North Carolina Department of Health and Human Services
Division of Health Service Regulation
Acute and Home Care Licensure and Certification Section
2712 Mail Service Center
Raleigh, North Carolina 27699-2712
Telephone: (919) 855-4620 Fax: (919) 715-3073

Exhibit 13

For Official Use Only
License # _____ NF
Provider #
Computer FID:
Hospital:

NURSING CARE FACILITY/UNIT BEDS
2011 Annual Data Supplement to Hospital License Application

To be completed by each hospital reporting Nursing Facility/Unit Beds as part of its total licensed capacity.

A separate form should be completed for each site.

Legal Identity of Applicant:
_____
(Full legal name of corporation, partnership, individual, or other legal entity owning the enterprise or service.)

Doing Business As (name(s) under which the facility or services are advertised or presented to the public):

PRIMARY: _____
Other: _____
Other: _____

Facility Mailing Address: Street/P.O. Box: _____
City: _____, State: _____ Zip: _____

Facility Site Address: Street: _____
City: _____, State: _____ Zip: _____
County:
Telephone:(____) _____ Fax: (____) _____

E-mail Address of Administrator:
_____

1. Was this facility in operation throughout the entire 12-month reporting period ending September 30, 2010?
___ Yes ___ No

If No, for what period was the facility in operation? ____ / ____ / ____ through ____ / ____ / ____
month/day/year month/day/year

If No, for what reason was the facility not in full operation during this period? _____

_____

_____

2. Was there a change of ownership anytime between October 1, 2009 to September 30, 2010? ___ Yes ___ No

If Yes, what was the date of the change? ____ / ____ / ____

PART A OWNERSHIP DISCLOSURE

(Please fill in any blanks and make changes where necessary.)

1. What is the name of the legal entity with ownership responsibility and liability?

Owner: _____
Street: _____
City: _____ *State:* _____ *Zip:* _____
Telephone: (____) _____ *Fax:* (____) _____
Email Address: _____
Senior Officer: _____

a. Legal entity is: ___ For Profit ___ Not For Profit

b. Legal entity is: ____ Corporation ___ LLC/LLP ___ Partnership
___ Proprietorship ___ Government Unit

c. Does the above entity (partnership, corporation, etc.) lease the building from which services are offered? ___ Yes ___ No

If Yes, name of building owner:

_____

2. Is the business operated under a management contract? ___Yes ___No

If Yes, name and address of the management company.

Name: _____
Street: _____
_____
City: _____ State: _____ Zip: _____
Telephone:(____) _____

3. If this business is a subsidiary of another entity, please identify the parent company below:

Name: NONE
Street: _____
Mailing _____
(*if different from Street*)
City: _____
State: _____ Zip:_____
Telephone:(____) _____ Fax:(____) _____) _____
Senior Officer: _____

PART B OPERATIONS

1. Facility Personnel

   a. Administration

   Name of the Administrator: _____

   Date Hired As Administrator: _____ N.C. License Number: _____

   b. Nursing

   Name of the Director: _____

   Date Hired As D.O.N.: _____ License Number: _____

   c. Medical Director:

   Name of Medical Director: _____
   _____

   Date Hired as Medical Director: _____

   Office Address: _____
   _____

2. Environmental Enhancements Supporting Culture Change
   ("Enhancements" refer to practices and products that help create a homelike atmosphere within the nursing home. Some may be unique to one facility while others may be central to a particular model of culture change.) Listed below are the enhancement components reported on your renewal application last year. Please update these records, as they are used by the state for statistical purposes with respect to its enhancement grant program.

   Please check all the environmental enhancements implemented this year:

Please check Yes or No if the facility is:	Yes	No
a. Currently practicing a formalized culture change process/program?		
b. Currently implementing enhancements, but following no formalized culture change process?		

If Yes to 2a or 2b above, please check which components have been implemented:

☐	Cats	☐	Children	☐	Staff Empowerment	☐	Residential building design
☐	Dogs	☐	Plants	☐	Neighborhoods	☐	Residential dining enhancements
☐	Birds	☐	Gardens	☐	Other Animals	☐	Snoezelen
☐	Bathing	☐	Teams	☐	Aroma Therapy	☐	Other enhancements Please specify

If applicable, please indicate either the culture change philosophy being practiced (i.e.: Eden Alternative, Person Centered Care, Well Spring Model, etc.) or a philosophy unique to your home:

_____

PART C PATIENT SERVICES

(Please fill in any blanks and make changes where necessary. Check Yes or No.)

1. Continuing Care Retirement Communities (CCRC)
   a. Is the facility licensed by the Department of Insurance as a Continuing Care Retirement Community? ___Yes ___No
   b. Does the CCRC own or operate a licensed home care agency? ___Yes ___No

2. Does the facility have an adult day care program? ___Yes ___No
   a. If Yes, indicate maximum number of clients that can be served on a daily basis. _____

3. Does the facility provide hospice care? ___Yes ___No

4. Does the facility have an adult respite program? ___Yes ___No

5. Does this facility provide outpatient rehabilitation therapy? ___ Yes ___No

6. Was there a change to the licensed bed capacity between Oct 1, 2009 to Sept 30, 2010? ___Yes ___No
   a. If Yes, what was the effective date of the change? ___ /___ /___
   b. If Yes, indicate previous number of licensed beds (Nursing Fac, Adult Care). ___ NF___Adult

7. Is the facility a Combination Facility, thereby incorporating licensed ACH beds? ___Yes ___No
   a. If Yes, indicate which rules the facility chooses to apply to the operation of these ACH BEDS (NH rules, ACH rules or both NH & ACH) ☐ ***Nursing Home Licensure Rules*** ☐ ***ACH Licensure Rules***

   If check both, complete checklist enclosed and submit with application.

8. Beds By Type (*Must complete Alzheimer's Special Care Unit data supplement sheet)
   a. Nursing Facility Beds (NF) (TOTAL)
      1. General Nursing Facility Beds
      2. *Alzheimer's Resident Special Care Unit Beds *
      3. HIV/AIDS Resident Beds
      4. Traumatic Brain Injury Resident Beds
      5. Ventilator Dependent Resident Beds
      6. Bariatric Beds _____
      7. Other (specify but do not include Medicare only unit): _____

   b. Adult Care Home Beds (ACH) (TOTAL)
      1. General Adult Care Home Beds
      2. * Alzheimer's Special Care Unit Beds *
      3. Bariatric Beds _____

   c. Total Licensed Beds

9. Bed Certification (based on form DHSR-4501, Breakdown of Room Numbers and Beds)

a. Number of beds certified for Medicare **only** (**Title 18 only**)	
b. Number of beds dually certified for both Medicare & Medicaid **(Title 18/19)**	
c. Number of beds certified for Medicaid **only** (**Title 19 only**)	

PART D PATIENT CENSUS

Important: Report patient census data for September 30, 2010 only.

1. Number of patients in facility on September 30, 2010	Nursing	Adult Care

2. Statistics on Nursing Home Patients

(a) Number of Nursing Level of Care patients on September 30, 2010 by age group	Male	Female
Under 35		
35 - 64 years old		
65 - 74 years old		
75 - 84 years old		
85 years old and older		

(b) Nursing hours worked on this day for Nursing Patients by direct care RNs, LPNs and Nurse Aides.	

3. Statistics on Adult Care Home residents on September 30, 2010 by age groups

	Male	Female
Under 35		
35 - 64 years old		
65 - 74 years old		
75 - 84 years old		
85 years old and older		

PART E PATIENT UTILIZATION DATA

Answer these questions for the reporting period of October 1, 2009 through September 30, 2010.

1. Beginning Census, Admissions, Discharges, and Deaths by Level of Care

- The "Beginning Census" refers to the number of patients/residents in your facility on October 1, 2009.
- "Admissions" refers to the number of persons admitted during the period from Oct 1, 2009 through Sept 30, 2010.
- "Discharges and Deaths" refer to all discharges and deaths from October 1, 2009 through September 30, 2010.

Tips:

- Your "Beginning Census" plus "Admissions" minus your total "Discharges" plus "Deaths" should be equal to, or less than, your facility's licensed capacity.
- Your totals for "Beginning Census" and for "Admissions" should agree with your totals on "Counties of Patient Origin" for Nursing Care and Adult Care, respectively.

Patients/Residents	Beginning Census	Admissions	Discharges (excluding deaths)	Deaths
(1) Nursing Patients				
(2) Adult Care Home Residents				

2. Inpatient Days of Care

Number of Days of Inpatient Care rendered during the reporting period.

a. Nursing Care (NC)

(1) NC Days Reimbursed by Medicare	
(2) NC Days Reimbursed by Medicaid	
(3) NC Days Reimbursed by Private Pay	
(4) NC Days Reimbursed by Other	
(**5**) Total { (1) + (2) + (3) + (4) }	

b. Adult Care Home (ACH)

(1) ACH Days reimbursed by Private Pay	
(2) ACH Days reimbursed by County Special Assistance	
(3) ACH Days reimbursed by Other	
(4) Total { (1) + (2) + (3) }	

3. Counties of Origin for Nursing Care Patients

- For the period of October 1, 2009 through September 30, 2010, list in Column A the counties where **Nursing Care patients** lived before coming to your facility.
- For each county in Column B1 give the number of nursing patients, from that county, who were living in the facility on October 1, 2009.
- For each county, in Column B2 give the total number of additional Nursing Care patients, from that county, who were admitted between October 1, 2009 and September 30, 2010.
- Report patients who were not NC residents as "Out-of-State" on lines 26 through 30. **Attach additional sheets if needed.**

For questions please call Medical Facilities Planning at (919) 855-3865

A	B		C	D
Permanent County of Residence for Individuals prior to Admission (if out-of-state indicate in last lines below)	Patient Census during reporting period:		TOTAL B1 plus B2	For each county indicate number of patients whose care was paid for, in whole or in part by Medicaid (Title XIX) program
	B1 In Facility at beginning	B2 Admitted during period		
EXAMPLE: 1. Wake	50	185	235	175
2. Yadkin	1	2	3	2
1.				
2.				
3.				
4.				
5.				
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19.				
20.				
21.				
22.				
23.				
24.				
25.				
26. Georgia				
27. South Carolina				
28. Virginia				
29. Tennessee				
30. Other Out-of-State				
31. TOTALS				

NOTE: Totals should correspond with the figures given in response to Question 1 under "Patient Utilization"

4. Counties of Origin for Adult Care Home Residents

- For the period of October 1, 2009 through September 30, 2010, list in Column A the counties where **Adult Care Home residents** lived before coming to your facility.
- For each county in Column B1 give the number of Adult Care Home residents, from that county, who were living in the facility on October 1, 2009.
- For each county, in Column B2 give the total number of additional Adult Care Home residents, from that county, who were admitted between October 1, 2009 and September 30, 2010.
- Report residents who were not NC residents as "Out-of-State" on lines 26 through 30. **Attach additional sheets if needed.**

For questions please call Adult Care Licensure at (919) 855-3765

A	B		C	D
Permanent County of Residence for Individuals prior to Admission (if "out-of-state" indicate in last lines below)	Patient Census during reporting period:		TOTAL B1 plus B2	For each county indicate number of patients whose care was paid for, in whole or in part by Medicaid (Title XIX) program
	B1 In Facility at beginning	B2 Admitted during period		
EXAMPLE: 1. Wake	50	185	235	175
2. Yadkin	1	2	3	2
1.				
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25.				
26. Georgia				
27. South Carolina				
28. Virginia				
29. Tennessee				
30. Other Out-of-State				
31. TOTALS				

NOTE: Totals should correspond with the figures given in response to Question 1 under "Patient Utilization"

PART F CURRENT OPERATING STATISTICS

1. Current Per Diem Reimbursement Rates/Charges.
Please state the CURRENT (as of the date the application is signed) basic daily charges/rates for residents or patients in your facility in the following categories of care.

For questions please call Certificate of Need at (919) 855-3873

Private Pay (Usual Customary Charge)	Private Room (1 bed/room)	Semi-Private (2 beds/room)	Ward
Nursing Care	$	$	$
Adult Care Home	$	$	$
Special Care Unit (specify)_____	$	$	$
Special Care Unit (specify)_____	$	$	$

Medicare	Code	Rate
Three most frequent RUGS codes and rates paid for them	1.	$
	2.	$
	3.	$

	Quarterly Rates			
Medicaid	Oct.-Dec.	Jan.-Mar.	Apr.-June	July-Sept.
Nursing Care	$	$	$	$

Medicaid Nursing Care	Rate
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

State/County Special Assistance	Rate
Adult Care Home	$
Special Care Unit (specify)_____	$
Special Care Unit (specify)_____	$

Please complete only if applicable:

Alzheimer's/Dementia Special Care Unit	Rate
Additional cost or fee to resident	$

(Use reverse side or separate sheet if needed)

2. Total Current Staff for Existing Facility

Do not include the following: courtesy or attending staff, private duty nurses, volunteer workers or the same employee in more than one category. These employees were on the payroll as of _____.
month/day/year

For questions please call Certificate of Need at (919) 855-3873

	Average Annual Salary	Hourly Consulting Fee	Total Facility FTE's	Total Facility Annual Consul. Hrs.
Routine Services				
Registered Nurses				
Licensed Practical Nurses (LPNs)				
Certified Nurse Aides				
Medical Director				
Director of Nurses				
Assistant Director of Nurses				
Staff Development Coordinator				
Ward Secretary				
Medical Records				
Pharmacy Consultant				
Administration and General				
Administrator				
Assistant Administrator				
Other Office Personnel				
Dietary				
Licensed Dietitian				
Food Service Supervisor				
Cooks				
Dietary Aides				
Social Work Services				
Social Services Director				
Social Services Assistant(s)				
Activity Services				
Activity Director				
Activity Assistant(s)				
Housekeeping/Laundry				
Housekeeping Supervisor				
Laundry Supervisor				
Housekeeping Aides				
Laundry Aides				
Maintenance				
Maintenance Supervisor				
Janitors				
Ancillary Services				
Physical Therapist				
Rehabilitation Aide				
Respiratory Therapist				
Occupational Therapist				
Speech/Hearing Therapist				
Total Positions / Total Consultant Hours				

ADULT CARE HOME (ACH) SUPPLEMENT

For questions please call Adult Care Licensure at (919) 855-3765

1. Please give the number (1, 2, 3, etc.) of Adult Care residents currently in facility with a physician's diagnosis of the following: a) **Mental Illness** (**MI**) which includes a psychiatric illness but does not include mental retardation, developmental disabilities or Alzheimer's/Dementia; b) **Mental Retardation/Developmentally Disabled** (**MR/DD**) such as Downs syndrome, autism, cerebral palsy, or epilepsy; or c) **Alzheimer's Disease** or related dementia which may include multi-infarct dementia, Parkinson's Disease, Huntington's Disease, Creutzfeldt-Jakob Disease or Picks Disease. If a resident is dually diagnosed, only count the resident once, based on the primary diagnosis.

Resident Age - years	**MI**	**MR/DD**	**Alzheimer's/Related Dementia**
Under 35			
35 - 64			
65 - 74			
75 - 84			
85 or older			
TOTAL			

2. On September 30, 2010, number of Adult Care residents receiving Medicaid reimbursed Basic Adult Care Home Personal Care (not Enhanced): _____

3. On September 30, 2010, number of Adult Care residents receiving Medicaid reimbursed Enhanced Adult Care Home Personal Care: _____

4. On September 30, 2010, number of Adult Care residents on State/County Special Assistance (SA): _____

5. On September 30, 2010, number of private pay Adult Care residents: _____

6. Current total monthly private pay charge (average base plus add-ons if more than one price) for:

	Rate
Private Room (1 bedroom)	$
Semi-Private (2 beds/room)	$
3 or more beds/room	$

7. Check any that apply:

		Number of Beds
❒	Alzheimer's Special Care Unit in facility [Rules 13F .1300 apply]	

This application must be completed and submitted with the "Hospital License Renewal Application" for each hospital reporting Nursing Facility/Unit Beds as part of its total licensed capacity.

The undersigned submits this data supplement for licensure for the year 2011 and certifies the accuracy of this information.

_____ _____
Name of Chief Administrative Officer Title

Signature: _____ Date: _____
(Chief Administrative Officer or Representative)

Please identify the contact person for questions regarding this application:

Name: _____ Telephone: (_____) _____
(Contact Person)