ANNUAL LONG-TERM CARE QUESTIONNAIRE FOR 2024
FOR FACILITIES WITH NURSING CARE 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 2024.

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
Covid-19 Pandemic Challenges and Responses

This questionnaire must be completed and submitted by April 30, 2025.
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.

FACILITY STAFFING

Please report the number of Full-Time Equivalent (FTE) staff employed directly by your facility during the first pay period of December, 2024. 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	1.00
Physicians	0.00
Director of Nursing	1.00
Registered Nurses	3.00
LPNs	6.50
Certified Aides	36.00
Other Healthcare Personnel	1.00
Other Non-Health Personnel	37.00
TOTALS	85.50

Please indicate the typical number of hours in a work week for a full-time employee: 40.00

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 2024.

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, 2024	73
Indicate the number of initial admissions to your facility during 2024	93
Indicate the number of permanent discharges from your facility during 2024	78
This number should be the number of patients in your facility on December 31, 2024	88

	SKILLED/INTERMEDIATE NURSING CARE	SHELTERED CARE	TOTALS
PATIENTS BY RACIAL GROUP AS OF DECEMBER 31, 2024			
ASIAN	0	0	0
AMERICAN INDIAN	0	0	0
BLACK/AFR. AMERICAN	0	0	0
HAWAIIAN/PAC. ISL.	0	0	0
WHITE	88	0	88
RACE UNKNOWN	0	0	0
TOTALS	88	0	88
PATIENTS BY ETHNICITY AS OF DECEMBER 31, 2024			
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, 2024			
MEDICARE	8		8
MEDICAID	51		51
OTHER PUBLIC PROG.	0	0	0
PRIVATE INSURANCE	0	0	0
PRIVATE PAYMENT	29	0	29
CHARITY CARE	0	0	0
TOTALS	88	0	88
PRIVATE PAYMENT DAILY ROOM RATES AS OF DECEMBER 31, 2024			
PRIVATE ROOM	275	0	
SHARED ROOM	240	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 4/1/2023 ENDING DATE 3/31/2024

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		

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, 2024 through January, 2024, received an influenza vaccination?	48	40	88
How many of your patients as of December 31, 2024, had received a pneumococcal pneumonia vaccination during the period of 2017 through 2024?	12	76	88

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	3
Outpatient Occupational Therapy	3
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: