ANNUAL LONG-TERM CARE QUESTIONNAIRE FOR 2025 FOR FACILITIES WITH 16 OR FEWER 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 2025.

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

This questionnaire must be completed and submitted by APRIL 30, 2026.
There will be no exceptions or extensions.

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.

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.

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 2025

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
- ☐ 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, 2025. 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 2021

Please report the number of initial admissions to and final discharges from your facility during Calendar Year 2025.

Count only new admissions to and permanent discharges from the facility. 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. If a person has been discharged from care, but later in the year is re-admitted, please count both the discharge and the re-admission. The calculated number in the yellow box must equal the totals in the yellow boxes on the following pages.

Indicate the number of patients in your facility on January 1, 2025	0
Indicate the number of initial admissions to your facility during 2025	0
Indicate the number of permanent discharges from your facility during 2025	0
This number should be the number of patients in your facility on December 31, 2025	**0**

FACILITY UTILIZATION – BEDS, RESIDENTS, PATIENT DAYS

Patient Days of Care are TOTALS for care provided during Calendar Year 2025. Patient Information is for Patients in the facility on December 31, 2025.

BEDS/OCCUPANCY	INTERMEDIATE DD CARE
Licensed Beds – 12/31/2025	0
Highest One-Day Beds Set Up	0
Highest One-Day Beds Occupied	0
Beds Set Up – 12/31/2025	0
Beds Occupied – 12/31/2025	0
TOTAL PATIENT DAYS OF CARE – CALENDAR YEAR 2025	
MEDICARE	
MEDICAID	0
OTHER PUBLIC PROGRAM	0
PRIVATE INSURANCE	0
PRIVATE PAYMENT	0
CHARITY CARE	0
TOTALS	0
PATIENTS AS OF DECEMBER 31, 2025	
MALES – Under 18	0
18-44 Years Old	0
45-59 Years Old	0
60-64 Years Old	0
65-74 Years Old	0
75-84 Years Old	0
85 or more Years Old	0
MALE TOTALS	0
FEMALES – Under 18	0
18-44 Years Old	0
45-59 Years Old	0
60-64 Years Old	0
65-74 Years Old	0
75-84 Years Old	0
85 or more Years Old	0
FEMALE TOTALS	0
TOTAL RESIDENTS	0

	INTERMEDIATE DD CARE
PATIENTS BY RACIAL GROUP AS OF DECEMBER 31, 2025	
ASIAN	0
AMERICAN INDIAN	0
BLACK/AFR. AMERICAN	0
HAWAIIAN/PAC. ISL.	0
WHITE	0
RACE UNKNOWN	0
TOTALS	0
PATIENTS BY ETHNICITY AS OF DECEMBER 31, 2025	
HISPANIC/LATINO	0
NOT HISPANIC/LATINO	0
ETHNICITY UNKNOWN	0
TOTALS	0
PATIENTS BY PRIMARY PAYMENT SOURCE AS OF DEC. 31, 2025	
MEDICARE	
MEDICAID	0
OTHER PUBLIC PROG.	0
PRIVATE INSURANCE	0
PRIVATE PAYMENT	0
CHARITY CARE	0
TOTALS	0
PRIVATE PAYMENT DAILY ROOM RATES AS OF DEC. 31, 2025	
PRIVATE ROOM	0
SHARED ROOM	0

RESIDENTS AS OF DECEMBER 31, 2025, DIAGNOSED AS MENTALLY ILL

How many of your patients on December 31, 2025, had diagnoses including Mental Illness (ICD-10 codes F01 - F69)?	0

RESIDENTS AS OF DECEMBER 31, 2025, CATEGORIZED AS IDENTIFIED OFFENDERS

How many of your patients on December 31, 2025, 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, 2025 through January 1 2026, received an influenza vaccination?	0	0	0
How many of your patients as of December 31, 2025, had received a pneumococcal pneumonia vaccination during the period of 2024 through 2025?	0	0	0

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 entering your name, title and date for 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 (Type Name) _____

Job Title _____ Certification Date (dd/mm/yyyy) _____

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

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