FORM SNH-F1
Revised 06/2020

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

PRINT

SELECT TEXT WITH MOUSE TO OVERTYPE IN FIELDS BELOW

ENTER ID NUMBER ASSIGNED BY SHPDA

ENTER NAME OF PROVIDER AS REFLECTED ON CURRENT ADPH LICENSE

SUBMIT REPORT

SAVE

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 (STATE) _____ (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 _____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

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 <u>MUST</u> 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)

○ 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

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? ○ 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. _____ BEDS _____ DAYS

f. Additional licensed beds and the number of days those beds were licensed _____ 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	0
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.) 0

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			0
19 – 34 Years			0
35 – 54 Years			0
55 – 64 Years			0
65 – 74 Years			0
75 – 84 Years			0
85 Years and Older			0
TOTALS	0	0	0

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			0
Workman's Compensation			0
Medicare			0
Medicaid			0
Tricare			0
Blue Cross **(not long term care insurance)**			0
Other Insurance Companies **(not long term care insurance)**			0
No Charge (charity & other)			0
Hospice			0
Long Term Care Insurance			0
Other (specify) _____			0
TOTALS	0	0	0

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: _____