NORTH CAROLINA MEDICAID CAPITAL DATA SURVEY 2024

FOR DATA THROUGH 9/30/2024

SKILLED NURSING FACILITIES

IMPORTANT NOTICE

This 2024 Survey is conducted for the purpose of gathering data to implement Fair Rental Value with Skilled Nursing Facilities. Data contained on the 2024 Survey must ONLY reflect Additions, Replacements, or Renovations which have been properly recorded between 10/1/2023 and 9/30/2024, NOT the calendar year 2024. The 2024 Capital Data Survey submitted by providers to DHB shall NOT contain Addition, Replacement or Renovation data previously furnished to DHB.

Providers must submit the 2024 Capital Data Survey and a detailed list of capitalized items to support each of the cost entries. The 2024 Capital Data Survey is due no later than December 31, 2024.

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 and payment receipts MUST BE emailed to:
medicaid.providerreimbursement@dhhs.nc.gov

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

FAIR RENTAL VALUE CALCULATIONS EFFECTIVE APRIL 1, 2025.

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

1. **Section III requires cost data for new building and 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.

10A NCAC 13D .3100-.3400
For more information on how to submit plans go to: https://info.ncdhhs.gov/dhsr/const/project.html
UPDATED Construction Project Plan Submittal Form: https://info.ncdhhs.gov/dhsr/const/pdf/healthcarejailplansubmittal.pdf

Column Reference	Expanded Explanation Of Capital Data Survey 2024
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/ NPI number/ Licensed number. Next row FID and Project numbers
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 9/30/2024)	
IIa.	**Prior Bed and Square Footage Data (As of 09/30 of last year)**
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 services.
L	Enter the square footage applicable to the non-nursing services. The services would include Assisted living, residential care, apartments, etc.
M	Enter the total gross square footage of the faciity.
N	If your facility expects to complete a major renovation (total cost of $500 per bed or greater), prior to September 30th, indicate YES. Otherwise, NO.
Worksheet	Complete CDS worksheet.
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 bulding or wing or number of beds added resulting from any bed addition corresponding to construction projects listed on Line P above. If Line P is a Bed Reduction, enter number of NF beds removed.
Q	Enter the total construction cost of any corresponding new building, new additionon or Reduction construction project listed on Line P above. **Include a detailed list of items capitalized.**
R	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.
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.
T	Enter the total construction cost of any corresponding bed replacement construction project listed on Line R above. **Include a detailed list of items capitalized.**

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

U	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. Do not include items aleady submitted on previous Capital Data Surveys.
V	Enter amount of any funds & payments include State & Federal Grants 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 2024 Capital Data Survey the dollar value percentage actually completed as of 9/30/2024. Submit the completed final copy of the AIA (American Institute of Architects), Construction Project Plan Submittal form and the Application and Certificate for Payment.
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.
Y	Enter amount for Disposals & Retirements items.
Z	Enter the total construction cost of any corresponding major renovation project listed on Line U above. **Include a detail list of items capitalized.**
Note:	Submit the **largest five paid** supporting electronic copies of invoices with payment receipts per your detailed list of expenses

Capital Data Survey

2024

I. Provider Information

A	Nursing Facility Name							
B	Provider Medicaid Numbers: NPI/SNF/LIC/FID	**NPI#**	123456789	**SNF#**	34xxxxx	**Licensed#**	NHxxxx	**FID#**	XXXXXX
	Facility Project Numbers							
C	Facility Physical Street Address							
D	Facility City & Zip Code	**City**					**Zip Code**	27611-1111
E	Facility Telephone Number and Fax Number	**Phone**	**(999) 999-9999**				**Fax#**	**(999) 999-9999**
F	Preparer's Name and Email Address	**Name**				**Email**		
G	Year of Initial Construction (YYYY)	XXXX						

II. Current Bed and Square Footage Data — **IIa. Prior Bed and Square Footage Data**

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)	0	0
K	Square Footage Applicable to the Nursing Services (add new sq.ft.)		
L	Square Footage Applicable to Non-Nursing Services (add new sq.ft.)		
M	Total Facility Gross Square Footage (add new sq.ft.)		
N	Does your facility expect to complete a major renovation project or new building, and beds or replaced building & beds for the following year ?		10/01/2023 to 09/30/2024 — NO

*** 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 that includes the largest five paid supporting electronic copies of invoices with payment receipts per your detailed list of expenses.

CDS Worksheet — Click link or Select CDS Worksheet

III. Construction of Additional New Beds, Reduction of Beds, or Replacement of Existing Beds

10/01/2023 to 09/30/2024

Information on how to submit plans: https://info.ncdhhs.gov/dhsr/const/project.html

UPDATED Construction Project Plan Submittal Form:: https://info.ncdhhs.gov/dhsr/const/pdf/healthcarejailplansubmittal.pdf

(10A NCAC 13D SECTIONS .3100-.3400)

Adobe Acrobat PDFXML Document

		New Building, Wing, Bed Addition / Reduction 1	New Building, Wing, Bed Addition / Reduction 2	New Building, Wing, Bed Addition / Reduction 3	New Building, Wing, Bed Addition / Reduction 4	New Building, Wing, Bed Addition / Reduction 5
O	Month and year addition / reduction completed **(MM/01/YYYY)**					
P	**Building and Number of beds increased / (decreased)**					
Q	Cost of construction project (whole dollars)					

		Building, Wing, Bed Replacement 1	Building, Wing, Bed Replacement 2	Building, Wing, Bed Replacement 3	Building, Wing, Bed Replacement 4	Building, Wing, Bed Replacement 5
R	Month and year construction completed **(MM/01/YYYY)**					
S	**Building and Number of beds replaced**					
T	Cost of construction project (whole dollars)					

IV. Major Renovation Not Involving New Building Addition, Reduction, or Replacement of Building and Beds

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). Do not include items already submitted on previous Capital Data Surveys **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.). SEE CDS WORKSHEET**

		Renovation / Disposals & Retirements 1	Renovation / Disposals & Retirements 2	Renovation / Disposals & Retirements 3	Renovation / Disposals & Retirements 4	Renovation / Disposals & Retirements 5
U	Month and year construction completed **(MM/01/YYYY)**					
V	Any Funds/Payments State & Federal Grants Received for Renovation					
W	**Transfer of Asset Prior to Useful Life**					
X	**Month and Year of Transfer (MM/01/YYYY)**					
Y	Disposals & Retirements costs					
Z	Cost of renovation project (whole dollars) See CDS Worksheet					

Print Name

Date Completed

Signature of Facility Representative

Title

CAPITAL DATA WORKSHEET

LINE					Threshold
A	Total Number of Licensed Nursing Facility Beds	100	x $500 =		$ 50,000
		Enter # of Beds			

		Cost of Qualifying Projects (add sheets if necessary)					TOTAL COST
		Project 1	Project 2	Project 3	Project 4	Projects 5+	
B	TOTAL Project Cost	$ 50,000					
C	% Completed by Sept. 30	100%	100%	100%	100%	100%	
D	Allowable Amount	$ 50,000	$ -	$ -	$ -	$ -	$ 50,000
				1ST			Eligible

	Cost Allocation - Statistical Basis	Square Feet	% of Total
E	Square Footage - Nursing Facility Rooms	30,000	90.91%
F	Square Footage - Non-Nursing Facility Rooms	3,000	9.09%
G	Square Footage - Other 1		0.00%
H	Square Footage - Other 2		0.00%
I	Total Square Footage -	33,000	100.00%

Types of non-nursing services would include ACH, Assisted living, Residential care, Apartments, Independent, etc.

J		Total Cost of Qualifying Renovations	$ 50,000
K		ENTER: Any Funds, State and Federal Grants Received (enter as positive)	
L		ENTER: Any non-allowable item costs (enter as positive)	
M	*	ENTER: Amount received for Transfer of Assets Previously Reported (enter as positive)	
N		Net Amount Subject to Allocation	$ 50,000
O		x Percent of Square Footage Allocated to Nursing Facility	90.91%
P		**Amount of Renovation Costs Allocable to Nursing Facility**	**$ 45,455**
		FINAL	**Ineligible - Capital Cost Under $500 per Bed**

* The value of any asset which has been claimed on a Capital Data Survey and which is transferred to another Medicaid certified provider prior to the end of its AHA-defined useful life must be reduced by any amount received for the asset.

PLEASE NOTE THE PROVIDER MUST FURNISH A DETAILED LIST OF CAPITALIZED ITEMS TO SUPPORT ALL COST ENTRIES ON THE CAPITAL DATA SURVEY that includes the largest five paid supporting electronic copies of invoices with payment receipts per your detailed list of expenses.

Capitalizable YES or NO	Project Number	Accounting Period	Location	Condition	Purchase Order Inv	Expenditure Item Date	Purchased Item Name	Expenditure Type	Number/ Units	Asset Amount

INVOICES

PAYMENT OF INVOICES