Annual Nursing Home Questionnaire Parts A-D for 7/1/2006-6/30/2007

UID:

Part A: General Information

Georgia Department of Community Health

1. Identification: Due Date: August 16, 2007 **Year: 2007**

UID:

Facility UID

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:

Is Facility a Medicaid Enrolled Provider ☑ Is Facility a Medicare Enrolled Provider ☑

Medicaid Provider Number Medicare Provider Number

Part B: Survey Contact Information

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 NA)	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.

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.

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

a. Check the box to the right if your facility is organizationally related to a retirement complex. ☐

Name

b. Check the box to the right if your facility is organizationally related to a licensed personal care home. ☐

Name

c. Check the box to the right if your facility is organizationally related to a hospital. ☐

Location

Hospital Name

d. Check the box to the right if your facility is organizationally related to a hospice ☐

Hospice 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? ☐
2. Respite care? ☐
3. Inpatient hospice? ☑
4. Adult day care? ☐
5. Any other? (specify) ☐ ☐

Part D: Beds and Utilization

1. Total beds set up and staffed for use as of June 30, 2007.
2. Report the total number of Medicare patients served during the Report Period.
3. Report the total number of Medicaid patients served during the Report Period.
4. Report the total number of Private and Other patients served during the Report Period.

5. Please report the total number of patients by age grouping as of 6/30/2007.

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

6. Please report the number of patients in your facility as of 6/30/2007 using the following race and ethnicity categories. The Total must match the calculated fields for D.5, D.7, D.8 and Part F.

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

7. Admissions, Discharges and Discharged Days of Care:

Patient Census as of 6/30/2006:	0
Total Admissions:	
Total Live Discharges:	
Total Discharges to Death:	
Patient Census as of 6/30/2007:	

8. **Diagnostic Categories: For the total patient census as of 6/30/2007 provide the number of patients by primary diagnosis. The total must agree with the Totals in Part D.5, D.6, D.7 and Part F.**

Category	# of Patients	Category	# of Patients
Mental Retardation		HIV/AIDS	
Mental Illness		Severe Physical Disability	
Alzheimer's Disease		All Other Diagnoses:	
		Total by Diagnoses:	

Annual Nursing Home Questionnaire Parts E-F for 7/1/2006-6/30/2007

Facility UID | | **Year:** **2007**
Facility Name | | **UID:**

Part E: Facility Workforce Information

1. **BUDGETED FTE**

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 06/30/2007.

Profession	Budgeted FTEs	Vacant Budgeted FTEs
Registered Nurses (RN's)		
Licensed Practical Nurses (LPNs}		
Nurse Aides/Assistants		

2. **FILLING VACANCIES**

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Registered Nurses (RNs)	
Licensed Practical Nurses (LPNs)	
Nurse Aides/Assistants	
Other Direct Care Staff	

Part F: Patient Origin

Please report the number of patients who were in your facility on 6/30/2007 by county of origin.

(To delete a row, click the gray box to the left of the row and press the Delete key. If you get an error message, press the Esc key and try again.)

County	Patients

Total Patients

Annual Nursing Home Questionnaire   Parts G-K for 7/1/2006-6/30/2007

Facility UID
Facility Name

Year: 2007
UID:

Part G: Days of Care Data for Medicaid Providers

Please report the inpataient days of care by payer type for the state fiscal year from 7/01/2006 to 6/30/2007.

Payer Type	Days of Care
Total Medicaid Service Days of Care	
Other Service Days of Care	
Total Service Days of Care	

Parts H-K: Days of Care and Financial Information for Non-Medicaid Providers

Skip Parts H-K and go to the Signature form if you are a Medicaid Provider

Part H: Inpatient Days of Care for Non-Medicaid Providers

1. Please report the inpatient days of care by payer type for patients who were in the facility during the state fiscal year from 7/01/2006 to 6/30/2007.

	Payment Source		Days of Care
a.	Medicare SNF Days		
b.	Other SNF Days (specify		
c..	Private and Other ICF and ICF/MR		
	Total		

2. Please report the inpataient days of care by payer type for patients who were away from the facility and where a bed was being held during the state fiscal year from 7/01/2006 to 6/30/2007.

	Payment Source	Days of Care
a.	Medicare SNF Days-On Leave	
b.	Other SNF Days - On Leave	
c..	Private and Other ICF and ICF/MR- On Leave	
	Total	

Part I : Operating Expenses for Non-Medicaid Providers

Total Addendum Operating Expenses	

Part J: Patient Revenue by Payer Source for Non-Medicaid Providers

Government Payers			
Payer		**Gross Patient Revenue**	**Net Patient Revenue**
1.. Medicare			
2. Other (specify)			

Non-Government Payers			
Payer		**Gross Patient Revenue**	**Net Patient Revenue**
1. Managed Care			
2. All Other Third-Party			
3. Self-Pay/Private Pay			
4. Other (specify)			

Part K: Total Average Daily Charges for Private Pay Patients for Non-Medicaid Providers

Type of Patient	**Private Room**	**Semi-Private Room**
1. Skilled Care Patient		
2. Intermediate Care Patient		

NOTE: You must go to the Signature Form and sign your survey before submitting it. The survey will not be deemed complete without an authorized signature.

Annual Nursing Home Survey

Signature Form **for 7/1/2005-6/30/2006**

Alvista Healthcare Center, Inc **UID:**

Georgia Department of Community Health

YOU MUST CHECK FOR ERRORS BEFORE ENTERING THE SIGNATURE

In order to ensure that the Signature Form will accept the authorized signature below you must first click the "View Error Messages" button. This button will produce a report detailing any missing data items that are required or balances that do not agree, but are required to be in balance. The Signature Form WILL NOT accept an authorized signature until each item on the Data Validation Report is corrected. After correcting errors, click the "View Error Messages" button again to make sure that the errors have been cleared.

Electronic Signature and Contact

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Exective Officer, Executive Director, or Principal Administrator of the facility pursuant to Rule 111-2-2-.04(1)(6). The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. 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:

Title:

Comments:

Unresolved Data Issues

Please explain any unresolved data issues in the comments box.