

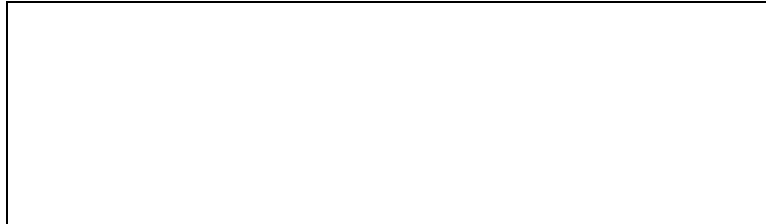
THIS REPORT IS DUE ON OR BEFORE AUGUST 17, 2020

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2020 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, 2019, through June 30, 2020*; 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: _____

THIS REPORT IS DUE ON OR BEFORE AUGUST 17, 2020

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 border="0" style="width: 100%;"> <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 border="0" style="width: 100%;"> <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 border="0" style="width: 100%;"> <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) _____ | _____ |

THIS REPORT IS DUE ON OR BEFORE AUGUST 17, 2020

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) _____

