



STATE FISCAL YEAR 2024 ANNUAL NURSING HOME QUESTIONNAIRE (ANHQ)

July 1, 2023 through June 30, 2024

- 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 Ga. Comp. R. & Regs. r. 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 Ga. Comp. R. & Regs. r. 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 Ga. Comp. R. & Regs. r. 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 Ga. Comp. R. & Regs. r. 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.

Pursuant to O.C.G.A. § 31-6-70 (h) all health care facilities, ambulatory surgical centers, and imaging centers required to submit an annual report pursuant to O.C.G.A. § 31-6-70(a) shall make such annual reports publicly available on their websites.

2024 ANNUAL NURSING HOME QUESTIONNAIRE WEBFORM

The 2024 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 <https://www.georgiahealthdata.info/>. Notification letters were mailed to facility administrators regarding the 2024 ANHQ which included a unique facility identification number (UID) and a facility 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 (<https://www.georgiahealthdata.info/>).

The deadline for filing the completed webform for your facility is August 16, 2024.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Georgia Department of Community Health, Office of Health Planning (“Department” or “DCH”). 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 Department, 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 Ga. Comp. R. & Regs. r. [111-2-2-.04\(1\)\(g\)](#) surveys that are received and determined to be complete by DCH may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Department with a detailed explanation of the revisions and any necessary documentation. The Department will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Department may also determine that additional data, information, or documentation is needed to support the proposed revisions.

Data Validation Requirements – The webform checks various totals as the survey is completed. Values that are out of balance or missing information will appear in red as the survey is completed. Once the survey is completed all edit and balance requirements will be checked before the survey can be signed and submitted. Survey respondents can check for errors or balance issues by clicking the Signature Page tab. The Signature Page will show any errors or balance issues that must be resolved before the survey can be signed. Respondents may also email error messages to DCH for additional assistance by clicking the button found with errors on the Signature

Page.

PART A: GENERAL INFORMATION

1. **Identification** - 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, 2023 through June 30, 2024 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, OPERATION AND MANAGEMENT INFORMATION

Part C, Question 1

Facility Owner - 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 - 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 Contractor - 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.

Part C, Question 2

Lessee - The entity that has rented the actual building in which the business is operated.

Sub-lessee - The entity that has rented from the original lessee.

Part C, Question 3: Changes – Report Owner or Operator changes that occurred during the report period or after the last day of the Report Period. This should NOT reflect any change solely in administrators.

Part C, Question 4: Other Health Care Facilities - Health care organizations such as but not limited to nursing homes, hospitals, home health agencies, ambulatory surgery centers, personal care homes, and hospices.

Part C, Question 5: 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.

Part C, Question 6: Special Programs – Indicate if the facility has special units to provide the following programs.

Alzheimer's Disease Program – Indicate yes if the facility offers a planned and structured array of services and daily routines for persons with Alzheimer's Disease/Dementia.

Respite Care Program – Indicate yes if the facility offers an organized and on-going 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 – Indicate yes if the facility provides 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 – Indicate yes if the facility offers a program that provides adults with personal care in a protective setting outside their own homes during a portion of a 24-hour day.

Any Other – Provide information on any other program that is organized and ongoing for patients falling into specific diagnostic groups or needing specific types of care.

PART D: BEDS AND UTILIZATION DEFINITIONS

Part D, Question 1: Total Beds - Report all beds that were set-up and staffed with personnel including both occupied and unoccupied beds as of the last day of the report period. Temporary changes in the number of beds due to renovations, painting, etc., do not affect bed count as reported here.

Part D, Questions 2, 3, and 4: Medicare, Medicaid, Private, and Other Patients – Report the total number of Medicare, Medicaid and Private and Other Patients. Count the patients reported on the census as of the first day of the report period plus new admissions during the report year. A patient may be included in more than one category.

Part D, Question 6: Patients by Race/Ethnicity - Report the number of unduplicated patients by race/ethnicity according to the indicated categories. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with the number of patients reported elsewhere on the ANHQ. The United States Census Bureau uses the following racial and ethnicity definitions:

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 or Some Other Race – A person having racial origins from two or more of the above definitions.

Part D, Question 7: Admissions, Discharges and Discharge Days of Care

Beginning Census – The total number of patients in the facility on the last day of the previous Report Period. If your facility submitted an Annual Nursing Home Questionnaire for the previous year, the patient census is pre-loaded for your convenience. **If you change the pre-loaded number you must submit a revised survey for the previous report year.**

Total Admission – The formal acceptance of a patient who is to receive inpatient services in the facility.

Total Discharges (Live and Death) - The release of a patient from the facility, who was discharged to home, transferred to another institution, or died.

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

Part D, Question 8: Diagnostic Categories – Report the number of patients in each of the following diagnostic categories. Report on the patients as of the ending census. Use the patient's primary diagnosis and report patients as unduplicated. Patient totals here must balance to unduplicated patients reported elsewhere on the

ANHQ.

Mental Retardation - ICD-10-CM DIAGNOSIS CODES F70-F73, F79

Alzheimer's Disease - ICD-10-CM DIAGNOSIS CODES G30.0, G30.1, G30.8, G30.9

HIV/AIDS - ICD-10-CM DIAGNOSIS CODES B20 and/or B97.35

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.

Mental Illness/Psychoses

All Other Diagnoses – Include patients who do not have a primary diagnosis which would fit any of the categories above.

PART E: FACILITY WORKFORCE INFORMATION

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

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 PROVIDERS

If the facility was a Medicaid Provider, report the inpatient days of care by provider category for the report period.

Inpatient Days of Care - 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 the facility was a Medicaid Provider, skip Parts H-K and go to the Signature Form. If the facility was not enrolled as a Medicaid provider complete Parts H, I, J, and K.

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 as defined above by payer type for patients who were in the facility during the report period.
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 report period.

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.

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.

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.)

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 facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility'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. Clicking on the Signature Page tab will run the error and balance checks on the entire survey and provide detailed messages if there are issues. Error and balance check issue messages will be accompanied by an email button allowing respondents to automatically send the error report to DCH for additional assistance.

Be sure to click the “Submit” button when the survey is complete and ready to be submitted to DCH. This will lock the survey as complete, and no additional changes can be made unless DCH unlocks the survey. Since clicking the “Submit” button will lock the survey, the facility's chief executive or administrator should review and electronically sign the survey as the final step of the submission process.