GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Annual Nursing Home Questionnaire

Part A : General Information

1. Identification

UID:NF194

Facility Name: Mountain View Health and Rehab

County: Rabun

Street Address: 547 Warwoman Road

City: Clayton

Zip: 30525

Mailing Address: 547 Warwoman Road

Mailing City: Clayton

Mailing Zip: 30525

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.
000143184A

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.
115688

2. Report Period

Report Data for the full twelve month period- 7/01/2011 to 6/30/2012.
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: Shari Jordan

Contact Title: Administrator

Phone: 706-782-4276

Fax: 706-782-1516

E-mail: shari.jordan@mmc1.net

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
Jack N. White	Not Applicable	4/1/1999

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Greystoke Health Systems, LTD	For Profit	1/1/2012

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Greystoke Health Systems, LTD	For Profit	1/1/2012

F. Management's Parent Organization

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

Change from Medical Management Concepts, LLC to Greystoke Health Systems, LTD 01/01/2012

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.

Gold City Health Care, Dalonega, Lumpkin Co.; Medical Management Health and Rehab, Macon, Bibb Co.; Porterfield, Macon, Bibb Co.; Molena Extended Care, Molena,Pike Co.

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:

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, 2012.

113

2. Medicare Patients

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

100

3. Medicaid Patients

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

143

4. Private and Other Patients

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

41

5. Patients by Age Group and Gender

Please report the total number of patients by age group as of 6/30/2012.

Gender	Ages 0-14	Ages 15-64	Ages 65-74	Ages 75-84	Ages 85+	Total
Male	0	17	13	8	8	46
Female	0	24	9	9	18	60
Total	**0**	**41**	**22**	**17**	**26**	**106**

6. Patients by Race/Ethnicity

Please report the total number of patients as of 6/30/2012 using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	7
Hispanic/Latino	2
Pacific Islander/Hawaiian	0
White	97
Multi-Racial	0
Total	**106**

7. Admissions, Discharges and Discharged Days of Care:

Patient Census as of 6/30/2012: 99
Total Admissons: 138
Total Live Discharges: 102
Total Discharges to Death: 29
Patient Census as of 6/30/2012: 106

8. Diagnostic Categories

For the total patient census as of 6/30/2012 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	15
Mental Illness	38
Alzheimer's Disease	37
HIV/AIDS	0
Severe Physical Disability	15
All Other Diagnoses	1
Total	**106**

Part E : Facility Workforce Information

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 06/30/2012.

Profession	Budgeted FTEs	Vacant Budgeted FTEs
Registered Nurses (RNs)	6	0
Licensed Practical Nurses (LPNs)	14	0
Nurse Aides/Assistants	41	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	31-60 Days
Licensed Practical Nurse	31-60 Days
Aide/Assistant	30 Days or Less
Allied Health/Therapists	More than 90 Days

Part F : Patient Origin

1. Patient Origin by County

Please report the number of patients who were in your facility on 6/30/2012 by county of origin.

County	Number of Patients
Habersham	13
Stephens	8
Rabun	45
Hall	11
Towns	2
Oconee	16
Forsyth	2
Cherokee	1
Jackson	2
Hart	2
Barrow	1
Madison	1
Banks	1
Union	1
Total	**106**

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 7/01/2011 to 6/30/2012.

Payer Type	Days of Care
Total Medicaid Service Days of Care	27,494
Other Service Days of Care	8,058

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 7/01/2011 to 6/30/2012. (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 7/01/2011 to 6/30/2012.

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: Shari Jordan

Date: 9/12/2012

Title: Administrator

Email:

Comments: