FORM SCALF-1
Revised 2/01/2012

THIS REPORT IS DUE ON OR BEFORE APRIL 16, 2012

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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2012 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, 2011, through February 29, 2012*; 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**

A member of administration MUST 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) ____________________ __________

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 366

2. Multiply line 1 by 366 for total available days = ______________

3. Total number of days beds were unoccupied due to vacancies, discharges and deaths (also include 366 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