



Protecting, Maintaining and Improving the Health of Minnesotans

ANNUAL STATISTICAL REPORT TO THE COMMISSIONER OF HEALTH 2007
NURSING HOME AND BOARDING CARE HOME REPORT

Please refer to the enclosed instructions and definitions before completing this report. Answer all questions completely and accurately to avoid unnecessary delay. The report shall be returned by January 31, 2008 to the Minnesota Department of Health, Licensing and Certification Program, P.O. Box 64900, St. Paul, MN 55164-0900.

GENERAL INFORMATION

Date _____

A. Identification

1. Please correct NAME and ADDRESS, if incorrect.

HFID _____*

Name _____

Street _____

City/Zip _____

2. Telephone Number: Area Code _____ Number _____

3. Name of county in which facility is located _____

4. Name of person to be contacted regarding questions on this report _____

Phone number if different than #2 above _____

E-Mail Address for Contact Person _____

5. Administrator's Name _____ Signature _____

B. Reporting Period

1. All data reported should be for the 12 month period 10/01/06 through 09/30/07. If data is for a different 12 month period than the above, indicate the time period used (please use two digit numbers):

Beginning Date [][] [][] [][]
Month Day Year

Ending Date [][] [][] [][]
Month Day Year

2. Were you in operation 12 months? Yes _____ No _____

* Health Facility Identification Number - Five digit number found on the address label on the notification letter. It is also the number utilized on background study forms.

C. BUDGETED PERSONNEL ON PAYROLL has been removed from the statistical report. The information is collected through the Federal survey process.

D. Bed, Patient and/or Resident Data for Reporting Period of ___ ___ ___ through ___ ___ ___
 mo. day year mo. day year

Was there a permanent change in the number of licensed beds during the reporting period? Yes ___ No ___

1. Census as of first day of reporting period NH _____ BCH _____

Nursing Homes with Boarding Care Units must give separate statistics for each unit.

<u>Licensure Category</u>	<u>Licensed Capacity</u>	<u>No. of Beds Set Up & Staffed</u>	<u>Medicare SNF Certified Beds</u>	<u>Medicare SNF Medicaid NF Certified Beds</u>	<u>Medicaid Certified NF Beds</u>	<u>Medicaid Certified ICF/MR Beds</u>
Boarding Care Home	_____	_____	_____	_____	_____	_____
Nursing Home	_____	_____	_____	_____	_____	_____
<u>TOTAL BEDS</u>	_____	_____	_____	_____	_____	_____

	<u>Nursing Home</u>	<u>Boarding Care Home</u>
2. Admissions - Formal	_____	_____
3. Discharges - Formal (bed not held)		
To:		
a. Boarding Care Home	_____	_____
b. Death	_____	_____
c. Home	_____	_____
d. Hospital (bed not held)	_____	_____
e. Nursing Home	_____	_____
f. Supervised Living Facility	_____	_____
g. Other	_____	_____
h. <u>TOTAL DISCHARGES</u>	_____	_____
4. Discharge Days (including Deaths)	_____	_____
5. Patient/Resident Days		
a. Medicare SNF	_____	_____
b. Medicaid NF	_____	_____
c. Medicaid ICF/MR	_____	_____
d. All Other (Including private pay)	_____	_____
e. <u>TOTAL PATIENT/RESIDENT DAYS</u>	_____	_____

AGE/SEX

(This box is designed for your census on the last day of the reporting period. Total census cannot exceed facility licensed beds.)

Number of Residents in each category:	Under 21		21 - 44		45 - 64		65 - 74		75 - 84		85 - 94		95 +		TOTAL
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
1. Nursing Home															
2. Boarding Care Home															
4. TOTAL															