

STATE OF INDIANA

**FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF MEDICAID POLICY AND PLANNING**

Instructions for the Nursing Facility Quality Assessment Fee Data Collection Form (Rev. 8/05)

General Requirements

All new Medicaid-certified nursing facilities are required to complete the Quality Assessment Data Collection Form. The form must be completed to report projected patient days from the date of certification to the first fiscal year in which the provider has six months of actual historical data. Subsequent to the first fiscal year in which the provider has six months of actual historical data the Nursing Facility Quality Assessment Data Collection Form must be completed to report actual patient days from the date of certification to the first fiscal year in which the provider has six months of actual historical data.

Check the box indicating whether the census data is projected or actual information.

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 questions should be answered ‘Yes.’ If your facility is a licensed hospital-based facility or is registered as a CCRC, you are exempt from the quality assessment fee and should not complete Schedule A.

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 provider’s reporting year, then the questions asking if the facility status has changed should be checked as ‘Yes’, the date of the change should be reported and Schedule A must be completed.

Provider Name and Identification Data

AIM Number It is very important that the provider’s AIM 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 from the date of certification to the fiscal year end in which the provider has six months of actual historical data.

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 or projected bed 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 or projected 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].

Medicaid Non-SCU Days and SCU Days [Lines 184 and 185] Special Care Unit (SCU) days (for Alzheimer's and dementia residents) or projected days for Medicaid residents should be reported separately on Line 185.

Do not send copies of census logs with the financial report unless documentation of census data is requested by the rate setting or audit contractor.

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**.