

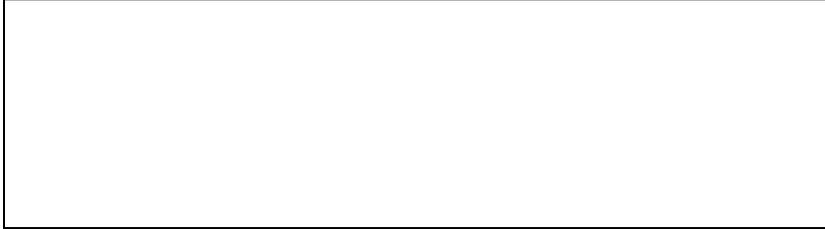
**THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2015**

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](http://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](mailto:bradford.williams@shpda.alabama.gov)

2015 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES



**This report should be typewritten or completed in ink only; no pencil submissions. Electronic submissions are requested.**

**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, 2014, through February 28, 2015\*; 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
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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***A member of administration MUST 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
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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**FOR OFFICE USE ONLY**

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



**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	_____	_____	_____
<b>TOTALS</b>	_____	_____	_____

**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
<b>TOTAL EXPENSES</b>	\$		.00

**Revenues**

Long Term Care Insurance	\$		.00
Private Pay	\$		.00
Other	\$		.00
<b>TOTAL REVENUES</b>	\$		.00

**IX. BASIC RESIDENT CHARGE**

	<b>Monthly</b>	<b>Daily</b>
Private Room	\$ <span style="border-bottom: 1px solid black; padding: 0 20px;"></span> .00	\$ <span style="border-bottom: 1px solid black; padding: 0 20px;"></span> .00
Semi-Private Room	\$ <span style="border-bottom: 1px solid black; padding: 0 20px;"></span> .00	\$ <span style="border-bottom: 1px solid black; padding: 0 20px;"></span> .00

Make and keep a copy of the completed report for the facility's records before submitting to SHPDA.

This report should be submitted to SHPDA only one time. ***The preferred method is electronic submission to [bradford.williams@shpda.alabama.gov](mailto:bradford.williams@shpda.alabama.gov)***. If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.