

THIS REPORT IS DUE ON OR BEFORE APRIL 15, 2022

STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

MAILING ADDRESS (U.S. Postal Service)
PO BOX 303025
MONTGOMERY AL 36130-3025
TELEPHONE: (334) 242-4103
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MONTGOMERY AL 36104
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bradford.williams@shpda.alabama.gov

2022 ANNUAL REPORT FOR SPECIALTY CARE ASSISTED LIVING FACILITIES

Mailing Address:

STREET ADDRESS	CITY	STATE	ZIP
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Physical Address:

STREET ADDRESS	CITY	AL	ZIP
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County of Location:

Facility Telephone:

_____ (AREA CODE) & TELEPHONE NUMBER

Facility Fax:

_____ (AREA CODE) & TELEPHONE NUMBER

This reporting period is for March 1, 2021, through February 28, 2022; 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
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DIRECT TELEPHONE NUMBER	TITLE OF PREPARER	E-MAIL ADDRESS
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A member of administration MUST 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
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DIRECT TELEPHONE NUMBER	TITLE OF ADMINISTRATION OFFICIAL	E-MAIL ADDRESS
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FOR OFFICE USE ONLY

Facility Verified: _____	Initial Scan: _____	Completed: _____
Entered: _____	Final Scan: _____	Audited: _____

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I. OWNERSHIP

<input type="checkbox"/> Corporation	<input type="checkbox"/> Non-Profit Organization	<input type="checkbox"/> Partnership
<input type="checkbox"/> Individual	<input type="checkbox"/> Healthcare Authority	<input type="checkbox"/> LLC
<input type="checkbox"/> Joint Venture	<input type="checkbox"/> Government	<input type="checkbox"/> Other (specify)

II. MANAGEMENT

Does this facility operate under a management contract? Yes No

Management Firm: _____
Name

Base Address	City	State	Zip
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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) _____

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			

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.

