ILLINOIS

Citation Assisted Living and Shared Housing Act: Title 210 ILCS 9
Assisted living and shared housing establishments: 77 ILL Admin. Code Part 295
Sheltered care facility: 77 ILL Admin. Code Part 330 et seq.
Supportive living facilities: Title 89, Chapter I, Subchapter d, Part 146

General Approach and Recent Developments

Legislation permitting issuance of a two year license and increasing the licensing fee is pending before the legislature. Rules governing assisted living establishments and shared housing establishments were amended in 2004. Legislation passed in 2005 that expands shared housing establishments from 12 to 16 residents; allows licensed health professionals to administer sliding scale insulin and requires all licensing applications to be complete within six months of the initial filing. SLF rules were amended in 2005 and 2006.

The law does not allow Medicaid to cover services in assisted living establishments; however, a "supportive living facility" program has been implemented in "certified" locations that offers similar services. The program serves elderly and disabled Medicaid beneficiaries who need assistance with ADLs. It targets lighter need nursing facility residents who are unable to remain in their homes. A SLF may be converted nursing home units or free-standing buildings that integrate housing, health, personal care, and supportive services in home-like residential settings. A maximum of 2,750 Medicaid residents can be served under a 1915(c) waiver that applies only to the demonstration.

Rules to implement P.A. 93-141, which added a provision for a floating license, are being developed. The floating license amendment allows an Assisted Living and Shared Housing Establishment in which 80% of the residents are at least 55 years of age or older, that is operated as housing for the elderly, and meets the construction and operating standards contained in Section 20 of the Act, to request a floating license for any number of individual living units within the establishment, up to, but not including, total capacity. The establishment must have adequate staff to meet the scheduled and unscheduled needs of the residents living in the licensed living units, and all staff must meet the requirements of the assisted living regulations. All mandatory and optional services must be available to residents of the licensed units. Designation as a licensed living unit may be temporary to accommodate a resident's changing needs without requiring the resident to move.

Changes to the sheltered care facility rules were made in 2006 and 2007 that modify requirements for criminal background and sex offender registry checks for residents.

Adult Foster Care

No provisions were reported.

Web Address	Content
http://www.ilga.gov/commission/jcar/admincode/077/07700295sections.html	Assisted living rules
http://www.ilga.gov/commission/jcar/admincode/077/077003300A01100R.html	Shelter care rules
http://www.idph.state.il.us/healthca/assisted_living_list.htm	Assisted living list
http://www.idph.state.il.us/healthca/sheltered_care_list.htm	Shelter care unit
http://www.idph.state.il.us/pdf/assistedlivingapp.pdf	Application
http://www.slfillinois.com/	Supportive living facility home page

Supply						
Category	2007		2004		2002	
	Facilities	Units	Facilities	Units	Facilities	Units
Assisted living	184	8,988	120	5,830	24	1,667
Shared housing	25	202	13	92	NA	NA
Shelter care facilities	137	7,610	149	8,484	156	8,740

Definition

Assisted living establishment means a home, building or residence, or any other place where sleeping accommodations are provided for at least three unrelated adults, at least 80% of whom are 55 years of age or older and where the following are provided:

- Services consistent with a social model that is based on the premise that a resident's unit in assisted living and shared housing is his or her own home.

- Community-based residential care for persons who need assistance with ADLs, including personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.

- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.

- A physical environment that is a home-like setting that includes the following and such other elements as established by the Department in conjunction with the assisted living and shared housing advisory board: individual living units each of which shall accommodate small kitchen appliances and contain private bathing, washing, and toilet facilities, or private washing and toilet facilities with a common bathing room readily accessible to each resident. Units shall be maintained for single occupancy unless shared by consent.

Shared housing establishment means a publicly or privately operated free-standing residence for 16 or fewer persons, at least 80% of whom are 55 years of age or older and who are unrelated to the owners and one manager of the residence, where the following are provided:

- Services consistent with a social model that is based on the premise that the resident's unit is his or her own home.

- Community-based residential care for persons who need assistance with ADLs, including housing and personal, supportive, and intermittent health-related services available 24 hours per day, if needed, to meet the scheduled and unscheduled needs of a resident.

- Mandatory services, whether provided directly by the establishment or by another entity arranged for by the establishment with the consent of the resident.

Sheltered care facility means a facility licensed under the nursing home care act that provides maintenance and personal care but does not provide routine nursing care.

Supportive living facility means a residential setting that provides or coordinates personal care services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health-related services with a service program and physical environment designed to minimize the need for residents to move within or from the setting to accommodate changing needs and preferences; has an organized mission, service programs, and a physical environment designed to maximize residents' dignity, autonomy, privacy, and independence; and encourages family and community involvement.

Unit Requirements

Assisted living establishments require single occupancy units unless shared by choice. Units must accommodate small appliances, including a sink, toilet, and assistive devices if needed. Bathing facilities may be in the unit or in a common room.

Shared housing establishments may have shared bathrooms (1:4) and tub/shower facilities (1:6).

Sheltered care facilities allow no more than four persons to share a room. Single rooms must be 70 square feet and multiple occupancy rooms 60 square feet per person. One lavatory is required for every ten residents and one shower/bath is required for every 15 residents. A lavatory and shower/bath is required on each floor.

Supportive living facility. Free-standing sites must provide apartments with 300 square feet of living space, including closets and bathroom. Apartments for individuals wishing to share the unit must have 450 square feet of living space, including closets and bathroom. Units must have a full bathroom, lockable doors, emergency call system, heating and cooling controls, wiring for private telephone, access to cable television or satellite dish, a sink, microwave oven or stove, and refrigerator and a separate bedroom for each unrelated occupant for SLFs approved for participation on or after October 18, 2004. Nursing homes converting a portion of a facility must offer apartments with 160 square feet for single occupancy and 320 square feet if two people want to share a unit.

Admission/Retention Policy

Assisted living establishments. Facilities may not accept residents who are a danger to themselves or others; are not able to communicate their needs and do not have a representative residing in the facility; require total assistance with two or more ADLs; require assistance of more than one paid caregiver with any ADL; or require more than minimal assistance in moving to a safe area in an emergency. Persons with severe mental illness may not be admitted, which is defined as substantially disabled for not less than one year in the areas of self-maintenance, social functioning, activities of community living and work skills. This does not include Alzheimer's disease and other forms of dementia. They may also not accept residents who need the following health services *unless* self-administered or administered by a qualified, licensed health care professional who is not employed by the owner or operator of the establishment, its parent entity, or any other entity with ownership common to either the owner or operator or parent entity, including but not limited to an affiliate of the owner or operator:

- IV therapy or feedings;
- Gastronomy feedings;
- Insertion, sterile irrigation, and replacement of a catheter, except for routine maintenance of urinary catheters;
- Sterile wound care;
- Sliding scale insulin;
- Routine insulin injections; and
- Stage III or IV decubitus ulcers.

In addition, residents may not be accepted who need five or more skilled nursing visits a week for three or more weeks unless the course of treatment is rehabilitative and the need is temporary.

If any of the above conditions are met, a resident's occupancy agreement shall be terminated, except for individuals who are terminally ill who receive or would qualify for hospice and such care coordinated by a licensed hospice provider.

Sheltered care facility. No resident needing nursing care may be admitted or retained. Persons who have a communicable disease or are mentally ill, need treatment for mental illness, are likely to harm others, or are destructive of property or themselves may not be admitted or retained.

Supportive living facilities may serve elderly (age 65 or older) or disabled residents age 22 or over who have been screened and determined to meet the nursing facility LOC criteria. Residents must also have their name checked against the sex offender registry data base. Residents may be discharged if they are a danger to self or others or have needs that cannot be met by the SLF. The SLF must develop a service plan and execute a written contract with each resident that includes services the resident will receive and other terms of the agreement.

Nursing Home Admission Policy

Waiver eligibility is based on a Determination of Need (DON) score. The score is derived from the MMSE, six ADLs, nine IADLs (including ability to perform routine health and special health tasks and ability to recognize and respond to danger when left alone). Each ADL, IADL and special factors are rated by level of impairment (0-3) and unmet need for care (0-3). Scores for each area are summed and applicants with a DON score of 29 or more are eligible. The MMSE component is weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports and people with lower levels of impairment without informal supports.

Services

Assisted living establishments. No more than 180 days prior to admission, a comprehensive assessment that includes an evaluation of a prospective resident's physical, cognitive, and psycho-social condition shall be completed by a physician. This assessment must be updated annually by a physician, or upon significant change in condition. Establishments may use their own evaluation/assessment tools, but this does not take the place of the physician assessment. Mandatory services include three meals a day, housekeeping, laundry, security, emergency response system, and assistance with ADLs. Optional services include medication reminders, supervision of self-administered medications and medication administration, and non-medical services defined by rule.

Assisted living, which promotes resident choice, autonomy, and decision making, should be based on a contract model designed to result in a negotiated agreement between the resident or the resident's representative and the provider, clearly identifying the services to be provided. This model assumes that residents are able to direct services provided for them and will designate a representative to direct these services if they themselves are unable to do so. This model supports the principle that there is an acceptable balance between consumer protection and resident willingness to accept risk and that most consumers are competent to make their own judgments about the services they are obtaining. Regulation of assisted living establishments and shared housing establishments must be sufficiently flexible to allow residents to age in place within the parameters of the statute. Services provided must ensure that the residents have the rights and responsibilities to direct the scope of services they receive and to make individual choices based on their needs and preferences. These establishments shall be operated in a manner that provides the least restrictive and most home-like environment and that promotes independence, autonomy, individuality, privacy, dignity, and the right to negotiated risk in residential surroundings.

"Negotiated risk" is the process by which a resident, or his or her representative, may formally negotiate with providers what risks each are willing and unwilling to assume in service provision and the resident's living environment. The provider assures that the resident and the resident's representative, if any, are informed of the risks of these decisions and of the potential consequences of assuming these risks. The rules allow assisted living and shared housing establishments to use a risk agreement that describes the problem, issue or service that is

covered, the choices available to the resident and their risks or consequences, the resulting agreement, mutual responsibilities, and a review time frame. The agreement is limited to the individual's care and personal environment and does not waive any requirements of the regulations.

Sheltered care facility may provide personal care, group and individual activities, assistance with self administration of medications or administration by a physician or licensed nurse. Flue shots and language assistance services were added in 2005.

Supportive living facilities must provide a combination of housing, personal, and health-related services that promote autonomy, dignity, and quality of life and respond to the individual needs of residents. Room and board includes three meals per day. Services include nursing services, personal care, medication oversight and assistance in self-administration, housekeeping services, laundry service, social and recreational programs, 24-hour response/security staff, emergency call systems, health promotion and referral, exercise, transportation, daily checks and maintenance services. Nursing services include completion of a resident assessment and service plan, a quarterly health status evaluation, administration of medication when residents are temporarily unable to self-administer, medication set-up, health counseling, episodic and intermittent health promotion or disease prevention counseling, and teaching self-care in meeting routine and special health care needs that can be met by other staff under supervision of a RN. Facilities are expected to involve family members in service planning. Residents must receive an initial assessment within 24 hours of admission and a comprehensive assessment within 14 days. Assessments are updated at least annually.

Dietary

Assisted living and shared housing facilities offering special diets must contract with or employ a dietician. Meals must be nutritionally balanced and accommodate resident preferences.

Shelter care facilities must provide three meals or two meals and a breakfast bar. Meals must meet the requirements for a general diet for an adult recommended by the Food and Nutrition Board, National Research Council. Therapeutic diets ordered by a physician must be provided.

SLFs must contract with a licensed dietitian who is on-site at least twice a quarter for at least eight hours (cumulative) to provide consultation and training.

Agreements

Assisted living and shared housing. Contracts with residents include the duration of the contract; base rate and a description of services; additional services available and their fee; description of the process for terminating or modifying the contract; the complaint resolution process; resident obligations; billing and payment procedures; the admission, risk management, and termination procedures; resident rights; the department's annual on-site review process;

terms of occupancy; charges during absences; refund policy; notice for changes in fees; and policy concerning notification of relatives of changes in the resident's condition. Contracts must also include statements that Medicaid is not available for payment of services and that there is a risk management procedure.

Supportive living facilities. Agreements cover services provided under Medicaid; arrangements for payment; grievance procedure; termination provisions; rules for staff, management, and resident conduct; and resident rights. The agreement includes services available for an additional fee and arrangements to share a unit.

Provisions for Serving People with Dementia

Assisted living and shared housing facilities that offer special care programs for people with dementia must file a disclosure statement if they serve people with dementia. The statement includes the form of care or treatment; philosophy; admission and retention policies; assessment care planning and implementation guidelines; staffing ratios; physical environment; activities; role of family members; and the cost of care.

Facilities are not allowed to serve people with dementia whose mental or physical condition is detrimental to the health, welfare, or safety of the resident or other residents as determined by the resident's physician prior to admission and annually thereafter. The rules specify that residents must be assessed prior to admission with any one or a combination of assessment tools, based upon the resident's condition and stage in the disease process. The rules list a number of tools that may be used, such as the Functional Activities Questionnaire, Clock Drawing Test, and Functional Assessment Staging, among others.

Operators offering special care must develop and implement policies and procedures that ensure the continued safety of all residents in the establishment; provide coordination of communications with each resident, resident's representative, relatives and other persons identified in the resident's service plan; provide, in the service plan, appropriate cognitive stimulation and activities to maximize functioning, which include a structure and rhythm that are comfortable and predictable; offer an appropriate balance of rest and activity, and private and social time; allow residents to express their accustomed social roles, whatever they may be; offer residents access to familiar activities that they enjoyed doing and that tap memories and retained abilities; and provide the flexibility to accommodate variations in the resident's mood, energy level, and inclination; provide an appropriate number of staff for its resident population.

Sufficient numbers of staff, with qualifications, adequate skills, education, and experience to meet the 24-hour scheduled and unscheduled needs of the residents must be available to serve the resident population. Special care facilities must provide 1.4 hours of services per resident per day (assistance with ADLs, activities-based programming, and services delivered to the resident to meet the unique needs of residents with dementia); require the manager and direct care staff to complete sufficient comprehensive and on-going dementia and cognitive deficit training; and develop emergency procedures and staffing patterns to respond to the needs of residents.

Shelter care facilities. The law does not allow facilities to serve anyone with dementia if they do not have the staff with the skills to meet the individual's needs. The rules will provide for use of a validated dementia specific standard to assess residents. The assessment must be completed and approved by the resident's physician prior to move-in and annually. Residents cannot be accepted if they pose a danger that cannot be eliminated through treatment. Facilities offering SCUs must disclose information about their program, ensure that residents have a designated representative, and develop and implement policies and procedures for people who wander, need supervision and assistance when evacuating. In addition, they must provide cognitive stimulation, appropriate staffing patterns, and emergency procedures. Facilities must provide each resident 1.4 hours of service per day (ADLs, activities, and other services to meet unique needs).

Managers of special care facilities must have a college degree with course work in dementia and one year of experience and must complete six hours of training a year. *Staff* receive four hours of orientation in dementia care, 16 hours of on-the-job training, and 12 hours in-service training a year. The rules list the topics that are covered under each requirement.

Medication Administration

Assisted living and shared housing establishments may assist with self-administered medications, supervise, or administer medications. Policies related to administration must be approved by a physician, pharmacist, or RN. Only a licensed health care professional employed by the establishment may administer medications including injections, oral medications, topical treatments, eye and ear drops, nitroglycerin patches Or sliding scale insulin injections.

Sheltered care facilities. All medications taken by residents shall be self-administered, unless administered by licensed personnel. No person shall be admitted to a facility who is not capable of taking his or her own medications. Facility staff may remind residents when to take medications and watch to ensure that they follow the directions on the container. All medications must be stored in a locked area at all times. Although there is some conflict between the sections of the regulation governing medication administration, in practice, licensed staff are allowed to administer medications "to some residents for control purposes" when it is not safe for the resident to self-administer.

Public Financing

Assisted living and shared housing. The law does not permit the use of Medicaid funds in licensed facilities.

Supportive living facilities. The state has implemented a program to serve elders and adults with disabilities who are Medicaid waiver beneficiaries in SLFs (see http://www.slfillinois.com). SLFs are certified. For Medicaid residents, participating facilities must be willing to accept the SSI rate, $623 a month in 2007 (less a $90 PNA) as payment for room and board. The service payment is based on 60% of the average nursing facility rate paid in the region. SLFs may be

certified as eligible Food Stamp vendors and receive these benefits for eligible residents. Room and board charges are limited $533 for single occupancy and $377 per person for shared occupancy. Income supplementation is allowed. Funding for services is included in the Medicaid nursing home budget and is not part of a separate appropriation.

A moratorium on new applications was removed. The program has 81 operating SLFs with 4,681 participants in 2007. The program targets "lighter" care nursing home eligible residents with a DON score (see below) between 29 and 47 on a 100-point scale. Residents with scores above 47 may be served if the facility has the capacity to do so.

Medicaid Participation					
2007		2004		2002	
Facilities	Participation	Facilities	Participation	Facilities	Participation
81	4,681	41	1,602	13	293

Medicaid Payment Rates by Geographic Area (2007)				
Region	Daily	R&B	Medicaid	Total
Chicago	$66.92	$533	$1,883	$2,540
South suburb	$62.57	$533	$1,797	$2,410
Northwest	$58.48	$533	$1,639	$2,287
Central	$56.13	$533	$1,552	$2,216
West central	$52.34	$533	$1,552	$2,103
St. Louis	$55.87	$533	$1,445	$2,209
South	$50.76	$533	$1,384	$2,056

Staffing

Assisted living and shared housing. Establishments must have sufficient numbers of trained staff to meet the 24-hour scheduled and unscheduled needs of residents. Assisted living establishments must have at least one awake staff on duty who has CPR training.

Sheltered care facility. Facilities must have staffing patterns that are sufficient to meet the needs of residents. At least one awake staff member is required.

Supportive living facilities must provide licensed and certified staff that are sufficient to meet the needs of residents in conjunction with contractual agreements. Personal care services and assistance with self-administration of medications must be provided by CNAs. SLFs must contract with a dietician.

Training

Assisted living and shared housing. Administrators must be 21 and have a high school diploma or equivalency, one year management experience or two years of experience in health care, housing, or hospitality.

Managers of SCUs must be 21 years of age and have: a college degree with documented course work in dementia care, plus one year of experience working with persons with dementia; or at least two years of management experience with persons with dementia. The manager or supervisor must complete six hours of additional annual continuing education regarding dementia care.

Staff must complete an orientation that addresses philosophy and goals; promotion of dignity, independence, self-determination, privacy, choice, and resident rights; confidentiality; hygiene and infection control; abuse and neglect prevention and reporting; and disaster procedures. Additional orientation covers needs of residents; service plans; internal policies; job responsibilities and limitations; and ADLs. Eight hours of annual training is required for staff and managers on topics listed above.

In SCUs, all staff members must receive an additional four hours of dementia-specific orientation prior to assuming job responsibilities without direct supervision within the Alzheimer's/dementia program. Training must cover, at a minimum: basic information about the causes, progression, and management of Alzheimer's disease and other related dementia disorders; techniques for creating an environment that minimizes challenging behavior; identifying and alleviating safety risks to residents with Alzheimer's disease; techniques for successful communication with individuals with dementia; and residents' rights.

Direct care staff must receive 16 hours of on-the-job supervision and training within the first 16 hours of employment following orientation. Training must cover: encouraging independence in and providing assistance with the ADLs emergency and evacuation procedures specific to the dementia population; techniques for creating an environment that minimizes challenging behaviors; resident rights and choice for persons with dementia, working with families, caregiver stress; and techniques for successful communication.

Direct care staff must annually complete 12 hours of in-service education regarding Alzheimer's disease and other related dementia disorders. Topics may include: assessing resident capabilities and developing and implementing service plans; promoting resident dignity, independence, individuality, privacy and choice; planning and facilitating activities appropriate for the dementia resident; communicating with families and other persons interested in the resident; resident rights and principles of self-determination; care of elderly persons with physical, cognitive, behavioral and social disabilities; medical and social needs of the resident; common psycho-tropics and side effects; local community resources; and other related issues.

Sheltered care facility. The *administrator* shall arrange for facility supervisory personnel to annually attend appropriate education programs on supervision, nutrition, and other pertinent subjects. *Staff* training shall include an in-service program embracing orientation to the facility and its policies, skill training, and on-going education carried out to enable all personnel to perform their duties effectively. Written records of program content and personnel attending shall be kept.

Supportive living facilities. Administrators must have at least five years' experience in providing health care services in assisted living settings, in-patient hospital, long-term care

setting, ADC, or in a related field. The manager also must have at least two years of progressive management experience.

Staff shall receive documented training by qualified individuals in their area(s) of responsibility, and on infection control, crisis intervention, prevention and notification of abuse and neglect, behavior intervention, negotiated risk and encouraging independence, training that includes techniques for working with persons with disabilities and the elderly populations; and in the case of an SLF serving persons with disabilities, disability specific sensitivity training conducted by an outside entity familiar with working with persons with disabilities as part of staff orientation and at least annually thereafter. Nurses' assistants must be certified or enrolled in and pursuing certification. A trained staff person must be responsible for planning and directing social and recreation activities. Nurses must be licensed. Twenty-four-hour response staff must be certified in emergency resuscitation.

Background Check

State legislation passed during the spring of 1995 prohibits sheltered care facilities from knowingly hiring, employing, or retaining any individual in a position with duties involving direct care for residents who have been convicted of committing or attempting to commit designated criminal offenses, unless a waiver has been granted by the Illinois Department of Public Health. The legislation was expanded to include SLFs in 1999.

Rules implementing the "Health Care Worker Background Check Code" were effective in 2004. Health care employers will be required to establish a policy concerning employment of individuals whose criminal history record checks indicate convictions for offenses that are not disqualifying. The employer is also required to develop a policy concerning employment of individuals who have been granted waivers. The rules require the establishment to check employee status with the Nurse Aide Registry. Establishments may be fined $100 for each failure to conduct a required criminal background check.

Rules passed in November 2003 changed the process for granting waivers of the health care worker criminal history background check requirements. The new rule specifies that waiver applicants must have met all court obligations (probation, adhering to a fine or restitution schedule) and satisfactorily completed a drug and/or alcohol recovery program, if applicable. Mitigating circumstances are expanded to reference drug/alcohol rehabilitation programs, anger management or domestic violence prevention programs, completion of court-ordered obligations, and nurse registry and criminal history status in other states.

Managers who provide direct care must complete a background check. The rules list specific offenses that preclude hiring of staff.

Monitoring

Assisted living and shared housing establishments are inspected annually. This is an annual unannounced visit. The annual visit focuses on compliance with rules, solving resident issues and concerns and the establishment's QI process. Each establishment must have a QI program that covers oversight and monitoring; resident satisfaction; and a QI process that has benchmarks, is data driven, and focuses on resident satisfaction. A system is needed to detect and resolve problems. The existence, results, and process of the QI system cannot be used as evidence in any civil or criminal proceeding.

Remedies for violations include consultation, a statement of correction, administrative warning, mandatory training, imposed order of correction, fines and revocation of the license. Civil penalties may be applied up to $10,000 for violations and up to $5,000-$10,000 per instance for keeping residents who exceed the care needs in the law.

The monitoring process is collaborative in nature, with an emphasis on meeting the needs of the residents. During this process, the state provides information on best practices and shares concerns about the quality of care with suggestions for how to fix the problems or the names of individuals the establishment may contact for assistance. Oversight is not enforcement-driven, but is based more on a social model promoting quality of care. The functions of surveying and providing education are the responsibility of the same staff. Assisted living staff consists of one RN program manager, one surveyor and an administrative assistant. Long-term care staff are only used for occasional complaint investigations.

Supportive living facilities. Participating facilities will be Medicaid certified and monitored, at least annually, by the Department of Healthcare and Family Services. Monitoring includes contract requirements, resident autonomy, resident rights, adequacy of service provision, quality assurance process, safety of the environment, program policies and procedures, information provided to low income residents, review of resident assessment and service plans, resident satisfaction surveys, check-in system, and food service.

Facilities must have a grievance process and a quality assurance process. Complaints may be heard informally. If not resolved or if the resident prefers, grievances may be submitted through the facility's formal process. Residents may use the Medicaid appeals process for denial or delay of service.

Internal quality assurance procedures must encompass resident satisfaction, oversight and monitoring; peer review; utilization review; procedures for preventing, detecting and reporting resident neglect and abuse; and on-going QI. The committee must establish review schedules, objectives for improving service quality, including quality indicators and measures, and a mechanism for tracking improvements based on care outcomes. A system with outcome indicators must be developed that measures: quality of services; residents' rating of services; cleanliness and furnishings in common areas; service availability and adequacy of service provision and coordination; provision of a safe environment; socialization activities; and resident autonomy.

Fees

Fees for sheltered care facilities are $995 per year. The fee for assisted living establishments is $300 per facility, plus $5 per unit. The fee for shared housing is $150.

RESIDENTIAL CARE AND ASSISTED LIVING COMPENDIUM: 2007

Files Available for This Report

REPORT INTRODUCTION (*including Cover, Table of Contents, Acknowledgments, and Acronyms*)

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom.pdf

SECTION 1. Overview of Residential Care and Assisted Living Policy

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom1.pdf

SECTION 2. Comparison of State Policies

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom2.pdf

SECTION 3. State Summaries

HTML: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.htm
PDF: http://aspe.hhs.gov/daltcp/reports/2007/07alcom3.pdf

Each state's summary can also be viewed separately at:

Alabama	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAL.pdf
Alaska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAK.pdf
Arizona	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAZ.pdf
Arkansas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomAR.pdf
California	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCA.pdf
Colorado	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCO.pdf
Connecticut	http://aspe.hhs.gov/daltcp/reports/2007/07alcomCT.pdf
Delaware	http://aspe.hhs.gov/daltcp/reports/2007/07alcomDE.pdf
District of Columbia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomDC.pdf
Florida	http://aspe.hhs.gov/daltcp/reports/2007/07alcomFL.pdf

Georgia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomGA.pdf
Hawaii	http://aspe.hhs.gov/daltcp/reports/2007/07alcomHI.pdf
Idaho	http://aspe.hhs.gov/daltcp/reports/2007/07alcomID.pdf
Illinois	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIL.pdf
Indiana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIN.pdf
Iowa	http://aspe.hhs.gov/daltcp/reports/2007/07alcomIA.pdf
Kansas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomKS.pdf
Kentucky	http://aspe.hhs.gov/daltcp/reports/2007/07alcomKY.pdf
Louisiana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomLA.pdf
Maine	http://aspe.hhs.gov/daltcp/reports/2007/07alcomME.pdf
Maryland	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMD.pdf
Massachusetts	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMA.pdf
Michigan	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMI.pdf
Minnesota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMN.pdf
Mississippi	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMS.pdf
Missouri	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMO.pdf
Montana	http://aspe.hhs.gov/daltcp/reports/2007/07alcomMT.pdf
Nebraska	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNE.pdf
New Hampshire	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNH.pdf
New Jersey	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNJ.pdf
New Mexico	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNM.pdf
New York	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNY.pdf
Nevada	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNV.pdf
North Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomNC.pdf
North Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomND.pdf
Ohio	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOH.pdf
Oklahoma	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOK.pdf
Oregon	http://aspe.hhs.gov/daltcp/reports/2007/07alcomOR.pdf
Pennsylvania	http://aspe.hhs.gov/daltcp/reports/2007/07alcomPA.pdf
Rhode Island	http://aspe.hhs.gov/daltcp/reports/2007/07alcomRI.pdf
South Carolina	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSC.pdf
South Dakota	http://aspe.hhs.gov/daltcp/reports/2007/07alcomSD.pdf
Tennessee	http://aspe.hhs.gov/daltcp/reports/2007/07alcomTN.pdf
Texas	http://aspe.hhs.gov/daltcp/reports/2007/07alcomTX.pdf
Utah	http://aspe.hhs.gov/daltcp/reports/2007/07alcomUT.pdf

Vermont	http://aspe.hhs.gov/daltcp/reports/2007/07alcomVT.pdf
Virginia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomVA.pdf
Washington	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWA.pdf
West Virginia	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWV.pdf
Wisconsin	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWI.pdf
Wyoming	http://aspe.hhs.gov/daltcp/reports/2007/07alcomWY.pdf