FORM SNH-F1
Revised 06/2021

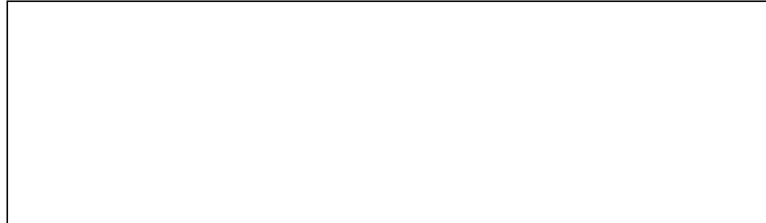
THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 2021

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

2021 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, 2020, through June 30, 2021*; 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:	______

FORM SNH-F1
Revised 06/2021

THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 2021

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 ______

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 16, 2021

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) ____________

THIS REPORT IS DUE ON OR BEFORE AUGUST 16, 2021

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: ____________________