

Revised December 2014

**STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY**

INSTRUCTIONS

NURSING FACILITIES MONTHLY REPORT PURSUANT TO NRS 422.3755

FEE ASSESSED TO INCREASE THE QUALITY OF NURSING CARE

- ❖ **When fees are paid by check, the Report must accompany the check**
- ❖ Reports must be filed by email or fax when payment of the fee is made by EFT
 - ✓ EFT must be set up with the Division prior to utilizing this method

Per NRS 353.1467, payments of \$10,000 or more from non-governmental entities are to be made by electronic transfer
- ❖ The report and payment are due 30 days after the end of the month being reported
- ❖ Payment must be postmarked at least 3 days, not including Sunday, before the due date
- ❖ Penalties and interest are outlined in the regulations

GROSS REVENUE

1. Gross revenue for services provided to patients
Include only revenue earned from services directly related to patients (such as physical therapy, transportation, pharmacy etc. as well as charges for nursing services)
2. Less Contractual Allowances and Discounts on Patient Accounts
This is any discounts you give to payers, e.g., Patients gets a discount for paying up front and in cash or the facility is contracted with an insurance company to give a discounted rate.
3. Net Patient Service Revenues. Line 1 minus line 2 (automatically calculates)

DAYS OF CARE PROVIDED

4. Number of **Medicaid** days (including Medicaid Managed Care days) provided during the month. This is any patient who is currently eligible for Medicaid and is not receiving any Medicare reimbursement for skilled nursing services.
5. Number of **Medicaid** Hospice days provided during the month. A patient whose long-term hospice care is being reimbursed by Medicaid.
6. Number of Pending **Medicaid** days (including Medicaid Managed Care days) provided during the month. Patients that are pending Medicaid enrollment and are not Medicare.
7. Number of **Medicare** days, including Managed Care and cross-over days. Patients who are eligible for Medicare paid skilled nursing facility days. Days that Medicare is paying any part of the per diem rate.
8. Number of **Medicare** Hospice days provided during the month. A patient whose nursing facility bed is paid for by Medicare and not reimbursed by Medicaid.

9. Number of all **Other** patient days. Patients with private insurance, patient pay, or are not accounted for in the above counts.
10. Total Patient Days. Total of lines 4-9 (automatically calculates).
11. All non-Medicare Days. Sum of lines 7 and 8 are subtracted from line 10 (automatically calculates). Total days the tax is based on.

Please note that days reported should be a snapshot of the report month and not a running total with prior months' days included. All facilities will have the opportunity to adjust their pending days during base quarter reviews.

FEE CALCULATION

12. The fees due equal the established rate times the number of days on line 11 (automatically calculates).
13. Calculation for any late penalty at 1% of fee for each day payment is late up to 10 days.
14. Calculation for any penalty for payment more than 10 days late. Calculate the interest at 1.5% per month for each month or fraction of a month (in addition to the penalty in line 13).
15. Adjustment Amount if there was an over or underpayment in a previous month.
16. Reason for the Adjustment.
17. Sum of lines 12 through 15, equals Total Amount Remitted (automatically calculates).

PERSON COMPLETING THE REPORT

- ❖ Please provide the name, title, e-mail address and phone number.

ADMINISTRATOR'S INFORMATION & SIGNATURE

- ❖ Please provide the name, title, e-mail address and phone number.

ELECTRONIC FILING

- ❖ When filing electronically, a letter must be sent to the Division, authorizing the e-mail address and/or electronic signature to be used.
- ❖ A renewal letter must be filed every January or when personnel changes take place.

Please contact Sarah Spohn at 775-684-3621 or Sarah.Spohn@dncfp.nv.gov with any questions. If you are paying by electronic funds transfer, email your invoice to Sarah Spohn, Keturah Stanford and our direct deposit email. The email addresses are Keturah.Stanford@dncfp.nv.gov, Sarah.Spohn@dncfp.nv.gov, and directdeposit@dncfp.nv.gov

Sincerely,



Janice Prentice
Chief, Reimbursement Analysis and Payment Unit

STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
1100 EAST WILLIAM STREET, SUITE 101
CARSON CITY, NV 89701

775-684-3791

FAX 775-684-3773

NURSING FACILITIES MONTHLY REPORT
and
FEE ASSESSED TO INCREASE THE QUALITY OF NURSING CARE

MEDICAID PROVIDER NUMBER / DATE-MM/DD/YYYY	MONTH-YEAR

FACILITY NAME	
LOCATION	
MAILING ADDRESS	

GROSS REVENUE	DIVISION USE ONLY
1 Gross revenue for services provided to patients	
2 Less Contractual Allowances and Discounts on Patient Accounts	
3 Net Patient Service Revenues	
DAYS OF CARE PROVIDED	
4 Medicaid Patient Days	
5 Medicaid Hospice Patient Days	
6 Pending Medicaid Days	
7 Medicare Patient Days	
8 Medicare Hospice Patient Days	
9 Other Patient Days	
10 Total Patient Days	
11 All non-Medicare days on which the fee is calculated	

FEE CALCULATION	
12 Fee X fee	
ADD IF PAYMENT IS LATE OR ADJUSTMENT TO PAYMENT IS REQUIRED	
13 Penalty at 1% of fee for each day payment is late up to 10 days	
14 Interest at the rate of 1.5% per month or fraction of a month	
15 Adjustment (Correction of under or over payment for previous month)	
16 Reason for Adjustment:	
17 TOTAL AMOUNT REMITTED to Division of Health Care Financing & Policy	

Person Completing Report			
Name	Title	e-mail address	Phone Number

Administrator's Information & Signature			
Name/Type or Print	Signature	e-mail address	Phone Number

Questions please contact Sarah Spohn at Sarah.Spohn@dncfp.nv.gov.