# NORTH CAROLINA MEDICAID CAPITAL DATA SURVEY 2020

## FOR DATA THROUGH 9/30/2020

## SKILLED NURSING FACILITIES

## IMPORTANT NOTICE

**This 2020 Survey is conducted for the purpose of gathering data to implement Fair Rental Value with Skilled Nursing Facilities. Data contained on the 2020 Survey must ONLY reflect Additions, Replacements, or Renovations which have been properly recorded between 10/1/2019 and 9/30/2020, NOT the calendar year 2020. The 2020 Capital Data Survey submitted by providers to DHB shall NOT contain Addition, Replacement or Renovation data previously furnished to DHB.**

**Providers must submit the 2020 Capital Data Survey and a detailed list of capitalized items to support each of the cost entries. The 2020 Capital Data Survey is due no later than Tuesday, December 31, 2020.**

**US MAIL (temporary adjustment)**

**Division of Health Benefits**
**Attention: Dolores Lawson/Provider Reimbursement**
**2501 Mail Service Center**
**Raleigh, North Carolina 27699-2501**

**Alternate Shipping (temporary adjustment)**

**Division of Health Benefits**
**Attention: Dolores Lawson/Provider Reimbursement**
**1985 Umstead Drive – Kirby Building**
**Raleigh, North Carolina 27603**

***CDS forms along with supporting documents can also be emailed to:***
***katrina.t.brown@dhhs.nc.gov***

**** Please note when emailing documents, the original signed form must be submitted by mail. ****

**ANY 2020 CAPITAL DATA SURVEYS RECEIVED AFTER 12/31/2020 WILL NOT BE CONSIDERED FOR FAIR RENTAL VALUE CALCULATIONS EFFECTIVE APRIL 1, 2021.**

**NOTE THAT THE FOLLOWING FIVE ITEMS ARE CLARIFIED FROM PRIOR YEAR INSTRUCTIONS**

1. **Section III no longer requires cost data for bed additions or reductions.**
2. **Combination facilities (SNF / ACH) must use square footage and not beds by level of care in Sections III and IV to allocate capitalized cost between nursing and non-nursing levels of care.**
3. **Capitalized cost in Sections III and IV must reflect arms-length transactions. If transactions are less than arms-length, only historical cost will be allowed.**
4. **Section III must reflect licensed beds. If a provider has reduced licensed nursing beds during the Survey period, the number of beds reduced and date of change must be recorded in this section.**
5. **Section III and IV must reflect disposal and retirement of capitalized assets if assets are disposed or retired prior to their AHA Guideline useful life.**

**ALL CAPITAL DATA SURVEY INFORMATION FURNISHED BY PROVIDERS TO DHB MUST AGREE TO SUPPORTING DOCUMENTATION AND IS SUBJECT TO AUDIT PER THE MEDICAID PROVIDER PARTICIPATION AGREEMENT AND THE NORTH CAROLINA STATE PLAN. ALL ITEMS CAPITALIZED AND CLAIMED ON THE CAPITAL DATA SURVEY MUST BE REASONABLE AND ALLOWABLE IN ACCORDANCE WITH THE NORTH CAROLINA STATE PLAN AND THE PROVIDER REIMBURSEMENT MANUAL.**

# North Carolina Medicaid Capital Data Survey 2019

## I. Provider Information

| | | | | |
|---|---|---|---|---|
| A | Nursing Facility Name | | | |
| B | Medicaid SNC Provider Number/ **and NPI number** | | **NPI Number** | |
| C | Street Address | | | |
| D | City, State | | Zip Code | |
| E | Telephone Number | | Fax Number | |
| F | Preparer's Name | | Email Address | |
| G | Year of Initial Construction (YYYY) | | | |

## II. Current Bed and Square Footage Data (Report data as of the 9/30/2020)

| | | |
|---|---|---|
| H | Total Number of Licensed Nursing Facility Beds | |
| I | Total Number of Non-Nursing Beds (ACH, Rest Home, etc.) | |
| J | Total Beds (Sum of H + I) | |
| K | Square Footage Applicable to the Nursing Facility Rooms | |
| L | Square Footage Applicable to Non-Nursing Services Rooms * | |
| M | Total Facility Gross Square Footage (including non-patient rooms) | |
| N | Does your facility expect to complete a major renovation project or add new beds between 10/1/2020 thru 9/30/2021? | |

*** Non-nursing services are services that your facility may provide to individuals not occupying a nursing facility bed. Types of non-nursing services would include ACH, assisted living, residential care, apartments, etc. The square footage applicable to non-nursing services should be reported separately above.**

When completing sections III and IV, include data capitalized for this facility since the previous survey. This does not mean from the time the current owner purchased the facility to present. This could involve reviewing the prior owner's records or, in the case of a lease, obtaining information from the lessor. The month and year of construction should reflect the month the addition was completed (placed in service) and capitalized on a depreciation schedule. **PLEASE NOTE THE PROVIDER MUST FURNISH A DETAILED LIST OF CAPITALIZED ITEMS TO SUPPORT ALL COST ENTRIES ON THE CAPITAL DATA SURVEY.**

## III. Construction of Additional New Beds, Reduction of Beds, or Replacement of Existing Beds (FOR DATA THROUGH 9/30/2020)

(If you have more than 5 additions / reductions / replacements, complete a second page)

Please report each addition / reduction / replacement of nursing facility beds which occurred since the time of the previous survey. **A project is considered a bed addition if licensed nursing facility beds increased. A project is considered a reduction of beds if licensed nursing facility beds decreased. A project is considered a replacement if an existing building or portion of a building was demolished and rebuilt with no additional beds added or if existing beds were relocated to a new building.**

If more than one addition / reduction was completed within a cost report year, please report the data for each addition separately.

| | | Addition / Reduction 1 | Addition / Reduction 2 | Addition / Reduction 3 | Addition / Reduction 4 | Addition / Reduction 5 |
|---|---|---|---|---|---|---|
| O | Month and year addition / reduction completed **(MM/01/YYYY)** | | | | | |
| P | Number of beds increased / (decreased) | | | | | |

| | | Replacement 1 | Replacement 2 | Replacement 3 | Replacement 4 | Replacement 5 |
|---|---|---|---|---|---|---|
| Q | Month and year construction completed **(MM/01/YYYY)** | | | | | |
| R | Cost of construction project (whole dollars) | | | | | |
| S | Number of beds replaced | | | | | |

## IV. Major Renovation Not Involving Addition, Reduction, or Replacement of Beds (FOR DATA THROUGH 9/30/2020)

(If you have more than 5 major renovations, complete a second page)

Please report for each cost report year the cost of major renovation projects completed since the previous survey to present. Major renovation projects include those items capitalized as either land, land improvements, building, building improvement, leasehold improvements and equipment. Do not include any costs associated with Section III above (Additional or Replacement of New Beds). **SEE INSTRUCTIONS**.

Major renovation projects have a total cost equal to or greater than **$500 per licensed bed at the time the project was completed**. A major renovation can be a project or series of projects that aggregate to the $500 per bed threshold over the cost report year. If a renovation project involved construction activities in both the licensed nursing facility and the non-nursing sections of the facility, only those construction costs associated with the licensed nursing facility section of the facility should be included. Square footage must be used to allocate costs between nursing home and non-nursing home (ACH, rest home etc.).

Enter the FID and Project number if the project cost is greater than 20% of total cost as of 9/30/2020. FID Number: ______ Project Number: ______

| | | Renovation / Disposal 1 | Renovation / Disposal 2 | Renovation / Disposal 3 | Renovation / Disposal 4 | Renovation / Disposal 5 |
|---|---|---|---|---|---|---|
| T | Month and year construction completed **(MM/01/YYYY)** | | | | | |
| U | Cost of renovation project (whole dollars) | | | | | |
| V | State and/or Federal Grants Received for Renovation | | | | | |
| W | **Transfer of Asset Prior to Useful Life** | | | | | |
| X | **Month and Year of Transfer (MM/01/YYYY)** | | | | | |

Print Name ______ Date Completed ______

Signature of Facility Representative ______ Title ______

| Column Reference | Expanded Explanation Of Capital Data Survey 2020 |
|---|---|

**Section I. Provider Information**

A Enter the name of the nursing facility as it appears on the nursing facility license.
B Enter the facility Medicaid skilled nursing number/ **and NPI number.**
C Enter the street address of the facility.
D Enter the City, State and Zip Code of the facility.
E Enter the telephone and fax number of the facility, including area code.
F Enter the preparer's name and email address.
G Enter the year in which the initial construction of the facility was completed. If the facility is already established in the Fair Rental Value Aging Schedule, leave blank.

**Section II. Current Bed and Square Footage Data (As of 9/30/2020)**

H Enter the number of licensed nursing facility beds in your facility.
I Enter the total number of non-nursing beds in your facility. This should include any Adult Care Home beds, Rest Home beds, etc.)
J Enter the total number of beds in your facility. This should equal the sum of the amount entered in rows H and I.
K Enter the square footage applicable to the nursing facility rooms.
L Enter the square footage applicable to the non-nursing facility rooms at the facility. The services would include Assisted living, residential care, apartments, etc.
M Enter the total of Lines K & L plus any facility areas not included in K & L.
N If your facility expects to complete a major renovation (total cost of $500 per bed or greater), prior to September 30, 2021, indicate YES. Otherwise, NO.

**Section III. Construction of Additional New Beds or Replacement of Existing Beds Data**

O Enter the Month and Year of the completion dates of any construction project that resulted in the addition of new nursing beds to the facility. The listed projects should include any bed additions since the time that the current building was originally constructed. Use the format MM/01/YYYY. If there was a licensed bed reduction due to conversion of NF Beds to ACH Beds or conversion of semi-private NF rooms to Private NF Rooms or other reason, enter the month and year the licensed bed reduction occurred.

P Enter the number of beds added resulting from any bed addition corresponding to construction projects listed on Line O above. If Line O is a Bed Reduction, enter number of NF beds removed.
Q Enter the Month and Year of the completion dates of any construction project that resulted in the replacement of a portion of the facility building that did not result in a change in the number of beds. The listed projects should include any replacement projects since the time the current building was originally constructed. Use the format MM/01/YYYY.
R Enter the total construction cost of any corresponding bed replacement construction project listed on Line R above. **Include a detailed list of items capitalized.**
S Enter the number of beds located in the replaced portion of the building of any corresponding bed replacement project listed on Line R above.

**Section IV. Major Renovation Not Involving Addition or Replacement of Beds**

T Enter the month and year of the completion dates of any major (cost equivalent to $500 per bed or greater) renovation project that did not result in the addition or replacement of beds. Use the format MM/01/YYYY.
U Enter the total construction cost of any corresponding major renovation project listed on Line U above. **Include a detail list of items capitalized.**
V Enter as a positive figure the amount of State and/or Federal Grants funds expended this period for renovations and improvements. That amount will be offset against the expense claimed for renovations and improvements on the Fair Rental Value Aging Schedule to preclude the provider claiming costs twice to a State / Federal Agency. (OMB A-87, CMS 15-1)

Note: For Major Construction Projects not involving addition or replacement of beds which exceed an estimated cost of $500,000 and exceed an estimated time to complete of greater than 12 months, the provider may report on the 2020 Capital Data Survey the dollar value percentage actually completed as of 9/30/2020. In order for an entry to be considered, the project amount must be greater than 20% as of 9/30/2020 and supported by a paid AIA (American Institute of Architects) invoice to a licensed contractor.

W The value of any asset which has been claimed on a Capital Data Survey which is transferred to another Medicaid certified provider prior to reaching the end of its AHA defined useful life must be reduced by any amount received for the asset. Enter on this line the amount received for transfered assets which meet this criteria.
X Enter the month and year of Transfer.