

# INSTRUCTIONS FOR COMPLETING THE 2015 ANNUAL REPORT FOR SKILLED NURSING FACILITIES



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AGENCY

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## INSTRUCTIONS FOR COMPLETION OF THE 2015 ANNUAL REPORT FOR SKILLED NURSING FACILITIES *Form SNH-F1*

These instructions for the 2015 Annual Report for Skilled Nursing Facilities are intended to assist 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. 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) 242-4103, or [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov).

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The agency identification number is assigned by SHPDA, and is referenced in the "Subject" line of the e-mail containing links to the annual report and these instructions. The agency name must match the name on the license issued by the Alabama Department of Public Health (ADPH) on the last day of the reporting period.

**Mailing Address:** Provide the complete mailing address to be used by SHPDA for mailing purposes. 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 on the last day of the reporting period.

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

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

**Facility Fax:** Provide the primary general fax telephone number of the provider, 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. The administration official may be contacted in the event the preparer is unavailable or for informational purposes. If the report is prepared by the administrator, a separate second signature is still required, and may be provided by either another member of Administration, or by a corporate official. Legible e-mail addresses for both the preparer and second verifying administrative individual **must** be provided.

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**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:

- 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 reported in item a.
- 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 reported in item a.
- 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 reported in item a.
- 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 those beds were licensed, **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 **beginning the first day of the new licensed bed count, and ending on the last day of the reporting period.** The addition of f and g Days should equal the total number of reporting days indicated on page 1.

### ***Computation Methods for Admissions, Re-Admissions, and Discharges to be Utilized in Sections II, III, and IV***

*All Admissions for the entire reporting period are to be included in Sections II and III. The total number of re-admissions is also included in Sections II and III if a patient is **discharged** for any reason and then re-admitted at a later date, or if a patient is re-admitted due to a change in payer source. If a patient is **transferred** from the SNF and returns at a later date or is **transferred** to a different payer source, but was never discharged, the patient is counted only once at the time of initial admission. Only patients **discharged** (not transferred) are to be reported in Section IV.*

### Section II – Admissions

**Total Admissions for the Reporting Period:** This should reflect **all** admissions and re-admissions for the **entire** reporting period utilizing the computation method outlined above.

**Admissions by Source of Payment:** The total number of admissions and re-admissions broken down by payer source.

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### Section III - Demographics:

#### Part A

**Total Admissions by Race for the Entire Reporting Period:** The total number of admissions and re-admissions broken down by race. The number of admissions by race must equal the Total Admissions for the Reporting Period listed in Section II-A.

#### Part B

**Total Admissions by Age and Gender for the Entire Reporting Period:** The total number of admissions and re-admissions broken down by gender in the age groups

specified. The number of admissions by age and gender must equal the Total Admissions for the Reporting Period listed in Section II-A.

#### **Section IV – Discharges**

For the purposes of this report, a discharge MUST occur prior to each readmission. If a patient is transferred from one payment category to another, it is not considered a readmit or discharge. If a patient is readmitted into a new payment category, that patient MUST first be discharged from the previous payment category.

**Total Discharges (including deaths):** The total number of discharges for the entire reporting period utilizing the computation method outlined above.

**Discharges due to death:** The total number of discharges reported above as the result of patient death.

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#### **Section V – Resident Days:**

For each payer source, provide 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). The total Occupied Resident Days, total Bed Holding Days, and Total Resident Days must also be reported where indicated.

#### **Section VI – Hospice**

SHPDA is gathering additional information from SNFs regarding hospice care available and provided in Nursing Homes. Please read the following instructions carefully.

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

**Number of hospice discharges:** Provide the total number of discharges of hospice patients from the facility broken down as a result of death; to the patient's place of residence; and to a hospital or other inpatient healthcare facility.

**Number of provider contracts:** Report the total number of hospice providers with which the facility held contract(s) on the last day of the reporting period to provide a bed for patients admitted to hospice.

**Dedicated hospice unit:** Report if the nursing home currently has a dedicated unit in which to locate all hospice patients, for which CON Authority to provide inpatient hospice services is not held. If hospice patients are placed into the first available open bed without regard to location within the facility, this question should be answered as "no".

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

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**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 salaries and benefits for employees.

**Non-payroll:** Total expenses for the reporting period spent on non-payroll

activities, i.e., office supplies, etc. for the facility.

**Medicare:** Reimbursements received from Medicare.

**Medicaid:** Reimbursements received from Medicaid.

**Long Term Care Insurance:**

Reimbursements received from insurance companies as a result of a Long Term Care insurance policy held by the patient.

**Hospice:** Reimbursements received directly from a hospice provider for hospice care provided under contract.

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

**Other Insurance:** Reimbursements received from an insurance company not as a result of a Long Term Care policy, Medicare, or Medicaid.

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

**Section VIII – Charges**

(Rounded off to whole dollars)

Report the monthly and daily charges incurred by patients residing at the facility for private and semi-private rooms. If the facility does not charge monthly, or does not provide either a private or a semi-private room, enter "0" in the appropriate space. If the facility does not provide services at a daily rate, the monthly charge should be divided by 30 to obtain the estimated daily rate.

**\*\*\*REMINDERS\*\*\***

- The annual report **MUST** be signed by both the preparer and an administrative or corporate official. Electronic signatures are acceptable.
- Make and keep a copy of the completed report for the provider's records before submitting to SHPDA.
- This report should be submitted to SHPDA only once via electronically, hard copy, or fax. The preferred method is electronic submission to [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov). If submitted electronically, please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.