E. FACILITY CHARGES

[E1-E10 NOT ASKED THIS VERSION.]

E11. Now, I would like to know about all facility charges for (SP) since [PREVIOUS ROUND END BILL DATE/ ADMISSION DATE]. Through what date up to (END DATE) do you have records for all facility charges?

FCHGENDM / **FCHGENDD** / **FCHGENDY** (ENTER ON FLAP AS END BILL DATE)
MONTH DAY YEAR

FACILITY CHARGE INFORMATION NOT AVAILABLE ..... 2 (SECTION F) **FCHG.FCHGAVAI**

BOX E1	ASK RESPONDENT FOR BEGINNING AND ENDING DATES FOR EACH BILLING PERIOD OCCURRING BETWEEN PREVIOUS ROUND END BILL DATE/ADMISSION DATE AND THE CURRENT END BILL DATE LISTED IN E11. BEGINNING WITH THE EARLIEST PERIOD, RECORD BEGINNING AND ENDING DATES FOR EACH PERIOD IN THE PERIOD COLUMN HEADINGS IN THE GRID BELOW. ASK E12, E13, and E13a FOR EACH PERIOD LISTED; THEN PROCEED WITH BOX E2. IF MORE THAN 4 PERIODS ATTACH SUPPLEMENTAL BILLING PERIOD PAGES.	PERIOD #5 **FBILBEGM**, **FBILBEGD**, **FBILBEGY** FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR **FBILENDM**, **FBILENDD**, **FBILENDY**

E12.	What would have been the total basic charges for a private-pay resident for the period from (DATE) to (DATE)? [The total basic charge will typically include room and board and some nursing care.] **NOPRIVPY**	E12. $ **FTOTBASE** _____._____ FACILITY HAS NO PRIVATE PAY..... 1
E13.	Including all sources of payment, what was the total payment for (SP's) basic charge for the period from (DATE) to (DATE). a. Please look at this card and tell me all the sources of payment for (SP's) basic charge for the period from (DATE) to (DATE). (CIRCLE ALL THAT APPLY) SHOW CARD E3 1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY) **PAYBOWN** 2. MEDICARE (TITLE XVIII) **PAYBMCR** 3. MEDICAID (TITLE XIX) **PAYBMCD** 4. VA (VETERANS ADMINISTRATION) **PAYBVA** 5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE **PAYBPRI** 6. SSI (SUPPLEMENTAL SECURITY INCOME) **PAYBSSI** 7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY **PAYBLIF** 91. OTHER SOURCE SPECIFY SOURCE **PAYBOTH** **PAYBOS** →	E13. $ **FTOTSRCE** _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $ **FOWNAMT** _____._____ 2 $ **FMCARAMT** _____._____ 3 $ **FMCADAMT** _____._____ 4 $ **FVAAMT** _____._____ 5 $ **FPINSAMT** _____._____ 6 $ **FSUPPAMT** _____._____ 7 $ **FLIFEAMT** _____._____ 91 $ **FOTHRAMT** _____._____ _____

BOX E2	a. E13 = E12 (E18) E13 < E12 (b) E13 > E12 (E18) b. SUBTRACT E13 FROM E12 AND RECORD AMOUNT IN EACH COLUMN; THEN GO TO E14.	b. $ **FTOTMORE** _____._____

☐ CHECK IF MEDICAID IS REPORTED AS A SOURCE OF PAYMENT AND WAS NOT REPORTED IN THE PREVIOUS ROUND.

PERIOD #6	PERIOD #7	PERIOD #8
FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	FROM: _____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR
E12. $_____._____ FACILITY HAS NO PRIVATE PAY ... 1	E12. $_____._____ FACILITY HAS NO PRIVATE PAY 1	E12. $_____._____ FACILITY HAS NO PRIVATE PAY 1
E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____._____ 2 $_____._____ 3 $_____._____ 4 $_____._____ 5 $_____._____ 6 $_____._____ 7 $_____._____ 91 $_____._____ _____	E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____._____ 2 $_____._____ 3 $_____._____ 4 $_____._____ 5 $_____._____ 6 $_____._____ 7 $_____._____ 91 $_____._____ _____	E13. $ _____ TOTAL PAYMENT E13b. (ASK FOR EACH SOURCE:) How much did or will (INSERT SOURCE) pay for the charge period from (DATE) to (DATE)? 1 $_____._____ 2 $_____._____ 3 $_____._____ 4 $_____._____ 5 $_____._____ 6 $_____._____ 7 $_____._____ 91 $_____._____ _____

b. $_____._____	b. $_____._____	b. $_____._____

		PERIOD #5
E14.	For the period from (DATE) to (DATE) the total basic charge for a private-pay resident was more than the total payments for (SP's) basic charge. Do you expect to receive all of the outstanding amount?	YES..... 1 (E18) NO..... 2 (E15) DON'T KNOW ..... -8 (E18) **BPAYALL**
E15.	How much of the (AMOUNT IN BOX E2b) do you expect that you will not receive?	**BNOPDAMT** $_____._____
E16.	What is the reason you will not receive that amount? (RECORD VERBATIM; THEN CODE ALL THAT APPLY.)	**BNOPDVB** _____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

BOX E3	CHECK E16: IS OPTION 2 CIRCLED, THIRD PARTY DOES NOT REIMBURSE IN FULL?	YES..... 1 (E17) NO..... 2 (E18)

E17.	Which of the payment sources does not reimburse in full? (CIRCLE ALL THAT APPLY)	
SHOW CARD E3	1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY)	**FNFULOWN** 1
	2. MEDICARE (TITLE XVIII)	**FNFULMCR** 2
	3. MEDICAID (TITLE XIX)	**FNFULMCD** 3
	4. VA (VETERANS ADMINISTRATION)	**FNFULVA** 4
	5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE	**FNFULPRI** 5
	6. SSI (SUPPLEMENTAL SECURITY INCOME)	**FNFULSSI** 6
	7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY	**FNFULLIF** 7
	91. OTHER SOURCE	**FNFULOTH** .....91 (SPECIFY) **FNFULLOS** _____

PERIOD #6	PERIOD #7	PERIOD #8
YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)	YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)	YES ..... 1 (E18) NO ..... 2 (E15) DON'T KNOW ..... -8 (E18)
$_____._____	$_____._____	$_____._____
_____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8	_____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8	_____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

YES ..... 1 (E17) NO 2 (E18)	YES ..... 1 (E17) NO 2 (E18)	YES ..... 1 (E17) NO 2 (E18)

..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 91 (SPECIFY) _____	..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 91 (SPECIFY) _____	..... 1 ..... 2 ..... 3 ..... 4 ..... 5 ..... 6 ..... 7 ..... 91 (SPECIFY) _____

The next questions are about medical charges that may have been billed by the facility between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE).

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
a. Dental Services? **FSCHDENT** YES ..... 1 → NO ..... 2 (b) DON'T KNOW ..... -8 (b)	**FDENTAMT** $_____._____ DON'T KNOW ..... -8 (E18b)
b. Private duty nursing? **FSCHNURS** YES ..... 1 → NO ..... 2 (c) DON'T KNOW ..... -8 (c)	**FNURSAMT** $_____._____ DON'T KNOW ..... -8 (E18c)
c. Turning and positioning? **FSCHTURN** YES ..... 1 → NO ..... 2 (d) DON'T KNOW ..... -8 (d)	**FTURNAMT** $_____._____ DON'T KNOW ..... -8 (E18d)
d. Physician services? **FSCHPHY** YES ..... 1 → NO ..... 2 (e) DON'T KNOW ..... -8 (e)	**FPHYSAMT** $_____._____ DON'T KNOW ..... -8 (E18e)
e. Services from a medical practitioner such as audiologist, optometrist, etc.? **FSCHMEDP** YES ..... 1 → NO ..... 2 (f) DON'T KNOW ..... -8 (f)	**FMEDPAMT** $_____._____ DON'T KNOW ..... -8 (E18f)
f. A doctor's office or clinic visit? **FSCHCLIN** YES ..... 1 → NO ..... 2 (g) DON'T KNOW ..... -8 (g)	**FCLINAMT** $_____._____ DON'T KNOW ..... -8 (E18g)
g. Mental Health Professional Services? **FSCHMENT** YES ..... 1 → NO ..... 2 (h) DON'T KNOW ..... -8 (h)	**FMENTAMT** $_____._____ DON'T KNOW ..... -8 (E18h)
h. Therapist Services such as physical, speech, etc.? **FSCHTHER** YES ..... 1 → NO ..... 2 (i) DON'T KNOW ..... -8 (i)	**FTHERAMT** $_____._____ DON'T KNOW ..... -8 (E18i)

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
i. Services from other medical persons such as a paramedic, etc.? **FSCHOMDP** YES ..... 1 → NO ..... 2 (j) DON'T KNOW ..... -8 (j)	**FOMDPAMT** $_____._____ DON'T KNOW ..... -8 (E18j)
j. Prescription drugs? **FSCHPMED** YES ..... 1 → NO ..... 2 (k) DON'T KNOW ..... -8 (k)	**FPMEDAMT** $_____._____ DON'T KNOW ..... -8 (E18k)
k. Diabetic equipment or supplies? **FSCHDIAB** YES ..... 1 → NO ..... 2 (l) DON'T KNOW ..... -8 (l)	**FDIABAMT** $_____._____ DON'T KNOW ..... -8 (E18l)
l Eyeglasses or contact lenses? **FSCHEYE** YES ..... 1 → NO ..... 2 (m) DON'T KNOW ..... -8 (m)	**FEYECAMT** $_____._____ DON'T KNOW ..... -8 (E18m)
m. Hearing aid or other communication device? **FSCHHAID** YES ..... 1 → NO ..... 2 (n) DON'T KNOW ..... -8 (n)	**FHAIDAMT** $_____._____ DON'T KNOW ..... -8 (E18n)
n. Ambulance service? **FSCHAMBU** YES ..... 1 → NO ..... 2 (o) DON'T KNOW ..... -8 (o)	**FAMBSAMT** $_____._____ DON'T KNOW ..... -8 (E18o)
o. Prosthesis? **FSCHPROS** YES ..... 1 → NO ..... 2 (p) DON'T KNOW ..... -8 (p)	**FPROSAMT** $_____._____ DON'T KNOW ..... -8 (E18p)
p. Other medical devices or equipment? **FSCHOTHR** YES ..... 1 → NO ..... 2 (q) DON'T KNOW ..... -8 (q)	**FODEVAMT** $_____._____ DON'T KNOW ..... -8 (E18q)

E18. Between (PREVIOUS ROUND END BILL DATE) and (CURRENT END BILL DATE) was there a separate charge billed by the facility for (INSERT CATEGORY)?	E19. What was the total charge billed by the facility for (INSERT CATEGORY) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)?
q. Any other medically necessary items or provider services that we haven't talked about already? **FSCHGPRO** YES (SPECIFY)..... 1 a. _____ **FSCHGOS1** b. _____ **FSCHGOS2** c._____ **FSCHGOS3** → d. _____ **FSCHGOS4** e. _____ **FSCHGOS5** f. _____ **FSCHGOS6** NO ..... 2 ***BOX E4*** DON'T KNOW ..... -8 ***BOX E4***	a. $_____._____ **FOS1AMT** b. $_____._____ **FOS2AMT** c. $_____._____ **FOS3AMT** ***BOX E4*** d. $_____._____ **FOS4AMT** e. $_____._____ **FOS5AMT** f. $_____._____ **FOS6AMT**

BOX E4	IS ANY ITEM CODED "YES" IN E18?
	YES ..... 1 (E20a) NO ..... 2 (SECTION F)

E20a. Altogether, how much was separately billed by the facility for medical services for (SP) from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE)? **FSCHGTOT**

$ _____._____

TOTAL AMOUNT BILLED

E20b. Have you received payment or do you expect to receive any payment for these services? **FSCHGPAY**

YES	1	(E21)
NO	2	(E23)
DON'T KNOW	-8	(E21)

E21. Please look at this card and tell me all the sources of payment or expected sources of payment for these special services from (PREVIOUS ROUND END BILL DATE) TO (CURRENT END BILL DATE). (CIRCLE ALL CODES THAT APPLY; THEN ASK E21a FOR EACH SOURCE.) (PROBE FOR ALL SOURCES.)

SHOW CARD E3

(ASK FOR EACH SOURCE:)
E21a. How much did or will (SOURCE) pay for special services for (SP) for that period?

1.	OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY)	**FSPAYOWN**	1 $_____._____ **FSOWNAMT**
2.	MEDICARE (TITLE XVIII)	**FSPAYMCR**	2 $_____._____ **FSMCRAMT**
3.	MEDICAID (TITLE XIX)	**FSPAYMCD**	3 $_____._____ **FSMCDAMT**
4.	VA (VETERAN'S ADMINISTRATION	**FSPAYVA**	4 $_____._____ **FSVAAMT**
5.	PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE	**FSPAYPRI**	5 $_____._____ **FSPRIAMT**
6.	SSI (SUPPLEMENTAL SECURITY INCOME)	**FSPAYSSI**	6 $_____._____ **FSSSIAMT**
7.	PREPAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY	**FSPAYLIF**	7 $_____._____ **FSLIFAMT**
91.	OTHER SOURCE	**FSPAYOTH**	91 $_____._____ **FSOTHAMT**
	SPECIFY	**FSPAYOS**	_____

BOX E5	a. TOTAL ALL PAYMENT SOURCES LISTED IN E21a.		a. $ **FSPYSRCE** ._____
	b. a = E20a	(SECTION F)	
	a < E20a	(c)	
	a > E20a	(SECTION F)	
	c. SUBTRACT a FROM E20a AND RECORD AMOUNT IN EACH COLUMN; THEN PROCEED WITH E22.		c. $ **FSPYMORE** ._____

E22.	For the period from (PREVIOUS ROUND END BILL DATE) to (CURRENT END BILL DATE) the total ancillary charges were more than the total payment sources. Do you expect to receive any or all of that amount? **APAYALL**	YES..... 1 (GO TO SECTION F) NO..... 2 (E23) DON'T KNOW ..... -8 (GO TO SECTION F)
E23.	How much of the (AMOUNT IN E20a/AMOUNT IN BOX E5c.) do you expect that you will not receive? **ANOPDAMT**	$_____._____
E24.	What is the reason? (RECORD VERBATIM; THEN CODE ALL THAT APPLY.) **ANOPDVB** **ANOPDDET** **ANOPDFUL** **ANOPDOTH**	_____ _____ _____ _____ FACILITY ABSORBS COST ..... 1 THIRD PARTY DOES NOT REIMBURSE IN FULL ..... 2 OTHER REASON ..... 3 DON'T KNOW ..... -8

BOX E6	CHECK E24: IS OPTION 2 CIRCLED, THIRD PARTY DOES NOT REIMBURSE IN FULL?	YES..... 1 (E25) NO..... 2 (GO TO SECTION F)

E25.	Which of the payment sources does not reimburse in full? (CIRCLE ALL THAT APPLY)	
	1. OWN INCOME OR FAMILY SUPPORT (INCLUDE SOCIAL SECURITY)	..... 1 **FSNOOWNF**
	2. MEDICARE (TITLE XVIII)	..... 2 **FSNOMCAR**
	3. MEDICAID (TITLE XIX)	..... 3 **FSNOMCAD**
	4. VA (VETERANS ADMINISTRATION)	..... 4 **FSNOVA**
	5. PRIVATE HEALTH INSURANCE OR LONG TERM CARE INSURANCE	..... 5 **FSNOPRIV**
	6. SSI (SUPPLEMENTAL SECURITY INCOME)	..... 6 **FSNOSSI**
	7. PAYMENT FOR CONTINUING OR LIFE CARE COMMUNITY	..... 7 **FSNOLIFC**
	91. OTHER SOURCE (SPECIFY)	.....91 (SPECIFY) _____ **FSNOOTHR** **FSNOOS**

GO TO SECTION F, TRACING AND CLOSING