

KANSAS DEPARTMENT ON AGING RESIDENT STATISTICS AS OF DECEMBER 31

Deadline for filing this report-January 10

All Nursing Facilities, Assisted Living Facilities, Residential Health Care Facilities, Home Plus, Nursing Facilities for Mental Health and Intermediate Care Facilities for The Mentally Retarded are required to complete this report in a web-based application located at www.agingkansas.org/kdoa/lce/LTC_Reports.html. The information is to be submitted by January 10. A separate report is to be completed for each level of care. Refer questions regarding how to complete the information to Sandra Dickison, LCE, KDOA (785) 296-1245 or by e-mail at SandraDickison@aging.state.ks.us. Any technical questions, please contact the KDOA Help Desk at (785) 296-4987 or by e-mail at Helpdesk@aging.state.ks.us.

This form is to be used as an aide for data entry into the Long Term Care Resident Statistics Web Application. If you do not have internet access, then return this form to the Licensure, Certification and Evaluation Commission, KDOA, 503 S. Kansas Avenue, Topeka, Kansas, 66603-3404.

SECTION I. TOTAL Number of residents in facility from January 1 through December 31.
 _____ (count each resident only once)

SECTION II. RESIDENT STATISTICS

Number of residents by age group and gender in facility on December 31.

NURSING FACILITIES/ICFMR			
Dec. 31 Resident Census	Male	Female	Total
1. Under 60	a.	b.	c.
2. 60-64	a.	b.	c.
3. 65-74	a.	b.	c.
4. 75-84	a.	b.	c.
5. 85 and Over	a.	b.	c.
6. TOTAL	a.	b.	c.*

ALF/RHCF/HOME PLUS			
Dec. 31 Resident Census	Male	Female	Total
1. Under 60	a.	b.	c.
2. 60-64	a.	b.	c.
3. 65-74	a.	b.	c.
4. 75-84	a.	b.	c.
5. 85 and Over	a.	b.	c.
6. TOTAL	a.	b.	c.*

*Total MUST AGREE with Resident Census on Section II. 10 of the ALF/RHCF, Home Plus and NF/NFMH Semi-Annual Report and Section II. 11 of the ICFMR Semi-Annual Report.

7. Number of residents in facility on December 31 by location of residence prior to admission.

- | | |
|---|----------------------------------|
| a. Private Residence _____ | b. Boarding Home _____ |
| c. Retirement Apts _____ | d. Assisted Living _____ |
| e. Nursing Facility/
LTCU in Hospital/Swingbed _____ | f. Residential Health Care _____ |
| g. General Hospital _____ | h. Psychiatric Hospital _____ |
| i. Veterans Hospital _____ | j. All other _____ |
| k. *TOTAL (a-j) _____ | |

*Total MUST AGREE with Resident Census on Section II. 10 of the ALF/RHCF, Home Plus, and NF/NFMH Semi-Annual Report and Section II. 11 of the ICFMR Semi-Annual Report.

KANSAS DEPARTMENT ON AGING RESIDENT STATISTICS AS OF DECEMBER 31 (continued)

FACILITY NAME: _____ **CITY, STATE, ZIP:** _____

SECTION II. RESIDENT STATISTICS (continued)

8. Number of residents in facility on December 31 by primary source of payment (greatest percentage of cost).

- | | | | |
|------------------|-------|-------------------------|-------|
| a. Medicare | _____ | b. Medicaid | _____ |
| c. Private Pay | _____ | d. Commercial Insurance | _____ |
| e. V.A. Benefits | _____ | f. All Other | _____ |
| g. *TOTAL (a-f) | | _____ | |

*Total MUST AGREE with Resident Census on Section II. 10 of the ALF/RHCF, Home Plus, and NF/NFMH Semi-Annual Report and Section II. 11 of the ICFMR Semi-Annual Report.

SECTION II. CARE AND SERVICES BY OR IN FACILITY

9. Services offered to individuals other than residents.

- | | | | | | |
|-----------------|--------------------------|----------------------------|--------------------------|------|--------------------------|
| Meals on Wheels | <input type="checkbox"/> | Meals to Community | <input type="checkbox"/> | None | <input type="checkbox"/> |
| Respite Care | <input type="checkbox"/> | Adult Day Care | <input type="checkbox"/> | | |
| Transportation | <input type="checkbox"/> | Intergenerational Day Care | <input type="checkbox"/> | | |

10. Special Care Units in facility.

- Yes No If yes, specify:
Special Care Dementia Capacity _____ Special Care Non Dementia Capacity _____

11. Hospice services by a Certified Provider.

- Yes No If answer is yes, number of providers _____

12. Universal or Multitask Employee(s).

- Yes No If yes, specify task(s):
- | | | | | | |
|--------------|--------------------------|------------------|--------------------------|---------|--------------------------|
| Direct Care | <input type="checkbox"/> | Food Preparation | <input type="checkbox"/> | Laundry | <input type="checkbox"/> |
| Housekeeping | <input type="checkbox"/> | Activities | <input type="checkbox"/> | | |

KANSAS DEPARTMENT ON AGING RESIDENT STATISTICS AS OF DECEMBER 31 (continued)

FACILITY NAME: _____ **CITY, STATE, ZIP:** _____

SECTION III. Number of residents in facility on December 31 by county of residence at time of INITIAL admission.

Allen		Douglas		Jefferson		Morton		Scott	
Anderson		Edwards		Jewell		Nemaha		Sedgwick	
Atchison		Elk		Johnson		Neosho		Seward	
Barber		Ellis		Kearny		Ness		Shawnee	
Barton		Ellsworth		Kingman		Norton		Sheridan	
Bourbon		Finney		Kiowa		Osage		Sherman	
Brown		Ford		Labette		Osborne		Smith	
Butler		Franklin		Lane		Ottawa		Stafford	
Chase		Geary		Leavenworth		Pawnee		Stanton	
Chautauqua		Gove		Lincoln		Phillips		Stevens	
Cherokee		Graham		Linn		Pottawatomie		Sumner	
Cheyenne		Grant		Logan		Pratt		Thomas	
Clark		Gray		Lyon		Rawlins		Trego	
Clay		Greeley		Marion		Reno		Wabaunsee	
Cloud		Greenwood		Marshall		Republic		Wallace	
Coffey		Hamilton		McPherson		Rice		Washington	
Comanche		Harper		Meade		Riley		Wichita	
Cowley		Harvey		Miami		Rooks		Wilson	
Crawford		Haskell		Mitchell		Rush		Woodson	
Decatur		Hodgeman		Montgomery		Russell		Wyandotte	
Dickinson		Jackson		Morris		Saline		Out-of-State	
Doniphan								*Total	

Administrator's/Operator's electronic Signature Date E-mail address Phone Number