FORM SCALF-1
Revised 2/01/2014

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2014

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2014 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

This report should be typewritten or completed in ink only; no pencil submissions

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, 2013, through February 28, 2014*; or for partial year of operation beginning

_____ (MONTH DAY) and ending _____ (MONTH DAY) a period of _____ days.

*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

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; and must be separate from the preparer

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

_____ Corporation _____ Non-Profit Organization _____ Partnership

_____ Individual _____ Healthcare Authority _____ LLC

_____ Joint Venture _____ Government _____ Other (specify)

_____

II. MANAGEMENT

Does this facility operate under a management contract? _____ Yes _____ No

Management Firm: _____

Name

_____

Base Address City State Zip

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) _____ _____

Has this provider had a waiting list for SCALF beds at any time during this reporting period?

_____ YES _____ NO

V. DISCHARGES

Total discharges (include deaths) _____

Discharges due to death _____

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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

1.	**Number of licensed beds** (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

IX. BASIC RESIDENT CHARGE

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