cardiac diseases that are performed in a cardiac cath lab or special procedures lab with cardiac cath capabilities.	
Dedicated Cardiac Catheterization Laboratory	A distinct lab that is staffed equipped and operated solely for the provision of diagnostic or interventional cardiac catheterization.	
Full Time Equivalent	Full Time Equivalent is a unit of measure which is equal to one filled, full time, annual-salaried	

	position.	
Interventional Cardiac Catheterization (ICC)	Treatment of cardiac diseases associated with the blockage or narrowing of the blood vessels and diseases of the heart by the performance of percutaneous coronary intervention or similar procedures in a cardiac cath lab or special procedures lab with cardiac cath capabilities. Cardiovascular interventions include but not limited to Percutaneous Transluminal Coronary Angioplasty (PTCA), rotational atherectomy, directional atherectomy, extraction atherectomy, laser angioplasty, implantation of intracoronary stents and other catheter devices for treating coronary atherosclerosis.	
Multiple Use Angiographic Laboratory	Lab that has equipment, staff, and support services required to provide diagnostic or interventional cardiac catheterization and routinely perform DCC and ICCs. They can be used to perform other angiographic procedures.	
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.	
Net Revenue	Net Revenue: Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).	
Other Public	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.	
Operations Room (Class C)	Operating Room (Class C) is defined as a setting designed and equipped for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions	(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-based Surgery, third edition, American College of Surgeons)

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 2006 for construction of a new bed wing. Construction takes approximately three years with payments being made to the contractor during 2006, 2007 and 2008. The entire \$2 million would be listed once as an obligation for 2006 and would not be listed in subsequent years.	
Patient Days	"Patient Days" means the total number of days of service provided to inpatients of a facility over a 12-month period. Inpatient days of care are counted as any beds occupied at the time the daily census is counted.	According to Administrative Rule 1100.220
Patients served by payment source	Include number of inpatients and outpatients served by their payment type.	Payment sources are defined within the questionnaire too.
Peak bed set up and staffed	Number of beds by category of service 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 CON Authorized beds at any one time during the reporting calendar year.	Measures the facility's peak utilization.
Project	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 or 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.	
Pediatric cardiac Catheterization	Cardiac Catheterization of patients 0-14 years.	According to Administrative rule 1110.1320
Private Pay	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.	
Revenue by payment source	Revenue by payment source: Include the amount of net revenue of the facility during the fiscal year for the patients served by the payment type.	Revenue to be listed
Stage 1 and Stage 2 Recovery Stations	Stage 1 and Stage 2 Recovery Stations are defined as the stations/units within the room providing post operative/post anesthetic care soon after the surgery. Stage 1 recovery is used for patients who received intensive anesthesia for major surgical procedures which would take more time to recuperate, while Stage 2 are used for less intensive procedures which involve less anesthesia there by need less time to recuperate.	According to ACOA (American College of Anesthesiologists).
Surgical Procedure Room (Class B)	Surgical Procedure room is defined as a setting designed and equipped for major or minor surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs.	(Source: Guidelines for Optimal Ambulatory Surgical Care and Office-

		based Surgery, third edition, American College of Surgeons)
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