LONG-TERM CARE BED UTILIZATION & OCCUPANCY REPORT

NURSING FACILITY:

ADDRESS:
(Street)    (City)    (County)    (Zip)

INDICATE THE QUARTER AND YEAR FOR WHICH THE INFORMATION IS BEING PROVIDED. CHECK THE BOX CORRESPONDING TO THE APPROPRIATE QUARTER.

[ ] JANUARY, FEBRUARY, MARCH _______ (Year)
[ ] APRIL, MAY, JUNE
[ ] JULY, AUGUST, SEPTEMBER
[ ] OCTOBER, NOVEMBER, DECEMBER

SPECIFY THE FOLLOWING INFORMATION:
A. Total number of residents on the last day of the quarter ______
B. Total number of days that each bed was occupied or held ______
   ▪ Occupied days mean the number of days each bed was in use during the quarter.
   ▪ Holding days mean the number of days each bed was held for residents in hospital, on home visits, on vacation leave, etc.
   ▪ Include ALL residents, regardless of payment source.

NAME OF PERSON COMPLETING REPORT:

TITLE:

PHONE:    DATE:

RETURN TO:
DHHS Division of Public Health    OR    FAX: 402-471-9728
Public Health Support
Office of Health Statistics
P.O. Box 95026
Lincoln, NE 68509

OR carla.becker@nebraska.gov

IMPORTANT: NEW CONTACT Carla Becker, 402-471-3575
Email: carla.becker@nebraska.gov