

OMB #
Expires:

SP ID #: _____

SP NAME: _____

INTERVIEWER NAME: _____

INTERVIEWER ID: _____

FACILITY ID #: _____

START TIME: _____ am/pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCE ADMINISTRATION

MEDICARE CURRENT BENEFICIARY SURVEY

FACILITY COMPONENT

FACILITY QUESTIONNAIRE

ROUNDS 18 AND 19

ASSURANCE OF CONFIDENTIALITY

Information contained on this form that would permit identification of any individual or establishment is collected with a guarantee that it will be held in strict confidence by the contractor and HCFA, will be used only for purposes stated in this study, and will not be disclosed or released to anyone other than authorized staff of HCFA without the consent of the individual or the establishment in accordance with the Privacy Act of 1974.

SECTION FA. FACILITY DEFINITION

BOX FA1	<p>If FA1-FA18 have already been completed, but ELIGIBILITY BLOCK (FA19-22) has not been completed for all facility parts, and a respondent is selected who was entered in FA18, go to FA17, p. 36.</p> <p>Others, go to FAVERIF1.</p>
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FAVERIF1

Before we begin, I need to verify that our information about you is correct.

Is {FACILITY} the exact name of this facility?

YES	1
NO	0
DK	-8
RF	-7

FACA.FNAMEOK

PROGRAMMER SPECS:

If 0 is entered in FAVERIF1, present NAME UPDATE SCREENS. The first NAME UPDATE screen is an overaly to FAVERIF1:

What is the exact name of this facility?

FACILITY NAME

ADDR.ADDRNAME

REMAPS TO PLAC.PLACNAME

REASON FOR NAME UPDATE:

- CORRECTING A TYPOGRAPHICAL ERROR 1
- CORRECTING SOME OTHER KIND OF ERROR 2
- SPECIFYING MORE COMPLETE INFORMATION 3
- FACILITY CHANGED ITS NAME
- WHEN BOUGHT BY ANOTHER COMPANY 5
- FACILITY CHANGED ITS NAME FOR SOME
- OTHER REASON 6
- OTHER (SPECIFY: _____) 91

ADDR.ADDRREAS .ADDRREOS

ADDR.ADDRCHNG

FAVERIF3

Is {FACILITY}'s address...

{ADDRESS1}
{CITY, STATE ZIP}?

YES	1
NO	0
DK	-8
RF	-7

FACA.FADDROK

ADDR.ADDRESS
.ADDRCITY
.ADDRSTAT
.ADDRZIP

BOX FA1A	If 0 is entered in FAVERIF3, review address fields. If interviewer pressed enter on each and all fields, go to FAVERIF4. Else, present ADDRESS UPDATE SCREEN. Set a flag to indicate a change has been made. The ADDRESS UPDATE screen collects the reason for change. Else, continue.
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REASON FOR ADDRESS UPDATE: ()

CORRECTING A <u>TYPOGRAPHICAL</u> ERROR	1
CORRECTING SOME <u>OTHER</u> KIND OF <u>ERROR</u>	2
SPECIFYING <u>MORE COMPLETE</u> INFORMATION	3
FACILITY <u>MOVED</u> TO A DIFFERENT ADDRESS	7
FACILITY CHANGED ITS ADDRESS FOR SOME <u>OTHER</u> REASON	8
OTHER (SPECIFY: _____)	91

ADDR.ADDRCHNG .ADDRREAS .ADDRREOS

FAVERIF4

{{Is ADMINISTRATOR'S NAME} {Are you/You are}} {still} the current administrator of {FACILITY}?

YES	1
NO	0
DK	-8
RF	-7

FACA.FADMNOK

PROGRAMMER SPECS:

If 0 is entered in FAVERIF4, go to RR1 with this question text displayed:

What is the current administrator's name?

FACR.FACRNAME ADDR.XFACRADM
.FACRTITL
.FACRTIOS

After the NAME has been entered and the TITLE confirmed, return to FAVERIF4 at the ADMINISTRATOR UPDATE SCREEN. The UPDATE screen captures the reason for the change:

REASON FOR ADMINISTRATOR NAME UPDATE: ()

CORRECTING A <u>TYPOGRAPHICAL</u> ERROR	1
CORRECTING SOME <u>OTHER</u> KIND OF <u>ERROR</u>	2
SPECIFYING <u>MORE COMPLETE</u> INFORMATION	3
FACILITY <u>CHANGED ADMINISTRATORS</u>	4
OTHER (SPECIFY: _____)	91

ADDR.ADDRCHNG .ADDRREAS .ADDRREOS

FAVERIF5

Is {FACILITY AREA CODE AND PHONE NUMBER} the correct phone number for {FACILITY}?

- YES 1
- NO 0
- DK -8
- RF -7

FACA.FPHONOK

PROGRAMMER SPECS:

If FAVERIF5=0 (NO), present PHONE UPDATE SCREENS. The first PHONE UPDATE screen is an overlay to FAVERIF5. If the area code and state from FAVERIF3 (ADDR.ADDRSTAT) do not match, display the error message: "Area code and state...area code" at the bottom of the screen.

What is the phone number?

() () - ()

{Area code and state do not match. Verify and re-enter state and area code.}

- ADDR.ADDRAREA**
- .ADDR EXCH**
- .ADDR LOCL**

The second UPDATE screen collects the reason for the change:

REASON FOR UPDATE: ()

- CORRECTING A TYPOGRAPHICAL ERROR 1
- CORRECTING SOME OTHER KIND OF ERROR 2
- SPECIFYING MORE COMPLETE INFORMATION 3
- FACILITY MOVED TO A DIFFERENT ADDRESS 7
- OTHER (SPECIFY: _____) 91

- ADDR.ADDRCHNG**
- .ADDR REAS**
- .ADDR REOS**

BOX FA1B	If first time FQ administered in this facility, go to FAVERIF5A. Else, go to FAVERIF6.
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FAVERIF5A

When was {FACILITY} founded?

MONTH () YEAR 19()

- FACL.FOUNDMM**
- .FOUN DYY**

FAVERIF5B

Did it previously have a different name or address?

YES 1
NO 0 (FAVERIF6)

FACL.DIFFNAME

FAVERIF5C

What was the previous name and address?

NAME: _____

ADDRESS: _____

CITY: _____ STATE: ___ ZIP CODE: _____

ADDR.ADDRNAME .ADDRESS .ADDRCITY .ADDRSTAT .ADDRZIP

FAVERIF5D

When did the name change occur?

MONTH () YEAR 19()

FACL.CHANGEMM .CHANGEYY

FAVERIF6

Is {FACILITY} part of a chain--that is, a group of long-term care facilities operating under common management?

YES 1
NO 0

PRESS F1 FOR EXPANDED DEFINITION.

FACL.FACCHAIN

BOX FA2	If Baseline FQ, go to FA1PRE. Else, go to BOX FB1A, page 67.
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FA1PRE

FACILITY-LEVEL QUESTIONNAIRE

Now I have a few questions about the structure of {FACILITY} and its certification and licensing to confirm that it is eligible for this study.

PRESS ENTER TO CONTINUE.

BOX FA1PRE	If FAVERIF6 = 1 (YES, FACILITY IS PART OF A CHAIN), go to FA1A. Else, go to FA1.
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FA1A

I understand that {FACILITY} is part of a chain -- that is, a group of long-term care facilities operating under common management. Setting that aside, this next question is about the physical location of the home here.

PRESS ENTER TO CONTINUE.

FA1

Is {FACILITY} a free-standing nursing home?

PROBE: Free-standing nursing homes are not physically part of any other place or organization.

YES	1 (FAVERIF2)
NO	0 (FAVERIF2)

IF VOLUNTEERED: {FACILITY} IS ...

CONTINUING CARE	ASSISTED LIVING FACILITY ...	8 (FAVERIF2)
RETIREMENT COMMUNITY	BOARD AND CARE HOME	9 (FAVERIF2)
(CCRC)	DOMICILIARY CARE HOME ...	10 (FAVERIF2)
3 (BOX FA5)	PERSONAL CARE HOME	11 (FAVERIF2)
NURSING HOME/UNIT WITHIN	REST HOME/	
A CCRC OR RETIREMENT	RETIREMENT HOME	12 (FAVERIF2)
CENTER	MENTAL HEALTH CENTER/	
4 (FA9)	PSYCHIATRIC SETTING	15 (FAVERIF2)
5 (BOX FA5)	INSTITUTION FOR THE	
HOSPITAL	MENTALLY RETARDED/	
6 (BOX FA5)	DEVELOPMENTALLY	
7 (FA9)	DISABLED	16 (FAVERIF2)
HOSPITAL-BASED SNF UNIT ..	REHABILITATION FACILITY ...	17 (FAVERIF2)
	HOME/MGMT. OFFICE	
	FOR CHAIN/OFF-SITE	
	NURSING FACILITIES.....	13 (FA5A)
	OTHER (SPECIFY:_____)	.91 (FAVERIF2)
	DK	-8 (FAVERIF2)
	RF	-7 (FAVERIF2)

PRESS F1 FOR DEFINITION OF FREE-STANDING AND HOSPITAL-BASED SNFS.

FACA.FREESTND
.FREESTOS
FACA.CHPL91TY

PLAC.PLACTYPE
.PLACTPOS

FAVERIF2

IF ALREADY KNOWN, CODE WITHOUT ASKING:

Do you prefer that I call {FACILITY} a home or a facility?

PREFERS HOME	1
PREFERS FACILITY	2
NO PREFERENCE	3

FACL.FACHOME

FA2

Is {FACILITY} part of a larger {home/facility} or campus?

- YES 1
- NO 0
- DK -8
- RF -7

PRESS F1 FOR DEFINITION, EXAMPLES OF "LARGER" PLACES.

FACA.FACLPART

BOX FA3	If FA1 = 1 and FA2 = 0, go to FA19, If FA1 = 8, 9, 10, 11, 12, 15, 16, 17, or 91 and FA2 = 0, -8 or -7 go to FA8. If FA2 = 1, go to FA3. Others, go to FA5.
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FA3

IF ALREADY VOLUNTEERED, CODE WITHOUT ASKING:
What type of place is {FACILITY} part of?

SHOW CARD FA1

- CONTINUING CARE RETIREMENT
- COMMUNITY (CCRC) 3
- RETIREMENT COMMUNITY 5
- HOSPITAL 6
- ASSISTED LIVING FACILITY 8
- BOARD AND CARE HOME 9
- DOMICILIARY CARE HOME 10
- PERSONAL CARE HOME 11
- REST HOME 12
- OTHER (SPECIFY: _____) 91

PRESS F1 FOR HOSPITAL DEFINITIONS.

PLAC.PLACTYPE .PLACTPOS
FACA.CHPL91TY

FA4

What is the name of the {CATEGORY SELECTED IN FA3/place}?

PLAC.PLACNAME

BOX FA4	Add to Place Roster, then Go to BOX FA5.
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PLAC.PLCREATE
 FACL.COMPLEXF
 .XPLACLF

FA5

What type of place is {FACILITY}?

SHOW CARD FA2

- | | |
|--|---|
| CONTINUING CARE | ASSISTED LIVING FACILITY . . . 8 (FA8) |
| RETIREMENT COMMUNITY | BOARD AND CARE HOME 9 (FA8) |
| (CCRC) 3 (BOX FA5) | DOMICILIARY CARE HOME . . .10 (FA8) |
| NURSING HOME/UNIT WITHIN | PERSONAL CARE HOME11 (FA8) |
| A CCRC OR RETIREMENT | REST HOME/RETIREMENT |
| CENTER 4 (FA9) | HOME 12 (FA8) |
| RETIREMENT COMMUNITY . . . 5 (BOX FA5) | MENTAL HEALTH CENTER/
PSYCHIATRIC SETTING15 (FA8) |
| HOSPITAL 6 (BOX FA5) | INSTITUTION FOR THE |
| HOSPITAL-BASED SNF UNIT . . 7 (FA9) | MENTALLY RETARDED/
DEVELOPMENTALLY |
| | DISABLED 16 (FA8) |
| | REHABILITATION FACILITY . . .17 (FA8) |
| | HOME OFFICE OR MANAGE-
MENT OFFICE FOR A CHAIN
OR GROUP OF OFF-SITE |
| | NURSING FACILITIES13 (FA5A) |
| | OTHER (SPECIFY:_____) .91 (FA8) |
| | DK -8 (FA8) |
| | RF -7 (FA8) |

PRESS F1 FOR HOSPITAL DEFINITIONS.

PLAC.PLACTYPE .PLACTPOS

FACA.CHPL91TY

FA9

What is the name of the {CATEGORY SELECTED IN FA1 OR FA5}?

PLAC.PLACNAME

BOX FA8	<p>Add to Place Roster. IF FA1 or FA5=7, add HOSPITAL NAME to database. Set the locator code for the place added to Place Roster =LARGER FACILITY, and set the locator code for the target facility = TARGET FACILITY, PART OF LARGER FACILITY. Then, if FA1 or FA5=7 (HOSPITAL-BASED SNF UNIT), go to FA16. Others, go to FA11.</p>
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- PLAC.PLCREATE**
- PLAC.LOCCODE**
- FACL.XPLACLF**
- FACL.COMPLEXF**

SAMPLE LAYOUT

FA11-15

FA11

Please tell me about all the parts or units of {LARGER FACILITY} where residents stay overnight. {Please do not include acute care departments or units in this list.}

PROBE: Any others?

FA11 NAME	FA12 PLACE TYPE	FA13 NUMBER OF BEDS/ UNITS	FA14 ANOTHER NAME? (YES = 1, NO = 0)	FA15 ALSO KNOWN AS...

PROBE: Any others?

PLAC.PLACNAME	.PLACTYPE	.BEDSNUM	.OTHRNAME	.PLACNAM2
	.PLACTPOS			

FA12

SHOW
CARD
FA4

What type of (place/unit) is that?

PROBE WITH CATEGORIES BELOW MATRIX.

PRESS F1 FOR DEFINITION OF ASSISTED LIVING FACILITY, BOARD AND CARE HOME, DOMICILIARY CARE HOME, PERSONAL CARE HOME, AND REST HOME.

PLAC.PLACTYPE .PLACTPOS

FA13

How many beds (or individual units) are in {PLACE/UNIT}?

PLAC.BEDSNUM

FA14

Is {PLACE/UNIT} also known by some other name?

YES 1
NO 0 (BOX FA10)

PLAC.OTHRNAME

FA15

What name is that?

ALSO KNOWN AS . . .

PLAC.PLACNAM2

BOX FA10	Post each Part/Unit to Place Roster. If target facility's locator code = TARGET FACILITY, PART OF LARGER FACILITY, code all other parts/units listed in FA11-15 as PART OF LARGER FACILITY. Otherwise, code all parts/units as PART OF TARGET FACILITY. If HOSPITAL selected as place type in FA12, go to FA16. Others, go to BOX FA11.
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**PLAC.PLCREATE
PLAC.LOCODE**

FA16

You mentioned that {NAME IN FA11} is a hospital. Please look at this card and tell me what kind of hospital it is.

SHOW
CARD
FA3

- A. ACUTE CARE HOSPITAL 1
- B. PRIVATE PSYCHIATRIC HOSPITAL 2
- C. STATE OR COUNTY HOSPITAL FOR THE
MENTALLY ILL 3
- D. VA HOSPITAL, VA MEDICAL CENTER 4
- E. STATE HOSPITAL FOR THE MENTALLY RETARDED .. 5
- F. CHRONIC DISEASE, REHABILITATION, GERIATRIC, OR
OTHER LONG-TERM CARE HOSPITAL 6
- OTHER (SPECIFY: _____) 91

PLAC.HOSPKIND .HOSPKIOS

BOX FA11	Review Status Code and Place Type for each Place. If missing for a Place, assign a value to the missing item(s) based on the following table:		
	IF	THEN ASSIGN: MCBS STATUS CODE FOR TARGET FACILITIES	MCBS PLACE TYPE
	FA1, FA3 or FA5 = 3 (CCRC)	ELIGIBLE	ELIGIBLE LTC
	5 (RETIREMENT COMMUNITY)	ELIGIBLE	ELIGIBLE LTC
	FA1 or FA5 = 13 (HOME OFFICE)	INELIGIBLE	COMMUNITY
	FA12 = 8 (ASSISTED LIVING FACILITY)	ELIGIBLE	ELIGIBLE LTC
	9 (BOARD AND CARE HOME)	ELIGIBLE	ELIGIBLE LTC
	10 (DOMICILIARY CARE HOME)	ELIGIBLE	ELIGIBLE LTC
	14 (INDEPENDENT LIVING UNITS)	INELIGIBLE	COMMUNITY
	15 (MENTAL HEALTH/ PSYCHIATRIC)	ELIGIBLE	ELIGIBLE LTC
	4 (NURSING HOME/ UNIT)	ELIGIBLE	ELIGIBLE LTC
	11 PERSONAL CARE HOME)	ELIGIBLE	ELIGIBLE LTC
	12 (REST HOME)	ELIGIBLE	ELIGIBLE LTC
	16 (MR/DD)	ELIGIBLE	ELIGIBLE LTC
	17 (REHABILITATION FACILITY)	ELIGIBLE	ELIGIBLE LTC
	91 (OTHER)	ELIGIBLE	ELIGIBLE LTC
	FA1, FA3, FA5, or FA12 = DK or RF	ELIGIBLE	ELIGIBLE LTC
	IF FA12=6 AND FA16 not=1 (ANY OTHER KIND OF HOSPITAL)	ELIGIBLE	ELIGIBLE LTC
	Leave blank all others with missing MCBS Status or Place Type. No further action is required in the Facility-level Questionnaire for all Places with MCBS Status=INELIGIBLE. Then go to FA16a (PLACROST).		

PLAC.NNHESTAT
.RHPLACTY

FA16a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

BOX FA12	<ol style="list-style-type: none">1. If the Target Facility's locator code = TARGET FACILITY AND LARGER FACILITY, set MCBS status=ELIGIBLE. (Eligibility will be determined for its parts in the steps below.) Go to next place. If no remaining places, go to Item 5 below.2. If Place has locator code=PART OF TARGET FACILITY, set TENTATIVE ADDITION flag = YES for this Place and go to the next Place or Item 5 below.3. If Place has locator code=PART OF LARGER FACILITY, set TENTATIVE ADDITION flag = YES for this Place and go to the next Place or Item 5 below.4. Unless the Place is the Target Facility, set MCBS status=INELIGIBLE for this Place and go to next Place or Item 5.5. If the target facility's MCBS status=INELIGIBLE, and no Place is flagged TENTATIVE ADDITION, go to CLOSING 5. Else, loop through FA17 and FA18 for each TENTATIVE ADDITION. Else, if no TENTATIVE ADDITIONS, go to FA19 for MCBS FACILITY.
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PLAC.TASTATUS
FACA.XFACRFST
FACL.ELIGSTAT
PLAC.NNHESTAT

FA17

Would you be able to answer some questions about the certification status and bed size for {TENTATIVE ADDITION}?

YES	1
NO	0
DK	-8
RF	-7

PLAC.ANSRELIG
.XFACRFEL

BOX FA13	<p>If 1 is entered in FA17: Repeat FA17 for all TENTATIVE ADDITIONS identified; if no remaining TENTATIVE ADDITIONS, go to BOX FA14.</p> <p>If 0, -7, or -8 is entered in FA17, go to RR1, using question text from FA18 for the NAME CELL.</p>
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FA18

Who would be the most knowledgeable person to answer questions about {TENTATIVE ADDITION}?

NAME

TITLE

PLAC.XFACRFEL

FACR.FACRNAME
.FACRTITL
.FACRTIOS

BOX FA14	<p>Repeat FA17 and FA18 for each TENTATIVE ADDITION identified for this respondent. When FA17 and FA18 have been asked for all TENTATIVE ADDITIONS for this respondent, set a counter for each TENTATIVE ADDITION FOR WHICH FA17=1 (YES).</p> <p>If TARGET FACILITY is eligible, go to FA19 for target facility.</p> <p>If target facility is ineligible, and FA17=1 (YES) for Tentative Additions for this respondent, go to FA19 for first such tentative addition.</p> <p>Else, go to CLOSING 3 (p. 71).</p>
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CTRL/E OK

FA19

{{Let's turn first to {FACILITY}/{Now let's turn to {FACILITY}.}}

{How many beds does {FACILITY} have?/According to the information I obtained earlier, {FACILITY} has [READ NUMBER BELOW] beds.}

 { }
NO. OF BEDS

{PRESS ENTER TO CONTINUE.}
PRESS F1 FOR EXPANDED DEFINITION OF "BEDS".

PLAC.BEDSNUM

SUM OF BEDS STORED IN
FACA.TNHBEDS

BOX FA14A	<p>If FA12=4 (Nursing Home), go to FA20.</p> <p>If FA12=16 (MR/DD), go to FA21B.</p> <p>Else, go to FA22B.</p>
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FA20

Does {FACILITY} have any beds certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as a Nursing Facility (NF) beds?

IF R MENTIONS:

ICF-MR (INTERMEDIATE CARE FACILITY--MENTAL RETARDATION), SAY THAT YOU WILL ASK ABOUT THOSE IN A MOMENT.

YES	1
NO	0
DK	-8
RF	-7

PLAC.CAIDCRT1 FACL.MCAIDCRT .MCAIDSAQ

FA21

Does {FACILITY} have any beds certified by Medicare as SNF beds?

YES	1
NO	0
DK	-8
RF	-7

PLAC.CARECRT1 FACL.MCARECRT .MCARESAQ

FA21B

Does {FACILITY} have any beds certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds?

YES	1
NO	0

PLAC.CAIDICF FACL.ICFMRCRT

FA22

Does {FACILITY} have any beds that are {not certified by {Medicaid or Medicare} but are} licensed as nursing {home/facility} beds by the {STATE} State Health Department or by some other State or Federal agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY: _____)	2
NO, NOT LICENSED	0

PLAC.HDEPTLIC .HDEPTLOS FACL.HDLICRT

BOX FA15_1	If FA20, FA21, or FA21B = 1, go to FA22B. Else, continue.
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FA22A

Does {FACILITY} provide 24-hour a day, on-site supervision by an RN or LPN 7 days a week?

YES	1	(BOX FA15A)
NO	0	
DK	-8	
RF	-7	

PLAC.RNLPNSUP FACL.SUPRVISN

FA22B

Does {FACILITY} have any beds licensed as personal care, board and care, assisted living, or domiciliary care beds by the {STATE} State Health Department or by some other state agency?

YES, LICENSED BY STATE HEALTH DEPARTMENT	1	
YES, LICENSED BY SOME OTHER AGENCY (SPECIFY: _____)	2	
NO, NOT LICENSED	0	
DK	-8	
RF	-7	

PLAC.HDEPTPCH .HDEPTPCH .HDEPTPOS FACL.PCHLIC

BOX FA15_2	If FA20, FA21, FA21B, FA22, FA22A, and FA22B = 0, go to FA22C. Else, go to BOX FA15A.
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FA22C

In addition to room and board, does {FACILITY/ELIGIBLE UNIT} routinely provide...

	YES=1, NO=0	
Nursing or medical care?	()	
Supervision over medications?	()	
Help with bathing?	()	
Help with dressing?	()	
Help with correspondence/shopping?	()	
Help with walking?	()	
Help with eating?	()	
Help with communications?	()	

**PLAC.NORMCARE .SUPRMEDI .HELPBATH .HELPDRES .HELPWALK
 .HELPSHOP .HELPEAT .HELPCOMM FACL.PROVHELP**

BOX FA15A1	If any item in FA22C = YES (1), go to BOX FA15A after all items asked. Else, go to FA23.
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FA23

Does {FACILITY} provide 24-hour a day, on-site supervision by a caregiver 7 days a week?

YES	1
NO	0
DK	-8
RF	-7

PLAC.CARESUP FACL.PROVSUPR

BOX FA15A	Return to FA19 for next PLACE that has FA17 = 1 (YES) for this respondent. If no remaining place, go to BOX FA16.
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BOX FA16

BOX FA16	<ol style="list-style-type: none"> 1. If FA19 is less than 3, flag FACILITY/TENTATIVE ADDITION as INELIGIBLE, set Place Type = INELIGIBLE LTC, decrement counter, and go to next Place or Item 6 below. Others, go to Item 2 below. [NOTE: This means DK and REF are assumed equal to 3 or more.] 2. If FA20 or FA21 = 1 (YES, CERTIFIED BY MEDICAID OR MEDICARE) or if FA22 = 1 or 2 (LICENSED BY STATE HEALTH DEPT. OR SOME OTHER AGENCY), or FA22A=1 (PROVIDES AROUND THE CLOCK NURSING SUPERVISION AS NH) or FA22B = 1 or 2 (LICENSED BY STATE HEALTH DEPARTMENT OR OTHER AGENCY AS OTHER LONG-TERM CARE FACILITY) or FA22C = at least one "YES" response or FA23 = 1 (PROVIDES AROUND-THE-CLOCK SUPERVISION), set MCBS STATUS = ELIGIBLE and go to next Place or Item 6 below. 3. If FA20, 21, 22, or 23 = -8 or -7, decrement counter, set a flag for retrieval, ask FA18 and go to next Place or Item 6. Others go to Item 4. 4. Set MCBS STATUS = INELIGIBLE, set Place Type = COMMUNITY, decrement counter, and go to next Place or Item 6. 5. If no remaining places for this respondent, but there are other pending tentative additions, go to CLOSING 3. <p>Else,</p> <ol style="list-style-type: none"> 6. If Nursing Home (FA12=4) or other long-term care facility (FA12=8, 9, 10, 11, 12, 15, 16 or 17), If counter > 1, go to FA24PRE. If counter = 1, go to FA25. If counter = 0, go to Closing. Else, go to FA31PRE.
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FACL.ELIGSTAT

FA24PRE

All of the remaining questions will refer to {FACILITY and} {[READ FAC/UNITS LISTED BELOW]} combined.

{PLACE ROSTER VERSION 5}

PRESS ENTER TO CONTINUE.

BOX FA17 omitted.

FA24a

The questions are about the number of nursing beds and residents by payor type, special care units, and staffing. Can you answer these questions about {all/both} of these places?

- YES 1 (FA25)
- NO 0 (RR1)
- DK -8 (FA25)
- RF -7 (RR1)

FACR.ANSRFACQ
FACA.XFACRFAQ

FA24b

Who would be the best person to answer questions about [READ FACILITIES/UNITS LISTED ABOVE]?

NAME

TITLE

FACR.FACRNAME
.FACRTITL
.FACRTIOS

PROGRAMMER SPECS:

After the name and title have been posted to the Respondent Roster, go to CLOSING 6.

BOX FA16A	<p>If nursing home (FA12=4): If FA19 (NUMBER OF BEDS) never equals DK or RF and the SUM OF FA19 can be calculated, go to FA25PRE. Else, go to FA25.</p> <p>If other long-term care (FA1, FA3 or FA5= CCRC(3) or Retirement Community (5) or FA12=8, 9, 10, 11, 12, 15, 16, 17, or 91), go to FA25PRE.</p>
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FA25PRE

{From information I collected earlier, I understand that {FACILITY/[READ FAC/UNITS LISTED ABOVE]} has {SUM OF FA19, NUMBER OF BEDS IN FACILITY} nursing or long-term care beds.}

FA25

Does {FACILITY/[READ FAC/UNITS LISTED ABOVE]} have any beds that are not licensed or certified or otherwise identified as nursing or other long-term care beds?

YES	1 (FA26)
NO	0 (BOX FA18)
DK	-8 (BOX FA18)
RF	-7 (BOX FA18)

PRESS F1 FOR DEFINITION OF "OTHERWISE IDENTIFIED".

FACA.ANYBEDUL
FACL.COMPLEXF

SAMPLE LAYOUT

FA26-29
{QUESTION DISPLAY AREA}

FA26 TYPE	FA27 NAME	FA28 BEDS/ UNITS	FA29 START DATE (YY)

{DISPLAY TYPE CATEGORIES ACROSS THE SCREEN HERE.}

PLAC.PLACTYPE .PLACTPOS	.PLACNAME	.ULBEDS .BEDSUNIT .BEDSUNOS .BEDSNUM	SUM OF UNLICENSED BEDS IS STORED IN: FACA.TULBEDS FACA.TELBEDS CALCULATED AS TNHBEDS-TULBEDS	.STARTYY
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FA26

Please look at this card and tell me how you would describe the beds or units that are not certified or licensed or otherwise identified as nursing or other long-term care {home/facility} beds.

PROBE: What kind of place is it?



PRESS F1 FOR MORE ON NON-NURSING BEDS.

PLAC.PLACTYPE
.PLACTPOS

FA27

What is the name of the place or unit?
IF SAME AS TYPE, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

PLAC.PLACNAME .PLSHIFT5

FA28

How many beds or individual units are dedicated to {UNIT NAME}?

_____ ()
NUMBER
BEDS = 1
INDIVIDUAL UNITS = 2
OTHER (SPECIFY: _____) = 91

PLAC.ULBEDS **remaps to .BEDSNUM**
.BEDSUNIT
.BEDSUNOS

FA29

When did the (place/unit) begin operation?

YEAR 19()

PROBE: Any other non-long-term care beds or units?

PLAC.STARTYY

PROGRAMMER SPECS:

After all entries have been made, post all Places added in FA26 to the Place Roster; assign MCBS status = INELIGIBLE; If {FACILITY} fill in FA25 is filled with PLACENAME from Place Roster (this means there is only one eligible place), set locator code = PART OF TARGET FACILITY; else if {FACILITY} fill in FA25 is filled with "[READ FACILITIES/UNITS IN HEADER ABOVE.]", set locator code = PART OF LARGER FACILITY; set Place Type according to table in BOX FA11 (substituting FA26 for FA12 in the column heading).

PLAC.NNHESSTAT .RHPLACTY
.LOCCODE
.PLCREATE

FACA.TULBEDS = SUM OF PLAC.ULBEDS
FACA.TELBEDS = FACA.TNHBEDS - FACA.TULBEDS

FA30

So, that is a total of {NUMBER OF BEDS AND UNITS/AN UNKNOWN TOTAL OF} beds (or units) that are not licensed or certified or otherwise identified as nursing or other long-term care beds (or units). Is that correct?

YES 1
NO 0

FACA.NHBEDCOR

FA30a

FA30a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

FA31PRE

Now we are going to ask only about the parts of {FACILITY} that have beds designated as nursing or other long-term care beds.

PRESS ENTER TO CONTINUE.

BOX FA18	If FACILITY is a LARGER FACILITY or is part of a LARGER FACILITY go to BOX FA19. Others, go to FA31.
-------------	---

FA31

Which one of the categories on this card best describes the ownership of {FACILITY}?

SHOW CARD FA6

FOR PROFIT (INDIVIDUAL, PARTNERSHIP, OR CORPORATION)	1
PRIVATE NONPROFIT (RELIGIOUS GROUP, NONPROFIT CORP., ETC.)	2
CITY/COUNTY GOVERNMENT	3
STATE GOVERNMENT	4
VETERAN'S ADMINISTRATION	5
OTHER FEDERAL AGENCY	6
OTHER (SPECIFY: _____)	91

FACA.EFOWNDES
.EFOWNDOS

FA43-46
SAMPLE LAYOUT

{Question text}			
	TOTAL BEDS {MINUS INDEPENDENT LIVING BEDS}	# OF BEDS { }	# OF BEDS LEFT { }
{FA43	<u>DUALY</u> CERTIFIED NURSING HOME BEDS	()	
{FA44	MEDICAID CERTIFIED { <u>ONLY</u> }	()	
{FA45	MEDICARE CERTIFIED { <u>ONLY</u> }	()	
{FA45A	{ <u>NOT</u> CERTIFIED BUT LICENSED AS NURSING BEDS	{ }	
{FA45B	CERTIFIED AS ICF-MR	{ }	
{FA45C	NOT CERTIFIED BUT LICENSED AS OTHER LTC	{ }	
{FA45D	OTHER LTC NOT CERTIFIED OR LICENSED	{ }	ENTER 1 IF CORRECT 0 IF NOT CORRECT
FA46	{TEXT FROM FA46}		()

BOX FA19	If FA20 and FA21 both = 1, go to FA43. Others, go to BOX FA20.
-------------	---

FA43

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds and by Medicare as Skilled Nursing Facility beds. How many beds are dually certified (that is, certified by both)?

NO. OF BEDS

FACA.MANDBED

BOX FA20	If FA20 = 1, go to FA44. Others, go to BOX FA21.
-------------	---

FA44

{I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as Nursing Facility beds.} How many beds are certified under {"PREFERRED" NAME FOR MEDICAID} {or {ALLOWED FOR NAME(S) FOR MEDICAID}} only?

NO. OF BEDS

FACA.MCAIDBED

BOX FA21	If FA21 = 1, go to FA45. Others, go to BOX FA22.
-------------	---

FA45

{I have recorded that {FACILITY} contains beds that are certified by Medicare as Skilled Nursing Facility beds.} How many beds are certified under Medicare only?

NO. OF BEDS

FACA.MCAREBED

BOX FA22	If FA22 = 1 or 2, and FA20≠1 and FA21≠1, go to FA45A. Others, go to BOX FA22A.
-------------	---

FA45A

I have recorded that {FACILITY} contains beds that are licensed as nursing facility beds (but not certified by {"PREFERRED NAME" FOR MEDICAID} {(or "ALLOWED NAME(S) FOR MEDICAID)} {or} {MEDICARE}). How many beds are licensed but not certified as nursing home beds {only}?

NO. OF BEDS

FACA.MNORMBED

BOX FA22A	If FA21B=1, go FA45B Else, go to BOX FA22B.
--------------	--

FA45B

I have recorded that {FACILITY} contains beds that are certified by {"PREFERRED" NAME {FOR MEDICAID}} {(or "ALLOWED NAME(S) FOR MEDICAID)} as ICF-MR (Intermediate Care Facility for the Mentally Retarded) beds. How many beds are certified as ICF-MR beds {only}?

NO. OF BEDS

FACA.ICFMRBED

BOX FA22B	If FA22B=1 or 2, and if FA20≠ and FA21≠1, go to FA45C Else, go to BOX FA22D.
--------------	---

FA45C

I recorded earlier that {FACILITY} contains beds that are licensed as a personal care, board and care, assisted living, domiciliary care, or other type of long-term care beds. How many beds are licensed as one of these types of long-term care {only}?

NO. OF BEDS

FACA.OTLTCBED

BOX FA22D	If cannot calculate number of remaining beds, go to BOX FA22E. Others, go to FA46.
--------------	---

FA46

So, there are a total of { } LTC beds in the facility:
 {{ } are dually certified nursing beds,}
 {{ } are certified by {"PREFERRED"MEDICAID"} as nursing beds {only},
 {{ } are certified as nursing beds by Medicare {only},
 {{ } are not certified by Medicare or {"PREFERRED"MEDICAID"} but are licensed as nursing beds,
 {{ } are certified by {"PREFERRED"MEDICAID"} as ICF-MR beds,
 {{ } are licensed as personal care, assisted living, or other type of long-term care beds,
 {{ } are other long-term care beds which are neither certified or licensed}.

Is that correct?

YES 1
 NO 0

FACA.NHBEDCOR

PROGRAMMER SPECS:

The first time 0 is entered in FA46, display the following message:

BACK UP TO CORRECT. PRESS F1 FOR DETAILS.

If 0 is entered a second time, present the following message as an overlay:

PLEASE ENTER A BRIEF EXPLANATION: _____

FACA.NHBEDEX1

.NHBEDEX2

.NHBEDEX3

.NHBEDEX4

BOX FA22E	IF FA20=1 or FA21=1, or FA21B=1, go to FA47 PRE; else go to FA49.
--------------	--

FA47PRE

Next, I'm going to ask about the number of current residents having {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID}), Medicare, and private pay/{"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID}) and private pay/Medicare and private pay/private pay} as their source of payment.

If you need to go get the relevant records, I can pause for a moment.

ALLOW RESPONDENT TIME TO GATHER RECORDS, IF NECESSARY.

PRESS ENTER TO CONTINUE.

BOX FA22F	If FA20 = 1, or FA21B=1, go to FA47. Else, if FA21 = 1, go to FA48. Else, go to FA49.
--------------	---

FA47

Based on your most recent daily census, how many current residents have {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})} as a source of payment?

NUMBER OF RESIDENTS

FACA.MCAIDRES

BOX FA22G	If FA21 = 1, go to FA48. Else, go to FA49.
--------------	---

FA48

Based on your most recent daily census, how many current residents have Medicare as their primary source of payment?

NUMBER OF RESIDENTS

FACA.MCARERES

FA49

Based on your most recent daily census, how many of the current residents in {FACILITY} have private pay as their only source of payment for basic care?

NUMBER OF RESIDENTS

FACA.PRPAYRES

FA52

How many residents were in {FACILITY} altogether at midnight last night?

NUMBER OF RESIDENTS

FACA.MIDNTRES

CTRL/E OK

FA54

Next, we're interested in learning about any special care units within {FACILITY} -- units with a specified number of beds identified and dedicated for residents with specific needs or diagnoses. Does {FACILITY} have any special care units, such as those listed on this card?

SHOW
CARD
FA7

AT LEAST ONE SPECIAL CARE UNIT MENTIONED	1	
NO SPECIAL CARE UNITS	0	(BOX FA27)
DK	-8	(BOX FA27)
RF	-7	(BOX FA27)

FACA.ANYBEDSC

SAMPLE LAYOUT

FA55-56	FA57-63						
	{QUESTION DISPLAY AREA}						
(FA55)	(FA56)	(FA57)	(FA59)	(FA60)	(FA61)	(FA63)	
UNIT TYPE	UNIT NAME	PLACE TYPE	BEDS	STAFF 1=YES 0=NO	START YEAR (YY)	MCAID 1=YES 0=NO	MCARE 1=YES 0=NO
SCREEN 1	SCREEN 2						
{DISPLAY TYPE CATEGORIES ACROSS THE SCREEN HERE.}							

PLAC.UNITTYPE	.PLACNAME	.SCBEDS	.DCPSTAFF	.STARTYY	.CAIDPAY
.UNITTPOS		.BEDSNUM			.CAREPAY

FA55

SHOW
CARD
FA7

What kind of special care unit(s) does {FACILITY} have?
 PROBE: Any others?
 PRESS F1 FOR DIALYSIS DEFINITION.

PLAC.UNITTYPE .UNITTPOS

FA56

What is the name of the unit?
IF SAME AS TYPE, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

PLAC.PLACNAME
.PLSHIFT5

FA57

How many beds are dedicated to {UNIT NAME}?

NO. OF BEDS

PLAC.SCBEDS **remaps to .BEDSNUM**

FA59

Does {UNIT NAME} have direct care patient staff dedicated to it?

YES	1
NO	0

PLAC.DCPSTAFF

FA60

In what year did the unit begin operation?

YEAR 19()

PLAC.STARTYY

FA61

Is any resident's care in the unit paid for by {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID})}?

YES	1
NO	0
DK	8
RF	-7

PLAC.CAIDPAY

FA63

Is any resident's care in the unit paid for by Medicare?

YES	1
NO	0
DK	-8
RF	-7

PLAC.CAREPAY

BOX FA23	<p>If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus SUM OF BEDS in FA57 > 0, go to FA65.</p> <p>If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus the SUM OF BEDS in FA57 < 0, present the following message: THE NUMBER OF BEDS IN SPECIAL CARE UNITS (SUM OF FA57) CANNOT BE GREATER THAN THE TOTAL NUMBER OF BEDS IN THE FACILITY (SUM OF FA19). BACK UP, REVIEW ENTRIES IN FA57, FA19, AND FA13 CORRECT IF NECESSARY.</p> <p>If sum of FA19 minus SUM OF BEDS OR UNITS IN FA28 minus SUM OF BEDS in FA57 = 0, go to Box FA23a.</p> <p>Others, if FA65 and FA66 have not been asked, go to FA65. Else, go to BOX FA23a.</p>
-------------	---

FA65

{So that makes a total of {SUM OF BEDS IN FA57} special care unit beds in {FACILITY}. You told me earlier that there are {SUM OF NUMBER OF BEDS IN FA43, FA44, FA45, FA45A} certified or licensed nursing {home/facility} beds in {FACILITY} altogether.

So that leaves {DIFFERENCE/some number of} beds that are not part of a special care unit.
Is that correct?

YES	1
NO	0
DK	-8
RF	-7

FACA.SCBEDCOR

FA66

What can I call that part of {FACILITY} -- the general population unit, or do you have another name for these beds?

IF GENERAL POPULATION UNIT, ENTER SHIFT/5. FOR ANY OTHER NAME, ENTER TEXT.

**PLAC.PLACNAME .UNITTYPE .SCBEDS remaps to .BEDSNUM
.UNITTPOS**

PLAC.PLSHIFT5

BOX FA23a	<p>Post all Places added in FA55-66 to the Place Roster. Set MCBS STATUS = ELIGIBLE;</p> <p>If {FACILITY} fill in FA25 is filled with PLACE NAME from Place Roster (this means there is only <u>one</u> eligible place), set locator code = PART OF TARGET FACILITY; else if {FACILITY} fill in FA25 is filled with "[READ FACILITIES/UNITS IN HEADER ABOVE.]", set locator code = PART OF LARGER FACILITY. set Place Type = ELIGIBLE LONG-TERM CARE.</p>
--------------	---

PLAC.NNHESTAT .LOCCODE .RHPLACTY .PLCREATE

FA66a (PLACROST)

HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

{PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

BOX FA27	<p>If {FACILITY} locator code = PART OF LARGER FACILITY or PART OF TARGET FACILITY, or TARGET FACILITY, PART OF LARGER FACILITY, or TARGET FACILITY AND LARGER FACILITY go to FA77PRE.</p> <p>Others, go to FR1PRE1.</p>
-------------	--

FA77PRE

The next question is about {LARGER FACILITY} as a whole.

PRESS THE F2 KEY TO REVIEW PLACE ROSTER.

PRESS ENTER TO CONTINUE.

FA77

Which one of the categories on this card best describes the ownership of {LARGER FACILITY}?

SHOW
CARD
FA6

FOR <u>PROFIT</u> (INDIVIDUAL, PARTNERSHIP, OR CORPORATION)	1
PRIVATE <u>NONPROFIT</u> (RELIGIOUS GROUP, NONPROFIT CORP., ETC.) ...	2
<u>CITY/COUNTY</u> GOVERNMENT	3
<u>STATE</u> GOVERNMENT	4
<u>VETERAN'S</u> ADMINISTRATION	5
<u>OTHER FEDERAL</u> AGENCY	6
OTHER (SPECIFY: _____)	91

FACA.LFOWNDES
.LFOWNDOS

BOX FA28 | Go to FR1PRE1.

SECTION FB

BOX FB1A	IF THERE IS ONLY ONE PLACE ROSTER LINE FOR THIS FACILITY (AS DETERMINED IN BASELINE FQ), GO TO FB1PRE; ELSE, GO TO FBOPRE.
-------------	---

FBOPRE
HERE IS THE CURRENT PLACE ROSTER FOR YOUR REVIEW:

 {PLACE ROSTER VERSION 1}

USE ARROW KEYS. TO EXIT, PRESS ESC.

FB0A

Would you be able to answer some questions about the certification status and services offered for [READ PLACES LISTED BELOW]?

 {ELIGIBLE PARTS OF FACILITY}

YES	1	(FB1PRE)
NO	0	(FBOB)
DK	-8	(FBOB)
RF	-7	(FBOB)

FACR.ANSWERFB

FB0B

Please tell me who in [READ PLACES LISTED BELOW] could give me that information?

USE YOUR PAPER FROG TO WRITE DOWN THE NAME OF THE RESPONDENT.

PRESS ENTER TO RETURN TO FACILITY NAVIGATION SCREEN.

FB1PRE

I would like to review with you some information that I collected about {FACILITY/[READ FAC/UNITS LISTED ABOVE]} the last time I was here.
PRESS ENTER TO CONTINUE.

BOX FB2

If PLAC.CAIDCRT1 = -1, go to BOX FB4AA.
Else, if PLAC.CAIDCRT1 = 1, go to FB1.
Otherwise, go to FB2.

FB1

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicaid as a Nursing Facility (NF)?

YES	1	(BOX FB3)
NO	0	(BOX FB3)
DK	-8	(BOX FB3)
RF	-7	(BOX FB3)

FARO.CAIDSTIL

FB2

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicaid as a Nursing Facility (NF)?

YES	1	(FB3)
NO	0	(BOX FB3)
DK	-8	(BOX FB3)
RF	-7	(BOX FB3)

FARO.CAIDCERT

FB3

How many beds are certified under Medicaid as Nursing Facility (NF) beds?

OF BEDS

FARO.CAIDBEDS

FB4

Based on your most recent daily census, how many current residents have {"PREFERRED" NAME FOR MEDICAID} {(or {"ALLOWED FOR" NAME(S) FOR MEDICAID});} as a source of payment?

OF MEDICAID RESIDENTS

FARO.CAIDRES

BOX FB3 If PLAC.CARECPT1 = 1, go to FB5;
Else, go to FB6.

FB5

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicare as a Skilled Nursing Facility (SNF)?

- YES 1 (BOX FB4)
NO 0 (BOX FB4)
DK -8 (BOX FB4)
RF -7 (BOX FB4)

FARO.CARESTIL

FB6

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicare as a Skilled Nursing Facility (SNF)?

- YES 1 (FB7)
NO 0 (BOX FB4)
DK -8 (BOX FB4)
RF -7 (BOX FB4)

FARO.CARECERT

FB7

How many beds are certified under Medicare?

OF BEDS

FARO.CAREBEDS

FB8

Based on your most recent daily census, how many current residents have Medicare as their primary source of payment?

OF MEDICARE RESIDENTS

FARO.CARERES

BOX FB4	IF FACILITY WAS CERTIFIED BY BOTH MEDICAID AND MEDICARE IN LAST FQ (BOX FB2=1 AND BOX FB3=1) AND HAS NOT LOST BOTH CERTIFICATIONS (FB1 AND FB5 ≠ 0), GO TO CLOSING 1. ELSE, IF FACILITY IS NOW CERTIFIED BY BOTH MEDICAID AND MEDICARE (FB1 OR FB2=1 <u>AND</u> FB5 OR FB6=1), GO TO FB9. ELSE, IF FACILITY HAS GAINED CERTIFICATION STATUS SINCE LAST FQ (FB2=1 OR FB6=1), GO TO FB10. ELSE, GO TO BOX FB4AA.
---------	---

FB9

How many beds are certified under both Medicaid and Medicare? (That is, how many beds are dually certified?)

OF BEDS

FARO.CANDCBED

FB10

Based on your most recent daily census, how many of the current residents in {FACILITY/[READ FAC/UNITS LISTED ABOVE]} have private pay as their only source of payment for basic care?

OF PRIVATE PAY RESIDENTS

FARO.PVPAYRES

Table with 2 columns: BOX FB4AA and conditional logic for .MCAIDCRT, .MCARECRT, .CAIDICF values.

FB11

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still certified by Medicaid as an Intermediate Care Facility for the Mentally Retarded (ICF/MR)?

Table with 3 columns: YES, NO, DK, RF and corresponding values and box references.

FARO.FMRSTIL

FB12

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} certified by Medicaid as an Intermediate Care Facility for the Mentally Retarded (ICF/MR)?

Table with 3 columns: YES, NO, DK, RF and corresponding values and box references.

FARO.FMRCERT

FB13

How many beds are certified under Medicaid as Intermediate Care Facility for the Mentally Retarded (ICF/MR) beds?

OF BEDS

FARO.FMRBEDS

Table with 2 columns: BOX FB4A and instructions for ICF-MR certification and licensing.

FB46

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} still licensed as a personal care home, board and care home, assisted living facility, domiciliary care home or rest home by the {STATE} State Health Department or by some other state agency?

- YES 1 (CLOSING 1)
NO 0 (CLOSING 1)
DK -8 (CLOSING 1)
RF -7 (CLOSING 1)

FARO.PCHSTIL

FB47

Is {FACILITY/[READ FAC/UNITS LISTED ABOVE]} licensed as a personal care home, board and care home, assisted living facility, domiciliary care home or rest home by the {STATE} State Health Department or by some other state agency?

- YES, LICENSED BY STATE HEALTH DEPARTMENT 1 (FB48)
YES, LICENSED BY SOME OTHER AGENCY 2 (FB48)
NO, NOT LICENSED 0 (CLOSING 1)
DK -8 (CLOSING 1)
RF -7 (CLOSING 1)

FARO.PCHLICEN

FB48

How many beds are covered under the license?

OF BEDS

FARO.PCHBED

CLOSING 1

THANK YOU.

THE FACILITY-LEVEL QUESTIONS FOR THIS CASE ARE COMPLETE FOR THIS ROUND.

PRESS ENTER TO RETURN TO NAVIGATION SCREEN.