

STATE OF INDIANA

DEPARTMENT OF REVENUE

**Instructions for the Nursing Facility Quality Assessment Fee Data Collection Form (Rev. 2/06)**

**General Requirements**

If the facility is licensed for the entire reporting period as a hospital based facility by the Department of Health or is registered as a Continuing Care Retirement community (CCRC) by the Secretary of State, then the appropriate question should be answered 'Yes.'

If the facility is not licensed as a hospital based facility by the Department of Health or is not registered as a Continuing Care Retirement community (CCRC) by the Secretary of State then questions stating the facility is hospital based or a CCRC should be marked 'No.'

If a facility's status as a licensed hospital based facility by the Department of Health or registered Continuing Care Retirement Community (CCRC) by the Secretary of State changes during the providers reporting year, then the questions asking if the facility status has changed should be checked as 'Yes,' and the date of the change should be reported.

**Provider Name and Identification Data**

Please note that it is very important that the name of the facility and ISDH Number should appear on each page of the data collection form.

ISDH Number Report the provider number assigned by the Indiana State Department of Health (ISDH). It is very important that this number be stated correctly in order to appropriately identify your facility.

Period of Report The beginning and ending dates of the period for which the financial and statistical data is reported should be listed on these lines. This form must be completed for the provider's most recently completed fiscal year end.

Type of Control Indicate whether the facility is proprietary for-profit, voluntary non-profit, or government-owned. If the facility is government-owned, indicate if it is state-, county-, or city-owned.

**Schedule A – Summary of Nursing Facility Occupant Days**

Report the number of resident days present in the nursing facility, and any reserve days that are charged the resident for which they are absent from the facility on hospital, therapeutic or other forms of leave from the facility. Census data must be accumulated from accurate census logs of the resident population. Do not send copies of census logs. Only report census data on this form associated with nursing facility level of care.

Reserve Days Column [01] Report the number of beds days held for a resident on hospital, therapeutic or other forms of leave from the facility that are billed to a resident.

Factor Column [02] Report the percentage of the daily room rate routinely charged for holding the bed for a resident. If the facility routinely charges residents one-half (1/2) of their full daily rate during periods of leave from the facility, then report 50% in column [02].

Adjusted Reserve Days Column [03] Report the product of Column [01] times Column [02].

Present in Facility Column [04] Report the total number of days a resident is present in the facility as of the midnight census for all days in the reporting period.

Total Column [05] Report the sum of Column [03] and Column [04].

## **Schedule B – Schedule of Revenue**

Report the revenue from routine daily services and other revenue associated with the nursing facility less any contractual/charity allowances and other reductions to revenue. The revenues should be reported in the appropriate columns as gross revenue by the primary payor source (Medicare Part A, Medicare Part B, Private Pay, or Other). Only report revenue information associated with nursing facility level of care.

### **Submission of Completed Forms**

Completed forms should be submitted to the following address.

Myers and Stauffer LC  
9265 Counselors Row, Suite 200  
Indianapolis, IN 46240

Questions concerning this form should be addressed to Myers and Stauffer at 1-800-877-6927, or (317) 846-9521.

### **Certification Statement**

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The certification statement submitted must contain **original signatures**.