FORM SNH-F1
Revised 05/14/2012

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2012

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2012 ANNUAL REPORT FOR SKILLED NURSING FACILITIES

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, 2011, through June 30, 2012*; 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 MUST 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 __________

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.) ______________

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

(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			
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

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	$ .00

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

VIII. CHARGES (rounded off to whole dollars)

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