FORM SNH-F1
Revised 06/2014

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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MONTGOMERY AL 36130-3025
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MONTGOMERY AL 36104
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2014 ANNUAL REPORT FOR SKILLED NURSING FACILITIES

ENTER SHPDA ID NUMBER HERE

ENTER NAME OF FACILITY HERE

This report should be typewritten or completed in ink only; no pencil submissions

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, 2013, through June 30, 2014*; 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; and must be separate from the preparer.

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

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 *(REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS)*

A. TOTAL ADMISSIONS FOR THE REPORTING PERIOD 0

B. 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

1.	White/Caucasian	
2.	Black/African American/Negro	
3.	Hispanic/Spanish/Latino	
4.	Asian	
5.	American Indian/Alaskan Native	
6.	Pacific Islander	
7.	India	
8.	Middle Eastern	
9.	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 (*REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS)*

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

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

B. Number of hospice discharges:

1. Deaths _____
2. Home _____
3. Hospital _____

C. Number of hospice provider contracts: _____

D. Dedicated hospice unit? ○ YES ○ NO

E. (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 (specify) _____	$	.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