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 AS A WORD DOCUMENT (.doc) TO:

carla.becker@nebraska.gov
402-471-3575

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