

## 2009 Overview of Assisted Living Survey Operational Information

This survey intends to quantify trends in the operation of Assisted Living properties.

Please have the Executive Director, Administrator, or whoever is in charge of Operations complete this survey.

**Please do NOT complete this survey if your community opened for senior care anytime in 2008.**

If you are unsure of any answers, please feel free to leave your response blank.

It is recommended that the survey be completed on a paper copy first, as a partially complete survey cannot be saved online. To submit this survey online, please browse to:  
[http://www.surveymonkey.com/s.aspx?sm=i2vJOOUrwUa2I1iZ0HW3Lg\\_3d\\_3d](http://www.surveymonkey.com/s.aspx?sm=i2vJOOUrwUa2I1iZ0HW3Lg_3d_3d)

Thank you for your time in completing this survey!



### 1. OPERATING INFORMATION

a. Community Main Phone Number: \_\_\_\_\_

b. State: \_\_\_\_\_

c. Zip Code of Property: \_\_\_\_\_

d. Located in:      \_\_\_ Urban                      \_\_\_ Suburban                      \_\_\_ Rural

e. Type of community:

Does this community operate ... (please check *all that apply*):

	<u>Yes</u>	<u>No</u>
Independent Living (IL) units?	<input type="checkbox"/>	<input type="checkbox"/>
Assisted Living (AL) units?	<input type="checkbox"/>	<input type="checkbox"/>
AL Dementia Care units?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing units?	<input type="checkbox"/>	<input type="checkbox"/>

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f. Is this AL property licensed, certified, and/or registered under state regulations?  
 Yes  No

g. Is your property "purpose built" construction (i.e., the intended use of the original construction was Assisted Living)?  
 Yes  No

Year property opened for senior care (if known): \_\_\_\_\_

h. This property is (*check one*):  For-profit  Not-for-profit

i. This property is (*check one*):  Publicly-held  
 Privately-owned  
 Government Sponsored

j. Is the operator of the community different from the owner of the property?  
 Yes  No

k. Is the community (*please check one*):  
 A single property  
 Part of a larger multi-property ownership organization (2 or more properties)

### **2. PROPERTY INFORMATION**

#### a. Units and Occupancy – Assisted Living

*Instructions:*

- To calculate responses, please pick a recent day to calculate census.
- If this property is set up for multiple levels of care, *please consider only the Assisted Living units in the following questions*; AL Dementia care will be considered in the next question.
- Definition of UNIT: "A unit is defined as a room or apartment where residents live. Do not include rooms within apartments."

\_\_\_\_\_ Total Number of Set Up / Operating Units

\_\_\_\_\_ Number of units currently occupied by one resident

\_\_\_\_\_ Number of units currently occupied by two or more related individuals

\_\_\_\_\_ Number of units currently occupied by two or more unrelated individuals

\_\_\_\_\_ Number of AL residents on January 1, 2008

\_\_\_\_\_ Number of AL residents on December 31, 2008

\_\_\_\_\_ Total number of move-ins for calendar year 2008 (do not include back from short term hospital stays)

\_\_\_\_\_ Total number of *permanent* move-outs (including deaths) during calendar year 2008

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### b. Units and Occupancy – AL Dementia Care

Does this property have a dedicated Alzheimer's or dementia care section?

\_\_\_ Yes                      \_\_\_ No (if no, skip to part c)

*Instructions:*

- To calculate responses, please pick a recent day to calculate census.
- If this property is set up for multiple levels of care, *please consider only the AL Dementia Care units in the following questions.*
- Definition of UNIT: "A unit is defined as a room or apartment where residents live. Do not include rooms within apartments."

- \_\_\_\_\_ Total Number of Set Up / Operating Units
- \_\_\_\_\_ Number of units currently occupied by one resident
- \_\_\_\_\_ Number of units currently occupied by two or more related individuals
- \_\_\_\_\_ Number of units currently occupied by two or more unrelated individuals
- \_\_\_\_\_ Number of AL Dementia Care residents on January 1, 2008
- \_\_\_\_\_ Number of AL Dementia Care residents on December 31, 2008
- \_\_\_\_\_ Total number of move-ins for calendar year 2008 (do not include back from short term hospital stays)
- \_\_\_\_\_ Total number of *permanent* move-outs (including deaths) during calendar year 2008

### c. Property Characteristics – Do the *majority* of units have the following amenities:

	<u>Yes</u>	<u>No</u>
Stove / Range / Oven	<input type="checkbox"/>	<input type="checkbox"/>
Microwave	<input type="checkbox"/>	<input type="checkbox"/>
Refrigerator	<input type="checkbox"/>	<input type="checkbox"/>
Full Bathroom	<input type="checkbox"/>	<input type="checkbox"/>
<i>(incl. toilet, sink, shower / tub within the room)</i>		
Half Bathroom	<input type="checkbox"/>	<input type="checkbox"/>
<i>(incl. toilet, sink)</i>		
Shared Bathroom	<input type="checkbox"/>	<input type="checkbox"/>
Cable TV access / hook-up in room	<input type="checkbox"/>	<input type="checkbox"/>
Landline telephone access in room	<input type="checkbox"/>	<input type="checkbox"/>
Internet access in room	<input type="checkbox"/>	<input type="checkbox"/>
Locks on doors	<input type="checkbox"/>	<input type="checkbox"/>
Furnishings provided by operator	<input type="checkbox"/>	<input type="checkbox"/>

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Fire Safety within the Property:

	<u>All</u>	<u>Some</u>	<u>None</u>
Smoke detectors in resident rooms / apartments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke detectors in common areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A sprinkler system in resident rooms / apartments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A sprinkler system in common areas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbon monoxide detectors in resident rooms / apartments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

d. Do you track why residents leave your property and where they relocate to?

\_\_\_ Yes                      \_\_\_ No

If Yes, how many residents moved out in the last 12 months due to:

Death	
Health reasons	
Financial reasons	
Dissatisfactions / personal reasons	
Other	

For those that moved out (other than due to death), how many moved to:

A hospital (other than short-term stay)	
A nursing home	
An independent living residence	
Another assisted living residence	
Back to resident's existing home	
Children's or other relative's home	
A hospice facility	
Other/don't know	

e. Information Systems

Other than for accounting purposes, does this community have a computerized system for resident service records? For example, an Electronic Medical records System."

\_\_\_ Yes                      \_\_\_ No

Does this system support electronic health information exchange with any external entities (e.g., physicians, nursing homes, hospitals, pharmacies)?

\_\_\_ Yes                      \_\_\_ No

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### **3. SERVICES PROVIDED**

a. What services provided by this community are included in the basic rate or require additional fees? (Please check applicable column for each item):

	<u>Included in Basic Rates</u>	<u>Provided at Extra Charge</u>	<u>Not Provided</u>
One meal per day (only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Two meals per day (only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Three meals per day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Therapeutic diets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Snacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Assistance with ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic health monitoring (e.g., blood pressure, weight)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wellness activities (e.g., exercise classes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social and recreational activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Incontinence care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency call system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport (to med. appts)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport to stores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maid (housekeeping) services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Linen (bedding) services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social services/casework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wander protection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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b. Medication Services Provided for AL:

	<u>Yes</u>	<u>No</u>
Administer medications?	<input type="checkbox"/>	<input type="checkbox"/>
Provide medication reminders / cues?	<input type="checkbox"/>	<input type="checkbox"/>
Assist residents with self-administration?	<input type="checkbox"/>	<input type="checkbox"/>
Are medications stored securely in a resident's room?	<input type="checkbox"/>	<input type="checkbox"/>
Are medications stored securely in a central location?	<input type="checkbox"/>	<input type="checkbox"/>
Does the community have an onsite pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>
Does the community contract with a long-term care pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>
Does the community contract with a retail pharmacy?	<input type="checkbox"/>	<input type="checkbox"/>
Does the community contract with a consultant pharmacist?	<input type="checkbox"/>	<input type="checkbox"/>
Does the community contract with a consultant Medical Director?	<input type="checkbox"/>	<input type="checkbox"/>

Who administers prescription medications to the residents? *(Select all that apply)*

- RN
- LPN
- Certified medication aide / supervisor / medication technician
- Personal care aide
- Owner / Administrator / assistant director / manager

c. Respite and hospice services for AL:

- Does this property provide respite (short-term) care?      \_\_\_ Yes      \_\_\_ No
- If yes, are there units dedicated to respite care?      \_\_\_ Yes      \_\_\_ No
- If respite care services are provided, what is the daily respite care rate?    \$ \_\_\_\_\_
- What is the average length of stay of a respite care resident (in days)?      \_\_\_\_\_
- How many days, if any, does this property require as a minimum for respite stays?      \_\_\_\_\_
- What is the average percent of overall revenue that comes from respite care?      \_\_\_\_\_%
- Does this property provide, allow, or arrange for hospice care?    \_\_\_ Yes      \_\_\_ No

d. Home-Like Environment

- Does this community provide a common pet?      \_\_\_ Yes      \_\_\_ No
- Are residents allowed to have a personal pet such as a cat, dog, or bird?      \_\_\_ Yes      \_\_\_ No

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### **4. OPERATING INFORMATION**

a. Does a home healthcare company provide services in this property on a contract basis with the property?       Yes       No

Does a home healthcare company provide services in this property on a contract basis with residents individually?       Yes       No

b. How are service fees for AL determined (what is the predominant basis used):

- One, all-inclusive rate regardless of what care and amenities are used / needed
- A la carte, fee-for-service
- By hourly charge or other time fee for each service provided
- Tiered pricing for bundled services provided, based on acuity level
- Other \_\_\_\_\_

c. Assessments and Care Plans

Is there a formal functional / physical assessment conducted prior to resident move-in?       Yes       No

Is there a formal cognitive assessment conducted prior to resident move-in?       Yes       No

Is there a formally-written service or care plan prepared for residents?       Yes       No

How often is a resident's written service or care plan reviewed? (*multiple selections allowed*)

- Annually
- Semi-Annually
- Quarterly
- Significant change in resident's condition
- Other

d. If there is a significant change in a resident's condition as reflected in an updated/modified written service plan, would the resident's service fees change?       Yes       No

If yes, how soon would the fee change take effect?

- Immediately
- Following month
- Following quarter
- Next contract anniversary
- Other (*please specify*) \_\_\_\_\_

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e. Average rates and pricing:

How often are the community base rents (room and board) increased? (*select one*)

- Annually
- Semi-Annually
- Quarterly
- Monthly
- Other (please specify) \_\_\_\_\_

Is a security deposit required?  Yes  No

If yes, what is the amount? \$ \_\_\_\_\_

Does this property charge a one-time community fee prior to moving in?  Yes  No

If yes, how much? \$ \_\_\_\_\_

Average Monthly Base Rates:

*Include only base care fees and rent if possible. If the community charges an all-inclusive rate, submit the all-inclusive rate.*

Average rate for unit occupied by one resident \$ \_\_\_\_\_

Average rate for unit occupied by two or more related individuals \$ \_\_\_\_\_

Average rate for unit occupied by two or more unrelated individuals \$ \_\_\_\_\_

Average rate for dedicated Alzheimer unit, per resident \$ \_\_\_\_\_

Do the above average monthly rates include care fees?  Yes  No

How often are residents billed? (*select one*)

- Annually
- Semi-Annually
- Quarterly
- Monthly
- Other (please specify) \_\_\_\_\_

f. Medicaid

Does this community participate in Medicaid?  Yes  No

If known, during the last 30 days, how many of the residents had some or all of their long-term care services at this community paid by Medicaid? \_\_\_\_\_



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During a typical day (24-hour basis), how many total hours were worked by ...

*e.g., two RNs each working 16 hours equals 32 hours*

	Allocated to AL	Allocated to AL Dementia	Total <i>(if breakout not available)</i>
Registered Nurses (R.N.)	_____	_____	_____
Licensed Practical Nurses (L.P.N.)	_____	_____	_____
Personal care aides / nursing assistants	_____	_____	_____

Do this community *only* hire personal care aides that are already trained as Certified Nursing Assistants or Home Health Aides?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

Additional Staffing Information:

Total number of full-time equivalent staff per resident assigned to AL and AL Dementia care, if known (total FTEs divided by # of residents) \_\_\_\_\_

Does this community use contracted staff for dietary services?

\_\_\_\_\_ Yes      \_\_\_\_\_ No

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h. Which of these employee benefits are *offered*? (check all that apply)

	<u>Full-time employees</u>	<u>Part-time employees</u>
Health Insurance (employee only)	<input type="checkbox"/>	<input type="checkbox"/>
Health Insurance (family coverage)	<input type="checkbox"/>	<input type="checkbox"/>
Reimbursement for school tuition / continuing education	<input type="checkbox"/>	<input type="checkbox"/>
Pension / 401k / 403b	<input type="checkbox"/>	<input type="checkbox"/>
Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Disability insurance	<input type="checkbox"/>	<input type="checkbox"/>
Long-Term Care insurance	<input type="checkbox"/>	<input type="checkbox"/>
Child care	<input type="checkbox"/>	<input type="checkbox"/>
Paid Sick Leave	<input type="checkbox"/>	<input type="checkbox"/>
Paid Vacation time	<input type="checkbox"/>	<input type="checkbox"/>
Transportation Allowance	<input type="checkbox"/>	<input type="checkbox"/>

On average, what percent of the health insurance premiums does this property pay:

... for employee's health insurance (if provided)? \_\_\_\_\_ %  
 ... for employee's family health insurance (if provided)? \_\_\_\_\_ %

i. Staff Training

On an annual basis, how many hours of in-service training are required for each direct care giver?

- \_\_\_ More than 16 hours
- \_\_\_ 12 to 16 hours
- \_\_\_ 8 to 12 hours
- \_\_\_ 4 to 8 hours
- \_\_\_ Fewer than 4 hours
- Other \_\_\_\_\_

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j. Experience and education of person responsible for overall management of Assisted Living Community (i.e., Executive Director / Administrator / General Manager):

Number of years as person responsible for overall management at current AL community?  
\_\_\_\_\_ Years      \_\_\_\_\_ Months

Number of years of service as an Executive Director / Administrator / General Manager in this industry?  
\_\_\_\_\_ Years      \_\_\_\_\_ Months

Highest level of education achieved by the Executive Director / Administrator / General Manager?

High School Diploma / GED \_\_\_\_\_  
Associate Arts Degree \_\_\_\_\_  
Baccalaureate Degree \_\_\_\_\_  
Graduate Degree \_\_\_\_\_  
Post-Graduate Degree \_\_\_\_\_  
Other \_\_\_\_\_

k. Does this community conduct a criminal background check on every employee prior to hire?  
\_\_\_\_\_ Yes      \_\_\_\_\_ No

### **5. CONFIDENTIAL CONTACT INFORMATION**

*(This information will not be published - please provide in order to receive your free copy of the survey results)*

Contact Person \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

Company \_\_\_\_\_

Community Name \_\_\_\_\_

THANK YOU for filling out this survey.

If you have any questions, please contact Gary Byala at (703) 860-3355 x104 or E-mail: [gary@acclaropartners.com](mailto:gary@acclaropartners.com)

To submit this paper survey, please send it to:

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