

# NURSING FACILITY QUALITY ASSESSMENT DATA COLLECTION FORM (Rev. 2/06)

This form should be completed by health facilities licensed under IC 16-28 that are not certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

Round all amounts to nearest whole number or dollar

ISDH Number:

<b>Period of Report</b>			
<b>From:</b>		<b>To:</b>	
<b>Name of Facility</b>		<b>Employer I.D. Number</b>	
<b>Mailing Address</b>			
<b>Street or P. O. Box</b>		<b>City</b>	<b>State</b>
			<b>Zip</b>
<b>Physical Address (If Different)</b>			
<b>Street</b>		<b>City</b>	<b>State</b>
			<b>Zip</b>
<b>Type of Control</b> <input type="checkbox"/> Proprietary For-Profit <input type="checkbox"/> Voluntary Non-Profit <input type="checkbox"/> Government-Owned <input type="checkbox"/> Other			
If Government-Owned, is the facility <input type="checkbox"/> State-Owned <input type="checkbox"/> County-Owned <input type="checkbox"/> City-Owned			
Is Facility Licensed as Hospital Based? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is Facility a Registered CCRC? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did facility status as a Licensed Hospital Based nursing facility change during the reporting year? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes: Effective date facility became registered:    /    /    Effective date facility registration terminated:    /    /			

### Schedule A - Summary of Nursing Facility Occupant Days

	Line No.	Reserve Days [01]	Factor [02]	Adjusted Reserve Days [03]	Present in Facility [04]	Total [05]
Medicare Days	181					
Private Pay Days	182					
Other Days	183					
<b>Total Nursing Facility</b>	<b>190</b>					

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.

### Schedule B - Schedule of Revenue

	Line No.	Medicare Part A [02]	Medicare Part B [03]	Private Pay [04]	Other [05]	Total [06]
Routine Daily Service	211					
Other Revenue	212					
Less Contractual/Charity Allowances	213					
Less Other Reductions to Revenue	214					
<b>Total</b>	<b>220</b>					

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DATA COLLECTION FORM (Rev. 2/06)**

**CERTIFICATION STATEMENT**

<b>Name of Facility</b>	<b>ISDH Number:</b>
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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 P.L. 186-2005, 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.

<b>Name of Authorized Person</b>	<b>Title/Position</b>	<b>Telephone Number</b>
<b>Signature of Authorized Person</b>	<b>Date</b>	<b>Address of Authorized Person</b>
<b>Name of Preparer</b>	<b>Title/Position</b>	<b>Telephone Number of Preparer</b>
<b>Signature of Preparer</b>	<b>Date</b>	<b>Address of Preparer</b>