FORM SCALF-1
Revised 1/2009

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2009

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2009 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, 2008, through February 28, 2009*; 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.

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) _____ _____

V DISCHARGES

Total discharges (include deaths) _____

Discharges due to death _____

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VI. RESIDENT CENSUS ***Please verify the information provided balances in each row and column***

This information is to be provided for the number of individuals in residence on **February 28, 2009**, (or last day of reporting period if facility closed before February 28)

Age Groups	Male	Female	Totals
18 & under			
19 – 34 years of age			
35 – 54 years of age			
55 – 64 years of age			
65 – 74 years of age			
75 – 84 years of age			
85 years and older			
TOTALS			

Ethnicity	Totals
White/Caucasian	
Black/African American/Negro	
Hispanic/Spanish/Latino	
Asian	
American Indian/Alaskan Native	
Pacific Islander	
India	
Middle Eastern	
Other	
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