Attachment 4.19-D
NF Supplement 1

Payment for Services

Background

Facility-specific nursing home rates are established prospectively using prices calculated using the base year cost report Each rate is the sum of the direct care rate component, the ancillary and support services price, the capital price, the tax rate component, the franchise permit fee rate component and the quality incentive payment.

Cost reports reflect allowable costs (costs determined by the Department of Job and Family Services to be reasonable and do not include fines paid). Unless otherwise specified, allowable costs are determined in accordance with the following, as currently issued and updated, in the following priority:

1) Title 42 Code of Federal Regulations (CFR) Chapter IV
2) The provider reimbursement manual (CMS Publication 15-1)
3) Generally accepted accounting principles.

A reasonable cost is one that is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs and that do not exceed what a prudent buyer pays for a given item or service. The costs of goods, services and facilities furnished to a provider by a related party are includable in the allowable costs of the provider at the reasonable cost to the related party.

Eligibility for Payment for Nursing Facility Services

In order to be eligible for Medicaid payments the operator of a nursing facility shall enter into a provider agreement with the department, apply for and maintain a valid license to operate if so required by law, and comply with all applicable state and federal laws and rules. The operator of a nursing facility that chooses to be a Medicaid provider must maintain Medicare certification for all beds participating in the Medicaid program.

Base Year
The initial base year, first used for rates in state fiscal year 2007, is calendar year 2003.

Relation to Other Services

The nursing facility rate is a comprehensive rate including many services otherwise provided through the Medicaid program on a fee for service basis. The following services are included in the nursing facility per diem and are not available to residents of a nursing facility on a fee for service basis:

1) Personal hygiene services provided by facility staff or contracted personnel;
2) The purchase and administration of tuberculin tests;
3) Drawing specimens and forwarding specimens to a laboratory;
4) Needed medical and program supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs, and intermittent positive-pressure breathing machines);
6) Contents of oxygen cylinders or tanks, including liquid oxygen, oxygen producing machines (concentrators), and equipment associated with oxygen administration (e.g., carts, regulators/humidifiers, cannulas, masks and demurrage);
7) Over the counter drugs and nutritional supplements;
8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
9) Services provided by a licensed psychologist;
10) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
11) Transportation of residents by ambulance, ambulette or other means, other than transport on the date of discharge and hospital to hospital transfers.

The following services are not included in the nursing facility per diem and are available to residents of a nursing facility on a fee for service basis:

1) Covered dental services provided by licensed dentists;
2) Laboratory and x-ray procedures covered under the Medicaid program;
3) Ventilators;
4) Prostheses and othoses;
5) Pharmaceuticals, subject to the limitations found in Attachment 4.19B, subject to the following conditions.
   a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
   b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;
   c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must me maintained by the pharmacy.
6) Psychologist services provided by a community mental health center;

7) Physician services, including all covered diagnostic and treatment services in accordance with Attachment 4.19B, all medically necessary physician visits in accordance with Attachment 4.19B, and required physician visits billed in accordance with Attachment 4.19B.
8) Podiatry services in accordance with Attachment 4.19B. Payment by ODJFS is limited to one visit per month for NF residents.
9) Vision care services in accordance with Attachment 4.19B.

Peer Groups

Peer groups are used to establish the direct care, ancillary and support and capital rate components for nursing facility rates. Providers are assigned to peer groups based on the provider's geographical location and the number of licensed beds reported on the provider's annual cost report for the calendar year preceding the fiscal year for which the rate is established. For a provider new to the Medicaid program, the initial number of licensed beds documented in the provider agreement shall be used; subsequently the number of beds reported on the provider's annual cost report will be used. In the case of a change of operator, the entering operator shall be assigned to the peer group that had been assigned to the exiting operator on the day immediately preceding the date on which the change of operator occurred; subsequently the number of licensed beds reported on the annual cost report shall be used. No adjustment will be made to the provider's placement in a peer group due to a change in bed size until the first day of the next fiscal year.

Direct Care

Three peer groups are used to establish the direct care component for nursing facility rates. Peer Group 1 consists of facilities located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities located in Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union and Wood counties. Peer Group 3 consists of facilities located in Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties.

Ancillary and Support and Capital

Six peer groups are used to establish the ancillary and support and capital components for nursing facility rates. Peer Group 1 consists of facilities with fewer than 100 beds located in Brown, Butler, Clermont, Clinton, Hamilton and Warren counties. Peer Group 2 consists of facilities in those counties with 100 or more beds.

Peer Group 3 consists of facilities with fewer than 100 beds located in Ashtabula, Champaign, Clark, Cuyahoga, Darke, Delaware, Fairfield, Fayette, Franklin, Fulton, Geauga, Greene, Hancock, Knox, Lake, Licking, Lorain, Lucas, Madison, Marion, Medina, Miami, Montgomery, Morrow, Ottawa, Pickaway, Portage, Preble, Ross, Sandusky, Seneca, Summit, Union and Wood counties. Peer Group 4 consists of facilities in those counties with 100 or more beds.

Peer Group 5 consists of facilities located in Adams, Allen, Ashland, Athens, Auglaize, Belmont, Carroll, Columbiana, Coshocton, Crawford, Defiance, Erie, Gallia, Guernsey, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Lawrence, Logan, Mahoning, Meigs, Mercer, Monroe, Morgan, Muskingum, Noble, Paulding, Perry, Pike, Putnam, Richland, Scioto, Shelby, Stark, Trumbull, Tuscarawas, Van Wert, Vinton, Washington, Wayne, Williams, and Wyandot counties. Peer Group 6 consists of facilities in those counties with 100 or more beds.

Direct Care

Costs Included in Direct Care

Direct care costs are reasonable costs incurred for the following:

1) Registered nurses, licensed practical nurses and nurse aides employed by the facility;
2) Direct care staff, administrative nursing staff, medical directors, respiratory therapists, and other persons holding degrees qualifying them to provide therapy;
3) Purchased nursing services;
4) Quality assurance;
5) Consulting and management fees related to direct care;
6) Allocated direct care home office costs;
7) Habilitation staff, other than habilitation supervisors;
8) Medical Supplies, habilitation supplies and universal precaution supplies;
9) Oxygen;
10) Over the counter pharmacy products;
11) Behavioral and mental health services;
12) Physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists
13) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in direct care;
14) Other direct care resources.

Calculation of Direct Care Price

A direct care price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Calculate the direct care cost per diem for each provider by dividing the direct care costs the provider reported on the base year cost report by the inpatient days reported on the same cost report.
3) Calculate the direct care cost per case mix unit (CPCMU) for each provider by dividing the provider's direct care cost per diem by the annual average case mix score for the provider during the base year. The annual average case mix score is the average of the quarterly case mix scores for all residents regardless of payer during the base year.
4) Determine the CPCMU of the provider at the twenty-fifth percentile in each peer group. When making this determination, exclude providers without a 12 month cost report in the base year and providers whose direct care costs are more than one standard deviation from the mean direct care costs in the peer group.
5) Multiply the CPCMU of the provider at the twenty-fifth percentile by 102%.
6) Multiple the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the employment cost index for total compensation, health services component, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the employment cost index for total compensation, nursing and residential care facilities occupational group, published by the United States Bureau of Labor Statistics will be used.
7) Increase the result in the previous step by one dollar and eighty-eight cents.
8) Multiply the result in the previous step by 105.08% to calculate the peer group price.

Calculating the Direct Care Rate

A facility specific direct care rate component is calculated by multiplying the peer group price by a facility specific semi-annual case mix score. For rates effective on the first day of July 2011 the fiscal year, the price is multiplied by the semi-annual Medicaid case mix score for the quarters ended June 30, 2010 and October 31, 2010. Subsequently, rates are adjusted for changes in acuity effective July 1 and January 1 of the fiscal year. The July 1 acuity adjustment will be made using the semi-annual Medicaid case mix scores for the preceding quarters ended December 31 and March 31. The January 1 acuity adjustment will be made using semi-annual Medicaid case mix scores for the preceding quarters ended June 30 and September 30.

Ancillary and Support

Costs Included In Ancillary and Support

Ancillary and support costs are reasonable costs incurred by a nursing facility that are not direct care costs, capital costs, or tax costs. They include, but are not limited to, costs incurred for the following:

1) Activities;
2) Social services;
3) Pharmacy consultants;
4) Habilitation supervisors, qualified mental retardation professionals, and program directors.
5) Program and incontinence supplies;
6) Food, enterals, dietary supplies, and dietary personnel;
7) Laundry and housekeeping;
8) Security;
9) Administration, bookkeeping, purchasing department, human resources, and communication;
10) Medical equipment, minor equipment, and wheelchairs;
11) Utilities;
12) Liability and property insurance;
13) Travel;
14) Dues, license fees, and subscriptions;
15) Home office costs not otherwise allocated;
16) Legal and accounting services;
17) Resident transportation;
18) Maintenance and repairs; maintenance and repairs are necessary and proper to maintain an asset in a normally efficient working condition and do not extend the useful life f the asset two years or more. Maintenance and repairs include, but are not limited to ordinary repairs such as painting and wallpapering.
19) Help wanted and informational advertising;
20) Start up costs and organizational expenses;
21) Other interest;
22) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in ancillary and support;

Calculating the Ancillary and Support Price and Rate

An ancillary and support price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Calculate the ancillary and support cost per diem for each provider by dividing the ancillary and support costs the provider reported on the base year cost report by the greater of inpatient days or 90% of licensed bed days available. For purposes of calculating the facility's occupancy rate and licensed bed days available, the department shall include any beds the nursing facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
3) Determine the ancillary and support per diem of the provider at the twenty-fifth percentile in each peer group. When making this determination, exclude providers without a 12 month cost report in the base year and providers whose ancillary and support costs are more than one standard deviation from the mean ancillary and support costs in the peer group.
4) Multiple the result in the step above by the rate of inflation for the eighteen month period beginning on the first day of July in the base year and ending on the last day of December in the following calendar year. Inflation is measured using the consumer price index for all items for all urban consumers for the north central region, published by the United States Bureau of Labor Statistics, as the index existed on July 1, 2005. When a new base year is selected, the consumer price index for all items for all urban consumers for the midwest region, published by the United States Bureau of Labor Statistics will be used.
5) Multiply the result in the previous step by 105.08% to calculate the peer group price.
6) The provider's ancillary and support rate component is equal to the ancillary and support price for the peer group.

Capital

Costs Included in Capital

Capital costs are reasonable costs incurred for depreciation, amortization and interest on any capital assets that cost $500 or more per item, including the following:

1) Buildings and building improvements;
2) Equipment;
3) Transportation equipment
4) Land improvements;
5) Leasehold improvements;
6) Financing costs.

Depreciation, amortization and interest for capital assets costing less than $500 per item may be considered capital costs in accordance with the provider's practice. Depreciation for costs paid or reimbursed by a government agency shall not be included in cost reports unless that part of the payment is used to reimburse the government agency. Amortization of the cost of acquiring operating rights for the relocated beds is not an allowable cost.

Capital costs also include rent and lease expense for land building and equipment. Allowable lease expense is determined as follows:

(1) For a lease of a facility that was effective on May 27, 1992, the entire lease expense is an allowable expense.

(2) For a renewal of a lease of a facility that was effective on May 27, 1992 that is pursuant to a renewal option in existence on May 27, 1992, the entire lease expense is an allowable expense.

(3) For a renewal of a lease between the same parties and for the same lease payment as a lease in effect on May 27, 1992, the entire lease expense is an allowable expense.

(4) For a lease of a facility in existence on May 27, 1992 but not operated under a lease on that date, the allowable lease expense is the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.

(5) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, the entire lease expense is an allowable capital cost if there was a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993.

(6) For a lease of a facility with a date of licensure on or after May 27, 1992 that is initially operated under a lease, if there was not a substantial commitment of money for construction of the facility after December 22, 1992 and before July 1, 1993, the allowable lease expense is the lesser of the annual lease expense or the sum of the following:

(a) Depreciation calculated at the inception of the lease using the lessor's capital asset cost basis; and

(b) The greater of the lessor's actual annual amortization of financing costs and interest expense at the inception of the lease or imputed interest calculated using 70% of the lessor's capital asset cost basis.

(7) For the lease of a facility with a date of licensure on or after May 27, 1992, that was not initially operated under a lease and has been in existence for ten years, the allowable capital costs are the lesser of the annual lease expense or depreciation and interest calculated using the lessor's historical capital asset cost basis adjusted for one half of the change in the consumer price index for all items for all urban consumers as published by the United State Bureau of Labor Statistics during the time the lessor held each asset until the beginning of the lease. Interest will be imputed at the lessor of the prime rate plus two percent or ten percent.

(8) For a subsequent lease of a facility that was operated under a lease on May 27, 1992, allowable capital costs are the lesser of the annual lease expense or the annual old lease payment. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.

(9) For a subsequent lease of a facility not in existence or not operated under a lease on May 27, 1992, allowable capital costs equal the lesser of the annual lease expense or the allowable capital costs under the old lease. If the old lease was in effect for at least ten years, the old lease payment will be adjusted by one half of the change in the consumer price index for all items for all urban consumers, as published by the United States Bureau of Labor Statistics, from the beginning of the old lease to the beginning of the new lease.

(10) A revision of a lease does not change the allowable capital costs under a lease.

(11) The allowable capital costs for a lease to a related party equal the lesser of the annual lease expense or the reasonable cost to the lessor.

Calculating the Capital Price and Rate

A capital price is established for each peer group using the base year costs reported by providers in that peer group using the following calculation:

1) Group providers into the peer groups defined above.
2) Calculate the capital cost per diem for each provider by dividing the capital costs the provider reported on the base year cost report by the licensed bed days available. For purposes of calculating the facility's licensed bed days available, the department shall include any beds the nursing facility removes from its Medicaid certified capacity unless the nursing facility also removes the beds from its licensed bed capacity.
3) Determine the capital per diem of the provider at the twenty-fifth percentile in each peer group.
4) Multiply the result in the previous step by 105.08% to calculate the peer group price.
5) The provider's capital rate component equals the capital price for the provider's peer group.

Capital Cost Basis

The capital cost basis of nursing facility assets is determined as follows:

(1) For facilities with dates of licensure on of before June 30, 1993 that have not undergone a change of operator since that date, the capital cost basis equals the actual allowable cost basis listed on the facility's cost report.

(2) For facilities with dates of licensure after June 30, 1993, the capital cost basis is determined in accordance with the principles of the Medicare program.

(3) If a provider transfers an interest in the facility to a related party, there is no increase in the cost basis of the asset unless the related party is a relative of the owner, the provider making the transfer retains no interest in the facility, and the Department of Job and Family Services determines that the transfer is an arm's length transaction.

(4) If a facility undergoes a change of operator after June 30, 1993 and the transfer is not to a related party, the basis of the asset is adjusted by one half the change in the consumer price index for all items for all urban consumers as published by the United States Bureau of Labor Statistic during the time the transferor held the asset.

Depreciation

All assets are depreciated using the straight-line method of depreciation. Buildings are depreciated over forty years or a different period approved by the department. Components and equipment shall be depreciated over a period consistent with the guidelines of the American Hospital Association or a different period approved by the department. If additional guidance is needed, the Internal Revenue Service Publication 946 "How to Depreciate Property" shall be used to determine the useful life of that capital assets.

No depreciation is recognized in the month that an asset is placed into service. A full month's depreciation expense is recognized in the month following the month the asset is placed into service. In the month an asset is disposed and it is not a change in ownership, depreciation equal to the difference between the historical cost and accumulated depreciation is recognized.

Taxes

The tax rate component is calculated on a facility specific basis and reflects costs incurred for real estate taxes, personal property taxes and corporate franchise taxes. To calculate the tax rate component, the tax costs reported on the facility's cost report in the base year are divided by the licensed bed days available in the base year. The result is multiplied by 105.08%.

If a nursing facility had a credit regarding its real estate taxes reflected on its cost report for calendar year 2003, the facility's rate for tax costs (until the fiscal year for which the department redetermines all nursing facilities' rates for tax costs) will be calculated using the tax costs paid for calendar year 2004 by the number of licensed bed days available in calendar year 2004.

Franchise Permit Fee

In state fiscal year 2012, the franchise permit fee rate component is $11.47. The franchise permit fee rate component is eliminated for state fiscal year 2013 and thereafter.

Quality Incentive Payment

Quality Measures
The rate for each facility includes a quality incentive payment calculated based on the following measures:

1) The facility had no health deficiencies on the facility's most recent standard survey;
2) The facility had no health deficiencies with a scope and severity level greater than E, as determined under nursing facility certification standards established under Title XIX, on the facility's most recent standard survey;
3) The facility's resident satisfaction survey score is above the statewide average. (This measure is used if a resident satisfaction survey was conducted by the Ohio Department of Aging in the calendar year preceding the fiscal year.)
4) The facility's resident satisfaction survey score is above the statewide average. (This measure is used if a resident satisfaction survey was conducted by the Ohio Department of Aging in the calendar year preceding the fiscal year.)
5) The number of hours the facility employs nurses is above the statewide average.
6) The facility's employee retention rate is above the average for the facility's direct care peer group.
7) The facility's occupancy rate is above the statewide average.
8) The facility's case mix score is above the statewide average.
9) The facility's Medicaid utilization rate is above the statewide average.

One point will be awarded for the first eight measures and three points will be awarded for the ninth measure.

Calculation of the Quality Incentive Payment

The quality incentive payment component of each provider's rate shall be the product of the number of points earned by the provider and the value per point. The value per point is calculated as follows:

1) Calculate the total dollars for the quality incentive payment by multiplying $3.03 by the total number of Medicaid days reported on cost reports for the calendar year preceding the fiscal year.
2) Calculate the total number of point days for each facility by multiplying the number of points the facility earned by the number of Medicaid days reported on the facility's cost report.
3) Calculate the total point days by adding the point days for all facilities.
4) Divide the total dollars for the quality incentive payment by the total point days to calculate the value per point.

Modified Stop Loss

State fiscal year 2012 is the final year of the transition to full implementation of the reimbursement methodology. For that year, a stop loss provision will limit the decrease in a provider's rate if the rate determined for the provider for fiscal year 2012 is less than 90% of the rate the provider was paid on June 30, 2011. For those providers, the amount of the decrease in their rate that exceeds 10% will be reduced by 50%.

Non-Standard Rates

Change of Operator (CHOP)
For an entering operator that begins participation in the Medicaid program, the operator's initial rate shall be the rate the exiting operator would have received had the exiting operator continued to participate in the Medicaid program.

New Facility

The initial rate for a facility with a first date of licensure or Medicaid certification on or after July 1, 2006, including a facility that replaces one or more existing facilities shall be calculated as follows:

1) The direct care rate component equals the product of the direct care price determined for the facility's peer group and the facility's case mix score.
   a) If the nursing facility replaces an existing facility that participated in the Medicaid program immediately prior to the first day the new facility begins to participate in the Medicaid program is the semiannual case mix score most recently determined for the facility being replaced, adjusted for any difference in the number of beds between the new facility and the facility being replaced.
   b) For all other new facilities, the case mix score shall be the median annual average case-mix score for the facility's peer group.
2) The ancillary and support rate component equals the ancillary and support price determined for the facility's peer group.
3) The capital cost rate component equals the capital price determined for the facility's peer group.
4) The tax rate component equals the median tax rate component for the facility's ancillary and support peer group.
5) The quality incentive payment equals the mean quality incentive payment made to nursing facilities.

Added and Replaced Beds

If a nursing facility adds or replaces one or more Medicaid certified beds, the rate for the added or replaced bed equals the rate for the nursing facility's existing bed.

Outlier

An outlier is a facility or unit in a facility serving residents with diagnoses or special care needs that require direct care resources not measured adequately by the MDS 3.0 or who serve residents with special care needs otherwise qualifying for consideration. An outlier rate is a contracted rate and may differ from a standard rate as follows:

1) The direct care rate component may be increased of deemed necessary based on analysis of historical direct care costs if the provider had previously been a Medicaid provider, a comparison of direct care costs and staffing ratios of facilities caring for individuals with similar needs, a comparison of payment rates paid by private insurers or other states, and an analysis of the impact on historical costs if there are plans to change the patient mix.
2) The ancillary and support rate component may be increased due to increased expenses deemed necessary by ODJFS for treatment of individuals requiring outlier services.
3) The capital rate component may be adjusted to reflect costs of specialized high cost equipment or their capital expenditures necessary for treatment of individuals requiring outlier services.

Individuals must receive prior approval for outlier services.

Medicaid Maximum Allowable Reimbursement Rate
(For Medicare Part A cost-sharing provisions, see Appendix to Item 3 of Supplement 1 to Attachment 4.19-B, page 1 of 1)

The Medicaid maximum allowable reimbursement rate is 109% of the nursing facility's Medicaid per diem. Effective January 1, 2012 and thereafter, the Medicaid maximum allowable reimbursement is 100% of the nursing facility's Medicaid per diem.

SECTION 309.30.25. FISCAL YEAR 2011 MEDICAID REIMBURSEMENT SYSTEM FOR NURSING FACILITIES

(A) Except as provided in division (A)(1)(f) of this section, the provider of a nursing facility that has a valid Medicaid provider agreement shall be paid the rate determined as follows:

(1) For nursing facility services the nursing facility provides during fiscal year 2011, determine the rate for the nursing facility under sections 5111.20 to 5111.33 of the Revised Code with the following adjustments:

(a) The cost per case mix-unit calculated under section 5111.231 of the Revised Code, the rate for ancillary and support costs calculated under section 5111.24 of the Revised Code, the rate for tax costs calculated under section 5111.242 of the Revised Code, and the rate for capital costs calculated under section 5111.25 of the Revised Code shall each be adjusted as follows:

(i) Increase the rate determined under division (A)(1)(a) of this section by two per cent;

(ii) Increase the rate determined under division (A)(1)(a)(i) of this section by two per cent;

(iii) Increase the rate determined under division (A)(1)(a)(ii) of this section by one per cent;

(iv) Increase the rate determined under division (A)(1)(a)(iii) of this section by the quality incentive payment calculated under section 5111.244 of the Revised Code. The quality incentive payment shall be established for each provider so that the mean payment is equal to three dollars and three cents.

(b) Except as provided in division (A)(1)(e) of this section, if the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2011 is more than one hundred two and twenty-five hundredths per cent of the nursing

facility's rate on June 30, 2010, the Department of Job and Family Services shall reduce the nursing facility's rate determined under division (A) of this section for fiscal year 2011 so that the rate is not more than one hundred two and twenty-five hundredths per cent of the nursing facility's rate on June 30, 2010. Except as provided in division (A)(1)(e) of this section, if the rate determined for a nursing facility under division (A) of this section for nursing facility services provided during fiscal year 2011 is less than ninety-nine per cent of the nursing facility's rate on June 30, 2010, the Department shall increase the nursing facility's rate determined under division (A) of this section for fiscal year 2011 so that the rate is not less than ninety-nine per cent of the nursing facility's rate on June 30, 2010.

(c) After the adjustments under division (A) of this section are made to a nursing facility's fiscal year 2011 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2011 rate by five dollars and seventy cents per Medicaid day. This increase shall be known as the workforce development incentive payment. The total amount of workforce development incentive payments paid to providers of nursing facilities shall be used to improve nursing facilities' employee retention and direct care staffing levels, including by increasing wages paid to nursing facilities' direct care staff. Not later than September 30, 2012, the Department shall submit a report to the Governor and, in accordance with section 101.68 of the Revised Code, the General Assembly detailing the impact that the workforce development incentive payments have on nursing facilities' employee retention, direct care staffing levels, and direct care staff wages.

(d) After the adjustment under division (A)(1)(c) of this section is made to a nursing facility's fiscal year 2011 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2011 rate by the consolidated services rate per Medicaid day. The consolidated services rate shall be three dollars and ninety-one cents.

(e) After the adjustments under division (A) of this section are made to a nursing facility's fiscal year 2011 rate, the Department of Job and Family Services shall increase the nursing facility's fiscal year 2011 rate by the

amount of real estate taxes reported on the nursing facility's cost report for calendar year 2004 divided by the number of inpatient days reported on that cost report if the nursing facility had a credit reducing its real estate taxes reflected on its cost report for calendar year 2003 to zero. When the rate is paid for Medicaid days, the payment is only for the Medicaid portion of the tax expense.

(f) If the fiscal year 2010 rate for a nursing facility as initially determined under section 309.30.20.000 is not subject to an adjustment under division (A)(1)(b) of that section, the nursing facility's fiscal year 2011 rate as initially determined under division (A) of this section shall not be subject to an adjustment under division (A)(1)(b) of this section regardless of whether the nursing facility's fiscal year 2011 rate as initially determined under division (A) of this section would, if not for this division, be subject to the adjustment. If the fiscal year 2011 rate for a nursing facility as initially determined under division (A) of this section is not subject to an adjustment under division (A)(1)(b) of this section, the nursing facility's rate shall not be subject to an adjustment under that division for the remainder of fiscal year 2011 regardless of any other adjustment made to the nursing facility's fiscal year 2011 rate under sections 5111.20 to 5111.33 of the Revised Code.

(2) For services provided after June 30, 2011, nursing facilities shall continue to be paid the nursing facility's rate for June 30, 2011. If a participating nursing facility does not have a rate paid on June 30, 2011, the nursing facility shall be paid pursuant to Sections 5111.254.000, 5111.254.001, 5111.676.000, and 5111.676.001.

(B) The Department of Job and Family Services shall follow this section in determining the rate to be paid to the provider of a nursing facility that has a valid Medicaid provider agreement on June 30, 2010, and a valid Medicaid provider agreement for fiscal year 2011 notwithstanding anything to the contrary in sections 5111.20 to 5111.33 of the Revised Code.

5101:3-3-22 **Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).**

(A) If the provider properly amends its cost report under rule 5101:3-3-20 of the Administrative Code, the Ohio department of job and family services (ODJFS) makes a finding based on an audit under rule 5101:3-3-21 of the Administrative Code, or ODJFS makes a finding based on an exception review of resident assessment information conducted under section 5111.27 of the Revised Code after the effective date of the rate for direct care costs that is based on the assessment information any of which results in a determination that the provider has received a higher rate than it was entitled to receive, ODJFS shall recalculate the provider's rate using the revised information. ODJFS shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment. In addition to requiring a refund under this rule, ODJFS may charge the provider interest at the applicable rate specified in this rule from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(3) ODJFS shall determine the average bank prime rate using statistical release H.15, "Selected Interest Rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor ceases to contain the bank prime rate information or ceases to be published, ODJFS shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

(B) ODJFS also may impose the following penalties:

(1) If a provider does not furnish invoices or other documentation that ODJFS requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an owner fails to provide notice of sale of the facility closure, voluntary withdrawal or voluntary termination of participation in the medical assistance medicaid program, or change of operator as required by rules 5101:3-3-51.6 and 5101:3-3-84.5 of the AdministrativeRevised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(C) If the provider continues to participate in the medical assistance medicaid program, ODJFS shall deduct any amount that the provider is required to refund under this rule, and the amount of any interest charged or penalty imposed under this rule, from the next available payment from ODJFS to the provider. ODJFS and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from ODJFS to the provider.

(D) ODJFS shall transmit refunds and penalties to the treasurer of state for deposit in the general revenue fund.

5101:3-3-64.1 Nursing facility (NF) payment for cost-sharing other than medicare part A.

(A) The NF per diem rate includes medicaid payments for medicare or other third-party insurance cost-sharing, including coinsurance or deductible payments, associated with services that are included in the NF per diem.

(B) Neither the NF resident nor the Ohio department of job and family services (ODJFS) is responsible for any medicare or other third-party insurance cost-sharing, including coinsurance or deductibles, associated with services that are included in the NF per diem.

5101:3-3-43.3 **Calculation of quarterly, semiannual and annual nursing facility (NF) average case mix scores.**

(A) The definitions of all terms used in this rule are the same as set forth in rules 5101:3-3-01, 5101:3-3-43.1 and 5101:3-3-43.4 of the Administrative Code.

(B) The Ohio department of job and family services (ODJFS) shall process resident assessment data submitted by NFs in accordance with rule 5101:3-3-43.1 of the Administrative Code and shall classify residents using the resource utilization groups, version III (RUG III) classification system to determine resident case mix scores in accordance with rule 5101:3-3-43.2 of the Administrative Code. These resident case mix scores, based on relative resource weights as set forth in appendix E of rule 5101:3-3-43.2 of the Administrative Code, are used to establish two quarterly facility average case mix scores each quarter.

(1) The first quarterly facility average case mix score shall be calculated using all records selected for the quarter and shall be the quarterly facility average total case mix score.

(2) The second quarterly facility average case mix score shall be calculated using only the records selected for the quarter that ODJFS identifies as medicaid records and shall be the quarterly facility average medicaid case mix score.

(C) ODJFS shall calculate a quarterly facility average total case mix score for all providers meeting the following requirements:

(1) In accordance with rule 5101:3-3-43.1 of the Administrative Code, the provider submitted resident assessment information by the filing date, and the data included resident assessments for all residents in medicaid certified beds as of the reporting period end date, and

(a) The provider's resident assessment data submitted timely for that reporting quarter provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four, or

(b) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedures outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for accurately classifying at least ninety per cent of all residents in medicaid certified beds into RUG III groups one through forty-four; and

(c) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average total case mix score.

(2) The quarterly facility average total case mix score for providers that submitted their minimum data set version 3.0 (MDS 3.0) data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) All resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of resident case mix scores is divided by the total number of residents.

(3) If a provider does not comply with paragraph (C)(1) of this rule, ODJFS shall assign the NF a penalty score. The penalty score for the quarterly facility average total case mix score shall be a score that is five per cent less than the quarterly facility average total case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly total facility average case mix score shall be the score that is five per cent less than the score determined by the exception review.

(b) If the facility was assigned a quarterly facility average total case mix score for the preceding calendar quarter, the assigned quarterly facility average total case mix score shall be the score that is five per cent less than the score assigned for the preceding quarter.

(D) ODJFS shall calculate a quarterly facility average medicaid case mix score for all providers meeting the following requirements:

(1) The provider's resident assessment data submitted timely for that reporting quarter provide sufficient information for classifying at least ninety per cent of records identified as medicaid records into RUG III groups one through forty-four, or

(a) The provider's resident assessment data submitted timely and corrected timely, in accordance with the procedure outlined in rule 5101:3-3-43.1 of the Administrative Code for correcting incomplete or inaccurate information, for that reporting quarter, provided sufficient information for

accurately classifying at least ninety per cent of all residents into RUG III groups one through forty-four; and

(b) There were no errors as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code that prevented ODJFS from verifying the records to be used in determining the quarterly facility average medicaid case mix score.

(2) ODJFS shall identify a MDS 3.0 as a medicaid record if the MDS 3.0 meets the following requirements:

(a) The MDS 3.0 is not completed to meet the requirements for a medicare part A stay.

(b) The social security number (SSN) on the MDS 3.0 matches a SSN on the medicaid recipient master file (RMF) and

(c) The assessment reference date (ARD) on the MDS 3.0 falls within the recipient's medicaid eligibility span.

(3) The quarterly facility average medicaid case mix score for providers that submitted their MDS 3.0 data in compliance with paragraph (C)(1) of this rule shall be calculated as follows:

(a) Medicaid resident case mix scores for the quarter, including resident case mix scores in the forty-fifth RUG III group, are added together; then

(b) The sum of medicaid resident case mix scores is divided by the total number of medicaid residents.

(4) If a provider does not comply with paragraph (D)(1) of this rule, ODJFS shall assign the NF a penalty score. The penalty score for the quarterly facility average medicaid case mix score shall be a score that is five per cent less than the quarterly facility average medicaid case mix score for the preceding calendar quarter.

(a) If the facility was subject to an exception review, in accordance with rule 5101:3-3-43.4 of the Administrative Code, for the preceding quarter, the assigned quarterly facility average medicaid case mix score shall be the score that is five per cent less than the score determined by the exception review.

(b) If the facility was assigned a quarterly facility average medicaid case mix score for the preceding calendar quarter, the assigned quarterly facility average medicaid case mix score shall be the score that is five per cent less than the score assigned for the preceding quarter.

(5) ODJFS shall use a facility's assigned penalty score to calculate the semiannual facility average medicaid case mix score.

(E) This paragraph describes the method for calculating the semiannual facility average medicaid case mix score.

(1) The semiannual facility average medicaid case mix score for the payment period beginning the first day of July for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding December and March reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the December and March reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(2) The semiannual facility average medicaid case mix score for the payment period beginning the first day of January for a given fiscal year shall be the average of the quarterly facility average medicaid case mix score from the preceding June and September reporting quarters. If a facility does not have a quarterly facility average medicaid case mix score for both the June and September reporting quarters, the median annual average case mix score for the NF's peer group shall be assigned as the semiannual facility average medicaid case mix score to determine the direct care rate.

(F) ODJFS shall calculate the annual facility average case mix score as follows. The PPS other medicare required assessments (OMRAs) may not be selected for calculating case mix scores due to the inability to assign the record to a RUG III classification.

(1) The annual facility average case mix score shall be calculated only for facilities with at least two quarterly facility average total case mix scores meeting the requirements of paragraphs (C)(1) and (C)(2) of this rule. In addition for any score meeting the requirements of paragraphs (C)(1) and (C)(2) that was adjusted, the adjusted score will be substituted according to the following hierarchy:

(a) Adjusted quarterly facility average total case mix scores established by a rate reconsideration decision resulting from an exception review of resident assessment information conducted before the effective date of the rate; or

(b) Adjusted quarterly facility average total case mix scores as a result of exception review findings.

(2) If ODJFS assigned a facility a quarterly facility average total case mix score in accordance with paragraph (C)(3) of this rule, said assigned score will not be used to calculate the provider's annual facility average case mix score.

(3) The qualifying case mix scores shall be summed and divided by the total number of quarters of qualifying scores to arrive at the annual facility average case mix score.

(G) For each provider that submits MDS 3.0 data in a given week, ODJFS shall send the "Case Mix Report" containing the following four components:

(1) The "Provider Detail Listing of Successfully Grouped Records," identifies records that were successfully grouped by ODJFS. The report will include all records received, even if the records will not be used in the quarterly score calculation;

(2) The "Critical Error Summary," that identifies the provider's records that will be assigned into the default group forty-five unless they are corrected before the end of the reporting quarter in accordance with rule 5101:3-3-43.1 of the Administrative Code.

(3) The "Provider Detail Listing of Records with Critical Errors," provides detail for each record listed on the "Critical Error Summary" identifying the failed edits.

(4) The "Discharge and Reentry Tracking Form Summary," that identifies all discharge and reentry tracking forms that were received by ODJFS.

(H) ODJFS shall provide two preliminary "Calculation of Facility Case Mix Scores" reports. The first report will reflect records submitted up to the quarterly filing date. The second report will reflect records submitted up to approximately two weeks prior to the quarterly corrections deadline. Both reports will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score. Providers may file corrections to the extent permitted by rule 5101:3-3-43.1 of the Administrative Code.

(I) After the quarterly corrections deadline specified in rule 5101:3-3-43.1 of the Administrative Code, ODJFS shall provide a final "Calculation of Facility Case Mix Scores" report. The report will include a calculation of the quarterly facility average total case mix score and the quarterly facility average medicaid case mix score.

(J) Following the determination of the two quarterly facility average medicaid case mix scores used to calculate the semiannual medicaid case mix scores effective July first and January first of the fiscal year, ODJFS shall provide a "Semiannual Medicaid Case Mix Score Calculation Report" to each provider.

(K) Following the calculation of the annual facility average case mix score, ODJFS shall provide an "Annual Facility Average Case Mix Score Calculation Report" to each provider.

Sec. 5111.232. Medicaid Only Case-Mix

(A) (1) The department of job and family services shall determine semiannual and annual average case-mix scores for nursing facilities by using all of the following:

(a) Data from a resident assessment instrument specified in rules adopted under section 5111.02 of the Revised Code pursuant to section 1919(e)(5) of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 1396r(e)(5), as amended, for the following residents:

(i) When determining semiannual case-mix scores, each resident who is a medicaid recipient;

(ii) When determining annual average case-mix scores, each resident regardless of payment source.

(b) Except as provided in rules authorized by divisions (A)(2)(a) and (b) of this section, the case-mix values established by the United States department of health and human services;

(c) Except as modified in rules authorized by division (A)(2)(c) of this section, the grouper methodology used on June 30, 1999, by the United States department of health and human services for prospective payment of skilled nursing facilities under the Medicare program established by Title XVIII.

(2) The director of job and family services may adopt rules under section 5111.02 of the Revised Code that do any of the following:

(a) Adjust the case-mix values specified in division (A)(1)(b) of this section to reflect changes in relative wage differentials that are specific to this state;

(b) Express all of those case-mix values in numeric terms that are different from the terms specified by the United States department of health and human services but that do not alter the relationship of the case-mix values to one another;

(c) Modify the grouper methodology specified in division (A)(1)(c) of this section as follows:

(i) Establish a different hierarchy for assigning residents to case-mix categories under the methodology;

(ii) Prohibit the use of the index maximizer element of the methodology;

(iii) Incorporate changes to the methodology the United States department of health and human services makes after June 30, 1999.

(B) The department shall determine case-mix scores for intermediate care facilities for the mentally retarded using data for each resident, regardless of payment source, from a resident assessment instrument and grouper methodology prescribed in rules adopted under section 5111.02 of the Revised Code and expressed in case-mix values established by the department in those rules.

(C) Each calendar quarter, each provider shall compile complete assessment data, from the resident assessment instrument specified in rules authorized by division (A) or (B) of this section, for each resident of each of the provider's facilities, regardless of payment source, who was in the facility or on hospital or therapeutic leave from the facility on the last day of the quarter. Providers of a nursing facility shall submit the data to the department of health and, if required by rules, the department of job and family services. Providers of an intermediate care facility for the mentally retarded shall submit the data to the department of job and family services. The data shall be submitted not later than fifteen days after the end of the calendar quarter for which the data is compiled. Except as provided in division (D) of this section, the department, every six months and after the end of each calendar year shall calculate a semiannual and annual average case-mix score for each nursing facility using the facility's quarterly case-mix scores for that six-month period or calendar year. Also except as provided in division (D) of this section, the department, after the end of each calendar year, shall calculate an annual average case-mix score for each intermediate care facility for the mentally retarded using the facility's quarterly case-mix scores for that calendar year. The department shall make the calculations pursuant to procedures specified in rules adopted under section 5111.02 of the Revised Code.

(D) (1) If a provider does not timely submit information for a calendar quarter necessary to calculate a facility's case-mix score, or submits incomplete or inaccurate information for a calendar quarter, the department may assign the facility a quarterly average case-mix score that is five per cent less than the facility's quarterly average case-mix score for the preceding calendar quarter. If the facility was subject to an exception review under

division (C) of section 5111.27 of the Revised Code for the preceding calendar quarter, the department may assign a quarterly average case-mix score that is five per cent less than the score determined by the exception review. If the facility was assigned a quarterly average case-mix score for the preceding quarter, the department may assign a quarterly average case-mix score that is five per cent less than that score assigned for the preceding quarter. The department may use a quarterly average case-mix score assigned under division (D)(1) of this section, instead of a quarterly average case-mix score calculated based on the provider's submitted information, to calculate the facility's rate for direct care costs being established under section 5111.23 or 5111.231 of the Revised Code for one or more months, as specified in rules authorized by division (E) of this section, of the quarter for which the rate established under section 5111.23 or 5111.231 of the Revised Code will be paid. Before taking action under division (D)(1) of this section, the department shall permit the provider a reasonable period of time, specified in rules authorized by division (E) of this section, to correct the information. In the case of an intermediate care facility for the mentally retarded, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the eighty-first day after the end of the calendar quarter to which the information pertains. In the case of a nursing facility, the department shall not assign a quarterly average case-mix score due to late submission of corrections to assessment information unless the provider fails to submit corrected information prior to the earlier of the forty-sixth day after the end of the calendar quarter to which the information pertains or the deadline for submission of such corrections established by regulations adopted by the United States department of health and human services under Titles XVIII and XIX.

(2) If a provider is paid a rate for a facility calculated using a quarterly average case-mix score assigned under division (D)(1) of this section for more than six months in a calendar year, the department may assign the facility a cost per case-mix unit that is five per cent less than the facility's actual or assigned cost per case-mix unit for the preceding calendar year. The department may use the assigned cost per case-mix unit, instead of calculating the facility's actual cost per case-mix unit in accordance with section 5111.23 or 5111.231 of the Revised Code, to establish the facility's rate for direct care costs for the following fiscal year.

(3) The department shall take action under division (D)(1) or (2) of this section only in accordance with rules authorized by division (E) of this section. The department shall not take an action that affects rates for prior

payment periods except in accordance with sections 5111.27 and 5111.28 of the Revised Code.

(E) The director shall adopt rules under section 5111.02 of the Revised Code that do all of the following:

(1) Specify whether providers of a nursing facility must submit the assessment data to the department of job and family services;

(2) Specify the medium or media through which the completed assessment data shall be submitted;

(3) Establish procedures under which the assessment data shall be reviewed for accuracy and providers shall be notified of any data that requires correction;

(4) Establish procedures for providers to correct assessment data and specify a reasonable period of time by which providers shall submit the corrections. The procedures may limit the content of corrections by providers of nursing facilities in the manner required by regulations adopted by the United States department of health and human services under Titles XVIII and XIX;

(5) Specify when and how the department will assign case-mix scores or costs per case-mix unit under division (D) of this section if information necessary to calculate the facility's case-mix score is not provided or corrected in accordance with the procedures established by the rules. Notwithstanding any other provision of sections 5111.20 to 5111.33 of the Revised Code, the rules also may provide for the following:

(a) Exclusion of case-mix scores assigned under division (D) of this section from calculation of an intermediate care facility for the mentally retarded's annual average case-mix score and the maximum cost per case-mix unit for the facility's peer group;

(b) Exclusion of case-mix scores assigned under division (D) of this section from calculation of a nursing facility's semiannual or annual average case-mix score and the cost per case-mix unit for the facility's peer group.

5101:3-3-43.1 **Nursing facility (NF) case mix assessment instrument: minimum data set version 3.0 (MDS 3.0).**

(A) As used in this rule:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case-mix unit.

(2) "Assessment reference date (ARD)" is the last day of the observation (or "look back") period that the MDS 3.0 assessment covers for the resident.

(3) "Care area assessment (CAA) process" is the mechanism to facilitate care planning decisions and includes care area triggers (CATs), assessment of a triggered care area to facilitate care planning decision making and completion of the CAA summary (on the MDS 3.0, section V, item V0200) titled CAAs and care planning.

(4) "Case mix report" is a report generated by the Ohio department of job and family services (ODJFS) and distributed to the provider on the status of all MDS 3.0 assessment data that pertains to the calculation of a quarterly, semiannual or annual facility average case mix score.

(5) "Comprehensive assessment" means an assessment that includes completion of not only the appropriate MDS 3.0 assessment type listed in paragraph (B)(2) of this rule and designated for use in Ohio but also completion of the care area assessment (CAA) process.

(6) "Critical elements" are data items from a resident's MDS 3.0 that ODJFS verifies prior to determining a resident's resource utilization group, version III (RUG III) class.

(7) "Critical errors" are errors in the MDS 3.0 critical elements that prevent ODJFS from determining the resident's RUG III classification.

(8) "Default group" is RUG III group forty-five, the case mix group assigned to residents with MDS 3.0 records with inconsistent date fields, missing, incomplete, out of range or inaccurate data, including inaccurate resident identifiers any of which precludes grouping the record into RUG III groups one through forty-four.

(9) "Encoded," when used with reference to a record, means that the record has been recorded in electronic format. The record must be encoded in accordance with

the United States centers for medicare and medicaid services (CMS) uniform data submission document and state specifications.

(10) "Filing date" is the deadline for submission of the NF's MDS 3.0 assessment data that will be used to calculate the preliminary facility quarterly average case mix score. The filing date is the fifteenth calendar day following the reporting period end date (RPED).

(11) "Medicare required assessment" means the MDS 3.0 specified for use in Ohio that is required only for facilities participating in the medicare prospective payment system but does not include the CAA process.

(12) "Omnibus Budget Reconciliation Act of 1987 (OBRA 1987)" is the statutory authority for the RAI which specifies the a minimum data set (MDS) of core elements for use in conducting assessments of nursing home residents. Assessments are federally mandated and must be performed for all residents of medicare and/or medicaid certified nursing homes.

(13) "Other medicare required assessment (OMRA)" is an unscheduled MDS 3.0 PPS assessment required to be completed during a resident's medicare Part A SNF covered stay based on the start or cessation of rehabilitation services.

(14) "PPS assessment" is the tool that skilled nursing facilities (SNFs) use to assess the clinical condition for each medicare resident receiving Part A SNF level care for reimbursement under the SNF PPS.

(15) "Quarterly facility average total case mix score" is the facility average case mix score based on both medicaid and non-medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(1) of rule 5101:3-3-43.3 of the Administrative Code.

(16) "Quarterly facility average medicaid case mix score" is the facility average case mix score based on only medicaid resident data submitted for one reporting quarter and calculated pursuant to paragraph (B)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(17) "Quarterly review assessment" means an assessment that is normally conducted no less than once every three months using the MDS 3.0 designated for use in Ohio that does not include the CAA process.

(18) "Record" means a resident's encoded MDS 3.0 assessment as described in paragraphs (B)(1) to (B)(4) of this rule.

(19) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix group versus another, indicating the relative amount and cost of staff time required on average for defined worker classifications to care for residents in a single case mix group. The methodology for calculating relative resource weights is described in paragraph (H) of rule 5101:3-3-43.2 of the Administrative Code.

(20) "Reporting period end date" (RPED) is the last day of each calendar quarter.

(21) "Reporting quarter" is the calendar quarter in which the MDS 3.0 is completed, as indicated by the assessment reference date in MDS 3.0 section A, item - A2300, except as specified in paragraphs (C)(7) and (C)(8) of this rule.

(22) "Resident Assessment Instrument (RAI)" is the instrument used by NFs in Ohio to comply with 42 code of federal regulations (CFR) section 483.20 (effective 8/11/09 http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?sid=2e0cc442b567f836691e8d460522a8a3 &c=ecfr&tpl=/ecfrbrowse/Title42/42tab_02.tpl) and provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and identifies medical problems. The Ohio specified and federally approved instrument is composed of the MDS 3.0, and CAA process.

(23) "Resident case mix score" is the relative resource weight for the RUG III group to which the resident is assigned based on data elements from the resident's MDS 3.0 assessment.

(24) "Resident identifier code" is an alternative resident identifier if the resident does not have a social security number. The resident identifier code shall be reported in MDS 3.0 item S0150. The following method must be used to construct the identifier code. In the first three boxes, enter the first three letters of the resident's last name. In the next six boxes, enter the six digits of the resident's date of birth. Omit the century in the birth date.

(25) "RUG III" is the resource utilization groups, version III system of classifying NF residents into case mix groups described in paragraph (B) of rule 5101:3-3-43.2 of the Administrative Code. Resource utilization groups are clusters of NF residents, defined by resident characteristics, that correlate with resource use.

(26) "Semiannual facility average medicaid case mix score" is the average of a facility's two quarterly facility average medicaid case mix scores. It is used to establish the direct care rate and is calculated pursuant to paragraph (E) of rule 5101:3-3-43.3 of the Administrative Code.

(B) For the purpose of assigning a RUG III classification determining medicaid payment rates for NFs, ODJFS shall utilize the data from the MDS 3.0 as specified by the state and approved by CMS. Each NF shall assess all residents of medicaid-certified beds using the appropriate MDS 3.0 for assessment reference dates (ARDs) on or after October 1, 2010 as set forth in appendix A to this rule for a comprehensive assessment, or appendix D to this rule for a quarterly assessment, or appendix E to this rule for a PPS assessment. When the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) assessment (admission assessment, annual assessment, quarterly assessment, or significant change in status or a significant correction to a prior assessment) and medicare assessment time frames coincide, one assessment shall be used to satisfy both assessments. Admission assessments must be combined with either the medicare five day or medicare fourteen day assessment. For a resident who is not a new admission to the facility, the quarterly, the annual, and significant change in status assessments must be combined with any medicare assessment if the assessment reference date (ARD) is within the assigned medicare observation period. When combining the OBRA and medicare assessments, the most stringent requirement for MDS completion must be met. ODJFS shall not utilize the data in the other medicare required assessments (OMRAs) for calculating case mix scores or determining medicaid payment rates.

(1) Comprehensive assessments, medicare-required assessments, quarterly review assessments and significant corrections of quarterly assessments must be conducted in accordance with the requirements and frequency schedule found at 42 CFR section 483.20.

(2) For a comprehensive assessment, NFs must use the Ohio specified MDS 3.0, including section S. The comprehensive assessment, as set forth in appendix A to this rule is completed upon admission, annually, and when a significant change in the resident's status has occurred or a significant correction to a prior comprehensive assessment is required. NFs must use either the Ohio specified nursing home quarterly MDS 3.0 as set forth in appendix D to this rule including section S or the nursing home PPS assessment set forth in appendix E to this rule for the quarterly review assessment or a significant correction to a prior quarterly assessment. The nursing home PPS assessment must be used for all medicare required assessments.

(3) NFs must use the MDS 3.0 discharge assessment as set forth in appendix B to this rule for any residents who transfer, or are discharged and the MDS 3.0 tracking record as set forth in appendix C to this rule for any residents entering or reentering or who died in the facility in accordance with 42 CFR section 483.20.

(4) NFs must use the MDS correction request in section X of the MDS 3.0 for modification or inactivation of MDS records that have been accepted into the national MDS database.

(C) All NFs must submit to the national database encoded, accurate, and complete MDS - 3.0 data for all residents of medicaid certified NF beds, regardless of pay source or anticipated length of stay.

(1) MDS 3.0 data completed in accordance with paragraphs (B)(1) to (B)(4) of this rule must be encoded in accordance with 42 CFR section 483.20, CMS' uniform data submission document, and state record layout specifications.

(2) MDS 3.0 data must be submitted in an electronic format and in accordance with the frequency schedule found in 42 CFR section 483.20. The data may be submitted at any time during the reporting quarter that is permitted by instructions issued by the state. Except as provided in paragraph (D) of this rule, all records used in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score must be submitted by the filing date.

(3) If a NF submits MDS 3.0 data needed for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score after the forty-fifth day after the RPED, ODJFS may assign a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) MDS 3.0 data submitted by a provider that can not be timely extracted by ODJFS from the CMS data server may result in assignment of a quarterly facility average total case mix score as set forth in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as set forth in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(5) The annual, semiannual, and quarterly facility average total case mix score and quarterly facility average medicaid case mix score will be calculated using the MDS 3.0 record in effect on the RPED for:

(a) Residents who were admitted to the medicaid certified NF prior to the RPED and continue to be physically present in the NF on the RPED; and

(b) Residents who were admitted to the medicaid certified NF on the RPED; and

(c) Residents who were temporarily absent on the RPED but are considered residents and for whom a return is anticipated from hospital stays, visits with friends or relatives, or participation in therapeutic programs outside the facility.

(6) Records for residents who were permanently discharged from the NF, transferred to another NF, or expired prior to or on the RPED will not be used for determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score.

(7) For a resident admitted within fourteen days prior to the RPED, and whose initial assessment is not due until after the RPED, both of the following shall apply:

(a) The NF shall submit the appropriate initial assessment as specified in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0" issued by CMS (November 2009 http://www.cms.gov/NursingHomeQualityInits/25_NHQIMDS30.asp) and in 42 CFR 483.20.

(b) The initial assessment, if completed and submitted timely in accordance with paragraphs (C)(1) and (C)(2) of this rule, shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score in the quarter the resident entered the facility even if the assessment reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(8) For a resident who had at least one MDS 3.0 assessment completed before being transferred to a hospital, who then reenters the NF within fourteen days prior to the RPED, and has experienced a significant change in status that requires a comprehensive assessment upon reentry, the following shall apply:

(a) The NF shall submit a significant change assessment within fourteen days of reentry, as indicated by the MDS 3.0 assessment reference date (MDS 3.0, item A2300).

(b) The significant change assessment shall be used for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score for the quarter in which the resident reentered the facility even if the assessment

reference date is after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code.

(D) Corrections to MDS 2.0 data with an ARD on or before September 30, 2010 must be made in accordance with the requirements in the "CMS Revised Long Term Care Resident Assessment Instrument User's Manual version 2.0", and the "State Operations Manual" issued by CMS (http://www.cms.gov/Manuals/IOM/). Corrections to MDS 3.0 data with an ARD on or after October 1, 2010 must be made in accordance with the requirements in the "Long-Term Care Facility Resident Assessment Instrument User's Manual version 3.0", and the "State Operations Manual" issued by CMS (Rev.1, May 21, 2004 http://www.cms.gov/Manuals/IOM/) and,

(1) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, the facility must transmit the corrections to the state no later than forty-five days after the RPED.

(2) For use in determining the quarterly facility average total case mix score and quarterly facility average medicaid case mix score, all significant correction assessments must contain an assessment reference date within the reporting quarter.

(3) The provider shall submit an accurate, encoded MDS 3.0 record for each resident in a medicaid certified bed on the RPED.

(a) The provider shall transmit MDS 3.0 assessments that were completed timely but omitted from the previous transmissions and ODJFS shall use the resident case mix scores from the assessments for determining the quarterly facility average total case mix score and may be used for determining the quarterly facility average medicaid case mix score, if the assessments are transmitted no later than forty-five days after the RPED provided the record is identified as a medicaid record pursuant to the calculation methodology in rule 5101:3-3-43.3 of the Administrative Code. If the assessments are not transmitted within forty-five days after the RPED, ODJFS may assign a default group for those records.

(b) The provider shall notify ODJFS within forty-five days of the RPED of any records for residents in medicaid certified beds on the RPED that were not completed timely and were not transmitted to the state. ODJFS may assign default scores to those records as described in paragraph (F) of rule 5101:3-3-43.2 of the Administrative Code.

(c) The provider has forty-five days after the RPED to transmit the appropriate discharge assessment to the national database, if more residents are determined as being in the facility on the RPED than the number of its medicaid certified beds. If the facility does not correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(d) The provider shall notify ODJFS within forty-five days of the RPED of any residents who were reported to be residents of the facility on the RPED, but who had actually been discharged prior to the RPED. If the provider fails to correct the error within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(e) The provider has forty-five days after the RPED to submit appropriate modifications or discharge assessments to rectify any discrepancy between the records selected for determining the quarterly facility average total case mix score and the facility census on the RPED. If the facility does not correct the error(s) within forty-five days after the RPED, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

(4) If the provider's number of records assigned to the default group in accordance with paragraphs (D)(3)(a) and (D)(3)(b) of this rule is greater than ten per cent, ODJFS may assign a quarterly facility average total case mix score as specified in paragraph (C)(3) of rule 5101:3-3-43.3 of the Administrative Code and a quarterly facility average medicaid case mix score as specified in paragraph (D)(4) of rule 5101:3-3-43.3 of the Administrative Code.

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code [ ]

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Middle initial: [ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

D. Suffix: [ ][ ][ ]

A0600. Social Security and Medicare Numbers

A. Social Security Number:

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number):

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code [ ]

1. **Male**
2. **Female**

A0900. Birth Date

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- [ ] **A. American Indian or Alaska Native**
- [ ] **B. Asian**
- [ ] **C. Black or African American**
- [ ] **D. Hispanic or Latino**
- [ ] **E. Native Hawaiian or Other Pacific Islander**
- [ ] **F. White**

A1100. Language

Enter Code [ ]

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

A1300. Optional Resident Items

A. Medical record number: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number: ☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Lifetime occupation(s) - put "/" between two occupations: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. No
1. Yes
9. Not a Medicaid certified unit

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

☐ A. Down syndrome

☐ B. Autism

☐ C. Epilepsy

☐ D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐ E. MR/DD with no organic condition

No MR/DD

☐ Z. None of the above

A1600. Entry Date (date of this admission/reentry into the facility)

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A1700. Type of Entry

Enter Code ☐

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2300. Assessment Reference Date

Observation end date:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2400. Medicare Stay

Enter Code [ ]

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, including regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code [ ]
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code [ ]

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code [ ]

Ask resident: *"Please tell me what year it is right now."*

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code [ ]

Ask resident: *"What month are we in right now?"*

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code [ ]

Ask resident: *"What day of the week is today?"*

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code [ ]

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code [ ]

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code [ ]

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score [ ][ ]

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- ☐ **A. Current season**
- ☐ **B. Location of own room**
- ☐ **C. Staff names and faces**
- ☐ **D. That he or she is in a nursing home**
- ☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

- ☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- ☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- ☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- ☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?

0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	☐	☐
B. *Feeling down, depressed, or hopeless*	☐	☐
C. *Trouble falling or staying asleep, or sleeping too much*	☐	☐
D. *Feeling tired or having little energy*	☐	☐
E. *Poor appetite or overeating*	☐	☐
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*	☐	☐
G. *Trouble concentrating on things, such as reading the newspaper or watching television*	☐	☐
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*	☐	☐
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	☐	☐

D0300. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?**
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		
B. Feeling or appearing down, depressed, or hopeless		
C. Trouble falling or staying asleep, or sleeping too much		
D. Feeling tired or having little energy		
E. Poor appetite or overeating		
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		
G. Trouble concentrating on things, such as reading the newspaper or watching television		
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		
I. States that life isn't worth living, wishes for death, or attempts to harm self		
J. Being short-tempered, easily annoyed		

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Psychosis

Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Enter Codes in Boxes

- ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0300. Overall Presence of Behavioral Symptoms

Enter Code ☐

Were any behavioral symptoms in questions E0200 coded 1, 2, or 3?
0. **No** → Skip to E0800, Rejection of Care
1. **Yes** → Considering all of E0200, Behavioral Symptoms, answer E0500 and E0600 below

E0500. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐ **A. Put the resident at significant risk for physical illness or injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly interfere with the resident's care?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly interfere with the resident's participation in activities or social interactions?**
0. **No**
1. **Yes**

E0600. Impact on Others

Did any of the identified symptom(s):

Enter Code ☐ **A. Put others at significant risk for physical injury?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Significantly intrude on the privacy or activity of others?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Significantly disrupt care or living environment?**
0. **No**
1. **Yes**

E0800. Rejection of Care - Presence & Frequency

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

Enter Code ☐
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0900. Wandering - Presence & Frequency

Enter Code [ ]

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavioral or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

E1000. Wandering - Impact

Enter Code [ ]

A. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

0. **No**
1. **Yes**

Enter Code [ ]

B. Does the wandering significantly intrude on the privacy or activities of others?

0. **No**
1. **Yes**

E1100. Change in Behavior or Other Symptoms

Consider all of the symptoms assessed in items E0100 through E1000

Enter Code [ ]

How does resident's current behavior status, care rejection, or wandering **compare to prior assessment (OBRA or PPS)?**

0. **Same**
1. **Improved**
2. **Worse**
3. **N/A** because no prior MDS assessment

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

F0300. Should Interview for Daily and Activity Preferences be Conducted? - Attempt to interview all residents able to communicate. If resident is unable to complete, attempt to complete interview with family member or significant other

Enter Code [ ]

0. **No** (resident is rarely/never understood and family/significant other not available) → Skip to and complete F0800, Staff Assessment of Daily and Activity Preferences
1. **Yes** → Continue to F0400, Interview for Daily Preferences

F0400. Interview for Daily Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

- [ ] ***A.*** *how important is it to you to* ***choose what clothes to wear?***
- [ ] ***B.*** *how important is it to you to* ***take care of your personal belongings or things?***
- [ ] ***C.*** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
- [ ] ***D.*** *how important is it to you to* ***have snacks available between meals?***
- [ ] ***E.*** *how important is it to you to* ***choose your own bedtime?***
- [ ] ***F.*** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
- [ ] ***G.*** *how important is it to you to* ***be able to use the phone in private?***
- [ ] ***H.*** *how important is it to you to* ***have a place to lock your things to keep them safe?***

F0500. Interview for Activity Preferences

Show resident the response options and say: ***"While you are in this facility..."***

Coding:
1. **Very important**
2. **Somewhat important**
3. **Not very important**
4. **Not important at all**
5. **Important, but can't do or no choice**
9. **No response or non-responsive**

↓ **Enter Codes in Boxes**

- [ ] ***A.*** *how important is it to you to* ***have books, newspapers, and magazines to read?***
- [ ] ***B.*** *how important is it to you to* ***listen to music you like?***
- [ ] ***C.*** *how important is it to you to* ***be around animals such as pets?***
- [ ] ***D.*** *how important is it to you to* ***keep up with the news?***
- [ ] ***E.*** *how important is it to you to* ***do things with groups of people?***
- [ ] ***F.*** *how important is it to you to* ***do your favorite activities?***
- [ ] ***G.*** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
- [ ] ***H.*** *how important is it to you to* ***participate in religious services or practices?***

F0600. Daily and Activity Preferences Primary Respondent

Enter Code [ ]

Indicate primary respondent for Daily and Activity Preferences (F0400 and F0500)
1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No response" to 3 or more items")

Resident _____ Identifier _____ Date _____

Section F Preferences for Customary Routine and Activities

F0700. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter Code ☐

0. **No** (because Interview for Daily and Activity Preferences (F0400 and F0500) was completed by resident or family/significant other) → Skip to and complete G0110, Activities of Daily Living (ADL) Assistance
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F0400 and F0500) were not completed by resident or family/significant other) → Continue to F0800, Staff Assessment of Daily and Activity Preferences

F0800. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F0400-F0500) was completed

Resident Prefers:

↓ **Check all that apply**

- ☐ **A. Choosing clothes to wear**
- ☐ **B. Caring for personal belongings**
- ☐ **C. Receiving tub bath**
- ☐ **D. Receiving shower**
- ☐ **E. Receiving bed bath**
- ☐ **F. Receiving sponge bath**
- ☐ **G. Snacks between meals**
- ☐ **H. Staying up past 8:00 p.m.**
- ☐ **I. Family or significant other involvement in care discussions**
- ☐ **J. Use of phone in private**
- ☐ **K. Place to lock personal belongings**
- ☐ **L. Reading books, newspapers, or magazines**
- ☐ **M. Listening to music**
- ☐ **N. Being around animals such as pets**
- ☐ **O. Keeping up with the news**
- ☐ **P. Doing things with groups of people**
- ☐ **Q. Participating in favorite activities**
- ☐ **R. Spending time away from the nursing home**
- ☐ **S. Spending time outdoors**
- ☐ **T. Participating in religious activities or practices**
- ☐ **Z. None of the above**

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		
C. Walk in room - how resident walks between locations in his/her room		
D. Walk in corridor - how resident walks in corridor on unit		
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses		
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)		
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag		
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)		

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

☐ **A. Moving from seated to standing position**

☐ **B. Walking** (with assistive device if used)

☐ **C. Turning around** and facing the opposite direction while walking

☐ **D. Moving on and off toilet**

☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)

☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

☐ **A. Cane/crutch**

☐ **B. Walker**

☐ **C. Wheelchair** (manual or electric)

☐ **D. Limb prosthesis**

☐ **Z. None of the above** were used

G0900. Functional Rehabilitation Potential

Complete only if A0310A = 01

Enter Code ☐ **A. Resident believes he or she is capable of increased independence** in at least some ADLs
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐ **B. Direct care staff believe resident is capable of increased independence** in at least some ADLs
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ B. **External catheter**
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐ A. **Has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training)** been attempted on admission/reentry or since urinary incontinence was noted in this facility?
0. **No** → Skip to H0300, Urinary Continence
1. **Yes** → Continue to H0200B, Response
9. **Unable to determine** → Skip to H0200C, Current toileting program or trial

Enter Code ☐ B. **Response** - What was the resident's response to the trial program?
0. **No improvement**
1. **Decreased wetness**
2. **Completely dry** (continent)
9. **Unable to determine** or trial in progress

Enter Code ☐ C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐ **Urinary continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐ **Bowel continence** - Select the one category that best describes the resident
0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐ **Is a toileting program currently being used to manage the resident's bowel continence?**
0. **No**
1. **Yes**

H0600. Bowel Patterns

Enter Code ☐ **Constipation present?**
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Cancer

- ☐ I0100. **Cancer** (with or without metastasis)

Heart/Circulation

- ☐ I0200. **Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ I0300. **Atrial Fibrillation or Other Dysrhythmias** (e.g., bradycardias and tachycardias)
- ☐ I0400. **Coronary Artery Disease (CAD)** (e.g., angina, myocardial infarction, and atherosclerotic heart disease (ASHD))
- ☐ I0500. **Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ I0600. **Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ I0700. **Hypertension**
- ☐ I0800. **Orthostatic Hypotension**
- ☐ I0900. **Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

Gastrointestinal

- ☐ I1100. **Cirrhosis**
- ☐ I1200. **Gastroesophageal Reflux Disease (GERD) or Ulcer** (e.g., esophageal, gastric, and peptic ulcers)
- ☐ I1300. **Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

Genitourinary

- ☐ I1400. **Benign Prostatic Hyperplasia (BPH)**
- ☐ I1500. **Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**
- ☐ I1550. **Neurogenic Bladder**
- ☐ I1650. **Obstructive Uropathy**

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)**
- ☐ I2000. **Pneumonia**
- ☐ I2100. **Septicemia**
- ☐ I2200. **Tuberculosis**
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ I2400. **Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ I2500. **Wound Infection** (other than foot)

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)
- ☐ I3400. **Thyroid Disorder** (e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ☐ I3700. **Arthritis** (e.g., degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA))
- ☐ I3800. **Osteoporosis**
- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I4000. **Other Fracture**

Neurological

- ☐ I4200. **Alzheimer's Disease**
- ☐ I4300. **Aphasia**
- ☐ I4400. **Cerebral Palsy**
- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)

Neurological Diagnoses continued on next page

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Neurological - Continued

- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5350. Tourette's Syndrome**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Manic Depression** (bipolar disease)
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Vision

- ☐ **I6500. Cataracts, Glaucoma, or Macular Degeneration**

None of Above

- ☐ **I7900. None of the above active diagnoses** within the last 7 days

Other

- ☐ **I8000. Additional active diagnoses**
  Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ ☐☐☐☐☐☐☐☐
B. _____ ☐☐☐☐☐☐☐☐
C. _____ ☐☐☐☐☐☐☐☐
D. _____ ☐☐☐☐☐☐☐☐
E. _____ ☐☐☐☐☐☐☐☐
F. _____ ☐☐☐☐☐☐☐☐
G. _____ ☐☐☐☐☐☐☐☐
H. _____ ☐☐☐☐☐☐☐☐
I. _____ ☐☐☐☐☐☐☐☐
J. _____ ☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Been on a scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐ Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐ **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐
0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- ☐ A. **Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ B. **Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- ☐ C. **Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ D. **Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ Z. **None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain
1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ A. **Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ B. **Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ C. **Shortness of breath** or trouble breathing **when lying flat**
- ☐ Z. **None of the above**

J1300. Current Tobacco Use

Enter Code ☐

Tobacco use
0. **No**
1. **Yes**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- ☐ A. **Fever**
- ☐ B. **Vomiting**
- ☐ C. **Dehydrated**
- ☐ D. **Internal bleeding**
- ☐ Z. **None of the above**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code [ ]
A. Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code [ ]
B. Did the resident have a fall any time in the **last 2-6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code [ ]
C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code [ ]
Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

[ ] **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

[ ] **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

[ ] **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches — **A. Height** (in inches). Record most recent height measure since admission

☐☐☐ pounds — **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ **Check all that apply**

- ☐ **A. Parenteral/IV feeding**
- ☐ **B. Feeding tube** - nasogastric or abdominal (PEG)
- ☐ **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **Z. None of the above**

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked

Enter Code ☐

A. Proportion of total calories the resident received through parenteral or tube feeding

1. **25% or less**
2. **26-50%**
3. **51% or more**

Enter Code ☐

B. Average fluid intake per day by IV or tube feeding

1. **500 cc/day or less**
2. **501 cc/day or more**

Section L Oral/Dental Status

L0200. Dental

↓ **Check all that apply**

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **B. No natural teeth or tooth fragment(s)** (edentulous)
- ☐ **C. Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
- ☐ **D. Obvious or likely cavity or broken natural teeth**
- ☐ **E. Inflamed or bleeding gums or loose natural teeth**
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**
- ☐ **G. Unable to examine**
- ☐ **Z. None of the above were present**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ **Check all that apply**

- ☐ **A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐

Is this resident at risk of developing pressure ulcers?

0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers

Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐

1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐

2. **Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐

2. **Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number ☐

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐

2. **Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐ **1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐ **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐ **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code [ ]

A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number [ ] **B. Stage 2**

Enter Number [ ] **C. Stage 3**

Enter Number [ ] **D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number [ ] **Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

- [ ] **A. Infection of the foot** (e.g., cellulitis, purulent drainage)
- [ ] **B. Diabetic foot ulcer(s)**
- [ ] **C. Other open lesion(s) on the foot**

Other Problems

- [ ] **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- [ ] **E. Surgical wound(s)**
- [ ] **F. Burn(s)** (second or third degree)

None of the Above

- [ ] **Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

- [ ] **A. Pressure reducing device for chair**
- [ ] **B. Pressure reducing device for bed**
- [ ] **C. Turning/repositioning program**
- [ ] **D. Nutrition or hydration intervention** to manage skin problems
- [ ] **E. Ulcer care**
- [ ] **F. Surgical wound care**
- [ ] **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
- [ ] **H. Applications of ointments/medications** other than to feet
- [ ] **I. Application of dressings to feet** (with or without topical medications)
- [ ] **Z. None of the above** were provided

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received

N0350. Insulin

Enter Days ☐ **A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/reentry if less than 7 days

Enter Days ☐ **B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/reentry if less than 7 days

N0400. Medications Received

↓ **Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days**

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**
- ☐ **E. Anticoagulant** (warfarin, heparin, or low-molecular weight heparin)
- ☐ **F. Antibiotic**
- ☐ **G. Diuretic**
- ☐ **Z. None of the above were received**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
G. BiPAP/CPAP	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care	☐	☐
L. Respite care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	☐	☐
None of the Above		
Z. None of the above	☐	☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
- 0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
- 1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
- 1. **Resident not in facility** during this year's flu season
- 2. **Received outside of this facility**
- 3. **Not eligible** - medical contraindication
- 4. **Offered and declined**
- 5. **Not offered**
- 6. **Inability to obtain vaccine** due to a declared shortage
- 9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
- 0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
- 1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
- 1. **Not eligible** - medical contraindication
- 2. **Offered and declined**
- 3. **Not offered**

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Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

B. Occupational Therapy

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

C. Physical Therapy

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

D. Respiratory Therapy

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Days [ ]

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400E, Psychological Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

E. Psychological Therapy (by any licensed mental health professional)

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Days [ ]

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0400F, Recreational Therapy
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

F. Recreational Therapy (includes recreational and music therapy)

Enter Number of Minutes [ ][ ][ ][ ]

Enter Number of Days [ ]

1. **Total minutes** - record the total number of minutes this therapy was administered to the resident in the last 7 days
   If zero, → skip to O0500, Restorative Nursing Programs
2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
[ ]	**A. Range of motion (passive)**
[ ]	**B. Range of motion (active)**
[ ]	**C. Splint or brace assistance**

Number of Days	Training and Skill Practice In:
[ ]	**D. Bed mobility**
[ ]	**E. Transfer**
[ ]	**F. Walking**
[ ]	**G. Dressing and/or grooming**
[ ]	**H. Eating and/or swallowing**
[ ]	**I. Amputation/prostheses care**
[ ]	**J. Communication**

O0600. Physician Examinations

Enter Days [ ][ ] Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days [ ][ ] Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐ **A. Resident participated in assessment**
0. **No**
1. **Yes**

Enter Code ☐ **B. Family or significant other participated in assessment**
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐ **C. Guardian or legally authorized representative participated in assessment**
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐ **A. Resident's overall goal established during assessment process**
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐ **B. Indicate information source for Q0300A**
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐ **A. Is there an active discharge plan in place for the resident to return to the community?**
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐ **B. What determination was made by the resident and the care planning team regarding discharge to the community?**
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to next active section (V or X)

Q0500. Return to Community

Enter Code ☐ **A. Has the resident been asked about returning to the community?**
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐ **B. Ask the resident** (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐ **Has a referral been made to the local contact agency?**
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section V Care Area Assessment (CAA) Summary

V0100. Items From the Most Recent Prior OBRA or Scheduled PPS Assessment

Complete only if A0310E = 0 and if the following is true for the **prior assessment**: A0310A = 01- 06 or A0310B = 01- 06

Enter Code [ ][ ]

A. Prior Assessment Federal OBRA Reason for Assessment (A0310A value from prior assessment)

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. Prior Assessment PPS Reason for Assessment (A0310B value from prior assessment)

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
99. **Not PPS** assessment

C. Prior Assessment Reference Date (A2300 value from prior assessment)

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

Enter Score [ ][ ]

D. Prior Assessment Brief Interview for Mental Status (BIMS) Summary Score (C0500 value from prior assessment)

Enter Score [ ][ ]

E. Prior Assessment Resident Mood Interview (PHQ-9©) Total Severity Score (D0300 value from prior assessment)

Enter Score [ ][ ]

F. Prior Assessment Staff Assessment of Resident Mood (PHQ-9-OV) Total Severity Score (D0600 value from prior assessment)

Resident _____ Identifier _____ Date _____

Section V Care Area Assessment (CAA) Summary

V0200. CAAs and Care Planning

1. Check column A if Care Area is triggered.
2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment of the care area. The Addressed in Care Plan column must be completed within 7 days of completing the RAI (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan.
3. Indicate in the Location and Date of CAA Information column where information related to the CAA can be found. CAA documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

A. CAA Results

Care Area	A. Care Area Triggered	B. Addressed in Care Plan	Location and Date of CAA Information
	↓ Check all that apply ↓		
01. Delirium	☐	☐	
02. Cognitive Loss/Dementia	☐	☐	
03. Visual Function	☐	☐	
04. Communication	☐	☐	
05. ADL Functional/Rehabilitation Potential	☐	☐	
06. Urinary Incontinence and Indwelling Catheter	☐	☐	
07. Psychosocial Well-Being	☐	☐	
08. Mood State	☐	☐	
09. Behavioral Symptoms	☐	☐	
10. Activities	☐	☐	
11. Falls	☐	☐	
12. Nutritional Status	☐	☐	
13. Feeding Tube	☐	☐	
14. Dehydration/Fluid Maintenance	☐	☐	
15. Dental Care	☐	☐	
16. Pressure Ulcer	☐	☐	
17. Psychotropic Drug Use	☐	☐	
18. Physical Restraints	☐	☐	
19. Pain	☐	☐	
20. Return to Community Referral	☐	☐	

B. Signature of RN Coordinator for CAA Process and Date Signed

1. Signature

2. Date ☐☐-☐☐-☐☐☐☐ (Month Day Year)

C. Signature of Person Completing Care Plan and Date Signed

1. Signature

2. Date ☐☐-☐☐-☐☐☐☐ (Month Day Year)

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code [ ]

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code [ ]

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

X0300. Gender on existing record to be modified/inactivated

Enter Code [ ]

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code [ ][ ]

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code [ ]

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code [ ]

D. Is this a Swing Bed clinical change assessment? Complete only if X0200 = 2
0. **No**
1. **Yes**

Enter Code [ ][ ]

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - **Complete one only**

A. Assessment Reference Date - Complete only if X0600F = 99
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. Entry Date - Complete only if X0600F = 01
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number [ ][ ]

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

↓ **Check all that apply**

- [ ] **A. Transcription error**
- [ ] **B. Data entry error**
- [ ] **C. Software product error**
- [ ] **D. Item coding error**
- [ ] **Z. Other error requiring modification**
  If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

↓ **Check all that apply**

- [ ] **A. Event did not occur**
- [ ] **Z. Other error requiring inactivation**
  If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. No
1. Yes

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Z0200. State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0250. Alternate State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG Case Mix group:**

B. **RUG version code:**

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month ___ - Day ___ - Year ___

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Discharge (ND) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge**

TN 10-002 Approval Date AUG 18 2011
Supersedes
TN 06-010 Effective Date 10-01-10

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code [ ]

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Middle initial: [ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

D. Suffix: [ ][ ][ ]

A0600. Social Security and Medicare Numbers

A. Social Security Number:

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number):

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code [ ]

1. **Male**
2. **Female**

A0900. Birth Date

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- [ ] **A. American Indian or Alaska Native**
- [ ] **B. Asian**
- [ ] **C. Black or African American**
- [ ] **D. Hispanic or Latino**
- [ ] **E. Native Hawaiian or Other Pacific Islander**
- [ ] **F. White**

A1100. Language

Enter Code [ ]

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

A1300. Optional Resident Items

A. Medical record number: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number: ☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Lifetime occupation(s) - put "/" between two occupations: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. No
1. Yes
9. Not a Medicaid certified unit

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

☐ A. Down syndrome

☐ B. Autism

☐ C. Epilepsy

☐ D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

☐ E. MR/DD with no organic condition

No MR/DD

☐ Z. None of the above

A1600. Entry Date (date of this admission/reentry into the facility)

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

A1700. Type of Entry

Enter Code ☐

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2300. Assessment Reference Date

Observation end date:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A2400. Medicare Stay

Enter Code [ ]

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

Resident _____ Identifier _____ Date _____

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code [ ]

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code [ ]

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code [ ]

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code [ ]

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code [ ]

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code [ ]

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code [ ]

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, including regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code [ ]

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code [ ]
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code [ ]

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code [ ]

Ask resident: *"Please tell me what year it is right now."*

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code [ ]

Ask resident: *"What month are we in right now?"*

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code [ ]

Ask resident: *"What day of the week is today?"*

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code [ ]

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code [ ]

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code [ ]

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score [ ][ ]

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code [ ]
0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code [ ]
Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code [ ]
Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- [ ] **A. Current season**
- [ ] **B. Location of own room**
- [ ] **C. Staff names and faces**
- [ ] **D. That he or she is in a nursing home**
- [ ] **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code [ ]
Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

- [ ] **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- [ ] **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- [ ] **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- [ ] **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code [ ]
Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?**

0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		
B. Feeling or appearing down, depressed, or hopeless		
C. Trouble falling or staying asleep, or sleeping too much		
D. Feeling tired or having little energy		
E. Poor appetite or overeating		
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		
G. Trouble concentrating on things, such as reading the newspaper or watching television		
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		
I. States that life isn't worth living, wishes for death, or attempts to harm self		
J. Being short-tempered, easily annoyed		

D0600. Total Severity Score

Enter Score: ☐☐ **Add scores for all frequency responses in Column 2**, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?**
0. **No**
1. **Yes**

Section E Behavior

E0100. Psychosis

↓ **Check all that apply**

☐ **A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐ **B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐ **Z. None of the above**

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Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance
Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. Walk in room - how resident walks between locations in his/her room	☐	☐
D. Walk in corridor - how resident walks in corridor on unit	☐	☐
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance

0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:

0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

- ☐ **A. Moving from seated to standing position**
- ☐ **B. Walking** (with assistive device if used)
- ☐ **C. Turning around** and facing the opposite direction while walking
- ☐ **D. Moving on and off toilet**
- ☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

- ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)
- ☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

- ☐ **A. Cane/crutch**
- ☐ **B. Walker**
- ☐ **C. Wheelchair** (manual or electric)
- ☐ **D. Limb prosthesis**
- ☐ **Z. None of the above** were used

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ B. **External catheter**
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Heart/Circulation

- ☐ I0200. **Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ I0600. **Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ I0700. **Hypertension**
- ☐ I0800. **Orthostatic Hypotension**

Genitourinary

- ☐ I1550. **Neurogenic Bladder**
- ☐ I1650. **Obstructive Uropathy**

Infections

- ☐ I1700. **Multidrug-Resistant Organism (MDRO)**
- ☐ I2000. **Pneumonia**
- ☐ I2100. **Septicemia**
- ☐ I2200. **Tuberculosis**
- ☐ I2300. **Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ I2500. **Wound Infection** (other than foot)

Metabolic

- ☐ I2900. **Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ I3100. **Hyponatremia**
- ☐ I3200. **Hyperkalemia**
- ☐ I3300. **Hyperlipidemia** (e.g., hypercholesterolemia)

Musculoskeletal

- ☐ I3900. **Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ I4000. **Other Fracture**

Neurological

- ☐ I4500. **Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ I4800. **Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ I4900. **Hemiplegia or Hemiparesis**
- ☐ I5000. **Paraplegia**
- ☐ I5100. **Quadriplegia**
- ☐ I5200. **Multiple Sclerosis (MS)**
- ☐ I5250. **Huntington's Disease**
- ☐ I5300. **Parkinson's Disease**
- ☐ I5400. **Seizure Disorder or Epilepsy**
- ☐ I5500. **Traumatic Brain Injury (TBI)**

Nutritional

- ☐ I5600. **Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ☐ I5700. **Anxiety Disorder**
- ☐ I5800. **Depression** (other than bipolar)
- ☐ I5900. **Manic Depression** (bipolar disease)
- ☐ I5950. **Psychotic Disorder** (other than schizophrenia)
- ☐ I6000. **Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)

Pulmonary

- ☐ I6200. **Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ I6300. **Respiratory Failure**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Other

☐ **I8000. Additional active diagnoses**

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ ☐☐☐☐☐☐☐☐

B. _____ ☐☐☐☐☐☐☐☐

C. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Been on a scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐ Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐ **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code [ ]

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- [ ] **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- [ ] **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- [ ] **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- [ ] **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- [ ] **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code [ ]

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- [ ] **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- [ ] **B. Shortness of breath** or trouble breathing **when sitting at rest**
- [ ] **C. Shortness of breath** or trouble breathing **when lying flat**
- [ ] **Z. None of the above**

J1400. Prognosis

Enter Code [ ]

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- [ ] **A. Fever**
- [ ] **B. Vomiting**
- [ ] **C. Dehydrated**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐ **A.** Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐ **B.** Did the resident have a fall any time in the **last 2-6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐ **C.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code ☐ Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0200, Height and Weight
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section K Swallowing/Nutritional Status

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches **A. Height** (in inches). Record most recent height measure since admission

☐☐☐ pounds **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐ **Loss of 5% or more in the last month or loss of 10% or more in last 6 months**
0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ **Check all that apply**

☐ **A. Parenteral/IV feeding**
☐ **B. Feeding tube** - nasogastric or abdominal (PEG)
☐ **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
☐ **Z. None of the above**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

Check all that apply

- ☐ **A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐ **Is this resident at risk of developing pressure ulcers?**
0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**
0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐ **A. Number of Stage 1 pressure ulcers**
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐ 1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ 2. **Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐ 1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐ 2. **Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number ☐ 1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐ 2. **Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐ **1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐ **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐ **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐ **A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?**

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ **Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

☐ **A. Infection of the foot** (e.g., cellulitis, purulent drainage)

☐ **B. Diabetic foot ulcer(s)**

☐ **C. Other open lesion(s) on the foot**

Other Problems

☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)

☐ **E. Surgical wound(s)**

☐ **F. Burn(s)** (second or third degree)

None of the Above

☐ **Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

☐ **A. Pressure reducing device for chair**

☐ **B. Pressure reducing device for bed**

☐ **C. Turning/repositioning program**

☐ **D. Nutrition or hydration intervention** to manage skin problems

☐ **E. Ulcer care**

☐ **F. Surgical wound care**

☐ **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet

☐ **H. Applications of ointments/medications** other than to feet

☐ **I. Application of dressings to feet** (with or without topical medications)

☐ **Z. None of the above** were provided

Resident _____ Identifier _____ Date _____

Section N Medications

N0400. Medications Received

↓ **Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days**

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
E. Tracheostomy care		☐
F. Ventilator or respirator		☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the influenza vaccine in this facility** for this year's Influenza season?
- 0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
- 1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If influenza vaccine not received, state reason:
- 1. **Resident not in facility** during this year's flu season
- 2. **Received outside of this facility**
- 3. **Not eligible** - medical contraindication
- 4. **Offered and declined**
- 5. **Not offered**
- 6. **Inability to obtain vaccine** due to a declared shortage
- 9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
- 0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
- 1. **Yes** → Skip to O0600, Physical Examinations

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
- 1. **Not eligible** - medical contraindication
- 2. **Offered and declined**
- 3. **Not offered**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0600. Physician Examinations

Enter Days	
	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days	
	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ Enter Codes in Boxes	
	Used in Bed
	A. Bed rail
	B. Trunk restraint
	C. Limb restraint
	D. Other
	Used in Chair or Out of Bed
	E. Trunk restraint
	F. Limb restraint
	G. Chair prevents rising
	H. Other

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

C. Guardian or legally authorized representative participated in assessment
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code [ ]

1. **Add new record** → Skip to Z0300, Insurance Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code [ ]

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Last name:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

X0300. Gender on existing record to be modified/inactivated

Enter Code [ ]

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code [ ][ ]

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code [ ]

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

TN 10-002 Approval Date AUG 18 2011
Supersedes
~~TN 06-010 Effective Date 10-01-10~~

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code [ ]

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code [ ][ ]

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - **Complete one only**

A. Assessment Reference Date - Complete only if X0600F = 99
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. Entry Date - Complete only if X0600F = 01
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number [ ][ ]

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

- [ ] **A. Transcription error**
- [ ] **B. Data entry error**
- [ ] **C. Software product error**
- [ ] **D. Item coding error**
- [ ] **Z. Other error requiring modification**
  If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

- [ ] **A. Event did not occur**
- [ ] **Z. Other error requiring inactivation**
  If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0300. Insurance Billing

A. RUG Case Mix group:

B. RUG version code:

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month – Day – Year

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home and Swing Bed Tracking (NT/ST) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code [ ]

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Middle initial: [ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

D. Suffix: [ ][ ][ ]

A0600. Social Security and Medicare Numbers

A. Social Security Number: [ ][ ][ ] – [ ][ ] – [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number): [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code [ ]

1. **Male**
2. **Female**

A0900. Birth Date

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- [ ] **A. American Indian or Alaska Native**
- [ ] **B. Asian**
- [ ] **C. Black or African American**
- [ ] **D. Hispanic or Latino**
- [ ] **E. Native Hawaiian or Other Pacific Islander**
- [ ] **F. White**

A1200. Marital Status

Enter Code [ ]

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

A1600. Entry Date (date of this admission/reentry into the facility)

Month – Day – Year

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A2400. Medicare Stay

Enter Code [ ]

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to X0100, Type of Record
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code [ ]

1. **Add new record** → Skip to Z0400, Signature of Persons Completing the Assessment or Entry/Death Reporting
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code [ ]

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

X0300. Gender on existing record to be modified/inactivated

Enter Code [ ]

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code [ ][ ]

A. Federal OBRA Reason for Assessment
- 01. **Admission** assessment (required by day 14)
- 02. **Quarterly** review assessment
- 03. **Annual** assessment
- 04. **Significant change in status** assessment
- 05. **Significant correction** to **prior comprehensive** assessment
- 06. **Significant correction** to **prior quarterly** assessment
- 99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay
- 01. **5-day** scheduled assessment
- 02. **14-day** scheduled assessment
- 03. **30-day** scheduled assessment
- 04. **60-day** scheduled assessment
- 05. **90-day** scheduled assessment
- 06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay
- 07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment
- 99. **Not PPS** assessment

Enter Code [ ]

C. PPS Other Medicare Required Assessment - OMRA
- 0. **No**
- 1. **Start of therapy** assessment
- 2. **End of therapy** assessment
- 3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code [ ]

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code [ ][ ]

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. Entry Date - Complete only if X0600F = 01
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number [ ][ ]

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

- [ ] **A. Transcription error**
- [ ] **B. Data entry error**
- [ ] **C. Software product error**
- [ ] **D. Item coding error**
- [ ] **Z. Other error requiring modification**
  If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

- [ ] **A. Event did not occur**
- [ ] **Z. Other error requiring inactivation**
  If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Quarterly (NQ) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code [ ]

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Middle initial: [ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

D. Suffix: [ ][ ][ ]

A0600. Social Security and Medicare Numbers

A. Social Security Number:

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number):

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code [ ]

1. **Male**
2. **Female**

A0900. Birth Date

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Month Day Year

A1000. Race/Ethnicity

↓ **Check all that apply**

- [ ] **A. American Indian or Alaska Native**
- [ ] **B. Asian**
- [ ] **C. Black or African American**
- [ ] **D. Hispanic or Latino**
- [ ] **E. Native Hawaiian or Other Pacific Islander**
- [ ] **F. White**

A1100. Language

Enter Code [ ]

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code [ ]

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

A1300. Optional Resident Items

A. Medical record number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Room number: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Name by which resident prefers to be addressed: [ ]

D. Lifetime occupation(s) - put "/" between two occupations: [ ]

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code [ ]

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. No
1. Yes
9. Not a Medicaid certified unit

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

[ ] A. Down syndrome

[ ] B. Autism

[ ] C. Epilepsy

[ ] D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

[ ] E. MR/DD with no organic condition

No MR/DD

[ ] Z. None of the above

A1600. Entry Date (date of this admission/reentry into the facility)

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A1700. Type of Entry

Enter Code [ ]

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2300. Assessment Reference Date

Observation end date:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

A2400. Medicare Stay

Enter Code [ ]

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Resident _____ Identifier _____ Date _____

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code [ ]

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code [ ]

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code [ ]

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code [ ]

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code [ ]

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code [ ]

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code [ ]

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, including regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code [ ]

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code [ ]
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code [ ]

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code [ ]

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code [ ]

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code [ ]

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code [ ]

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code [ ]

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code [ ]

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score [ ][ ]

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code [ ]

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code [ ]

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code [ ]

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- [ ] **A. Current season**
- [ ] **B. Location of own room**
- [ ] **C. Staff names and faces**
- [ ] **D. That he or she is in a nursing home**
- [ ] **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code [ ]

Made decisions regarding tasks of daily life

0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

- [ ] **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- [ ] **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- [ ] **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- [ ] **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code [ ]

Is there evidence of an acute change in mental status from the resident's baseline?

0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. No
1. Yes

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Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things		
B. Feeling or appearing down, depressed, or hopeless		
C. Trouble falling or staying asleep, or sleeping too much		
D. Feeling tired or having little energy		
E. Poor appetite or overeating		
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		
G. Trouble concentrating on things, such as reading the newspaper or watching television		
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		
I. States that life isn't worth living, wishes for death, or attempts to harm self		
J. Being short-tempered, easily annoyed		

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Psychosis

Check all that apply

- ☐ A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ Z. **None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Enter Codes in Boxes

- ☐ A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		
C. Walk in room - how resident walks between locations in his/her room		
D. Walk in corridor - how resident walks in corridor on unit		
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses		
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)		
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag		
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)		

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

- ☐ **A. Moving from seated to standing position**
- ☐ **B. Walking** (with assistive device if used)
- ☐ **C. Turning around** and facing the opposite direction while walking
- ☐ **D. Moving on and off toilet**
- ☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

- ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)
- ☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

- ☐ **A. Cane/crutch**
- ☐ **B. Walker**
- ☐ **C. Wheelchair** (manual or electric)
- ☐ **D. Limb prosthesis**
- ☐ **Z. None of the above** were used

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ B. **External catheter**
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Heart/Circulation

- ☐ **I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
- ☐ **I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**

Genitourinary

- ☐ **I1550. Neurogenic Bladder**
- ☐ **I1650. Obstructive Uropathy**

Infections

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I2000. Pneumonia**
- ☐ **I2100. Septicemia**
- ☐ **I2200. Tuberculosis**
- ☐ **I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
- ☐ **I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
- ☐ **I2500. Wound Infection** (other than foot)

Metabolic

- ☐ **I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
- ☐ **I3100. Hyponatremia**
- ☐ **I3200. Hyperkalemia**
- ☐ **I3300. Hyperlipidemia** (e.g., hypercholesterolemia)

Musculoskeletal

- ☐ **I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
- ☐ **I4000. Other Fracture**

Neurological

- ☐ **I4200. Alzheimer's Disease**
- ☐ **I4300. Aphasia**
- ☐ **I4400. Cerebral Palsy**
- ☐ **I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I4800. Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
- ☐ **I4900. Hemiplegia or Hemiparesis**
- ☐ **I5000. Paraplegia**
- ☐ **I5100. Quadriplegia**
- ☐ **I5200. Multiple Sclerosis (MS)**
- ☐ **I5250. Huntington's Disease**
- ☐ **I5300. Parkinson's Disease**
- ☐ **I5400. Seizure Disorder or Epilepsy**
- ☐ **I5500. Traumatic Brain Injury (TBI)**

Nutritional

- ☐ **I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Manic Depression** (bipolar disease)
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Other

- ☐ **I8000. Additional active diagnoses**
  Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ ☐☐☐☐☐☐☐☐

B. _____ ☐☐☐☐☐☐☐☐

C. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Been on a scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐ Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐ **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

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Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code [ ]

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- [ ] **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- [ ] **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- [ ] **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- [ ] **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- [ ] **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code [ ]

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- [ ] **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- [ ] **B. Shortness of breath** or trouble breathing **when sitting at rest**
- [ ] **C. Shortness of breath** or trouble breathing **when lying flat**
- [ ] **Z. None of the above**

J1400. Prognosis

Enter Code [ ]

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- [ ] **A. Fever**
- [ ] **B. Vomiting**
- [ ] **C. Dehydrated**
- [ ] **D. Internal bleeding**
- [ ] **Z. None of the above**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐
A. Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐
B. Did the resident have a fall any time in the **last 2-6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐
C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code ☐
Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

↓ **Check all that apply**

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches — **A. Height** (in inches). Record most recent height measure since admission

☐☐☐ pounds — **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

↓ **Check all that apply**

- ☐ **A. Parenteral/IV feeding**
- ☐ **B. Feeding tube** - nasogastric or abdominal (PEG)
- ☐ **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **Z. None of the above**

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked

Enter Code ☐

A. Proportion of total calories the resident received through parenteral or tube feeding

1. **25% or less**
2. **26-50%**
3. **51% or more**

Enter Code ☐

B. Average fluid intake per day by IV or tube feeding

1. **500 cc/day or less**
2. **501 cc/day or more**

Section L Oral/Dental Status

L0200. Dental

↓ **Check all that apply**

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

Check all that apply

- ☐ A. **Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ B. **Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ C. **Clinical assessment**
- ☐ Z. **None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐ **Is this resident at risk of developing pressure ulcers?**

0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐ **A. Number of Stage 1 pressure ulcers**

Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐ 1. **Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ 2. **Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐ 1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐ 2. **Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number ☐ 1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐ 2. **Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐ **1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐ **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐ **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code	
☐	**A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?** 0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers 1. **Yes** → Continue to M0900B, Stage 2
	Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0
Enter Number ☐	**B. Stage 2**
Enter Number ☐	**C. Stage 3**
Enter Number ☐	**D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number	
☐	**Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
	None of the Above
☐	**Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Ulcer care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

Enter Days ☐ **Record the number of days that injections of any type** were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received

N0350. Insulin

Enter Days ☐ **A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/reentry if less than 7 days

Enter Days ☐ **B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/reentry if less than 7 days

N0400. Medications Received

↓ **Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days**

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

B. Occupational Therapy

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

C. Physical Therapy

Enter Number of Minutes [ ]

1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]

2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]

3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

Enter Number of Days [ ]

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

Month [ ] - Day [ ] - Year [ ]

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

	D. Respiratory Therapy
Enter Number of Days ☐	2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
	E. Psychological Therapy (by any licensed mental health professional)
Enter Number of Days ☐	2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	**A. Range of motion (passive)**
☐	**B. Range of motion (active)**
☐	**C. Splint or brace assistance**
Number of Days	**Training and Skill Practice In:**
☐	**D. Bed mobility**
☐	**E. Transfer**
☐	**F. Walking**
☐	**G. Dressing and/or grooming**
☐	**H. Eating and/or swallowing**
☐	**I. Amputation/prostheses care**
☐	**J. Communication**

O0600. Physician Examinations

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐ **A. Resident participated in assessment**
0. **No**
1. **Yes**

Enter Code ☐ **B. Family or significant other participated in assessment**
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐ **C. Guardian or legally authorized representative participated in assessment**
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐ **A. Resident's overall goal established during assessment process**
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐ **B. Indicate information source for Q0300A**
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐ **A. Is there an active discharge plan in place for the resident to return to the community?**
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐ **B. What determination was made by the resident and the care planning team regarding discharge to the community?**
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code ☐ **A. Has the resident been asked about returning to the community?**
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐ **B. Ask the resident** (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐ **Has a referral been made to the local contact agency?**
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code [ ]

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code [ ]

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

X0300. Gender on existing record to be modified/inactivated

Enter Code [ ]

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code [ ][ ]

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code [ ]

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code [ ]

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code [ ][ ]

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

C. Entry Date - Complete only if X0600F = 01
[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number [ ][ ]

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

- [ ] **A. Transcription error**
- [ ] **B. Data entry error**
- [ ] **C. Software product error**
- [ ] **D. Item coding error**
- [ ] **Z. Other error requiring modification**
  If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

- [ ] **A. Event did not occur**
- [ ] **Z. Other error requiring inactivation**
  If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. **Medicare Part A HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Enter Code

C. **Is this a Medicare Short Stay assessment?**
0. No
1. Yes

Z0150. Medicare Part A Non-Therapy Billing

A. **Medicare Part A non-therapy HIPPS code** (RUG group followed by assessment type indicator):

B. **RUG version code:**

Z0200. State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0250. Alternate State Medicaid Billing (if required by the state)

A. **RUG Case Mix group:**

B. **RUG version code:**

Z0300. Insurance Billing

A. **RUG Case Mix group:**

B. **RUG version code:**

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month ___ - Day ___ - Year ___

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home PPS (NP) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code [ ]

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

B. Middle initial: [ ]

C. Last name: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

D. Suffix: [ ][ ][ ]

A0600. Social Security and Medicare Numbers

A. Social Security Number:

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

B. Medicare number (or comparable railroad insurance number):

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

A0800. Gender

Enter Code [ ]

1. **Male**
2. **Female**

A0900. Birth Date

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Month Day Year

A1000. Race/Ethnicity

Check all that apply

- [ ] **A. American Indian or Alaska Native**
- [ ] **B. Asian**
- [ ] **C. Black or African American**
- [ ] **D. Hispanic or Latino**
- [ ] **E. Native Hawaiian or Other Pacific Islander**
- [ ] **F. White**

A1100. Language

Enter Code [ ]

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code [ ]

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

A1300. Optional Resident Items

A. Medical record number:

B. Room number:

C. Name by which resident prefers to be addressed:

D. Lifetime occupation(s) - put "/" between two occupations:

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code [ ]

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. No
1. Yes
9. Not a Medicaid certified unit

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

- [ ] A. Down syndrome
- [ ] B. Autism
- [ ] C. Epilepsy
- [ ] D. Other organic condition related to MR/DD

MR/DD Without Organic Condition

- [ ] E. MR/DD with no organic condition

No MR/DD

- [ ] Z. None of the above

A1600. Entry Date (date of this admission/reentry into the facility)

Month - Day - Year

A1700. Type of Entry

Enter Code [ ]

1. Admission
2. Reentry

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code [ ][ ]

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A2300. Assessment Reference Date

Observation end date:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

A2400. Medicare Stay

Enter Code [ ]

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

[ ][ ] – [ ][ ] – [ ][ ][ ][ ]
Month Day Year

Resident _____ Identifier _____ Date _____

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code [ ]

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code [ ]

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code [ ]

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code [ ]

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code [ ]

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code [ ]

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code [ ]

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, including regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code [ ]

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code [ ]
0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Enter Code [ ]

Number of words repeated after first attempt
0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Ask resident: *"Please tell me what year it is right now."*

Enter Code [ ]

A. Able to report correct year
0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Ask resident: *"What month are we in right now?"*

Enter Code [ ]

B. Able to report correct month
0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Ask resident: *"What day of the week is today?"*

Enter Code [ ]

C. Able to report correct day of the week
0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Ask resident: *"Let's go back to an earlier question. What were those three words that I asked you to repeat?"*
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter Code [ ]

A. Able to recall "sock"
0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code [ ]

B. Able to recall "blue"
0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code [ ]

C. Able to recall "bed"
0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score [ ][ ]

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code [ ]

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code [ ]

Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code [ ]

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

- [ ] **A. Current season**
- [ ] **B. Location of own room**
- [ ] **C. Staff names and faces**
- [ ] **D. That he or she is in a nursing home**
- [ ] **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code [ ]

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

↓ **Enter Codes in Boxes**

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

- [ ] **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
- [ ] **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
- [ ] **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?
- [ ] **D. Psychomotor retardation** - Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code [ ]

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: *"About **how often** have you been bothered by this?"*
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
- 0. **No** (enter 0 in column 2)
- 1. **Yes** (enter 0-3 in column 2)
- 9. **No response** (leave column 2 blank)

2. Symptom Frequency
- 0. **Never or 1 day**
- 1. **2-6 days** (several days)
- 2. **7-11 days** (half or more of the days)
- 3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

☐☐ Total Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
- 0. **No**
- 1. **Yes**

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Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

☐☐ Enter Score **Add scores for all frequency responses in Column 2**, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐ **Was responsible staff or provider informed that there is a potential for resident self harm?**
0. **No**
1. **Yes**

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Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Psychosis

↓ **Check all that apply**

- ☐ **A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ **B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ **Z. None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ **Enter Codes in Boxes**

- ☐ **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture		
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)		
C. **Walk in room** - how resident walks between locations in his/her room		
D. **Walk in corridor** - how resident walks in corridor on unit		
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
G. **Dressing** - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses		
H. **Eating** - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)		
I. **Toilet use** - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag		
J. **Personal hygiene** - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)		

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance

0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:

0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

- ☐ **A. Moving from seated to standing position**
- ☐ **B. Walking** (with assistive device if used)
- ☐ **C. Turning around** and facing the opposite direction while walking
- ☐ **D. Moving on and off toilet**
- ☐ **E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:

0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

- ☐ **A. Upper extremity** (shoulder, elbow, wrist, hand)
- ☐ **B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

- ☐ **A. Cane/crutch**
- ☐ **B. Walker**
- ☐ **C. Wheelchair** (manual or electric)
- ☐ **D. Limb prosthesis**
- ☐ **Z. None of the above** were used

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

Check all that apply

- ☐ A. **Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ B. **External catheter**
- ☐ C. **Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

C. **Current toileting program or trial** - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
	Genitourinary
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**
	Infections
☐	**I1700. Multidrug-Resistant Organism (MDRO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☐	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100. Hyponatremia**
☐	**I3200. Hyperkalemia**
☐	**I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
	Musculoskeletal
☐	**I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐	**I4000. Other Fracture**
	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5100. Quadriplegia**
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5400. Seizure Disorder or Epilepsy**
☐	**I5500. Traumatic Brain Injury (TBI)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Manic Depression** (bipolar disease)
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Other

- ☐ **I8000. Additional active diagnoses**

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ ☐☐☐☐☐☐☐☐

B. _____ ☐☐☐☐☐☐☐☐

C. _____ ☐☐☐☐☐☐☐☐

D. _____ ☐☐☐☐☐☐☐☐

E. _____ ☐☐☐☐☐☐☐☐

F. _____ ☐☐☐☐☐☐☐☐

G. _____ ☐☐☐☐☐☐☐☐

H. _____ ☐☐☐☐☐☐☐☐

I. _____ ☐☐☐☐☐☐☐☐

J. _____ ☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code [ ] **A. Been on a scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code [ ] **B. Received PRN pain medications?**
0. **No**
1. **Yes**

Enter Code [ ] **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?
Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code [ ]
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code [ ] Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code [ ] Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code [ ] **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code [ ] **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating [ ][ ] **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code [ ] **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code [ ]
0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- [ ] **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- [ ] **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- [ ] **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- [ ] **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- [ ] **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code [ ]
Frequency with which resident complains or shows evidence of pain or possible pain
1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- [ ] **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- [ ] **B. Shortness of breath** or trouble breathing **when sitting at rest**
- [ ] **C. Shortness of breath** or trouble breathing **when lying flat**
- [ ] **Z. None of the above**

J1400. Prognosis

Enter Code [ ]
Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)
0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- [ ] **A. Fever**
- [ ] **B. Vomiting**
- [ ] **C. Dehydrated**
- [ ] **D. Internal bleeding**
- [ ] **Z. None of the above**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission
Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐
A. Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐
B. Did the resident have a fall any time in the **last 2-6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐
C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code ☐
Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder
Signs and symptoms of possible swallowing disorder

Check all that apply

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches — **A. Height** (in inches). Record most recent height measure since admission

☐☐☐ pounds — **B. Weight** (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

Check all that apply

- ☐ **A. Parenteral/IV feeding**
- ☐ **B. Feeding tube** - nasogastric or abdominal (PEG)
- ☐ **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **Z. None of the above**

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked

Enter Code ☐

A. Proportion of total calories the resident received through parenteral or tube feeding

1. **25% or less**
2. **26-50%**
3. **51% or more**

Enter Code ☐

B. Average fluid intake per day by IV or tube feeding

1. **500 cc/day or less**
2. **501 cc/day or more**

Section L Oral/Dental Status

L0200. Dental

Check all that apply

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ **Check all that apply**

- ☐ **A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐ **Is this resident at risk of developing pressure ulcers?**
0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐ **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**
0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐ **A. Number of Stage 1 pressure ulcers**
Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐ **1. Number of Stage 2 pressure ulcers** - If 0 → Skip to M0300C, Stage 3

Enter Number ☐ **2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown:

☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

Enter Number ☐ **1. Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐ **2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

Enter Number ☐ **1. Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐ **2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐ **1. Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐ **1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐ **1. Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐ **2. Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)

Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge). If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

TN 10-002 Approval Date AUG 18 2011

Supersedes

~~TN 06-010 Effective Date 10-01-10~~

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐ **A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?**

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number ☐ **B. Stage 2**

Enter Number ☐ **C. Stage 3**

Enter Number ☐ **D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number ☐ **Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

Foot Problems

☐ **A. Infection of the foot** (e.g., cellulitis, purulent drainage)

☐ **B. Diabetic foot ulcer(s)**

☐ **C. Other open lesion(s) on the foot**

Other Problems

☐ **D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)

☐ **E. Surgical wound(s)**

☐ **F. Burn(s)** (second or third degree)

None of the Above

☐ **Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

☐ **A. Pressure reducing device for chair**

☐ **B. Pressure reducing device for bed**

☐ **C. Turning/repositioning program**

☐ **D. Nutrition or hydration intervention** to manage skin problems

☐ **E. Ulcer care**

☐ **F. Surgical wound care**

☐ **G. Application of nonsurgical dressings** (with or without topical medications) other than to feet

☐ **H. Applications of ointments/medications** other than to feet

☐ **I. Application of dressings to feet** (with or without topical medications)

☐ **Z. None of the above** were provided

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

Enter Days [ ] **Record the number of days that injections of any type** were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received

N0350. Insulin

Enter Days [ ] **A. Insulin injections - Record the number of days that insulin injections** were received during the last 7 days or since admission/reentry if less than 7 days

Enter Days [ ] **B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders** during the last 7 days or since admission/reentry if less than 7 days

N0400. Medications Received

↓ **Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days**

- [ ] **A. Antipsychotic**
- [ ] **B. Antianxiety**
- [ ] **C. Antidepressant**
- [ ] **D. Hypnotic**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
- 0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
- 1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
- 1. **Resident not in facility** during this year's flu season
- 2. **Received outside of this facility**
- 3. **Not eligible** - medical contraindication
- 4. **Offered and declined**
- 5. **Not offered**
- 6. **Inability to obtain vaccine** due to a declared shortage
- 9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
- 0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
- 1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
- 1. **Not eligible** - medical contraindication
- 2. **Offered and declined**
- 3. **Not offered**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes [ ]
1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Days [ ]
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
   Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing
   Month [ ] - Day [ ] - Year [ ]

B. Occupational Therapy

Enter Number of Minutes [ ]
1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Days [ ]
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
   Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing
   Month [ ] - Day [ ] - Year [ ]

C. Physical Therapy

Enter Number of Minutes [ ]
1. **Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes [ ]
2. **Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes [ ]
3. **Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

Enter Number of Days [ ]
4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
   Month [ ] - Day [ ] - Year [ ]

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing
   Month [ ] - Day [ ] - Year [ ]

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

Enter Number of Days ☐	**D. Respiratory Therapy** 2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
Enter Number of Days ☐	**E. Psychological Therapy** (by any licensed mental health professional) 2. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐	**A. Range of motion (passive)**
☐	**B. Range of motion (active)**
☐	**C. Splint or brace assistance**
Number of Days	**Training and Skill Practice In:**
☐	**D. Bed mobility**
☐	**E. Transfer**
☐	**F. Walking**
☐	**G. Dressing and/or grooming**
☐	**H. Eating and/or swallowing**
☐	**I. Amputation/prostheses care**
☐	**J. Communication**

O0600. Physician Examinations

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐ **A. Resident participated in assessment**
0. **No**
1. **Yes**

Enter Code ☐ **B. Family or significant other participated in assessment**
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐ **C. Guardian or legally authorized representative participated in assessment**
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐ **A. Resident's overall goal established during assessment process**
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐ **B. Indicate information source for Q0300A**
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐ **A. Is there an active discharge plan in place for the resident to return to the community?**
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐ **B. What determination was made by the resident and the care planning team regarding discharge to the community?**
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code ☐ **A. Has the resident been asked about returning to the community?**
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐ **B. Ask the resident** (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐ **Has a referral been made to the local contact agency?**
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code [ ]

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code [ ]

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

C. Last name:

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

X0300. Gender on existing record to be modified/inactivated

Enter Code [ ]

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

[ ][ ] - [ ][ ] - [ ][ ][ ][ ]
Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code [ ][ ]

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code [ ][ ]

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code [ ]

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ - ☐☐ - ☐☐☐☐
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

☐ **A. Transcription error**
☐ **B. Data entry error**
☐ **C. Software product error**
☐ **D. Item coding error**
☐ **Z. Other error requiring modification**
If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

☐ **A. Event did not occur**
☐ **Z. Other error requiring inactivation**
If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month - Day - Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):

B. RUG version code:

Enter Code

C. Is this a Medicare Short Stay assessment?
0. **No**
1. **Yes**

Z0150. Medicare Part A Non-Therapy Billing

A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):

B. RUG version code:

Z0200. State Medicaid Billing (if required by the state)

A. RUG Case Mix group:

B. RUG version code:

Z0250. Alternate State Medicaid Billing (if required by the state)

A. RUG Case Mix group:

B. RUG version code:

Z0300. Insurance Billing

A. RUG Case Mix group:

B. RUG version code:

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

Month – Day – Year

5101:3-3-43.2 **Resource utilization groups, version III (RUG III): the nursing facility case mix payment system.**

The Ohio department of job and family services (ODJFS) shall pay each eligible nursing facility (NF) provider a per resident per day rate for direct care costs established prospectively for each facility. The department shall establish each provider's rate for direct care costs semiannually. Each provider's rate for direct care costs shall be based on a case mix payment system.

(A) The Ohio medicaid case mix payment system for direct care contains the following core components:

(1) As set forth in rule 5101:3-3-43.1 of the Administrative Code, a uniform resident assessment instrument (the minimum data set version 3.0, (MDS 3.0) including - section S) and as set forth in appendix A to this rule, a database which provides the core data elements that are used to group residents into case mix categories;

(2) A methodology for grouping residents into case mix groups in a way that is clinically meaningful and uses criteria that sufficiently differentiates one group from another, as outlined in paragraphs (B) to (F) of this rule;

(3) The identification of those specific costs within the direct care cost category which will be affected by changes in case mix, as described in paragraph (G) of this rule.

(4) A means of measuring the relative costliness of caring for residents in one group versus another, known as "relative resource weights", as described in paragraph (H) of this rule.

(B) The medicaid provider case mix payment system shall use the methodology for grouping residents known as RUG III developed through the United States centers for medicare and medicaid services (CMS) multistate nursing home case-mix and quality demonstration project and described in this rule. Residents in each RUG III group utilize similar quantities and patterns of resources. The RUG III classification system includes the following seven mutually exclusive major categories of resident types from which forty-four RUG III groups are classified:

(1) Extensive care, which includes three groups;

(2) Special rehabilitation, which includes five resident subtypes and fourteen groups;

(3) Special care, which includes three groups;

(4) Clinically complex, which includes six groups;

(5) Impaired cognition, which includes four groups;

(6) Behavior problems, which includes four groups; and

(7) Reduced physical functioning, which includes ten groups. The RUG III categories are listed in descending order of hierarchy. Based on the items in the MDS 3.0, if a resident meets the criteria for placement in more than one group, the resident will be placed in a group within the highest major category of resident types according to the hierarchy unless the activities of daily living (ADL) index score is not met for placement within the highest major category of resident types. Residents without any of the characteristics which result in assignment to the higher categories comprise the last resident type. Rehabilitation is the highest category in the national RUG III version; however, it is ranked second to extensive services in Ohio.

(C) The RUG III classification system defines the criteria that are used to assign residents into one of the seven major categories of resident types. These criteria are summarized in paragraph (D) of this rule. Assignment of a resident to one of the RUG III groups within the major category is then based upon either or both of the following additional dimensions described below: resident functionality as measured by an ADL index score outlined in paragraph (C)(1) of this rule and additional problems or services required, outlined in paragraphs (C)(2) and (C)(3) of this rule.

(1) With the exception of the extensive care category, each group within a major category of resident types is identified by an ADL index score, which is computed using a special scoring technique. The ADL index score is based on four ADL variables (bed mobility, toileting, transfer and eating) and is calculated by assigning a score for the resident on each ADL variable and summing the scores. A resident's ADL index score may range from four to eighteen.

(a) The ADL scores for bed mobility, toileting, and transfer are as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one for each ADL activity.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "2" for limited assistance are assigned an ADL score of three in each ADL activity.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for extensive assistance, "4" for total dependence or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of four in each ADL activity if they are coded on MDS 3.0 item (G0110A2), (G0110B2), or (G0110I2), respectively, as "-" for unknown, "0" for no set up or physical help from staff, "1" for setup help only, or "2" for "one person physical assist".

(iv) On the MDS 3.0 at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), and (G0110I1), residents coded with "3" for "extensive assistance," "4" for "total dependence," or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of five in each ADL activity if they are coded on ADL support provided item (G0110A2), (G0110B2), or (G0110I2), respectively, as "3" for "two+ persons physical assist" or "8" for "ADL activity itself did not occur during entire period".

(b) The ADL score for eating is as follows:

(i) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with a "-" for unknown, "0" for independent, "1" for supervision, or "7" for activity occurred only once or twice are assigned an ADL score of one.

(ii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "2" for limited assistance are assigned an ADL score of two.

(iii) On the MDS 3.0 at section G: functional status, ADL self performance, item (G0110H1), residents coded with "3" for "extensive assistance", "4" for "total dependence" or "8" for "activity did not occur during entire 7 days" are assigned an ADL score of three. This score is also assigned if section K: swallowing/nutritional status, item (K0500A) for "parenteral/IV feeding" is checked or item (K0500B) for "feeding tube" is checked and if fifty-one per cent or more of total calories are received through parenteral or tube feeding, item (K0700A) is coded "3", or twenty-six per cent to fifty per cent of total calories received

through parenteral or tube feeding item (K0700A) is coded "2", and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2".

(2) Symptoms of depression are used to determine groupings for those who qualify for the clinically complex category using the criteria outlined in paragraph (D)(6) of this rule.

(a) On the MDS 3.0 at section D: mood, Should Resident Mood Interview be Conducted, item (D0100), for residents coding yes "1", the assessor will attempt to complete the interview. If the assessor is unable to complete the interview or if item D0100 is coded "0" no, the assessor will complete the Staff Assessment of Resident Mood (PHQ-9-OV), item (D0500).

(b) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to 10 coded on the MDS 3.0 at section D: mood, total severity score, item (D0300).

(c) The total severity score is the sum of the frequency of the following symptoms on the MDS 3.0 section D: mood, resident mood interview (PHQ-9), item (D0200):

(i) Little interest or pleasure in doing things (on MDS 3.0 at section D: mood, item (D0200A2)).

(ii) Feeling down, depressed, or hopeless (on MDS 3.0 at section D: mood, item (D0200B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on MDS 3.0 at section D: mood, item (D0200C2)).

(iv) Feeling tired or having little energy (on MDS 3.0 at section D: mood, item (D0200D2)).

(v) Poor appetite or overeating (on MDS 3.0 at section D: mood, item (D0200E2)).

(vi) Feeling bad about yourself-or that you are a failure or have let yourself or your family down (on MDS 3.0 at section D: mood, item (D0200F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on MDS 3.0 at section D: mood, item (D0200G2)).

(viii) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual (on MDS 3.0 at section D: mood, item (D0200H2)).

(ix) Thoughts that you would be better off dead, or of hurting yourself in some way (on MDS 3.0 at section D: mood, item (D0200I2)).

(d) If the Resident Mood Interview (PHQ-9) is not successfully completed, the staff assessment of resident mood (PHQ-9-OV) on the MDS 3.0 section D: mood, item (D0500) is used to determine grouping for those who qualify for the clinically complex resource utilization group using the criteria outlined in paragraph (D)(6) of this rule.

(e) The resident is assessed with symptoms of depression if a total severity score is greater than or equal to 10 coded (on the MDS 3.0 at section D: mood, item (D0600)). The total severity score is the sum of the frequency of the following symptoms:

(i) Little interest or pleasure in doing things (on the MDS 3.0 section D: mood, item (D0500A2)).

(ii) Feeling or appearing down, depressed, or hopeless (on the MDS 3.0 section D: mood, item (D0500B2)).

(iii) Trouble falling or staying asleep, or sleeping too much (on the MDS 3.0 section D: mood, item (D0500C2)).

(iv) Feeling tired or having little energy (on the MDS 3.0 section D: mood, item (D0500D2)).

(v) Poor appetite or overeating (on the MDS 3.0 section D: mood, item (D0500E2)).

(vi) Indicating that s/he feels bad about self, is a failure, or has let self or family down (on the MDS 3.0 section D: mood, item (D0500F2)).

(vii) Trouble concentrating on things, such as reading the newspaper or watching television (on the MDS 3.0 section D: mood, item (D0500G2)).

(viii) Moving or speaking so slowly that other people have noticed. Or the opposite-being so fidgety or restless that s/he has been moving around a lot more than usual (on the MDS 3.0 section D: mood, item (D0500H2)).

(ix) States that life isn't worth living, wishes for death, or attempts to harm self (on the MDS 3.0 section D: mood, item (D0500I2)).

(x) Being short-tempered, easily annoyed (on the MDS 3.0 section D: mood, item (D0500J2)).

(3) Restorative nursing programs, current toileting program or trial, and/or bowel toileting program are used to determine grouping within three categories of resident types and in classifying residents into the low intensity resident subtype of the rehabilitation category.

(a) Two or more of the following activities, each occurring within the timeframes described in paragraph (C)(3)(b) of this rule places an individual in a higher resource use group within the impaired cognition, behavior problems, or reduced physical functioning categories:

(i) Passive range of motion and/or active range of motion (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500A) or (O0500B));

(ii) Splint or brace assistance (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500C));

(iii) Training and skill practice in any of the following:

(a) Walking and/or bed mobility (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500F) or (O0500D)),

(b) Transfer (on the MDS 3.0, at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500E)),

(c) Dressing and/or grooming (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500G)),

(d) Eating and/or swallowing (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500H)),

(e) Amputation/prostheses care (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500I)),

(f) Communication (on the MDS 3.0 at section O: special treatments, procedures, and programs, restorative nursing programs, item (O0500J)),

(iv) Current toileting program or trial, and/or bowel toileting program (on the MDS 3.0 at section H: bladder and bowel, item (H0200C) or (H0500)). The current toileting program or trial at item (H0200C) must be managed 4 or more days of the 7 day look back period.

(b) Restorative nursing programs that are used to determine grouping within the rehabilitation category, low intensity subtype, are listed in paragraphs (C)(3)(a)(i) to (C)(3)(a)(iv) of this rule. Each restorative nursing program must be performed at least six days a week for at least fifteen minutes a day to be counted. The current toileting program or trial at item (H0200C) must be managed 4 or more days of the 7 day look back period.

(D) The RUG III criteria for classification into the seven major categories and the forty-four groups is listed below:

(1) The extensive care category includes residents who have a RUG III ADL index score of seven through eighteen and is determined by the two sets of qualifiers set forth in paragraphs (D)(1)(a) and (D)(1)(b) of this rule.

(a) The presence of extensive treatments received are the initial qualifiers for the extensive care category. The following clinical indicators are the initial qualifiers. If the initial qualifiers are met but the ADL index score is four, five or six the record shall be placed in the special care category SSA.

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) Suctioning, including nasopharyngeal or tracheal aspiration (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100D1 "while NOT a resident") and/or (O0100D2 "while a resident")),

(iii) Tracheostomy care (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100E1 "while NOT a resident") and/or (O0100E2 "while a resident")),

(iv) Ventilator or respirator (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100F1 "while NOT a resident") and/or (O0100F2 "while a resident")), and

(v) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident") and/or (O0100H2 "while a resident")).

(b) Once the resident has qualified for the extensive care category, a secondary set of qualifiers determines the RUG III grouping. The qualifiers are:

(i) Parenteral/IV feeding (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500A)),

(ii) IV medications (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100H1 "while NOT a resident) and/or (O0100H2 "while a resident")),

(iii) Eligible for special care (as described in paragraph (D)(4) of this rule,

(iv) Eligible for clinically complex (as described in paragraph (D)(6) of this rule) or

(v) Eligible for impaired cognition (as described in paragraph (D)(8) of this rule.

(2) The extensive care category has three groups of residents who meet one or more of the secondary extensive qualifiers listed in paragraph (D)(1) of this rule:

(a) Class "SE3" residents are in RUG III group one and meet four or five of the secondary qualifiers.

(b) Class "SE2" residents are in RUG III group two and meet two or three of the secondary qualifiers.

(c) Class "SE1" residents are in RUG III group three and meet zero or one of the secondary qualifiers.

(3) The special rehabilitation category is split into five resident subtypes and has fourteen groups. Therapies refers to any combination of physical therapy, occupational therapy, or speech-language pathology and audiology services. On the MDS3.0, at section O: special treatments, procedures, and programs, items (O0400A4), (O0400B4), and (O0400C4), the number of days each type of therapy is administered for fifteen minutes or more in the last seven calendar days is recorded. On the MDS 3.0, at section O: special treatments, procedures, and programs, items (O0400A1 through O0400A3), (O0400B1 through O0400B3), and (O0400C1 through O0400C3), the total number of minutes each type of therapy is provided for individual, concurrent, and group therapy in the last seven days is recorded.

(a) Ultra high intensity multidisciplinary rehabilitation is the first subtype for residents who receive:

(i) Seven hundred twenty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day; and

(iii) At least one type of therapy three or more days per week and at least fifteen minutes per day.

(b) The ultra high intensity rehabilitation subtype has three groups:

(i) Class "RUC" residents are in RUG III group four and have an ADL index score of sixteen to eighteen.

(ii) Class "RUB" residents are in RUG III group five and have an ADL index score of nine through fifteen.

(iii) Class "RUA" residents are in RUG III group six and have an ADL index score of four through eight.

(c) Very high intensity rehabilitation is the second subtype for residents who receive:

(i) Five hundred minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(d) The very high intensity rehabilitation subtype has three groups.

(i) Class "RVC" residents are in RUG III group seven and have an ADL index score of sixteen through eighteen.

(ii) Class "RVB" residents are in RUG III group eight and have an ADL index score of nine through fifteen.

(iii) Class "RVA" residents are in RUG III group nine and have an ADL index score of four through eight.

(e) High intensity rehabilitation is the third subtype for residents who receive:

(i) Three hundred twenty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least one type of therapy for five or more days per week and at least fifteen minutes per day.

(f) The high intensity rehabilitation subtype has three groups.

(i) Class "RHC" residents in RUG III group ten have an ADL index score of thirteen through eighteen.

(ii) Class "RHB" residents in RUG III group eleven have an ADL index score of eight through twelve.

(iii) Class "RHA" residents in RUG III group twelve have an ADL index score of four through seven.

(g) Medium intensity rehabilitation is the fourth subtype for residents who receive:

(i) One hundred fifty minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least five days per week of any combination of rehabilitation therapy.

(h) The medium intensity rehabilitation subtype has three groups.

(i) Class "RMC" residents in RUG III group thirteen have an ADL index score of fifteen through eighteen.

(ii) Class "RMB" residents in RUG III group fourteen have an ADL index score of eight through fourteen.

(iii) Class "RMA" residents in RUG III group fifteen have an ADL index score of four through seven.

(i) Low intensity rehabilitation is the fifth subtype for residents who receive the following:

(i) Forty-five minutes or more of any combination of rehabilitation therapy per week; and

(ii) At least three days per week of any combination of rehabilitation therapy; and

(iii) At least two types of restorative nursing programs each provided at least six days per week, current toileting program or trial managed for 4 or more days of the 7 days, or bowel toileting program. Programs counted for the rehabilitation category are listed in paragraphs (C)(3)(a)(i) to (C)(3)(a)(iv) of this rule.

(j) The low intensity rehabilitation subtype has two groups.

(i) Class "RLB" residents in RUG III group sixteen have an ADL index score of fourteen through eighteen.

(ii) Class "RLA" residents in RUG III group seventeen have an ADL index score of four through thirteen.

(4) Except as set forth in paragraph (D)(4)(d) of this rule, the special care category includes residents who have a RUG III ADL index score of seven through eighteen and either:

(a) Have one or more of the following conditions:

(i) Cerebral palsy (on the MDS 3.0 at section I: active diagnoses, item (I4400)), with an ADL index score greater than or equal to ten;

(ii) Surgical wound(s) or open lesion(s) other than ulcers, rashes, cuts (on the MDS 3.0 at section M: skin conditions, item (M1040E) or (M1040D)) and surgical wound care (on the MDS 3.0 at section M: skin conditions, item (M1200F)) or application of nonsurgical dressings with or without topical medications other than to feet or application of ointments/medications other than to feet (on the MDS 3.0 section M: skin conditions, items (M1200G or M1200H));

(iii) Fever with vomiting, pneumonia, weight loss, dehydrated, or feeding tube with percent intake by artificial route qualifiers (on the MDS 3.0 at section J: health conditions, item (J1550A) is checked and at least one of the following: At section J: item (J1550B) is checked, or at section I: active diagnoses item (I2000) is checked, or at section K: weight - loss, item (K0300) is scored "1" or "2", or at section J: health conditions item (J1550C) is checked) or at section K: swallowing/nutritional status, item (K0500B) is checked and fifty-one per cent or more of total calories are received through parenteral or tube feeding intake (item (K0700A) is coded "3") or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding intake (item (K0700A) is coded "2") and fluid intake is five hundred one or more cubic centimeters (CCs) per day (item (K0700B) is coded "2";

(iv) Multiple sclerosis (on the MDS 3.0 at section I: active diagnoses, item (I5200)) with an ADL index score greater than or equal to ten;

(v) Stage three or four pressure ulcer or unstageable pressure ulcer-slough and/or eschar (on the MDS 3.0 at section M: skin conditions, items (M0300C1), (M0300D1), or (M0300F1)) and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, items (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C) turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet) or two or more ulcers of any type (on the MDS 3.0 at section M: skin conditions, item (M0300A), (M0300B1), (M0300C1), (M0300D1), (M0300F1), or (M1030) number of venous and arterial ulcers and two or more selected skin and ulcer treatments (on the MDS 3.0 at section M: skin conditions, item (M1200A), pressure reducing device for chair, or (M1200B) pressure reducing device for bed, (M1200C)

turning/repositioning program, (M1200D) nutrition or hydration intervention to manage skin problems, (M1200E) ulcer care, (M1200G) application of nonsurgical dressings (with or without topical medications) other than to feet or (M1200H) application of ointments/medications other than to feet);

(vi) Quadriplegia (on the MDS 3.0 at section I: active diagnoses, item (I5100)), with an ADL index score greater than or equal to ten; or

(b) Receive one or more of the following types of special care:

(i) Seven days of respiratory therapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0400D2)),

(ii) Radiation treatment (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100B1 "while NOT a resident") and/or (O0100B2 "while a resident)), or

(iii) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) with parenteral or tube feeding intake (on the MDS 3.0 at section K: parenteral or tube feeding intake item (K0700A) is coded "3" or item (K0700A) is coded "2" and item (K0700B) is coded "2" and aphasia (on the MDS 3.0 section I, active diagnoses, item (4300)).

(c) Meet the conditions for the extensive care category but have a RUG III ADL index score of four, five, or six.

(d) If the ADL index score is four, five or six the record shall be placed in the clinically complex category CA1.

(5) The special care category has three groups.

(a) Class "SSC" residents in RUG III group eighteen have an ADL index score of seventeen through eighteen.

(b) Class "SSB" residents in RUG III group nineteen have an ADL index score of fifteen through sixteen.

(c) Class "SSA" residents in RUG III group twenty have an ADL index score of seven through fourteen.

(6) The clinically complex category includes residents who have at least one of the following conditions or are receiving at least one of the following treatments:

(a) Burns (on the MDS 3.0 at section M; skin conditions, item (M1040F)),

(b) Comatose (on the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) is scored "1", and at section G: functional status, ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days).

(c) Diabetes mellitus (on the MDS 3.0 at section I: active diagnoses, item (I2900)) and injections on seven days (on the MDS 3.0 at section N: medications, item (N0300)) and physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)).

(d) Dehydrated (on the MDS 3.0 at section J: health conditions, item (J1550C)),

(e) Hemiplegia or hemiparesis (on the MDS 3.0 at section I: active diagnoses, item (I4900)), with an ADL index score greater than or equal to ten,

(f) Internal bleeding (on the MDS 3.0 at section J: health conditions, item (J1550D)),

(g) Pneumonia (on the MDS 3.0 at section I: active diagnoses, item (I2000)),

(h) Infection of the foot, diabetic foot ulcer(s) or other open lesion(s) on the foot (on the MDS 3.0 at section M: skin conditions, items (M1040A), (M1040B) or (M1040C)) and application of dressings to feet (with or without topical medications) (on the MDS 3.0 at section M: skin conditions, item (M1200I-)),

(i) Septicemia (on the MDS 3.0 at section I: active diagnoses, item (I2100)),

(j) Feeding tube (on the MDS 3.0 at section K: swallowing/nutritional status, item (K0500B)) and fifty-one per cent or more of total calories are received through parenteral or tube feeding intake, item (K0700A) is coded "3" or twenty-six per cent to fifty per cent of total calories received through parenteral or tube feeding, item (K0700A) is coded "2" and fluid intake is five hundred one or more cubic centimeters (CCs) per day, item (K0700B) is coded "2",

(k) Chemotherapy (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100A1 "while NOT a resident") and/or (O0100A2 "while a resident")),

(l) Dialysis (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100J1 "while NOT a resident") and/or (O0100J2 "while a resident")),

(m) Physician order changes on four or more days in the last fourteen days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations of one or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0600) or physician order changes on two or more days (on the MDS 3.0 at section O: special treatments, procedures, and programs, item (O0700)) and physician examinations on two or more days (on the MDS 3.0 section O: special treatments, procedures, and programs, item (O0600)),

(n) Oxygen therapy (on the MDS at section O: special treatments, procedures, and programs, items (O0100C1 "while NOT a resident") and/or (O0100C2 "while a resident")),

(o) Transfusions (on the MDS 3.0 at section O: special treatments, procedures, and programs, items (O0100I1 "while NOT a resident") and/or (O0100I2 "while a resident")),

(p) Meet the conditions for the special care categories but have a RUG III ADL index score of four, five or six.

(7) The clinically complex category has six groups.

(a) Class "CC2" residents in RUG III group twenty-one have an ADL index score of seventeen through eighteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(b) Class "CC1" residents in RUG III group twenty-two have an ADL index score of seventeen through eighteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(c) Class "CB2" residents in RUG III group twenty-three have an ADL index score of twelve through sixteen and have symptoms of depression as described in paragraph (C)(2) of this rule.

(d) Class "CB1" residents in RUG III group twenty-four have an ADL index score of twelve through sixteen and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(e) Class "CA2" residents in RUG III group twenty-five have an ADL index score of four through eleven and have symptoms of depression as described in paragraph (C)(2) of this rule.

(f) Class "CA1" residents in RUG III group twenty-six have an ADL index score of four through eleven and do not have symptoms of depression as described in paragraph (C)(2) of this rule.

(8) The impaired cognition category includes residents with a RUG III ADL index score of four through ten, and a Brief Interview for Mental Status (BIMS) score less than or equal to 9 or a cognitive performance scale of three through six. The BIMS score ranges from 0 to 15 and is based on resident responses to 7 questions. On the MDS 3.0 at section C: cognitive patterns, Should Brief Interview for Mental Status be conducted, item (C0100), for residents coding yes "1", the assessor will attempt to complete the BIMS. If coded "0" no, the cognitive performance scale described in paragraph (D)(8)(b) of this rule is computed to determine impaired cognition.

(a) The BIMS is based on 3 qualifiers: repetition of three words, temporal orientation, and recall. The summation of the following qualifiers on the MDS 3.0 at section C: cognitive patterns, summary score, item (C0500) determine the BIMS score for the impaired cognition category:

(i) Repetition of three words (on the MDS 3.0 at section C: cognitive patterns, item (C0200)),

(ii) Able to report correct year (on the MDS 3.0 at section C: cognitive patterns, item (C0300A)),

(iii) Able to report correct month (on the MDS 3.0 at section C: cognitive patterns, item (C0300B)),

(iv) Able to report correct day of week (on the MDS 3.0 at section C: cognitive patterns, item (C0300C)),

(v) Able to recall "sock" (on the MDS 3.0 at section C: cognitive patterns, item (C0400A)),

(vi) Able to recall "blue" (on the MDS 3.0 at section C: cognitive patterns, item (C0400B)),

(vii) Able to recall "bed" (on the MDS 3.0 at section C: cognitive patterns, item (C0400C)).

(b) If the BIMS cannot be completed, the cognitive performance scale is computed to determine impaired cognition. The cognitive performance scale values range from zero to six and are based on three qualifiers: the presence or absence of coma, self-performance in eating and the summation of an impairment count and a severity count which evaluates the resident using the MDS 3.0 variables. These three qualifiers, evaluated in the following manner, determine the resident's cognitive performance scale for the impaired cognition category:

(i) On the MDS 3.0 at section B: hearing, speech, and vision, item (B0100) residents coded with a "one" for comatose, section G: functional status-ADL self performance, items (G0110A1), (G0110B1), (G0110H1), and (G0110I1) are scored "4" for total dependence or "8" for activity did not occur during entire seven days, and in section C: cognitive patterns, cognitive skills for daily decision making item (C1000) is not coded "-", "0", "1" or "2", the cognitive performance scale is assigned a score of six.

(ii) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making item (C1000), residents coded with a "3" for severely impaired and section G: functional status, ADL self-performance, eating item (G0110H1), is coded "4" for total dependence or "8" for activity did not occur during entire seven days, the cognitive performance scale is assigned a score of six. If section G, eating item (G0110H1) is coded "-" for unknown, "0" for independent, "1" for supervision, "2" for limited assistance, or "3" for extensive assistance, the cognitive performance scale is assigned a score of five.

(iii) The summation of the impairment count and severity count are used in assigning values of one through four on the cognitive performance scale and are calculated as follows:

(*a*) The impairment count identifies deficits in three key cognitive areas and is determined by summing the scores for the following variables:

(*i*) Short term memory, on the MDS 3.0 at section C: cognitive patterns, item (C0700) residents coded "1" for a memory problem are assigned a score of one.

(ii) Cognitive skills for daily decision making, on the MDS 3.0 at section C: cognitive patterns, item (C1000), residents coded with a "1" for modified independence or "2" for moderately impaired are assigned a score of one.

(iii) Makes self understood, on the MDS 3.0 at section B: hearing, speech, and vision, item (B0700), residents coded "1" for usually understood, "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(b) The severity count identifies the deficit level of residents with moderate to severe impairment in cognitive skills for daily decision making (C1000) and in makes self understood (B0700). This count is determined by summing the scores for the following variables:

(*i*) On the MDS 3.0 at section C: cognitive patterns, cognitive skills for daily decision making, item (C1000), residents coded with a "2" for moderately impaired are assigned a score of one.

(ii) On the MDS 3.0 at section B: hearing, speech, and vision, makes self understood, item (B0700), residents coded with "2" for sometimes understood or "3" for rarely/never understood are assigned a score of one.

(c) If the total for the impairment count is two or three and the total for the severity count is two, the cognitive performance scale is assigned a score of four.

(d) If the total for the impairment count is two or three and the total for the severity count is one, the cognitive performance scale is assigned a score of three.

(e) If the total for the impairment count is two or three and the total of the severity count is zero, the cognitive performance scale is assigned a score of two. Residents would not qualify for the impaired cognition category.

(f) If the total of the impairment count is one, the cognitive performance scale is assigned a score of one. Residents would not qualify for the impaired cognition category.

(9) The impaired cognition category has four groups.

(a) Class "IB2" residents in RUG III group twenty-seven have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "IB1" residents in RUG III group twenty-eight have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "IA2" residents in RUG III group twenty-nine, have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "IA1" residents in RUG III group thirty have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(10) The behavior problems category includes residents with a RUG III ADL index score of four through ten, and

(a) Have hallucinations and/or delusions (on the MDS 3.0 at section E: behavior, items (E0100A) or (E0100B)), or

(b) Problem displayed in any one of the following on four or more days per week:

(i) Wandering (on the MDS 3.0 at section E: behavior, item (E0900)), or

(ii) Verbal behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200B)), or

(iii) Physical behavioral symptoms directed toward others (on the MDS 3.0 at section E: behavior, item (E0200A)), or

(iv) Other behavioral symptoms not directed toward others (on the MDS 3.0 at section E: behavior, item (E0200C)), or

(v) Rejection of care (on the MDS 3.0 at section E: behavior, item (E0800)).

(11) The behavior problems category has four groups.

(a) Class "BB2" residents in RUG III group thirty-one have an ADL index score of six through ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "BB1" residents in RUG III group thirty-two have an ADL index score of six through ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "BA2" residents in RUG III group thirty-three have an ADL index score of four through five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "BA1" residents in RUG III group thirty-four have an ADL index score of four through five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(12) The reduced physical function category has ten groups and includes residents who do not meet the conditions of any of the previous categories, including those who would meet the criteria for the impaired cognition or behavior problems categories but have a RUG III ADL index score of more than ten.

(a) Class "PE2" residents in RUG III group thirty-five have an ADL index score of sixteen through eighteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial

managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(b) Class "PE1" residents in RUG III group thirty-six have an ADL index score of sixteen through eighteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(c) Class "PD2" residents in RUG III group thirty-seven have an ADL index score of eleven through fifteen and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(d) Class "PD1" residents in RUG III group thirty-eight have an ADL index score of eleven through fifteen and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(e) Class "PC2" residents in RUG III group thirty-nine have an ADL index score of nine or ten and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(f) Class "PC1" residents in RUG III group forty have an ADL index score of nine or ten and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(g) Class "PB2" residents in RUG III group forty-one have an ADL index score of six through eight and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(h) Class "PB1" residents in RUG III group forty-two have an ADL index score of six through eight and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or

more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(i) Class "PA2" residents in RUG III group forty-three have an ADL index score of four or five and receive two or more restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(j) Class "PA1" residents in RUG III group forty-four have an ADL index score of four or five and receive only one or no restorative nursing programs six days or more per week, current toileting program or trial managed 4 or more days or bowel toileting program as described in paragraph (C)(3) of this rule.

(E) A list of the MDS 3.0 data elements used to group residents in the RUG III classification system is set forth in appendix A to this rule. The ADL index scoring system is set forth in a table in appendix B to this rule. A description of classification branches in the RUG III system is summarized in the table set forth in appendix C to this rule. A graphic description of the RUG III classification system is set forth in appendix D to this rule.

(F) The RUG III classification system has forty-four different groups. All MDS 3.0 data elements related to the RUG III classification system must be completed before a resident can be classified. Residents whose MDS 3.0 forms contain missing or out-of-range responses to data elements used to determine the RUG III classification shall be assigned by default into a forty-fifth group. Corrections to MDS 3.0 data can be made only as described in paragraph (D) of rule 5101:3-3-43.1 of the Administrative Code.

(G) The relationship between resident characteristics and resource utilization, as measured by staff time for the registered nurses (RNs), licensed practical nurses (LPNs), and nurse aides (NAs) worker classifications, was analyzed for the RUG III system to identify characteristics which differentiate resource use among residents. Staff time and assessment data were collected by the federal multistate nursing home case-mix and quality demonstration project for the purpose of establishing common nursing staff times associated with all resident categories that are standard across residents, nursing staff, facilities, units and states. Resident specific and resident non-specific time for each worker classification (RN, LPN, and NA) was averaged for each of the forty-four RUG III groups.

(H) Each of the forty-four RUG III groups is assigned a relative resource weight. This weight indicates the relative amount of staff time required on average for all three

worker classifications listed in paragraph (G) of this rule to deliver care to residents in that RUG III group.

(1) The relative resource weight is calculated as follows using the average minutes per worker classification per RUG III group provided by the United States department of health and human services, and three-year averages, beginning with calendar year 1989, of RN, LPN, and NA wages in Ohio medicaid certified NFs as reported to ODJFS.

(a) By setting the NA wage weight at one, wage weights for RNs and LPNs are calculated by dividing the NA wage into the RN or LPN wage.

(b) To calculate the total weighted minutes for each RUG III group, the wage weight for each worker classification is multiplied by the average number of minutes that classification of workers spends caring for a resident in the RUG III group and the products are summed.

(c) The RUG III group with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the lowest group's total weighted minutes into each group's total weighted minutes. Weight calculations are rounded to the fourth decimal place.

(2) The lowest weight for the forty-four RUG III groups is used as the weight for the forty-fifth default group.

(3) Relative resource weights for the forty-five NF case-mix RUG III groups are set forth in appendix E to this rule.

(4) Except as provided in paragraph (H)(4)(b) of this rule, relative resource weights may be recalibrated using wage weights based on three-year statewide averages of RN, LPN, and NA wages in Ohio NFs as reported on the long term care facility medicaid cost report for NFs, and minutes per worker classification per RUG III group as follows:

(a) Upon receipt of revised worker classification minutes from the United States department of health and human services, ODJFS shall recalibrate the relative resource weights based on the revised minutes and the averages of RN, LPN, and NA wages from cost report data from the most recent three calendar years, to be effective at the beginning of the next state fiscal year.

(b) ODJFS may recalibrate the relative resource weights at least once every ten years, using the most current worker classification minutes from the United

States department of health and human services and the average worker classification wages, to be effective at the beginning of the next state fiscal year. When recalibrating the relative resource weights, as permitted by paragraph (H)(4)(b) of this rule ODJFS shall use cost report wage data from the most recent three calendar years available ninety days prior to the start of the fiscal year.

(c) ODJFS may recalibrate relative resource weights more frequently if significant variances in wage ratios between worker classifications occur.

(d) After recalibrating relative resource weights under paragraph (H)(4)(a), (H)(4)(b), or (H)(4)(c) of this rule, ODJFS shall use the recalibrated relative resource weights to calculate the semiannual NF case mix score effective for the start of the fiscal year and to recalculate the annual NF case mix score for the calendar year preceding the fiscal year.

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APPENDIX A

MDS 3.0 DATA ELEMENTS USED IN THE RUG III CLASSIFICATION SYSTEM

Attachment 4.19D
Supplement 1

ITEM #	DESCRIPTION	IMACT ON RUG III CATEGORY
B0100	Comatose	Clinically Complex, Impaired Cognition
C0700	Short term memory	Impaired Cognition
C1000	Cognitive Skills for Daily Decision Making	Impaired Cognition
B0700	Makes self understood	Impaired Cognition
D0200A2	Little interest or pleasure in doing things	Clinically Complex
D0200B2	Feeling down, depressed, or hopeless	Clinically Complex
D0200C2	Trouble falling or staying asleep, or sleeping too much	Clinically Complex
D0200D2	Feeling tired or having little energy	Clinically Complex
D0200E2	Poor appetite or overeating	Clinically Complex
D0200F2	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	Clinically Complex
D0200G2	Trouble concentrating on things, such as reading the newspaper or watching television	Clinically Complex
D0200H2	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	Clinically Complex
D0200I2	Thoughts that you would be better off dead, or of hurting yourself in some way	Clinically Complex
D0300	Total Severity Score	Clinically Complex
D0500A	Little interest or pleasure in doing things	Clinically Complex
D0500B	Feeling or appearing down, depressed, or hopeless	Clinically Complex
D0500C	Trouble falling or staying asleep, or sleeping too much	Clinically Complex
D0500D	Feeling tired or having little energy	Clinically Complex
D0500E	Poor appetite or overeating	Clinically Complex
D0500F	Indicating that s/he feels bad about self, is a failure, or has let self or family down	Clinically Complex
D0500G	Trouble concentrating on things, such as reading the newspaper or watching television	Clinically Complex
D0500H	Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he have been moving around a lot more than usual	Clinically Complex
D0500I	States that life isn't worth living, wishes for death, or attempts to harm self	Clinically Complex
D0500J	Being short - tempered, easily annoyed	Clinically Complex
D0600	Total Severity Score	Clinically Complex
C0200	Repetition of three words	Impaired Cognition
C0300A	Able to report correct year	Impaired Cognition
C0300B	Able to report correct month	Impaired Cognition
C0300C	Able to report correct day of the week	Impaired Cognition
C0400A	Able to recall "sock"	Impaired Cognition
C0400B	Able to recall "blue"	Impaired Cognition
C0400C	Able to recall "bed"	Impaired Cognition
C0500	Summary Score	Impaired Cognition
E0900	Wandering	Behavior Problems
E0200B	Verbal behavioral symptoms directed toward others	Behavior Problems
E0200A	Physical behavioral symptoms directed toward others	Behavior Problems
E0200C	Other behavioral symptoms not directed toward others	Behavior Problems
E0800	Rejection of care	Behavior Problems
G0110A1	Bed Mobility - Self Performance	ADL Index
G0110A2	Bed Mobility - Support	ADL Index
G0110B1	Transfer - Self Performance	ADL Index
G0110B2	Transfer - Support	ADL Index
G0110H1	Eating - Self Performance	ADL Index
G0110I1	Toilet Use - Self Performance	ADL Index
G0110I2	Toilet Use - Support	ADL Index
H0200C	Current toileting program or trial	Impaired Cognition, Behavior Problems, Reduced Physical Function, Rehabilitation
H0500	Bowel toileting program	Impaired Cognition, Behavior Problems, Reduced Physical Function, Rehabilitation
I2900	Diabetes Mellitus	Clinically Complex
I4300	Aphasia	Special Care
I4400	Cerebral palsy	Special Care
I4900	Hemiplegia or Hemiparesis	Clinically Complex
I5200	Multiple Sclerosis	Special Care
I5100	Quadriplegia	Special Care
I2000	Pneumonia	Special Care, Clinically Complex
I2100	Septicemia	Clinically Complex
J1550C	Dehydrated	Special Care, Clinically Complex
E0100B	Delusions	Behavior Problems
J1550A	Fever	Special Care
E0100A	Hallucinations	Behavior Problems
J1550D	Internal bleeding	Clinically Complex
J1550B	Vomiting	Special Care

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MDS 3.0 DATA ELEMENTS USED IN THE RUG III CLASSIFICATION SYSTEM

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K0300	Weight Loss	Special Care
K0500A	Parenteral/IV feeding	Extensive Care
K0500B	Feeding tube	Special Care, Clinically Complex
K0700A	Proportion of total calories	Special Care, Clinically Complex
K0700B	Average fluid intake	Special Care, Clinically Complex
M0300A	Stage 1 pressure ulcers	Special Care
M0300B1	Stage 2 pressure ulcers	Special Care
M0300C1	Stage 3 pressure ulcers	Special Care
M0300D1	Stage 4 pressure ulcers	Special Care
M0300F1	Unstageable pressure ulcers - slough and/or eschar	Special Care
M1040F	Burn(s) (second or third degree)	Clinically Complex
M1040D	Open lesion(s) other than ulcers, rashes, cuts	Special Care
M1040E	Surgical wound(s)	Special Care
M1200A	Pressure reducing device for chair	Special Care
M1200B	Pressure reducing device for bed	Special Care
M1200C	Turning/repositioning program	Special Care
M1030	Number of venous and arterial ulcers	Special Care
M1200D	Nutrition or hydration intervention to manage skin problems	Special Care
M1200E	Ulcer care	Special Care
M1200F	Surgical wound care	Special Care
M1200G	Application of nonsurgical dressings other than to feet	Special Care
M1200H	Application of ointments/medications other than to feet	Special Care
M1040A	Infection of the foot	Clinically Complex
M1040C	Other open lesion(s) on the foot	Clinically Complex
M1200I	Application of dressings to feet	Clinically Complex
M1040B	Diabetic foot ulcer(s)	Clinically Complex
N0300	Injections	Clinically Complex
O0100A(1,2)	Chemotherapy	Clinically Complex
O0100J(1,2)	Dialysis	Clinically Complex
O0100H(1,2)	IV medications	Extensive
O0100C(1,2)	Oxygen therapy	Clinically Complex
O0100B(1,2)	Radiation	Special Care
O0100D(1,2)	Suctioning	Extensive
O0100E(1,2)	Tracheostomy care	Extensive
O0100I(1,2)	Transfusions	Clinically Complex
O0100F(1,2)	Ventilator or respirator	Extensive
O0400A4	Speech-language pathology & audiology services days	Rehabilitation
O0400A1,2,3	Speech-language pathology & audiology services minutes	Rehabilitation
O0400B4	Occupational therapy days	Rehabilitation
O0400B1,2,3	Occupational therapy minutes	Rehabilitation
O0400C4	Physical therapy days	Rehabilitation
O0400C1,2,3	Physical therapy minutes	Rehabilitation
O0400D2	Respiratory therapy days	Special Care
O0500A	Range of motion (passive)	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500B	Range of motion (active)	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500C	Splint or brace assistance	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500D	Bed mobility	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500E	Transfer	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500F	Walking	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500G	Dressing and/or grooming	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500H	Eating and/or swallowing	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500I	Amputation/prostheses care	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0500J	Communication	Rehabilitation, Impaired Cognition, Behavior Problems, Reduced Physical Function
O0600	Physician Examinations	Clinically Complex
O0700	Physician Orders	Clinically Complex

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APPENDIX B
RUG III ADL SCORE INDEXING WEIGHTS

MDS 3.0 REFERENCE	ACTIVITY OF DAILY LIVING	SCORE
Items G0110A, G0110I,and G0110B: Self perf = "-", 0, 1, 7	**Bed mobility, Toileting, and Transfer:** Unknown, Independent, Supervision, or Activity occurred only once or twice	1
Self perf = 2	Limited Assistance	3
Self perf. = 3, 4, 8 Staff support = "-", 0 ,1 ,2	Extensive Assistance or Total Dependence: With 1 person physical assistance	4
Self perf. = 3, 4, 8 Staff support = 3, 8	Extensive Assistance or Total Dependence or Activity did not occur With 2+ person physical assistance or Activity did not occur	5
Item G0110H: Self perf. = "-", 0, 1, 7	**Eating**: Unknown, Independent, Supervision, or Activity occurred only once or twice	1
Self perf. = 2	Limited Assistance	2
Self perf. = 3, 4, 8 Parenteral/IV feeding: Item K0500A Feeding tube: Item K0500B with Percent intake by artificial route: Item K0700A and K0700B	Extensive Assistance or Total Dependence or Activity did not occur Parenteral IV/ feeding, or feeding tube with 51% or more of total calories, or 26-50% of total calories and fluid intake of 501cc or more	3

Self perf. means " ADL self performance" as used in MDS 3.0, item G01101.
Staff support means " ADL support provided" as used in MDS 3.0, item G01102.

To determine the RUG III ADL Index:
Add the scores for the four ADL variables
The index ranges from 4-18 point

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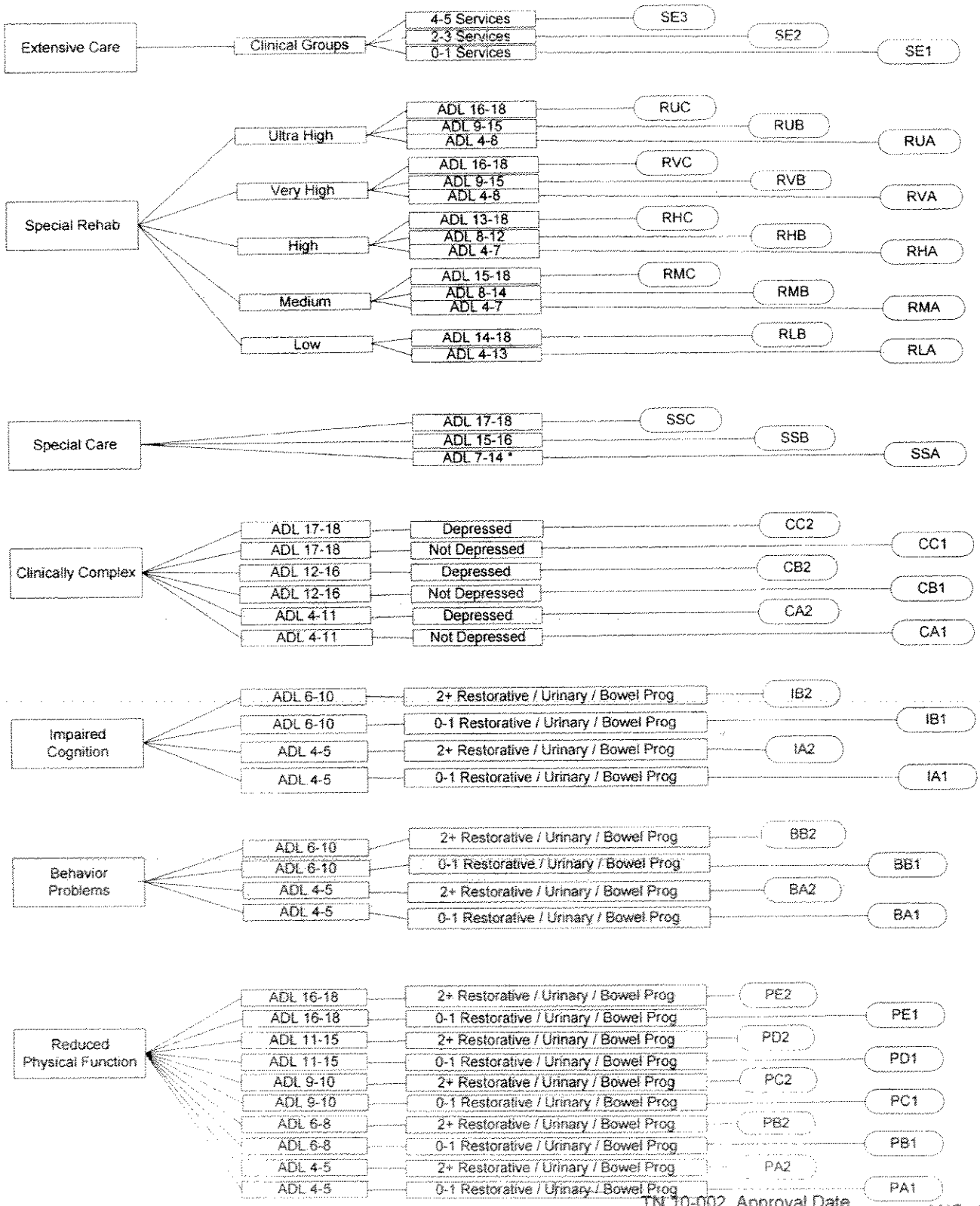
APPENDIX C

DESCRIPTION OF RUG-III CLASSIFICATION BRANCHES

HIERARCHY CATEGORY (First Level)	ACTIVITIES OF DAILY LIVING (Second Level)	PROBLEM/ SERVICE SPLIT (Third Level)
EXTENSIVE CARE	Not Used	COUNT OF TWO SETS OF QUALIFIERS
REHABILITATION: ULTRA HIGH VERY HIGH HIGH MEDIUM LOW	 3 LEVELS 3 LEVELS 3 LEVELS 3 LEVELS 2 LEVELS	Not Used
SPECIAL CARE	3 LEVELS	Not Used
CLINICALLY COMPLEX	3 LEVELS	SYMPTOMS OF DEPRESSION
IMPAIRED COGNITION	2 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count
BEHAVIOR PROBLEMS	2 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count
REDUCED PHYSICAL FUNCTIONING	5 LEVELS	RESTORATIVE NURSING/ URINARY/BOWEL PROGRAMS Actual Count

Appendix D

Rug III Classification System



* Also includes those which meet the criteria for Extensive Care but have an ADL Index score of 4, 5, or 6.

APPENDIX E

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RUGIII CLASSIFICATION SYSTEM
RESOURCE UTILIZATION GROUPS

Attachment 4.19D
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	RUGIII GROUP	ADL	RUGS CLASS	RELATIVE WEIGHTS
1	Extensive Special Care 3	>6	SE3	3.6037
2	Extensive Special Care 2	>6	SE2	2.9532
3	Extensive Special Care 1	>6	SE1	2.5253
4	Rehabilitation Ultra High	16-18	RUC	2.7812
5	Rehabilitation Ultra High	9-15	RUB	2.0327
6	Rehabilitation Ultra High	4-8	RUA	1.6546
7	Rehabilitation Very High	16-18	RVC	2.4192
8	Rehabilitation Very High	9-15	RVB	2.2206
9	Rehabilitation Very High	4-8	RVA	1.7320
10	Rehabilitation High	13-18	RHC	2.6820
11	Rehabilitation High	8-12	RHB	2.2565
12	Rehabilitation High	4-7	RHA	1.8480
13	Rehabilitation Medium	15-18	RMC	2.8835
14	Rehabilitation Medium	8-14	RMB	2.3328
15	Rehabilitation Medium	4-7	RMA	2.0480
16	Rehabilitation Low	14-18	RLB	2.4124
17	Rehabilitation Low	4-13	RLA	1.7119
18	Special Care	17-18	SSC	2.4449
19	Special Care	15-16	SSB	2.2715
20	Special Care	7-14*	SSA	2.1546
21	Clinically Complex with Symptoms of Depression	17-18	CC2	2.4231
22	Clinically Complex	17-18	CC1	2.1474
23	Clinically Complex with Symptoms of Depression	12-16	CB2	1.9681
24	Clinically Complex	12-16	CB1	1.8232
25	Clinically Complex with Symptoms of Depression	4-11	CA2	1.7925
26	Clinically Complex	4-11	CA1	1.6009
27	Cognitive Impairment with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-10	IB2	1.5112
28	Cognitive Impairment	6-10	IB1	1.4600
29	Cognitive Impairment with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	IA2	1.2366
30	Cognitive Impairment	4-5	IA1	1.1481
31	Behavior Problem with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-10	BB2	1.4861
32	Behavior Problem	6-10	BB1	1.4116
33	Behavior Problem with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	BA2	1.2090
34	Behavior Problem	4-5	BA1	1.0259
35	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	16-18	PE2	1.7400
36	Physical Function	16-18	PE1	1.6983
37	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	11-15	PD2	1.5821
38	Physical Function	11-15	PD1	1.5509
39	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	9-10	PC2	1.4489
40	Physical Function	9-10	PC1	1.3925
41	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	6-8	PB2	1.1054
42	Physical Function	6-8	PB1	1.0892
43	Physical Function with Restorative Nursing/Current Toileting Program or Trial/Bowel Toileting Program	4-5	PA2	1.0503
44	Physical Function	4-5	PA1	1.0000
45	Default		BC1	1.0000

* Also includes those which meet the criteria for Extensive Care but have an ADL Index Score of 4, 5, or 6.

Sec. 5111.26 Annual Cost Report for Each Facility; Reported by New Provider

(A)(1)(a) Except as provided in division (A)(1)(b) of this section, each provider shall file with the department of job and family services an annual cost report for each of the provider's nursing facilities and intermediate care facilities for the mentally retarded that participate in the medicaid program. A provider shall prepare the reports in accordance with guidelines established by the department. A report shall cover a calendar year or the portion of a calendar year during which the facility participated in the medicaid program. A provider shall file the reports within ninety days after the end of the calendar year. The department, for good cause, may grant a fourteen-day extension of the time for filing cost reports upon written request from a provider. The director of job and family services shall prescribe, in rules adopted under section 5111.02 of the Revised Code, the cost reporting form and a uniform chart of accounts for the purpose of cost reporting, and shall distribute cost reporting forms or computer software for electronic submission of the cost report to each provider at least sixty days before the reporting date.

(b) If rates for a provider's nursing facility or intermediate care facility for the mentally retarded were most recently established under section 5111.254 or 5111.255 of the Revised Code, the provider shall submit a cost report for that facility no later than ninety days after the end of the facility's first three full calendar months of operation. A If a nursing facility or intermediate care facility for the mentally retarded undergoes a change of provider thatthe department determines, in accordance with rules adopted under section 5111.02 of the Revised Code, is an arm's length transaction, the new provider shall submit a cost report for that facility not later than ninety days after the end of the facility's first three full calendar months of operation under the new provider. The provider of a facility that opens or undergoes a cha nge of provider that is an arm's length transaction after the first day of October in any calendar year is not required to file a cost report for that calendar year.

(c) If a nursing facility undergoes a change of provider that the department determines, in accordance with rules adopted under section 5111.02 of the Revised Code, is not an arms length transaction, the new provider shall file a cost report under division (A)(1)(a) of this section for the facility. The cost report shall cover the portion of the calendar year during which the new provider operated the nursing facility and the portion of the calendar year during which the previous provider operated the nursing facility.

(2) If a provider required to submit a cost report for a nursing facility or intermediate care facility for the mentally retarded does not file the report within the required time period or within fourteen days thereafter if an extension is granted under division (A)(1)(a) of this section, or files an incomplete or inadequate report for the facility, the department shall provide immediate written notice to the provider that the provider agreement for the facility will be terminated in thirty days unless the provider submits a complete and adequate cost report for the facility within thirty days. During the thirty-day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, the provider shall be paid the facility's then current per resident per

day rate, minus two dollars. On July 1, 1994, the department shall adjust the two-dollar reduction to reflect the rate of inflation during the preceding twelve months, as shown in the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics. On July 1, 1995, and the first day of July of each year thereafter, the department shall adjust the amount of the reduction in effect during the previous twelve months to reflect the rate of inflation during the preceding twelve months, as shown in the same index.

(B) No provider shall report fines paid under sections 5111.35 to 5111.62 or section 5111.99 of the Revised Code in any cost report filed under this section.

(C) The department shall develop an addendum to the cost report form that a provider may use to set forth costs that the provider believes may be disputed by the department. Any costs reported by the provider on the addendum may be considered by the department in setting the facility's rate. If the department does not consider the costs listed on the addendum in setting the facility's rate, the provider may seek reconsideration of that determination under section 5111.29 of the Revised Code. If the department subsequently includes the costs listed in the addendum in the facility's rate, the department shall pay the provider interest at a reasonable rate established in rules adopted under section 5111.02 of the Revised Code for the time that the rate paid excluded the costs.

(2005 H 66, eff. 7-1-05)

5101:3-3-20 **Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): medicaid cost report filing, record retention, and disclosure requirements.**

As a condition of participation in the Title XIX medicaid program, each NF and ICF-MR shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, JFS 02524N "Medicaid Nursing Facility Cost Report" ~~(rev. 01/2007)~~(Rev. 1/2010 as found in appendix A rule 5101:3-3-42.1 of the Administrative Code for NFs, and JFS 02524 "Medicaid ICF-MR Cost Report" (Rev. 01/2007) as found in appendix A rule 5101:3-3-71.1 of the Administrative Code for ICFs-MR, including its supplements and attachments as specified under paragraphs (A) to (L) of this rule or other approved forms for state-operated ICFs-MR, must be filed electronically within ninety days after the end of the reporting period. Except as specified under paragraph (E) of this rule, the report shall cover a calendar year or the portion of a calendar year during which the NF or ICF-MR participated in the medicaid program. In the case of a NF or ICF-MR that has a change of operator during a calendar year, the report by the new provider shall cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December thirty-first, except as specified under paragraph (G) of this rule. In the case of a NF or ICF-MR that begins participation after January first and ceases participation before December thirty-first of the same calendar year, the reporting period shall be the first day of participation to the last day of participation. ODJFS shall issue the appropriate software and an approved list of vendors for an electronically submitted cost report no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state-operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code respectively, or relate its chart of accounts directly to the cost report.

(A) For good cause, as deemed appropriate by ODJFS, cost reports may be submitted within fourteen days after the original due date if written approval from ODJFS is received prior to the original due date of the cost report. Requests for extensions must be in writing and explain the circumstances resulting in the need for a cost report extension.

(1) For purposes of this rule, "original due date" means each facility's cost report is due ninety days after the end of each facility's reporting period. Unless waived by ODJFS, the reporting period ends as follows:

(a) On the last day of the calendar year for the health care facility's year end cost report, except as provided in a paragraph (G)(2) of this rule; or

(b) On the last day of medicaid participation or when the facility closes in accordance with rule 5101:3-3-02(A)(1) of the Administrative Code; or

(c) On the last day before a change of operator; or

(d) On the last day of the new facility's or new provider's first three full calendar months of participation under the medicaid program which encompasses the first day of medicaid participation.

(2) If a facility does not submit the cost report within fourteen days after the original due date, or by the extension date granted by ODJFS or submits an incomplete or inadequate report, ODJFS shall provide immediate written notice to the facility that its provider agreement will be terminated in thirty days unless the facility submits a complete and adequate cost report within thirty days of receiving the notice.

(3) During the thirty day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, ~~For~~for each day ~~the~~a complete and adequate cost report is ~~submitted after its original due date~~not received, the provider shall be assessed a late file penalty. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by the penalty. The penalty shall be two dollars per patient day adjusted each July first for inflation during the preceding twelve months as stated in division (A)(2) of section 5111.26 of the Revised Code. The late file penalty period will begin ~~the day after the cost report's due date~~the date ODJFS issues its written notice and continue until the complete and adequate cost report is received by ODJFS or the facility is terminated from the medicaid program. The late file penalty shall be a reduction to the medicaid payment. No penalty shall be imposed during a fourteen-day extension granted by ODJFS as specified in paragraph (A) of this rule.

(B) An "Addendum for Disputed Costs" shall be an attachment to the cost report that a NF or ICF-MR may use to set forth costs the facility believes may be disputed by ODJFS. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the cost report and/or chart of accounts for the cost report period in question (either in the reimbursable or the nonreimbursable cost centers). Any costs reported by the facility on the addendum may be considered by ODJFS in establishing the facility's prospective rate.

(C) ODJFS shall conduct a desk review of each cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. Before issuing the determination ODJFS shall notify the facility of any information on the cost report that requires further support. The facility shall provide any documentation or other information requested by ODJFS and may submit any information that it believes supports the reported costs. ODJFS shall notify each NF and ICF-MR of any costs preliminarily determined not to be allowable and provide the reasons for the determination.

(1) The desk review is an analysis of the provider's cost report to determine its adequacy, completeness, and accuracy and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.

(2) A facility may revise the cost report within sixty days after the original due date without the revised information being considered an amended cost report.

(3) The cost report is considered accepted after the cost report has passed the desk review process.

(4) After final rates have been issued, a provider who disagrees with a desk review decision may request a rate reconsideration.

(D) During the time when a cost report is open for audit, the provider may amend the cost report upon discovery of a material error or material additional information. ~~that increases or decreases the total per diem cost of the applicable cost center or rate by ten cents per patient day or greater. If the error or additional information would change the per diem cost or rate by less than ten cents per patient day, the provider may not, amend the cost report.~~ ODJFS shall not charge interest under division (B) of section 5111.28 of the Revised Code based on any error or additional information that is not required to be reported under this paragraph. ODJFS shall review the amended cost report for accuracy and notify the provider of its determination in accordance with section 5111.27 of the Revised Code. Since the audit determines reasonable and allowable costs, a cost report cannot be amended once an audit has been completed. However, should subsequent events occur or information become available to the provider after the audit is completed that affects the costs for the cost-reporting period, such information may be submitted to ODJFS if the final settlement of the cost report period has not been adjudicated.

(E) The annual cost report submitted by state-operated facilities shall cover the twelve-month period ending June thirtieth of the preceding year, or portion thereof, if medicaid participation was less than twelve months.

(F) Cost reports submitted by county and state-operated facilities may be completed on accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

(G) Three-month cost reports:

(1) Facilities and providers new to the medicaid program shall submit a cost report pursuant to paragraph (A)(1) of this rule for the period which includes the date of certification and subsequent three full calendar months of operations. The new provider of a facility that has a change of operator, on or after the effective date of this amendment shall submit a cost report within ninety days after the end of the facility's first three full calendar months after the change of operator.

(2) If a facility described in paragraph (G)(1) of this rule opens or changes operators on or after October second, the facility is not required to submit a year end cost report for that calendar year.

(H) Providers are required to identify all known related parties as set forth under paragraph (BB) of rule 5101:3-3-01 of the Administrative Code.

(I) Providers are required to identify all of the following:

(1) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership as set forth under paragraphs (BB) and (CC) of rule 5101:3-3-01 of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the facility. When the facility or the common owner is a publicly owned and traded corporation, this information beyond basic identifying criteria is not required as part of the cost report but must be available within two weeks when requested. Publicly disclosed information must be available at the time of the audit; and

(2) Each corporate officer or director, if the provider is a corporation; and

(3) Each partner, if the provider is a partnership; and

(4) Each provider, whether participating in the medicare or medicaid program or not, which is part of an organization which is owned, or through any other device controlled, by the organization of which the provider is a part; and

(5) Any director, officer, manager, employee, individual, or organization having direct or indirect ownership or control of five per cent or more [see paragraph (H) of this rule], or who has been convicted of or pleaded guilty to a civil or criminal offense related to his involvement in programs established by Title XVIII (medicare), Title XIX (medicaid), or Title XX (social services) of the Social Security Act, as amended (through 1/1/07); and

(6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (H) of this rule, in a managerial, accounting, auditing, legal, or similar capacity who was employed by ODJFS, the Ohio department of health, the office of attorney general, the Ohio department of aging, the Ohio department of mental retardation and developmental disabilities, the Ohio department of commerce or the industrial commission of Ohio within the previous twelve months.

(J) Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is ten thousand dollars or more in a twelve-month period; or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is ten thousand dollars or more in a twelve-month period, the audit provisions of 42 C.F.R. 420 subpart (D) (effective 12/30/82), apply to these contractors.

(1) For purposes of this rule, "contract for service" is defined as the component of a contract that details services provided exclusive of supplies and equipment. It includes any contract which details services, supplies and equipment to the extent the value of the service component is ten thousand dollars or more within a twelve-month period.

(2) For purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, who contract with a provider to supply a service, either to the provider or directly to the beneficiary, where medicaid reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is ten thousand dollars or more in a twelve-month period.

(K) Financial, statistical and medical records (which shall be available to ODJFS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODJFS issues an audit report, or six years after all appeal rights relating to the audit report are exhausted.

(1) Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages of the greater amount:

(a) One thousand dollars per audit; or

(b) Twenty-five per cent of the amount by which the undocumented cost increased the medicaid payments to the provider, during the fiscal year.

(2) Failure to retain the required financial, statistical, or medical records to the extent that filed cost reports are unauditable shall result in the penalty as specified in paragraph (K)(1) of this rule. Providers whose records have been found to be unauditable will be allowed sixty days to provide the necessary documentation. If, at the end of the sixty days, the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ODJFS, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, ODJFS shall impose the penalty as specified in paragraph (K)(1) of this rule.

(3) Refusing legal access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (K)(1) of this rule for outstanding medical services until such time as the requested information is made available to ODJFS.

(4) All requested financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for facilities certified for participation in the medicaid program by this state within at least sixty days after request by the state or its subcontractors. The preferred Ohio location is the facility itself, but may be a corporate office, an accountant's office, or an attorney's office elsewhere in Ohio. This requirement, however, does not preclude the state or its subcontractors from the option of conducting the audit and/or a review at the site of such records if outside of Ohio.

(L) When completing cost reports, the following guidelines shall be used to properly classify costs:

(1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two years or more, is to be reported in the capital cost component set forth under the Administrative Code. The costs of equipment acquired by an operating lease, including vehicles, executed before December 1, 1992, may be reported in the ancillary/support cost component for NFs and indirect care cost component for ICFs-MR if the costs were reported as administrative and general costs on the facility's cost report for the reporting period ending December 31, 1992, until the current lease term expires. The costs of any equipment leases executed before December 1, 1992 and reported as capital costs, shall continue to be reported under the capital cost component. The costs of any new leases for equipment executed on or after December 1, 1992, shall be reported under the capital costs component. Operating lease costs for equipment, which result from extended leases under the provision of a lease option negotiated on or after December 1, 1992, shall be reported under the capital cost component.

(2) Except for employers' share of payroll taxes, workers compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost centers shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expended under separate cost centers if performed by separate staff may be expended to separate cost centers based upon documented hours worked, provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide for the remainder of the shift may be expended to separate cost centers provided the facility maintains adequate documentation of hours worked in each cost center.

(3) The costs of resident transport vehicles are reported under the capital cost component. Maintenance and repairs of these vehicles is reported under the ancillary/support cost component for NFs and the indirect care cost component for ICFs-MR.

5101:3-3-42 **Nursing facilities (NFs): chart of accounts.**

(A) The Ohio department of job and family services (ODJFS) requires that all facilities file cost reports annually to comply with section 5111.26 the Revised Code.

(1) The use of the chart of accounts in table 1 to table 8 of appendix A of this rule is recommended to establish the minimum level of detail to allow for cost report preparation.

(2) If the recommended chart of accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report.

(3) Where a chart of accounts number has sub-accounts, it is recommended that the sub-accounts capture the information requested so that the information will be broken out for cost reporting purposes.

(4) For example, when revenue accounts appear by payor type, it is required that those charges be reported by payor type where applicable; when salary accounts are differentiated between "supervisory" and "other", it is required that this level of detail be reported on the cost report where applicable.

(B) While the chart of accounts facilitates the level of detail necessary for medicaid cost reporting purposes, providers may find it desirable or necessary to maintain their records in a manner that allows for greater detail than is contained in the recommended chart of accounts.

(1) The recommended chart of accounts allows for a range of account numbers for a specified account.

(2) For example, account 1001 is listed for petty cash, with the next account, cash, beginning at account 1010. Therefore, a provider could delineate sub-accounts 1010-1, 1010-2, 1010-3, 1010-4, to 1010-9 as separate cash accounts. Providers need only use the sub-accounts applicable for their facility.

(C) Within the expense section (tables 5, 6, and 7), accounts identified as "salary" accounts are only to be used to report wages for facility employees.

(1) Wages are to include wages for sick pay, vacation pay and other paid time off, as well as any other compensation to be paid to the employee.

(2) Expense accounts identified as "contract" accounts are only to be used for reporting the costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll.

(3) Expense accounts identified as "purchased nursing services" are only to be used for reporting the costs incurred for personnel acquired through a nursing pool agency.

(4) Expense accounts designated as "other" can be used for reporting any appropriate nonwage expenses, including contract services and supplies.

(D) Completion of the cost report as required by section 5111.26 of the Revised Code will require that the number of hours paid be reported (depending on facility type of control, on an accrual or cash basis) for all salary expense accounts. Providers' record keeping should include accumulating hours paid consistent with the salary accounts included within the recommended chart of accounts.

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TABLE 1

BALANCE SHEET ACCOUNTS-ASSETS

CURRENT ASSETS

1001 Petty Cash

1010 Cash in Bank

- 1010.1 General Account
- 1010.2 Payroll account
- 1010.3 Savings account
- 1010.4 Imprest cash funds
- 1010.5 Certificates of deposit
- 1010.6 Money market
- 1010.7 Resident funds

These cash accounts represent the amount of cash deposited in banks or financial institutions.

1030 Accounts Receivable

- 1030.1 Private
- 1030.2 Medicare
- 1030.3 Medicaid
- 1030.4 Other Payers

The balances in these accounts represent the amounts due the LTCF for services delivered and/or supplies sold.

1040 Allowance for Uncollectible Accounts Receivable

This account represents the estimated amount of uncollectible receivables.

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1050 Notes Receivable

This account represents notes receivable due on demand, or that portion of notes due within twelve (12) months of the balance sheet date.

1060 Allowance for Uncollectible Notes Receivable

This account represents the estimated amount of uncollectible notes receivables.

1070 Other Receivables

1070.1 Employees
1070.2 Sundry

1080 Cost Settlements

1080.1 Medicare
1080.2 Medicaid

These accounts represent amounts due provider from current or prior unsettled cost reporting periods.

1090 Inventories

1090.1 Medical and program supplies
1090.2 Dietary
1090.3 Gift shop
1090.4 Housekeeping supplies
1090.5 Laundry and linen
1090.6 Maintenance

These accounts represent the cost of unused LTCF supplies.

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1100 Prepaid Expenses

1100.1 Insurance
1100.2 Interest
1100.3 Rent
1100.4 Pension plan
1100.5 Service contract
1100.6 Taxes
1100.7 Other

These accounts represent payments for costs which will be charged to future accounting periods.

1110 Short - Term Investments

1110.1 U.S. Government securities
1110.2 Marketable securities
1110.3 Other

1120 Special Expenses

1120.1 Telephone systems
1120.2 Prior authorized medical equipment

Unamortized cost of telephone systems and prior authorized medical equipment. Amortized cost of telephone systems acquired before 12/1/92, if the costs were reported as administrative and general on the facility's cost report for the period ending 12/31/92, should be reported in account 7620.

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1200 Property, Plant and Equipment

Nursing facilities that did not change operator on or after 7/01/93 need only use group (A). Nursing facilities that did change operator on or after 7/01/93 use groups (A) and (B).

(A)

1200.1	Land
1200.2	Land improvements
1200.3	Building and building improvements
1200.4	Equipment
1200.5	Transportation equipment
1200.6	Leasehold improvements
1200.7	Financing cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) NFs that changed operator on or after 7/01/93 use this group to report assets acquired through a change of operator on or after 7/01/93.

1200.8	Land acquired on or after 7/01/93 through a change of operator
1200.9	Building and building improvements acquired on or after 7/01/93 through a change of operator
1200.10	Equipment acquired on or after 7/01/93 through a change of operator

(C) (Assets under capital lease)

1200.18	Assets under capital lease - prior to 5/27/92
1200.19	Assets under capital lease - on or after 5/27/92

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1250 Accumulated Depreciation and Amortization - Prop., Plant and Equip.

Nursing facilities that did not change operator on or after 7/01/93 need only use group (A). Nursing facilities that did change operator on or after 7/01/93 use groups (A) and (B).

(A) 1250.1 Land improvements
1250.2 Building and building improvements
1250.3 Equipment
1250.4 Transportation equipment
1250.5 Leasehold improvements
1250.6 Financing cost-cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) NFs that changed operator on or after 7/01/93 use this group to report assets acquired through a change of operator on or after 7/01/93.

1250.7 Building and building improvements acquired on or after 7/01/93 through a change of operator
1250.8 Equipment acquired on or after 7/01/93 through a change of operator

(C) (Assets under capital lease)

1250.18 Assets under capital lease - prior to 5/27/92
1250.19 Assets under capital lease - on or after 5/27/92

1300 Nonextensive Renovations
As defined in the Ohio Revised Code (ORC).

(A) 1300.1 Building and building improvements
1300.2 Equipment
1300.3 Leasehold improvements
1300.4 Financing Cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) (Assets under capital lease)

1300.9 Assets under capital lease - prior to 5/27/92
1300.10 Assets under capital lease - on or after 5/27/92

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1350 Accumulated Depreciation and Amortization – Nonextensive Renovations

(A) 1350.1 Building and building improvements
1350.2 Equipment
1350.3 Leasehold improvements
1350.4 Financing cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) (Assets under capital lease)

1350.9 Assets under capital lease - prior to 5/27/92
1350.10 Assets under capital lease - on or after 5/27/92

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OTHER ASSETS

1400 Non-Current Investments

- 1400.1 Certificates of deposit
- 1400.2 U.S. Government securities
- 1400.3 Bank savings account
- 1400.4 Marketable securities
- 1400.5 Cash surrender value of insurance
- 1400.6 Replacement reserve
- 1400.7 Funded depreciation

1410 Deposits

- 1410.1 Workers' compensation
- 1410.2 Leases
- 1410.3 Other

1420 Due From Owners/Officers

- 1420.1 Officers
- 1420.2 Owners

1430 Deferred Charges and Other Assets

- 1430.1 Escrow accounts
- 1430.2 Deferred loan costs and finance charges except property, plant and equipment
- 1430.3 Organization expenses
- 1430.4 Goodwill
- 1430.5 Start-up costs

1440 Notes Receivable - Long Term

This account represents notes receivable or portion thereof due more than twelve (12) months from balance sheet date.

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TABLE 2

BALANCE SHEET ACCOUNTS – LIABILITIES

CURRENT LIABILITIES

2010 Accounts Payable

2010.1 Trade
2010.2 Resident deposits-private
2010.3 Resident funds

These accounts represent amounts due to vendors, creditors, and residents for services and supplies purchased, which are payable within one (1) year of the balance sheet date.

2020 Cost Settlements

2020.1 Medicare
2020.2 Medicaid

These accounts represent amounts due to medicare or medicaid from current or prior unsettled cost reporting periods.

2030 Notes Payable

2030.1 Notes payable - vendors
2030.2 Notes payable - bank
2030.3 Notes payable - other

These accounts represent amounts due vendors and banks, evidenced by promissory notes, payable on demand, or due within one year of the balance sheet date.

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2040 Current Portion of Long Term Debt

This account represents the principal of notes, loans, mortgages, capital lease obligations or bonds due within twelve (12) months of the balance sheet date.

2050 Accrued Compensation

- 2050.1 Salaries and wages
- 2050.2 Vacations
- 2050.3 Sick leave
- 2050.4 Bonuses
- 2050.5 Pensions - retirements plans
- 2050.6 Profit sharing plans

2060 Payroll Related Withholding and Liabilities

- 2060.1 Federal income
- 2060.2 FICA
- 2060.3 State
- 2060.4 Local income
- 2060.5 Employer's portion of FICA/Medicare taxes or OPERS
- 2060.6 Group insurance premium
- 2060.7 State unemployment taxes
- 2060.8 Federal unemployment taxes
- 2060.9 Worker's compensation
- 2060.10 Union dues

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2080 Taxes Payable

- 2080.1 Real estate
- 2080.2 Personal property
- 2080.3 Federal income tax
- 2080.4 State income tax/franchise tax
- 2080.5 Local income tax
- 2080.6 Sales taxes
- 2080.7 Other taxes

2090 Other Liabilities

- 2090.1 Accrued interest
- 2090.2 Dividends payable
- 2090.3 Other
- 2090.4 Franchise permit fee

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LONG TERM LIABILITIES

2410 Long Term Debt

- 2410.1 Mortgages
- 2410.2 Bonds
- 2410.3 Notes payable
- 2410.4 Construction loans
- 2410.5 Capital lease obligations
- 2410.6 Life insurance policy loan

These accounts reflect liabilities that have maturity dates extending beyond one (1) year after the balance sheet date.

2420 Related Party Loans
Interest allowable under medicare guidelines.

2430 Related Party Loans
Interest non-allowable under medicare guidelines.

2440 Non-Interest Bearing Loans From Owners
See the "Centers for Medicare and Medicaid Services (CMS) Publication 15-1," section 1210

2450 Deferred Liabilities

- 2450.1 Revenue
- 2450.2 Federal income taxes
- 2450.3 State income taxes
- 2450.4 Local income taxes

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TABLE 3

BALANCE SHEET ACCOUNT-CAPITAL

This account represents the difference between total assets and total liabilities for the reporting entity. This account includes capital of for-profit entities and not-for-profit entities (fund balance). It also represents the net effect of all the transactions within account balances, including but not limited to contributions, distributions, transfers between funds and current year profit or loss. In addition, it represents capital stock and associated accounts.

3000 Capital

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TABLE 4

REVENUE ACCOUNTS

ROUTINE SERVICE REVENUES

5010 Room and Board - Private
5011 Room and Board - Medicare
5012 Room and Board - Medicaid
5013 Room and Board - Veterans
5014 Room and Board - Other

ANCILLARY SERVICE REVENUES

5020 Physical Therapy
5030 Occupational Therapy
5040 Speech Therapy
5050 Audiology Therapy
5060 Respiratory Therapy
5070 Medical Supplies - Medicare
Items which are billable to medicare regardless of payor type.

5070.1 Medicare B-Medicaid
5070.2 Medicare B-Other
5070.3 Private
5070.4 Medicare A
5070.5 Veterans
5070.6 Other
5070.7 Medicaid

5080 Medical Supplies - Routine
Medicaid allowable supplies which are not billable to medicare regardless of payor type.

5085 Habilitation Supplies

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5090 Medical Minor Equipment - Medicare
Items which are billable to medicare regardless of payor type.

- 5090.1 Medicare B-Medicaid
- 5090.2 Medicare B-Other
- 5090.3 Private
- 5090.4 Medicare A
- 5090.5 Veterans
- 5090.6 Other
- 5090.7 Medicaid

5100 Medical Minor Equipment - Routine
Medicaid allowable equipment which are not billable to medicare regardless of payor type.

5110 Enteral Nutrition Therapy - Medicare
Items which are billable to Medicare regardless of payor type.

- 5110.1 Medicare B-Medicaid
- 5110.2 Medicare B-Other
- 5110.3 Private
- 5110.4 Medicare A
- 5110.5 Veterans
- 5110.6 Other
- 5110.7 Medicaid

5120 Enteral Nutrition Therapy - Routine
Medicaid allowable enterals which are not billable to Medicare regardless of payor type.

5140 Incontinence Supply
5150 Personal Care
5160 Laundry Service - Routine

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OTHER SERVICE REVENUES

These accounts represent other charges for services as well as for certain services not covered by the medicaid program.

5310 Dry Cleaning Service
5320 Communications
5330 Meals
5340 Barber and Beauty
5350 Personal Purchases - Residents
5360 Radiology
5370 Laboratory
5380 Oxygen
5390 Legend Drugs
5400 Other, Specify

NON-OPERATING REVENUES

5510 Management Services
5520 Cash Discounts
5530 Rebates and Refunds
5540 Gift Shop
5550 Vending Machine Revenues
5555 Vending Machine Commissions
5560 Rental-Space
5570 Rental-Equipment
5580 Rental-Other
5590 Interest Income - Working Capital
5600 Interest Income - Restricted Funds
5610 Interest Income - Funded Depreciation
5620 Interest Income - Related Party Revenue
5625 Interest Income - Contributions
5630 Endowments
5640 Gain/Loss on Disposal of Assets
5650 Gain/Loss on Sale of Investments
5660 Nurse Aide Training Program Revenue
5670 Unrestricted Contributions

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DEDUCTIONS FROM REVENUES

5710 Contractual Allowance - Medicare
5720 Contractual Allowance - Medicaid

5730 Contractual Allowance - Other
A single account which is the sum of 5710, 5720 and 5730 can be maintained by those LTCFs that do not record contractual allowances by payment source. Detail supporting this single account must be available.

5740 Charity Allowance

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TABLE 5

TAX COST

TAXES

6060 Real Estate Taxes
Real property tax expense incurred by the provider.

6070 Personal Property Taxes
Personal property tax expense incurred by the provider.

6080 Franchise Tax
Allowable portion of franchise tax as defined in section 2122.4, of the "CMS Publication 15-1."

6085 Commercial Activity Tax (CAT)
Annual business privilege tax; begun July 1, 2005.

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TABLE 6

DIRECT CARE COSTS

These accounts include costs that are specified and represent expenses related to the delivery of nursing and habilitation/rehabilitation services. The term "licensed" refers to state of Ohio licensure.

NURSING AND HABILITATION/REHABILITATION

6100 Medical Director
A physician licensed under state law to practice medicine, that is responsible for the implementation of resident care policies, and the coordination of medical care in the facility.

6100.1 Medical director salary
6100.2 Medical director contract

6105 Director of Nursing
A full time registered nurse who has, in writing, administrative authority, responsibility, and accountability for the functions, activities and training of the nursing services staff, and serves only one nursing facility in this capacity. (NFs that receive a waiver from the state of Ohio are not required to have a full-time director of nursing.)

6105.1 Director of nursing salary
6105.2 Director of nursing contract

6110 RN Charge Nurse
A registered nurse (RN) designated by the director of nursing who is responsible for the supervision of the nursing activities in the facility.

6110.1 RN charge nurse salary
6110.2 RN charge nurse contract

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6115 LPN Charge Nurse
A licensed practical (vocational) nurse designated by the director of nursing who is responsible for the supervision of the nursing activities in the facility.

6115.1 LPN charge nurse salary
6115.2 LPN charge nurse contract

6120 Registered Nurse
Salary of registered nurses providing direct nursing care to residents. This account does not include registered nurses from a nursing pool agency (purchased nursing).

6120.1 Registered nurse salary
6120.2 Registered nurse contract

6125 Licensed Practical Nurse
Salary of licensed practical nurses providing direct nursing care to residents. This account does not include licensed practical nurses from a nursing pool agency (purchased nursing).

6125.1 Licensed practical nurse salary
6125.2 Licensed practical nurse contract

6130 Nurse Aides
Salary of individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to: bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. This account does not include nurse aides from a nursing pool agency (purchased nursing). (Excludes housekeeping and laundry duties.)

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6170 Habilitation Staff
Personnel trained in habilitation who provide habilitation services.

6170.1 Habilitation staff salary
6170.2 Habilitation staff contract

6185 Respiratory Therapist
A professional licensed under state law to render respiratory care.

6185.1 Respiratory therapist salary
6185.2 Respiratory therapist contract

6205 Quality Assurance
Individuals providing the quality assurance functions in the facility, as overseen by the committee established under 42 CFR, Section 483.75 (O). (Supplies are included in program supplies.) This account includes costs previously reported as utilization review personnel.

6205.1 Quality assurance salary
6205.2 Quality assurance contract

6207 Behavioral and Mental Health Services

6207.1 Behavioral and Mental Health Services salary
6207.2 Behavioral and Mental Health Services contract

6210 Consulting and Management Fees
Direct care consulting fees paid to a non-related entity pursuant to the OAC, necessary pursuant to CMS Pub. 15-1, Section 2135, and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.

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6220 Other Direct Care Medical Services
Direct care medical services not previously listed.

6220.1 Other direct care salary
6220.2 Other direct care contract

6230 Home Office Costs/Direct Care
Direct care expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to patient care and are limited to home office personnel functioning in place of the facility personnel in the nursing and habilitation/rehabilitation costs as specified in the direct care cost center, and are allocated to the facility in accordance with "CMS Publication 15-1," sections 2150 through 2150.3, "Home Office Costs".

6230.1 Home office/direct care salary
6230.2 Home office/direct care other

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MEDICAL SUPPLIES

Medical supplies - items which are disposable, or have a limited life expectancy, including but not limited to: atomizers and nebulizers, catheters, adhesive backed foam pads, eye shields, hypodermic syringes and needles. Routine nursing supplies such as: isopropyl alcohol, analgesic rubs, antiseptics, cotton balls and applicators, elastic support stockings, dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, stockinette), enema administration apparatus and enemas, hydrogen peroxide, glycerin swabs, lubricating jellies (Vaseline, KY Jelly, etc.), plastic or adhesive bandages (e.g. Band-Aids), medical tape, tongue depressors, tracheotomy care sets and suction catheters, tube feeding sets and component supplies, some over the counter drugs, etc. (excludes incontinence supplies, enterals, and all items that are directly billed by supplier to Medicare and Medicaid.)

For those facilities participating in medicaid and not in medicare, all medical supplies are to be classified in account 6311. For those facilities participating in both the medicare and medicaid programs, medical supplies must be categorized and classified as follows:

6301 Medical Supplies Billable to Medicare
Medical supplies for facilities participating in medicare which are billable to Medicare regardless of payor type.

6311 Medical Supplies Non-Billable to Medicare
Medical supplies for facilities not participating in medicare, as well as medical supplies for facilities which are not billable to medicare regardless of payor type.

6321 Oxygen – Emergency stand-by only

6322 Oxygen
Report all oxygen other than emergency stand-by oxygen in this account. This includes contents of oxygen cylinders or tanks, including liquid oxygen, oxygen producing machines (concentrators) for specific use by an individual recipient, and costs of equipment associated with oxygen administration, such as: carts, regulators/humidifiers, cannulas, masks, and demurrage, pursuant to rule 5101:3-3-19 of the Administrative Code.

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6330 Habilitation Supplies
Supplies used to provide services measured by the current version of the minimum data set (MDS), which assist the resident to cope with: daily living, aging process, and perform tasks normally performed at his/her chronological stage of development. Does not include cost of meals for out of facility functions.

6340 Universal Precaution Supplies
Supplies required for the protection of residents and facility staff while performing procedures which involve the handling of bodily fluids. Supplies include: masks, gloves, gowns, goggles, boots, and eye wash. (Excludes trash bags and paper towels.)

PURCHASED NURSING SERVICES

Expenses incurred by the facility to a nursing pool agency for temporary direct care personnel.

6401 Registered Nurse Purchased Nursing
Registered nurses providing direct nursing care to residents.

6411 Licensed Practical Nurse Purchased Nursing
Licensed practical nurses providing direct nursing care to residents.

6421 Nurse Aides Purchased Nursing
Individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to: bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. (Excludes housekeeping and laundry duties.)

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NURSE AIDE TRAINING

6500 In-House Trainer Wages
This account includes and is limited to, train the trainer salary or wages while attending a state approved program, guest speaker fees, salaries and wage expense for the primary instructor and program coordinator providing facility-based nurse aide training programs in order to comply with the ORC.

6511 Classroom Wages: Nurse Aides
This account is limited to, wages paid to nurse aides during the classroom portion of the state approved training and competency evaluation programs, wages paid for continuing education pursuant to the ORC, and wages paid during the state approved competency test including travel time. Include only those wages paid for your own facility staff.

6521 Clinical Wages: Nurse Aides
This account is limited to, wages paid to nurse aides during the clinical portion of the state approved training and competency evaluation programs and wages paid for continuing education pursuant to the ORC. Include only those wages paid for your own facility staff.

6531 Books and Supplies
This account is limited to books and supplies expense incurred by the facility for nurse aide training, i.e., textbooks, reference material used for class preparation. This account does not include costs that may be used in more than one cost center, i.e., office supplies, expense of operating a copier, linens, computers, etc. (Mannequins will only be considered in their entirety and are subject to the capitalization policy stated in the capital cost center, paragraph A.)

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6541 Transportation
This account is limited to the mileage allowance, e.g., using the individual's own vehicle, paid to nurse aides from your facility to attend either a classroom or clinical training session at a state approved nurse aide training program and/or mileage allowance paid to nurse aides to attend state approved competency tests. This account does not include expense incurred for the use of a facility's own vehicle.

6551 Tuition Payments
This account is limited to tuition payments to other entities that provide state approved nurse aide training for your nurse aides in order to comply with the ORC, excluding payments to other nursing facilities.

6560 Tuition Reimbursement
This account is limited to the reimbursement of costs incurred by the facility to reimburse an individual who is not employed, or does not have an offer to be employed, as a nurse aide but becomes employed by, or received an offer for employment from, the facility not later than twelve months after completing a nurse aide training and competency evaluation program. Reimbursement to the nurse aide shall be made on a prorata basis during the period in which the individual is employed as a nurse aide.

6570 Contractual Payments to Other Nursing Facilities
The account is limited to payments to other nursing facilities that provide state approved nurse aide training for your nurse aides in order to comply with the ORC.

6580 Registration Fees and Application Fees
This account is limited to all registration fees and application fees necessary to comply with the ORC, i.e., train the trainer fees in order to comply with the ORC and state approved competency exam fees for nurse aides.

6590 Employee Fringe Benefits
Nurse aide training (series # 6500) - This account is limited to fringe benefits for employees providing and/or attending state approved nurse aide training/testing programs pursuant to the ORC. Includes self insurance funds. (This account excludes vacation and sick pay salary.)

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DIRECT CARE THERAPIES

6600 Physical Therapist
A qualified professional licensed under Ohio law as physical therapist.
6600.1 Physical therapist salary
6600.2 Physical therapist contract

6605 Physical Therapy Assistant
An individual licensed under Ohio law as a physical therapy assistant.
6605.1 Physical therapy assistant salary
6605.2 Physical therapy assistant contract

6610 Occupational Therapist
A qualified professional licensed under Ohio law as an occupational therapist.
6610.1 Occupational therapist salary
6610.2 Occupational therapist contract

6615 Occupational Therapy Assistant
An individual licensed under Ohio law as an occupational therapy assistant.
6615.1 Occupational therapy assistant salary
6615.2 Occupational therapy assistant contract

6620 Speech Therapist
A qualified professional licensed under Ohio law as a speech therapist.
6620.1 Speech therapist salary
6620.2 Speech therapist contract

6630 Audiologist
A qualified professional licensed under Ohio law as an audiologist.
6630.1 Audiologist salary
6630.2 Audiologist contract

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DIRECT CARE THERAPIES PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

6640 Payroll Taxes – Therapy

Direct care therapies payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6; and federal unemployment taxes (excludes purchased nursing).

6650 Workers' Compensation – Therapy

Direct care therapies premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (excludes purchased nursing).

6660 Employee Fringe Benefits – Therapy

Direct care therapies fringe benefits such as: medical and life insurance premiums or self insurance funds; employee stock option program; pension and profit sharing; personal use of autos; employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. This account does not include benefits for nursing facility personnel in account 6590, employee fringe benefits for nurse aide training. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6665 Employee Assistance Program Administrator – Therapy

An individual who performs the duties of the employee assistance program administrator for direct care therapies personnel.

6665.1 EAP administrator therapy – salary
6665.2 EAP administrator therapy – contract

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6670 Self Funded Program Administrator – Therapy
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to direct care therapies.)

6670.1 Self funded admin. therapy – salary
6670.2 Self funded admin. therapy – contract

6680 Staff Development – Therapy
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with direct care therapies personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

6680.1 Staff development therapy – salary
6680.2 Staff development therapy – other

DIRECT PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

This series represents payroll taxes, workers' compensation, fringe benefits, EAP administrator, self funded programs administrator and staff development. These accounts should not be used to report payroll taxes, workers compensation, and fringe benefits for Direct Care Therapies, which should be reported in accounts 6640 through 6645.2.

6700 Payroll Taxes
Direct care payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6; and federal unemployment taxes (excludes purchased nursing).

6710 Workers' Compensation
Direct care premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (excludes purchased nursing).

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6720 Employee Fringe Benefits
Direct care fringe benefits such as: medical and life insurance premiums or self insurance funds; employee stock option program; pension and profit sharing; personal use of autos; employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. This account does not include benefits for nursing facility personnel in account 6590, employee fringe benefits for nurse aide training. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6730 Employee Assistance Program Administrator - Direct Care
An individual who performs the duties of the employee assistance program administrator for direct care personnel.

6730.1 EAP administrator direct care salary
6730.2 EAP administrator direct care contract

6740 Self Funded Programs Administrator - Direct Care
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to direct care.)

6740.1 Self funded admin. direct care salary
6740.2 Self funded admin. direct care contract

6750 Staff Development - Direct Care
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with direct care personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

6750.1 Staff development direct care salary
6750.2 Staff development direct care contract

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TABLE 7

ANCILLARY/SUPPORT COSTS

Ancillary/Support costs includes costs other than direct care costs, tax costs, or capital costs.

7000 Dietitian
Service provided by a professional licensed under Ohio law, as qualified in the ORC.

7000.1 Dietitian salary
7000.2 Dietitian contract

7005 Food Service Supervisor
An individual supervising the dietary procedures and/or personnel.

7005.1 Food service supervisor salary
7005.2 Food service supervisor contract

7015 Dietary Personnel
Personnel providing dietary services. (Excludes dietitian, food service supervisor, and personnel reported in account 7050, contract meals personnel.)

7015.1 Dietary personnel salary
7015.2 Dietary personnel contract

7025 Dietary Supplies and Expenses
Dietary items such as: dishes, dish-washing liquid, plastic wrap, cooking utensils, silverware and dietary supplies. (Excludes equipment or repairs as well as housekeeping items such as paper towels, trash bags, etc.)

7030 Dietary Minor Equipment
Dietary equipment which does not meet the facility's capitalization criteria specified in the Ohio Administrative Code (OAC).

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7035 Dietary Maintenance and Repair
Maintenance supplies, purchased services and maintenance contracts for the dietary department.

7040 Food In-Facility
Food required to prepare meals in the facility.

7045 Employee Meals
Employee meals that do not qualify under "CMS Publication 15-1," section 2144 "Fringe Benefits".

7050 Contract Meals and Contract Meals Personnel
Expenses associated with contracting for the food service function in the facility. (Includes food services delivered to the facility from an outside vendor.)

For those facilities participating in medicaid and not in medicare, all enteral nutritional therapy and additives (food facilitators), whether administered orally or tube fed, are to be classified in account 7056. For those facilities participating in both the medicare and medicaid programs, enterals must be categorized and classified as follows:

7055 Enterals: Medicare Billable
Enteral nutritional therapy and additive (food facilitators), whether administered orally or tube fed, for facilities participating in medicare which are billable to medicare regardless of payor type.

7056 Enterals: Medicare Non-Billable
Enteral nutritional therapy and additives (food facilitators), whether administered orally or tube fed, for facilities not participating in medicare, as well as enterals for facilities which are not billable to medicare regardless of payor type.

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DIETARY PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

7060 Payroll Taxes - Dietary
(series #7000) Payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio public employees retirement system (OPERS), state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6, and federal unemployment taxes.

7065 Workers' Compensation - Dietary
(series #7000) premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6.

7070 Employee Fringe Benefits - Dietary
(series #7000) fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes vacation and sick pay salary.)

7075 Employee Assistance Program Administrator-Dietary
(series #7000) an individual who performs the duties of the employee assistance program administrator for dietary personnel.

7075.1 EAP administrator dietary salary
7075.2 EAP administrator dietary contract

7080 Self Funded Programs Administrator - Dietary
(series #7000) an individual who performs the administrative functions of the self insured programs. (Report only the portion related to dietary.)

7080.1 Self funded administrator dietary salary
7080.2 Self funded administrator dietary contract

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7090 Staff Development - Dietary
(series #7000) continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with dietary personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

7090.1 Staff development dietary salary
7090.2 Staff development dietary other

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MEDICAL/HABILITATION, PHARMACEUTICAL AND INCONTINENCE SUPPLIES

7105 Medical/Habilitation Records
Personnel responsible for maintaining clinical records on each resident in accordance with accepted professional standards and practices.

7105.1 Medical/habilitation records salary
7105.2 Medical/habilitation records contract

7110 Pharmaceutical Consultant
The services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility as stated in 42 CFR, Section 483.60(b)

7110.1 Pharmaceutical consultant salary
7110.2 Pharmaceutical consultant contract

7115 Incontinence Supplies
Reusable and disposable incontinence supplies, (except catheters). Supplies include cloth or disposable diapers, under-pads, plastic pants, and the cost of diaper service of such items.

7120 Personal Care
Supplies required to maintain routine personal hygiene of the body, hair, and nails of the hands and feet. Includes body lotion, body powder, toothbrush and toothpaste, disposable razors and shaving supplies, hair cuts, shampoo and routine hair care supplies provided by facility. (Excludes contract beautician performing non-routine services.)

7125 Program Supplies
Supplies used to provide activity, social services and religious programs available to all residents. Does not include cost of meals for out of facility functions.

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ACTIVITY AND HABILITATION/REHABILITATION

7201 Activity Director
A professional, as required by the code of federal regulations, who oversees and is responsible for the activity program.

7201.1 Activity director salary
7201.2 Activity director contract

7211 Activity Staff
Personnel providing services related to the activity program.

7211.1 Activity personnel salary
7211.2 Activity personnel contract

7221 Recreational Therapist
A professional, as required by the code of federal regulations, who oversees and is responsible for the recreational program.

7221.1 Recreational therapist salary
7221.2 Recreational therapist contract

7231 Psychologist
A professional licensed under state law to practice psychology.

7231.1 Psychologist salary
7231.2 Psychologist contract

7241 Psychology Assistant
An individual trained in psychology to assist the psychologist.

7241.1 Psychology assistant salary
7241.2 Psychology assistant contract

7251 Social Work/Counseling
A professional licensed under state law to practice social work or counseling.

7251.1 Social work/counseling salary
7251.2 Social work/counseling contract

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7261 Social Services/Pastoral Care
Personnel providing social services and/or pastoral services.

7261.1 Social services/pastoral care salary
7261.2 Social services/pastoral care contract

7271 Habilitation Supervisor
Supervisor responsible for the delivery of services to residents with mental retardation or developmental disabilities in a nursing facility to allow them to attain or maintain their highest practicable level of functioning.

7271.1 Habilitation supervisor salary
7271.2 Habilitation supervisor contract

7281 Program Director
An individual to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan; must implement the active treatment or specialized service program defined by each resident's individual program plan; works directly with residents and with paraprofessional, nonprofessional and other

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MEDICAL MINOR EQUIPMENT

Medical minor equipment limited to: enteral pumps, bed cradles, headgear, heat cradles, hernial appliances, splints, traction equipment, hypothermia or hyperthermia blankets, egg crate mattresses, and gel cushions. Medical equipment that does not qualify for the facility asset capitalization policy and is not included in this group should be reported in minor equipment, account 7730.

For those facilities participating in medicaid and not in medicare, all medical minor equipment should be classified in account 7302. For those facilities participating in both the medicare and medicaid programs, medical minor equipment must be categorized and classified as follows:

7301 Medical Minor Equipment Billable to Medicare

Medical minor equipment for facilities participating in medicare which are billable to Medicare regardless of payor type.

7302 Medical Minor Equipment Non-Billable to Medicare

Medical minor equipment for facilities not participating in medicare, as well as medical minor equipment for facilities which are not billable to medicare regardless of payor type.

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UTILITY EXPENSES

7501 Heat, Light, Power
Services provided to furnish heat, light and power. (This account does not include costs associated with on-site salaries or maintenance of heat, light, power.)

7511 Water and Sewage
Services provided to furnish water and sewage treatment for facilities without on-site water and sewage plants. For facilities which have on-site water and sewer plants, this account includes the costs associated with the maintenance and repair of such operations, including the EPA test. The supplies are limited to: expendable water and sewage treatment and water softener supplies, which are used on the water and sewer system. Payroll taxes and fringe benefits should be reported under accounts 7800 and 7820, respectively.

7511.1 Water and sewage salary
7511.2 Water and sewage other

7521 Trash and Refuse Removal
Services provided to furnish trash and refuse removal, including grease trap removal fees. (This excludes housekeeping items such as trash bags.)

7531 Hazardous Medical Waste Collection
Contract services provided to furnish hazardous waste collection bags, containers and removal service.

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ADMINISTRATIVE AND GENERAL SERVICES

7600 Administrator
Expenses incurred by a facility for an individual(s) who functions as the administrator licensed by the state of Ohio and who is responsible for the direction, supervision and coordination of facility functions.

7600.1 Administrator salary
7600.2 Administrator contract

7605 Other Administrative Personnel
Administrator in training, assistant administrator, business manager, purchasing agent, human resources, receptionist, secretarial and clerical staff.

7605.1 Other administrative salary
7605.2 Other administrative contract

7610 Consulting and Management Fees
Ancillary/Support consulting fees paid to a non-related entity pursuant to the OAC, necessary pursuant to CMS Pub. 15-1, Section 2135, and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.

7615 Office and Administrative Supplies
Supplies such as: copier supplies, printing, postage, office supplies, nursing/habilitation and medical records forms, and data service supplies.

7620 Communications
Service charges for telephone services.

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7625 Security Services
Salaries, purchased services, or supplies to protect property and residents.

7625.1 Security services salary
7625.2 Security services other

7630 Travel and Entertainment
Expenses such as: mileage allowance, gas, and oil for vehicles owned or leased by the facility, meals, lodging, and commercial transportation expense incurred in the normal course of business. Includes all purchased commercial transportation services for ambulatory/non-ambulatory residents. Excludes transportation cost that is directly reimbursed by medicaid to the transportation provider as set forth in the OAC.

7631 Resident Transportation
Report all resident transportation in this account.

7631.1 Resident transportation salary
7631.2 Resident transportation other

7635 Laundry/Housekeeping Supervisor
An individual supervising the laundry/housekeeping functions and/or personnel.

7635.1 Laundry/Housekeeping supervisor salary
7635.2 Laundry/Housekeeping supervisor contract

7640 Housekeeping
Housekeeping services, including supplies, wages, and purchased services. This includes trash bags and paper towels.

7640.1 Housekeeping salary
7640.2 Housekeeping other

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7645 Laundry and Linen
Laundry services, including supplies, wages, and purchased services, as well as linens for all areas. Excluding incontinence supplies specified in account 7115.

7645.1 Laundry/linen salary
7645.2 Laundry/linen other

7650 Legal Services
Legal services except as excluded in the OAC.

7655 Accounting
Accounting, Bookkeeping Fees and Salaries.

7655.1 Accounting salary
7655.2 Accounting contract

7660 Dues, Subscriptions and Licenses
Expense of dues, subscriptions and licenses incurred by facility.

7665 Interest - Other
Expense of short term credit and working capital interest incurred. (This account does not include late fees, fines or penalties.)

7670 Insurance
Expense of insurance such as: general business, liability, malpractice, vehicle, and property insurance.

7675 Data Services
Data services personnel and purchased services.

7675.1 Data services salary
7675.2 Data services contract

7680 Help Wanted/Informational Advertising
Help wanted ads, yellow pages, and other advertising media that are informational as opposed to promotional in nature as stated in "CMS Publication 15-1," section 2136.1.

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7685 Amortization of Start-Up Costs
Amortization of cost included in the account 1430.5, not otherwise allocated to other cost centers, in accordance with "CMS Publication 15-1," section 2132, which were incurred by a facility.

7686 Amortization of Organizational Costs
Amortization of cost included in account 1430.3, as described in "CMS Publication 15-1," section 2134.

7690 Other Ancillary/Support Administrative Services - Specify below
Ancillary/Support administrative services not previously listed.

7690.1 Other Ancillary/Support salary
7690.2 Other Ancillary/Support contract

HOME OFFICE COSTS

7695 Home Office Costs/Ancillary/Support
Ancillary/Support expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to administrative and management services allocated to the facility in accordance with "CMS Publication 15-1," section 2150 through 2150.3, "Home Office Costs".

7695.1 Home office/Ancillary/Support salary
7695.2 Home office/Ancillary/Support other

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MAINTENANCE AND MINOR EQUIPMENT

7700 Plant Operations and Maintenance Supervisor
An individual supervising the plant operations and maintenance procedures and/or personnel.

7770.1 Operations/maintenance supervisor salary
7770.2 Operations/maintenance supervisor contract

7710 Plant Operations and Maintenance
Salaries for all maintenance personnel employed by the facility.

7720 Repair and Maintenance
Supplies, purchased services and maintenance contracts for all departments. (Excludes dietary maintenance account 7035 and on-site water and sewage account 7511.)

7730 Minor Equipment
Equipment which does not meet the facility's capitalization criteria specified under the OAC. The general characteristics are: comparatively small in size and unit cost, subject to inventory control, fairly large quantity is used, and generally, a useful life of approximately three years or less. (Exclude account 7030 - dietary minor equipment and items listed in accounts 7301 and 7302-medical minor equipment.)

7735 Custom Wheelchairs
This account includes the cost of all custom wheelchairs and related repairs.

EQUIPMENT ACQUIRED BY OPERATING LEASE

7740 Leased Equipment
This account includes the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992 (all leases effective after 12/01/92, should be reported in account 8065 for assets acquired prior to 7/01/93).

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ANCILLARY/SUPPORT PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT

7800 Payroll Taxes
Ancillary/Support payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio public employees retirement system (OPERS); state unemployment taxes or self insurance funds for unemployment compensation ("CMS Publication 15-1," section 2122.6; and federal unemployment taxes.

7810 Workers' Compensation
Ancillary/Support premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6.

7820 Employee Fringe Benefits
Ancillary/Support fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes vacation and sick pay salary.)

7830 Employee Assistance Program Administrator – Ancillary/Support
An individual who performs the duties of the employee assistance program administrator for Ancillary/Support personnel.

7830.1 EAP administrator Ancillary/Support salary
7830.2 EAP administrator Ancillary/Support contract

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7840 Self Funded Programs Administrator – Ancillary/Support
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to Ancillary/Support.)

7840.1 Self funded admin. Ancillary/Support salary
7840.2 Self funded admin. Ancillary/Support contract

7850 Staff Development – Ancillary/Support
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with Ancillary/Support personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

7850.1 Staff development Ancillary/Support salary
7850.2 Staff development Ancillary/Support other

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NON-REIMBURSABLE EXPENSES

These are costs described in rules regarding therapy under Chapter 5101:3-3 of the OAC, which are billable either to medicare, directly to medicaid by NFs, or other third-party payers.

9705 Legend Drugs
9710 Radiology
9715 Laboratory

9725 Other Non-Reimbursable - Specify Below:

9725.1 Other Non-Reimbursable – salary
9725.2 Other Non-Reimbursable – other

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9730 Late Fees, Fines or Penalties
Includes those fees, fines, or penalties as stated in "CMS Publication 15-1" and audit fines assessed pursuant to Section 5111.271 of the Ohio Revised Code.

9735 Federal Income Tax
9740 State Income Tax
9745 Local Income Tax

9750 Insurance-Officer's life
This is non-reimbursable expense when the facility is the beneficiary, except as referenced in "CMS Publication 15-1," section 2130.

9755 Promotional Advertising and Marketing

9755.1 Promotional advertising/marketing salary
9755.2 Promotional advertising/marketing other

9760 Contributions and Donations
"CMS Publication 15-1," section 608

9765 Bad Debt
9770 Parenteral Nutrition Therapy

9776 Franchise Permit Fee
Franchise permit fee incurred by the provider. This is the franchise permit fee assessed by the Ohio department of job and family services (ODJFS) to nursing facilities. The provider shall report one hundred per cent of the franchise permit fee in account 9776. Franchise taxes are to be reported in account 6080, Franchise Tax.

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CAPITAL COSTS

Capital costs means the actual expense incurred for all of the following:

(A) Depreciation and interest on any capital asset with a cost of five hundred dollars or more per item and a useful life of at least two (2) years. Provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the five hundred dollars criteria be exceeded.

(1) Buildings;
(2) Building improvements
(3) Equipment;
(4) Extensive renovations;
(5) Transportation equipment;

(B) Amortization and interest on land improvements and leasehold improvements;
(C) Amortization of financing costs;
(D) Lease and rent of land, building, and equipment that does not qualify for account 7740 leased equipment.

Nursing facilities that did not change operator on or after 7/1/93 need only use group (A).

Nursing facilities that did change operator on or after 7/1/93 use groups (A) and (B).

GROUP (A) ASSETS ACQUIRED

8010 Depreciation - Building and Building Improvements
Depreciation of building and building improvements.

8020 Amortization - Land Improvements
Amortization expense for land improvements.

8030 Amortization - Leasehold Improvements
Leasehold improvements are amortized over the remaining life of the lease or the useful life of the improvement, but no less than five years. However, if the useful life of the improvement is less than five years, it may be amortized over its useful life. Options on leases will not be considered in the computation for amortization of leasehold improvements.

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8040 Depreciation - Equipment
Depreciation expense for equipment.

8050 Depreciation - Transportation equipment
Depreciation expense for transportation equipment.

8060 Lease and Rent - Building
Expense incurred for lease and rental expenses relating to buildings. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation accounts.

8065 Lease and Rent - Equipment
Expense incurred for lease and rental expenses relating to equipment. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation account. This account includes all leases effective after 12/01/92 for assets acquired prior to 7/01/93. (Cost of equipment, including vehicles, acquired by operating lease executed before 12/01/92, and the costs are reported as administrative and general on the facility's cost report for period ending 12/31/92, are to be reported in account 7740.)

8070 Interest Expense - Property, Plant and Equipment
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for the acquisition of land, buildings and equipment.

8080 Amortization of Financing Cost
Amortization expense of long term financing cost such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

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NONEXTENSIVE RENOVATIONS

Expenses for nonextensive renovations including depreciation, interest and amortization of financing cost completed prior to July 1, 2005.

8085 Depreciation/Amortization
Depreciation and amortization expenses for nonextensive renovations.

8086 Interest - Renovations
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for nonextensive renovation purposes.

8087 Amortization of Financing Cost - Renovations
Amortization expense for cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc. incurred for nonextensive renovations.
Amortization expense of long term financing costs such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc., acquired through a change of operator on or after 7/1/93.

8090 Home Office Costs/Capital Cost
Capital expenses of a separate division or entity which owns, leases or manages more that one facility (home office). These costs must be related to capital cost as specified in the capital cost center, and are allocated to the facility in accordance with "CMS Publication 15-1," sections 2150 through 2150.3, "Home Office Costs". (All home office costs for group (A) are to be entered in this account. They are not to be distributed to any other account in this group.)

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GROUP (B) ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR

Nursing facilities, other than leased facilities, that changed operator on or after 7/1/93 use this group to report expenses incurred through a change of operator on or after 7/1/93. Leased nursing facilities that changed operator on or after 5/27/92 use this group to report expenses incurred through a change of operator on or after 5/27/92.

8110 Depreciation - Building and Building Improvements
Depreciation of building and building improvements acquired through a change of operator on or after 7/1/93.

8140 Depreciation - Equipment
Depreciation expense for equipment acquired through a change of operator on or after 7/1/93.

8170 Interest Expense - Property, Plant and Equipment
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for the acquisition of land, buildings and equipment acquired through a change of operator on or after 7/1/93.

8180 Amortization of Financing Cost
Amortization expense of long term financing costs such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc., acquired through a change of operator on or after 7/1/93.

8195 Lease Expense
Lease expenses incurred through a change of operator on or after 5/27/92.

5101:3-3-42.1 **Nursing Facility (NF): medicaid cost report.**

(A) The NF medicaid cost report must be filed in accordance with the requirements set forth in rules 5101:3-3-20 and 5101:3-3-42 of the Ohio Administrative Code (OAC). Appendix A of this rule is the cost report which shall be issued to NF providers at least sixty days before the due date of the cost report for each cost reporting period.

Instructions for completing the Ohio department of job and family services (ODJFS) calendar year medicaid cost report for nursing facilities (NFs)

GENERAL INSTRUCTIONS

OVERVIEW

As a condition of participation in the Title XIX medicaid program, each NF shall file a cost report with ODJFS. The cost report, including its supplements and attachments, must be filed within ninety days after the end of the reporting period. The cost report shall cover a calendar year. However, if the provider participated in the medicaid program for less than twelve months during the calendar year, then the cost report shall cover the portion of a calendar year during which the NF participated in the medicaid program.

If a provider begins operations on or after October 2, the cost report shall be filed in accordance with rule 5101:3-3-20 of the Ohio Administrative Code (OAC).

For cost reporting purposes, NFs, other than state-operated facilities, shall use the Chart of Accounts as set forth in rule 5101:3-3-42 of the OAC, or relate its chart of accounts directly to the cost report.

ELECTRONIC SUBMISSION OF THE MEDICAID COST REPORT

In accordance with the OAC, all providers are required to use the electronic cost report submission process. Providers should use the ODJFS sponsored computer software for electronic submission of the cost report.

FILING REQUIREMENTS

A complete and adequate medicaid cost report must be filed with the department or postmarked on or before ninety days after the end of each facility's reporting period. Pursuant to Ohio Revised Code (ORC) section 5111.26, a provider whose cost report is filed or postmarked after this date, is subject to a reduction of their per diem rate in the amount of two dollars ($2.00) per resident day, adjusted for inflation. The late file period will begin at the start of the thirty day termination period and continue until the complete and adequate cost report is received by ODJFS or the facility is terminated from the medicaid program.

A provider may request a fourteen-day extension of the cost report filing deadline. Such requests must be made in writing, including an explanation of the reason the extension is being requested, and must demonstrate good cause in order to be granted. Requests should be made to the Rate Setting and Cost Settling Unit, DDO, OHP.

In the absence of a timely filed complete and adequate cost report, or request for filing extension, a provider will be notified by ODJFS of its failure to file a complete and adequate cost report and will be given thirty days to file the appropriate cost report and attachments. During this thirty day period, the late filing rate reduction described previously will be assessed. If a provider fails to submit a complete and adequate cost report within this time period, its medicaid provider agreement will be terminated according to section 5111.26 (A)(2) of the ORC.

REASONABLE COST

Please read all instructions carefully before completing the cost report.

Reasonable cost takes into account direct, ancillary/support, capital and tax costs of providers of services, including normal standby costs. Departmental regulations regarding the reasonable and allowable costs are contained in Chapter 5101:3-3 of the OAC. In addition, the following additional provisions establish guidelines and procedures to be used in determining reasonable costs for services rendered by NFs:

- Ohio Revised Code and uncodified state law,
- ODJFS-promulgated regulations (OAC) codified in accordance with state law,
- Principles of reimbursement for provider costs with related policies described in the Centers for Medicare and Medicaid Services (CMS) Publication 15-1,
- Principles of reimbursement for provider costs with related policies described in the Code of Federal Regulations (CFR), Title 42, Part 413.

ROUTINE SERVICES

The OAC lists covered services for all providers who serve NF residents. The OAC delineates services reimbursed through the cost reporting mechanism of NFs, and the costs directly billed to medicaid by service providers other than NFs.

ACCOUNTING BASIS

Except for county-operated facilities which operate on a cash method of accounting, all providers are required to submit cost data on an accrual basis of accounting. County-operated facilities which utilize the cash method of accounting may submit cost data on a cash basis.

OHIO MEDICAID COST REPORT FORMS

The Ohio medicaid nursing facility cost report (JFS 02524N Rev. 09/2011) is designed to provide statistical data, financial data, and disclosure statements as required by federal and state rules. Exhibits to the cost report are part of the documents that may be required to file a complete cost report. Each exhibit to the cost report must be identified and cross-referenced to the appropriate schedule(s). Please refer to Attachment 3 for instruction on the use of exhibits.

COST REPORT SCHEDULES

The provider must complete the information requested on each cost report schedule. Except for the cost report schedules and attachments listed below, responses such as "Not Applicable," "N/A," "Same as Above," "Available upon request," or "Available at the time of Audit," will result in the cost report being deemed incomplete or inadequate. Pursuant to section 5111.26(A)(2) of the ORC, an incomplete or an inadequate cost report is subject to a rate reduction of $2.00 per resident per day, adjusted for inflation as well as proposed termination of the provider agreement.

TABLE OF COST REPORT SCHEDULES

Cost Report Schedules	Title	Page Number
Schedule A, Page 1	Identification and Statistical Data	Page 1
Schedule A, Page 2	Chain Home Office/Certification by Officer of Provider	Page 2
Schedule A-1	Summary of Inpatient Days	Page 3
Schedule A-2	Determination of Medicare Part B Costs to Offset	Page 4
Schedule A-3	Summary of Costs	Page 5
Schedule B-1	Tax Costs	Page 6
Schedule B-2	Direct Care Costs	Pages 7 - 8
Schedule C	Ancillary/Support Costs	Pages 9 - 11
Schedule C-1	Administrators' Compensation	Page 12
Schedule C-2	Owners'/Relatives' Compensation	Pages 13 - 14
Schedule C-3	Cost of Services From Related Parties	Pages 15 - 17
Schedule D	Capital Costs	Page 18
Schedule D-1	Analysis of Property, Plant and Equipment	Page 19
Schedule D-2	Capital Additions and/or Deletions	Page 20
Schedule E	Balance Sheet	Page 21
Schedule E-1	Equity Capital of Proprietary Providers	Page 22
Attachment 1	Revenue Trial Balance	Pages 23 - 25
Attachment 2	Adjustment to Trial Balance	Page 26
Attachment 3	Medicaid Cost Report Supplemental Information	Page 27
Attachment 6	Wage and Hours Survey	Pages 28 - 29
Attachment 7	Addendum for Disputed Costs	Page 30
Attachment 8	Employee Retention Rate	Page 31

COST REPORT INSTRUCTIONS

The following cost report instructions are in the order of schedule completion sequence.

- All expenses are to be rounded to the nearest dollar.
- All dates should contain eight digits and be formatted as follows: Month-Day-Year (MM-DD-YYYY).
- All date fields are denoted as From/Through or Beginning/Ending.

Example: January 1, (20CY) should be recorded as 010120CY (zero, one, zero, one, 20CY).

Sequence and Procedures for Completing Cost Report (JFS 02524N REV. 09/2011)	Cost Report Page Number
1. Schedule A, Page 1 of 2, Identification	1
2. Schedule A-1	3
3. Schedule A, Page 1 of 2, statistical data line 1 through line 8	1
4. Attachment 1	23 - 25
5. Schedule A-2	4
6. Schedule B-1 (columns 1 through 3)	6
7. Schedule B-2 (columns 1 through 3)	7 - 8
8. Schedule C (columns 1 through 3)	9 - 11
9. Schedule D-1	19
10. Schedule D-2	20
11. Schedule D (column 3)	18
12. Attachment 2	26
13. Schedules B-1, B-2, C and D (columns 4 - 7)	6 - 11, 18
14. Schedule C-1	12
15. Schedule C-2	13 - 14
16. Schedule C-3	15 - 17
17. Schedule E	21
18. Schedule E-1	22
19. Schedule A-3	5
20. Attachment 6	28 – 29
21. Attachment 7	30
22. Attachment 8	31
23. Attachment 3	27
24. Schedule A, Page 2 of 2	2

1. **Schedule A, Page 1 of 2 - Identification and Statistical Data**

INTRODUCTION:

The various cost report types are explained below. Except for 4.1, year end cost report, all other cost report types must be accompanied with a cover letter explaining the reason for filing the cost report information. An explanation of the cost report types is as follows:

4.1 - Year End	Cost reports by providers with continued medicaid participation having ending dates of December 31, pursuant to Ohio Administrative Code.
4.2 - New Facility	For facilities new to the medicaid program, where the actual cost of operations are reported for the first three (3) full calendar months, which includes the date of certification, pursuant to OAC.
4.3 - Change of Operator	For the new operators' three (3) month cost report resulting from a change of operator pursuant to OAC, which reports the actual cost of operations for the first three full calendar months of medicaid participation including the date of certification for the new operator, pursuant to OAC.
4.5 - Final	For the final cost report of a provider who has experienced a change of operator pursuant to OAC.
4.6 - Amended	For cost reports filed after the fiscal year rate setting, which corrects errors of the cost report used to establish the fiscal year rate, pursuant to OAC.

Facility Identification

Provider Name (DBA) – Enter the "doing business as" (DBA) name of the facility as it appears on the medicaid provider agreement.

National Provider Identifier (NPI) – Enter the NPI.

Medicaid Provider Number – Enter the seven digit medicaid provider number as it appears on the medicaid provider agreement.

Medicare Provider Number – Enter the six digit medicare provider number furnished by the Ohio Department of Health (ODH) or the CMS. Medicare numbers are assigned to each facility regardless of the facility's medicare certification status. The medicare number also appears on the medicaid provider agreement.

Complete Facility Address – Enter the address of the facility. Include city and ZIP code where the facility is physically located.

Federal ID Number – Enter the Federal Tax Identification Number as it is reported to the United States Internal Revenue Service.

ODH ID Number – Enter the Ohio Department of Health (ODH) 4-digit home number, also referred to by ODH as the "Fac ID" Number.

County – Enter the Ohio county in which the facility is physically located.

Period Covered by the Cost Report

This is a twelve-month period ending December thirty-first unless another period has been designated by the Department. New facilities, closed facilities, or exiting or entering operators as a result of a change of provider must indicate the time period of medicaid participation.

Provider Legal Entity Identification

Name and address of Provider of NF Services Enter the legal business name for the provider of this facility as reported to the IRS for tax purposes and as it appears on the medicaid provider agreement, Furnish the address of this legal entity.

Type of Control of Provider

Check the category that describes the form of business, nonprofit entity or government organization under which the facility is operated, which corresponds for non-government organizations with the way the operator legal entity is registered with the Ohio Secretary of State's office. If item 1.4, 2.6 or 3.6 Other [specify] is checked, the provider must identify that specific type of control. Descriptions for the "For Profit" control types are furnished below.

For Profit

Sole Proprietor – Exclusively owned; Private; Owned by a private individual or corporation under a trademark or patent; Ownership – for profit. In a sole proprietorship the individual proprietor is subject to full liability (personal assets and business assets) resulting from business acts.

Partnerships – An association of two or more persons or entities that conducts a business for profit as co-owners. A partnership cannot exist beyond the lives of the partners. The partners are taxed as individuals and are personally liable for torts and contractual obligations. Active partners are subject to self-employment tax. Each partner is viewed as the other's agent and traditionally is jointly and severally liable for the tortuous acts of any one of the partners. A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in some fixed proportion in profits and losses.

General Partnership – A partnership in which each partner is liable for all partnership debts and obligations in full, regardless of the amount of the individual partner's capital contribution.

Limited Partnership – A partnership in which the business is managed by one or more general partners and is provided with capital by limited partners who do not participate in management but who share in profits and whose individual liability is limited to the amount of their respective capital contributions. A limited partnership is taxed like a partnership but has many of the liability protection aspects of a corporation. To form a limited partnership, a certificate of limited partnership must be executed and filed with the Secretary of State (Secretary of State prescribes the form required). The name of a limited partnership must include the words "Limited Partnership," "L.P.," "Limited," or "Ltd."

Limited Liability Partnership – a partnership formed under applicable state statute in which the partnership is liable as an entity for debts and obligations and the partners are not liable personally. This type of partnership must register with the Secretary of State as a limited liability partnership.

Corporation – An invisible, intangible, artificial creation of the law existing as a voluntary chartered association of individuals that has most of the rights and duties of natural persons but with perpetual existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest.

Limited Liability Companies – An unincorporated company formed under applicable state statute whose members cannot be held liable for the acts, debts, or obligations of the company and that may elect to be taxed as a partnership. A limited liability company may be formed in Ohio by any person without regard to residence, domicile or state or organization. The entity is formed when one or more persons of their authorized representatives signs and files articles of organization with the Secretary of State. The name of the limited liability company must include the words "limited liability company," "LLC," "L.L.C.," "Ltd.," "Ltd," or "Limited." A "person" includes any natural person, corporation, partnership, limited partnership, trust, estate, association, limited liability company, any custodian, nominee, trustee, executor, administrator, or other fiduciary.

Business Trust – A business trust is created by a trust agreement and can only be created for specific purposes: To hold, manage, administer, control, invest, reinvest, and operate property; to operate business activities; to operate professional activities; to engage in any lawful act or activity for which business trusts may be formed under Chapter 1746. of the ORC.

Real Estate Investment Trust (REIT) – means a trust created by an instrument, pursuant to common law or enabling legislation, under which any estate or interest in real property is held, managed, administered, controlled, invested, reinvested, or operated by a trustee or trustees for the benefit and profit of persons who are or may become the holders of transferable certificates of beneficial interest, issued pursuant to the provisions of the trust instrument, such transferability being either restricted or unrestricted, which trust intends to comply or has at any time complied or intended to comply with 26 U.S.C. 1, Sec. 856-859.

Location of Entity, Organization or Incorporation

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

Domestic refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

Foreign refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio.

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

Nonprofit

Nonprofit Corporation – A "nonprofit corporation" is a domestic or foreign corporation organized otherwise than for pecuniary gain or profit. A nonprofit corporation can be either a "mutual benefit corporation" or a "public benefit corporation." A "public benefit corporation" is a corporation that is recognized as exempt from federal income taxation under 26 U.S.C. 1, Sec. 501(c)(3), or is organized for a public or charitable purpose and, that upon dissolution, must distribute its assets to a public benefit corporation, the United States, a state or any political subdivision of a state, or a person that is recognized as exempt from federal income taxation under 26 U.S.C. 1, Sec. 501(c)(3).

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

Domestic refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

Foreign refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio.

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

Nonfederal Government

State – entity operated under the authority of the state.

County – entity operated under the authority of the county as a County Home, County Nursing Home, or District Home in accordance with the ORC.

City – entity operated under the authority of the city.

City/County – entity operated under the authority of the city & county.

Care Setting

Indicate the care setting of the facility, in accordance with licensure standards filed with ODH when applicable. Please check all that apply.

Definitions

Rehab Hospital Based – serves an inpatient population of whom at least 75% require intensive rehabilitative services; has a preadmission screening procedure which determines whether the patient will benefit significantly from an intensive inpatient hospital program or assessment; and uses a coordinated multidisciplinary team approach in the rehabilitation of each inpatient. Inpatients using rehabilitative services usually have one or more of the following diagnoses: stroke, spinal cord injury, congenital deformity, major multiple trauma, femur fracture, brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders and burns.

General/Acute Hospital Based – means a hospital which primarily functions to furnish the array of diagnostic and therapeutic services needed to provide care for a variety of medical conditions, including diagnostic x-ray, clinical laboratory, and operating room services.

Continuing Care Retirement Center (CCRC) – means a living setting which encompasses a continuum of care ranging from an apartment or lodging, meals, and maintenance services to total nursing home care. All services are provided on the premises of the continuing care retirement community and are provided based on the contract signed by the individual resident. The residents may or may not qualify for medicaid for nursing home care, based on the services covered by each resident's individually signed contract.

Other Assisted Living/Nursing Home combination – A facility that does not fit the description of a CCRC but has a nursing home as well as some other combination of assisted living or residential care facility services on the same campus.

Religious Nonmedical Health Care Institution (RNHCI) – An institution in which health care is furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets for care and healing, as set forth in Code of Federal Regulations (CFR), Title 42, Part 403.

Free Standing – A facility that stands independent of attachment or support.

Combined with ICF-MR, other recognized Medicaid NF and/or Medicaid Outlier Unit – A distinct part of a facility that is in the same building and/or shares the same license with a certified ICF-MR, or is in same building as a recognized separate provider of medicaid, such as a provider of outlier services (e.g., for pediatric residents or residents with traumatic brain injury), or for the outlier unit, is housed with a NF providing non-outlier services. [Note: A provider of NF Outlier Services holds an Ohio medicaid provider agreement addendum authorizing the provision of outlier services to a special population (e.g., pediatric subacute).]

Name and Address of Owner of Real Estate – Enter the name and address of the owner of the real estate where the facility is located. If the provider of NF services is the identical legal entity that owns the real estate, re-enter the provider's legal entity identification here.

2. Schedule A-1, Summary of Inpatient Days

Column 1: Record the number of ODH-certified beds, by month. If the number of beds certified as nursing facility beds by ODH changed during the middle of any given month, then calculate a weighted average for that particular month rounded to the nearest whole number.

For example:

March 1, 20CY 100 certified beds

March 16, 20CY 120 certified beds

Calculation : (15 days x 100 beds) + (16 days x 120 beds)
divided by 31 days in month of March = 110.3226

Average medicaid certified beds for March 20CY = 110

Column 2: Record the number of authorized skilled, intermediate, and pending medicaid patient days, by month.

The day of admission, but not the day of discharge, is an inpatient day. When a resident is admitted and discharged on the same day, this is counted as one inpatient day. Inpatient days include those leave days that are reimbursable under the Ohio medicaid program. Private leave days are not included as inpatient days. Carry the total on line 13, column 9 forward to Schedule A, line 4, column 1.

Column 3 and 4: Record the total monthly reimbursable leave days for medicaid residents [see the OAC - coverage of medically necessary days and limited absences].

NFs report each medically necessary day and limited absence as 50% of an inpatient day through December 31, 2011. Beginning January 1, 2012, report each medically necessary day and limited absence as either 50% or 18% of an inpatient day depending on the provider's occupancy rate for the preceding calendar year. Pursuant to Section 5111.331 of the Ohio Revised Code, NFs with occupancy rates over 95% for the preceding calendar year are reimbursed for leave days at 50% of an inpatient day; NFs with occupancy rates of 95% or less for the preceding calendar year are reimbursed for leave days at 18% of an inpatient day. Report days at 50% of inpatient days in columns 3a and 4b and days at 18% of inpatient days in columns 3b and 4b.

For Example:

January 20CY 100 certified beds

January 20CY 3100 bed days available
(100 certified beds x 31 days in January)

Actual number of days residents are in facility = 3000
Actual number of days residents out of facility on medical leave = 60
Actual number of days residents are out of facility on therapeutic leave = 40

Report as follows if paid at 50% of an inpatient day:

Column 3a	Hospital Leave Days	30	(60 days x 50%)
Column 4a	Therapeutic Leave Days	20	(40 days x 50%)

Report as follows if paid at 18% of an inpatient day:

Column 3a	Hospital Leave Days	11	(60 days x 18%)
Column 4a	Therapeutic Leave Days	7	(40 days x 18%)

Note that the calculation of inpatient days should round to two decimal places.

Column 5: Total of columns 2, 3a, 3b, 4a and 4b. Carry the total on line 13, column 5 forward to Schedule A, line 7.

Column 6 Record the number of Medicaid managed care days.

Column 7, 8 and 9: Record the number of inpatient days for non-medicaid eligible residents, by month. Leave days should not be included in these columns.

Column 10: Record the number of inpatient days for all residents, by month. This column is the sum of columns 5 through 9.

3. Schedule A, Page 1 of 2, Statistical Data

Lines 1 and 2: Licensed Beds:

Enter the total number of beds licensed by ODH in column 2. Enter the total number of beds licensed by ODH and certified by medicaid in column 1. Temporary changes because of alterations, painting, etc. do not affect bed capacity.

Line 3: Total Bed Days:

For column 1, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH and certified by medicaid during the reporting period. Take into account increases or decreases in the number of beds licensed and certified and the number of days elapsed since the increase or decrease in licensed and certified beds.

For column 2, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH during the reporting period. Take into account increases or decreases in the number of beds licensed and the number of days elapsed since the increases or decreases.

Line 4: Total Inpatient Days:

For column 1, obtain the answer from Schedule A-1, column 10, line 13. For column 2, enter the total number of inpatient days for the facility for all ODH licensed beds.

Line 5: Percentage of Occupancy:

This amount is the proportion of total inpatient/resident days to total bed days during the reporting period. Obtain the answer by dividing line 4 by line 3.

Line 6: Ancillary/Support Allowable Days:

For computing Ancillary/Support costs, ODJFS will not recognize an occupancy rate of less than 90%. If percentage of occupancy is 90% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 90%, enter 90% of the number of bed days stated on line 3 (See the OAC). For providers on the medicaid program less than 12 months, also consult the OAC.

"** Number of beds involved in the change" refers only to those beds which were added, replaced, or removed.

4. Attachment 1 – Revenue Trial Balance

Column 2: Enter total revenue for each line item.

Column 3: Enter any adjustments. Detail the adjustment(s) on your exhibit and submit with the cost report.

5. **Schedule A-2, Determination of Medicare Part B Costs to Offset:**

This schedule is designed to determine the amount of Medicare Part B revenue to offset on the cost report by cost center to comply with the OAC.

Section A: Revenues

Lines 1a, 2a, and 3a: List gross charges for all residents by payer type. Gross charges must be reported from a uniform charge structure that is applicable to all residents. Revenue reported under chart of account numbers 5080 (medical supplies-routine), 5100 (medical minor equipment-routine), and 5110 (enteral nutritional therapy) must be distributed among all non-medicare categories.

Lines 1b, 2b, and 3b: For columns 2 through 7, these lines represent the percentages of the individual revenue reported by payer type divided by the total revenue reported in column 8. Report the percentages by payer type and limit the precision to four places to the right of the decimal. The total of all percentages must equal 100%.

Line 4: Total all revenue reported on lines 1a, 2a, and 3a.

Section B: Costs

Line 5: Enter the ratio of Medicare Part B charges where the primary payer is medicaid from column 2 line 1b, 2b, and 3b. These ratios must be entered in the corresponding column, e.g., medical supplies percentage from column 2 line 1b must be entered on line 5, column 2 medical supplies.

Line 6: Enter the corresponding costs from Schedules B-2 and C, column 3 in the appropriate column.

Line 7: Multiply line 5 times line 6. The result is the costs to offset on the appropriate line on Schedule B-2 and C, column 4.

Section C: Ancillary/Support Cost-Offset

NOTE: Failure to complete Schedule A-2 will result in all Medicare Part B revenue being offset against direct care expenses on Schedule B-2, line 15.

6. **Schedule B-1, Tax Costs (Columns 1-4)**

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s).

Column 1: This column does not pertain to any account in this schedule.

Column 2: Report any appropriate non-wage expenses.

Column 4: Report any increases or decreases of each line item. Any entries in this column which are not from Attachment 2, should be fully explained in accordance with the instructions on Attachment 3.

7. **Schedule B-2, Direct Care Costs (Columns 1-3)**

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to "Other Direct Care" line 12 and specify the detail in the spaces provided at the bottom of Schedule B-2, page 1 of 2. Provide supporting documentation as exhibits with cross references to applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll. Also, report any appropriate non-wage expenses, including contract services and supplies.

Column 3: Total of columns 1 and 2.

8. Schedule C, Ancillary/Support Costs (Columns 1-3)

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "Other Ancillary/Support" line 64 and specify the detail in the spaces provided at the bottom of Schedule C, page 2 of 3. Provide supporting documentation as exhibits with cross references to applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll. Also, report any appropriate non-wage expenses, including contract services and supplies.

Column 3: Total of columns 1 and 2.

9. Schedule D-1, Analysis of Property, Plant and Equipment

Complete per instructions on the form. This schedule should tie to Schedule E, (balance sheet) property, plant, and equipment section.

10. Schedule D-2, Capital Additions and/or Deletions

Complete per instructions on the form. Completion of this schedule is optional if the detailed depreciation schedule is submitted which includes all criteria noted on Schedule D-2 except for columns 8 and 11. Columns 12 and 13 are mandatory only in the event of an asset deletion.

11. Schedule D (Column 3), Capital Cost Center

Complete per instructions on the form. NFs that did not change operator on or after July 1, 1993, should use group (A). NFs that did change operator on or after July 1, 1993, should use groups (A) and (B).

12. Attachment 2, Adjustment to Trial Balance

Columns 2 and 3, lines 1 through 20:

Enter the appropriate adjustments as necessary to comply with CMS 15-1, federal regulations, state laws, and Ohio medicaid program regulations. Items included on Attachment 2 must have attached supportive detail. Cost adjustments for related party transactions must offset the appropriate expense account in column 4 of Schedules B-1, B-2, C and D.

Column 5, lines 1 through 20:

In column 5, cross-reference adjustments to the appropriate expense account number. Carry the adjustment in column 4 to the appropriate expense account on Schedules B-1, B-2, C and D, column 4.

Note: All adjustments to expense accounts should be made to the appropriate line of Schedules B-1, B-2, C and D and the appropriate expense account number entered on Attachment 2, column 5.

Column 6, lines 1-20, line reference from Attachment 1 (if applicable).

After completing Attachment 2 and entering adjustments to expense Schedules B-1, B-2, C and D, column 4, the adjusted total expenses (Schedules B-1, B-2, C and D, column 5) can be computed.

13. Schedules B-1, B-2, C and D (Columns 4-7)

Column 4: Report any increases or decreases in each line item. Any entries in this column which are not from Attachment 2 should be fully explained in accordance with the instructions on Attachment 3.

If no allocations are used, columns 6 and 7 need not be completed. If allocations are used, the allocation ratio should be calculated to four places to the right of the decimal.

14. Schedule C-1, Administrators Compensation

A separate schedule must be completed for each person claiming reimbursement as an administrator in this facility.

Section A:

Line 2: Work Experience

For this administrator, report the number of years of work experience in the health care field. Ten years experience is the maximum allowance. Thus, for this category, if the administrator has ten or more years experience in the health care field, then record ten years in this box.

Line 3: Formal Education

For this administrator, report the number of years of formal education beyond high school. Six years formal education is the maximum allowance for this category. Thus, if the administrator has six or more years formal education, then record six years in this box.

Line 3.1: Baccalaureate Degree

For this administrator, record yes if the administrator has obtained a baccalaureate degree. If the administrator has not obtained a baccalaureate degree, then record no.

Line 4: Other Duties:

Record the total number of other duties not normally performed by an administrator. This administrator may claim up to four additional duties. If this administrator performed four or more extra duties, then report the maximum of four.

Include the following *other duties* in your count: accounting, maintenance, and housekeeping. If the administrator performed any other duties, please complete the "Other, specify" lines.

For example, if the administrator performed laundry duties, then record as follows: Other, specify laundry.

Do not include any of the direct care duties listed below. If the administrator performed any of the eight duties listed below, complete page 1 of Schedule C-2. If the administrator is an owner or relative of the owner, complete Page 2 also.

(a) Medical director
(b) Director of nursing
(c) Registered nurse (RN)
(d) Licensed practical nurse (LPN)
(e) Respiratory therapist
(f) Charge nurse; registered
(g) Charge nurse; licensed practical

Section B:

For each administrator complete the following:

Beginning and ending dates of employment during the reporting period should be confined to periods of employment in 20CY only. For example, if the administrator was employed by the provider from March 1, 20CY through March 31, 20CY, then for the 20CY reporting period the record of employment dates is as follows: 03/01/20CY - 03/31/20CY.

Hours and percentage of time worked weekly on site at the facility.

Use account number 7600 or account number 7695, as appropriate. All administrators compensated through the home office use account 7695. All other administrators use account 7600.

Amount of compensation: Except for county facilities which operate on a cash basis, list all compensation actually accrued to employees who perform duties as the administrator. County facilities which operate on a cash basis should list all compensation actually paid to employees who perform duties as the administrator.

If the administrator is an owner or relative of an owner, then complete Schedule C-2, Page 2 of 2. Do not complete Schedule C-2, Page 2 of 2 for a nonowner/administrator. Report the cost of all ancillary/support-related duties performed by administrator on Schedule C, line 44, account number 7600 or Schedule C, line 65, account number 7695, whichever is applicable.

The applicable Direct Care duties are:

(a) Medical Director;
(b) Director of Nursing;
(c) Registered Nurse (RN);
(d) Licensed Practical Nurse (LPN);
(e) Respiratory Therapist;
(f) Charge Nurse; Registered; and,
(g) Charge Nurse; Licensed Practical

Example: An owner/administrator (or relative of owner) earned $65,000 compensation performing duties as follows:

RN $15,000; Administrator $45,000; Laundry $5,000; Total = $65,000

Compensation may be reported as follows:

Schedule C-1 = $50,000 – Administrator plus laundry compensation

Schedule B-2 = $15,000 – RN compensation

Please note the reporting procedures are the same regardless of whether the administrator is an owner/administrator, or a relative of the owner.

Nonowner administrators will report their wages on Schedule C-1 (administrative and general wages) and, if it applies, Schedule B-2 (direct care wages, as stipulated in the direct care duties list above). Wages for nonowner/administrators are never reported on Schedule C-2.

15. Schedule C-2

Page 1 of 2:

List all owners and/or relatives who received compensation from this provider. Also, complete the schedule if any administrator wages are reported on Schedule B-2 for the direct care duties listed on page 21 of the instructions. This applies regardless of whether the administrator is a non-owner/administrator, an owner/administrator, or a relative of the owner.

Specify the name of person(s) claiming compensation, position number (see below), relationship to owner(s), years of experience in this field, dates of employment in this reporting period, number of hours worked in facility during the week, as well as the corresponding percentage of time worked at this facility, account number, and amount claimed for each person listed on the cost report. Social Security numbers are not required for non-profit or governmental facilities.

For purposes of completing Schedule C-2, the following relationships are considered related to the owner:

(1) Husband and wife;
(2) Natural parent, child, and sibling;
(3) Adopted child and adoptive parent;
(4) Stepparent, stepchild, stepbrother, stepsister;
(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, and brother-in-law;
(6) Grandparent and grandchild; and,
(7) Foster parent, foster child, foster brother, or foster sister.

Page 2 of 2:

Except for nonowner administrators, for each individual identified above, list all the compensation received from other facilities participating in the medicaid program (in Ohio and other states). Also, list any individual owning a 5% or more interest in this provider. Compensation claimed must be for necessary services and related to resident care. Services rendered and compensation claimed must be reasonable based upon the time spent in performing the duty, and reasonable for the duty being performed.

If Schedule C-2, Page 1 is completed for a nonowner administrator, then do not complete this page for the nonowner administrator. All other owners, relatives of owners, or owner/administrators identified on Page 1 must also be reported on Page 2 of Schedule C-2. Social Security numbers are not required for non-profit or governmental facilities.

Position Numbers for Corporate Officers

Select the four-digit position number that appropriately identifies the job duty of the corporate officer.

Example: Where there is a corporate president of a 50-bed facility, the four digit position number is: CP01 (C, P, zero, one).

1. **Corporate President Series (CP)**

CP01 - Corporate President 1 (1 - 99 beds)
CP02 - Corporate President 2 (100 - 199)
CP03 - Corporate President 3 (200 - 299)
CP04 - Corporate President 4 (300 - 599)
CP05 - Corporate President 5 (600 - 1199)
CP06 - Corporate President 6 (1200 +)

2. **Corporate Vice - President Series (CV)**

CV01 - Corporate Vice-President 1 (1 - 99 beds)
CV02 - Corporate Vice-President 2 (100 - 199)
CV03 - Corporate Vice-President 3 (200 - 299)
CV04 - Corporate Vice-President 4 (300 - 599)
CV05 - Corporate Vice-President 5 (600 - 1199)
CV06 - Corporate Vice-President 6 (1200 +)

3. **Corporate Treasurer Series (CT)**

CT01 - Corporate Treasurer 1 (1 - 99 beds)
CT02 - Corporate Treasurer 2 (100 - 199)
CT03 - Corporate Treasurer 3 (200 - 299)
CT04 - Corporate Treasurer 4 (300 - 599)
CT05 - Corporate Treasurer 5 (600 - 1199)
CT06 - Corporate Treasurer 6 (1200 +)

4. **Board Secretary Series (BS)**

BS01 - Corporate Board Secretary 1 (1 - 99 beds)
BS02 - Corporate Board Secretary 2 (100 - 199)
BS03 - Corporate Board Secretary 3 (200 - 299)
BS04 - Corporate Board Secretary 4 (300 - 599)
BS05 - Corporate Board Secretary 5 (600 - 1199)
BS06 - Corporate Board Secretary 6 (1200 +)

Position Number for Owners/Relatives of Owner

Select the five-digit position number, which appropriately identifies the job duty of the owner and/or relative of the owner. Please note that **WH** references the Wage and Hour Survey - Attachment 6 of the cost report.

Example: Where the owner served as medical director of the facility, the five-digit position number is: WH002 (W, H, zero, zero, two).

WH Code	Title	Account	Schedule / Line
WH002	Medical Director	6100	Schedule B-2, Line 1
WH003	Director of Nursing	6105	Schedule B-2, Line 2
WH004	RN Charge Nurse	6110	Schedule B-2, Line 3
WH005	LPN Charge Nurse	6115	Schedule B-2, Line 4
WH006	Registered Nurse	6120	Schedule B-2, Line 5
WH007	Licensed Practical Nurse	6125	Schedule B-2, Line 6
WH008	Nurse Aides	6130	Schedule B-2, Line 7
WH016	Habilitation Staff	6170	Schedule B-2, line 8
WH019	Respiratory Therapist	6185	Schedule B-2, line 9
WH023	Quality Assurance	6205	Schedule B-2, line 10
WH066	Behavioral and Mental Health Services	6207	Schedule B-2, line 11
WH024	Other Direct Care Salaries - Specify	6220	Schedule B-2, line 13
WH025	Home Office Costs/Direct Care - Salary	6230	Schedule B-2, line 14
WH026	DO NOT USE THIS POSITION CODE		
WH027	In-House Trainer Wages	6500	Schedule B-2, line 27
WH028	Classroom Wages: Nurse Aides	6511	Schedule B-2, line 28
WH029	Clinical Wages: Nurse Aides	6521	Schedule B-2, line 29
WH030	Physical Therapist	6600	Schedule B-2, line 38
WH031	Physical Therapy Assistant	6605	Schedule B-2, line 39
WH032	Occupational Therapist	6610	Schedule B-2, line 40
WH033	Occupational Therapy Assistant	6615	Schedule B-2, line 41
WH034	Speech Therapist	6620	Schedule B-2, line 42
WH035	Audiologist	6630	Schedule B-2, line 43
WH063	EAP Administrator - Therapy	6643	Schedule B-2, line 47
WH064	Self Funded Program Admin.-Therapy	6644	Schedule B-2, line 48
WH065	Staff Development - Therapy	6645	Schedule B-2, line 49
WH036	EAP Administrator - Direct Care	6730	Schedule B-2, line 54
WH037	Self Funded Programs Admin. - Direct Care	6740	Schedule B-2, line 55
WH038	Staff Development - Direct Care	6750	Schedule B-2, line 56
WH039	Dietitian	7000	Schedule C, line 1
WH040	Food Service Supervisor	7005	Schedule C, line 2
WH041	Dietary Personnel	7015	Schedule C, line 3
WH042	EAP Administrator - Dietary	7075	Schedule C, line 15
WH043	Self-Funded Programs Administrator: Dietary	7080	Schedule C, line 16

WH Code	Title	Account	Schedule / Line
WH044	Staff Development - Dietary	7090	Schedule C, line 17
WH045	Medical/Habilitation Records	7105	Schedule C, line 19
WH046	Pharmaceutical Consultant	7110	Schedule C, line 20
WH009	Activity Director	7201	Schedule C, line 25
WH010	Activity Staff	7211	Schedule C, line 26
WH011	Recreational Therapist	7221	Schedule C, line 27
WH017	Psychologist	7231	Schedule C, line 28
WH018	Psychology Assistant	7241	Schedule C, line 29
WH020	Social Work/Counseling	7251	Schedule C, line 30
WH021	Social Services/Pastoral Care	7261	Schedule C, line 31
WH014	Habilitation Supervisor	7271	Schedule C, line 32
WH013	Program Director	7281	Schedule C, line 33
WH022	Qualified Mental Retardation Professional	7291	Schedule C, line 34
WH001	Water and Sewage	7511	Schedule C, line 40
WH047	DO NOT USE THIS POSITION CODE		
WH048	Other Administrative Personnel	7605	Schedule C, line 45
WH049	Security Services (Salary Only)	7625	Schedule C, line 49
WH050	Laundry/Housekeeping Supervisor	7635	Schedule C, line 51
WH051	Housekeeping	7640	Schedule C, line 52
WH052	Laundry and Linen	7645	Schedule C, line 53
WH053	Accounting	7655	Schedule C, line 55
WH054	Data Services (Salary Only)	7675	Schedule C, line 59
WH055	Other Ancillary/Support - Specify: (Salary)	7690	Schedule C, line 63
WH056	Home Office Costs/Ancillary/Support (Salary)	7695	Schedule C, line 64
WH057	DO NOT USE THIS POSITION CODE		
WH058	Plant Operations/Maintenance Supervisor	7700	Schedule C, line 66
WH059	Plant Operations and Maintenance	7710	Schedule C, line 67
WH060	EAP Administrator - Ancillary/Support	7830	Schedule C, line 75
WH061	Self-Funded Programs Admin. - Ancillary/Support	7840	Schedule C, line 76
WH062	Staff Development - Ancillary/Support	7850	Schedule C, line 77

16. Schedule C-3, Cost of Services from Related Organizations

Complete per instructions on the form. Social Security numbers are not required for non-profit or governmental facilities.

Related Party – means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

(1) An individual who is a relative of an owner is a related party.

(a) "Relative of owner" means an individual who is related to an owner of a facility by one of the following relationships:

(1) Spouse;
(2) Natural parent, child, or sibling;
(3) Adopted parent, child, or sibling;
(4) Stepparent, stepchild, stepbrother, or stepsister;
(5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
(6) Grandparent or grandchild;
(7) Foster caregiver, foster child, foster brother, or foster sister.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

Partnerships – An association of two or more persons or entities that conduct a business for profit as co-owners, a partnership cannot exist beyond the lives of the partners. The partners are taxed as individuals and are personally liable for torts and contractual obligations. Active partners are subject to self-employment tax. Each partner is viewed as the other's agent and traditionally is jointly and severally liable for the tortuous acts of any one of the partners. A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in some fixed proportion in profits and losses.

Corporations – An invisible, intangible, artificial creation of the law existing as a voluntary chartered association of individuals that has most of the rights and duties of natural persons but with perpetual existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest. In the ORC, unless a corporation is specified as nonprofit, it is assumed to be for-profit.

Limited Liability Companies – An unincorporated company formed under applicable state statute whose members cannot be held liable for the acts, debts, or obligations of the company and that may elect to be taxed as a partnership. A limited liability company may be formed in Ohio by any person without regard to residence, domicile or state or organization. The entity is formed when one or more persons of their authorized representatives signs and files articles of organization with the Secretary of State. The name of the limited liability company must include the words "limited liability company," "LLC," "L.L.C.," "Ltd.," "Ltd," or "Limited." A "person" includes any natural person, corporation, partnership, limited partnership, trust, estate, association, limited liability company, any custodian, nominee, trustee, executor, administrator, or other fiduciary.

17. Schedule E, Balance Sheet

Enter balances recorded in the facility's books at the beginning and at the end of the reporting period in the appropriate columns. Where the facility is a distinct part of a NF, enter total amounts applicable only to the distinct part.

18. Schedule E-1, (Optional) Equity Capital of Proprietary Providers

Schedule E-1 (Optional) is provided for computing equity.

Lines 1 through 21 - calculate equity.

Note: Lines 8 through 21 - Must specifically identify any amounts entered. An example of amounts that may be included on these lines is inter-company accounts.

19. Attachment 6, Wage and Hour Survey

Complete Attachment 6 per instructions to provide necessary information on the wage and hour supplement. There must be corresponding hours listed if wages are indicated.

NOTE: Wages are to include wages for sick pay, vacation pay, and other paid time off as well as any other compensation paid to the employee. Please do not include contract wages or negative wages on this form. Except as noted below, the amounts reported in column (C) must agree to the corresponding account numbers on Schedules B-2 and C, column 1.

In circumstances involving related party transactions or adjustments due to home office wages, the amounts reported in column (C) may not agree to the corresponding account numbers on Schedules B-2 and C, column 1. If the amounts reported do not agree, please explain the reason for the difference on Attachment 3, Exhibit 5 [or greater (i.e. Exhibit 6, Exhibit 7, etc.)

20. Attachment 7, Addendum for Disputed Cost

This Attachment is for the reporting of costs as specified in the ORC, that the provider believes should be classified differently than as reported on the cost report. Enter in the "Reclassification From" column the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3. Enter in the "Reclassification To" column the schedule, line number and reason you believe these costs should be reclassified.

21. Attachment 8, Employee Retention Rate

- 1 FTE is equal to 80 hours worked per pay period and/or 2080 hours worked per year.
- Hours worked includes use of vacation, personal, sick, bereavement, disability, and FMLA leave time.
- Line 1 FTEs are calculated as hours worked on the payroll divided by 80.
- Line 2 FTEs are calculated as hours worked on the payroll divided by 80.
- Line 3 should be rounded to 4 decimal places.

Employees included in the calculation are all those employed by the facility as well as allocated home office staff, contracted staff other than purchased nursing, and leased staff.

22. Attachment 3, Supplemental Information

Attach requested documentation as instructed.

23. Schedule A, Page 2 of 2, Certification by Officer of Provider

Chain organizations are generally defined as multiple providers owned, leased, or through any other devise, controlled by a single organization. For medicare and/or medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by for profit /proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

The controlling organization is known as the chain "home office." Typically, the chain "home office:"

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills, and
- Maintains and centrally controls individual provider cost reports and fiscal records.
- In addition, a major portion of the medicare audit for each provider in the chain can be performed centrally at the chain "home office."

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office.

A. **Check Box** – If this section does not apply to this provider, check the box provided and skip to the certification section.

B. **Chain Home Office Information** – If there has been a change in the home office information since the previous cost reporting period, check "Change," and provide the effective date of the change.

Complete the appropriate fields in this section:

- Furnish the legal business name and tax identification number of the chain home office as reported to the IRS.
- Furnish the street address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.

C. **Provider's Affiliation to the Chain Home Office** – If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office since the last cost reporting period, check "Change," and provide the effective date of the change.

Check all that apply to indicate how this provider is affiliated with the home office.

All cost reports submitted by the provider must contain a completed certification signed by an administrator, owner, or responsible officer. The original signature must be notarized.

If the cost report preparer is a company, complete the "Report Prepared by (Company)" line only. If the cost report is completed by an individual, complete the "Report Prepared by (Individual)" line only.

Ohio Department of Job and Family Services
MEDICAID NURSING FACILITY COST REPORT

Type of Cost Report Filing. (Please check one of the following)

_____ 4.1 Year-End _____ 4.3 Change of Operator _____ 4.5 Final
_____ 4.2 New Facility _____ 4.6 Amended

INSTRUCTIONS: This cost report must be postmarked pursuant to Ohio Administrative Code. Failure to file timely will result in reduction of the current prospective rate by two dollars ($2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with Ohio Revised Code. Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit a diskette or compact disc to Ohio Department of Job and Family Services, Deputy Director's Office, Cost Reporting Unit, P.O. Box 182709, Columbus, Ohio 43218-2709

Provider Name (DBA)	National Provider Identifier	Medicaid Provider Number	Medicare Provider Number ## - ####
Complete Facility Address: Address (1) Address (2) City State of Ohio Zip Code		Federal Tax ID Number	Period Covered by Cost Report
		ODH ID Number	From:
		County	Through:

TYPE OF CONTROL OF PROVIDER (please check one of the following:)

For Profit
____ Sole Proprietorship (1.1)
____ Partnership (1.2)
  ____ 1. General
  ____ 2. Limited
  ____ 3. Limited Liability Partnership
____ Corporation (1.3)
____ Limited Liability Company (1.5)
____ Business Trust (1.6)
____ Real Estate Investment Trust (REIT) (1.7)
____ Other (Specify): _____ (1.4)

Location of Entity, Organization, or Incorporation:
If facility has a For Profit type of control , check one below:
____ Domestic (1.8)
____ Foreign (1.9) Location:_____

Non-Profit
____ Domestic Non-Profit Corporation (2.4)
____ Foreign Non-Profit Corporation: Location:_____ (2.5)
____ Other (not yet defined "non-profit" entity) Specify: _____ (2.6)

Non-Federal Government
____ State (3.1)
____ County (3.2)
____ City (3.3)
____ City - County (3.4)
____ Other (Specify): _____ (3.6)

PROVIDER LEGAL ENTITY IDENTIFICATION

Name of Legal Entity
Address (1)
Address (2)
City
Zip Code State

NAME AND ADDRESS OF OWNER OF REAL ESTATE

Name
Address (1)
Address (2)
City
Zip Code State

CARE SETTING

Check all that apply:
____ a. Rehab Hospital Based
____ b. General/Acute Hospital Based
____ d. Continuing Care Retirement Center (CCRC)
____ e. Other Assisted Living/Nursing Home Combination
____ f. Religious Non-Medical Health Care Institution
____ g. Free Standing
____ h. Combined with ICF-MR and/or Outlier Unit
____ i. Other (Specify): _____

	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
ALL PATIENTS		
1. Licensed beds at beginning of period		
** 2. Licensed beds at end of period		
3 Total bed days available		
4. Total inpatient days		
5. Percentage of occupancy (line 4 divided by line 3 X 100)		
6. Ancillary/Support allowable days (greater of line 4 or .9 X line 3)		
OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS		
7 Total patient days (from Schedule A-1, line 13, column 5)		
8 Utilization Rate (line 7 divided by line 4, col. 1 X 100)		

**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE _____ AND NUMBER OF BEDS INVOLVED IN CHANGE _____
**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE _____ AND NUMBER OF BEDS INVOLVED IN CHANGE _____
**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE _____ AND NUMBER OF BEDS INVOLVED IN CHANGE _____

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CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

CHAIN HOME OFFICE INFORMATION

This section is to be completed with information about the "HOME OFFICE" for those providers that are members of, or are joining, a chain organization.

A. If this section does not apply check here _____

B. Chain Home Office Information _____ Change Effective Date :

1. Name of Home Office as Reported to the IRS | Federal Tax ID Number
2. Home Office Business Street Address Line 1
   Home Office Business Street Address Line 2
   City | State | ZIP Code

C. Provider's Affiliation to the Chain Home Office _____ Change Effective Date :

Check the appropriate box:

1. _____ Joint Venture / Partnership
2. _____ Operated / Related
3. _____ Managed / Related
4. _____ Wholly Owned
5. _____ Leased
6. _____ Other (Specify): _____

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18 all cost reports submitted to ODJFS will be certified as follows:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) _____, Medicaid Provider Number _____ for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider		Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider (Last) (First) (M.I.)		
Title	Telephone Number Area code ( )	Fax Number Area Code ( )

Report Prepared by (Company)	
Report Prepared by (Individual) (Last) (First) (M.I.)	Title
Address	
City, State, Zip Code	
Telephone Number of Person Preparing Cost Report Area Code ( )	Fax Number Area Code ( )

Location of Records or Probable Audit Site		Telephone Number for Audit Contact Person Area Code ( )
Address		County
City	State	Zip Code

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this _____ day of _____ 20____ at _____, county of _____, and state of _____.

Signature of Notary

Schedule A-1

SUMMARY OF INPATIENT DAYS

Provider Name	Medicaid Provider Number		Reporting Period From: Through:

INSTRUCTIONS: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. Nursing Facilities must report each medically necessary leave day and limited absence as either 50% or 18% of an inpatient day. Please refer to the Ohio Administrative Code for details.

	of Medicaid Certified Beds	Medicaid Patients							Non-Medicaid Patients			Total Inpatient Days (sum cols. 5-9)
		Authorized Days	Hospital Leave Days (@ 50%)	Hospital Leave Days (@ 18%)	Therapeutic Leave Days (@ 50%)	Therapeutic Leave Days (@ 18%)	Total Medicaid Days (sum cols. 2-4)	Managed Care Days	Private Days	Medicare Days	Veterans and Other Days	
	(1)	(2)	(3a)	(3b)	(4a)	(4b)	(5)	(6)	(7)	(8)	(9)	(10)
1. Jan												
2. Feb												
3. Mar												
4. Apr												
5. May												
6. Jun												
7. Jul												
8. Aug												
9. Sep												
10. Oct												
11. Nov												
12. Dec												
13. TOTAL sum of lines 1 through 12							Schedule A, page 1, line 7, column 2					Schedule A, page 1, line 4, column 1

Note: All leave days should round to two decimal places.

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Schedule A-2

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: Enter gross charges for resident days reported in Schedule A-1 and Attachment 4. These gross charges must be reported from a uniform charge structure applicable to all residents.

Description	Medicare Part B Primary Payer is:		Private	Medicare Part A Services	Veteran and Other	Medicaid	Total Revenue (sum of columns 2 through 7)
SECTION A: REVENUES (1)	Medicaid (2)	Other (3)	(4)	(5)	(6)	(7)	(8)
1a. Medical Supplies Revenue							
1b. Percent of Medical Supplies Revenue by Payer Source							100%
2a. Medical Minor Equipment Revenue							
2b. Percent of Medical Minor Equipment Revenue by Payer Source							100%
3a. Enteral Feeding Revenue							
3b. Percent of Enteral Feeding Revenue by Payer Source							100%
4. Total Revenue by Payer Source							

SECTION B: COSTS (1)	MEDICARE PART B OFFSET CALCULATIONS: Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)
5. Percentage of Medicare Part B charges where primary payer is Medicaid (from Schedule A-2, column 2, applicable line b)				
6. Costs (from Schedule B-2, line 16, column 3, and Schedule C, lines 10 and 36, column 3)				
7. Costs to be offset (line 5 times line 6). Offset costs in column 4 on the schedules and lines identified in line 6 above.				
SECTION C: ANCILLARY/SUPPORT COSTS - OFFSET				
8. Ancillary/Support costs (Schedule C, line 81, column 3 less Schedule C, lines 18, 24, 52, 53, 54 and 73, column 3)				
9. **Total costs** (total of Schedule B-1, line 5, Schedule B-2, line 58, Schedule C, line 81, Schedule D, lines 12 and 18, column 3)				
10. Ancillary/Support costs as a percent of total costs (line 8 divided by line 9)				
11. Costs offset (from line 7 column 5 above)				
12. Ancillary/Support costs to be offset (line 10 times line 11) offset costs on Schedule C line 64 column 4				

Schedule A-3

SUMMARY OF COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REIMBURSABLE COSTS	Schedule Reference Line (1)	Sub Total (2)	Total Cost (3)
TAX COST CENTER			
1. Tax Cost	B-1 line 5 Col 7		
DIRECT CARE COST CENTER			
2. Direct Care Cost	B-2 line 58 Col 7		
ANCILLARY/SUPPORT COST CENTER			
3. Ancillary/Support Cost	C line 81 Col 7		
CAPITAL COST CENTER			
4. Assets Acquired Group A	D line 12 Col 7		
5. Assets thru Change of Operator Group B	D line 18 Col 7		
6. TOTAL CAPITAL COST (Sum of lines 4 and 5) Col 2			
7. **TOTAL REIMBURSABLE COSTS** (sum of lines 1, 2, 3 and 6) Col 3			

RECONCILIATION OF COSTS

Schedule / Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
8. B1/5	col 3	col 4	col 5	col 7
9. B2/58	col 3	col 4	col 5	col 7
10. C/97	col 3	col 4	col 5	col 7
11. D/12	col 3	col 4	col 5	col 7
12. D/18	col 3	col 4	col 5	col 7
13. Totals	$ (A)	$ (B)	$	$
14. Less Non-reimbursable from Schedule C, page 3, line 109			col 5 ( )	col 7 ( )
15. Total Reimbursable			$	$ (C)

(A) Agrees to Total Expenses per Working Trial Balance.
(B) Agrees to Attachment 2, line 21, column 4, and Schedule A-2, lines 7 and 12, column 5.
(C) Agrees to Schedule A-3, line 7, column 3.

NOTE: All cost data should be rounded to the nearest whole dollar.

Schedule B-1

TAX COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

TAX COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
1. Real Estate Taxes	6060							
2. Personal Property Taxes	6070							
3. Franchise Tax (Attach FT 1120)	6080							
4. Commercial Activity Tax (CAT)	6085							
5. **TOTAL Tax Costs** (sum of lines 1 through 4)								

*** If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COSTS

Schedule B-2
1 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
NURSING AND HABILITATION/REHABILITATION								
1. Medical Director	6100							
2. Director of Nursing	6105							
3. RN Charge Nurse	6110							
4. LPN Charge Nurse	6115							
5. Registered Nurse	6120							
6. Licensed Practical Nurse	6125							
7. Nurse Aides	6130							
8. Habilitation Staff	6170							
9. Respiratory Therapist	6185							
10. Quality Assurance	6205							
11. Behavioral and Mental Health Services	6207							
12. Consulting and Management Fees - Direct	6210							
13. Other Direct Care - Specify below	6220							
14. Home Office Costs/Direct Care **	6230							
15. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 14)								
MEDICAL, HABILITATION, AND UNIVERSAL PRECAUTION SUPPLIES								
16. Medical Supplies - Medicare Billable	6301							
17. Medical Supplies - Medicare Non-Billable	6311							
18. Oxygen - Emergency stand-by	6321							
19. Oxygen - other than Emergency stand-by	6322							
20 Habilitation Supplies	6330							
21 Universal Precaution Supplies	6340							
22 TOTAL Medical, Habilitation, and Universal Precaution Supplies (sum of lines 16 through 22)								
PURCHASED NURSING SERVICES								
23 Registered Nurse - Purchased Nursing	6401							
24 Licensed Practical Nurse - Purchased Nursing	6411							
25 Nurse Aides - Purchased Nursing	6421							
26 TOTAL Purchased Nursing (sum of lines 24 through 26)								

Line 13 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 13, Columns 1 and 2)		

** Home office costs are to be entered on line 14 only. They are not to be distributed to any other line on this schedule.

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

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Schedule B-2
2 of 2

DIRECT CARE COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
NURSE AIDE TRAINING								
27 In-House Trainer Wages	6500							
28 Classroom Wages - Nurse Aides	6511							
29 Clinical Wages - Nurse Aides	6521							
30 Books and Supplies	6531							
31 Transportation	6541							
32 Tuition Payments	6551							
33 Tuition Reimbursement	6560							
34 Contractual Payments to Other NFs	6570							
35 Registration Fees/Application Fees	6580							
36 Employee Fringe Benefits	6590							
37 **TOTAL Nurse Aide Training** (sum of lines 27 through 36)								
DIRECT CARE THERAPIES								
38 Physical Therapist	6600							
39 Physical Therapy Assistant	6605							
40 Occupational Therapist	6610							
41 Occupational Therapy Assistant	6615							
42 Speech Therapist	6620							
43 Audiologist	6630							
44 Payroll Taxes - Therapy	6640							
45 Workers' Compensation - Therapy	6650							
46 Employee Fringe Benefits - Therapy	6660							
47 EAP Administrator - Therapy	6665							
48 Self Funded Program Admin. - Therapy	6670							
49 Staff Development - Therapy	6680							
50 **TOTAL Direct Care Therapies** (sum of lines 38 through 49)								
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOP. (No Purchased Nursing)								
51 Payroll Taxes - Direct Care	6700							
52 Worker's Compensation - Direct Care	6710							
53 Employee Fringe Benefits - Direct Care	6720							
54 EAP Administrator - Direct Care	6730							
55 Self Funded Programs Admin. - Direct Care	6740							
56 Staff Development - Direct Care	6750							
57 **TOTAL Payroll Taxes, Fringe Benefits, and Staff Development** (sum of lines 51 thru 56)								
58 **TOTAL REIMBURSABLE DIRECT CARE COST** (sum of lines 15, 22, 26, 37, 50 and 57)								

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Schedule C
1 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
DIETARY COST								
1. Dietitian	7000							
2. Food Service Supervisor	7005							
3. Dietary Personnel	7015							
4. Dietary Supplies and Expenses	7025							
5. Dietary Minor Equipment	7030							
6. Dietary Maintenance and Repair	7035							
7. Food In-Facility	7040							
8. Employee Meals	7045							
9. Contract Meals/Contract Meals Personnel	7050							
10. Enterals: Medicare Billable	7055							
11. Enterals: Medicare Non-Billable	7056							
12. Payroll Taxes - Dietary	7060							
13. Workers' Compensation - Dietary	7065							
14. Employee Fringe Benefits - Dietary	7070							
15. EAP Administrator - Dietary	7075							
16. Self Funded Programs Admin. - Dietary	7080							
17. Staff Development - Dietary	7090							
18. TOTAL Dietary (sum of lines 1 through 17)								
MEDICAL RECORDS, PHARMACY, AND SUPPLIES								
19. Medical/Habilitation Records	7105							
20. Pharmaceutical Consultant	7110							
21. Incontinence Supplies	7115							
22. Personal Care - Supplies	7120							
23. Program Supplies	7125							
24. TOTAL Medical Records, Pharmacy, and Supplies (sum of lines 19 through 23)								
ACTIVITIES, HABILITATION, AND SOCIAL SERVICES								
25. Activity Director	7201							
26. Activity Staff	7211							
27. Recreational Therapist	7221							
28. Psychologist	7231							
29. Psychology Assistant	7241							
30. Social Work/Counseling	7251							
31. Social Services/Pastoral Care	7261							
32. Habilitation Supervisor	7271							
33. Program Director	7281							
34. Qualified Mental Retardation Professional	7291							
35. TOTAL Activities, Habilitation, and Social Services (sum of lines 25 through 34)								
MEDICAL MINOR EQUIPMENT								
36. Medical Minor Equip. - Medicare Billable	7301							
37. Medical Minor Equip. - Medicare Non-Billable	7302							
38. TOTAL Medical Minor Equipment (sum of lines 36 through 37)								
UTILITY COSTS								
39. Heat, Light, Power	7501							
40. Water and Sewage	7511							
41. Trash and Refuse Removal	7521							
42. Hazardous Medical Waste Collection	7531							
43. TOTAL Utility Costs (sum of lines 39 through 42)								

*** If allocation is used, the allocation ratio should be calculated _to four places to the right of the decimal.
Note: All cost data should be rounded to the nearest whole dollar.

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ANCILLARY/SUPPORT COSTS

Schedule C
2 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
ADMINISTRATIVE AND GENERAL SERVICES								
44. Administrator	7600							
45. Other Administrative Personnel	7605							
46. Consulting and Management Fees - Ancillary/Support	7610							
47. Office and Administrative Supplies	7615							
48. Communications	7620							
49. Security Services	7625							
50. Travel and Entertainment	7630							
51. Resident Transportation	7631							
52. Laundry/Housekeeping Supervisor	7635							
53. Housekeeping	7640							
54. Laundry and Linen	7645							
55. Legal Services	7650							
56. Accounting	7655							
57. Dues, Subscriptions and Licenses	7660							
58. Interest - Other	7665							
59. Insurance	7670							
60. Data Services	7675							
61. Help Wanted/Informational Advertising	7680							
62. Amortization of Start-Up Costs	7685							
63. Amortization of Organizational Costs	7686							
64. Other Ancillary/Support - Specify below	7690							
65. Home Office Costs - Ancillary/Support **	7695							
66. TOTAL Administative and General Services (sum of lines 44 thru 65)								
MAINTENANCE AND MINOR EQUIPMENT								
67. Plant Operations/Maintenance Supervisor	7700							
68. Plant Operations and Maintenance	7710							
69. Repair and Maintenance	7720							
70. Minor Equipment	7730							
71. Custom Wheelchairs	7735							
72. Leased Equipment	7740							
73. TOTAL Maintenance and Minor Equipment (sum of lines 67 through 72)								
PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT								
74. Payroll Taxes - Ancillary/Support	7800							
75. Workers' Compensation - Ancillary/Support	7810							
76. Employee Fringe Benefits - Ancillary/Support	7820							
77. EAP Administrator - Ancillary/Support	7830							
78. Self Funded Prog. Admin. - Ancillary/Support	7840							
79. Staff Development - Ancillary/Support	7850							
80. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 74 through 79)								
81. TOTAL Reimbursable Ancillary/Support Cost (sum of lines 18, 24, 35, 38, 43, 66, 73, and 80)								

** Home office costs are to be entered on line 65 only. They are not to be distributed to any other line on this schedule.

Line 64 Other Ancillary/Support

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 64, Columns 1 and 2)		

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.
Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Schedule C
3 of 3

Provider Name:	Medicaid Provider Number	Reporting Period From: Through:

ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other / Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
NON-REIMBURSABLE EXPENSES								
82. Legend Drugs	9705							
83. Radiology	9710							
84. Laboratory	9715							
85. Other Non-Reimbursable - Specify below	9725							
86. Late Fees, Fines or Penalties	9730							
87. Federal Income Tax	9735							
88. State Income Tax	9740							
89. Local Income Tax	9745							
90. Insurance - Officers' Life	9750							
91. Promotional Advertising and Marketing	9755							
92. Contributions and Donations	9760							
93. Bad Debt	9765							
94. Parenteral Nutrition Therapy	9770							
95. Franchise Permit Fees	9776							
96. TOTAL Non-Reimbursable Expenses (sum of lines 82 through 95)								
97. TOTAL Ancillary/Support Cost Reimbursable and Non-Reimbursable (sum of lines 81 and 96)								

Line 85 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 85, Columns 1 and 2)		

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

JFS 02524N (REV. 09/2011)

Schedule C-1

ADMINISTRATORS' COMPENSATION

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

SECTION A:

First Name of Administrator	Last Name of Administrator	Administrator License Number*	Social Security Number

Relationship to Provider
Is the administrator an owner or a relative? _____ Yes _____ No

1. Base percentage allowance			100%
2. Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years).	_____	Times 4 =	%
3. Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate in not obtained)	_____	Times 5 =	%
3.1 Was baccalaureate degree obtained?	_____ Yes	_____ No	
4. Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)			
a. Accounting			
b. Maintenance			
c. Housekeeping			
d. Other - specify			
e. Other - specify			
Total Duties		Times 4 =	%
5. County Adjustment			%
6. Ownership Points			%
7. Subtotal of lines 1 through 6			%
8. Allowance Percentage (enter line 7, not to exceed 150%).			%

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Paid Weekly		Compensation		
		Hrs. **	%	Account Number ***	Column Number	Amount
Beginning Date (MMDDYY) (1)	Ending Date (MMDDYY) (2)	(3)	(4)	(5)	(6)	(7)
		TOTAL COMPENSATION				

* Administrators of hospital based nursing facilities report Social Security number.

** Report the number of hours consistent with the amount of compensation reported. If the amount in column (7) is allocated, hours paid must be allocated using the same ratio.

*** This schedule must be completed for all administrators regardless of whether the administrator's salary is reported in account number 7600 or account number 7695. (Use only account number 7600 or 7695, whichever is appropriate.)

Schedule C-2
1 of 2

OWNERS' / RELATIVES' COMPENSATION
OTHER THAN COMPENSATION FOR FACILITY ADMINISTRATOR DUTIES

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed. However, Social Security numbers are not required for non-profit or governmental facilities. Detail owners' and/or relatives' compensation included on JFS 02524N, Schedules B-2 and C net of applicable column 4 adjustments.

Individual's Name	Social Security Number	Position Number **	Relationship to Owner	Years of Exper.	Dates of Employment During this Reporting Period		Paid Weekly		Compensation		
					Beginning	Ending	Hours *	%	Account Number	Col. No.	Amount
(1)	(2)	(3)	(4)	(5)	(6)	(6)	(8)	(9)	(10)	(11)	(12)

* Report the number of hours consistent with the amount of compensation reported. If the amount in column 12 is allocated, hours paid must be allocated the same way.

** See cost report instructions: pages 23, 24, and 25 for position numbers.

Schedule C-2
2 of 2

OWNERS'/RELATIVES' COMPENSATION

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: All items within this schedule must be completed. However, Social Security numbers are not required for non-profit or governmental facilities. List all compensation received from other long-term care facilities in the Medicaid program (in Ohio or other states)by persons listed on Schedule C-2, page 1 of 2, and/or owning a 5% or more interest in this facility.

Individual's Name (1)	Social Security Number (2)	Facility Name (3)	Number of Beds (4)	Medicaid Provider Number (5)	Paid Weekly Hours * (6)	Paid Weekly % (7)	Amount of Compensation (8)

* Report the number of hours consistent with the amount of compensation reported. If the amount in column 8 is allocated, hours paid must be allocated the same way.

Schedule C-3
1 of 3

COST OF SERVICES FROM RELATED PARTIES

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

1. In the amount of costs to be reimbursed by the Ohio Medicaid Program, are any costs included which are a result of transactions with a related party? *

Yes _____ No _____ If yes, complete item 2.

2. Does this cost report include payments to related parties in excess of the costs to the related party?

Yes _____ No _____ If yes, complete the table below.

Name of Owner (1)	Social Security No. (2)	Name of Related Party (3)	Federal ID. No. (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Party (9)

* For further explanation see Ohio Administrative Code.

Note: Social Security numbers are not required for non-profit or governmental facilities.

Schedule C-3
2 of 3

COST OF SERVICES FROM RELATED PARTIES

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

3. List each individual, partner, related corporation, or related LLC which owns, in whole or in part, any mortgage or deed of trust, of the facility or of any property or asset of the provider. (All individuals owning greater than 10% of the land or building, and/or greater than 5% of non real estate business, etc., must be identified by name and Social Security number.) *
Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Title/Position (if applicable)	% Ownership	SSN or Fed ID #	Address	State	Zip Code

4. List all persons performing the duties of officer, director or equivalence (President, VP, Secretary, or other related positions).
Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Job Title (if applicable)

5. List all other facilities that have related ownership as set forth in Section 5111.20 of the ORC.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

* For further explanation see Ohio Administrative Code.

MAR 08 2013

TN 12-001 Approval Date _____
Supersedes
TN 09-028 Effective Date 01/19/12

Schedule C-3
3 of 3

COST OF GOODS OR SERVICES FROM RELATED PARTIES

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?

Yes _____ No _____ If yes, list names below: Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Job and Family Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, the Ohio Department of Commerce, or the Ohio Department of Industrial Commission within the previous twelve months?

Yes _____ No _____ If yes, list names below: Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Name	Social Security Number

8. List all contracts in effect during the cost report period for which the imputed value or cost of goods or service from any individual or organization is ten thousand dollars or more in a twelve month period.

Contractor Name	Contract Amount	Goods or Services Provided

Schedule D

CAPITAL COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.
Facilities that did change operator on or after 7/01/93 use groups A and B.

GROUP A **ASSETS ACQUIRED**

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant & Equip.	8070					
9. Amortization of Financing Costs	8080					
10. Nonextensive Renovations - Depreciation/Amortization and Interest	8085, 8086, 8087					
11. Home office costs - capital **	8090					
12. TOTAL Capital Costs Group A						

** Home Office Costs are to be entered on line 11 only. They are not to be distributed to any other line in Group A.

GROUP B **ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR**

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.
Leased facilities that changed operator on or after 5/27/92 use this group to report expenses incurred through a change of operator on or after 5/27/92.
[Use column (4) to adjust reported costs to the allowable costs as defined in Ohio Administrative Code.]

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
13. Depreciation - Building	8110					
14. Depreciation - Equipment	8140					
15. Interest Exp. - Prop., Plant & Equip.	8170					
16. Amortization of Financing Costs	8180					
17. Lease Expense	8195					
18. TOTAL Capital Costs Group B						

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

Schedule D-1

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.
Facilities that did change operator on or after 7/01/93 use groups A and B.

GROUP A **ASSETS ACQUIRED**

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
1. Land							
2. Buildings							
3. Land Improvements							
4. Leasehold Improvements							
5. Equipment							
6. Transportation							
7. Financing Costs							
8. TOTAL							

NONEXTENSIVE RENOVATIONS

INSTRUCTIONS: Complete for nonextensive renovations in use during cost report period and completed prior to 7/1/05.

ACCOUNT	Cost at Beginning of Period (1)	Additions or Reductions (2)	Project Cost End of Period (Col 1 + Col 2) (3)	Accumulated Depreciation End of Period (4)	Net Book Value End of Period (Col 3 - Col 4) (5)	Depreciation/ Amortization this Period (6)	Interest this Period (7)	Total Columns (6 + 7) (8)**
9. Depreciation/Amoritzation and Interest								
10. TOTAL								

GROUP B **ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOF**

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 2 - Col 5) (6)	Depreciation this Period (7)
11. Land							
12. Buildings							
13. Equipment							
14. Financing Costs							
15. TOTAL							

Has there been any change in the original historical cost of capital assets? _____ YES _____ NO

If yes, submit complete detail.

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Supersedes
TN 09-028 Effective Date 01/19/12

Schedule D-2

CAPITAL ADDITIONS/DELETIONS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: The completion of this schedule is optional if the detailed depreciation schedule submitted contains all the information required in D-2 with the exception of columns 8 and 11. Entries into columns 12 and 13 are mandatory only in the event of asset deletions.

Asset Description (1)	Asset Account Title (2)	Date Acquired (MM/DD/YY) (3)	Date Disposed (MM/DD/YY) (4)	Method of Deprec. (5)	Acquisition Cost (6)	Useful Life (7)	Annual Depreciation (8)	Depreciation for C/R Period (9)	C/R Period Ending Accum Depreciation (10)	Net Book Value (11)	Sales Price (12)	Gain or (Loss) on Disposal (13)
TOTAL												

NOTE: Columns 6, 9, 10, and 11 should tie to Schedule D-1 Capital Cost for each column.

Schedule E

BALANCE SHEET

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	Chart of Acct. No.	BALANCE PER BOOKS Beginning of Period	End of Period
CURRENT ASSETS			
1. Petty Cash	1001		
2. Cash in Banks - General Account	1010		
3. Accounts Receivable	1030		
4. Allowance for Uncollectible Accounts	1040		
5. Notes Receivable	1050		
6. Allowance for Uncollectible Notes Receivable	1060		
7. Other Receivables	1070		
8. Cost Settlement	1080		
9. Inventories	1090		
10. Prepaid Expenses	1100		
11. Short-Term Investments	1110		
12. Special Expenses	1120		
13. Total Current Assets (sum of lines 1 through 12)			
PROPERTY, PLANT AND EQUIPMENT			
14. Property, Plant and Equipment	1200		
15. Accumulated Depreciation and Amortization	1250		
16. Nonextensive Renovations	1300		
17. Accumulated Depreciation and Amortization - Nonextensive Renovations	1350		
18. Total Property, Plant and Equipment (sum of lines 14 through 17)			
OTHER ASSETS			
19. Non-Current Investments	1400		
20. Deposits	1410		
21. Due from Owners/Officers (to Sch. E-1, line 2)	1420		
22. Deferred Charges and Other Assets	1430		
23. Notes Receivable - Long-Term	1440		
24. Total Other Assets (sum of lines 19 through 23)			
25. Total Assets (sum of lines 13, 18 and 24)			
CURRENT LIABILITIES (Report credit balances as positive amounts)			
26. Accounts Payable	2010		
27. Cost Settlements	2020		
28. Notes Payable	2030		
29. Current Portion of Long Term Debt	2040		
30. Accrued Compensation	2050		
31. Payroll Related Withholding and Liabilities	2060		
32. Taxes Payable	2080		
33. Other Liabilities - Specify below	2090		
34. Total Current Liabilities (sum of lines 26 through 33)			
LONG TERM LIABILITIES (Report credit balances as positive amounts)			
35. Long-Term Debt	2410		
36. Related Party Loans - Interest Allowable	2420		
37. Related Party Loans - Interest Non-Allowable (to Sch. E-1, line 3)	2430		
38. Non-Interest Bearing Loans from Owners (to Sch. E-1, line 4)	2440		
39. Deferred Liabilities	2450		
40. Total Long-Term Liabilities (sum of lines 35 through 39)			
41. Total Liabilities (sum of lines 34 and 40)			
42. Capital (line 25 less line 41) (to Sch. E-1, line 1)	3000		
43. TOTAL LIABILITIES AND CAPITAL (must equal line 25)			

Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
TOTALS (must tie to line 33)		

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Schedule E-1

EQUITY CAPITAL OF PROPRIETARY PROVIDERS

This Schedule is Optional

Provider Name:	Medicaid Provider Number	Reporting Period From: Through:

SECTION A: TOTAL EQUITY

TOTAL EQUITY	BALANCE PER BOOKS Beginning of Period (1)	End of Period (2)
1. Capital (from Sch. E, line 42)		
2. Due from Owners/Officers (from Sch. E, line 21)	( )	( )
3. Related Party Loans - Interest Non-Allowable (from Sch. E, line 37)		
4. Non-Interest Bearing Loans from Owners (from Sch. E, line 38)		
5. Equity in Assets Leased from Related Party (attach detail)		
6. Home Office Equity (attach detail)		
7. Cash Surrender Value of Life Insurance Policy	( )	( )
8. Other, Specify:		
9. Other, Specify:		
10. Other, Specify:		
11. Other, Specify:		
12. Other, Specify:		
13. Other, Specify:		
14. Other, Specify:		
15. Other, Specify:		
16. Other, Specify:		
17. Other, Specify:		
18. Other, Specify:		
19. Other, Specify:		
20. Other, Specify:		
21. Other, Specify:		
22. TOTAL Equity		

REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REVENUE ACCOUNT NAME		Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
ROUTINE SERVICE - ROOM AND BOARD					
1. Private		5010			
2. Medicare		5011			
3. Medicaid		5012			
4. Veterans		5013			
5. Other		5014			
6. TOTAL Routine Service - Room and Board (lines 1 through 5)					
DEDUCTIONS FROM REVENUES					
7. Contractual Allowance-Medicare		5710			
8. Contractual Allowance-Medicaid		5720			
9. Contractual Allowance-Other		5730			
10. Charity Allowance		5740			
11. TOTAL Deductions from Revenues (lines 7 through 10)					
THERAPY SERVICES					
12. Physical Therapy		5020			
13. Occupational Therapy		5030			
14. Speech Therapy		5040			
15. Audiology Therapy		5050			
16. Respiratory Therapy		5060			
17. TOTAL (lines 12 through 16)					
MEDICAL SUPPLIES					
18. Medicare B - Medicaid	To Sch. A-2, Line 1a, Col. 2	5070-1			
19. Medicare B - Other	To Sch. A-2, Line 1a, Col. 3	5070-2			
20. Private	To Sch. A-2, Line 1a, Col. 4	5070-3			
21. Medicare A	To Sch. A-2, Line 1a, Col. 5	5070-4			
22. Veterans	To Sch. A-2, Line 1a, Col. 6	5070-5			
23. Other	To Sch. A-2, Line 1a, Col. 6	5070-6			
24. Medicaid	To Sch. A-2, Line 1a, Col. 7	5070-7			
25. Medical Supplies - Routine		5080			
26. Habilitation Supplies		5085			
27. TOTAL Medical Supplies (lines 18 through 26)					
MEDICAL MINOR EQUIPMENT					
28. Medicare B - Medicaid	To Sch. A-2, Line 2a, Col. 2	5090-1			
29. Medicare B - Other	To Sch. A-2, Line 2a, Col. 3	5090-2			
30. Private	To Sch. A-2, Line 2a, Col. 4	5090-3			
31. Medicare A	To Sch. A-2, Line 2a, Col. 5	5090-4			
32. Veterans	To Sch. A-2, Line 2a, Col. 6	5090-5			
33. Other	To Sch. A-2, Line 2a, Col. 6	5090-6			
34. Medicaid	To Sch. A-2, Line 2a, Col. 7	5090-7			
35. Medical Minor Equipment - Routine		5100			
36. TOTAL Medical Minor Equipment (lines 28 through 35)					

REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REVENUE ACCOUNT NAME		Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
ENTERAL NUTRITION THERAPY					
37. Medicare B - Medicaid	To Sch. A-2, Line 3a, Col. 2	5110-1			
38. Medicare B - Other	To Sch. A-2, Line 3a, Col. 3	5110-2			
39. Private	To Sch. A-2, Line 3a, Col. 4	5110-3			
40. Medicare A	To Sch. A-2, Line 3a, Col. 5	5110-4			
41. Veterans	To Sch. A-2, Line 3a, Col. 6	5110-5			
42. Other	To Sch. A-2, Line 3a, Col. 6	5110-6			
43. Medicaid	To Sch. A-2, Line 3a, Col. 7	5110-7			
44. Enteral Nutrition Therapy - Routine		5120			
45. TOTAL Enteral Nutrition Therapy (lines 37 through 44)					
OTHER ANCILLARY SERVICE					
46. Incontinence Supply		5140			
47. Personal Care		5150			
48. Laundry Service - Routine		5160			
49. TOTAL Other Ancillary Service (lines 46 through 48)					
OTHER SERVICES					
50. Dry Cleaning Service		5310			
51. Communications		5320			
52. Meals		5330			
53. Barber and Beauty		5340			
54. Personal Purchases - Residents		5350			
55. Radiology		5360			
56. Laboratory		5370			
57. Oxygen		5380			
58. Legend Drugs		5390			
59. Other - Specify below		5400			
60. TOTAL Other Services (lines 50 through 59)					

Line 59 Other

Account Title	Amount
TOTAL (must tie to line 59, Column 2)	

REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REVENUE ACCOUNT NAME	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
NON-OPERATING				
61. Management Services	5510			
62. Cash Discounts	5520			
63. Rebates and Refunds	5530			
64. Gift Shop	5540			
65. Vending Machine Revenues	5550			
66. Vending Machine Commissions	5555			
67. Rental - Space	5560			
68. Rental - Equipment	5570			
69. Rental - Other	5580			
70. Interest Income - Working Capital	5590			
71. Interest Income - Restricted Funds	5600			
72. Interest Income - Funded Depreciation	5610			
73. Interest Income - Related Party Revenue	5620			
74. Interest Income - Contributions	5625			
75. Endowments	5630			
76. Gain / Loss on Disposal of Assets	5640			
77. Gain / Loss on Sale of Investments	5650			
78. Nurse Aide Training Program Revenue	5660			
79. Contributions	5670			
80. TOTAL Non-operating (lines 61 through 79)				
81. TOTAL (Sum of Lines 6, 11, 17, 27, 36, 45, 49, 60 and 80)				

Attachment 2

ADJUSTMENT TO TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

DESCRIPTION	Revenue Chart of Account Number (1)	Salary Increase (Decrease) (2)	Other Increase (Decrease) (3)	Total Increase (Decrease) (Col. 2 + Col. 3) (4)	Expense Chart of Account Number (5)	Revenue Reference Attachment 1 Line (6)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21. TOTAL						

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Attachment 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

As per the cost report instructions, any documentation (required by the Department or needed to clarify individual line items or groupings) must be submitted as hard copy and labeled as an exhibit. To facilitate the reporting and review process of the submitted cost report (including exhibits) ODJFS requires that exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and shall be labeled accordingly. Exhibits 3 and 4, if needed, shall also be labeled accordingly. In certain situations, if exhibits 3 and 4 are not applicable, the corresponding exhibit number shall not be used. Any other additional exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

Please attach one copy of the following:

Exhibit 1. Facility trial balance that details the general ledger account names as of December 31, 20CY.

IF THE RECOMMENDED CHART OF ACCOUNTS PER OHIO ADMINISTRATIVE CODE IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT.
(One copy with each cost report is required.)

Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)

Exhibit 3. Home office trial balances and the allocation work sheets that show how the home office trial balance is allocated to each individual facility's cost report.
Include the account groupings for each home office account. The allocation procedures are pursuant to CMS Publication 15-1, (If applicable - one copy with each cost report is required.)

Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported.
(If applicable - one copy with each cost report is required.)

Exhibit 5. Any other documentation which is necessary to explain costs.
Identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8, col. 4.

Failure to cross-reference exhibits, to the applicable cost report schedule, line, and column qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to Ohio Administrative Code.

WAGE AND HOURS SURVEY

Provider Name	Medicaid Provider Number	Reporting Period From: Through

INSTRUCTIONS: Report the number of hours consistent with the amount of compensation reported.

Column (C): Enter wages (net of adjustments) paid to facility personnel (This must agree with the sum of column 1 on schedules B-2, C and attachment 2, column 2).

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with schedule C-2).

Column (E): Column (C) minus column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus column (G).

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
DIRECT CARE NURSING AND HABILITATION / REHABILITATION							
1. Medical Director	6100						
2. Director of Nursing	6105						
3. RN Charge Nurse	6110						
4. LPN Charge Nurse	6115						
5. Registered Nurse	6120						
6. Licensed Practical Nurse	6125						
7. Nurse Aides	6130						
8. Habilitation Staff	6170						
9. Respiratory Therapist	6185						
10. Quality Assurance	6205						
11. Behavioral and Mental Health Services	6207						
12. Consulting and Management Fees-Direct	6210						
13. Other Direct Care - Specify below	6220						
14. Home Office Costs/Direct Care (salary)	6230						
15. TOTAL Nursing and Habilitation / Rehabilitation (sum of lines 1 through 14)							
NURSE AIDE TRAINING							
16. In-House Trainer Wages	6500						
17. Classroom Wages: Nurse Aides	6511						
18. Clinical Wages: Nurse Aides	6521						
19. TOTAL Nurse Aide Training (sum of lines 16 through 18)							
DIRECT CARE THERAPIES							
20. Physical Therapist	6600						
21. Physical Therapy Assistant	6605						
22. Occupational Therapist	6610						
23. Occupational Therapy Assistant	6615						
24. Speech Therapist	6620						
25. Audiologist	6630						
26. EAP Administrator - Therapy	6665						
27. Self Funded Program Admin. - Therapy	6670						
28. Staff Development - Therapy	6680						
29. TOTAL Direct Care Therapies (sum of lines 20 through 28)							
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - DIRECT CARE							
30. EAP Administrator - Direct Care	6730						
31. Self funded Programs Administrator - Direct Care	6740						
32. Staff Development - Direct Care	6750						
33. TOTAL Payroll Tax, Fringe Benefits, and Staff Development (sum of lines 30 through 32)							
34. TOTAL Page 1 (sum of lines 15, 19 , 29 and 33)							

WAGE AND HOURS SURVEY

Provider Name	Medicaid Provider Number	Reporting Period From: Through

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
ANCILLARY/SUPPORT DIETARY COST							
35 Dietitian	7000						
36 Food Service Supervisor	7005						
37 Dietary Personnel	7015						
38 EAP Administrator - Dietary	7075						
39 Self Funded Programs Admin - Dietary	7080						
40 Staff Development - Dietary	7090						
41 TOTAL Dietary (sum of lines 35 through 40)							
HABILITATION AND PHARMACEUTICAL							
42 Medical/Habilitation Records	7105						
43 Pharmaceutical Consultant	7110						
44 TOTAL Habilitation and Pharmaceutical (sum of lines 42 and 43)							
ACTIVITIES, HABILITATION, AND SOCIAL SERVICES							
45 Activity Director	7201						
46 Activity Staff	7211						
47 Recreational therapist	7221						
48 Psychologist	7231						
49 Psychology Assistant	7241						
50 Social Work/Counseling	7251						
51 Social Services/Pastoral Care	7261						
52 Habilitation Supervisor	7271						
53 Program Director	7281						
54 Qualified Mental Retardation Professional	7291						
55 TOTAL Activities, Habilitation, and Social Services (sum of lines 45 through 54)							
UTILITIES							
56 Water and Sewage (salary only)	7511						
ADMINISTRATIVE AND GENERAL SERVICES							
57 Administrator	7600						
58 Other Administrative Personnel	7605						
59 Security Services - (salary only)	7625						
60 Resident Transportation	7631						
61 Laundry/Housekeeping Supervisor	7635						
62 Housekeeping	7640						
63 Laundry and Linen	7645						
64 Accounting	7655						
65 Data Services (salary only)	7675						
66 Other Ancillary/Support (salary only)	7690						
67 Home Office Ancillary Care Salary	7695						
68 TOTAL Administrative and General Services (sum of lines 57 through 67)							
MAINTENANCE PERSONNEL							
69 Plant Operations Maintenance Supervisor	7700						
70 Plant Operations and Maintenance	7710						
71 TOTAL Maintenance Personnel (sum of lines 69 and 70)							
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - ANCILLARY/SUPPORT							
72 EAP Administrator - Ancillary/Support	7830						
73 Self Funded Prog. Admin.- Ancillary/Support	7840						
74 Staff Development - Ancillary/Support	7850						
75 TOTAL Payroll Taxes, Fringe Benefits, and Staff Development - Ancillary/Support (sum of lines 72 thru 74)							
76 TOTAL Page 2 (sum of lines 41, 44, 55, 56, 68, 71, and 75)							
77 TOTAL ATTACHMENT 6 Pages 1 and 2 (sum of lines 34 and 76)							

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Attachment 7

ADDENDUM FOR DISPUTED COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From" columns the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To" columns the schedule, line number, and reason you believe these costs should be reclassified.

Reclassification From:					Reclassification To:		
CURRENT COST CENTERS	Chart of Acct.	Salary Facility Employed (1)	Other/ Contract Wages (2)	Adjusted Allocated Total (3)	Schedule (4)	Line (5)	Reason (6)
TAX COSTS							
1.							
2.							
3.							
4.							
5. TOTAL Tax Costs (sum of lines 1 through 4)							
DIRECT CARE COSTS							
6.							
7.							
8.							
9.							
10. TOTAL Direct Care Costs (sum of lines 6 through 9)							
ANCILLARY/SUPPORT COSTS							
11.							
12.							
13.							
14.							
15. TOTAL Ancillary/Support Costs (sum of lines 11 through 14)							
NON REIMBURSABLE EXPENSES							
16.							
17.							
18.							
19.							
20. TOTAL Non Reimbursable Expenses (sum of lines 16 through 19)							
CAPITAL COSTS							
21.							
22.							
23.							
24.							
25. TOTAL Capital Cost (sum of lines 21 through 24)							
26. TOTAL COST CENTERS (sum of lines 5, 10, 15, 20, and 25)							

Attachment 8

Employee Retention Rate

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

1. Number of FTEs on first full payroll ending date of the cost reporting period _____

2. Number of FTEs on last payroll ending date of the cost reporting period remaining from line 1 _____

3. Employee Retention Rate ((Line 2 divided by Line 1)*100%) _____

5111.27.000

Sec. 5111.27. (A) The department of job and family services shall conduct a desk review of each cost report it receives under section 5111.26 of the Revised Code. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. The department shall notify each provider of whether any of the reported costs are preliminarily determined not to be allowable, the rate calculation under sections 5111.20 to 5111.33 of the Revised Code that results from that determination, and the reasons for the determination and resulting rate. The department shall allow the provider to verify the calculation and submit additional information.

(B) The department may conduct an audit, as defined by rule adopted under section 5111.02 of the Revised Code, of any cost report and shall notify the provider of its findings.

Audits shall be conducted by auditors under contract with or employed by the department. The decision whether to conduct an audit and the scope of the audit, which may be a desk or field audit, shall be determined based on prior performance of the provider and may be based on a risk analysis or other evidence that gives the department reason to believe that the provider has reported costs improperly. A desk or field audit may be performed annually, but is required whenever a provider does not pass the risk analysis tolerance factors. The department shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a desk or field audit on the report or a report for a subsequent cost reporting period, whichever is earlier. During the time within which the department may issue an audit report, the provider may amend the cost report upon discovery of a material error or material additional information. The department shall review the amended cost report for accuracy and notify the provider of its determination.

The department may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. The department shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by department employees:

(1) Comply with the applicable rules prescribed pursuant to Titles XVIII and XIX;

(2) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants;

(3) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principles and department rules, and whether, in all material respects, allowable costs are documented, reasonable, and related to patient care;

(4) Are conducted by accounting firms or auditors who, during the period of the auditors' professional engagement or employment and during the period covered by the cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(5) Are conducted by accounting firms or auditors who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or auditor;

(6) Are conducted by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants;

(7) Are completed within the time period specified by the department;

(8) Provide to the provider complete written interpretations that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and departmental policies, with explanations and examples, that are sufficient to permit the provider to calculate with reasonable certainty those costs that are allowable and the rate to which the provider's facility is entitled.

For the purposes of division (B)(4) of this section, employment of a member of an auditor's family by a nursing facility or intermediate care facility for the mentally retarded that the auditor does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

(C) The department, pursuant to rules adopted under section 5111.02 of the Revised Code, may conduct an exception review of assessment data submitted under section 5111.232 of the Revised Code. The department may conduct an exception review based on the findings of a certification survey conducted by the department of health, a risk analysis, or prior performance of the provider.

Exception reviews shall be conducted at the facility by appropriate health professionals under contract with or employed by the department of job and family services. The professionals may review resident assessment forms and supporting documentation, conduct interviews, and observe residents to identify any patterns or trends of inaccurate assessments and resulting inaccurate case-mix scores.

The rules shall establish an exception review program that requires that exception reviews do all of the following:

(1) Comply with Titles XVIII and XIX;

(2) Provide a written summary that states whether the resident assessment forms have been completed accurately;

(3) Are conducted by health professionals who, during the period of their professional engagement or employment with the department, neither have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state;

(4) Are conducted by health professionals who, as a condition of their engagement or employment with the department, shall not review any provider that has been a client of the professional.

For the purposes of division (C)(3) of this section, employment of a member of a health professional's family by a nursing facility or intermediate care facility for the mentally retarded that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of the facility.

If an exception review is conducted before the effective date of the rate that is based on the case-mix data subject to the review and the review results in findings that exceed tolerance levels specified in the rules adopted under this division, the department, in accordance with those rules, may use the findings to recalculate individual resident case-mix scores, quarterly average facility case-mix scores, and annual average facility case-mix scores. The department may use the recalculated quarterly and annual facility average case-mix scores to calculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters.

(D) The department shall prepare a written summary of any audit disallowance or exception review

finding that is made after the effective date of the rate that is based on the cost or case-mix data. Where the provider is pursuing judicial or administrative remedies in good faith regarding the disallowance or finding, the department shall not withhold from the provider's current payments any amounts the department claims to be due from the provider pursuant to section 5111.28 of the Revised Code.

(E) The department shall not reduce rates calculated under sections 5111.20 to 5111.33 of the Revised Code on the basis that the provider charges a lower rate to any resident who is not eligible for the medicaid program.

(F) The department shall adjust the rates calculated under sections 5111.20 to 5111.33 of the Revised Code to account for reasonable additional costs that must be incurred by ~~nursing facilities and~~ intermediate care facilities for the mentally retarded to comply with requirements of federal or state statutes, rules, or policies enacted or amended after January 1, 1992, or with orders issued by state or local fire authorities.

5101:3-3-21 **Audits of nursing facilities (NFS)facility (NF) and intermediate care facilities for the mentally retarded (ICFS-MR)cost reports.**

(A) The Ohio department of job and family services (ODJFS) may conduct audits an audit of the JFS 02524 medicaid NF and ICF-MR cost report in accordance with Chapter 119. under section 5111.27 of the Revised Code, and shall notify the NF or ICF-MR provider of its audit findings.

(1) Until an audit is conducted or until three years have elapsed since the cost report was filed with ODJFS, whichever is earlier, a facility may amend the cost report as set forth in the final rate recalculation provision pursuant to section 5111.28 of the Revised Code and rule 5101:3-3-20 of the Administrative Code. The amended cost report shall be submitted to ODJFS in duplicate on the appropriate JFS 02524 cost report forms on a diskette or compact disk along with a signed certification page addressed to "Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414".

(2) ODJFS may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. The ODJFS shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by ODJFS employees:

(a) Comply with applicable rules prescribed pursuant to title XVIII of the "Social Security Act," 79 Stat. 286 (1965), 42 U.S.C. 1395, as amended and title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301 79 Stat. 286 (1965), 42 U.S.C. 1396, as amended; and

(b) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants, www.aicpa.org; and

(c) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principles and ODJFS rules, whether in all material aspects, allowable costs are documented, reasonable, and related to patient care; and

(d) Are conducted by ODJFS employees auditors or by accounting firms who, during the period of the professional engagement or employment and during the period covered by the financial statements cost reports, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility (NF) or intermediate care facility for the mentally retarded in this state; and

(e) Are conducted by ODJFS employees auditors or by accounting firms who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or an ODJFS employee auditor; and

(f) Are conducted by ODJFS employees auditors or by auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants www.aicpa.org; and

(g) Are completed within the time period as specified by ODJFS in paragraph (A)(1) of this rule; and

(h) Provide to the facility provider complete written interpretations which that explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and ODJFS policies, with explanations and examples, that are sufficient to permit the facility provider to calculate with reasonable certainty those costs that are allowable and the rate to which the provider's facility is entitled.

(B) ODJFS shall prepare a written summary of any audit disallowance set forth in paragraph (A) of this rule. Where the facility provider is pursuing judicial and administrative remedies in good faith regarding the disallowance or finding, ODJFS shall not withhold from the facility's provider's current payments any amounts the department claims to be due from the facility set forth in the final rate recalculation provision provider pursuant to section 5111.28 of the Revised Code.

5101:3-3-43.4 **Exception review process for nursing facilities (NFs).**

(A) The definitions of all terms not defined in this rule are the same as set forth in rules 5101:3-3-01 and 5101:3-3-43.1 of the Administrative Code.

(1) "Combination review" is a type of exception review where the Ohio department of job and family services (ODJFS) reviews records selected in one of the following ways:

(a) A combination of records selected pursuant to random and targeted criteria; or

(b) Records initially selected for a targeted review, but insufficient records were available to meet the targeted review sample size requirements, are combined with randomly selected records to complete the sample size.

(c) Records initially selected for a random review combined with records selected for a targeted review as a result of findings of the random review.

(2) "Exception review" is a review of minimum data set (MDS) assessment data. It is conducted at a selected nursing facility (NF) by registered nurses and other appropriate licensed or certified health professionals employed by or under contract with ODJFS for purposes of identifying any patterns or trends related to resident assessments submitted in accordance with rule 5101:3-3-43.1 of the Administrative Code, which could result in inaccurate case mix scores used to calculate the direct care rate.

(3) "Effective date of the rate" is either the first day of July or January for a given fiscal year.

(4) "Exception review tolerance level" is the level of variance between the facility and ODJFS in MDS assessment item responses affecting the resource utilization groups, version III (RUG III) classification of a facility's residents. Two kinds of tolerance levels have been established for exception reviews: initial sample tolerance level, and expanded review tolerance level.

(a) "Initial sample tolerance level" is the percentage of unverifiable records found during the initial sample of an exception review, below which no further review will be pursued for the same six month period. The initial sample tolerance level shall be less than fifteen per cent of the entire sample.

(b) "Expanded review tolerance level" is an acceptable level of variance in the calculation of a provider's quarterly facility average medicaid case mix score or an acceptable per cent of the records sampled at exception review that were unverifiable.

(5) "Random review" is a type of exception review that examines randomly selected records from any of the RUG III major categories identified in rule 5101:3-3-43.2 of the Administrative Code.

(6) "Record" is an MDS assessment identified as a medicaid record as set forth in paragraph (D)(2) of rule 5101:3-3-43.3 of the Administrative Code.

(7) "Targeted review" is a type of exception review that targets records in restorative nursing programs, current toileting program or trial, and/or bowel toileting program, clinically complex with symptoms of depression, or one or more of the seven mutually exclusive RUG III major categories identified in rule 5101:3-3-43.2 of the Administrative Code. Nursing rehabilitation/restorative care includes records grouped in the following RUG III classifications: RLB, RLA, IB2, IA2, BB2, BA2, PE2, PD2, PC2, PB2, and PA2 as identified in rule 5101:3-3-43.2 of the Administrative Code. Clinically complex with depression includes records grouped in the following RUG III classification: CC2, CB2, and CA2 as identified in rule 5101:3-3-43.2 of the Administrative Code.

(8) The "variance" is the percentage difference between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records.

(a) The exception review tolerance level shall be either less than a two per cent variance between the quarterly facility average medicaid case mix score based on exception review findings and the quarterly facility average medicaid case mix score from the provider's submitted MDS records or less than twenty per cent of the medicaid records sampled at exception review were unverifiable.

(b) The variance calculation will not recognize modifications to MDS assessments and new assessments following an inactivation, submitted by the facility after notification of the exception review.

(9) A "verifiable MDS record" is a provider's completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter, which upon examination by ODJFS during an exception review, has been determined to accurately represent the

aspects of the resident's condition, during the specified assessment time frame, that affect the correct RUG III classification of that record.

(10) An "unverifiable MDS record" is a provider's completed MDS assessment form, based on facility supplied MDS assessment data, submitted to the state for a resident for a specific reporting quarter which, upon examination by ODJFS, has been determined to inaccurately represent the aspects of the resident's condition, during the specified assessment time frame, that affect the RUG III classification of that record. MDS coding may be deemed unsupported if inconsistencies are found in the sources of information through verification activities.

(B) All exception reviews will comply with the applicable provisions of the medicare and medicaid programs.

(C) Providers may be selected for an exception review by ODJFS based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health that may indicate that the facility is not accurately assessing residents, which may result in the resident's inaccurate classification into the RUG III system;

(2) A risk analysis profile that may include, but is not limited to, one or more of the following:

(a) A change in the frequency distribution of their residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression; or

(b) The frequency distribution of residents in the major RUG III categories, nursing rehabilitation/restorative care, or clinically complex with depression that exceeds statewide averages; or

(c) A sudden or drastic change in the facility average case mix score; or

(d) A change in the frequency distribution of coded responses to a MDS item.

(3) Prior resident assessment performance of the provider, may include but is not limited to, ongoing problems with assessment submission deadlines, error rates, incorrect assessment dates, and apparent unchanged assessment practice(s) following a previous exception review.

(D) Exception reviews shall be conducted at the facility by registered nurses and other licensed or certified health professionals under contract with or employed by ODJFS. When a team of ODJFS reviewers conducts an on-site exception review, the team

shall be led by a registered nurse. Persons conducting exception reviews on behalf of ODJFS shall meet the following conditions:

(1) During the period of their professional employment with ODJFS, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a NF which they review in Ohio.

(2) Reviewers shall not review any provider where a member of their family is a current resident.

(3) Reviewers shall not review any provider that has been a client of the reviewer within the past twenty-four months.

(4) Employment of a member of a health professional's family by a provider that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of a NF.

(5) Reviewers shall not review any provider that has been an employer of the reviewer within the past twenty-four months.

(E) Prior notice: ODJFS shall notify the provider by telephone at least two working days prior to the review.

(F) Providers selected for exception reviews must provide ODJFS reviewers with reasonable access to residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments and supporting documentation regarding the residents' care needs and treatments. Providers must also provide ODJFS with sufficient information to be able to contact the resident's attending or consulting physicians, other professionals from all disciplines who have observed, evaluated or treated the resident, such as contracted therapists, and the resident's family/significant others. These sources of information may help to validate information provided on the resident assessment instrument submitted to the state. Verification activities may include reviewing resident assessment forms and supporting documentation, conducting interviews with staff knowledgeable about the resident during the observation period for the MDS, and observing residents.

(G) An exception review shall be conducted of a random, targeted, or a combination of random and targeted samples of completed resident assessment instruments. The initial sample size shall be greater than or equal to the minimum sample size presented in appendix A to this rule. The expanded sample is based on the initial sample findings. The expanded sample size is presented in appendix B to this rule.

(H) Results from review of the initial sample shall be used to decide if further action by ODJFS is warranted. If the initial sample is to be expanded for further review,

ODJFS reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(4)(a) of this rule, ODJFS:

(1) May subsequently expand the exception review process to review MDS assessments as follows:

(a) If the initial sample was a targeted review, the expanded sample size shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(b) If the initial sample was a random review that became a targeted review, the expanded sample shall be the lesser of the remaining records in the targeted category or the applicable minimum expanded sample size presented in appendix B to this rule.

(c) If the initial sample was a random review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule.

(d) If the initial sample was a combination review, the expanded sample size shall be at least the applicable minimum sample size as presented in appendix B to this rule. The expanded sample may consist of the remaining records in the targeted and random categories.

(e) If the expanded review tolerance level is exceeded, ODJFS may subsequently expand the sample size for the same reporting quarter up to and including one hundred per cent of the records and continue the review process.

(I) At the conclusion of the on-site portion of the exception review process, ODJFS reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify RUG III classification for reviewed records. Reviewers will give provider representatives one written preliminary copy of the exception review findings indicating whether the facility was under or over the established tolerance levels.

(J) All exception reviews shall include a final written summary of the exception review findings including the final facility tolerance level calculations and revised quarterly facility average total case mix score and revised quarterly facility average medicaid case mix score. ODJFS shall mail a copy of the final written summary to the provider.

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(K) All exception review reports shall be retained by ODJFS for at least six years.

(L) If the expanded review tolerance level is exceeded, ODJFS shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly, semiannual, and annual facility average case mix scores. Calculations or recalculations shall apply only to records actually reviewed by ODJFS and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODJFS shall recalculate quarterly facility average case mix scores by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

(M) ODJFS shall use the quarterly, semiannual, and annual facility average case mix scores based on exception review findings which exceed the exception review tolerance level to calculate or recalculate the facility's rate for direct care costs for the appropriate six month period(s). However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average case mix score or a peer group cost per case mix unit made in accordance with rule 5101:3-3-43.3 of the Administrative Code as a result of the facility's failure to submit, or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly or semiannual facility average case mix score or peer group cost per case mix unit than the one to be assigned.

(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding six month period, and the review results in findings that exceed the tolerance level, ODJFS shall use the recalculated quarterly facility average case mix scores to calculate the facility's semiannual average case mix score for the facility's direct care rate for that six month period. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility's submission of assessment information.

(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODJFS shall increase the direct care rate prospectively for the remainder of the six month period, beginning one month after the first day of the month after the exception review is completed.

(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding six month period, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODJFS shall

reduce the direct care rate and apply it to the six month periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule 5101:3-3-22 of the Administrative Code.

(N) Except for additional information submitted to ODJFS as part of the processes set forth in paragraphs (O) and (P) of this rule, the ODJFS exception review determination for any resident case mix score shall be considered final. A provider may submit corrections for individual records in accordance with rule 5101:3-3-43.1 of the Administrative Code; however, the exception review determination for any resident assessment case mix score will be used to establish the facility average case mix score.

(O) The provider may seek reconsideration of any prospective direct care rate which was established by recalculating the direct care rate as a result of an exception review of resident assessment information conducted before the effective date of the rate. Requests for rate reconsideration related to exception review findings must be submitted in accordance with the following procedures:

(1) A reconsideration of a prospective direct care rate on the basis of a dispute with ODJFS exception review findings shall be submitted to ODJFS no more than thirty days after receipt of exception review findings.

(2) The request for a reconsideration of a prospective rate on the basis of a dispute with exception review findings shall be filed in accordance with the following procedures:

(a) The request shall be in writing; and

(b) The request shall be addressed to "Ohio Department of Job and Family Services, Ohio Health Plans, Bureau of Long Term Care Services and Supports, Disability and Aging Policy Section"; and

(c) The request shall indicate that it is a request for rate reconsideration due to a dispute with exception review findings; and

(d) The request shall include a detailed explanation of the items on the resident assessment records under dispute as well as copies of relevant, supporting documentation from specific individual records. The request shall also include the provider's proposed resolution.

(3) ODJFS shall respond in writing within sixty days of receiving each written request for a rate reconsideration related to disputed exception review findings. If ODJFS requests additional information to determine if the rate adjustment is

warranted, the provider shall respond in writing and shall provide additional supporting documentation no more than thirty days after the receipt of the request for additional information. ODJFS shall respond in writing within sixty days of receiving the additional information to the request for a rate reconsideration due to disputed exception review findings.

(4) If the rate is increased pursuant to a rate reconsideration due to disputed exception review findings, the rate adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(5) When calculating the annual and semiannual facility average case mix scores in accordance with rule 5101:3-3-43.3 of the Administrative Code, ODJFS shall use any resident case mix scores adjusted as a result of a rate reconsideration determination in lieu of the resident case mix scores from the exception review findings.

(P) The findings of an exception review conducted after the effective date of the rate may be appealed under provisions of the Administrative Procedure Act, Chapter 119. of the Revised Code. ODJFS shall not withhold from the facility's current payments any amounts ODJFS claims to be due from the facility as a result of the exception review findings while the provider is pursuing administrative or judicial remedies in good faith.

Appendix A
Exception Review Resident Initial Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
1-4	All
5-10	5
11-20	8
21-40	10
41-44	11
45-48	12
49-52	13
53-56	14
57-75	15
76-80	16
81-85	17
86-90	18
91-95	19
96-100	20
101-105	21
106-110	22
111-115	23
116-160	24
161-166	25

Continued: Appendix A
Exception Review Resident Initial Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
167-173	26
174-180	27
181-186	28
187-193	29
194-300	30
301-310	31
311-320	32
321-330	33
331-340	34
341-350	35
351-360	36
361-370	37
371-380	38
381-400	39
401-410	40
411-420	41
421-430	42
431-440	43
441-450	44
451-460	45

Continued: Appendix A
Exception Review Resident Initial Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
451-460	46
461-470	47
471-480	48
481-490	49
491 or greater	50

Appendix B
Exception Review Resident Expanded Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (includes initial sample)
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9
10-11	10
12	11
13	12
14-15	13
16	14
17	15
18-19	16
20	17
21-22	18
23	19
24-25	20

Continued: Appendix B
Exception Review Resident Expanded Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (includes initial sample)
26	21
27-28	22
29-30	23
31	24
32-33	25
34-35	26
36-37	27
38-39	28
40-41	29
42-43	30
44-45	31
46-47	32
48-50	33
51-52	34
53-55	35
56-57	36
58-60	37
61-62	38
63-65	39
66-68	40
69-71	41

Continued: Appendix B
Exception Review Resident Expanded Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (includes initial sample)
72-74	42
75-77	43
78-81	44
82-84	45
85-88	46
89-92	47
93-95	48
96-100	49
101-104	50
105-108	51
109-113	52
114-118	53
119-123	54
124-128	55
129-134	56
135-140	57
141-146	58
147-152	59
153-159	60
160-167	61

Continued: Appendix B
Exception Review Resident Expanded Sample Selection

Medicaid Resident Census on Reporting Period End Date	Minimum Expanded Sample Size Required (includes initial sample)
168-174	62
175-183	63
184-191	64
192-201	65
202-211	66
212-221	67
222-232	68
233-245	69
246-258	70
259-272	71
273-287	72
288-304	73
305-322	74
323-342	75
343-364	76
365 or greater	77

Sec. 5111.28 Operators Required to Refund Certain Payments; Interest; Penalties, Rate Adjustments

(A) If a provider properly amends its cost report under section 5111.27 of the Revised Code and the amended report shows that the provider received a lower rate under the original cost report than it was entitled to receive, the department of job and family services shall adjust the provider's rate prospectively to reflect the corrected information. The department shall pay the adjusted rate beginning two months after the first day of the month after the provider files the amended cost report. If the department finds, from an exception review of resident assessment information conducted after the effective date of the rate for direct care costs that is based on the assessment information, that inaccurate assessment information resulted in the provider receiving a lower rate than it was entitled to receive, the department prospectively shall adjust the provider's rate accordingly and shall make payments using the adjusted rate for the remainder of the calendar quarter for which the assessment information is used to determine the rate, beginning one month after the first day of the month after the exception review is completed.

(B) If the provider properly amends its cost report under section 5111.27 of the Revised Code, the department makes a finding based on an audit under that section, or the department makes a finding based on an exception review of resident assessment information conducted under that section after the effective date of the rate for direct care costs that is based on the assessment information, any of which results in a determination that the provider has received a higher rate than it was entitled to receive, the department shall recalculate the provider's rate using the revised information. The department shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment.

In addition to requiring a refund under this division, the department may charge the provider interest at the applicable rate specified in this division from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the current average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(C) The department also may impose the following penalties:

(1) If a provider does not furnish invoices or other documentation that the department requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an exiting operator or owner fails to provide notice of a facility closure, voluntary termination, or voluntary withdrawal of participation in the medicaid program as required by section 5111.66 of the Revised Code, or an exiting operator or owner and entering operator fail to provide notice of a change of operator as required by section 5111.67 of the Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(D) If the provider continues to participate in the medicaid program, the department shall deduct any amount that the provider is required to refund under this section, and the amount of any interest charged or penalty imposed under this section, from the next available payment from the department to the provider. The department and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from the department to the provider.

(E) The department shall transmit refunds and penalties to the treasurer of state for deposit in the general revenue fund.

(F) For the purpose of this section, the department shall determine the average bank prime rate using statistical release H.15, "selected interest rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor, ceases to contain the bank prime rate information or ceases to be published, the department shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

(2005 H 66, eff. 7-1-05)