

## FISCAL YEAR 2009 ANNUAL NURSING HOME QUESTIONNAIRE (ANHQ)

### - IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05 and other regulations or statutes.

The chief executive officer, executive director or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1) (b), 111-2-2-.05(1) (a) 1, and 111-2-2-.05(1) (a) 7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

## INSTRUCTIONS AND DEFINITIONS

### *REVIEW INSTRUCTIONS AND DEFINITIONS BEFORE COMPLETING THE SURVEY*

The Annual Nursing Home Questionnaire is being administered for all nursing homes operated in Georgia. You should have received an identification number for your facility that is required to complete the survey. Please retain a copy of the completed survey for your records. You may print a hard copy of the completed survey prior to submission for review.

Please respond to all questions. When a numerical answer is required, enter "0" (zero) if that is the correct response.

Data should be submitted for the entire Report Period or the last day of the Report Period as requested. If the nursing home was sold or leased during the Report Period, it is the responsibility of the **current nursing home operator** to obtain all necessary records from the previous operator(s) to complete this questionnaire.

Some totals must balance and agree with relevant totals in the questionnaire. If relevant totals do not balance and agree as appropriate, the survey instrument will prompt the respondent and will not allow submission of the questionnaire.

**If you have any questions, please contact:**

**Virginia Seery,  
Division of Health Planning  
Georgia Department of Community Health  
404 656 0463  
vseery@dch.ga.us**

## **PART A: GENERAL INFORMATION**

1. **Respond as requested.** Please be sure to provide both the nursing home's **Medicaid** and **Medicare** provider numbers; **use numbers only** plus one alpha character, if appropriate.
2. **Report Period:** July 1, 2008 through June 30, 2009 is the **required** report period. If the facility was in operation for a full year **you must** report data for a full year. If the ownership, operation or management of the facility changed during the report period, it is the responsibility of the **current owner or operating entity** to obtain the necessary data from the prior owner or operator.

## **PART B: CONTACT INFORMATION**

Provide the name, title, email, fax, and phone numbers of the person authorized to respond to inquiries about the responses to the survey. This person must retain a copy of the completed questionnaire.

## **PART C: OWNERSHIP, PROGRAMS & LICENSURE**

### **DEFINITIONS:**

**Facility Owner** - refers to the person or entity that owns the building and grounds. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

**Facility Operator** - refers to the owner of the business accountable for the profits and losses. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

**Management** - refers to a specific entity that the Owner or Operator has contracted to manage the routine business. Include the appropriate organizational code from the table in question C.1 and the effective date by month, day and year.

**Lessee** - refers to the entity that has rented the actual building in which the business is operated.

**Sub-lessee** - refers to the entity that has rented from the original lessee.

**Changes** - refers to any Owner or Operator changes that occurred during the report period **7/1/08 through 6/30/09** or after the last day of the Report Period. This should **NOT** reflect any change solely in administrators.

**Other Health Care Facilities** - refers to health care organizations such as but not limited to nursing homes, hospitals, home health agencies, ambulatory surgery centers, personal care homes, and hospices.

**Organizational Affiliations** - refers to your facility being affiliated with a retirement complex, a licensed personal care home, a hospital, or a hospice. Generally, such affiliations are indicated when the facilities are on the same campus and share the same administrative control.

### **Special Programs:**

**Alzheimer's Disease Program** – planned and structured array of services and daily routines for persons with Alzheimer's Disease/Dementia.

**Respite Care Program** – an organized program that provides care and supervision to a dependent client to sustain the family or other primary care giver by providing that person with temporary relief from the ongoing responsibility of care.

**Inpatient Hospice Program** – an inpatient program of specialized palliative and supportive services from terminally ill persons and their families, including medical, psycho-social, volunteer and bereavement services.

**Adult Day Care Program** – a program that provides adults with personal care in a protective setting outside their own homes during a portion of a 24-hour day.

## **PART D: BEDS AND UTILIZATION**

### **DEFINITIONS:**

**Beginning Census** - the total number of patients in your facility on the last day of the previous Report Period, **6/30/08**. If your facility submitted an Annual Nursing Home Questionnaire for 2008, the patient census for 6/30/08 that was reported in the 2008 survey is pre-loaded for your convenience. **IF YOU CHANGE THIS NUMBER, YOU MUST SUBMIT A REVISED SURVEY FOR THE 2008 REPORT YEAR.**

**Ending Census** – the total number of patients in your facility on the last day of the current Report Period, **6/30/09**. This field is calculated by adding the net increase in patients (admissions minus discharges) to the Beginning Census.

**Admission** - the formal acceptance of a patient who is to receive inpatient services in the facility.

**Discharge** - the release of a patient from the facility, who was discharged to home, transferred to another institution, or died.

**Beds Set Up and Staffed** - all beds that are staffed with personnel including both occupied and unoccupied beds. Temporary changes in the number of beds due to renovations, painting, etc., do not affect bed count as reported here.

**Number of total Medicare, Medicaid and Private and Other Patients** - count the patients reported on the census of 6/30/2008 plus the new admissions from July 1, 2008 to June 30, 2009; then sort each patient by payment source. **Remember**, a patient may be included in more than one category.

### **Race/Ethnicity Categories: (as defined by the U.S. Census Bureau)**

**American Indian or Alaska Native** - A person having racial origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

**Asian** - A person having racial origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, but not limited to, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

**Black or African American** – A person having racial origins in any of the Black racial groups of Africa.

**Hispanic or Latino** – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term “Spanish Origin” can be used in addition to “Hispanic” or “Latino.”

**Native Hawaiian or Other Pacific Islander** – A person having racial origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**White** – A person having racial origins in any of the original peoples of Europe, the Middle East, or North Africa. Include people who indicate their race as “White” or report entries such as Irish, German, Lebanese, Near Easterner, Arab, or Polish.

**Multi-Racial** – A person having racial origins from two or more of the above definitions.

### **DIAGNOSTIC CATEGORIES:**

**Mental Retardation** ICD-9-CM DIAGNOSIS CODES 317-319

**Mental illness/Psychoses** ICD-9-CM DIAGNOSIS CODES 290-316

**Alzheimer's Disease** ICD-9-CM DIAGNOSIS CODE 331.0

**HIV/AIDS** ICD-9-CM DIAGNOSIS CODES 042 and/or 079.53

**Severe Physical Disability** **Persons with severe physical impairment and/or traumatic brain injury that substantially limit one or more functional activities of daily living and require assistance of another individual,**

### **PART E: FACILITY WORKFORCE INFORMATION:**

The Division of Health Planning is collecting workforce information to support the State's workforce planning activities. The Division is currently focusing on planning efforts for Registered Nurses, Licensed Practical Nurses, Nurse Aides/Assistants, and other direct care staff. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of **June 30, 2009**.

Also, please report the average time your facility has spent during the past six months filling vacant positions. Use one of the four time periods provided for each professional category.

### **PART F: PATIENT ORIGIN:**

**Patient Origin** – This represents the place where each patient was living prior to being admitted to your facility. This must reflect the Georgia County before he/she was admitted to your facility, or if the patient was from out-of-state, indicate where the patient was living prior to being admitted to your facility.

### **PART G: Days of Care for Medicaid Provider**

If you are a Medicaid Provider, report the inpatient days of care by provider for the state fiscal year from **7/1/2008 to 6/30/2009**.

Beginning with the state fiscal year for 2006, the Division of Health Planning is collecting inpatient services days of care for Medicaid and other payers.

**Inpatient days** - is defined as the care of one patient during the period between the census-taking hours of two successive calendar days. Normally, the day of discharge should not be counted as an inpatient day of care. If a patient is admitted and discharged on the same day, then one (1) day of inpatient care is assigned to that patient. The adjective, **Service**, is used to indicate that the patient received care. The facility may or may not have received compensation for the care.

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

If you are a Medicaid Provider, skip Parts H-K and go to the Signature form.

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

1. Please report the inpatient days of care as defined above by payer type for patients who were **in the facility** during the state fiscal year from 7/1/2008 to 6/30/2009.
2. Please report the inpatient 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 7/1/2008 to 6/30/2009.

### **Part I: Operating Expenses for Non-Medicaid Providers**

Please report your total operating expenses in whole dollars. Include the costs for payroll, employee benefits, depreciation, interest, contract services, consultant services, and all other expenses.

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

Please report the patient revenue by payer source. Round the amount to whole dollars. Enter "0" in the field if the category is not applicable.

### **Revenue Categories:**

**Gross Patient Revenue** - report the nursing home's gross patient revenue which will include charges generated by **all nursing home patients at full established rates** before contractual and other adjustments, including indigent/charity care.

**Net Patient Revenue** - report the nursing home's gross patient revenue less contractual allowances.

### **Government Payers**

**Medicare** - in the appropriate columns report the nursing home's gross and net patient revenue for Medicare.

**Other Government Payers** - in the appropriate columns report the nursing home's gross and net patient revenue for all government payers other than Medicare. (e.g. TRICARE.)

### **Non-Government Payers**

**Managed Care** - report the nursing home's gross and net patient revenue for managed care third-party payers such as HMOs, PPOs, etc.

**All Other Third-Party Payers** - report the nursing home's gross and net patient revenue for all other third-party payers such as commercial insurance.

**Self-Pay/Private Pay** - report the nursing home's gross and net patient revenues for self-pay payers.

**Other Non-Government** - report the nursing home's gross and net patient revenue for all non-government payers other than third-party and self-pay, e.g., a sponsorship by a charitable organization.

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

Report the average daily charges for private pay patients for both routine and ancillary services by level of care and type of room. Include charges for lodging, meals, and routine nursing care as well as charges for ancillary services such as physician services, private duty nursing, therapy, drugs, special medical supplies, special diet, laboratory tests and medical equipment.

## **SIGNATURE FORM: ELECTRONIC SIGNATURE AND CONTRACT**

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer, Executive Director or Principal Administrator of the facility pursuant 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.