



[Sample Form](#) -- Click here to print sample form.

INSTRUCTIONS FOR PART II - RESIDENTS

SECTION I. DAYS OF OPERATION

- a. Number of residents in the facility from January 1st through December 31st. Count each resident once.
- b. Select the checkbox if there were no residents for the 6 month period. After "SAVE", a comment box will be displayed to enter the reason for no residents. Saving the comments will forward you to the last page to submit this form.

SECTION II. RESIDENT STATISTICS

All totals must agree with Section II, item 10 under Resident Census of Part I for NF/NFMH, ALF/RHCF and home plus facilities; Section II, item 11 for individuals with intellectual disabilities facilities; totals in Section II, items 1-3 and Section III of this form.

1. Number of residents by age group and gender in facility on December 31st.
2. Number of residents in facility on December 31st in specified location prior to initial admission
 - Where did the resident live the day before they were initially admitted to the facility?
3. Number of residents in facility on December 31st by primary source of payment.
 - Primary payment source is entity that pays the greatest percentage of cost.
 - Count resident's payment source on December 31st.
 - If a resident is a Medicaid beneficiary and receives services from hospice, record source of payment as Medicaid. If a resident is a Medicare beneficiary and receives services from hospice, record source of payment as Medicare.

SECTION III. NUMBER OF RESIDENTS IN FACILITY ON DECEMBER 31ST BY COUNTY OF RESIDENCE AT THE TIME OF INITIAL ADMISSION TO FACILITY

The total of all counties must agree with Section II, item 10 under Resident Census of Part I for NF/NFMH, ALF/RHCF and home plus facilities; Section II, item 11 for individuals with intellectual disabilities facilities; with totals in Section I, items 7-8 and Section III of this form.

SECTION IV. SERVICES AND CARE PROVIDED BY OR IN FACILITY OFFERED ON DECEMBER 31ST

4. Services facility offered to individuals other than residents. Check appropriate box(es).
5. Special care units in facility.
 - "Capacity" is number of beds designated for special care unit.
6. Hospice services provided by a certified provider.
 - If answer is "yes", number of certified hospital providers caring for residents in facility on December 31st.
7. Universal of multi-task employee(s).
 - Does the facility have such an employee position?
 - If answer is "yes" check appropriate box(es) identifying tasks performed.

COMPLETE AND SUBMIT PART II

When submitted, a validation will compare all totals in Section II and III to the Resident Census entered in Section II of Part I. If Part I has not been submitted, a comparison cannot be done.

- Enter the date and click on the “Submit Form” button.
- Successful completion closes the form and returns to the facility home page. To view the form go to the facility statistical reports section at the bottom of the facility home page and click view in the form status column.
- If Part II cannot be submitted because of errors that cannot be immediately corrected, the form can be accessed later through the facility home page. Go to facility statistical reports section at the bottom of the page and click edit in the form status column to open the form for correction and submission.

Submitting Part II is considered the legal signature and title of the individual authorized to represent the governing body, corporation, partnership, joint venture, individual or organization in the operation of this facility.