INSTRUCTIONS FOR COMPLETING THE 2011 ANNUAL REPORTS FOR SKILLED NURSING HOMES

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INSTRUCTIONS FOR COMPLETION OF THE 2011 ANNUAL REPORT FOR SKILLED NURSING FACILITIES

Form SNF-F1

These instructions for the 2011 Annual Report for Skilled Nursing Facilities are intended to assist you in the completion and submission of accurate data. To ensure data integrity, and determine utilization rates of services provided by skilled nursing facilities, information reported must be consistent from all facilities throughout the state. These instructions are intended to assist in the collection of data, minimizing the number of errors experienced in previous years. Selected verification procedures for reported information are also outlined, and are indicated by (**). Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Bradford L. Williams, Data/Planning Director, at (334) 242-4109 or bradford.williams@shpda.alabama.gov.

Page 1

The identification number as indicated on the mailing label is assigned by SHPDA.

Verify the name of the facility identified on the mailing label is the name of the facility as indicated on the license issued by the Alabama Department of Public Health (ADPH). Make any necessary changes to the label.

Mailing Address: Provide the complete mailing address to be used by SHPDA for the mailing of annual reports, data, and requests for additional information. This address may be different from the physical address of the facility.

Physical Address: Provide the complete physical address of this facility as indicated on the ADPH license.

County of Location: Provide the county of physical location of the facility.

Facility Telephone: Provide the general telephone number of the facility, including the area code.

Facility Fax: Provide the general fax telephone number of the facility, including the area code.

The signatures and requested identifying information **must** be provided by two separate individuals. The primary preparer of the annual report will be contacted first for additional/corrected information. If the primary preparer is not available at the time of attempted contact, the administration official will be contacted to provide additional/corrected information, and to answer any questions.

Page 2

Ownership: Provide the organizational structure of the facility as reported to ADPH.

Management: Indicate if this facility is operated by a management firm. If so, check yes and provide the name of the management firm and all contact information requested. If this facility is not operated under a management contract, go to Section I-A.

Section I - Facilities:

Indicate whether the facility is a Skilled Nursing Home or is a separate Skilled Nursing Unit of an Acute Care Hospital

a. Indicate the total number of beds licensed by ADPH on the last day of the reporting period.

b. Indicate the number of beds staffed and in operation on the last day of the reporting period. This number may be less than the number of licensed beds, but may not be more than the number of beds licensed.

c. Indicate the number of beds certified for Medicare patients. This number may be less than the number of licensed beds, but may not be more than the number of beds licensed.

d. Indicate the number of beds certified for Medicaid patients. This number may be less than the number of licensed beds, but may not be more than the number of beds licensed.

e. Indicate whether the number of licensed beds in the facility changed during the current reporting period.

f. If the number of licensed beds changed, enter the number of beds and the total number of days the facility was licensed for **beginning on the first day of the reporting period.**

g. Indicate the number of beds licensed after the change and the total number of days between the first day of the new licensed bed count and the **end of the**

reporting period. The addition of f and g should equal the total number of days in the reporting period listed on page 1.

Section II – Admissions

Total Admissions for the Reporting Period: This should reflect **all** admissions for the **entire** reporting period. If a patient is discharged and readmitted due to a change in payer source, or is discharged to an acute care facility and then readmitted after a stay, these count as an admission in this section.

Admissions by Source of Payment: List the total number of admissions for each payer source. **The number of admissions by payer source should add up to equal the Total Admissions for the Reporting Period listed above. If they do not match, it will be viewed as an error, and corrections will be requested from your facility.**

Page 3

Section III - Demographics:
Part A

Total Admissions by Race for the Entire Reporting Period: This should reflect **all** admissions for the **entire** reporting period. If a patient is discharged and readmitted due to a change in payer source, or is discharged to an acute care facility and then readmitted after a stay, these count as an admission in this section. **This total should equal the Total Admissions for the Reporting Period listed on page 2.**

List the total number of admissions for each race listed. **The number of admissions by race should add up to equal the Total Admissions for the previous section. If they do not match, it will be viewed as an error, and corrections will be requested from your facility.**

Part B

Admissions by Age and Gender for the Entire Reporting Period: This should reflect **all** admissions for the **entire** reporting period. If a patient is discharged and readmitted due to a change in payer source, or is discharged to an acute care facility and then readmitted after a stay, these count as an admission in this section. **The total should equal the Total Admissions for the Reporting Period listed on page 2 as well as the Total Admissions by Race listed at the top of page 3. If they do not match, it will be viewed as an error, and corrections will be requested from your facility.**

Section IV – Discharges

Total Discharges (including deaths): List all discharges occurring from the facility. If a patient is discharged and readmitted due to a change in payer source, or is discharged to an acute care facility and then readmitted after a stay, these count as a discharge in this section.

Discharges due to death: Please list the total number of discharges that occurred due to the death of the patient.

Page 4

Section V – Resident Days:

For each listed payer source, please list the total occupied resident days (days when the resident was actually present at the facility), bed holding days (days when the patient was at another location, but the bed was being held on behalf of the patient by the facility) and the total resident days (the sum of the previous two categories). Then, list the total at the bottom of the three columns where indicated.

Section VI – Hospice

Pursuant to a request from the Alabama Nursing Home Association, SHPDA is requesting additional information from all Nursing Homes in the State of Alabama for hospice care provided in Nursing Homes.

Please read the following instructions carefully.

Total hospice service days (regardless of payer source): Please list the total number of days patients received hospice care in the facility, regardless of whether the care was paid for by a hospice provider or another payer source such as Medicare/Medicaid, etc.

Number of hospice discharges: Please list the total number of discharges of hospice patients from your facility by the location to which the patient was discharged, or if the patient died at the facility while under hospice care.

Number of provider contracts: Please list the total number of hospice providers with which the facility currently contracts to provide a bed in which a patient may receive hospice care.

Dedicated hospice unit: Please list if the nursing home currently has a dedicated unit in which to locate all hospice patients. If hospice patients are placed into the first available open bed without regard to location within the facility, please answer no to this question.

Number of beds in hospice unit: List the number of beds the facility has in a dedicated hospice unit, **only if the facility answered yes to the previous question.**

Page 5

Section VII – Expenses and Revenues
(Please note that these amounts do not have to be audited)

DEFINITIONS:

Payroll: Total expenses for the reporting period spent on payroll for employees.

Non-payroll: Total expenses for the reporting period spent on non-payroll activities, i.e. office supplies, etc. for the provider.

Medicare: Any payments received from Medicare.

Medicaid: Any payments received from Medicaid.

Long Term Care Insurance: Any payments received from Long Term Care Insurance companies.

Hospice: Any payments received directly from a hospice provider for hospice care to a current resident.

Private Pay: Any payments received directly from a patient or patient's primary caregiver.

Other Insurance: Any payments received from any insurance company other than a dedicated Long Term Care Insurance provider or policy.

Other: Any/all other revenues gathered by the provider.

Section VIII – Charges
(Rounded off to whole dollars)

Please list both the monthly and daily charges incurred by patients residing at the facility for both a private and a semi-private room. If your facility does not charge monthly, or does not provide either a private or a semi-private room, please enter N/A in the appropriate blank.

*****REMINDER*****

The annual report **MUST** be signed by both the preparer and an administrative official.