

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2011

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2011 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

Mailing Address:

_____ STREET ADDRESS _____ CITY _____ STATE _____ ZIP

Physical Address:

_____ STREET ADDRESS _____ CITY _____ **AL** _____ ZIP

County of Location:

Facility Telephone:

_____ (AREA CODE) & TELEPHONE NUMBER

Facility Fax:

_____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for March 1, 2010, through February 28, 2011*; or for partial year of operation beginning _____ and ending _____ a period of _____ days.

MONTH DAY

MONTH DAY

*Data for the agency's fiscal year, other than the time frame specified, may be provided, but no more than 12 months of consecutive data should be reported. ***If there was a change in ownership during the reporting period, data for the full year should be reported by the current owner.***

We hereby affirm and attest that the reported information has been verified, and to the best of our knowledge, the information contained in the following pages of this report is a true and accurate representation of the services, equipment, and utilization of this facility.

PRINTED NAME OF PREPARER	SIGNATURE OF PREPARER	DATE
DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
<i>A member of administration <u>MUST</u> also sign below verifying the accuracy of the information contained herein, as reported by the preparer listed above.</i>		
PRINTED NAME OF ADMINISTRATION OFFICIAL	SIGNATURE OF ADMINISTRATION OFFICIAL	DATE
DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS

FOR OFFICE USE ONLY

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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I OWNERSHIP

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify)

II MANAGEMENT

Does this facility operate under a management contract? Yes No

Management Firm: _____

Name

Base Address	City	State	Zip
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III FACILITIES

Total number of licensed beds: _____

Number of beds set up in this facility for use: _____

IV ADMISSIONS

Total Admissions for the reporting period: _____

Admissions by source of payment:

Private Pay	_____
Long Term Care Insurance	_____
Other (specify) _____	_____

V DISCHARGES

Total discharges (include deaths) _____

Discharges due to death _____

VI. DEMOGRAPHICS

A. TOTAL ADMISSIONS BY RACE FOR THE ENTIRE REPORTING PERIOD
(Total must agree with The totals provided in Section IV and Section VI-B.)

- a. White/Caucasian _____
 - b. Black/African American/Negro _____
 - c. Hispanic/Spanish/Latino _____
 - d. Asian _____
 - e. American Indian/Alaskan Native _____
 - f. Pacific Islander _____
 - g. India _____
 - h. Middle Eastern _____
 - i. Other (specify) _____
- TOTAL** _____

B. TOTAL ADMISSIONS BY AGE AND GENDER FOR THE ENTIRE REPORTING PERIOD
(Total must agree with the totals provided in Section IV and Section VI-A.)

AGE GROUPS	MALE	FEMALE	TOTALS
18 & under	_____	_____	_____
19 – 34 Years	_____	_____	_____
35 – 54 Years	_____	_____	_____
55 – 64 Years	_____	_____	_____
65 – 74 Years	_____	_____	_____
75 – 84 Years	_____	_____	_____
85 Years and Older	_____	_____	_____
TOTALS	_____	_____	_____

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VII RESIDENT DAYS

Number of licensed beds

- | | | | |
|---|---|--------------|--|
| 1. (Section III of this report) | | _____ | |
| | | x 365 | |
| 2. Multiply line 1 by 365 for total available days | = | _____ | |
| 3. Total number of days beds were unoccupied due to vacancies, discharges and deaths (also include 365 days for each bed that is licensed but not set up for use in this facility) | | _____ | |
| 4. TOTAL RESIDENT DAYS (subtract line 3 from line 2) | | _____ | |

VIII REVENUES AND EXPENSES

These amounts **DO NOT** have to be audited prior to reporting.

Expenses

Payroll	\$	_____	.00
Non-Payroll	\$	_____	.00
TOTAL EXPENSES	\$	_____	.00

Revenues

Long Term Care Insurance	\$	_____	.00
Private Pay	\$	_____	.00
Other	\$	_____	.00
TOTAL REVENUES	\$	_____	.00

VIII BASIC RESIDENT CHARGE

	Monthly		Daily	
Private Room	\$	_____	\$	_____
		.00		.00
Semi-Private Room	\$	_____	\$	_____
		.00		.00