

Part A: General Information

Georgia Department of Community Health

Date Received Date Revised Notes

1. Identification:

Facility UID Year
 a. Facility Name b. County
 c. Street Address d. City e. Street Zip
 f. Mail Address g. City h. Mail Zip

2. Report Period:

Report data for the full 12-month period, July 1, 2006 through June 30, 2007 (365 days). Do not use a different report period.

Check the box to the right if your facility was operational for the entire year.

If your facility was NOT operational for the entire year, provide the dates the facility was operational below:

Part B: Electronic Signature and Contact

I hereby certify that I am authorized to submit this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature Date
 Signature Title

Person authorized to respond to inquiries about the responses to this survey:

Name Title
 Telephone Fax E-mail

Part C: Ownership, Programs, and Licensure

1. OWNERSHIP, OPERATION AND MANAGEMENT as of the last day of the Report Period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the Organization Type.

Category	Full Legal Name (or "Not Applicable")	Organization Type	Effective Date
a. Facility Owner:			
b. Owner's Parent Org:			
c. Facility Operator:			
d. Operator's Parent Org:			
e. Mgmt. Contractor:			
f. Mgmt's Parent Org:			

2. Check the appropriate boxes below if the operator, if any, reported in C.1.c:

Lessee? Sublessee?

3. Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period.

If you checked the box for yes, please provide a list of the parties involved and the date of change.

Part C: Ownership, Programs, and Licensure (continued)

4. Check the box to the right if the Owner(s) reported in question C.1.a/b. above also own or operate any other nursing home(s) and/or any other health care facility in Georgia as of the last day of the Report Period.

If you checked the box for yes, please provide a list of the facilities, including the city and county of each location.

Organizational Affiliations as of the last day of the Report Period. If item 5a, 5b, 5c, or 5d is checked, provide the name of the organization.

- 5a. Check the box to the right if your facility is organizationally related to a retirement complex.
 Name
- 5b. Check the box to the right if your facility is organizationally related to a nursing home.
 Name
- 5c. Check the box to the right if your facility is organizationally related to a hospital.
 Location Type - Select One -
 Name
- 5d.. Check the box to the right if your facility is organizationally related to a hospice. (not available before 2004)
 Name

6. Special Programs Does your facility have special unit(s) to provide any of the following programs? (check the appropriate boxes)

- | | | | |
|---|-------------------------------------|-------------------------|--------------------------|
| 1. Alzheimer's disease | <input type="checkbox"/> | 4. Adult day care | <input type="checkbox"/> |
| 2. Respite care | <input checked="" type="checkbox"/> | 5. Any other? (specify) | <input type="checkbox"/> |
| 3. Mental Retardation/Mental Health Residential | <input type="checkbox"/> | | |

Part D: Beds and Utilization

- | | |
|--|--|
| 1. Total beds set up and staffed for use as of 6/30/2007. | |
| 2. Report the average percent of persons living at your facility who pay by private insurance. | |
| 3. Report the Average Daily Census (number of beds rented) during the Report Period. | |
| 4. Report the average monthly charge for room and board (no extra services) for the Report Period. | |

5. Please report the number of residents in your facility as of 6/30/2007 by age grouping.

Total Residents by Age Group						Total
Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-85	Ages 85 +		
Male						
Female						

6. Please report the number of residents in your facility as of 6/30/2007 using the following race and ethnicity categories.

Residents by Race/Ethnicity							Total
American Indian/ Alaska Native	Asian	Black African American	Hispanic or Latino	Pacific Hawaiian Pacific Islander	White	Multi-Racial	

7. Admissions, Discharges and Discharged Days of Care for the Report Period:

- | | |
|----------------------------------|--|
| Resident Census as of 6/30/2006: | |
| Total Admissions: | |
| Total Live Discharges: | |
| Total Discharges to Death: | |
| Resident Census as of 6/30/2007: | |

Part E: Financial Data and Indigent/Charity Care

Indigent Charity Care Policies:

Check the box to the right if the home had a formal written policy or policies during the current Report Year concerning the provision of care for residents who are indigent?

Financial Data:

Please provide the following financial data for the current Report Year. Responses should be limited to financial data from the personal care home program only.

Category	Dollar Amount	Number of Residents
Gross Revenue:		
Bad Debt:		
Indigent/Charity Care:		

AGR
I/C % AGR

Part F: Resident Origin

Please report the county of origin for the residents in your facility as of 6/30/2007.

(Please see the instructions for further information.)

Year	UID	County	Residents

Total Residents

Part G: Comments

Please enter below any comments and suggestions that you have about this survey.