

**ANNUAL**  
**LONG-TERM CARE FACILITY QUESTIONNAIRE**  
**2009**

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# 2009 LONG-TERM CARE FACILITY QUESTIONNAIRE

## PREFACE

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/). It is self reported long-term care data and is the responsibility of facility management to assure the accuracy of the data submitted. IDPH verifies the data and strives for accuracy and completeness of the profiles before they are published for public viewing and usage in the form of the Annual Long-Term Care Facility Profiles: <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. The completed data, along with signature verification, are submitted electronically to IDPH. Signature of the Executive Officer of the facility attesting to the best of his or her knowledge that "...data contained in the questionnaire are true and accurate" is mandatory for the data to be deemed complete. This year the signature page was part of the questionnaire and, by checking the tick mark on the last page, the officer of each facility attested to the validity of the data being submitted. This differed from previous years in that submittal of hard-copy signature was no longer required.

Email contacts were tested prior to the original transmission of the survey. The questionnaire was sent by email or regular mail to all long term care facilities on April 1, 2010 as a formal request for information, with a due date of May 7, 2010. This allowed each respondent six weeks for completion. Facilities that did not return their questionnaires by May 21, 2010 received a certified letter informing them they had been entered on our non-compliance list and that referrals would be made to the Health Facilities and Services Review Board for the issuance of fine, for those facilities who did not submit their complete questionnaires by June 30, 2010. There were no facilities from whom the survey was not received within this extended time frame.

### Differences between Previous LTCQs and 2009 LTCQ

This year's survey collected additional information about whether facilities were part of a Continuing Care Retirement Community or a Life Care Facility. Facilities were additionally asked to report the number of residents on the last day of the year with a

diagnosis of mental illness and the number of residents who were categorized as Identified Offenders.

### **Validation and Compilation of Data**

Once submitted, the questionnaires are checked for data irregularities with regard 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 received calls from IDPH 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 called by staff to verify the total patient days for the calendar year. Ultimately, management in each hospital is responsible for assuring and ensuring the accuracy and completeness of the data submitted by the hospital.

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 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, 2009.

### **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.

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Questions may be addressed to:

Data Section  
Division of Health Systems Development  
525 West Jefferson Street, Second Floor  
Springfield, IL 62761

or

[DPH.FacilitySurvey@illinois.gov](mailto:DPH.FacilitySurvey@illinois.gov)

**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009**

**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 several parts:**

**Part I**

**Information on your facility and facility utilization  
THIS PART MUST BE REPORTED FOR CALENDAR YEAR 2009**

**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**

**Part IV**

**Older Adult Services Survey**

**The Long Term Care Questionnaire must be completed and submitted by [May 7, 2010](#).**

**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](mailto:DPH.FacilitySurvey@illinois.gov), or by telephone at **217-782-3516**.**

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LTC Questionnaire for 2009 Data - Microsoft Internet Explorer provided by Infor...

File Edit View Favorites Tools Help

**Illinois Department of Public Health (IDPH)**  
**Long-Term Care Facility Questionnaire for 2009**

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.

**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](mailto:DPH.FacilitySurvey@illinois.gov) with any questions.

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**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009**

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 information shown IS NOT CORRECT, do NOT change the values shown.  
Please contact the Health Facilities and Services Review Board as soon as possible to obtain a  
corrected survey.**

**Facility Information**

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

Facility Address

Facility City

Facility Zip Code

 , IL 

Licensed

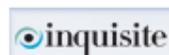
Beds [\[Help\]](#)

Licensed Beds shown here for information. Do not change.

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**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 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 1 - Is your facility designated as any of the following:**

- Life Care Facility
- Continuing Care Retirement Community

**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. [\[Help\]](#)**

- |   |   |
|---|---|
| <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 3 - 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).**

<b>Name of Registered Agent:</b>	<input type="text"/>
<b>Address of Registered Agent</b>	<input type="text"/>
<b>City, State and Zip Code (plus Four):</b>	<input type="text"/>
<b>Telephone Number:</b>	<input type="text"/>



Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2009
Part I - Facility and Utilization Data

Question 4 - 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 2009 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.

Table with 2 columns: EMPLOYMENT CATEGORIES and FULL TIME EQUIVALENTS (FTEs). Rows include Administrators, Physicians, Director of Nursing, Registered Nurses, LPNs, Certified Aides, Other Health Personnel, Other Non-Health Personnel, and Totals.

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

**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009  
Part I - Facility and Utilization Data**

**Question 5 - Resident Information for December 31, 2009**

<b>Beds</b>	<b>1. Nursing Care</b>	<b>2. Sheltered</b>	<b>3. Total</b>
1. Licensed Beds - 12/31/2009	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/> 0
2. Peak Beds Set Up - 2009*	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/> 0
3. Peak Beds Occupied - 2009*	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/> 0
4. Beds Set Up - 12/31/2009	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/> 0
5. Beds Occupied - 12/31/2009	<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, 2009" [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"/>
<b>13. Total Males</b>	<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"/>
<b>21. Total Females</b>	<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"/>
0	0	0

	1. Nursing Care	2. Sheltered	3. Total
<b>Patient Days for 2009</b> <i>Patient day values should be based on resident count for CALENDAR YEAR 2009.</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"/>
<b>29. Total All Patient Days</b>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Room Rates</b>			
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
<b>Racial Group</b> <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"/>
<b>38. Total All Races</b>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<b>Ethnicity</b> <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"/>
<b>42. Total All Ethnicity</b>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
	1. Nursing Care	2. Sheltered	3. Total
<b>Primary Payment Source*</b>			
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"/>
<b>49. Total Residents</b>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<p><b>*"OTHER PUBLIC"</b> 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.</p> <p><b>"PRIVATE PAY"</b> 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.</p>			

Illinois Department of Public Health (IDPH)
Long-Term Care Facility Questionnaire for 2009
Part I - Facility and Utilization Data

Question 6 - Admissions and Discharges during the Calendar Year 2009.

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.

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.

A. Residents on the FIRST DAY of the 2009. [Input field with 0]

Indicate the number of residents in your facility at the BEGINNING of the day on January 1, 2009 on Line A. The resident count should be the same as the resident count your facility reported to the Department on December 31, 2008.

B. Total Admissions DURING Calendar Year 2009. [Input field with 0]

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

C. Total Discharges DURING Calendar Year 2009. [Input field with 0]

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 2009. [Input field with 0]

Indicate the total number of residents your facility had on December 31st 2009.

**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 Part I - Facility and Utilization Data**

**Question 7 - Primary Diagnosis of Residents on DECEMBER 31, 2009.**

Report the number of residents in your facility at the END OF THE LAST DAY OF 2009 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"/>
	<b>Total Residents</b>	<input type="text" value="0"/>

**Question 8 - Residents on December 31, 2009, whose Diagnosis included Mental Illness.**

Report the number of residents in your facility on December 31, 2009, whose diagnosis included Mental Illness (ICD-9 CODE 293-297,300). Include all the residents reported with Primary Diagnosis of Mental Illness in Question 7, and all residents with a diagnosis of Mental Illness in addition to their Primary Diagnosis.

Residents with Diagnosis of Mental Illness

**Question 9 - Residents on December 31, 2009, who were Identified Offenders\***

Report the number of residents in your facility on December 31, 2009, who were categorized as Identified Offenders\*.

Residents who were Identified Offenders

\* 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 Part II - Financial and Capital Expenditures Data

**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009  
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.** 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.

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  Ending

Source of Financial Data Used

**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 Part II - Financial & Capital Expenditures Data**

**A. CAPITAL EXPENDITURES**

Provide the following information for all projects / capital expenditures IN EXCESS OF \$292,000 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.				

[\[Help\]](#)

Report the TOTAL of ALL Capital Expenditures for your reported Fiscal Year (include expenditures below \$292,000):

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR (including those below \$292,000)

**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 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
<b>TOTAL NET REVENUES FOR REPORTED FISCAL YEAR</b>	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

[A worksheet has been developed to assist you in calculating the Actual Cost of Charity Care. CLICK HERE to download a copy of this worksheet.](#)

**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 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, 2009 through February, 2010	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 2004 through 2009	0	0

**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2009  
 Part IV - Older Adult Services Survey**

The Older Adult Services Advisory Committee, created by Public Act 093-1031, is required to gather information about services being provided to older adults in the State of Illinois as part of its mandate to "promote a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services".

**1. What outpatient or community based services to clients, other than your nursing home residents, does your facility or affiliated agency offer?**

<b>Outpatient/Community-Based Services.</b>	<b>Average Daily Number of Clients Served in the Previous Month</b>
Outpatient Physical Therapy	<input type="text"/>
Outpatient Occupational Therapy	<input type="text"/>
Outpatient Speech Therapy	<input type="text"/>
In House Respite Care Program 24 Hours or More	<input type="text"/>
In House Respite Care Program Less than 24 Hours Per Day	<input type="text"/>
Adult Day Care Services Not Part of Respite Care Program	<input type="text"/>
Alzheimer's Adult Day Care Services Not Part of Respite Care Program	<input type="text"/>
Home Health Care for Medicare or Medicaid Clients	<input type="text"/>
Home Care Services for Private Pay Clients	<input type="text"/>
Homemakers and Personal Care Assistants	<input type="text"/>
Home Delivered Meals Program	<input type="text"/>
Transportation Services for Persons in the Community	<input type="text"/>
Outpatient Wound Care and/or Specialized Wound Care	<input type="text"/>
Outpatient Dialysis	<input type="text"/>
Community Family Caregiver Training or Support*	<input type="text"/>
Community Nutrition Site	<input type="text"/>
Outpatient Telephone Reassurance for Community Seniors	<input type="text"/>
Private Duty Nursing Services	<input type="text"/>

\* For Community Members Other than Residents Family Members

**2. What Other Outpatient/Community Services Does Your Facility Offer?**

**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009**

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"/>

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

Administrator's Name	<input type="text"/>
Administrator's Title	<input type="text"/>
Administrator Telephone	<input type="text"/>
Administrator E-Mail Address	<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.

LTC Questionnaire for 2009 Data - Microsoft Internet Explorer provided by Infor...  
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**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2009**

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**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

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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**

**EXAMPLE:**

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

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**WORKSHEET FOR YOUR FACILITY:**

Total Gross Patient Revenues	\$ _____
Total Operating Expenses less bad debt expense	\$ _____
Total Operating Expenses (Costs) to Total Gross Patient Revenues (Charges) Ratio	
_____ / _____ = .__	

Cost of Charity Care Calculation

Total days of unreimbursed care for 2009*	_____ A).
Room Rate**	X _____ B).
Revenue written off related to unreimbursed care	\$ _____
Total Expenses/Total Revenues Ratio (calculated above)	X _____
Total Cost of Charity Care	\$ _____ C).

\*Not including those charged to bad debt

\*\*Average Daily Shared Room Rate

A). Entered in survey at page 6, question 5, line 28.

B). Entered in survey at page 6, question 5, line 31.

C). Entered in survey at page 11, question C.

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. <b>Medicare Cost to Charge Ratio</b> 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	<b>Construction or Modification</b> 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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