GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA057

Facility Name: Three Rivers of Dodge

County: Dodge

Street Address: 205 Foster Street

City: Eastman

Zip: 31023-1752

Mailing Address: PO Box 640

Mailing City: Eastman

Mailing Zip: 31023-0640

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.
000186766A

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.
117053

2. Report Period

Report Data for the full twelve month period, January 1,2014 - December 31, 2014 (365 days).
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: WANDA DANIELS

Contact Title: EXECUTIVE ADMINISTRATOR

Phone: 478-374-3468

Fax: 478-374-6741

E-mail: wdaniels@123rivers.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. Agency Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
THREE RIVERS HOME HEALTH SERVIES, INC.	For Profit	06/01/1979

B. Owner's Parent Organization

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

C. Agency Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Branch Offices

If your agency has a branch office or branch offices please check the box to the right. ☑

3. Branch Office Locations

If your agency operates branch offices please provide the following information on branch locations.

Branch Office	Street Address	Street City	County	Date Est.
COCHRAN	147 EAST DYEKS STREET	COCHRAN	Bleckley	01/01/1984

DUBLIN	205 INDUSTRIAL BLVD	DUBLIN	Laurens	01/01/1981
TELFAIR	167 8TH STREET	HELENA	Telfair	02/01/1994
ABBEVILLE	402 SOUTH BROAD STREET	ABBEVILLE	Wilcox	05/01/1998

Part D : Agency Utilization and Patient Caseload Information

1. Health-Related Visits

Please report the number of health-related visits (not units) during the report period by service/discipline. Also, please provide the per visit rate your agency charges for providing each of the services indicated. Use the blank lines to report other services/disciplines.

Service/Discipline	Number of Visits	Charge per Visit
Skilled Nursing	16,481	170
Physical Therapy	17,365	180
Home Health Aide	5,059	90
Occupational Therapy	3,716	180
Medical Social Services	33	190
Speech Pathology	1,036	180
	0	0
	0	0
	0	0

2. Agency Caseload

Please report the total number of cases at the end of the business day on December 31,2014.

267

4. Completed Medicare Episodes of Care

Provide the total number of completed Medicare episodes of care during the report year. Include all completed episodes including Low Utilization Payment Adjustments (LUPA).

1579

5. Health-Related Patients by Race/Ethnicity

Please report the number of health-related patients during the report period using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	1
Asian	6
Black/African American	453
Hispanic/Latino	2
Pacific Islander/Hawaiian	1
White	1,359
Multi-Racial	0

6. Health-Related Patients by Gender

Report the number of health-related patients by gender served during the report period.

Gender	Number of Patients
Male	686
Female	1,136

7. Health-Related Visits by Payer

Please report the number of Health-Related visits, unduplicated patients, and the gross and net

patient revenue during the report period by each payer. Please note that gross and net patient revenue totals must balance to those reported in Part E.)

Payer	Patients	Visits	Gross Revenue	Net Revenue
Medicare	1,064	28,212	4,205,755	4,157,699
Medicaid	127	2,213	143,422	11,829
Other Government Payers	62	1,132	220,686	199,998
Managed Care (HMO/PPO)	367	9,328	1,331,860	1,228,101
Other Third Party Insurers	192	2,731	488,976	459,316
Self Pay	10	74	14,880	14,238
Other Non Government	0	0	0	0

Part E : Agency Financial Summary, Indigent and Charity Care Provided and Patient Point of Origin

1.Indigent and/or Charity Care Policy

Check the box to the right if the agency had a formal written policy or written policies concerning the provision of indigent and/or charity care during 2014. ☐

If you indicated yes above, please indicate the effective date of the policy or policies.

2. Person Responsible

Please indicate the name and title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.

3. Charity Care Provision

Check the box if the policy or policies included provision for the care that is defined as charity. ☐

4. Financial Table

Please complete the following financial table for the 2014 calendar year. Please note that Total Uncompensated Indigent and Charity Care Charges (automatically calculated by the database) should not exceed Gross Indigent and Charity Care Charges.

Revenue or Expense	Amount
Gross Patient Revenue	6,405,579
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	8,069
Other Contractual Adjustments	74,372
Total Contractual Adjustments	**82,441**
Bad Debt	40,189
Indigent Care Gross Charges	145,900
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**145,900**
Charity Care Gross Charges	65,868
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**65,868**
Other Free Care	0
Total Net Patient Revenue	**6,071,181**
Adjusted Gross Patient Revenue	**6,357,321**
Other Revenue	0
Total Net Revenue	**6,071,181**
Total Expenses	4,342,396
Adjusted Gross Revenue	**6,357,321**
Total Uncompensated I/C Care	**211,768**
Percent Uncompensated Indigent/Charity Care	**3.33%**

5. Indigent or Charity Care Cases

Report the number of home health care patients who were classified as being indigent or charity care cases and for which patient charges were written off to indigent or charity care accounts as reproted in Part E, Question 4 above.

26

6. Patient Point of Origin

Report the number of home health care patients who were referred to your agency by each of the following healthcare points of origin

Point of Origin	Number of Patients Referred
Hospitals (via discharge planner)	1,041
Physicians	670
Other Home Health Agencies	99
All Other Healthcare Providers	12

7. Referral Hospitals

Please provide the names of the hospitals above who referred patients during the report year.

Hospital Name	Patients Referred
ABERCORN REHABILITATION CENTER	1
ARCHBOLD MEDICAL CENTER	1
ATHENS REGIONAL MEDICAL CENTER	1
ATLANTA MEDICAL CENTER	2
BLECKLEY MEMORIAL HOSPITAL	51
CANDLER HOSPITAL	2
CENTRAL GEORGIA REHAB HOSPITAL	10
CHILDRENS HEALTHCARE OF ATLANTA AT EGLESTON	1
COFFEE REGIONAL HOSPITAL	6
COLISEUM NORTHSIDE HOSPITAL	9
COLISEUM MEDICAL CENTER	53
COLISEUM PSYCHIATRIC CENTER	1
COLISEUM REHABILITATION CENTER	8
COLUMBUS REGIONAL HUGHSTON HSOPITAL	4
CRISP REGIONAL HOSPITAL	8
DOCTORS HOSPITAL OF AUGUSTA	2
DODGE COUNTY HOSPITAL	122
DORMINY MEDICAL CENTER	7
DWIGHT D EISENHOWER ARMY MEDICAL CENTER	1
EASTSIDE MEDICAL CENTER	1
EMORY UNIVERSITY HOSPITAL	13
EMORY UNIVERSITY HOSPITAL MIDTOWN	6
EMORY WINSHIP CANCER INSTITUTE	1
FAIRVIEW PARK HOSPITAL	335
GEORGIA HEALTH SCIENCES MEDICAL CENTER	1
GEORGIA REGENTS MEDICAL CENTER	12

HOUSTON MEDICAL CENTER	18
HOUSTON MEDICAL CENTER PERRY	3
IRWIN COUNTY HOSPITAL	1
JACK HUGHSTON MEMORIAL HOSPITAL	9
JEFF DAVIS HSOPITAL	3
LOWER OCONEE COMMUNITY HOSPITAL	8
MAYO CLINIC	2
MEADOWS REGIONAL HOSPITAL	13
MEDICAL CENTER NAVICENT HEALTH	165
MEDICAL CENTER OF CENTRAL GEORGIA	7
MEDICAL COLLEGE OF GEORGIA	5
MEMORIAL HOSPITAL	16
OCONEE REGIONAL MEDICAL CENTER	1
OPTIM MEDICAL CENTER TATTNALL	8
PEIDMONT HOSPITAL	3
PERRY HOSPITAL	2
PHOEBE PUTNEY MEMORIAL HOSPITAL	2
PIEDMONT ATLANTA HOSPITAL	5
PIEDMONT MEDICAL CENTER	3
REGENCY HOSPITAL OF CENTRAL GEORGIA	9
REGIONAL REHABILITATION HOSPITAL	2
ST JOSEPH'S HOSPITAL	1
SELECT SPECIALITY HOSPITAL	1
SHEPHERD CENTER	2
SOUTH GEORGIA MEDICAL CENTER	2
SOUTHEASTERN REGIONAL MEDICAL CENTER	1
TAYLOR REGIONAL HOSPITAL	28
ST JOSEPH / CANDLER	2
MEDICAL CENTER OF PEACH COUNTY	1
TIFT REGIONAL MEDICAL CENTER	9
UNIVERSITY HEALTH CARE SYSTEM	2
WASHINGTON REGIONAL MEDICAL CENTER	1
VAMC - ATLANTA, AUGUSTA, DUBLIN	33
REHABILITATION HOSPITAL NAVICENT HEALTH	14
Total	**1,041**

Part F : Agency Workforce Information

This information is being collected to support Georgia's healthcare workforce planning activities.

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2014.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	15	0	0
Licensed Practical Nurses (LPNs)	6	0	0
Aides/Assistants	13	0	0
Allied Health/Therapists	6	0	5

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	1 MONTH
Licensed Practical Nurse	< 1 MONTH
Aide/Assistant	< 1 MONTH
Allied Health/Therapists	1 MONTH

Part G : Monthly Admissions, Readmissions and Utilization by Patient County

1. Monthly Admissions and Readmissions

Provide the number of new admissions and readmissions in each of the months during the report year

Month	New Admissions	Re-Admissions
January	148	7
February	103	10
March	117	11
April	124	12
May	125	12
June	118	14
July	116	23
August	107	9
September	102	8
October	136	10
November	111	9
December	117	7

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2014. Admissions should capture all admissions during the report year. Visits should capture all visits during the report year. Report patients served for the four age cohort groups. The Total Patients column will be automatically calculated. You will not be able to enter data in that column. Also provide patients for ages 60 to 79 in the column provided.

County	Beginning Caseload	Admissions	Total Visits	Patients 60-79	I/C Patients	Patients Under 18	Patients 18-64	Patients 65-79	Patients 80 & Over	Total by Age
Dodge	78	361	12,961	188	0	2	152	142	143	439
Laurens	84	619	14,740	339	0	1	202	265	235	703
Pulaski	8	35	1,116	21	0	0	15	16	12	43
Wheeler	10	60	1,704	37	0	0	24	25	21	70
Wilcox	27	96	2,855	59	0	0	21	51	51	123
Telfair	32	229	6,126	109	0	1	84	91	85	261
Bleckley	27	156	4,188	88	0	0	54	71	58	183
Total by Age	**0**	**0**	**0**	**0**	**0**	**4**	**552**	**661**	**605**	**1,822**

2B. Patient Origin Part B.

Please report the Gross Charges, Adjusted Gross Patient Revenue and Net Uncompensated Charges by County. The grand total of each of these must balance to the Gross Patient Revenue, Adjusted Gross Patient Revenue and Net Uncompensated Charges reported in Part E Question 4.

County	Gross Charges	Adjusted Gross Patient Revenue	Net Uncompensated Charges
Dodge	1,543,387	1,531,758	51,024
Laurens	2,471,527	2,452,907	81,709
Pulaski	151,174	150,036	4,998
Wheeler	246,098	244,244	8,135
Wilcox	432,429	429,172	14,296
Telfair	917,594	910,681	30,336
Bleckley	643,370	638,523	21,270
Total	**6,405,579**	**6,357,321**	**211,768**

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: Hal M. Smith, Jr.

Date: 11/09/2015

Title: Executive Director

Comments: