INSTRUCTIONS FOR COMPLETING THE 2014 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

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INSTRUCTIONS FOR COMPLETION OF THE 2014 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

Form SCALF-1

These instructions for the 2014 Annual Report for Specialty Care Assisted Living Facilities are intended to assist in the completion and submission of accurate data. To ensure data integrity, and determine utilization rates of Specialty Care Assisted Living Facilities, information reported must be consistent throughout the state. These instructions are intended to assist in the collection of data and in minimizing the number of errors. Should these instructions not address a particular concern, please request additional assistance by contacting the State Health Planning and Development Agency (SHPDA), Bradford L. Williams at (334) 242-4103, bradford.williams@shpda.alabama.gov, or Karen McGuire at (334) 353-7585, karen.mcguire@shpda.alabama.gov. .

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The facility identification number is assigned by SHPDA, and is referenced in the e-mail for electronic transmissions/label for manual transmissions. For electronic completion, manually enter this ID number. The facility name must match the name on the license issued by the Alabama Department of Public Health (ADPH). For needed facility name corrections to manual transmissions, necessary changes should be made to the label. For electronic completion, manually enter the name of the facility.

Mailing Address: Provide the complete mailing address to be used by SHPDA for mailing purposes. This address may be different from the physical address of the facility.

Physical Address: Provide the complete physical address of this facility as indicated on the ADPH license.

County of Location: Provide the county of physical location of the facility.

Facility Telephone: Provide the primary general telephone number of the facility, including the area code.

Facility Fax: Provide the primary general fax telephone number of the facility, including the area code.

The signatures and requested identifying information **must** be provided by two separate individuals. The primary preparer of the annual report will be contacted first for additional/corrected information. The administration official may be contacted in the event the preparer is unavailable or for informational purposes. Legible e-mail addresses for both the preparer and second verifying administrative individual **must** be provided.

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I: Ownership

Ownership: Provide the organizational structure of the facility as filed with the Secretary of State's Office, or as reported to the IRS in abstention of Secretary of State filing.

II: Management

Management: Indicate if this facility is operated by a management firm. If so, check yes and provide the name of the management firm and all contact information requested. If this facility is not operated under a management contract, go to section III.

III: Facilities

Total number of licensed beds: Indicate the number of CON-Authorized beds (licensed by ADPH) on the last day of the reporting period.

Number of beds set up in this facility for use: Indicate the number of beds staffed and in operation on the last day of the reporting period. This number may be less than the number of CON-Authorized (licensed) beds, but may not be more than the number of CON-Authorized beds licensed.

IV: Admissions

Admissions: Indicate the total number of admissions during the reporting period, regardless of source of payment.

Admissions by Source of Payment: Indicate on the appropriate line the number of admissions for each payment source listed. *Please note that the total number of admissions for each category should equal the total number of admissions reported.*

Private Pay: List the total number of patients whose primary source of payment at the time of admission was private or self pay.

Long Term Care Insurance: List the total number of patients whose primary source of payment at the time of admission was a provider of Long Term Care Insurance.

Other: List the total number of patients whose primary source of payment at the time of admission was anything other than listed above. Indicate the source(s) of payment on the line provided.

Indicate if there was a waiting list for SCALF beds at any time during the reporting period.

V: Discharges

Total Discharges (including deaths): List the total number of patients discharged from this facility during the reporting period, regardless of the reason for discharge.

Total Deaths: List the total number of patients discharged from this facility during the reporting period due to *only* death of the patient.

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VI: Demographics

A: Total Admissions by Race

Provide the total number of Admissions for the reporting period broken down by race. The Total Admissions **MUST** equal the total number of admissions reported on page 2, Section IV.

B: Total Admissions by Age and Gender

Provide the total number of Admissions for the reporting period broken down by age groups and gender. The Total Admissions **MUST** equal the total number of admissions reported on page 2, Section IV.

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VII: Resident Days

1. Number of Licensed Beds: List the total number of CON-Authorized beds licensed by ADPH during the reporting period. *Note: If the number of licensed beds either increased or decreased during the reporting period, indicate the number of licensed beds and the number of days during the reporting period for each licensed capacity. Example: If the facility was licensed for 14 beds for 120 days and 16 beds for the remaining 245 days of the reporting period, line 1 would show 14 x120 + 16 x 245. The calculation of this line would then be reported on line 2.*

2. Multiply the number of licensed beds listed above by 365 (the number of days in the reporting year) to determine the total number of available days.

3. Total number of unoccupied days: List the total number of days in which beds were unoccupied due to vacancies, deaths and discharges. Also, include 365 days for *every bed* (CON-Authorized) licensed by ADPH but not set up and staffed during the reporting period.

4. Total Resident Days: Subtract the total number of unoccupied days (line 3) from the total number of available days (line 2) to determine the total number of resident days for the facility during the reporting period.

VIII: Revenues and Expenses

Please note: These amounts do not need to be audited prior to reporting.

Payroll: Total expenses for the reporting period spent on payroll for employees of the facility, including benefits.

Non-payroll: Total remaining expenses for the reporting period of the provider for all items except payroll, and employee benefits.

Long Term Care Insurance: Total revenues received from all patients whose primary source of payment was Long Term Care Insurance.

Private Pay: Total revenue received from all patients whose primary source of payment was private or self pay.

Other: All other revenues received during the reporting period not otherwise listed in this section.

Basic Resident Charge:

Provide the charges for one patient for a private room and for a semi-private room at both monthly and daily rates. If this facility does not provide either a private room or a semi-private room enter "N/A" on the appropriate line. If set monthly/daily rates are not utilized by the facility, determine a monthly rate by multiplying the daily rate by 30. To determine a daily rate, divide the monthly rate by 30.

REMINDERS

The annual report MUST be signed by two separate individuals, including an administrative official.

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

This report should be submitted to SHPDA only once via electronically, hard copy, or fax. The preferred method is electronic submission to 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.