

**NURSING FACILITY QUALITY ASSESSMENT
DATA COLLECTION FORM (Rev. 6/05)**

Round all amounts to nearest whole number or dollar Projected Actual AIM Number: _____

Period of Report

From: _____ To: _____

Name of Facility _____ Employer I.D. Number _____

Mailing Address

Street or P. O. Box _____ City _____ State _____ Zip _____

Physical Address (If Different)

Street _____ City _____ State _____ Zip _____

Type of Control

Is Facility Licensed as Hospital Based? Yes No Is Facility a Registered CCRC? Yes No

Did facility status as a Licensed Hospital Based nursing facility change during the reporting year? Yes No

If Yes: Effective date facility became licensed: / / Effective date facility licensure terminated: / /

Did facility status as a Continuing Care Retirement Community change during the reporting year? Yes No

If Yes: Effective date facility became registered: / / Effective date facility registration terminated: / /

Schedule A - Nursing Facility Only

Summary of Occupant Days From Census Logs	Line. No.	Reserve Days [01]	Factor [02]	Adjusted Reserve Days [03]	Present in Facility [04]	Total [05]
Medicaid - Non-SCU Days	184					
Medicaid - SCU Days	185					
Medicare Days	187					
Private Pay Days	188					
Other Days	189					
Total Nursing Facility	190					

For reserve days, Column 1 times factor in Column 2 is equal to Column 3. For all lines, Column 3 plus Column 4 is equal to Column 5. Column 1 reports occupant days for which a bed is being held but patient is not present in the facility. Column 4 reports occupant days for which patient is actually in the facility for midnight census.

CERTIFICATION STATEMENT

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to nursing facility patient care. I understand that this information is submitted for the purpose of calculating the quality assessment under HB 1662, and the ultimate collection of the quality assessment will be based upon the information contained herein. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge. Preparer may (but not required) also include a compilation statement.

Name of Authorized Person _____ Title/Position _____ Telephone Number _____

Signature of Authorized Person _____ Date _____ Address of Authorized Person _____

Name of Preparer _____ Title/Position _____ Telephone Number of Preparer _____

Signature of Preparer _____ Date _____ Address of Preparer _____

Name of Preparer _____ Title/Position _____ Telephone Number of Preparer _____

Signature of Preparer _____ Date _____ Address of Preparer _____

Name of Preparer _____ Title/Position _____ Telephone Number of Preparer _____

Signature of Preparer _____ Date _____ Address of Preparer _____