

**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 \_\_\_\_\_ and ending \_\_\_\_\_ a period of \_\_\_\_\_ days.

MONTH DAY

MONTH DAY

\*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 MUST 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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**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	_____	_____	_____
<b>TOTALS</b>	_____	_____	_____

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

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

**VIII. CHARGES (rounded off to whole dollars)**

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