**FORM SCALF-1** Revised 02-2016

## THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2016

## STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

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

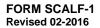
STREET ADDRESS (Commercial Carrier) 100 NORTH UNION STREET STE 870 MONTGOMERY AL 36104 FAX: (334) 242-4113 bradford.williams@shpda.alabama.gov

2016 ANNUA	L REPORT FOR SPECIA	ALTY CARE ASSISTED LIV	/ING FACILITI	ES
***This report should be ty	/pewritten or completed in ink oા	only; no pencil submissions. Electro	onic submissions ar	re requested.
Mailing Address:				
	STREET ADDRESS	CITY	STATE	ZIP
Physical Address:			AL	
	STREET ADDRESS	CITY	_	ZIP
County of Location:				
		<u>-</u>		
Facility Telephone:	(	Facility Fax:	/:\ 9 TELEBLO	
The state of the s	(AREA CODE) & TELEPHONE NUMBE		(AREA CODE) & TELEPHON	
This reporting period is for	March 1, 2015, through ⊢eprua	ary 29, 2016; or for partial year of o	operation beginning	g
	and ending	a period of		_ days.
MONTH DAY	MONTH DAY	Y .		•
		specified, may be provided, but no morship during the reporting period, o		
reported by the current own		Ship during the reporting police,	data ioi uie iaii , .	idi Silvulu 🏎
		*** * 14-4		
		ation has been verified, and to the		
information contained in equipment, and utilization	<b>.</b>	report is a true and accurate repr	resentation of the	services,
едигритень, ана инплано	N OI WIIS TACHILY.			
PRINTED NAME OF PRE	DADED SI	IGNATURE OF PREPARER	DATE	
FIMILIAN SWILL S	AKEK	SNATURE OF FINEL ANEN		
DIRECT TELEPHONE NU	IMRER	TITLE OF PREPARER	E-MAIL ADDRI	FSS
		erifying the accuracy of the infor		
	r listed above; and must be se			· · · · · · · · · · · · · · · · · · ·
PRINTED NAME OF ADMINISTRAT	TION OFFICIAL SIGNATURE	E OF ADMINISTRATION OFFICIAL	DATE	
DIRECT TELEPHONE NU	MBER TITLE OF	F ADMINISTRATION OFFICIAL	E-MAIL ADDRI	ESS
	FOR OF	FFICE USE ONLY		
Facility Verified:	Initial Scan:	:	Completed:	
Entered:	Final Scan:	<u></u> :	Audited:	

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I. OWNERSHIP				
Corporation	Non-Pro	fit Organization	Partnership	
Individual	Healthca	are Authority	LLC	
Joint Venture	Governr	nent	Other (specify)	
II. MANAGEMEN  Does this facility opera		ent contract?	Yes	No
Management Firm:	Name			
	Name			
	Base Address	City	State	Zip
III. FACILITIES				
Total number of licen	sed beds:			
IV. ADMISSIONS				
Total admissions for	the reporting period:			
Admissions by sour	ce of payment:			
Priva	nte Pay			
Othe	er (specify)			
V. DISCHARGES	3			
Total discharges (in				



# **VI. DEMOGRAPHICS**

A.			HE ENTIRE REPORTING in Section	
a.	White/Caucasian			
b.	Black/African American/I	Negro		
C.	Hispanic/Spanish/Latino			
d.	Asian			
e.	American Indian/Alaskar	n Native		
f.	Pacific Islander			
g.	India			
h.	Middle Eastern			
i.	Other (specify)			
	TOTAL			
В.			NDER <i>FOR THE ENTIRI</i> s provided in Section IV a	
AGI	E GROUPS	MALE	FEMALE	TOTALS
18 8	& under			
19 -	- 34 Years			
35 -	- 54 Years			
55 -	- 64 Years			
65 -	- 74 Years			
75 -	- 84 Years			
85 \	ears and Older			
	i cars and Older			

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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.	<b>Total number of days beds were unoccupied</b> 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)		

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

This report should be submitted to SHPDA only one time. *The preferred method is electronic* submission to data.submit@shpda.alabama.gov. If submitted electronically please do not also submit via hard copy unless specifically requested to do so by SHPDA staff.