

**LONG TERM CARE SEMI-ANNUAL REPORT  
REPORTING PERIOD JULY 1, 2003 TO DEC. 31, 2003**

 **ASSISTED LIVING AND RESIDENTIAL HEALTH CARE FACILITIES**

In accordance with KAR 28-39-163 (d), this report shall be filed with the Licensure, Certification & Evaluation Commission (LCE), Ks. Dept. on Aging by **Jan. 9, 2004**. Administrators/Operators shall indicate resident and employee data for the six month period - July 1, 2003 through December 31, 2003. Refer questions to Caryl Gill, LCE, (785) 296-4222.

- I. a) Was your facility in operation in the full six months of the reporting period (07/01/03 - 12/31/03)?  YES  NO  
 b) If answer was "no," how many days was your facility in operation? \_\_\_\_\_ days
- II. Resident Capacity: ALF \_\_\_\_\_ RHCf \_\_\_\_\_
- III. Resident Information (include only 24 hour residents in Nos. 1 through 14). Complete all blanks. If nothing to report, enter zero.

	ALF	RHCf
1. Inpatient days of care during the six month reporting period	_____	_____
2. Admissions during the six month reporting period (include new admissions and re-admission)	_____	_____
3. Discharges by hospitalization	_____	_____
4. Discharges by death	_____	_____
5. Discharges by transfer to a LTC Unit in a hospital, nursing facility, NF/MH or ICF/MR	_____	_____
6. Discharges by transfer to another ALF, RHCf or Home Plus, Boarding Care	_____	_____
7. Discharges by transfer to community	_____	_____
8. Other discharges (excluding 3, 4, 5, 6, 7)	_____	_____
9. Total discharges during six month reporting period (sum of numbers 3 through 8)	_____	_____
10. Resident census on last day of reporting period	_____	_____
11. Respite care residents admitted during the six month reporting period (residents admitted on a temporary basis not to exceed 30 days)	_____	_____
12. Resident census. Indicate 24 hour resident census for your facility on each day during the <b>week of November 16-22, 2003.</b> Sun _____ Mon _____ Tue _____ Wed _____ Thur _____ Fri _____ Sat _____		

**Note: Do not include day of discharge or days resident was hospitalized.**

13. Adult Day Care (ADC) residents are persons who spend part of the day at the facility and return to their own home part of the day.  
 ADC Participant Census:  
 Sun \_\_\_\_\_ Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thur \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_
14. ADC Hours Provided:  
 Sun \_\_\_\_\_ Mon \_\_\_\_\_ Tue \_\_\_\_\_ Wed \_\_\_\_\_ Thur \_\_\_\_\_ Fri \_\_\_\_\_ Sat \_\_\_\_\_

IV. Staffing Information. Complete all blanks. If nothing to report, enter zero.

15. Number of Direct Care Staff. Include employees on payroll and those hired through contract who provide direct care. Indicate below how many full-time and part-time staff were in the position listed during the **week of November 16- 22, 2003.**

Direct Care Staff	ALF or RHCf # Full-Time	ALF or RHCf # Part-Time
Registered Nurses		
Licensed Practical Nurses		
Medication Aides (CMA's, LMHT's)		
Nurse Aides (CNA's) (Exclude CMA's, LMHT's)		
Nurse Aide Trainees		
Activities Staff		
Social Service Staff		
Licensed Social Workers (Do not include consultants)		

16. Number of Hours Worked Each Day (24 hours) by Staff in Selected Positions in the Assisted Living Facility or Residential Health Care Facility during the **week of November 16-22, 2003**. 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 your facility uses two 12 hour shifts, report hours as though the facility uses three 8 hour shifts.

<b>DAY SHIFT</b>	<b>Sun</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>	<b>Sat</b>
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							
<b>EVENING SHIFT</b>	<b>Sun</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>	<b>Sat</b>
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							
<b>NIGHT SHIFT</b>	<b>Sun</b>	<b>Mon</b>	<b>Tue</b>	<b>Wed</b>	<b>Thur</b>	<b>Fri</b>	<b>Sat</b>
1. Registered Nurses							
2. Licensed Practical Nurses							
3. Medication Aides (CMA's, LMHT's)							
4. Nurse Aides (CNA's)							
5. Nurse Aide Trainees							
6. Activities Staff							
7. Social Service Staff (Exclude LSW)							
8. Licensed Social Worker							

I verify this information is correct and staffing information can be verified by payroll records.

<b>Signature of Administrator/Operator</b>	<b>Adm. License No.</b>	<b>Date (mm/dd/yyyy)</b>	<b>E mail address</b>	<b>Phone Number</b>
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