ANNUAL END-STAGE RENAL DISEASE (ESRD) FACILITY QUESTIONNAIRE FOR 2020

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

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

Facilities failing to submit this survey by the stated deadline will be reported to the Illinois Health Facilities and Services Review Board for its consideration of imposition of sanctions as mandated by the Illinois Health Facilities Planning Act.

THIS COMPLETED SURVEY MUST BE SUBMITTED BY 5 P.M. ON WEDNESDAY, MARCH 31, 2021.

There will be no exceptions or extensions granted.

Please note that this survey is divided into two sections:

SECTION I

This section deals with facility details and utilization data.

The utilization data must be reported for Calendar Year 2020.

SECTION II

This section deals with financial and capital expenditure data.

Information in this section must be reported for your most recent Fiscal Year.

To submit your completed questionnaire:

Step 1. Save the completed questionnaire to your computer system for your records and future reference.

Step 2. Send Email, with saved file attached, to DPH.FacilitySurvey@illinois.gov

Put "ESRD Questionnaire" in the subject of the email.

If you experience any problems, or have any questions regarding this survey instrument, please contact this office by telephone at 217/782-3516, or by email to DPH.FacilitySurvey@illinois.gov

Thank you for your cooperation.

ANNUAL END-STAGE RENAL DISEASE (ESRD) FACILITY QUESTIONNAIRE FOR 2020

SECTION I

Please provide the following information regarding your ESRD facility:

Facility Medicare Certification Number	
Facility Name	
Facility Address	
Facility City	
Facility Zip Code	
Facility Federal Employer Identification Number (FEIN)	
Legal entity which owns and operates the facility:	

Indicate the category of ownership of your ESRD facility (choose only one):

FOR PROFIT	GOVERNMENTAL	NOT FOR PROFIT
◯ Corporation	◯ County	◯ Church-Related
◯ Limited Partnership	◯ City	◯ Other Corporation (not Church-related)
◯ Limited Liability Partnership	◯ Township	◯ Other Not for Profit
◯ Limited Liability Company	◯ Hospital District	
◯ Other For Profit	◯ Other Governmental	

What is the name of the Administrator of this facility?	
What is the name of the Medical Director of this facility?	

What is the name and address of the entity/entities which own(s) the building/structure where the facility is located?

Building Owner(s)	Street Address	City, State and Zip Code

What are the names and relational interests of any entities which are legally, financially or otherwise related to the facility (e.g., parent company, subsidiaries, affiliates, management agreements, etc)?

Related Entity/Entities	Relationship	Type of Interest

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SECTION I (continued)

FACILITY STAFFING

How many hours per week are worked by full-time employees of your facility?

Please indicate the number of Full-Time Equivalents (FTEs) employed by your facility in the first pay period of December 2020 by indicted category (FTEs are calculated by dividing the total number of hours worked by the normal weekly hours for a full-time employee):

Personnel Category	Number of FTEs
Registered Nurses	0.00
Dialysis Technicians	0.00
Dieticians	0.00
Social Workers	0.00
LPNs	0.00
Other Health-related Professionals	0.00
Other Non Health-related Professionals	0.00
Total FTEs Employed	0.00

If you reported any FTEs for Other Health or Non-Health Professionals above, please provide a brief explanation:

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SECTION I (continued)

How many authorized ESRD stations did the facility have on January 1, 2020? ☐

How many of these stations were certified by CMS on that date? ☐

How many authorized ESRD stations did the facility have on December 31, 2020? ☐

How many of these stations were certified by CMS on that date? ☐

What was the highest number of authorized stations in operation at any time in Calendar Year 2020? ☐

How many authorized stations were set up and staffed during the week of October 1-7, 2020? ☐

How many authorized isolation stations were set up and staffing October 1-7, 2020? ☐

How many in-center hemodialysis treatments were performed in the facility during 2020? ☐

What was the average time spent (in minutes) per treatment performed? ☐

How many missed **treatments** (not patients) or "no shows" did you have in Calendar Year 2020? ☐

How many shifts did your facility operate per day in Calendar Year 2020?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Shifts	☐	☐	☐	☐	☐	☐	☐

Did your facility operate In-Center Nocturnal Dialysis during Calendar Year 2020? ◯ Yes ◯ No

Report the number of normal scheduled hours of operation for your facility during the week of October 1-7, 2020:

	October 1	October 2	October 3	October 4	October 5	October 6	October 7
Number of Hours	☐	☐	☐	☐	☐	☐	☐

Listed the number of patients treated per day for the week of October 1-7, 2020:

	October 1	October 2	October 3	October 4	October 5	October 6	October 7
Number of Patients	☐	☐	☐	☐	☐	☐	☐

If your facility operated a fourth shift during October 1-7, 2020, please indicate that in the Comments box on page 10.

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SECTION I (continued)

Patient Information

How many patients were receiving chronic in-center dialysis at your facility on January 1, 2020?

How many patients were receiving chronic in-center dialysis at your facility on December 31, 2020?

How many unduplicated patients received chronic in-center dialysis at your facility during 2020?

Please list the following patients who began or ended treatment at your facility during 2020:

Patients Added

The number of new patients to the facility (includes transfers to the facility):

The number of transient patients:

The number of patient who re-started in-center hemodialysis:

The number of patients who resumed treatment after transplant:

Patients Lost to Treatment

The number or patients who recovered kidney function:

The number of kidney transplant recipients who ended treatment:

The number of patients who were transferred out (including transients):

The number of patients who voluntarily discontinued treatment (not transfers or transplants):

The number of patients lost to follow-up:

The number of patient who ceased dialysis due to death:

PATIENTS TREATED IN 2018 BY PRIMARY SOURCE OF PAYMENT

Report each unduplicated patient treated by your facility in 2020 by their primary (major) source of payment:

	Medicare	Medicaid	Other Public Program	Private Insurance	Private Payment	Charity Care	TOTAL
Patients							0

Charity Care means care provided by a 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/or other Federal, State or local indigent health care programs.

Private Payment includes funds from a private account, such as a Medical Saving Account, and any government funds paid to the resident which are then transferred to the facility. Also includes out-of-pocket self-pay.

Other Public includes all forms of direct public payment excluding Medicare and Medicaid. Includes DHS and VA funds paid directly to the facility for services.

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SECTION I (continued)

For the questions on this page, the total patients in the yellow boxes must equal the total patients (yellow box) from the previous question on patients by payment source on the previous page.

Please report the number of unduplicated patients treated by your facility in 2020 by Gender and Age Group:

Age Groups	Males	Females	TOTALS
Under 14 years			0
15 to 44 years			0
45 to 64 years			0
65 to 74 years			0
75 years and over			0
TOTALS	0	0	0

Please report the number of unduplicated patients treated by your facility in 2020 by Racial Group:

Racial Group	Patients
Asian	
American Indian/ Native Alaskan	
Black/African-American	
Native Hawaiian/ Pacific Islander	
White	
Unknown Race	
TOTALS	0

Please report the number of unduplicated patients treated by your facility in 2020 by Ethnicity:

Ethnicity	Patients
Hispanic/Latino	
Not Hispanic/Latino	
Ethnicity Unknown	
TOTALS	0

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SECTION II

Record the Starting Date and Ending Date of your most recent available Fiscal Year

Starting Date (mm/dd/yyyy format) | Ending Date (mm/dd/yyyy format)

Select the source of your reported financial information for this section:

CAPITAL EXPENDITURES

Total Capital Expenditures during the Fiscal Year:

Below, list **ONLY** the projects/capital expenditures in excess of **$350,000** obligated by or on behalf of the facility during the Fiscal Year:

Project/Expenditure Description	Amount Obligated	Method of Financing	CON Project Number

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SECTION II (continued)

LONG-TERM DEBT

Report the amount of long-term debt indebtedness (including current maturities) incurred by or on behalf of the facility, as reported in the facility's audited financial statements for the most recent Fiscal Year. If the facility does not have its own financial statements, indicate the amount of debt allocated to the facility by the controlling entity. :

Long-Term Debt Reported	

NET REVENUES BY SOURCE DURING THE FISCAL YEAR

	Medicare	Medicaid	Other Public Payment	Private Insurance	Private Payment	TOTALS
Net Revenues ($)						0
Patients by Payment reported on page 5	0	0	0	0	0	

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

Other Public Payment includes all forms of direct government payment excluding Medicare and Medicaid. DHS and Veterans' Administration funds and other government funds paid directly to the facility are to be included here.

ACTUAL COST OF CHARITY CARE

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

	Dollar Value	Charity Patients reported on page 5
Actual Cost of Charity Care Services Provided	$ 0.00	0

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

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COVID-19 PANDEMIC AND EFFECTS

The Covid-19 pandemic which began in early 2020 affected all aspects of our lives, health care services probably more than any other. We understand that 2020 was far from a typical year for your facility, your staff and your patients. We would like to get some perspectives on the challenges this pandemic posed for you, your staff and patients. Please use the space provided below to share these challenges and your responses to the difficulties of operating during the pandemic. Thank you for your efforts to cope with these trying circumstances.

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Please provide the following information concerning the individual responsible for the completion of this questionnaire:

Contact Person Name	
Contact Person Job Title	
Contact Person Telephone	
Contact Person Email	

CERTIFICATION OF SURVEY INFORMATION

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

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

Person Certifying	
Job Title	
Date of Certification	

COMMENTS

If you have any comments concerning this survey, or any of the information provided, please enter them here:

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Thank you.