



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

HFS Assessment Tax ID: _____ (7-digit number)

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 D-SNP	Medicare Part A D-SNP	Medicare Part A	Private Pay	Other	Total
1	SNF								
2	MCDD								
3	ICF								
4	ICF/DD								
5	TOTAL								

Assessment Calculation

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