FORM SCALF-1
Revised 2/7/2011

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2011

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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bradford.williams@shpda.alabama.gov

2011 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

TYPE FACILITY ID # HERE

TYPE FACILITY NAME HERE

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, 2010, through February 28, 2011*; 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.

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: 0
(This field is automatically calculated)

Admissions by source of payment:

Private Pay _____

Long Term Care Insurance _____

Other (specify) _____ _____

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	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	=	0
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) (This line is automatically subtracted.)		
4.	**TOTAL RESIDENT DAYS** (subtract line 3 from line 2)		0

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

VIII BASIC RESIDENT CHARGE

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