

**INSTRUCTIONS SEMI-ANNUAL REPORT
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED**

ADOBE ACROBAT FORM INSTRUCTIONS: IF YOU ARE COMPLETING THE ADOBE ACROBAT VERSION OF THIS FORM, PLEASE NOTE THESE ADDITIONAL INSTRUCTIONS. To move through this interactive form use either the mouse button to place the cursor in a field or use the “Tab” key to place the cursor in the first field and then sequentially move through the other fields. Use “Shift-Tab” to move backwards. To print this form use the “PRINT” button at the bottom of the form.

FACILITY INFORMATION: Insert Facility Name, Street Address, City, State, Zip+4, Licensure Type, State ID Number as indicated.

If the information is not correct according to your records please contact Rita Bailey at (785) 296-1259.

Refer questions to Sandra Dickison, LCE, (785) 296-1245.

Complete information for Six Month Reporting Period except for Items 11, 12, 13, & 14. The instructions for completion of this form are specific only to this report and do not apply to any other required federal and/or state reports.

SECTION I. DAYS OF OPERATION

- a. Answer “YES” if facility was in operation for all days of six-month period. (Go to Section II) Answer “NO” if facility was not in operation one or more days of six-month period.
- b. If answer was “NO”, record number of days facility was in operation during six-month period.

SECTION II. RESIDENT CAPACITY Enter number of resident beds indicated on facility license.

SECTION III. RESIDENT INFORMATION Do not include residents in Adult Day Care in this section.

1. Total Number of Days of Resident Care in Facility

- Count day of admission to facility.
- Count day of death if resident died in facility and before midnight.
- Do not count day of admission to hospital, hospitalization day(s), or bed hold day(s).
- Do not count day of discharge.
- Do not count day (s) of temporary leave/visits of 150 days or less.
- Total Days of Resident Care are calculated as follows. Example: During 181 days of six-month reporting period, facility had 60 residents for 85 days and 58 residents for 96 days, $(60 \times 85) + (58 \times 96) = 10,668$ days of care.

2. Total Admissions

- Count both initial and readmission.
- Include residents admitted for Respite Care (item 2).
- Include residents admitted for Hospice Care provided by a certified Hospice Provider (item 3).

3. **Discharges to hospital**
 - **Count** resident(s) admitted to hospital or psychiatric hospital. Include resident(s) on bed-hold.
 - **Include** Hospice or Respite care residents admitted to hospital.
 - **Include** resident(s) who died while in hospital.
4. **Discharges by death**
 - **Do not count** resident(s) who died in hospital.
5. **Discharges to a swing bed unit, hospital LTC unit, Nursing Facility or Nursing Facility Mental Health**
6. **Discharges to a Home and Community Based Program**
7. **Discharges to a State Institution** – Parsons State Hospital and Training Center or Kansas Neurological Institute
8. **Discharges to another ICFMR**
9. **Other Discharges.**
 - **Do not** include discharges listed in items 5,6,7, and 8.
 - **Include** resident(s) who leave facility for **151 or more days** to visit elsewhere.
10. **Total Discharges. Add items 5,6,7,8, and 9.**
 - **If completing interactive version of form, this total will be calculated automatically.**
11. **Resident Census on last day of reporting period**
 - **Count** resident(s) admitted on that date.
 - **Count** resident(s) who died in facility before midnight on that date.
 - **Do not count** resident(s) on Temporary Leave/Visits for 150 days or less.
 - **Do not count** resident(s) discharged on that date.
 - **Do not count** resident(s) in hospital, including those on bed hold on that date.
12. **Resident Census for 24 hour period, 12:00 AM to 11:59 PM, on each day of reference week**
 - If the facility was not in operation during reference week, use census from last full week of reporting period.
 - These instructions do not change how you are to report reserve days or census information for Medicaid purposes.
 - **Do not count** residents who are hospitalized.
 - **Do not count** resident who are on temporary leave/visit.

SECTION IV. SELECTED STAFFING INFORMATION during reference week

- If the facility was not in operation during reference week, use staffing information from last full week of reporting period.
 - Complete all blanks. If nothing to report, enter zero.
13. **Number of Selected Staff during reference week**
 - **Fulltime** is defined as at least 35 hours per 40-hour workweek.
 - **Professional Program staff** is defined as licensed staff e.g. social worker, OT, PT, psychologist, dietitian.
 - **Count** full-time and part-time employees on facility payroll.
 - **Count** full-time and part-time staff provide through outside staffing agencies.
 - **Count** employees and staff on orientation.

14. Number of Actual Whole Hours Worked by Selected Staff on each day of reference week

- Report number of hours worked in whole numbers only.
- If facility uses two 12 hours shifts per day, report hours as though facility uses three 8-hour shifts.
- **Count** consultant hours if services provided in facility during the week.
- **Count** hours of work of all employees on payroll and staff provided through outside staffing agencies.
- **Count** hours of work of employees and staff on orientation.
- **Administrator/QMRP** must sign, date, and (if applicable) provide his/her administrator number at bottom of Section IV. Please provide contact telephone number and e-mail address for administrator/operator.