



## 2014 Home Health Survey

### Part A : General Information

#### 1. Identification

UID:HHA068

**Facility Name:** VNA of Southwest Georgia, Inc.

**County:** Decatur

**Street Address:** 117 Donalson Street

**City:** Bainbridge

**Zip:** 39817

**Mailing Address:** 117 Donalson Street

**Mailing City:** Bainbridge

**Mailing Zip:** 39817

#### **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.

0000166944A

#### **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.

117040

#### 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:** Tara King

**Contact Title:** Staff Accountant

Phone: 229-228-2228

Fax: 229-228-2290

E-mail: tking@archbold.org

## 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
Archbold Health Services, Inc.	Not for Profit	01/01/2012

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Archbold Medical Center, Inc.	Not for Profit	01/01/2012

#### C. Agency Operator

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

#### D. Operator's Parent Organization

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

#### E. Management Contractor

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

#### F. Management's Parent Organization

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

### 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.
	315 Columbia Street	Blakely	Early	10/01/1978

	210 S Wiley Avenue	Donalsonville	Seminole	10/01/1978
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## 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	15,755	125
Physical Therapy	3,738	175
Home Health Aide	6,245	70
Occupational Therapy	0	0
Medical Social Services	0	0
Speech Pathology	498	150
	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.

223

### 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).

1364

### 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	0
Asian	1
Black/African American	419
Hispanic/Latino	5
Pacific Islander/Hawaiian	0
White	622
Multi-Racial	17

### 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	441
Female	623

### 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	808	22,270	2,524,461	2,481,995
Medicaid	92	1,616	219,573	71,383
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	125	1,882	320,046	195,570
Self Pay	39	468	62,708	20,694
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.

01/01/2012

### 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.

Amy Ferry, Administrator

### 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	3,126,788
Medicare Contractual Adjustments	42,466
Medicaid & Peachcare Contractual Adjustments	148,190
Other Contractual Adjustments	0
<b>Total Contractual Adjustments</b>	<b>190,656</b>
Bad Debt	124,476
Indigent Care Gross Charges	42,014
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>42,014</b>
Charity Care Gross Charges	0
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>0</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>2,769,642</b>
<b>Adjusted Gross Patient Revenue</b>	<b>2,811,656</b>
Other Revenue	1,166
<b>Total Net Revenue</b>	<b>2,770,808</b>
Total Expenses	3,010,192
<b>Adjusted Gross Revenue</b>	<b>2,812,822</b>
<b>Total Uncompensated I/C Care</b>	<b>42,014</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>1.49%</b>

### 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 reported in Part E, Question 4 above.

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### **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

<b>Point of Origin</b>	<b>Number of Patients Referred</b>
Hospitals (via discharge planner)	804
Physicians	333
Other Home Health Agencies	1
All Other Healthcare Providers	114

### **7. Referral Hospitals**

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

<b>Hospital Name</b>	<b>Patients Referred</b>
Archbold Memorial	78
Bainbridge Health Care	10
Bainbridge Hospital	123
Bay Medical Center	1
Capital Regional Medical	5
Cleveland Clinic	1
Crawford Long	2
Crowne Health Care of Eufaula	2
Donalsonville Hospital	110
Early Memorial	33
Emory University	9
Flowers Hospital	49
Grady General Hospital	10
Hughston Sports Medicine Hospital	7
Jack Hughston Memorial Hospital	5
Lakeview Community Hospital	3
Mayo Clinic	3
Medical Center Barbour	6
Medical Center of Central Georgia	1
Miller County Hospital	33
Mitchell County Hospital	5
Northside Hospital	2
Peidmont Hospital	2
Phoebe Putney Hospital	29
SE Alabama Medical	1
Select Specialty Hospital	1

Shand's Hospital	2
South Alabama Medical	223
South Georgia Medical Center	2
Southwest Georgia Regional Hospital	2
Southwestern Regional Medical Center	1
St Francis	3
Tallahassee Memorial Regional	23
University Alabama Hospital	3
VA Medical	6
VAMC Montgomery Alabama	1
West Florida Hospital	1
Westside Terrace	6
<b>Total</b>	<b>804</b>



## 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)	10	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	6	0	0
Allied Health/Therapists	4	1	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	
Licensed Practical Nurse	
Aide/Assistant	
Allied Health/Therapists	Over 1 Year

## 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	49	40
February	45	51
March	42	53
April	44	51
May	48	45
June	41	43
July	41	37
August	59	52
September	34	56
October	49	42
November	45	54
December	43	46

### 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
Decatur	104	298	12,110	190	30	7	159	140	96	402
Early	30	141	3,512	82	8	2	53	69	47	171
Miller	19	54	1,999	24	3	0	19	19	35	73
Seminole	51	234	5,444	145	8	0	79	122	84	285
Baker	4	3	65	3	1	0	0	3	4	7
Clay	11	44	1,612	26	1	0	20	19	16	55
Quitman	7	43	1,033	28	1	0	16	19	15	50
Randolph	4	17	461	13	0	0	8	10	3	21
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>354</b>	<b>401</b>	<b>300</b>	<b>1,064</b>

## **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
Decatur	1,443,261	1,297,802	29,062
Early	418,558	376,374	3,185
Miller	238,239	214,229	9,236
Seminole	648,812	583,422	344
Baker	7,747	6,966	69
Clay	192,117	172,755	57
Quitman	123,112	110,704	61
Randolph	54,942	49,404	0
<b>Total</b>	<b>3,126,788</b>	<b>2,811,656</b>	<b>42,014</b>

## **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 inaccurate 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:** William Clay Campbell

**Date:** 03/06/2015

**Title:** President, Archbold Health Services, Inc.

**Comments:**