INSTRUCTIONS FOR 2019 LONG-TERM CARE QUESTIONNAIRE

This year's Long-Term Care (LTC) Facility Questionnaire is an Adobe Form. You can open and complete the form using the Adobe Reader program.

This format should be more convenient for you in several respects. You can easily print out all or any page of the form as needed. You can fill in part of the form, save it to your computer, and re-open it later to add more data. You can save the completed form to your computer for future reference.

When you have completed the form, send an email, with a copy of the completed form attached, to DPH.FacilitySurvey@illinois.com

The completed form is due by Friday, April 24, 2020.

Thank you

ANNUAL LONG-TERM CARE QUESTIONNAIRE FOR 2019
FOR FACILITIES WITH NURSING AND/OR SHELTERED CARE BEDS

This is a formal request by the Illinois Department of Public Health for full, complete and accurate information as stated herein. This request is made under the authority of the Illinois Health Facilities Planning Act [20 ILCS 3960/]. Failure to respond may result in sanctions including the following:

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

This questionnaire is divided into the following sections:

SECTION I
Information on your facility and facility utilization during Calendar Year 2019

SECTION II
Financial and Capital Expenditure information for your facility for your Most Recent Available Fiscal Year

SECTION III
Patient and Staff Influenza and Pneumonia Immunization
Authorized Electronic Monitoring
Older Adult Services Provided by your facility

This questionnaire must be completed and submitted by April 24, 2020.
There will be no exceptions or extensions.

INSTRUCTIONS FOR SUBMITTING COMPLETED QUESTIONNAIRE

When you have completed this form and saved the completed form to your computer system, please attach the completed form to an Email and send to DPH.FacilitySurvey@illinois.gov

Please put "LTC Questionnaire" in the subject line.

Facilities failing to submit the completed 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 as mandated by the Act.

If you have any questions or issues with this form, please contact this office by telephone at 217/782-3516, or by Email to DPH.FacilitySurvey@illinois.gov

Thank you for your cooperation.

SECTION I

FACILITY INFORMATION AND UTILIZATION DURING CALENDAR YEAR 2019

Please provide the following information for your long-term care facility:

Facility License Number

Facility Name

Facility Address

Facility City

Facility Zip Code

Facility FEIN Number

Is your facility designated as a Life Care Facility or a Continuing Care Retirement

Community? If so, please mark the applicable choice(s):

- ☐ Life Care Facility
- ☐ Continuing Care Retirement Community

If any of the conditions listed below will prevent a prospective patient from admission to your facility, please mark the applicable conditions:

- ☐ Aggressive/Anti-Social Behavior
- ☐ Chronic Alcoholism
- ☐ Developmental Disability
- ☐ Drug Addiction
- ☐ Medicaid Recipient
- ☐ Medicare Recipient
- ☐ Mental Illness
- ☐ Patient Non-Ambulatory
- ☐ Patient Non-Mobile
- ☐ Government Payment Recipient
- ☐ Under 65 Years of Age
- ☐ Patient Unable to Self-Medicate
- ☐ Patient Ventilator Dependent
- ☐ Infectious Disease Requiring Isolation
- ☐ Any other Admission Restriction
- ☐ None Applicable

If your facility ownership requires that the facility have a agent registered with the Illinois Secretary of State, indicate the name, address and telephone number of the Registered Agent:

Registered Agent Name

Registered Agent Street Address

Registered Agent City, State and Zip Code

Registered Agent Telephone Number

FACILITY STAFFING

Please report the number of Full-Time Equivalent (FTE) staff employed directly by your facility during the first pay period of December, 2019. DO NOT REPORT NUMBER OF HOURS WORKED. A Full-Time Equivalent of a staff member's employment is calculated by dividing the number of hours that person worked by the typical hours worked by a full-time staff member in that position. For example, if a staff member worked 16 hours in the pay period, and a full-time employee would typically work 40 hours, that staff person accounted for 0.4 Full-Time Equivalent (FTE).

Due to the wide range of services provided in long-term care facilities, we have included 2 aggregated employment categories: Other Healthcare Personnel, for health-related staff not listed separately, and Other Non-Health Personnel, for staff not directly involved in the provision of health care to patients.

EMPLOYMENT CATEGORIES	FULL-TIME EQUIVALENTS (FTEs)
Administrators	0.00
Physicians	0.00
Director of Nursing	0.00
Registered Nurses	0.00
LPNs	0.00
Certified Aides	0.00
Other Healthcare Personnel	0.00
Other Non-Health Personnel	0.00
TOTALS	**0.00**

Please indicate the typical number of hours in a work week for a full-time employee: 0.00

FACILITY ADMISSIONS AND DISCHARGES DURING CALENDAR YEAR 2019

Please report the number of initial admissions to and final discharges from your facility during Calendar Year 2019.

Short-term discharges for Acute or Sub-Acute hospital care, or temporary releases to visit friends or relatives for patients expected to return to the facility are not to be counted as discharges and re-admissions. Count only new admissions to and permanent discharges from the facility. If a person has been permanently discharged from care, but is re-admitted later in the year, please count both the discharge and the re-admission.

Indicate the number of patients in your facility on January 1, 2019	0
Indicate the number of initial admissions to your facility during 2019	0
Indicate the number of permanent discharges from your facility during 2019	0
Indicate the number of patients in your facility on December 31, 2019	**0**

FACILITY UTILIZATION – BEDS, RESIDENTS, PATIENT DAYS

Patient Information is for Patients in the facility on December 31, 2019. Patient Days of Care are for care provided during Calendar Year 2019.

BEDS	SKILLED/INTERMEDIATE NURSING CARE	SHELTERED CARE	TOTALS
Licensed Beds – 12/31/2019	0	0	0
Peak Beds Set Up	0	0	
Peak Beds Occupied	0	0	
Beds Set Up – 12/31/2019	0	0	0
Beds Occupied – 12/31/2019	0	0	0
PATIENT DAYS OF CARE – 2019			
MEDICARE	0		0
MEDICAID	0		0
OTHER PUBLIC PROGRAM	0	0	0
PRIVATE INSURANCE	0	0	0
PRIVATE PAYMENT	0	0	0
CHARITY CARE	0	0	0
TOTALS	0	0	0
PATIENTS AS OF DECEMBER 31, 2019			
MALES – Under 18	0	0	0
18-44 Years Old	0	0	0
45-59 Years Old	0	0	0
60-64 Years Old	0	0	0
65-74 Years Old	0	0	0
75-84 Years Old	0	0	0
85 or more Years Old	0	0	0
MALE TOTALS	0	0	0
FEMALES – Under 18	0	0	0
18-44 Years Old	0	0	0
45-59 Years Old	0	0	0
60-64 Years Old	0	0	0
65-74 Years Old	0	0	0
75-84 Years Old	0	0	0
85 or more Years Old	0	0	0
FEMALE TOTALS	0	0	0
TOTAL RESIDENTS	0	0	0

	SKILLED/INTERMEDIATE NURSING CARE	SHELTERED CARE	TOTALS
PATIENTS BY RACIAL GROUP AS OF DECEMBER 31, 2019			
ASIAN	0	0	0
AMERICAN INDIAN	0	0	0
BLACK/AFR. AMERICAN	0	0	0
HAWAIIAN/PAC. ISL.	0	0	0
WHITE	0	0	0
RACE UNKNOWN	0	0	0
TOTALS	0	0	0
PATIENTS BY ETHNICITY AS OF DECEMBER 31, 2019			
HISPANIC/LATINO	0	0	0
NOT HISPANIC/LATINO	0	0	0
ETHNICITY UNKNOWN	0	0	0
TOTALS	0	0	0
PATIENTS BY PRIMARY PAYMENT SOURCE AS OF DECEMBER 31, 2019			
MEDICARE	0		0
MEDICAID	0		0
OTHER PUBLIC PROG.	0	0	0
PRIVATE INSURANCE	0	0	0
PRIVATE PAYMENT	0	0	0
CHARITY CARE	0	0	0
TOTALS	0	0	0
PRIVATE PAY DAILY ROOM RATES AS OF DECEMBER 31, 2019			
PRIVATE ROOM	0	0	
SHARED ROOM	0	0	

RESIDENTS AS OF DECEMBER 31, 2019 BY PRIMARY DIAGNOSIS – ICD-10
Please list the number of patients in your facility on December 31, 2019, by the ICD-10 coding group of the primary diagnosis of the patient. Each patient should be counted once and only once.

ICD-10 CM Code Groups	Primary Diagnostic Group	Number of Residents
C00 - D49	Neoplasms	0
D50 - D69	Blood Disorders	0
E00 – E89	Endocrine/Metabolic Disorders	0
F01 – F69	Mental Illness	0
F70 – F99	Developmental Disabilities	0
G300 – G309	Alzheimer's Disease	0
G00 – G99	Nervous System Disorders (excluding Alzheimer's Disease)	0
I00 – I99	Circulatory System Disorders	0
J00 – J99	Respiratory System Disorders	0
K00 – K95	Digestive System Disorders	0
L00 – L99	Skin Disorders	0
M00 – M99	Musculo-Skeletal Disorders	0
N00 – N99	Genitourinary System Disorders	0
S00 – T88	Injuries and Poisonings	0
	Other Medical Conditions	0
	Non-Medical Conditions	0
	Sum of Total Residents by Diagnosis on December 31, 2019	0
	Total Occupied Beds on December 31, 2019 (from page 4)	0

RESIDENTS AS OF DECEMBER 31, 2019, DIAGNOSED AS MENTALLY ILL
How many of your patients on December 31, 2019, had diagnoses including Mental Illness (ICD-10 codes F01 - F69)? 0

RESIDENTS AS OF DECEMBER 31, 2019, CATEGORIZED AS IDENTIFIED OFFENDERS
How many of your patients on December 31, 2019, had been identified by a Criminal Background Check, as required by the Nursing Home Care Act (210 ILCS 45/2-201.5 paragraphs b and c)? 0

SECTION II

Financial and Capital Expenditure information for your facility
for your Most Recent Available Fiscal Year

The information from this section will come from your Most Recent Annual Financial Statements, which include your Income Statement and Balance Sheet. Sources of Financial Data can be Audited Financial Statements, Review or Compilation Financial Statements, or Tax Return Documents for your Most Recent Fiscal Year.

Please indicate the Starting Date and Ending Date (format mm/dd/yyyy) for your Fiscal Year:

STARTING DATE ENDING DATE

Please select the Data Source used for the information reported in this section:

Audited Financial Statements

CAPITAL EXPENDITURES

Capital expenditures are defined as "Any expenditure : (A) made by or on behalf of a health care facility …….and (B) which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance, or is made to obtain by lease or comparable arrangement any facility or part there of or any equipment for a facility or part… and includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities essential to the acquisition, improvement, expansion or replacement of any plant or equipment with respect to which an expenditure is made… and includes donations of equipment of facilities or a transfer of equipment or facilities at fair market value."

Please report the TOTAL CAPITAL EXPENDITURES DURING YOUR REPORTING YEAR: $0.00

Please provide the following information ONLY FOR PROJECTS/EXPENDITURES IN EXCESS OF $350,000 obligated by, or on behalf of, the facility during the reporting year.

Description of Project/Expenditure	Amount Obligated	Method of Financing	CON Project Number (if applicable)
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		
	$ 0.00		

NET REVENUE BY PAYMENT SOURCE FOR REPORTED FISCAL YEAR
Please report the Net Revenue of the facility during the reported Fiscal Year by the listed sources of revenue:

Source of Payment*	Net Revenue (Dollars)
Medicare	$0.00
Medicaid	$0.00
Other Public Payment	$0.00
Private Insurance	$0.00
Private Payment	$0.00
TOTALS	**$0.00**

*OTHER PUBLIC PAYMENT includes payments from Veterans' Administration, County Boards, Community Aid Agencies, grants, CHAMPUS, CHAMP-VA, and other government-sponsored programs, excluding Medicare and Medicaid.

PRIVATE INSURANCE refers to payments made through private insurance policies.

PRIVATE PAYMENT includes money from a private account, such as a Medical Savings Account, and any government funding paid to the resident and then transferred to the facility in payment for services.

Revenue from Medicare-Medicaid Alignment Initiative (MMAI) should be included in Medicare.

Revenue from Medicaid Managed Care should be included in Medicaid.

ACTUAL COST OF SERVICES PROVIDED TO CHARITY CARE RECIPIENTS FOR THE REPORTED FISCAL YEAR
Please report the Actual Cost of Services provided by your facility to recipients of Charity Care* during the reported Fiscal Year.

	Amount (Dollars)
Actual Cost of Charity Care Services	$ 0.00

*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.

SECTION III

Patient and Staff Influenza and Pneumonia Immunization

The Immunization Section of the Illinois Department of Public Health requests that you provide the following information regarding immunization policies and the immunization status of facility staff and patients in regard to immunizations for influenza and pneumococcal pneumonia. Thank you.

	YES	NO
Does your facility have a written policy for administering influenza vaccine to your patients?		
Does your facility have a written policy for administering pneumococcal vaccine to your patients?		
Does your facility have a written policy for administering influenza vaccine to staff members?		
Does your facility have a written policy for administering pneumococcal vaccine to staff members?		
Does your facility have a written policy for the use of amantadine and/or rimantadine during an influenza outbreak?		

	Number Receiving Vaccine	Number Not Receiving Vaccine	TOTALS
How many patients of your facility from October, 2019 through January, 2020, received an influenza vaccination?	0	0	0
How many of your patients as of December 31, 2019, had received a pneumococcal pneumonia vaccination during the period of 2014 through 2019?	0	0	0

SECTION III
Authorized Electronic Monitoring

Effective January 1, 2016, the Authorized Electronic Monitoring in Long-Term Care Facilities Act (210 ILCS 32/), Public Act 99-0430, set forth conditions and processes whereby a long-term care resident could request authroized electronic monitoring of his/her living quarters. As part of this Act, each long-term care facility covered by the Act must annually report to the Illinois Department of Public Health the number of requests the facility has received for electronic monitoring.

In order to reduce the number of separate data requests, the Office of Health Care Regulation of the Illinois Department of Public Health has requested that this reporting be incorporated into the HFSRB Annual Long-Term Care (LTC) Facility Questionnaire.

Please note that this information wll not be used in the Certificate of Need process. Should you have any questions regarding the Authorized Electronic Monitoring Act, please contact the IDPH Office of Health Care Regulation at 217/782-5180.

Thank you.

Authorized Electronic Monitoring	
How many Electronic Monitoring Notification and Consent Forms were submitted by facility residents in Calendar Year 2019?	0
How many of the above requests for electronic monitoring in Calendar Year 2019 were approved?	0
How many of the above requests for electronic monitoring in Calendar Year 2019 were denied?	0

SECTION IV

Older Adult Services Provided by your facility

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 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 delivery system, taking into account the continuing need for 24-hour skilled nursing care and congregate housing with services."

Please indicate the average daily number of clients (not facility residents) served by your facility in the past month for the following services

Outpatient/Community-Based Services	Average Daily Clients Served in the Past Month
Outpatient Physical Therapy	0
Outpatient Occupational Therapy	0
Outpatient Speech Therapy	0
In-house Respite Care Program – 24 Hours or More	0
In-house Respite Care Program – Less than 24 Hours per Day	0
Adult Day Care Services – Not Respite Care Program	0
Alzheimer's Adult Day Care Services – Not Respite Care Program	0
Home Health Care for Medicare or Medicaid Clients	0
Home Care Services for Private Pay Clients	0
Homemakers and Personal Care Assistants	0
Home Delivered Meals Program	0
Transportation Services for Community Members	0
Outpatient Wound Care and/or Specialized Wound Care	0
Outpatient Dialysis	0
Community Family Caregiver Training or Support	0
Community Nutrition Site	0
Outpatient Telephone Reassurance for Community Seniors	0
Private Duty Nursing Services	0

If your facility offers other Outpatient/Community Services not listed above, please report them here:

CONTACT INFORMATION AND DATA CERTIFICATION

Please provide the following contact information for the administrator of this facility:

Administrator Name	
Administrator Job Title	
Administrator Telephone	
Administrator Email	

Please provide the following contact information for the individual responsible for completion of this form:

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

By completing this certification, you agree to the following statement

CERTIFICATION OF DATA CONTAINED IN THIS FORM

Pursuant to the Health Facilities Planning Act [20 ILCS 3960/13], the State Board requires "all health facilities operating in the State of Illinois 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. The individual named below certifies that he/she has reviewed this 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 _____ Certification Date _____

If you have any comments regarding this survey or the information contained herein, please enter them below:

INSTRUCTIONS FOR SUBMITTING COMPLETED QUESTIONNAIRE

When you have completed this form and saved the completed form to your computer system, please attach the completed form to an Email and send to DPH.FacilitySurvey@illinois.gov
Please put "LTC Questionnaire" in the subject line. **The form is due by April 24, 2020.**