

CENSUS COVER SHEET

DATES OF QUARTERLY CENSUS: ___/___/___ thru ___/___/___

*FACILITY NAME: _____

*(This information must also be on the census)

MEDICAID PROVIDER NUMBER: _____

NATIONAL PROVIDER NUMBER: _____

Instructions – When computing total bed days used and available, include all NF beds, including bed reserve, regardless of payer source. (Do not include personal care beds.)

(1) Total bed days used (month 1) = _____

(2) Total bed days used (month 2) = _____

(3) Total bed days used (month 3) = _____

(4) Total bed days used for quarter = _____

(Add lines 1, 2 and 3 to compute this total)

(5) Total available bed days for NF = _____

(# of beds multiplied by days in the quarter)

(6) Percentage occupancy used for quarter = _____ (2 decimal places)

(Line 4 divided by Line 5)

(7) Is the % in line 6 equal to 95% or higher? (Yes/No) _____

Yes:

Number of beds = _____

Have the number of beds changed since last quarter? (Yes/No) _____

If yes, effective date of change = ___/___/___

No: Do nothing. You will automatically be paid 50% of your per diem rate for bed reserve.

COMMENTS: _____

Signature/Title of Facility Staff _____

Contact Phone Number _____

Printed Name of Facility Staff _____

_____/_____/_____
Date

Attach this form to the Quarterly Census