



STATE OF OKLAHOMA  
OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2006-04

April 11, 2006

Dear Long Term Care Provider:

Effective July 1, 2006, the form used to collect data for the required monthly [Quality of Care Report](#) (QOCR) and the e-mail address for electronic reporting will change. Facilities are required to utilize the enclosed new report and new e-mail address for June 2006 information due by 5:00 p.m., July 17, 2006. The new e-mail address is [LTCAUDIT@okhca.org](mailto:LTCAUDIT@okhca.org).

To reiterate, we have outlined below the significant changes in addition to clarification on Part C of the QOCR:

- Effective July 1, 2006, all "e-filed" reports are submitted to [LTCAUDIT@okhca.org](mailto:LTCAUDIT@okhca.org).
- Effective July 1, 2006, the QOCR (June 2006) is utilized.
  - Note: This updated report reflects the change in the e-mail address and mailing addressee to Provider Compliance only.
- In Part C of the QOCR, "Compensable" days are considered all days for which any payment is or will be received (even at less than the daily charge) and are reported. Leave days that are not compensable are not counted while days in facilities awaiting certification that may not be compensable in the future are not reported.

Please find enclosed a copy of the new Quality of Care Report. It is important that this new form be distributed with the appropriate personnel within your facility or contractor to ensure timely and accurate submission. This will allow staff to respond to any questions that may arise. Current providers who submit the monthly Quality of Care Report via electronic mail will also receive an e-mail notification and revised form within the next few weeks.

If you wish to obtain a copy of the new Quality of Care Report in the excel format, please e-mail [LTCAUDIT@okhca.org](mailto:LTCAUDIT@okhca.org) and request the new form. Facilities may also visit the OHCA website at [www.okhca.org](http://www.okhca.org).

Should you have any questions, please contact Teri Dalton, (405) 522-7209 or Tana Parrott, (405) 522-7538. Clarification on compensable days should be directed to David Branson, (405)-522-7294.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Fogarty".

Mike Fogarty  
Enclosure

Facility Name: \_\_\_\_\_ Reporting Month: \_\_\_\_\_ Reporting Year: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_ Facility Address: \_\_\_\_\_

**A) Direct Care Staffing\***

Day of the Month	Day Shift _____ to _____		Evening Shift _____ to _____		Night Shift _____ to _____		Flexible Staff Scheduling 24 Hour Staffing (Only)	
	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Peak In-House Resident Count	Direct Care Staff Hours	Daily Peak In-House Resident Count	Total Daily Direct Care Hours
1	_____	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____	_____	_____	_____
11	_____	_____	_____	_____	_____	_____	_____	_____
12	_____	_____	_____	_____	_____	_____	_____	_____
13	_____	_____	_____	_____	_____	_____	_____	_____
14	_____	_____	_____	_____	_____	_____	_____	_____
15	_____	_____	_____	_____	_____	_____	_____	_____
16	_____	_____	_____	_____	_____	_____	_____	_____
17	_____	_____	_____	_____	_____	_____	_____	_____
18	_____	_____	_____	_____	_____	_____	_____	_____
19	_____	_____	_____	_____	_____	_____	_____	_____
20	_____	_____	_____	_____	_____	_____	_____	_____
21	_____	_____	_____	_____	_____	_____	_____	_____
22	_____	_____	_____	_____	_____	_____	_____	_____
23	_____	_____	_____	_____	_____	_____	_____	_____
24	_____	_____	_____	_____	_____	_____	_____	_____
25	_____	_____	_____	_____	_____	_____	_____	_____
26	_____	_____	_____	_____	_____	_____	_____	_____
27	_____	_____	_____	_____	_____	_____	_____	_____
28	_____	_____	_____	_____	_____	_____	_____	_____
29	_____	_____	_____	_____	_____	_____	_____	_____
30	_____	_____	_____	_____	_____	_____	_____	_____
31	_____	_____	_____	_____	_____	_____	_____	_____

B) Minimum Wage reporting revoked on July 2003.

**C) Total Gross Receipts and Total Patient Days**

Total Gross Receipts \_\_\_\_\_

Total Patient Days \_\_\_\_\_

**\*\*Important - The facility shall complete the applicable signature blocks on page 2 for regulatory submission compliance.**

Facility Name: \_\_\_\_\_ Reporting Month: \_\_\_\_\_ Reporting Year: \_\_\_\_\_

***This report must be signed by the preparer and by the Owner, Authorized Corporate Officer or Administrator of the facility for verification and attestation that this report was compiled in accordance with OAC 317:30-5-131.2 and 310:675-1 et seq.***

***I hereby certify that I have examined the Quality of Care Report, and to the best of my knowledge, is a true, correct and complete statement prepared from the books and records of the facility in accordance with applicable instructions, state and federal rules and regulations.***

1) \_\_\_\_\_ ( ) \_\_\_\_\_  
Preparer's Name and Title Phone Number Date

\_\_\_\_\_  
Signature

2) \_\_\_\_\_ ( ) \_\_\_\_\_  
Owner, Authorized Corporate Officer or Administrator's Name & Title Phone Number Date

\_\_\_\_\_  
Signature

**This signature box shall be completed for flexible staff reporting (24 hour staffing) by authorized facilities.**

***I hereby attest that the Oklahoma State Department of Health has authorized this facility to utilize the flexible staff schedule (24 hour staffing) option for the reporting month in accordance with OAC 310:675-1 et seq.***

3) \_\_\_\_\_ ( ) \_\_\_\_\_  
Owner, Authorized Corporate Officer or Administrator's Name & Title Phone Number Date

\_\_\_\_\_  
Signature

**DIRECT CARE STAFFING**

For purposes of this report, direct care staff is limited to:

Registered Nurses	Physical Therapist (Professional)	Activity and Social Services staff
Licensed Practical Nurses	Occupational Therapist (Professional)	performing direct hands-on care
Nurse Aides	Respiratory Therapist (Professional)	
Certified Medication Aides	Speech Therapist (Professional)	
QMRP (ICFs/MR only)	Therapy Aide / Assistant	

\*For information on staffing requirements reference OAC 310:675-1 et seq. and 63 O.S. 2001, Section 1-1925.2.

Send the completed form by **certified mail** to: **OR** **by electronic mail** to:

**Oklahoma Health Care Authority**  
Provider Compliance Audits  
4545 N. Lincoln Blvd., Suite 124  
Oklahoma City, OK 73105

**LTCAUDIT@okhca.org**