

## STATE FISCAL YEAR 2011 ANNUAL NURSING HOME QUESTIONNAIRE (ANHQ)

July 1, 2010 through June 30, 2011

### - 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, .09 and other regulations or statutes.

The chief executive officer 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.

### SFY 2011 Annual Nursing Home Questionnaire SURVEY FORM

The 2011 Annual Nursing Home Questionnaire (ANHQ) can be completed using an online interface. Providers of nursing facility services may access the online survey by pointing their web browser to <http://www.georgiahealthdata.info/>. Notification letters were mailed to facility administrators regarding the 2011 ANHQ which included a unique agency identification number (UID) and agency password. Both the UID and password will be needed to access and complete your survey. Instructions for accessing and completing the web-based survey are provided at the Health Planning Surveys web interface (<http://www.georgiahealthdata.info/>).

**The deadline for filing the completed webform for your facility is September 16, 2011.**

**Survey Completion Status** – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. Generally, the survey will be deemed complete on the day it is received by DCH. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date.

**Copy of Completed Survey** – The webform allows for printing (or saving) at completed copy of the survey. It is extremely important that you retain a copy of your completed survey. You must have your browser's pop-up blocker turned off for our website for the save and print feature to function properly.

**Revising or Amending the Survey** – Pursuant to Rule [111-2-2-.04\(1\)\(g\)](#) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

**Data Validation Requirements** – Once you are ready to submit the survey, you can determine if the required survey totals are in balance and that all required items are complete by viewing the error message on the Signature Page. This message containing a description of any out of balance totals and any required data items that are missing. If there are no errors or validation issues you can sign and then submit the survey.

## PART A: GENERAL AGENCY 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, 2010 through June 30, 2011 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: SURVEY 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 **7/1/09 through 6/30/10** 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, **6/30/09**. If your facility submitted an Annual Nursing Home Questionnaire for 2010, the patient census for 6/30/09 that was reported in the 2010 survey is pre-loaded for your convenience. **IF YOU CHANGE THIS NUMBER, YOU MUST SUBMIT A REVISED SURVEY FOR THE 2010 REPORT YEAR.**

**Ending Census** – the total number of patients in your facility on the last day of the current Report Period, **6/30/10**. 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 6/30/2010 plus the new admissions from July 1, 2010 to June 30, 2011; 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:**

<b>Mental Retardation</b>	ICD-9-CM DIAGNOSIS CODES 317-319
<b>Mental illness/Psychoses</b>	ICD-9-CM DIAGNOSIS CODES 290-316
<b>Alzheimer's Disease</b>	ICD-9-CM DIAGNOSIS CODE 331.0
<b>HIV/AIDS</b>	ICD-9-CM DIAGNOSIS CODES 042 and/or 079.53
<b>Severe Physical Disability</b>	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, 2011**.

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 **7/1/2010 to 6/30/2011**.

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 7/1/2010 to 6/30/2011.
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 7/1/2010 to 6/30/2011.

## **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 PAGE**

The Signature Page is where the agency's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The agency's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. An electronic manually entered version of the signature is being accepted as an original signature pursuant to the [Georgia Electronic Records and Signature Act](#).

The Signature Page also will identify any out of balance edit checks and any validation rule criteria that are not correct. All edit and balance requirements and all required fields must be completed before the survey can be submitted.