

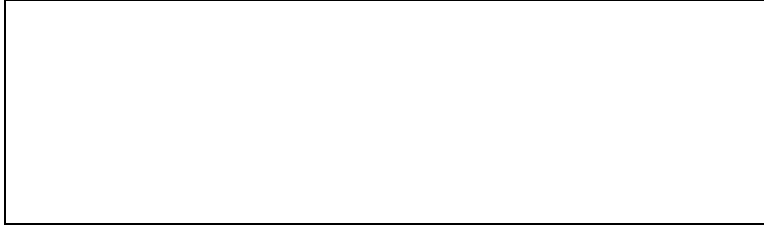
THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2018

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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2018 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
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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, 2017, through June 30, 2018*; 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;">YES</td> <td style="width: 50%; 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;">BEDS</td> <td style="width: 50%; 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;">BEDS</td> <td style="width: 50%; 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: _____