Nursing Facilities COVID - 19 Impact Survey

Page description:
The Ohio Department of Medicaid is reaching out to Nursing Facilities (NFs) to obtain information on the financial impact from COVID-19. Please provide the following information by end of the business day, Thursday, April 9, 2020. Thank you for your cooperation.

Name of Facility *

Medicaid Provider Number: *

County *

Name of Individual who completed survey: *

E-mail Address: *

(untitled)

1. What is your census as of midnight 4/8/2020? *

Medicaid

Medicare

VA

Private

2. What is your current revenue per day (census x per diem)? *

Medicaid

Non-Medicaid

3. Have you seen a recent decrease in daily revenue? *

- Yes
- No

If yes, how much and why?

	Reason for decrease	Cost of decrease (Dollar amount)
1		
2		
3		

4. Have you experienced a recent increase in daily costs? *

- Yes
- No

If yes, how much increase have you experienced and why?

	Reason for increase	Cost of increase (Dollar amount)
1		
2		
3		

5. Have you experienced changes with vendor relationships (e.g., vendors fearful of COVID-19 exposure, need for additional contracted services, etc)? *

- Yes
- No

Please describe and quantify the cost of the changes.

	Reason for change in relationship	Cost of changes (Dollar amount)
1		
2		
3		

(untitled)

For all the following, please indicate whether you have had a cost increase or decrease and quantify the approximate amount. Check all that apply: *

	Increase	Decrease	No Changes
Staffing	○	○	○
Transportation	○	○	○
PPE including googles, gowns, masks, gloves, hand sanitizer, sanitizing wipes	○	○	○
Other	○	○	○

6. If you experienced a recent loss in staff, how many full time employees have you lost? *

- ○ 0-5
- ○ 6-11
- ○ 11-20
- ○ >20, please specify number

What was the reason(s) for the loss of staff? Please check all that apply: *

- ☐ Illness
- ☐ For quarantining
- ☐ Dependency issues
- ☐ Staff resignations

Please explain any related cost to the decrease in staff.

	Reason for decrease	Cost of decrease (Dollar amount)
1		
2		
3		

7. If you had an increase in staff, how many more staff members have you hired? *

- 0-5
- 6-10
- 11-20
- >20, please specify number

How many additional hours per day have you been paying new staff? *

- 0-40
- 41-80
- 81-120
- >120, please specify additional hours

Please explain any related cost to the increase in staff.

	Reason for increase in staff	Cost of increase (Dollar amount)
1		
2		
3		

8. If you had an increase in expenditure for transportation, please specify the reason(s) and average increase per day.

	Reason for increase	Cost of increase (Dollar amount)
1		
2		
3		

If you had an decrease in expenditure for transportation, please specify reason(s) and average decrease per day.

	Reason for decrease	Cost of decrease (Dollar amount)
1		
2		
3		

9. Please specify what Personal Protective Equipment (PPE) including googles, gowns, masks, gloves, hand sanitizer and sanitizing wipes you saw an increase in and the services they are associated with.

	PPE	Service
1		
2		
3		

For the cost increases cited above, please specify what your estimated daily cost is.

	Reason for increase	Cost of increase (Dollar amount)
1		
2		
3		

If you had an decrease in expenditure for PPEs, please specify reason(s) and average decrease per day.

	Reason for decrease	Cost of decrease (Dollar amount)
1		
2		
3		

10. Have you experienced any other increases or decreases in expenditures not previously specified (e.g., biohazard medical waste disposal)? *

- [ ] Increase in expenditure, please specify type

*

- [ ] Decrease in expenditure, please specify type

*

If there are increases, please describe the service(s) and quantify those expenditures.

	Service	Cost of increase (Dollar amount)
1		
2		
3		

If there are decreases, please describe the service(s) and quantify those expenditures.

	Service	Cost of service (Dollar amount)
1		
2		
3		

(untitled)

11. On a daily basis, please describe and quantify in dollar amounts any other new or increased costs attributable to COVID-19 not previously addressed. Indicate NA if there are no new or other increased costs.

	New or increased cost	Dollar amount
1		
2		
3		
4		
5		