

**THIS FORM IS TO BE USED AS AN AIDE FOR DATA ENTRY INTO
THE LONG TERM CARE RESIDENT STATISTICS WEB APPLICATION**

KANSAS DEPARTMENT ON AGING SEMI-ANNUAL REPORT

FACILITY NAME: _____ STREET ADDRESS: _____ CITY, STATE, ZIP: _____ RESIDENT CAPACITY _____	REPORTING PERIOD: JAN 1 to JUN 30 or JULY 1 to DEC 31 STATE ID NUMBER: B-
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HOME PLUS FACILITIES

In accordance with KAR 28-39-163 (d), this report shall be filed with the Licensure, Certification & Evaluation Commission (LCE), Kansas Department on Aging by July 10 or by January 10. Administrators shall indicate resident and employee data for the appropriate period – January 1 through June 30 or July 1 through December 31. Refer questions to Sandra Dickison, LCE, (785) 296-1245.

I. Days of Operation

- a) Was facility in operation for full six months of the period? YES NO
 b) If answer is "No," how many days was facility in operation? _____ Days

II. Resident Information (Do not include Adult Day Care). Complete all blanks. If nothing to report, enter zero.

	HP
1. Number of Days of Resident Care in Facility during six month reporting period	_____
2. Initial admissions and re-admissions	_____
3. Discharges to hospitals, including psychiatric hospitals	_____
4. Discharges by death	_____
5. Discharges to a swing bed unit, LTC Unit in a hospital, nursing facility or NFMH	_____
6. Discharges to a ALF, RHC, Home Plus or Boarding Care Facility	_____
7. Discharges to community	_____
8. Other discharges	_____
9. Total discharges during six-month reporting period (items 3 through 8)	_____
10. Resident census on last day of reporting period (June 30 or Dec 31)	_____
11. On June 30 or Dec 31:	
a. Number of Private _____ / Semi-Private _____	b. Number occupied: Private _____ / Semi-Private _____
12. Resident census. Indicate 24 hour resident census for facility on each day during the see separate timeframe notification .	
Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____	

Adult Day Care (ADC) residents are residents who spend part of the day at the facility and return to their home part of the day. Indicate census on each day during **see separate timeframe notification**

13. ADC Resident Census: Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____

14. ADC Hours Provided: Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____

15. Home And Community Based Services (HCBS) during 6 month reporting period.

- a. Frail Elderly Waiver Provider: YES NO If Yes, number of customers (residents) on last day of reporting period. _____
 b. Physically Disabled Waiver Provider: YES NO If Yes, number of customers (residents) on last day of reporting period. _____
 c. Traumatic Brain Injury Waiver Provider: YES NO If Yes, number of customers (residents) on last day of reporting period. _____

III. Staffing Information during **see separate timeframe notification**

16. Complete all blanks. If nothing to report, enter zero. If facility not in operation during reference week use staff information from last full week of the reporting period. Number of Staff in selected positions. Do not include consultants. Include employees on payroll and staff provided through outside staffing agency.

Staff	Full-Time	Part-Time
Registered Nurses		
Licensed Practical Nurses		
Medication Aides (CMAs, LMHTs)		
Nurse Aides (CNAs) (Exclude CMAs, LMHTs)		
Nurse Aide Trainees		
Paid Nutrition Assistants		
Activities Staff		
Social Services Staff		
Licensed Social Workers (Do not include consultant)		

FACILITY NAME: _____

CITY, STATE, ZIP: _____

17. **Number of Whole Hours** Worked in the Facility Each Day (24 hours) by Staff in Selected Positions during the **see separate timeframe notification**. This is not the number of staff. Indicate below hours actually worked by shift by all staff (full-time and part-time) for the positions listed below. Report number of hours worked in **whole numbers only**. If facility uses two 12-hour shifts, report hours as though facility uses three 8-hour shifts.

DAY SHIFT HOURS	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMAs, LMHTs)							
4. Nurse Aides (CNAs)							
5. Nurse Aide Trainees							
6. Paid Nutrition Assistants							
7. Activities Staff							
8. Social Services Staff (Exclude LSW)							
9. Licensed Social Worker							
EVENING SHIFT HOURS	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMAs, LMHTs)							
4. Nurse Aides (CNAs)							
5. Nurse Aide Trainees							
6. Paid Nutrition Assistants							
7. Activities Staff							
8. Social Services Staff (Exclude LSW)							
9. Licensed Social Worker							
NIGHT SHIFT HOURS	Sun	Mon	Tue	Wed	Thur	Fri	Sat
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMAs, LMHTs)							
4. Nurse Aides (CNAs)							
5. Nurse Aide Trainees							
6. Paid Nutrition Assistants							
7. Activities Staff							
8. Social Services Staff (Exclude LSW)							
9. Licensed Social Worker							

For KDOA Office Use Only

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