FORM SNH-F1
Revised 05/23/2011

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2011

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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TELEPHONE: (334) 242-4109
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MONTGOMERY AL 36104
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2011 ANNUAL REPORT FOR SKILLED NURSING FACILITIES

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

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, 2010, through June 30, 2011*; 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	0
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.) 0

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			0
19 – 34 Years			0
35 – 54 Years			0
55 – 64 Years			0
65 – 74 Years			0
75 – 84 Years			0
85 Years and Older			0
TOTALS	0	0	0

(*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			0
Workman's Compensation			0
Medicare			0
Medicaid			0
Tricare			0
Blue Cross **(not long term care insurance)**			0
Other Insurance Companies **(not long term care insurance)**			0
No Charge (charity & other)			0
Hospice			0
Long Term Care Insurance			0
Other (specify) _____			0
TOTALS	0	0	0

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	$	0.00
Medicare	$	.00
Medicaid	$	.00
Long Term Care Insurance	$	.00
Hospice	$	.00
Private Pay	$	.00
Other Insurance	$	.00
Other	$	.00
TOTAL REVENUES	$	0.00

VIII. CHARGES (rounded off to whole dollars)

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