FORM SCALF-1
Revised 02-2021

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2021

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
www.shpda.alabama.gov

STREET ADDRESS (Commercial Carrier)
100 NORTH UNION STREET STE 870
MONTGOMERY AL 36104
FAX: (334) 242-4113
bradford.williams@shpda.alabama.gov

2021 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

Mailing Address: ______________ ______________ ______ ______
STREET ADDRESS CITY STATE ZIP

Physical Address: ______________ ______________ AL ______
STREET ADDRESS CITY ZIP

County of Location: ______________

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

This reporting period is for March 1, 2020, through February 28, 2021; 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 <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 Sections IV, VI-B and VIII.)

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 Sections IV, VI-A and VIII.)

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 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) ______________

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

Pursuant to ALA. ADMIN. CODE r. 410-1-3-.09, all Mandatory Reports shall be submitted electronically [via e-mail] to data.submit@shpda.alabama.gov.

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VIII. PATIENT ORIGIN BY ZIP CODE

Please report, by zip code of patient's residence, the total number of admissions to this provider during the reporting period. (This total should equal the totals reported in Sections IV, VI-A and VI-B) (Make additional copies of this page and attach as required)

ZIP CODE OF RESIDENCE	TOTAL NUMBER OF ADMISSIONS