

**ANNUAL**  
**LONG-TERM CARE FACILITY QUESTIONNAIRE**  
**2010**

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**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2010**

**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 2010**

**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**

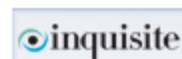
**Older Adult Services Survey**

**The Long Term Care Questionnaire must be completed and submitted by [March 1, 2011](#).**

**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](tel:217-782-3516).**

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**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2010**

**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 2010**

This survey has been customized for your facility based on information in the IDPH databases.  
Please verify the information on this page.

**Facility Information**

Facility Name

Facility Address

Facility City

Facility Zip Code

 , IL 

Licensed Beds [<Definitions>](#)

Licensed Beds shown here for information. Do not change.

**Illinois Department of Public Health (IDPH)**  
**Long-Term Care Facility Questionnaire for 2010**  
**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:

Use this link to access definitions: [Definitions](#)

- 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. [Definitions](#)

- |   |   |
|---|---|
| <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).

Name of Registered Agent:


Address of Registered Agent

City, State and Zip Code (plus Four):

Telephone Number:

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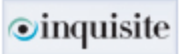
**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2010  
 Part I - Facility and Utilization Data**

**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 2010 to account for your employees.**

Due to the broad range of services provided in LTC facilities, IDPH is leaving the definition of 'Other Healthcare Personnel' broad enough to include all categories of healthcare staff not covered in the six listed major categories of personnel.

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

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





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

**Question 5 - Resident Information for December 31, 2010**

| <b>Beds</b>                   | <b>1.<br/>Nursing Care</b> | <b>2.<br/>Sheltered</b> | <b>3.<br/>Total</b> |
|-------------------------------|----------------------------|-------------------------|---------------------|
| 1. Licensed Beds - 12/31/2010 | 99                         | 0                       | 99                  |
| 2. Peak Beds Set Up - 2010*   | 0                          | 0                       | 0                   |
| 3. Peak Beds Occupied - 2010* | 0                          | 0                       | 0                   |
| 4. Beds Set Up - 12/31/2010   | 0                          | 0                       | 0                   |
| 5. Beds Occupied - 12/31/2010 | 0                          | 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, 2010" [20 ILCS 3960/13]

**Males**

|               |   |   |   |
|---------------|---|---|---|
| 6. Under 18   | 0 | 0 | 0 |
| 7. 18 - 44    | 0 | 0 | 0 |
| 8. 45 - 59    | 0 | 0 | 0 |
| 9. 60 - 64    | 0 | 0 | 0 |
| 10. 65 - 74   | 0 | 0 | 0 |
| 11. 75 - 84   | 0 | 0 | 0 |
| 12. 85 & Over | 0 | 0 | 0 |

**13. Total Males**

|  |   |   |   |
|--|---|---|---|
|  | 0 | 0 | 0 |
|--|---|---|---|

**Females**

|               |   |   |   |
|---------------|---|---|---|
| 14. Under 18  | 0 | 0 | 0 |
| 15. 18 - 44   | 0 | 0 | 0 |
| 16. 45 - 59   | 0 | 0 | 0 |
| 17. 60 - 64   | 0 | 0 | 0 |
| 18. 65 - 74   | 0 | 0 | 0 |
| 19. 75 - 84   | 0 | 0 | 0 |
| 20. 85 & Over | 0 | 0 | 0 |

**21. Total Females**

|  |   |   |   |
|--|---|---|---|
|  | 0 | 0 | 0 |
|--|---|---|---|

**22. Total Residents**

|  |   |   |   |
|--|---|---|---|
|  | 0 | 0 | 0 |
|--|---|---|---|

|   | 1.<br>Nursing Care             | 2.<br>Sheltered                | 3.<br>Total                    |
|---|--------------------------------|--------------------------------|--------------------------------|
| <b>Patient Days for 2010</b>  |                                |                                |                                |
| <i>Patient day values should be based on resident count for CALENDAR YEAR 2010.</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> Each resident in your facility on the last day of the year should be accounted for and counted only once. |                                |                                |                                |
| 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> Each resident in your facility on the last day of the year should be accounted for and counted only once.    |                                |                                |                                |
| 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"/> |

LTC Questionnaire - 2010 Data - Microsoft Internet Explorer provided by Infor...

https://survey.dph.illinois.gov/survey/cg

LTC Questionnaire - 2010 Data

| Primary Payment Source*    | 1. Nursing Care | 2. Sheltered | 3. Total |
|----------------------------|-----------------|--------------|----------|
| 43. Medicare               | 0               | n/a          | 0        |
| 44. Medicaid               | 0               | n/a          | 0        |
| 45. Other Public           | 0               | 0            | 0        |
| 46. Private Insurance      | 0               | 0            | 0        |
| 47. Private Pay            | 0               | 0            | 0        |
| 48. Charity Care           | 0               | 0            | 0        |
| <b>49. Total Residents</b> | 0               | 0            | 0        |

\*OTHER PUBLIC\* includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

PRIVATE PAY includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

INSURANCE refers to payment made through private insurance policies.

Charity care means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3] Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

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**Illinois Department of Public Health (IDPH)**  
**Long-Term Care Facility Questionnaire for 2010**  
**Part I - Facility and Utilization Data**

**Question 6 - Admissions and Discharges during the Calendar Year 2010.**

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 2010.**

Indicate the number of residents in your facility at the BEGINNING of the day on January 1, 2010 on Line A. The resident count should be the same as the resident count your facility reported to the Department on December 31, 2009.

**B. Total Admissions DURING Calendar Year 2010.**

Indicate the total number of residents your facility admitted during 2010 on Line B.

**C. Total Discharges DURING Calendar Year 2010.**

Indicate the total number of residents your facility discharged during 2010 on Line C. Remember, this value is final discharges only, not administrative discharges of any type.

**D. Residents on the LAST DAY of 2010.**

Indicate the total number of residents your facility had on December 31, 2010.

## Long-Term Care Facility Questionnaire for 2010 Part I - Facility and Utilization Data

### Question 7 - Primary Diagnosis of Residents on DECEMBER 31, 2010.

Report the number of residents in your facility at the END OF THE LAST DAY OF 2010 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, 2010, whose Diagnosis included Mental Illness.

Report the number of residents in your facility on December 31, 2010, 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, 2010, who were Identified Offenders\*

Report the number of residents in your facility on December 31, 2010, 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 2010  
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 2010  
 Part II - Financial & Capital Expenditures Data**

**A. CAPITAL EXPENDITURES**

Provide the following information for all projects / capital expenditures IN EXCESS OF \$293,500 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. |  |                  |                     |                                  |

[<Definitions>](#)

Report the TOTAL of ALL Capital Expenditures for your reported Fiscal Year (include expenditures below \$293,500):

TOTAL CAPITAL EXPENDITURES FOR YOUR REPORTED FISCAL YEAR (including those below \$293,500)



**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2010  
 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> | <b>0</b>                 |

\* 'OTHER PUBLIC PAY' includes all forms of direct public payment EXCLUDING Medicare and Medicaid. DMH/DD and Veterans Administration funds and other public funds paid directly to a facility should be recorded here.

'PRIVATE INSURANCE' refers to payment made through private insurance policies.

'PRIVATE PAYMENT' includes money from a private account AND any government funding made out and paid to the resident which is then transferred to the facility to pay for services.

**C. ACTUAL COST OF CHARITY CARE SERVICES PROVIDED IN YOUR REPORTED FISCAL YEAR**

*"Charity care" means care provided by a health care facility for which the provider does not expect to receive payment from the patient or a third-party payer. [20 ILCS 3960, Section 3]*

Charity care does not include bad debt or the unreimbursed cost of Medicare, Medicaid, and other federal, State, or local indigent health care programs, eligibility for which is based on financial need.

|  | Amount |
|--|--------|
| Actual Cost of Services Provided to Charity Care Residents in Reported Fiscal Year | 0      |



**Illinois Department of Public Health (IDPH)  
 Long-Term Care Facility Questionnaire for 2010  
 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, 2010 through January, 2011 | 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 2005 through 2010 | 0                                     | 0   |

**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?

| Outpatient/Community-Based Services.                                 | Average Daily Number of Clients Served in the Previous Month |
|--|--|
| 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 2010**

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.

**Illinois Department of Public Health (IDPH)  
Long-Term Care Facility Questionnaire for 2010****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

**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](mailto:DPH.FACILITYSURVEY@ILLINOIS.GOV)**

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| <b>Term</b>                          | <b>Definition</b>  | <b>Comments</b>                           |
|--------------------------------------|--|---|
| Admissions                           | Number of patients accepted for service during a 12 month period.  | According to Administrative rule 1100.220 |
| Charity Care                         | <p><b>“Charity Care”</b> is defined as care for which the provider does not expect to receive payment from the patient or a third party payor.</p> <p>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.</p> <p>In reporting charity care, the reporting entity must report the actual cost of services provided, not the actual charges for the services.</p> | Actual cost of service to be reported.    |
| Continuing Care Retirement Community | <p>“Continuing Care Retirement Community” provides a continuum of care for a geriatric population that includes independent living and/or congregate housing (such as unlicensed apartments, high rises for the elderly and retirement villages and related health and social services); licensed supportive living, sheltered care or assisted living; and a licensed nursing care facility.</p>  |   |

|                             |   |   |
|-----------------------------|---|---|
|                             | The housing complex shall be on the same site as the health facility component of the project.  |   |
| Life Care Facility          | <p>“Life Care Facility” is an organization that has written authorization from IDPH to administer a place or places in which the provider undertakes to provide a resident with nursing services, medical services or personal care services, in addition to maintenance services for a term in excess of one year or for life, pursuant to a life care contract.</p> <p>The term also means a place or places in which a provider undertakes to provide such services to a non-resident.</p> |   |
| Patient Days                | <p>"Patient Days" means the total number of days of service provided to patients in a facility over a 12-month period. Patient days of care are counted as beds occupied at the time the daily census is counted.</p>   | According to Administrative Rule 1100.220 |
| Peak bed set up and staffed | Maximum number of beds 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 at any one time during the reporting calendar year.  | Measures the facility's peak utilization. |
| <p>Revenue by payment source</p> <p>a. Private Pay</p> <p>b. Other Public</p> | <p>Include the amount of <b>net revenue</b> of the facility during the fiscal year for patients served by the payment type.</p> <p>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.</p> <p>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.</p> |   |
| Source of Financial Data Used   | Indicate the source from which the financial information has been taken. The sources include audited financial statements, review or compilation of financial statements or tax return for most recent fiscal year.   |   |

### **Financial/Capital Expenditures Definitions:**

1. **ON BEHALF OF HEALTH CARE FACILITY:** Any transactions undertaken by the facility or by any other entity other than the facility which results in constitution 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.
2. **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 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.
3. **CONSTRUCTION OR MODIFICATION:** The establishment, erection, building, alteration, reconstruction, modernization, improvement, extension, discontinuation, change of ownership, of or by a health care facility, or the purchase or acquisition by or through a health care facility of equipment of 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.
4. **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.
5. **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.

6. **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 of 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.

7. **NET REVENUE:** Net Revenue is the result of gross revenue less provision for contractual adjustments from third party payors (Source: AICPA).