FORM SNH-F1
Revised 06/2022

THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2022

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2022 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, 2021, through June 30, 2022; 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: _____

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PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE FY 20** INPATIENT REHABILITATION PATIENT ORIGIN SURVEY DATA SUPPLEMENT MUST INCLUDE DISCHARGE DATA FOR JULY 1, 2021 - JUNE 30, 2022

The data in this section should be reported by all Skilled Nursing Facilities providing inpatient rehabilitation services. This information should be provided as a separate Microsoft Excel or CSV file and should be provided **IN ADDITION TO** the data required on pages 1-4 of this survey. All submissions must comply with the filing requirements set forth in Ala. Admin. Code 410-1-3-.09. The Annual Report (Form BHD 134A) AND the Patient Origin data electronic file must be submitted for the annual report to be deemed materially complete by the Agency. A provider whose report is deemed materially incomplete by the Agency is subject to penalties as defined in Ala. Admin. Code 410-1-3-.11.

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
FacilityID#	SHPDA Nursing Home ID number	**SHPDA Assigned**
PatientNumber	Patient identification number. *This number may be a blind number assigned in sequential order.* Patient ID numbers **cannot** be duplicated.	**MDS A1300**
Age	The numeric value of the patient's age.	**MDS A0900** (calculated from patient Date of Birth)
Sex	Use the following values: ***MALE:* 1 *FEMALE:* 2 *OTHER/UNKNOWN:* 9**	**MDS A0800**
Race	Use the following values: ***WHITE/CAUCASIAN*---------- 1** ***BLACK/AFRICAN AMERICAN*---------- 2** ***HISPANIC/SPANISH/LATINO*---------- 3** ***ASIAN*---------- 4** ***AMERICAN INDIAN/ALASKAN NATIVE*---------- 5** ***PACIFIC ISLANDER*---------- 6** ***INDIA*---------- 7** ***MIDDLE EASTERN*---------- 8** ***OTHER*---------- 9**	**MDS A1000**
ZipCode	Patient's residence zip code. **Report only the 5 digit zip code where possible. Report unknown zip codes as "99999".**	**UB-04 9d**

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
LengthOfStay	The number of days calculated from the date of admission until the date of discharge. Discharges for this year include any patients admitted in previous years and discharged during the current reporting period.	**MDS A2000 – MDS A1900**
DateOfDischarge	Date the patient was discharged from care. Submit in MM/DD/YYYY format.	**MDS A2000**
Service	All Service Codes for patients receiving inpatient rehabilitation services should be assigned a service code of '8'.	**N/A** (Assign all patients a code of '8')
HIPPS	Primary HIPPS Code for Patient	**MDS Z0100**
Payor	Use the following values: ***SELF PAY/PRIVATE PAY*** **1** ***WORKMAN'S COMPENSATION*** **2** ***MEDICARE*** **3** ***MEDICAID*** **4** ***TRI-CARE*** **5** ***BLUE CROSS/BLUE SHIELD*** **6** ***NO CHARGE/CHARITY*** **7** ***HMO*** **8** ***ALL KIDS*** **9** ***OTHER INSURANCE*** **10** ***HOSPICE*** **11** ***MEDICARE ADVANTAGE*** **12** ***OTHER*** **13**	**MDS Z0300**
ICD-10Primary	Patient's Primary ICD-10 Diagnosis Code	**MDS I0020B**
ICD-10Secondary	Additional Active Diagnosis ICD-10 Code #1	**MDS I8000A**
ICD-10Secondary2	Additional Active Diagnosis ICD-10 Code #2	**MDS I8000B**
ICD-10Secondary3	Additional Active Diagnosis ICD-10 Code #3	**MDS I8000C**
ICD-10Secondary4	Additional Active Diagnosis ICD-10 Code #4	**MDS I8000D**
ICD-10Secondary5	Additional Active Diagnosis ICD-10 Code #5	**MDS I8000E**
ICD-10Secondary6	Additional Active Diagnosis ICD-10 Code #6	**MDS I8000F**
ICD-10Secondary7	Additional Active Diagnosis ICD-10 Code #7	**MDS I8000G**

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
ICD-10Secondary8	Additional Active Diagnosis ICD-10 Code #8	MDS I8000H
ICD-10Secondary9	Additional Active Diagnosis ICD-10 Code #9	MDS I8000I
ICD-10Secondary10	Additional Active Diagnosis ICD-10 Code #10	MDS I8000J
Condition	Patient's primary medical condition category	MDS I0020
Admit	Facility Type from which patient was admitted	MDS A1800
Discharge	Facility type/location to which patient was discharged	MDS A2100
Cancer	Cancer Diagnosis	MDS I0100
Anemia	Anemia (e.g. aplastic, iron deficiency, pernicious, and sickle cell) diagnosis	MDS I0200
Atrial	Atrial Fibrillation or Other Dysrhythmias Diagnosis	MDS I0300
Coronary	Coronary Artery Disease (CAD) (e.g. angina, myocardial infarction, and atherosclerotic heart disease (ASHD)) diagnosis	MDS I0400
DVT	Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE) or Pulmonary Thrombo-Embolism (PTE) diagnosis	MDS I0500
Heart	Heart Failure (e.g. congestive heart failure (CHF) and pulmonary edema) Diagnosis	MDS I0600
Hypertension	Hypertension Diagnosis	MDS I0700
Orthostatic	Orthostatic Hypotension Diagnosis	MDS I0800
PVD	Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD) Diagnosis	MDS I0900
Cirrhosis	Cirrhosis Diagnosis	MDS I1100
GERD	Gastroesophageal Reflux Disease (GERD) or Ulcer (e.g. esophageal, gastric, and peptic ulcers) Diagnosis	MDS I1200
Colitis	Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease Diagnosis	MDS I1300
BPH	Benign Prostatic Hyperplasia (BPH) Diagnosis	MDS I1400
ESRD	Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD) Diagnosis	MDS I1500
Bladder	Neurogenic Bladder Diagnosis	MDS I1550
Uropathy	Obstructive Uropathy Diagnosis	MDS I1650
MDRO	Multidrug-Resistant Organism (MDRO) Diagnosis	MDS I1700
Pneumonia	Pneumonia Diagnosis	MDS I2000
Septicemia	Septicemia Diagnosis	MDS I2100
Tuberculosis	TB Diagnosis	MDS I2200
UTI	Urinary Tract Infection (UTI) (Last 30 days) Diagnosis	MDS I2300

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
Hepatitis	Viral Hepatitis (e.g. Hepatitis A, B, C, D and E) Diagnosis	**MDS I2400**
Infection	Wound Infection (other than foot) Diagnosis	**MDS I2500**
Diabetes	Diabetes Mellitus (DM) (e.g. diabetic retinopathy, nephropathy and neuropathy) Diagnosis	**MDS I2900**
Hyponatremia	Hyponatremia Diagnosis	**MDS I3100**
Hyperkalemia	Hyperkalemia Diagnosis	**MDS I3200**
Hyperlipidemia	Hyperlipidemia Diagnosis	**MDS I3300**
Thyroid	Thyroid Disorder (e.g. hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis) Diagnosis	**MDS I3400**
Arthritis	Arthritis (e.g. degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA) Diagnosis	**MDS I3700**
Osteoporosis	Osteoporosis Diagnosis	**MDS I3800**
Hip	Hip Fracture (any hip fracture that has a relationship to current status, treatments, monitoring (e.g. sub-capital fractures, and fractures of the trochanter and femoral neck)) Diagnosis	**MDS I3900**
Fracture	Other Fracture Diagnosis	**MDS I4000**
Alzheimers	Alzheimer's Disease Diagnosis	**MDS I4200**
Aphasia	Aphasia Diagnosis	**MDS I4300**
Palsy	Cerebral Palsy Diagnosis	**MDS I4400**
CVA	Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or Stroke Diagnosis	**MDS I4500**
Dementia	Non-Alzheimer's Dementia (e.g. Lewy body dementia, vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia such as Pick's disease, and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases) Diagnosis	**MDS I4800**
Hemiplegia	Hemiplegia or Hemiparesis Diagnosis	**MDS I4900**
Paraplegia	Paraplegia Diagnosis	**MDS I5000**
Quadriplegia	Quadriplegia Diagnosis	**MDS I5100**
MS	Multiple Sclerosis Diagnosis	**MDS I5200**
Huntingtons	Huntington's Disease Diagnosis	**MDS I5250**
Parkinsons	Parkinson's Disease Diagnosis	**MDS I5300**
Tourettes	Tourette's Syndrome Diagnosis	**MDS I5350**
Epilepsy	Seizure Disorder or Epilepsy Diagnosis	**MDS I5400**
TBI	Traumatic Brain Injury (TBI) Diagnosis	**MDS I5500**

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
Malnutrition	Malnutrition (protein or calorie) or at risk for malnutrition Diagnosis	**MDS I5600**
Anxiety	Anxiety Disorder Diagnosis	**MDS I5700**
Depression	Depression (other than bipolar) Diagnosis	**MDS I5800**
Bipolar	Bipolar Disorder Diagnosis	**MDS I5900**
Psychotic	Psychotic Disorder (other than schizophrenia) Diagnosis	**MDS I5950**
Schizophrenia	Schizophrenia (e.g. schizoaffective and schizophreniform disorders) Diagnosis	**MDS I6000**
PTSD	Post Traumatic Stress Disorder (PTSD) Diagnosis	**MDS I6100**
Asthma	Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g. chronic bronchitis and restrictive lung diseases such as asbestosis) Diagnosis	**MDS I6200**
Respiratory	Respiratory Failure Diagnosis	**MDS I6300**
Cataracts	Cataracts, Glaucoma or Macular Degeneration Diagnosis	**MDS I6500**
None	None of the above active Diagnoses	**MDS I7900**
PITherapyDischarge	Physical Therapy Individual Therapy minutes, total since start date of most recent stay	**MDS O0425 C1**
PCTherapyDischarge	Physical Therapy Concurrent Therapy minutes, total since start date of most recent stay	**MDS O0425 C2**
PGTherapyDischarge	Physical Therapy Group Therapy minutes, total since start date of most recent stay	**MDS O0425 C3**
PTTherapyDischarge	Physical Therapy Co-Treatment Therapy minutes, total since start date of most recent stay	**MDS O0425 C4**
PTherapyDaysDischarge	Physical Therapy days, total number of days therapy administered since start date of most recent stay	**MDS O0425 C5**
OITherapyDischarge	Occupational Therapy Individual Therapy minutes, total since start date of most recent stay	**MDS O0425 B1**
OCTherapyDischarge	Occupational Therapy Concurrent Therapy minutes, total since start date of most recent stay	**MDS O0425 B2**
OGTherapyDischarge	Occupational Therapy Group Therapy minutes, total since start date of most recent stay	**MDS O0425 B3**
OTTherapyDischarge	Occupational Therapy Co-Treatment Therapy minutes, total since start of most recent stay	**MDS O0425 B4**
OTherapyDaysDischarge	Occupational Therapy days, total number of days therapy administered since start date of most recent stay	**MDS O0425 B5**
SITherapyDischarge	Speech-Language Pathology and Audiology Services Individual Therapy minutes, total since start date of most recent stay	**MDS O0425 A1**
SCTherapyDischarge	Speech-Language Pathology and Audiology Services Concurrent Therapy minutes, total since start date of most recent stay	**MDS O0425 A2**
SGTherapyDischarge	Speech-Language Pathology and Audiology Services Group Therapy minutes, total since start date of most recent stay	**MDS O0425 A3**

FIELD NAME	INSTRUCTIONS	FIELD LOCATION
STTherapyDischarge	Speech-Language Pathology and Audiology Services Co-Treatment Therapy minutes, total since start date of most recent stay	**MDS O0425 A4**
STherapyDaysDischarge	Speech-Language Pathology and Audiology Services days, total number of days therapy administered since start date of most recent stay	**MDS O0425 A5**