ARKANSAS HEALTH SERVICES PERMIT AGENCY
ASSISTED LIVING / RESIDENTIAL CARE FACILITY ANNUAL SURVEY
2019 SERVICES

THIS REPORT MUST BE SUBMITTED ELECTRONICALLY. PAPER FORMS WILL NOT BE ACCEPTED!

All information given in this Annual Report should be for services rendered to clients in Arkansas. Please do not include data on clients residing in a state other than Arkansas.

I. MANAGEMENT/OWNERSHIP

A. Contact Information

Facility Name: _____

Name of License Owner: _____

Vendor number: _____
License number: _____

County: _____

Mailing Address: _____
_____

Phone: _____ **Fax:** _____

Facility's E-mail address: _____

Name of Facility Administrator: _____

Facility Administrator's E-mail address: _____

B. Type of Ownership (Please select one option)

✓	**For Profit - Private**
	For Profit - Public
	Not For Profit
	Partnership
	Sole Proprietorship
	Wholly owned or subsidiary
	Government (County owned)
	Chain Affiliate
	Corporate

C. Type of Facility and Number of Licensed Beds

	Number of Licensed Beds
Residential Care Facility	
Assisted Living Facility , Level I	
Assisted Living Facility, Level II	
ALF, Level II / Specialty (i.e. Alzheimer or dementia unit)	
Total Number of licensed beds	

II. FACILITY

A. Resident Occupancy Days

1. _____Number of licensed beds in your facility?

2. _____Number of days your facility was open in 2019

   (*If your facility was open for the entire year, enter 365 days. If the facility was open for less than a year, enter the number of days your facility was open and operational in 2019).*

3. _____Number of Resident Occupancy Days (ROD)
   (equals item #1 times item # 2)

4. _____Number of unavailable resident occupancy days

   (*Number of RODs for which beds were not available for immediate occupancy*; *for example, beds that were in rooms that were converted to office, storage or other than resident use or rooms licensed for 2 beds but used for 1 resident bed in 2019*).

5. _____Number of licensed and available RODs in 2019
   (equals item # 3 minus item #4)

6. _____Number of occupied RODs in 2019

   (*days that residents are using beds or beds that are being held for residents)*

7. _____Number of RODs that are available & vacant during 2019
   (equals item #5 minus item # 6)

❖ **Note: Recheck** all conclusions for Section II, questions 1-5 so that:
item #1 x *item #* 2 = *item #*3
*item #*3 minus *item #*4 = *item #*5
*item #*5 minus *item #* 6 = *item #*7

B. Facility History

1. Please state the age of the physical structure of your facility - please check the appropriate age.
   a._____ 2011-2019
   b._____ 2006-2010
   c._____ 2001-2005
   d._____ 1996-2000
   e._____ 1991-1995
   f._____ 1986-1990
   g._____ Before 1986
   h._____ Unknown

2. Has the facility undergone a major remodeling/renovation (that required plans to be filed with the DHS Office of Long Term Care) in the last five years?
   Yes ____ ***No*** ____

2b. Does your building include a sprinkler system?
   Yes ____ ***No*** ____

2c. Is the sprinkler system a partial _____ or full _____ system? *(check one)*

C. Resident Rooms

(*This question refers to the number of rooms, <u>not the number of beds</u> and not the number of residents).*

Type of Resident Room	Average Rate Per Room	Number of Rooms
Studio / Efficiency		
1 Bedroom		
2 Bedrooms		
Rooms used for more than 2 residents		
Total number of resident <u>rooms</u> *(should equal the first 4 rows)*	**N/A**	

D. Utilization

1. _____Total number of admissions in 2019

2. _____Total number of residents in 2019

   (This total includes the number of residents in your facility on January 1, 2019 plus the number of new admissions in 2019).

3. _____Total number of <u>resident days</u> for your facility in 2019.

   (A resident day is one resident in a bed for one day. If you had one resident for a year that would be 365 resident days; for a resident that did not stay for the entire year, count the number of days that the resident was in your facility. For example, a resident who stayed for 54 days would equal 54 resident days).

4. _____Total number of residents who were discharged (including death) from your facility in 2019.

5. _____Total number of Discharge days for your facility in 2019.

*** Note**: The term "Discharge Days" is one method of calculating an average length of stay for long term care facilities.

(Discharge days is the sum of the number of resident days for each resident who was discharged in 2019. For example, if 5 persons were discharged after 100 days in your facility and 6 residents were discharged after 400 days in your facility, the total number of discharge days would be (5 x 100) +(6 x 400) which equals 500 +2400 = 2900 total discharge days).

6. _____Average length of stay (in days) for **discharged** residents in your facility.

(Average length of stay [LOS] is calculated by total discharge days / number of total discharges. Using the above example in # 5, total discharge days = 2900 and total discharges = 5+6 or 11; therefore, the average LOS = 2900/11= 263.6 days.)
[*item* #5 total divided by *item* #4 equals this total *item # 6*]

7. _____Average length of stay for the total facility for 2019.

(Average length of stay for one year period is calculated by adding the number of resident days [item 3] and dividing it by the total number of residents in 2019 (item 2).
[Total for *item* #3 divided by Total for *item* # 2]

8. _____Annual Percentage of Resident Turnover

(Annual Turnover Percentage is calculated by the number of discharges (item #4) divided by the number of residents during 2019. For example of the number of discharges = 10 and the number of residents who lived in your facility in 2019 is 120, then your turnover is 8%).

III. OPERATIONS/COST

A. Payment Source

(Note: Changes made to match National Survey)

Resident Reimbursement	Number of 2019 residents who utilize this payment source
Self	
Veteran's Administration benefits	
Medicaid / Personal Care	
Medicaid Waiver (for low income)	
Family	
SSI	
Long Term Care Insurance	
Other (Specify)	

B. Resident Cost

(Note: Changes made to match National Survey)

Do you charge by	Check one
One all-inclusive rate	
A la carte/fee for service	
Hourly charge or other time fee for each service provided	
Tiered pricing for bundled services	
Combination of any of the above	
Other	

IV. RESIDENT INFORMATION:

A. 2019 Admissions by Age and Gender:

Age Range	Number of male residents admitted in 2019 by age range	Number of female residents admitted in 2019 by age range	Married	Widowed	Divorced/ Separated	Never Married
Under 65 years old						
65 – 74 years old						
75 – 84 years old						
Over 85 years old						
Don't Know						
Total						

B. 2019 Admissions by Race / Ethnicity

Number of Hispanic residents admitted in 2019	
Hispanic	
Non- Hispanic	

Number of residents admitted in 2019 by race	
American Indian or Alaskan Native	
African American or Black	
Asian	
Native Hawaiian or other Pacific Islander	
White or Caucasian	
Another Race	
Don't Know	
Total (*should equal total # of admissions for 2019 and totals for Sections C & D*)	

C. Referral Sources for 2019 Resident Admissions

Referred from	Number of residents admitted in 2019 by source of referral
Hospitals	
Nursing Home	
ICF/MR	
Home or self-referral	
Human Development Center	
Home Health Agency	
Physician	
Group Home	
Mental / Behavioral Health Provider	
Other (Identify)	
Don't Know	
Total *(should equal totals in Sections B & D)*	

D. Residence prior to admission

(Note: this does not refer to an interim stay in another facility prior to admission)

Private Home or Apartment	
Family residence (lived w/ adult children or others)	
Different RCF or ALF or other group home	
Retirement or Independent Living Community	
Nursing Home	
Homeless	
Other	
Don't Know	
Total (s*hould equal the total # of admissions in Sections B & C*)	

E. Of the total number of residents admitted in your facility in 2019, how many would be diagnosed or classified by age as:

Classification	**Number of Admissions by Age**			
	Under 65 years old	**65-74 years old**	**75-84 years old**	**Over 85 years old**
Intellectual Disability *formerly labeled as Mentally Retarded*				
Mentally ill				
Alzheimer's				
Dementia				
Dually diagnosed w/ more than one of the above				
Traumatic Brain Injury				

F. 2019 DISCHARGES

Discharged To	Number of Residents
Own Home	
Hospital / Rehab Center	
Nursing Home	
Relative's Home	
Another RCF or Assisted Living Facility	
Group Home	
Death (died while a resident in your facility)	
Other (Specify	
***Total** *(should equal the resident discharge total in Section II, D, item #4)*	

G. Formal Services Used (Within Last 90 Days)

	RCF	ALF I	ALF II	Total
Day Care				
Hospice				
Mental Health				
Occupational Therapy				
Physical Therapy				
Speech Therapy				
Podiatry				

Did individual residents contract with a home health company in the last year?
Yes ____ *No* ____ If yes, how many? _____

Comments and / or explanations

Please comment on any responses not completed or responses that require clarification.

Date of Completion_____

Signature of Administrator: _____

Thank you for completing this annual report. If there are any questions about your responses to this report, who should be contacted?

Name_____

Title or Position: _____

(Please print)

Phone Number: _____

E-mail: _____