# Nursing Home 2020 Extraordinary Revenues and/or Expenses Survey

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## Nursing Home 2020 Extraordinary Revenues and/or Expenses Survey

NYSDOH is collecting data on specific extraordinary revenues and/or expenses included in your 2020 cost report.

These questions relate to the supplemental nursing home staffing funding totaling $187 million designated in the State Fiscal Year 2022-2023 budget, for services and expenses to increase resident facing staffing services by registered nurses, licensed practical nurses and certified nursing assistants sufficient to attain the highest practicable physical, mental and psychological well-being of each resident.

The State Plan Amendment (22-0007) has been approved by the Centers for Medicare and Medicaid Services (CMS) for the release of these funds. To ensure that all eligible nursing homes receive the designated supplemental funding, please complete this survey to allow the Department to develop and apply the methodology for releasing funds.

The information in your 2020 cost reports submitted to the Department shall be the basis for what you provide through this survey, as applicable for your nursing home.

- Facilities that filed a RHCF-4 for 2020: Based on your certified 2020 RHCF-4 report.
- Facilities that filed a RHCF-2 for 2020: Based on your 2020 audited ICR report and 2020 certified RHCF-2 report. (When utilizing the ICR only data applicable to Nursing Home Services (NH, SNF, Vent unit, Pediatric unit, etc. shall be included.)
- Facilities that filed a RHCF-1 for 2020: Based on the information required in the standard RHCF-4 full report period.

This survey must be completed and **submitted by August 20, 2024** for the Department to consider extraordinary revenues and/or expenses incurred by your facility in 2020. Submissions are subject to requests by the Department for additional information.

### Identifying Information

**Facility ID** * | **Operating Certificate ID** * | **Facility Name** * | **Reporting Period Year** *

**Street Address** * | **City** * | **Zip** *

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## Schedule A: Grant Funds for Federal Reimbursement of COVID-19 pandemic-related Expenses

Pursuant to 10 NYCRR 415.34 (b)(4), any grant funds from the federal government for reimbursement of COVID-19 pandemic-related expenses, including but not limited to funds received from the Federal Emergency Management Agency or Health Resources and Services Administration are to be excluded from "revenue".

**Did your nursing home receive any federal grant funds in 2020 for reimbursement of COVID-19 pandemic-related expenses?***

- (●) Yes
- ( ) No

As federal COVID-19 pandemic grant funds are not uniformly discernable in 2020 cost reports submitted to the Department, please provide the required information requested below to indicate the classification of these funds in your 2020 cost report (*Schedule or Exhibit, Class Code, and Line Number*). If you filed a RHCF-1 cost report in 2020, complete the chart based on information as it would be reported in the standard RHCF-4.

**Select the 2020 Report Cost type***

- ( ) RHCF-4 or RHCF-1
- ( ) ICR/RHCF-2

**Enter information into the chart below as follows:***

- Enter in one row the total dollar amount of all grant revenues reported in the same classification (Schedule or Exhibit, Class Code and Line Number).
- If the facility reported revenues from one grant program in more than one classification (Schedule or Exhibit, Class Code, and Line Number), those revenues should each be entered in separate rows below.
- Within each classification (Schedule or Exhibit, Class Code and Line Number) identify all applicable federal grant programs, separated by commas (e.g., FEMA, HRSA, etc.).

**Cost Report Classification**

| Schedule or Exhibit | Class Code | Line Number | Total Funding $ Amount within Classification | Grant program(s). If multiple programs, list each separated by commas. |
|---|---|---|---|---|
| | | | | |
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# Nursing Home 2020 Extraordinary Revenues and/or Expenses Survey

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**Schedule B – Revenues and Expenses Due to Declared Natural Disaster**

Under the following circumstances, a facility can apply to have revenues and expenses excluded from the assessment of their compliance:

- If the facility incurred revenues and expenses due to a natural disaster, where a federal, State, or local declaration of emergency has been issued (10 NYCRR 415.34(d)(3)(i)).

## Revenues and Expenses Due to Declared Natural Disaster

***Schedule B is not intended for requests*** *to exclude revenues from federal grant funds for reimbursement of COVID-19 pandemic-related expenses per 10 NYCRR 415.34 (b)(4).To request exclusion of such federal grant funds complete Schedule A instead.*

**Is the facility applying, on the basis of a "natural disaster" (10 NYCRR 415.34(d)(3)(i)), to have certain revenues and/or expenses reported in the facility's 2020 cost report excluded from the Department's assessment of their compliance with 10 NYCRR § 415.34(d)? For this purpose, "natural disaster" means, flooding from natural waterway, earthquake, hurricane, tornado, high water, landslide, mudslide, wind, storm, wave action, volcanic activity, or drought.***

- (●) Yes (To request that such revenues be excluded, you must provide the required information. )
- ( ) No

**Identify the natural disaster(s) that impacted the facility.***

**Identify the authority that declared the event a natural disaster. Select one.***

- ( ) Federal
- ( ) State
- ( ) Local Authority having Jurisdiction

**Provide a narrative describing the impact of the natural disaster(s) on the facility.** *

**Describe how the disaster cited above led to the revenue gained or expenses incurred.** *

**Select the 2020 Report Cost type** *

○ RHCF-4 or RHCF-1 ○ ICR/RHCF-2

**Please outline the revenue and/or expenses related to the natural disaster cited above, which you are requesting be excluded, as they were reported in your 2020 cost report submission.**

- **All revenue and expenses should be provided pursuant to the definitions and standards cited in 10 NYCRR 415.34, or if not specified therein, as established in 10 NYCRR Subpart 86-2 or 10 NYCRR Chapter V Subchapter A, Articles 8 and 9, as they pertain to financial reporting standards for a Residential Health Care Facility.**
- **Select each applicable row and provide the total applicable amount**.

## Nursing Home Revenues

**Net Patient Services Revenue (revenue from, or on behalf of, residents)**

- ICR/RHCF-2 Filers ( 2020), please reference ICR Exhibit 46 - Patient Services Revenue - Part II - Inpatient Services
- RHCF-4 and RHCF-1 (2020) Filers, please reference Schedule 7 Analysis of Net patient Revenue & Total Operating Revenue

**Net Patient Services Revenue $ Amount:** *

**All Other Operating Revenue**

- ICR/RHCF-2 Filers (2020), please reference ICR Exhibit 26A - Statement of Revenues and Expenses, Class Code/Line Number 0037/100
- RHCF-4 and RHCF-1 (2020) Filers, please reference Schedule 7 Analysis of Net patient Revenue & Total Operating Revenue, Class Code/Line Number 0161/15

**All Other Operating Revenue $ Amount:** *

## Nursing Home Expenses

**Total Non-Operating Expenses**

- ICR/RHCF-2 Filers (2020), please reference ICR Exhibit 26A - Statement of Revenues and Expenses, Class Code/Line Number 0037/204
- RHCF-4 and RHCF-1 (2020) Filers, please reference Exhibit E Statement of Revenue & Expenses, Class Code/Line Number 11/74

**Total Non-Operating Expenses $ Amount:** *

**Total Operating Expenses** *

- ICR/RHCF-2 Filers (2020), please reference the ICR Medicaid Ancillary Stepdown
- RHCF-4 and RHCF-1 (2020) Filers, please reference Exhibit E Statement of Revenue & Expenses, Class Code/Line Number 11/50

**Total Operating Expenses $ Amount:** *

**Do your Total Operating Expenses entered above include Direct Resident Care Expenses or Resident Facing Staffing Expenses?***

- (●) Yes
- ( ) No

**Direct Resident Care Expenses Breakdown**

- ICR/RHCF-2 (2020) Filers , please complete using the comparable cost centers in the corresponding ICR, and enter the numeric cost center code used in either **Exhibit 11- Detail of Specific Hospital Service Expenses** and/or **Medicaid Cost/Ancillary Stepdown**.
- RHCF-1 (2020) Filers, complete the chart based on information as it would be reported in the standard RHCF-4.

| Direct Resident Care Expense | RHCF-4 Class Code/Line Number | ICR Cost Center Code (s) | $ Amount |
|---|---|---|---|
| Plant Operation & Maintenance | 44/6 N | | |
| Laundry and Linen | 44/9 N | | |
| Housekeeping | 44/11 N | | |
| Patient Food Service | 44/6 N | | |

| | | | |
|---|---|---|---|
| Nursing Administration | 44/13 N | | |
| Activities Program | 44/14 N | | |
| Nonphysician Education | 44/15 N | | |
| Medical Education | 44/16 N | | |
| Medical Director's Office | 44/17 N | | |
| Social Service | 44/21 N | | |
| Transportation | 44/22 N | | |
| Laboratory Services | 44/31 N | | |
| Electrocardiology | 44/32 N | | |
| Electroencephalogy | 44/33 N | | |
| Radiology | 44/34 N | | |
| Inhalation Therapy | 44/35 N | | |
| Podiatry | 44/36 N | | |
| Dental | 44/37 N | | |
| Psychiatric | 44/38 N | | |
| Physical Therapy | 44/39 N | | |
| Occupational Therapy | 44/40 N | | |

| | | | |
|---|---|---|---|
| Speech/Hearing Therapy | 44/41 N | | |
| Pharmacy | 44/42 N | | |
| Central Service Supply | 44/43 N | | |
| Medical Staff Services | 44/44 N | | |
| Ancillary - Other | 44/45 N | | |
| Ancillary - Other | 44/46 N | | |
| Ancillary - Other | 44/47 N | | |
| RHCF | 44/51 N | | |
| Adult Care Facility | 44/53 N | | |
| I.C.F. Mental Retardation | 44/54 N | | |
| Independent Living | 44/55 N | | |
| Outpatient Clinics | 44/57 N | | |
| ADHC 1 | 44/58 N | | |
| Home Health Care | 44/59 N | | |
| Meals on Wheels | 44/61 N | | |
| Barber & Beauty Shops | 44/67 N | | |
| Other | 44/69 N | | |
| Pediatric | 44/71 N | | |

| | | | |
|---|---|---|---|
| Head Injury | 44/72 N | | |
| AIDS | 44/73 N | | |
| Long Term Ventilator | 44/74 N | | |
| Respite Care | 44/75 N | | |
| Behavioral Intervention | 44/76 N | | |
| Neurodegenerative | 44/77 N | | |
| ADHC 2 | 44/80 N | | |

**Resident Facing Staffing Expenses – Breakdown**

- ICR/RHCF-2 (2020) Filers , please complete using the comparable cost centers in the corresponding ICR, and enter the numeric cost center code used in either **Exhibit 11- Detail of Specific Hospital Service Expenses** and/or **Medicaid Cost/Ancillary Stepdown**.
- RHCF-1 (2020) Filers, complete the chart based on information as it would be reported in the standard RHCF-4.

| Resident Facing Staffing Expenses – Breakdown | Total Type | RHCF-4 Class Code/Line Number | ICR Exhibit 11 Class Code/Line Number | $ Amount |
|---|---|---|---|---|
| Salaries & Wages | Ancillary Total | 34/50 N | | |
| Salaries & Wages | Program Total | 34/90 N | | |
| Employee Benefits | Ancillary Total | 36/50 N | | |
| Employee Benefits | Program Total | 36/90 N | | |
| Fees | Ancillary Total | 37/50 N | | |
| Fees | Program Total | 37/90 N | | |

| | | | | |
|---|---|---|---|---|
| **Purchased and Contracted Services** | **Ancillary Total** | **39/50 N** | | |
| **Purchased and Contracted Services** | **Program Total** | **39/90 N** | | |

**If Fees or Purchased and Contracted Services were entered above, provide the total spent for services provided by registered professional nurses, licensed practical nurses, or certified nurse aides through a contractual or other employment agreement.**

$ 0.00

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# Nursing Home 2020 Extraordinary Revenues and/or Expenses Survey

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## Schedule C – Extraordinary, Nonrecurring Revenue

***Schedule C is not intended for*** *requests to exclude revenues from federal grant funds for reimbursement of COVID-19 pandemic-related expenses per 10 NYCRR 415.34 (b)(4). To request exclusion of such federal grant funds, complete Schedule A instead.*

**Under the following circumstance, a facility can apply to have revenues excluded from the assessment of their compliance:**

- If the facility received extraordinary, non-recurring revenue which, in the discretion of the Commissioner, does not accurately reflect operating revenue for the purposes of this rule, including but not limited to revenue received through insurance or legal settlements (10 NYCRR 415.34(3)(d)(ii).

**Is the facility applying, on the basis of the facility receiving "extraordinary, nonrecurring revenue" (10 NYCRR 415.34(3)(d)(ii)), to have certain revenues reported in the facility's 2020 cost report excluded from the Department's assessment of their compliance with Title 10 Section 415.34(d)?** *

- (●) Yes
- ( ) No

**Select the 2020 Report Cost type***

- ( ) RHCF-4 or RHCF-1
- ( ) ICR/RHCF-2

**Enter each revenue received as one transaction in the chart below. (If the facility receives a settlement in their favor, each settlement would be one transaction)***

- In the first column, briefly describe the revenue received (transaction). For example, "Resolution of Facility vs. Insurer".
- In the next two columns, provide the class code and line number in the cost report for the relevant compliance year that includes this revenue.
- In the fourth column provide the specific amount of revenue to be excluded based on this transaction and in the fifth column, provide the date received.

The Department reserves the right to request and inspect any documents related to any transactions listed below.

| Transaction | Class Code | Line Number | Amount | Date |
|---|---|---|---|---|
| | | | | mm/dd/yyyy |
| | | | | mm/dd/yyyy |
| | | | | mm/dd/yyyy |
| | | | | mm/dd/yyyy |
| | | | | mm/dd/yyyy |

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## Operator's Certification Instructions

**Pursuant to 10 NYCRR Section 86-2.6(a) this certification must be signed by an individual authorized to bind the Operator, such as a partner, officer, or director of the Operator. Please enter only one signature.**

Certification

I certify that:

I have examined the information provided in the Nursing Home 2020 Extraordinary Revenues and/or Expenses Survey, and that all statements, data and information transmitted in it are true, accurate and complete to the best of my knowledge; no material fact has been omitted.

I understand that funds, if any, that may be paid as a result of information supplied here will be from federal, state and local public funds, and that I may be fined and/or prosecuted under applicable federal and state laws for any violation of the terms of this certification, including but not limited to false claims, statements or documents, or concealment of a material fact.

I also understand that failure to provide complete information, to the satisfaction of the Department, may result in the facility not receiving any of the supplemental funding that the facility might otherwise be eligible under the above-mentioned subpart.

**Name** *

**Signature***

Reset

Sign above

**Date*** mm/dd/yyyy

**Official Title within the Organization** *

**Email***

**Phone Number***

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Submit