Center for Health Information and Analysis
Nursing Facility Quarterly User Fee Assessment Form Instructions

The Center for Health Information and Analysis (Center) Nursing Facility Quarterly User Fee Assessment Form is used to calculate your facility's user fee assessment in accordance with regulation 114.5 CMR 12.04(1) & (2). All Class I, II, III and IV Massachusetts Nursing Facilities that are licensed by the Department of Public Health under Chapter 111 Section 71 of the Massachusetts General Laws, including nursing facilities, transitional care units, etc., are required to file. For any questions, please call the Center's Help Desk at 1-617-988-3297.

Due Dates	
Assessment period	**Payment and Form Due Date**
July 1 – September 30	November 1
October 1– December 31	February 1
January 1 – March 31	May 1
April 1 – June 30	August 1

The Nursing Facility Quarterly User Fee Assessment Form can be accessed on DHCFP-INET at https://dhcfpinet.hcf.state.ma.us/inetn/ , the Center's web-based reporting tool. Prior to filing the form electronically, you must complete two verification forms to log-in to INET: the non-confidential data security and nursing facility user agreements.

You can access these forms at http://www.mass.gov/chia/inet/ and clicking on "INET Questions and Answers". These forms must be submitted at least ten days before the due date in order to process the application. Completed forms can be scanned and emailed to patty.mccusker@state.ma.us or faxed to 617-727-7662 with a cover sheet to the attention of Patricia McCusker. Following receipt of your electronic documents you will receive an email to confirm receipt of scanned documents. If you cannot submit the forms via email or fax, you can mail paper copies to:
Center for Health Information and Analysis
Two Boylston Street
Boston, MA, 02116
Attn: Patricia McCusker.

I. Total Nursing Patient Days for the Quarter Ending _____

Total Qtr NH Patient Days: Patient Day. A day of care provided to an individual patient by a Facility. A Patient Day includes the date of admission and the date of discharge if both occur on the same day. All Reserved Vacant Bed Days held, except for the period of September 1, 2003 – June 30, 2004, should be included. A Patient Day does not include the date of discharge or days of service to Residential Care residents. Effective 2/1/05, PACE and MassHealth SCO days are considered Massachusetts Medicaid days. Hospice days should be reported based on the patient day definition in regulation 114.5 CMR 12.02. A Patient Day includes any day that has not yet been reimbursed by the insurer. The days reported on the Quarterly Assessment form should agree with the days reported on the HCF-1 cost report for that period.

Enter the patient days into the proper patient day classification. Column 7 is the sum on columns 1 – 5 only. Do not include Medicare days in the total.

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II. Calculation of the Nursing Facility User Fee Assessment: Effective July 1, 2010

Facility Class	Criteria	User Fee Effective 7/1/10
Class I	All facilities that do not qualify for classes 2 – 4.	$18.41
Class II	Non-profit continuing care retirement communities and residential care facilities.	$1.84
Class III	Non-profit nursing facilities that participate in the Medicaid program and that provided more than 66,000 annual Medicaid bed days in FY2005.	$1.84
Class IV	Facilities that: (1) have 100 or fewer licensed beds; and (2) were established and licensed in Massachusetts prior to the enactment of the Health Insurance for the Aged Act, Pub. L. 89-97, Title I, 79 Stat. 290, and the Medicaid Act, Pub. L. 89-97, Title I, §121(a), 79 Stat. 343, on July 30, 1965; and (3) are not participating in either of the Medicare or Medicaid programs. In addition, Class IV includes homes located in Essex, Middlesex, and Suffolk counties that meet criteria (1) and (2) above but that do participate in the Medicaid program.	$0.00

Total Qtr Non-Medicare Days (col. 7): Using the grid above, please enter the number of Non-Medicare Days reported in column 7 of the table in Section I onto the designated line in Section II according to your facility's class.

NH User Fee: Please enter the product of the reported *"Total Qtr Non-Medicare Days"* multiplied by the *"User Fee Rate"* on the designated *"NH User Fee"* line.

III. Comments: Please enter any additional pertinent information that you would like the Center to be aware of, such as changes in beds, significant changes in days, prior period adjustments for the reclassification of days by payer type made in the current reporting quarter, etc. You may be prompted to explain why your facility's reported days are less than anticipated. Use this section to explain the variance. Attach additional comment pages to this form if necessary. Please enter the facility name, vendor payment number and quarter ending date on the top of each additional comment page attached to this form.

Owner, Partner, Officer or Administrator Information: Please check all of the information carefully prior to signing this form. Once you are satisfied that the information reported on the form is accurate to the best of your knowledge, sign your name, enter the date, enter your name and title on the designated lines.