

2010 Residential Care Facilities Survey - Short Form

Si vous préférez recevoir ce questionnaire en français, veuillez cocher

Confidential when completed

This annual survey is conducted under the authority of the *Statistics Act*, Revised Statutes of Canada 1985, Chapter S19.

Completion of this questionnaire is a legal requirement under the *Statistics Act*.

Correct mailing address information if necessary using the corresponding boxes below:

Legal Name: C0001	Business Name: C0002
Mailing Address: C0004	City: C0005
Province/Territory: C0006	Postal Code: C0007
Language Preference: C0010 <input type="radio"/> English <input type="radio"/> French	
Last name of facility contact: C0028	First name of facility contact: C0008
Title of facility contact: C0021	

Confidentiality:

Statistics Canada is prohibited by law from releasing any information from this survey which would identify any person, business, or organisation, unless consent has been given by the respondent as permitted by the *Statistics Act*. The information from this survey will be treated in strict confidence, used for statistical purposes and published in aggregate form only. The confidentiality provisions of the *Statistics Act* are not affected by either the *Access to Information Act* or any other legislation.

Data-Sharing Agreement:

To reduce the responder burden, Statistics Canada has entered into data-sharing agreements with provincial and territorial statistical agencies and other government and non-government organizations, which must keep the data confidential and use them only for statistical purposes. Information on data-sharing agreements and record linkages can be found in the guide accompanying the questionnaire.

Survey purpose:

This survey collects social, financial and operating data required to produce statistics for your industry.

Coverage:

Please complete a questionnaire for the operation and location described on the label. You should only report for those facilities located in Canada.

Return of questionnaire:

Please complete and return your questionnaire within 30 days of receipt. Please note that audited data is not required for this survey. Please send the completed questionnaire in the enclosed envelope or by facsimile toll-free to 1 888 883-7999.

Statistics Canada advises you that there could be a risk of disclosure during facsimile or other electronic transmission. However, upon receipt, Statistics Canada will provide the guaranteed level of protection afforded all information collected under the authority of the *Statistics Act*.

Do you have any questions? Do you need another questionnaire? For assistance and information please call: 1 800 565-1685

Name of person completing this questionnaire:

Last Name: (please print)

C0054

First Name:

C0013

Telephone:

Area Code Number

C0017

Extension:

C0027

Facsimile:

Area Code Number

C0016

Title:

C0014

Email address:

C0018



Facility Characteristics

Reporting Instructions:

- Please DO NOT wait for audited financial statements before completing the survey.
- When precise figures are not available, please provide your best estimate.
- Please DO NOT include commas, decimals or special symbols (\$, #, %, etc.) with your report.
- Please consult the reporting guides at www.statcan.gc.ca/ for additional information.

A. Administrative characteristics

Section contains administrative questions regarding the reporting of your facilities.

1. Please indicate your type of organization (Check one only).

- | | | | |
|---|--|--|---|
| 031 1 <input type="radio"/> Sole proprietorship | 3 <input type="radio"/> Incorporated company | 5 <input type="radio"/> Joint venture | 7 <input type="radio"/> Government |
| 2 <input type="radio"/> Partnership | 4 <input type="radio"/> Co-operative | 6 <input type="radio"/> Government business entity | 8 <input type="radio"/> Non-profit organization |

2. Does your business have a GST Registration Account Number or a Business Number (BN)?

- 040 1 Yes → If yes, please report your GST number or Business Number 041
- 3 No

3. Are you reporting for more than one facility on this questionnaire?

For facilities that operate more than one location under a single legal entity and for which a single consolidated income statement only is available, please answer 'Yes' and report for the number of locations. If you are reporting for one or more facilities that are distinct legal entities with individual income statement, please answer 'No' and respond individually for each facility. If you have questions on this, please refer to the guide or contact us at 1-800-565-1685.

- 050 1 Yes → If yes, please report the number of locations you are reporting for with this form 051
- 3 No

4. Please indicate your fiscal period.

For the purpose of this survey, please report information for your 12-month fiscal period for which the final day occurred on or between April 1, 2010 and March 31, 2011. For example, if your fiscal period ended December 31, 2010, please report for the period January 1, 2010 to December 31, 2010.

- | | |
|---|---|
| From | To |
| Year Month Day | Year Month Day |
| 011 <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> | 012 <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> |

5. Please indicate your type of ownership (Check one only).

- | | |
|--|------------------------------|
| Proprietary | 102 <input type="radio"/> 11 |
| Religious | <input type="radio"/> 02 |
| Lay (i.e., not for profit, non-profit voluntary associations, societies) | <input type="radio"/> 01 |
| Municipal | <input type="radio"/> 04 |
| Provincial or Territorial | <input type="radio"/> 05 |
| Federal | <input type="radio"/> 12 |
| Regional Health Authority, Board, District, Corporation | <input type="radio"/> 14 |

B. Number of beds as of the last day of the fiscal period

6. Please report the number of beds licensed or approved by provincial or municipal authorities and the number of beds available for use.

- | | | |
|---|---|---|
| | Licensed or approved | Staffed and in operation (in use or vacant) |
| Number of beds (including respite beds) | 121 <input style="width: 50px; height: 20px;" type="text"/> | 122 <input style="width: 50px; height: 20px;" type="text"/> |

Characteristics of Residents

C. Total days of care (by responsibility for payment)

7. Please report the number of days of care by responsibility of payment.

Number of Days

a. Provincial Health Department or Ministry (i.e., Provincial Health Insurance Plan, Regional Health Authority)	131	<input style="width: 100%;" type="text"/>
b. Provincial Social Services Department or Ministry (i.e., Provincial Social Services Plan)	132	<input style="width: 100%;" type="text"/>
c. Other Provincial Department or Ministry (<i>specify</i>) 520 <input style="width: 100%;" type="text"/>	133	<input style="width: 100%;" type="text"/>
d. Municipalities, regional or district administration	134	<input style="width: 100%;" type="text"/>
e. All other, including federal government and self-pay by residents	135	<input style="width: 100%;" type="text"/>
f. Total days (Sum of boxes 131 to 135)	136	<input style="width: 100%;" type="text"/>

D. Movement of residents

8. Please report the number of residents in each of the following categories.

Number of Residents

a. In facility on the first day of the fiscal period	151	<input style="width: 100%;" type="text"/>
b. Admissions during reporting period	152	<input style="width: 100%;" type="text"/>
c. Total under care (Box 151 plus 152)	153	<input style="width: 100%;" type="text"/>
d. Discharges during reporting period	154	<input style="width: 100%;" type="text"/>
e. Deaths during reporting period	155	<input style="width: 100%;" type="text"/>
f. Total separations (Box 154 plus 155)	156	<input style="width: 100%;" type="text"/>
g. In facility on the last day of the fiscal period (Box 153 minus 156)	157	<input style="width: 100%;" type="text"/> *

* Box 157 must agree with boxes 221, 240 and 272.

E. Age and sex of residents in facility on the last day of the fiscal period

9. Please report the number of residents for each of the following age and sex grouping.

Age Groups <i>(Count each person once only)</i>	Number of Residents		Age Groups <i>(Count each person once only)</i>	Number of Residents	
	Male	Female		Male	Female
a. Less than 10 years	201	202	g. 75 to 79 years	213	214
b. 10 to 17 years	203	204	h. 80 to 84 years	215	216
c. 18 to 24 years	205	206	i. 85 years and over	217	218
d. 25 to 64 years	207	208	(Sum of lines for males)		
e. 65 to 69 years	209	210	(Sum of lines for females)		
f. 70 to 74 years	211	212	j. Total residents	219	220
			10. Grand Total Residents		
			221 <input style="width: 100%;" type="text"/> *		

* Box 221 must agree with boxes 157, 240 and 272.

Characteristics of Residents

F. Type of care

11. Please report the number of residents per type of care received on the last day of the fiscal period.
(Count each person once only)

	Number of Residents
a. Room and board only	228 <input type="text"/>
b. Room and board with guidance/counselling with respect to social, employment, addiction problems, or parental guidance with skilled counselling (i.e., child care homes)	229 <input type="text"/>
c. Room and board with custodial care and/or special school, sheltered workshop, etc..	230 <input type="text"/>
d. Type I (i.e., supervision and/or assistance with daily living and meeting psycho-social needs)	232 <input type="text"/>
e. Type II (i.e., medical and professional nursing supervision, etc.)	234 <input type="text"/>
f. Type III (i.e., medical management, skilled nursing care, etc.)	236 <input type="text"/>
g. Higher type	238 <input type="text"/>
h. Total residents (Sum of boxes 228 to 238)	240 <input type="text"/> *

*Box 240 must agree with boxes 157, 221 and 272.

G. Principal characteristics of residents in facility on the last day of the fiscal period

12. Please report the number of residents by the most appropriate principal characteristic.
(Count each person once only)

	Number of Residents
a. Aged (65 years of age and over)	261 <input type="text"/>
b. Physically Challenged and/or Disabled	262 <input type="text"/>
c. Developmentally Delayed	263 <input type="text"/>
d. Psychiatrically Disabled	264 <input type="text"/>
e. Emotionally Disturbed Children	265 <input type="text"/>
f. Addictions	266 <input type="text"/>
g. Transients	269 <input type="text"/>
h. Others (specify) 521 <input type="text"/>	271 <input type="text"/>
i. Total residents (Sum of boxes 261 to 271)	272 <input type="text"/> *

* Box 272 must agree with boxes 157, 221 and 240.

Personnel and Expenses

- Do not include contract staff or professionals paid by an outside source. You may provide financial statements instead of completing the financial questions. Please indicate your questionnaire identification number on your financial statements. Ensure page 1 and sections A through H are completed.

H. Personnel

13. Please report all personnel whose time is mainly spent with the residents for direct care and those offering general services in the following categories.

Hours reported for salaries and wages should have corresponding dollar values in Section I.

Personnel employed on the last day of the fiscal period (excluding casuals)

Total accumulated hours during reporting period (including casuals)

Full-time

Part-time

a. Direct Care Services

331

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332

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333

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hrs

b. General Services (see definitions)

369

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370

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371

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hrs

c. Total (Sum of lines a. and b.)

381

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382

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383

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hrs

I. Expenses

14. Please report the costs of operating and maintaining the facility that can be attributed to the following categories.

Dollar values reported for salaries and wages should have corresponding hours reported in Section H.

Financial information should be reported for the most recent fiscal year that ended at any time between April 1, 2010 and March 31, 2011. (Round to nearest dollar)

When precise figures are not available please provide your best estimates.

Salaries and wages

All other expenses

Total

a. Direct Care Services

432

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433

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434

b. General Services (include all employee benefits in box 462)

461

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462

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463

c. Other expenses (includes interest, rent, taxes, overhead (head office), depreciation, etc.)

483

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484

d. Total Expenses (Sum of lines a. to c.)

495

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496

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497

Revenue – You may provide financial statements instead of completing the financial questions. Please indicate your questionnaire identification number on your financial statements. Ensure page 1 and sections A through H are completed.

J. Source of Revenue

15. Please report the revenues by their source.

Financial information should be reported for the most recent fiscal year that ended at anytime between April 1, 2010 and March 31, 2011. (Round to nearest dollar)

When precise figures are not available, please provide your best estimates.

Accommodations

a. Provincial **Health** Department or Ministry (i.e., Provincial Health Insurance Plan, Regional Health Authority)

Amount

501

b. Provincial **Social Services** Department or Ministry (i.e., Provincial Social Services Plan)

502

c. Other Provincial Department or Ministry (specify)

503

d. Municipalities, regional or district administrations

504

e. All other (i.e., federal government and W.C.B.)

505

f. Residents - co-insurance or self-pay

506

g. Differential - preferred accommodation

507

h. Total revenue from accommodation (Sum of boxes 501 to 507)

508

i. Other Sundry earnings

509

j. TOTAL REVENUE (Sum of boxes 508 and 509)

510

k. Surplus (Box 510 minus box 497)

511

l. Deficit (Box 497 minus box 510)

512

I certify that the information contained herein is complete and correct to the best of my knowledge.

Signature:

Date:

C0015

Year

Month

Day

Thank you for completing this questionnaire.

1. How long did you spend collecting the data and completing this form?

9910

hours

9909

minutes

2. Comments:

We invite you to assist us in improving the survey. Your comments and general remarks would be greatly appreciated:

9910

9913

9914

9915

Lost the postpaid envelope?

Please call us at 1 800 565-1685 or fax us at 1 888 883-7999.

FOR INFORMATION ONLY

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