

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BUREAU OF HEALTH SYSTEMS
DIVISION OF NURSING HOME MONITORING

Facility Information Sheet

Instructions: Fill out this form completely, legibly and accurately. You may need to contact the facility's corporate office to obtain certain information. If the form is not completed it may be returned to the facility. Please provide this form to the survey team prior to their exit. Keep a copy for your records.

Facility Information	
Facility Name/D.B.A. (Doing Business As)	State Facility Number
CMS Certification (CCN) # 23-	
Address	City
	County
	Zip Code
Phone Number	Fax Number
Primary Contact Person for Facility	Phone Number
Emergency Contact Person	Phone Number
MDS Assessment Contact Person	Phone Number
NPI#(s) (National Provider Identifier) Please attach a separate sheet if necessary.	

Licensed Administrator	
Administrator Name	E-mail Address
License Number	License Expiration Date
4 8	

Licensed Director of Nursing	
Director of Nursing Name	
License Number	License Expiration Date
4 7	

Bed Information/Air Conditioning	
<p style="text-align: center;">Current Beds</p> <p>Medicare (SNF) _____</p> <p>Medicaid (NF) _____</p> <p>Medicare/Medicaid (SNF/NF) _____</p> <p>Total Certified Beds: _____</p> <p>Licensed Only Beds: _____</p> <p>Total Facility Beds: _____</p>	<p>Does the facility have any of the following beds that are <i>not</i> part of the "<i>Special Pool Beds</i>" issued by Certificate of Need?</p> <p><input type="checkbox"/> Religious Beds</p> <p><input type="checkbox"/> Ventilator Dependent</p> <p><input type="checkbox"/> Dialysis</p> <p><input type="checkbox"/> Alzheimer's Beds</p> <p><input type="checkbox"/> Hospice</p> <hr/> <p>Does the facility have a locked Unit?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what special population is serving that unit?</p>

AIR CONDITIONING	
Is the facility air conditioned?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
If yes, is it <input type="checkbox"/> fully or <input type="checkbox"/> partially (please attach a map indicating the area(s))	

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Fiscal Intermediary (Complete this section only if the facility is certified.)																				
Fiscal Intermediary					Intermediary/Carrier Number (This is not the Provider # or CCN)															
Address			City		State			Zip Code												
Ownership (legal entity which directly owns the facility)																				
Company/Owner Legal Name					Primary Owner															
Phone Number			Fax Number		E-mail Address															
Address				City			State		Zip Code											
Tax ID				Is the Ownership for:			Does the Owner													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>						-								<input type="checkbox"/> Profit			<input type="checkbox"/> Own the building			or
						-														
<input type="checkbox"/> Non Profit			<input type="checkbox"/> Is this a management company																	
Type of Entity																				
<input type="checkbox"/> Profit Individual			<input type="checkbox"/> Non Profit Religious			<input type="checkbox"/> State		<input type="checkbox"/> City/County												
<input type="checkbox"/> Profit Partnership			<input type="checkbox"/> Non Profit Corporation			<input type="checkbox"/> County		<input type="checkbox"/> Hospital District												
<input type="checkbox"/> Profit Corporation			<input type="checkbox"/> Non Profit Other			<input type="checkbox"/> City		<input type="checkbox"/> Federal												
Parent Organization Name				Contact Person				Phone Number												
Address				City		State		Zip Code												
Tax ID				Contact Name			E-mail address													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>						-														
						-														
Chain Affiliation																				
Is the facility chain affiliated?					If yes, does this chain own															
<input type="checkbox"/> No					<input type="checkbox"/> More than 30															
<input type="checkbox"/> Yes, if "yes", complete below. (Attached additional sheet is necessary)					<input type="checkbox"/> Less than 30															
Name				Address																
City			State			Zip Code														
Officers/Directors/Trustees: (attach additional pages if necessary)																				
Name					Phone Number															
Address			City		State		Zip Code													
Tenure From (date)		Primary Contact	Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President												
		<input type="checkbox"/> Yes		<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President												
		<input type="checkbox"/> No		<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer												
Tax ID				Percentage Owned																
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Officers/Directors/Trustees: (continued)										
Name						Phone Number				
Address				City			State		Zip Code	
Tenure From (date)		Primary Contact <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President	
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President	
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer	
Tax ID						Percentage Owned				
		-								
Name						Phone Number				
Address				City			State		Zip Code	
Tenure From (date)		Primary Contact <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President	
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President	
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer	
Tax ID						Percentage Owned				
		-								
Name						Phone Number				
Address				City			State		Zip Code	
Tenure From (date)		Primary Contact <input type="checkbox"/> Yes <input type="checkbox"/> No		Position	<input type="checkbox"/> Director		<input type="checkbox"/> Manager		<input type="checkbox"/> President	
					<input type="checkbox"/> Secretary		<input type="checkbox"/> Treasurer		<input type="checkbox"/> Vice President	
					<input type="checkbox"/> Senior Officer		<input type="checkbox"/> Junior Officer		<input type="checkbox"/> Principal Officer	
Tax ID						Percentage Owned				
		-								
Are there any directors, officers, agents, or managing employees of the institution agency or organization who have been convicted of a criminal offense? <input type="checkbox"/> No <input type="checkbox"/> Yes → If "yes", please attach an additional sheet describing the event.										
Does anyone listed own or have an interest in other healthcare facilities (for example: sole proprietor, partner, member of a partnership, board of directors)? <input type="checkbox"/> No <input type="checkbox"/> Yes → If "yes", please attach an additional sheet indicating name, address, city, state & zip code and interest of parent corporation.										
Are any persons who have ownership interest required to file a beneficial ownership report pursuant to the Federal Securities Exchanges Act of 1934 [15 U.S.C. 78p, Sec. 16 (a)]? <input type="checkbox"/> Yes – If yes, attach copies of such report <input type="checkbox"/> No										
Building Owner										
Legal Owner of Building						Phone Number				
Address				City			State		Zip Code	
Lien Holder (if different from building owner)										
Lien Holder						Phone Number				
Address				City			State		Zip Code	

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Management Company (who is responsible for nursing home day to day operations, if different than applicant?)			
Name of Company		Phone Number	
Address	City	State	Zip Code
Contact Person	E-mail address		
Certification of Applicant			
The applicant certifies that the information provided on this form is true, complete and accurate to the best of his/her knowledge.			
_____ Signature of Authorized Representative		_____ Title	_____ Date