

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
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																															
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;"></td> <td style="text-align: center;">Current Beds</td> <td style="border-bottom: 1px solid black; width: 200px;"></td> </tr> <tr> <td>Medicare (SNF)</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Medicaid (NF)</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Medicare/Medicaid (SNF/NF)</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Total Certified Beds:</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Licensed Only Beds:</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td>Total Facility Beds:</td> <td style="text-align: center;">_____</td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>							Current Beds		Medicare (SNF)	_____		Medicaid (NF)	_____		Medicare/Medicaid (SNF/NF)	_____		Total Certified Beds:	_____		Licensed Only Beds:	_____		Total Facility Beds:	_____		<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>				
	Current Beds																														
Medicare (SNF)	_____																														
Medicaid (NF)	_____																														
Medicare/Medicaid (SNF/NF)	_____																														
Total Certified Beds:	_____																														
Licensed Only Beds:	_____																														
Total Facility Beds:	_____																														
						<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																															
<p>Is the facility air conditioned?</p> <p><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))</p>																															

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Fiscal Intermediary (Complete this section only if the facility is certified.)									
Fiscal Intermediary					Intermediary/Carrier Number <small>(This is not the Provider # or CCN)</small>				
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		
- - - - -				<input type="checkbox"/> Profit <input type="checkbox"/> Non Profit			<input type="checkbox"/> Own the building or <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	
- - - - -									
Chain Affiliation									
Is the facility chain affiliated?						If yes, does this chain own			
<input type="checkbox"/> No <input type="checkbox"/> Yes, if "yes", complete below. (Attached additional sheet is necessary)						<input type="checkbox"/> More than 30 <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"/> No			<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			
- - - - -									

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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