

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 OVER 16 INTERMEDIATE DD 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

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

Patient Non-Mobile

Chronic Alcoholism

Government Payment Recipient

Developmental Disability

Under 65 Years of Age

Drug Addiction

Patient Unable to Self-Medicate

Medicaid Recipient

Patient Ventilator Dependent

Medicare Recipient

Infectious Disease Requiring Isolation

Mental Illness

Any other Admission Restriction

Patient Non-Ambulatory

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	
Physicians	
Director of Nursing	
Registered Nurses	
LPNs	
Certified Aides	
Other Healthcare Personnel	
Other Non-Health Personnel	
TOTALS	

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

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 discharged from care, but later is re-admitted, please count both the discharge and the re-admission.

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

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

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

RESIDENTS AS OF DECEMBER 31, 2018 BY PRIMARY DIAGNOSIS – ICD-10

Facilities for the Developmentally Disabled are not required to complete this item.

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)?

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)?

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	
Medicaid	
Other Public Payment	
Private Insurance	
Private Payment	
TOTALS	

*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	

*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?			
How many of your patients as of December 31, 2019, had received a pneumococcal pneumonia vaccination during the period of 2014 through 2019?			

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 authorized 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 will 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?	
How many of the above requests for electronic monitoring in Calendar Year 2019 were approved?	
How many of the above requests for electronic monitoring in Calendar Year 2019 were denied?	

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:

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