

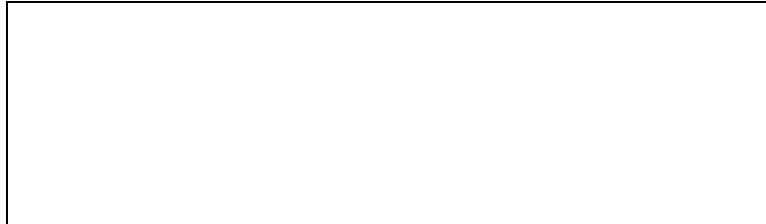
THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2016

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
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2016 ANNUAL REPORT FOR SKILLED NURSING FACILITIES



Pencil submissions of this report will not be accepted. This report should be completed and submitted electronically. All dark gray fields contain formulas to help with the accuracy of the report. Please do NOT complete this report manually.

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, 2015, through June 30, 2016*; or for **partial** year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY

MONTH DAY

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; 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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Corporation | <input type="checkbox"/> Non-Profit Organization | <input type="checkbox"/> Partnership |
| <input type="checkbox"/> Individual | <input type="checkbox"/> Healthcare Authority | <input type="checkbox"/> LLC |
| <input type="checkbox"/> Joint Venture | <input type="checkbox"/> Government | <input type="checkbox"/> 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 beds certified for Medicare patients (NOTE: Medicaid patients ARE ALLOWED to reside in Medicare beds) | _____ | | | | |
| c. Number of beds certified for Medicaid patients | _____ | | | | |
| d. Was this facility licensed for the number of beds indicated in item I-a for the entire reporting period? | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table> | _____ | _____ | YES | NO |
| _____ | _____ | | | | |
| YES | NO | | | | |
| e. If "No" was answered in item (e), indicate the number of licensed beds and the number of days those beds were licensed. | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">BEDS</td> <td style="text-align: center;">DAYS</td> </tr> </table> | _____ | _____ | BEDS | DAYS |
| _____ | _____ | | | | |
| BEDS | DAYS | | | | |
| f. Additional licensed beds and the number of days those beds were licensed | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">BEDS</td> <td style="text-align: center;">DAYS</td> </tr> </table> | _____ | _____ | BEDS | DAYS |
| _____ | _____ | | | | |
| BEDS | DAYS | | | | |

II. ADMISSIONS (REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS)

- | | |
|--|-------|
| A. TOTAL ADMISSIONS FOR THE REPORTING PERIOD | _____ |
| 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 Sections II-A and III-B.)

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

IV. DISCHARGES (REFER TO PAGE 2 OF INSTRUCTIONS FOR CORRECT COMPUTATION METHODS FOR ADMISSIONS, READMISSIONS, DISCHARGES, AND TRANSFERS)

Total discharges (including deaths) _____

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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	_____	_____	_____
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) _____	_____	_____	_____
TOTALS	_____	_____	_____

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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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 one time. ***The preferred method is electronic submission*** to data.submit@shpda.alabama.gov.
If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.