Georgia Department of Community Health

2010 Annual Nursing Home Questionnaire

Part A : General Information

1. Identification

UID:NF036

Facility Name: Carrollton Nursing & Rehab Center

County: Carroll

Street Address: 2327 North Highway 27

City: Carrollton

Zip: 30117

Mailing Address: 2327 North Highway 27

Mailing City: Carrollton

Mailing Zip: 30117

Medicaid Provider?
Check the box to the right if the agency is a medicaid provider. ☑
If you indicated yes above, please report the medicaid number below.
000059661A

Medicare Provider?
Check the box to the right if the agency is a medicare provider. ☑
If you indicated yes above, please report the medicare number below.
115368

2. Report Period

Report Data for the full twelve month period- 7/01/2009 to 6/30/2010.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

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

Contact Name: Rhonda Blankenship

Contact Title: Administrator

Phone: 770-834-4404

Fax: 770-830-9729

E-mail: rblankenship@gramercyhealth.com

Part C : Ownership, Operation and Management

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. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Carrollton NRC, LLC	For Profit	9/1/2003

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Great Oaks Nursing Home Inc	For Profit	9/1/2003

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CHC-Carrollton Nursing & Rehab Ctr, LLC	For Profit	9/1/2003

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SA-GA Operator Holdings, LLC	For Profit	9/1/2003

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
NA	Not Applicable	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
NA	Not Applicable	

2A. Operator Lessee? ☐

2B. Operator SubLessee? ☑

3. Changes in Ownership, Operation or Management
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. Owner Operation of Other Nursing Home(s)
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.
CHC-Cedar Valley Nursing & Rehab Ctr, LLC Cedartown-Polk CHC-Chestnut Ridge Nursing & Rehab Ctr, LLC Cumming-Forsyth CHC-Hart Care Center, LLC Hartcare CHC Pine Knoll Nursing & Rehab Ctr, LLc Carrollton-Carroll CHC-Roswell Nursing & Rehab Ctr, LLC Roswell-Fulton CHC-Social Circle Nursing & Rehab Ctr, LLC Social Circle-Walton CHC-University Nursing & Rehab Ctr, LLC Athens-Clarke CHC-Woodstock Nursing & Rehab Ctr, LLC Woodstock-Cherokee

5. Organization Affiliations
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. ☐
Retirement Complex Name:

5b.
Check the box to the right if your facility is organizationally related to a licensed personal care home. ☐
Personal Care Home Name:

5c.
Check the box to the right if your facility is organizationally related to a hospital. ☐
Hospital Name:

Location:

5d.
Check the box to the right if your facility is organizationally related to a hospice. ☑
Hospice Name:
Oak Brook Hospice of Georgia, LLC

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

6a. Alzheimer's Disease? ☐

6b. Respite Care? ☐

6c. Inpatient Hospice? ☐

6d. Adult Day Care? ☐

6e. Any Other? ☐

Specify:

6f. Any Other? ☐

Specify:

Part D : Beds and Utilization

1. Total Beds

Please report the total beds set up and staffed for use as of June 30, 2010.

159

2. Medicare Patients

Please report the total number of Medicare patients served during the Report Period.

71

3. Medicaid Patients

Please report the total number of Medicaid patients served during the Report Period.

139

4. Private and Other Patients

Please report the total number of Private and Other patients served during the Report Period.

72

5. Patients by Age Group and Gender

Please report the total number of patients by age group as of 6/30/2010.

Gender	Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-84	Ages 85+	Total
Male	0	6	4	10	6	26
Female	0	16	4	37	47	104
Total	**0**	**22**	**8**	**47**	**53**	**130**

6. Patients by Race/Ethnicity

Please report the total number of patients as of 6/30/2010 using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	35
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	95

Multi-Racial	0
Total	**130**

7. Admissions, Discharges and Discharged Days of Care:

Patient Census as of 6/30/2010: 134
Total Admissons: 113
Total Live Discharges: 84
Total Discharges to Death: 33
Patient Census as of 6/30/2010: 130

8. Diagnostic Categories

For the total patient census as of 6/30/2010 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	Number of Patients
Mental Retardation	9
Mental Illness	28
Alzheimer's Disease	26
HIV/AIDS	0
Severe Physical Disability	28
All Other Diagnoses	39
Total	**130**

Part E : Facility Workforce Information

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 06/30/2010.

Profession	Budgeted FTEs	Vacant Budgeted FTEs
Registered Nurses (RNs)	4	0
Licensed Practical Nurses (LPNs)	22	1
Nurse Aides/Assistants	45	3

2. Filling Vacancies

Please enter 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 Nurse	30 Days or Less
Licensed Practical Nurse	30 Days or Less
Aide/Assistant	30 Days or Less
Allied Health/Therapists	Not Applicable

Part F : Patient Origin

1. Patient Origin by County

Please report the number of patients who were in your facility on 6/30/2010 by county of origin.

County	Number of Patients
Carroll	100
Coweta	4
Haralson	8
Paulding	2
Douglas	6
Heard	2
Fulton	2
Polk	3
Randolph	3
Total	**130**

Part G : Days of Care Data for Medicaid Providers

1. Inpatient Days of Care by Payer Type

Please report the inpatient days of care by payer type for the state fiscal year from 7/01/2009 to 6/30/2010.

Payer Type	Days of Care
Total Medicaid Service Days of Care	37,116
Other Service Days of Care	0

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

1. Inpatient Days of Care by Payer Type

Please report the inpatient days of care by payer type for patients who were in the facility during the state fiscal year from 7/01/2009 to 6/30/2010. (Use the blank row to specify other SNF Days)

Payment Source	Days of Care
Medicare SNF Days	0
Private and Other ICF and ICF/MR	0
	0

2. Inpatient Days of Care by Payer Type for Patients On Leave

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 7/01/2009 to 6/30/2010.

Payment Source	Days of Care
Medicare SNF Days- On Leave	0
Other Private and Other ICF and	0
Other SNF Days- On Leave	0

Part I : Operating Expenses for Non-Medicaid Providers

1. Total Addendum Operating Expenses

Please report the total addendum operating expenses.

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

1. Government Payers

Please report the patient revenue by payment source for government payers.

Payer	Gross Patient Revenue	Net Patient Revenue
Medicare	0	0
	0	0

2. Non-Government Payers

Please report the patient revenue by payment source for non-government payers.

Payer	Gross Patient Revenue	Net Patient Revenue
Managed Care	0	0
All Other Third-Party	0	0
Self-Pay/Private Pay	0	0
	0	0

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

1. Total Average Daily Charges by Type of Patient and Room Type

Please report the total average daily charges for private pay patients for Non-Medicaid Providers by room type and patient type.

Type of Patient	Private Room	Semi-Private Room
Skilled Care Patient	0	0
Intermediate Care Patient	0	0

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. 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 incaccurate 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 further 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: Rhonda Blankenship

Date: 9/14/2010

Title: Administrator

Email:

Comments: