STATE OF SOUTH DAKOTA
ASSISTED LIVING SERVICES
FINANCIAL AND STATISTICAL REPORT

Agency _____

ADDRESS _____

PERIOD OF REPORT _____

Agency Type:
(Please check all that apply)

☐ For Profit ☐ Not For Profit ☐ Freestanding ☐ Chain ☐ Hospital Based

☐ Regular Assisted Living ☐ Waiver Assisted Living

Number of Assisted Living Beds: ☐

1) Does your agency provide the following line of insurance?

			Policy Limits
Health Insurance to your employees	☐ Yes	☐ No	
Professional Insurance	☐ Yes	☐ No	
General	☐ Yes	☐ No	
Property	☐ Yes	☐ No	

2) Check the following services your Agency provides?

☐ Respite Adult Services
☐ Meals on Wheels
☐ Other(Please List Below)

_____

In the event the Department has further questions on the completion of this report, the Department should contact:

Name: _____ **Phone Number:** _____

THANK YOU

SCHEDULE A - EXPENSES

Assisted Living Services

0
0

Account Number and Title	Total Costs	Non Allowable Costs	Other Program Costs	Allocated AL Administrative Costs	Total AL Program Cost
2100 PERSONNEL SALARIES:					
2110 Administrative					$0
2120 Direct					$0
TOTAL PERSONNEL SERVICES	$0	$0	$0	$0	$0
2200 & 2300 BENEFITS AND TAXES:					
2210 Health Benefit Plans	$0				$0
2220 Retirement Plans	$0				$0
2280 Vacation/Personal Paid Leave					$0
2290 Other Benefits					$0
2310 FICA Taxes					$0
2320 Unemployment Insurance					$0
2350 Worker's Comp. Insurance					$0
TOTAL PERSONNEL BENEFITS AND TAXES	$0	$0	$0	$0	$0
2500 PROF FEES & CONTRACT SVCS:					$0
TOTAL PROF FEES & CONTRACTS	$0	$0	$0	$0	$0
2600 SUPPLIES:					$0
TOTAL SUPPLIES	$0	$0	$0	$0	$0
3100 OCCUPANCY:					
3110 Rent or Lease of Space					$0
3120 Building Repairs/Maintenance					$0
3130 Utilities					$0
3140 Building Depreciation					$0
3160 Property Insurance and Taxes					$0
3190 Other					$0
TOTAL OCCUPANCY	$0	$0	$0	$0	$0
3200 OTHER AGENCY COSTS					
3240 Advertising/Employee Recruiting					$0
3250 Dues/Membership/Subscriptions/Training/Videos					$0
3270 Bad Debt					$0
3275 Professional/General Liability Insurance					$0
3280 Travel/Transportation					$0
3290 Other Miscellaneous					$0
TOTAL OTHER AGENCY COSTS	$0	$0	$0	$0	$0
4400 DEPRECIATION					
4410 Vehicles					$0
4420 Equipment					$0
TOTAL DEPRECIATION	$0	$0	$0	$0	$0
TOTAL EXPENDITURES	**$0**	**$0**	**$0**	**$0**	**$0**

SCHEDULE B - REVENUES

Assisted Living Services

0
0

	Program Revenue Total
INCOME:	
Resident Cost Share	
Waivered Title 19 Revenue	
Room & Board Subsidy	
State Pay Program Revenue	
Private Pay Assisted Living	
Long-Term Care Insurance	
Other (Please List Below)	
TOTAL REVENUE	$ -

Schedule C - STAFF SALARIES

0
0

POSITION/JOB TITLE	Total # of Full Time Employee Posistions	Total Number of FTE Employees separated during current fiscal year	AVERAGE WAGE PER EMPLOYEE	TOTAL WAGES PAID	TOTAL # OF HOURS
Total	-	-	$ -	$ -	-

SCHEDULE D

Assisted Living Services

0
0

	Private Pay	Waivered Assisted Living					State Pay Assisted Living			
	Total Paid Days	Days in Agency	Days in Hospital	Days in Excess of 5 Hosptial Days	Days out on Leave	Days in Excess of 5 Leave Days	Days in Agency	Days in Hospital	Days out on Leave	Total Days
Jan 20___										0
Feb 20___										0
Mar 20___										0
Apr 20___										0
May 20___										0
Jun 20___										0
Jul 20___										0
Aug 20___										0
Sep 20___										0
Oct 20___										0
Nov 20___										0
Dec 20___										0
Totals	0	0	0	0	0	0	0	0	0	0

Total Private Pay	0
Total Waivered	0
Total Regular	0

SCHEDULE E

Assisted Living Services

0
0

Month	Medication Administration	Supplemental Oxygen	Self Preservation	Therapeutic Diet
January 20__				
February 20__				
March 20__				
April 20__				
May 20__				
June 20__				
July 20__				
August 20__				
September 20__				
October 20__				
November 20__				
December 20__				
Totals	0	0	0	0

ATTESTATIONS

0
AGENCY

0
ADDRESS

PERIOD OF REPORT: 0

AGENCY DIRECTOR _____ TELEPHONE NUMBER _____

CONTACT NAME (if different) _____ TELEPHONE NUMBER _____

PROVIDER NUMBER _____

ATTESTATIONS:

STATE OF SOUTH DAKOTA)
)
COUNTY OF _____)

_____ being first duly sworn on oath states and
(Name of Owner/Director) alleges as follows:

I declare and affirm under the penalties of perjury that this report and all statements have been examined by me and, to the best of my knowledge and belief, is in all things a true and correct statement of total operating expenditures, balance sheet, earnings and expenses, and supplemental information and that this report is submitted under the terms of the South Dakota Department of Social Services. I understand that any payment resulting from this report may be from both federal and state funds, and that any false statements or documents, or the concealment of a material fact, may be prosecuted under applicable Federal and State laws. I also understand that all information in this report and all attachments may be subject to a complete audit and verification by the Department of Social Services and/or by the United States Department of Health and Human Services. I will keep all records, books, and other information pertaining to this cost statement for a period of six years. If there is an unresolved audit exception, I will keep these records until all issues are resolved.

Dated this _____ day of _____, at _____

_____
Signature & Title of Owner/Director