



**2005 STATE OF GEORGIA
ANNUAL NURSING HOME QUESTIONNAIRE
FINANCIAL AND UTILIZATION ADDENDUM-NON-MEDICAID NURSING HOMES
JULY 1, 2004 – JUNE 30, 2005**

FACILITY NAME	ADDRESS

PART A: Inpatient Days of Care

PAYMENT SOURCE	DAYS OF CARE
1. Medicare SNF	
2. Other SNF Days (Specify) _____	
3. Private and Other ICF & ICF/MR	

PART B: Financial Data

Please provide your total expenses for each category. All responses should be reflected as whole dollars. Enter "0" if you had no expenses in a category.

EXPENSE CATEGORY	AMOUNT	EXPENSE CATEGORY	AMOUNT
3. Payroll	\$	7. Contract Services	\$
4. Employee Benefits	\$	8. Consultant Services	\$
5. Depreciation	\$	9. All Other Expenses	\$
6. Interest	\$		

PART C: Patient Revenue by Payer Source

Please Round to whole dollars and Place "0's" in all blanks spaces

GOVERNMENT PAYERS			
PAYER	GROSS PATIENT REVENUE	NET PATIENT REVENUE	
10. Medicare			
11. Other (specify): _____			
NON-GOVERNMENT PAYERS (Third-Party Payers)			
12. Managed Care			
13. ALL Other Third-Party			
14. Self-Pay/Private Pay			
15. Other (specify): _____			

PART D: Total Average Daily Charges for Private Pay Patients

Provide the total average daily charges for both routine and ancillary services for private pay patients by level of care and type of room. Include charges for lodging, meals and routine nursing care as well as charges for physician services, private duty nursing, therapy, drugs, special medical supplies, special diet, lab tests, and medical equipment.

TYPE OF PATIENT	PRIVATE ROOM	SEMI-PRIVATE ROOM
16. Skilled Care Patient	\$	\$
17. Intermediate Care Patient	\$	\$