status at time of admission. Significant ethnic disparities in quality-of-care aspects such as hospitalizations, preventive care, and the management of chronic conditions exist and these patterns extend to sex and ethnicity-specific subgroups of individuals with AD. However, there is a paucity of knowledge on the actual size of sex and ethnicity-related disparities in AD within this high-risk population. In this study we used 100% of all nursing home resident evaluations (N=23,080,518; Male:40.66%; Female:59.34%; White: 77.29%; Black:11.62%; Other:3.80%; Hispanic:4.97%; Asian:1.81%; Pacific Islander:0.15%; Native American Native:0.39%), 1999-2012, from the Minimum Dataset to assess sex and ethnicity-specific differences in age-specific prevalence of AD. Total AD prevalence increases sharply (numbers are prevalence proportions with 95% confidence intervals) from 1.79 (1.75-1.84) at age 60 to 13.45 (13.39-13.51) at 85. Notable statistically significant sex and ethnicity-related disparities were present at all ages. For example, at age 85 the prevalence of AD was for: i)Males: 11.34 (11.24-11.44); ii)Females: 14.53 (14.45-14.62); iii)Whites: 13.21 (13.14-13.28); iv)Blacks: 15.32 (15.09-15.55); v)Other/Unknown: 9.75 (9.42-10.07); vi)Hispanics: 18.17 (17.82-18.52); vii)Asians: 11.30 (10.87-11.72); viii)Pacific Islanders: 10.33 (8.65-12.01); ix)North American Natives: 11.78 (10.62-12.94). In depth analysis of the causes, time-trends, and geographic distribution of these disparities is needed.