

**THIS REPORT IS DUE ON OR BEFORE AUGUST 15, 2024**

**STATE HEALTH PLANNING AND DEVELOPMENT AGENCY**

*MAILING ADDRESS (U.S. Postal Service)*  
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**2024 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
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**Physical Address:**

STREET ADDRESS	CITY	<b>AL</b>	ZIP
----------------	------	-----------	-----

**County of Location:**

\_\_\_\_\_

**Facility Telephone:**

\_\_\_\_\_ (AREA CODE) & TELEPHONE NUMBER

**Facility Fax:**

\_\_\_\_\_ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for July 1, 2023, through June 30, 2024; 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
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***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
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**FOR OFFICE USE ONLY**

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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**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 <b>licensed</b> by the Alabama Department of Public Health  | _____  |       |       |      |      |
| b. Number of beds certified for Medicare patients ( <b>NOTE:</b> Medicaid patients <b>ARE ALLOWED</b> 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;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">YES</td> <td style="text-align: center;">NO</td> </tr> </table>    | _____ | _____ | YES  | NO   |
| _____   | _____  |       |       |      |      |
| YES   | NO   |       |       |      |      |
| e. If "No" was answered in item (d), 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;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">BEDS</td> <td style="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;">_____</td> <td style="width: 50%; text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">BEDS</td> <td style="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) _____                                    | _____ |

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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.)

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	_____	_____	_____
<b>TOTALS</b>	_____	_____	_____

**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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**PROCESSING NOTES & LEGEND FOR SUBMISSIONS OF THE  
FY 20\*\* INPATIENT REHABILITATION PATIENT ORIGIN SURVEY DATA SUPPLEMENT  
MUST INCLUDE DISCHARGE DATA FOR JULY 1, 2023 - JUNE 30, 2024**

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

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

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

<b>FIELD NAME</b>	<b>INSTRUCTIONS</b>	<b>FIELD LOCATION</b>
<b>Hepatitis</b>	Viral Hepatitis (e.g. Hepatitis A, B, C, D and E) Diagnosis	<b>MDS I2400</b>
<b>Infection</b>	Wound Infection (other than foot) Diagnosis	<b>MDS I2500</b>
<b>Diabetes</b>	Diabetes Mellitus (DM) (e.g. diabetic retinopathy, nephropathy and neuropathy) Diagnosis	<b>MDS I2900</b>
<b>Hyponatremia</b>	Hyponatremia Diagnosis	<b>MDS I3100</b>
<b>Hyperkalemia</b>	Hyperkalemia Diagnosis	<b>MDS I3200</b>
<b>Hyperlipidemia</b>	Hyperlipidemia Diagnosis	<b>MDS I3300</b>
<b>Thyroid</b>	Thyroid Disorder (e.g. hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis) Diagnosis	<b>MDS I3400</b>
<b>Arthritis</b>	Arthritis (e.g. degenerative joint disease (DJD), osteoarthritis, and rheumatoid arthritis (RA)) Diagnosis	<b>MDS I3700</b>
<b>Osteoporosis</b>	Osteoporosis Diagnosis	<b>MDS I3800</b>
<b>Hip</b>	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	<b>MDS I3900</b>
<b>Fracture</b>	Other Fracture Diagnosis	<b>MDS I4000</b>
<b>Alzheimers</b>	Alzheimer's Disease Diagnosis	<b>MDS I4200</b>
<b>Aphasia</b>	Aphasia Diagnosis	<b>MDS I4300</b>
<b>Palsy</b>	Cerebral Palsy Diagnosis	<b>MDS I4400</b>
<b>CVA</b>	Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA) or Stroke Diagnosis	<b>MDS I4500</b>
<b>Dementia</b>	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	<b>MDS I4800</b>
<b>Hemiplegia</b>	Hemiplegia or Hemiparesis Diagnosis	<b>MDS I4900</b>
<b>Paraplegia</b>	Paraplegia Diagnosis	<b>MDS I5000</b>
<b>Quadriplegia</b>	Quadriplegia Diagnosis	<b>MDS I5100</b>
<b>MS</b>	Multiple Sclerosis Diagnosis	<b>MDS I5200</b>
<b>Huntingtons</b>	Huntington's Disease Diagnosis	<b>MDS I5250</b>
<b>Parkinsons</b>	Parkinson's Disease Diagnosis	<b>MDS I5300</b>
<b>Tourettes</b>	Tourette's Syndrome Diagnosis	<b>MDS I5350</b>
<b>Epilepsy</b>	Seizure Disorder or Epilepsy Diagnosis	<b>MDS I5400</b>
<b>TBI</b>	Traumatic Brain Injury (TBI) Diagnosis	<b>MDS I5500</b>



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

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FIELD NAME	INSTRUCTIONS	FIELD LOCATION
<b>STTherapyDischarge</b>	Speech-Language Pathology and Audiology Services Co-Treatment Therapy minutes, total since start date of most recent stay	<b>MDS 00425 A4</b>
<b>STherapyDaysDischarge</b>	Speech-Language Pathology and Audiology Services days, total number of days therapy administered since start date of most recent stay	<b>MDS 00425 A5</b>