Clear Form

State of Illinois
Illinois Department of Healthcare and Family Services

LONG TERM CARE (SNF/ICF) PROVIDER MONTHLY ASSESSMENT REPORT

HFS Assessment Tax ID: **6** _____ (7 digit number beginning with 6)

Facility Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Initial Report: _____ **Corrected Report:** _____

Reporting Period: _____ **to** _____ **Payment due date:** _____

The table below is the census for the entire reporting period.
Provide occupied bed days by level of care and primary payment sources.

	1	2	3	4	5	6	7	8	9
	Level of Care	**Medicaid**	**Medicaid MLTSS**	**Medicaid MMAI**	**Medicare Part A MMAI**	**Medicare Part A**	**Private Pay**	**Other**	**Total**
1	SNF								0
2	MCDD								0
3	ICF								0
4	ICF/DD								0
5	**TOTAL**	0	0	0	0	0	0	0	**0**

Assessment Calculation

6	Number of Occupied Beds (Line 5 Column 9)	0
7	Minus Number of Medicare Occupied Beds (Line 5 Sum of Columns 4, 5, and 6)	0
8	Net Occupied Beds (Line 6 Minus Line 7)	0
9	Assessment per Occupied Bed (Rate based on paid Medicaid beds per annum-**use dropdown menu**)	**$ 6.07**
10	**Assessment Amount Due** (Multiply Line 8 by line 9 and **round to the nearest dollar**)	**$ 0.00**

MAKE CHECK PAYABLE TO: HEALTHCARE AND FAMILY
SERVICES Please remit to: HFS/Bureau of Fiscal Operations
P.O. Box 19491
Springfield, Illinois 62794-9491

PAYMENT IS ENCLOSED: **YES** **NO** **Check #:** _____

I have examined the contents of the accompanying report for the period through to the State of Illinois, and certify that, to the best of my knowledge and belief, the said contents are true, accurate and complete statements in accordance with applicable instructions. Intentional misrepresentation or falsification of any information on this report may be punishable by fine and/or imprisonment.

PROVIDER OFFICER OR ADMINISTRATOR SIGNATURE

Signature: _____ Date: _____

Print Name: _____ Title: _____

Contact person to whom HFS should direct questions regarding information contained on this form:
Name: _____ Title: _____

Phone Number: _____ Extension: _____ E-Mail: _____