A. J. RENNER & ASSOCIATES, INC.
6 WEST HUBBARD STREET, 4TH FLOOR
CHICAGO, IL 60610-4606
PHONE (312) 755-0084 / FAX (312) 755-1390

LONG TERM SOLUTIONS FOR LONG TERM CARE

Addendum I

Named Insured: _____

Provide facility classifications and bed census:

Skilled Care Services

Professional nursing care – 24 hours by licensed nurses. Registered nurse coverage during the day shift. LPN coverage required during other shifts. Skilled care services usually include some or all of the following: Medical Administration, other procedures ordered by physician, injections, tube feeding, catheterizations.

Intermediate Care Services (Run under a skilled license)

Nursing care during the day shift, 7 days, per week, by either RN's or LPN's. No complex nursing care (IV's, tube feeding, etc). Assistance with activities of daily living (e.g., walking, bathing, dressing, eating). Some assistance with administering medications.

Residential Care Services / Assisted Living / Personal Care

Residents are ambulatory with possible minor disorders, provided protective environments (meals and planned programs for social and/or spiritual needs). Residents are eligible for incidental health care services, including assistance with medications

Independent Living

Residents at retirement age and in general good health, occupy apartment, condominium, or dwelling units that normally include cooking facilities. Residents do not receive any health care services or assistance with medications.

Total Admissions

Total number of admissions the facility has had over the past twelve months. For example, a 100 bed licensed facility could have 150 to 175 admissions in the previous 12 months.

Facility Name	Skilled		Intermediate		Assisted Living		Independent	Total Admissions	SNE
	Licensed	Occupied	Licensed	Occupied	Licensed	Occupied	# of Residents		
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0
									0

Staffing Turnover Percentage

Please provide the annual turnover percentage for each facility. In the event any percentage is greater than 100%, please provide narrative detailing the reason why the percentage is so high.			
Facility Name	***Annual Turnover Percentage***		
	RN's	LPN's	CNA's
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Staffing Ratios

Please provide the ratios of staff to residents for each building			
Facility Name	***Staffing Ratios***		
	RN's to residents	LPN's to residents	CNA's to residents
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			
0			

Risk Management Percentages

Please provide the number of instances for each category:
1) Elopement: Number of residents **who have left the facility premises** in the past twelve months
2) Falls: Number of falls that **resulted in injuries and required transportation to hospital or other facility for treatment** in the past 12 months
3) Developed Ulcers: Number of residents who have **developed pressure sores after admission** in the past twelve months.

Facility Name	Number of Elopements		Number of Falls	%	Number of Developed Ulcers	%
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!
0				#DIV/0!		#DIV/0!

Abuse

Please provide the number of **substantiated abuse complaints** by category for each facility in the past twelve months

Facility	# of Substantiated **Physical Abuse** Complaints	# of Substantiated **Sexual Abuse** Complaints
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		
0		

Resident Age Breakdown

Please provide the number of residents by category						
Facility	# Residents Above 50	% Non-Ambulatory	# of Residents Under 50	% Non-Ambulatory	# of Residents on Ventilators	# Residents under 50 who are Rehab Patients
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
0						
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0						

BY SIGNING THIS DOCUMENT THE INSURED WARRANTS THAT THEY HAVE POLICIES AND PROCEDURES THAT THEY CONSIDER TO BE IN KEEPING ORDER WITH INDUSTRY STANDARDS FOR **FALL PREVENTION, ELOPEMENT / WANDERING, PRESSURE SORE / ULCER, PHYSICAL ABUSE, SEXUAL ABUSE, ORIENTATION DOCUMENTATION, IN-SERVICES, AND ADMISSIONS.**

THE UNDERSIGNED DECLARES THAT THE STATEMENTS SET FORTH HEREIN ARE TRUE. THE UNDERSIGNED AGREES THAT IF THE INFORMATION SUPPLIED ON THIS APPLICATION CHANGES BETWEEN THE DATE OF THIS APPLICATION AND THE EFFECTIVE DATE OF THE INSURANCE, HE/SHE (UNDERSIGNED) WILL IMMEDIATELY NOTIFY THE COMPANY OF SUCH CHANGES, AND THE COMPANY MAY WITHDRAW OR MODIFY ANY OUTSTANDING QUOTATIONS, AUTHORIZATION OR AGREEMENT TO BIND THE INSURANCE.

Applicant Signature _____ Date _____