FORM SCALF-1
Revised 02-2020

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2020

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
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TELEPHONE: (334) 242-4103
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2020 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

SELECT TEXT WITH MOUSE TO OVERTYPE IN FIELDS BELOW

PRINT

SAVE

ENTER ID NUMBER ASSIGNED BY SHPDA

ENTER NAME OF PROVIDER AS REFLECTED ON CURRENT ADPH LICENSURE

SUBMIT REPORT

Mailing Address: _____ (STREET ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Physical Address: _____ (STREET ADDRESS) _____ (CITY) AL (STATE) _____ (ZIP)

County of Location: CHOOSE COUNTY...

Facility Telephone: _____ (AREA CODE) & TELEPHONE NUMBER **Facility Fax:** _____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for March 1, 2019, through February 28, 2020; 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: _____

IV. ADMISSIONS

Total admissions for the reporting period: _____

Admissions by source of payment:

Private Pay _____

Other (specify) _____ _____

V. DISCHARGES

Total discharges (include deaths) _____

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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	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

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) _____