



**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								
2	MCDD								
3	ICF								
4	ICF/DD								
5	<b>TOTAL</b>								

**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- <u>use dropdown menu</u> )	\$
10	<b>Assessment Amount Due</b> (Multiply Line 8 by line 9 and <u>round to the nearest dollar</u> )	\$ <b>.00</b>

**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: \_\_\_\_\_