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)
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MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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2014 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

ENTER FACILITY ID NUMBER

ENTER FACILITY NAME

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** (STATE) _____ (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 _____

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	**0**

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			**0**
19 – 34 Years			**0**
35 – 54 Years			**0**
55 – 64 Years			**0**
65 – 74 Years			**0**
75 – 84 Years			**0**
85 Years and Older			**0**
TOTALS	**0**	**0**	**0**

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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	$ **0**	.00

Revenues

Long Term Care Insurance	$ _____	.00
Private Pay	$ _____	.00
Other	$ _____	.00
TOTAL REVENUES	$ **0**	.00

IX. BASIC RESIDENT CHARGE

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