



Nursing Facility Provider Fee CCRC Fee Exemption Provider Attestation

General Requirements

Colorado Nursing facilities are required to complete this form and attest to the information provided for exemption to the Nursing Facility Provider Fee assessment. The form must be completed to report independent living beds, and assisted living beds. Documentation to support your reason for exemption must also be provided. Information must be reported for the most recent facility fiscal year. This form must be completed each year to qualify for exemption from the Nursing Facility Provider Fee Assessment.

This attestation form and supporting documentation must be submitted to the email address below no later than **June 1, 2015** to qualify for the CCRC exemption:

Kevin Berg

Provider Fee Analyst

Colorado Department of Health Care Policy and Financing

1570 Grant Street, Denver, CO 80203

Kevin.Berg@state.co.us

Provider Name and Medicaid Id Number

Please provide the name of your facility and the Medicaid ID number.

Facility Name

Medicaid ID Number:



Continuing Care Retirement Community

Colorado statutory language defines a fee exemption qualifying Continuing Care Retirement Community (CCRC) as follows:

“A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services, and skilled nursing care on a single, contiguous campus. Assisted living services include an assisted living residence as defined in section 25-27-102, C.R.S., or that provides assisted living services on-site, twenty-four hours per day, seven days per week.”¹

CCRC Exemption Requirements:

- 1. Is your facility currently operated as a CCRC? **Yes or No**
- 2. Is your facility one operational entity? **Yes or No**
- 3. Does your facility provide SNF, AL, and IL services (all three)? **Yes or No**
- 4. Does your facility provide services for SNF, AL, and IL
 on one contiguous campus? **Yes or No**
- 5. Designated Assisted Living (AL):
 Number of **AL** Service Days²: _____
- 6. Independent Living:
 Number of **IL** Service Days³: _____
 or
 Number of **IL** Lease Agreements⁴: _____

¹ C.R.S. 25.5-6-203(c)(I)

² Service Days and Lease Agreements during Calendar Year 2014 (Jan. 1-Dec. 31)

³ Service Days and Lease Agreements during Calendar Year 2014 (Jan. 1-Dec. 31)

⁴ Service Days and Lease Agreements during Calendar Year 2014 (Jan. 1-Dec. 31)



Supporting Documentation

In order to qualify for CCRC exemption, your facility must meet all of the above listed statutory requirements AND be able to provide supporting documentation for each requirement. Please provide a detailed summary explaining how your facility meets the requirements for CCRC exemption from the Nursing Facility Provider Fee assessment. Include explanations and documentation of how your facility is currently being marketed and operated as a CCRC, the levels of care provided, that your facility operates on one continuous campus, and that the all levels of care are under one operational entity. Please also indicate if this attestation represents a change in CCRC status for the facility.

The Department will review the attestation and documentation for accuracy and completeness. If there are any questions regarding this attestation and/or the submitted documentation, the Department will contact you directly to discuss any issues with this submission by June 12, 2015.

If you have any questions or need any additional information please contact Matt Haynes, Provider Fee Financing Unit Supervisor at Matt.Haynes@state.co.us or at 303.866.6305.



ATTESTATION

In accordance with State statutory language in C.R.S. 25.5-6-203(c)(I), I attest, to the best of my knowledge, that the information reported on this form and any supporting documentation provided is accurate, and that my facility meets the requirements for CCRC exemption from the Nursing Facility Provider Fee Assessment.

I understand that information reported on this form may be public information and may be posted on the Colorado Department of Health Care Policy and Financing web site. I further understand the Department may audit compliance with this attestation at any time.

I also attest, that as a member of the facility's governing body or as a duly authorized official of the licensed entity, I am authorized to make this statement on behalf of the facility. Signing my name below signifies my agreement with the above statements.

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Phone Number: _____

Email Address: _____