FORM SNH-F1
Revised 05/26/2010

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2010

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2010 ANNUAL REPORT FOR SKILLED NURSING FACILITIES

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) **AL** _____ (ZIP)

County of Location: _____

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for July 1, 2009, through June 30, 2010*; or for **partial** year of operation beginning _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS

A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.

PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified:		Initial Scan:		Completed:	
Entered:		Final Scan:		Audited:	

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OWNERSHIP (check one)

_____ Corporation	_____ Non-Profit Organization	_____ Partnership
_____ Individual	_____ Healthcare Authority	_____ LLC
_____ Joint Venture	_____ Government	_____ Other (specify) _____

Does this facility operate under a management contract? _____ Yes _____ No

Management Firm: _____
Name

_____
Base Address City State Zip

I. FACILITIES

_____ Skilled Nursing Home
_____ Skilled Nursing Unit of Hospital

a. TOTAL beds **licensed** by the Alabama Department of Public Health _____

b. Number of **staffed and operational beds** on last day of reporting period _____

c. Number of beds certified for Medicare patients (**NOTE**: Medicaid patients ***ARE ALLOWED*** to reside in Medicare beds) _____

d. Number of beds certified for Medicaid patients (**NOTE:** Medicare patients ***ARE NOT ALLOWED*** to reside in Medicaid beds) _____

e. Was this facility licensed for the number of beds indicated in item I-a for the entire reporting period? _____
YES **NO**

f. If "No" was answered in item (e), indicate the number of licensed beds and the number of days those beds were licensed. _____ _____
BEDS **DAYS**

g. Additional licensed beds and the number of days those beds were licensed _____ _____
BEDS **DAYS**

II. ADMISSIONS

TOTAL ADMISSIONS FOR THE REPORTING PERIOD _____

ADMISSIONS BY SOURCE OF PAYMENT:

Private Pay _____
Workman's Compensation _____
Medicare _____
Medicaid _____
Tricare _____
Blue Cross (**not Long Term Care Insurance)** _____
Other Insurance Companies (**not Long Term Care Insurance)** _____
No Charge (charity & other) _____
Hospice _____
Long Term Care Insurance _____
Other (specify) _____ _____

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III. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE *FOR THE ENTIRE REPORTING PERIOD*

(Total must agree with The totals provided in Section II and Section III-B.) _____

a. White/Caucasian _____
b. Black/African American/Negro _____
c. Hispanic/Spanish/Latino _____
d. Asian _____
e. American Indian/Alaskan Native _____
f. Pacific Islander _____
g. India _____
h. Middle Eastern _____
i. Other (specify) _____ _____

B. TOTAL ADMISSIONS BY AGE AND GENDER *FOR THE ENTIRE REPORTING PERIOD*

(Total must agree with the totals provided in Section II and Section III-A.)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under			
19 – 34 Years			
35 – 54 Years			
55 – 64 Years			
65 – 74 Years			
75 – 84 Years			
85 Years and Older			
TOTALS			

(*Please verify the information provided balances in each row and column****)***

IV. DISCHARGES

Total discharges (including deaths) _____

Discharges due to death _____

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V. RESIDENT DAYS

(This information is to be provided for the number of individuals in residence during the reporting period.)

	OCCUPIED RESIDENT DAYS	BED HOLDING DAYS	TOTAL RESIDENT DAYS
Private Pay			
Workman's Compensation			
Medicare			
Medicaid			
Tricare			
Blue Cross **(not long term care insurance)**			
Other Insurance Companies **(not long term care**			
No Charge (charity & other)			
Hospice			
Long Term Care Insurance			
Other (specify) _____			
TOTALS			

VI. HOSPICE

1. Total hospice service days (regardless of payer source): _____

2. Number of hospice discharges:

   a. Deaths _____

   b. Home _____

   c. Hospital _____

3. Number of provider contracts: _____

4. Dedicated hospice unit? _____ YES _____ NO

5. (If Yes) Number of beds in dedicated hospice unit: _____

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VII. EXPENSES & REVENUES *(AMOUNTS DO NOT HAVE TO BE AUDITED)*

Payroll Expenses	$ .00
Non-Payroll Expenses	$ .00
TOTAL EXPENSES	$ .00
Medicare	$ .00
Medicaid	$ .00
Long Term Care Insurance	$ .00
Hospice	$ .00
Private Pay	$ .00
Other Insurance	$ .00
Other	$ .00
TOTAL REVENUES	$ .00

VIII. CHARGES (rounded off to whole dollars)

BASIC RESIDENT CHARGE	**MONTHLY**	**DAILY**
Private Room	$ .00	$ .00
Semi-Private Room	$ .00	$ .00