Georgia Department of Community Health

# 2015 Annual Nursing Home Questionnaire

## Part A : General Information

### 1. Identification

**UID:NF292**

**Facility Name:** Peachbelt Health & Rehab Center

**County:** Houston

**Street Address:** 801 Elberta Road

**City:** Warner Robins

**Zip:** 31093-1795

**Mailing Address:** 801 Elberta Rd

**Mailing City:** Warner Robins

**Mailing Zip:** 31093

**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.
000142381A

**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.
115552

### 2. Report Period

Report Data for the full twelve month period- 7/01/2013 to 6/30/2015.
***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:** Debbie Meade

**Contact Title:** CEO

**Phone:** 478-328-3800

**Fax:** 478-328-3899

**E-mail:** debbiemeade@healthmngt.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 |
|---|---|---|
| Peachbelt Properties, Inc | For Profit | 4/1/1981 |

#### B. Owner's Parent Organization

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

#### C. Facility Operator

| Full Legal Name (Or Not Applicable) | Organization Type | Effective Date |
|---|---|---|
| Peachelt Health and Rehabilitation Center, LLC | For Profit | 4/1/1999 |

#### D. Operator's Parent Organization

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

#### E. Management Contractor

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

#### F. Management's Parent Organization

| Full Legal Name (Or Not Applicable) | Organization Type | Effective Date |
|---|---|---|
| Health Management, LLC | For Profit | 4/1/2001 |

**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.

**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, 2015.

30

**2. Medicare Patients**

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

6

**3. Medicaid Patients**

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

16

**4. Private and Other Patients**

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

4

**5. Patients by Age Group and Gender**

Please report the total number of patients by age group as of 6/30/2015.

| Gender | Ages 0-14 | Ages 15-64 | Ages 65-74 | Ages 75-84 | Ages 85+ | Total |
|---|---|---|---|---|---|---|
| Male | 0 | 0 | 0 | 0 | 6 | 6 |
| Female | 0 | 0 | 1 | 8 | 11 | 20 |
| **Total** | **0** | **0** | **1** | **8** | **17** | **26** |

**6. Patients by Race/Ethnicity**

Please report the total number of patients as of 6/30/2015 using the following race and ethnicity categories.

| Race/Ethnicity | Number of Patients |
|---|---|
| American Indian/Alaska Native | 0 |
| Asian | 0 |
| Black/African American | 5 |
| Hispanic/Latino | 0 |
| Pacific Islander/Hawaiian | 0 |
| White | 21 |
| Multi-Racial | 0 |
| **Total** | **26** |

## 7. Admissions, Discharges and Discharged Days of Care:

**Patient Census as of 6/30/2014:** 98
**Total Admissons:** 138
**Total Live Discharges:** 205
**Total Discharges to Death:** 5
**Patient Census as of 6/30/2015:** 26

## 8. Diagnostic Categories

For the total patient census as of 6/30/2015 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 | 1 |
| Mental Illness | 0 |
| Alzheimer's Disease | 4 |
| HIV/AIDS | 0 |
| Severe Physical Disability | 8 |
| All Other Diagnoses | 13 |
| **Total** | **26** |

# Part E : Facility Workforce Information

## 1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 06/30/2015.

| Profession | Budgeted FTEs | Vacant Budgeted FTEs |
|---|---|---|
| Registered Nurses (RNs) | 2 | 0 |
| Licensed Practical Nurses (LPNs) | 12 | 1 |
| Nurse Aides/Assistants | 26 | 0 |

## 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 | 30 Days or Less |
| Aide/Assistant | 31-60 Days |
| 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 6/30/2015 by county of origin.

| County | Number of Patients |
|---|---|
| Bleckley | 2 |
| Peach | 4 |
| Houston | 20 |
| **Total** | **26** |

## 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 7/01/2013 to 6/30/2015.

| Payer Type | Days of Care |
|---|---|
| Total Medicaid Service Days of Care | 19,159 |
| Other Service Days of Care | 8,172 |

## 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 7/01/2013 to 6/30/2015. (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 7/01/2013 to 6/30/2015.

| Payment Source | Days of Care |
|---|---|
| Medicare SNF Days- On Leave | 0 |
| Other Private and Other ICF and ICF/MR Days- On Leave | 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:** Deborah L. Meade

**Date:** 9/1/2016

**Title:** CEO

**Email:** debbiemeade@healthmngt.com

**Comments:**