



## 2014 Home Health Survey

### Part A : General Information

#### 1. Identification

UID:HHA141

**Facility Name:** Three Rivers Home Health of Bibb

**County:** Bibb

**Street Address:** Suite 103 1760 Bass Road

**City:** Macon

**Zip:** 31210-1096

**Mailing Address:** Suite 103 1760 Bass Road

**Mailing City:** Macon

**Mailing Zip:** 31210-1096

#### **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.

000821026B

#### **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.

117135

#### 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 Services, Inc.	For Profit	12/13/2002

#### 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.
Milledgeville	2485 N. Columbia St., Suite 86	Milledgeville	Baldwin	02/01/2005

Evans	609 Ponder Place Dr., Suite A	Evans	Columbia	04/13/2012
Warner Robins	281 Carl Vinson Parkway, Suite J	Warner Robins	Houston	09/01/2004

## 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	13,298	170
Physical Therapy	10,963	180
Home Health Aide	4,511	90
Occupational Therapy	1,996	180
Medical Social Services	29	190
Speech Pathology	512	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.

214

### 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).

1138

### 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	2
Asian	0
Black/African American	422
Hispanic/Latino	7
Pacific Islander/Hawaiian	2
White	1,071
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	566
Female	938

### 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	802	18,165	2,814,455	2,763,976
Medicaid	114	1,588	199,908	73,194
Other Government Payers	72	999	162,397	145,543
Managed Care (HMO/PPO)	326	7,785	1,149,723	1,055,674
Other Third Party Insurers	181	2,665	502,699	461,212
Self Pay	9	107	18,266	17,170
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	4,847,448
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	7,745
Other Contractual Adjustments	80,703
<b>Total Contractual Adjustments</b>	<b>88,448</b>
Bad Debt	37,706
Indigent Care Gross Charges	118,969
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>118,969</b>
Charity Care Gross Charges	85,556
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>85,556</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>4,516,769</b>
<b>Adjusted Gross Patient Revenue</b>	<b>4,801,997</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>4,516,769</b>
Total Expenses	3,482,776
<b>Adjusted Gross Revenue</b>	<b>4,801,997</b>
<b>Total Uncompensated I/C Care</b>	<b>204,525</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>4.26%</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.

38

**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)	772
Physicians	539
Other Home Health Agencies	25
All Other Healthcare Providers	168

**7. Referral Hospitals**

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

Hospital Name	Patients Referred
Archbold Medical Center	1
Athens Regional Medical Center	5
Atlanta Medical Center	1
Bleckley Memorial Hospital	5
Candler Hospital	1
Central Georgia Rehab	16
Childrens Healthcare of Atlanta At Egleston	1
Coliseum Medical Center	54
Coliseum Northside Hospital	23
Coliseum Rehab Hospital	19
Columbus Regional Hughston Hospital	2
Doctors Hospital of Augusta	24
Dodge County Hospital	2
East Cooper Medical Center	1
Eastside Medical Center	1
Dwight D Eisenhower Army Medical Center	19
Emory St Joseph's Hospital	1
Emory University Hospital	30
Emory University Hospital Midtown	10
Fairview Park Hospital	22
Fort Valley	3
Georgia Health Services Medical Center	3
Georgia Regents Medical Center	8
Good Samaritan Hospital	2
Grady Health System	1
HealthSouth Walton Rehabilitation Hospital	4

Houston Medical Center	90
Houston Medical Center Perry	4
Jack Hughston Memorial Hsopital	6
Medical Center Navicent Health	125
Medical College of Georgia	1
Memorial Health	2
Northside Hospital	1
Oconee Regional Medical Center	101
Peach Regional Medical Center	1
Perry Hospital	56
Piedmont Hospital	14
Putnam General Hospital	10
Regency Hospital of Central Georgia	14
Rehabilitation Hospital Navicent Health	13
St Joseph's Hsopital	1
Select Speciality Hospital	2
Shepherd Center	2
Southeastern Regional Medical Center	1
St Francis Hospital	2
St Mary's Health Care System	5
St Joseph's Hospital Savannah	1
St Thomas Midtown Hospital	1
Taylor Regional Hospital	3
Medical Center of Peach County	3
University Hospital McDuffie	2
Upton Regional Medical Center	1
Washington County Regional Medical Center	1
VAMC - Atlanta, Augusta, Dublin	50
<b>Total</b>	<b>772</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)	15	0	0
Licensed Practical Nurses (LPNs)	5	0	0
Aides/Assistants	4	0	0
Allied Health/Therapists	7	0	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	> 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	131	6
February	87	8
March	94	5
April	86	10
May	98	13
June	100	9
July	82	12
August	103	17
September	115	3
October	106	10
November	94	5
December	98	16

### 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
Baldwin	24	187	5,429	94	0	0	73	77	61	211
Bibb	34	164	5,196	95	0	0	61	76	61	198
Burke	0	1	0	24	0	0	0	0	1	1
Columbia	21	122	2,634	62	0	0	42	46	55	143
Crawford	4	8	152	8	0	0	3	7	2	12
Glascocock	0	2	19	1	0	0	1	1	0	2
Hancock	4	37	785	21	0	0	12	18	11	41
Houston	62	447	9,507	222	0	3	137	185	184	509
Jefferson	0	1	1	0	0	0	0	0	1	1

Jenkins	0	0	0	0	0	0	0	0	0	0
Jones	3	17	514	8	0	0	9	5	6	20
Lincoln	4	16	376	4	0	0	10	4	6	20
Monroe	2	12	261	7	0	0	5	5	4	14
Peach	8	93	1,741	47	0	2	36	33	30	101
Putnam	10	53	1,194	24	0	1	16	22	24	63
Twiggs	8	69	1,328	34	0	1	17	28	31	77
Washington	2	0	26	0	0	0	1	0	1	2
Wilkinson	10	79	2,122	47	0	0	18	43	28	89
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7</b>	<b>441</b>	<b>550</b>	<b>506</b>	<b>1,504</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.

<b>County</b>	<b>Gross Charges</b>	<b>Adjusted Gross Patient Revenue</b>	<b>Net Uncompensated Charges</b>
Baldwin	680,061	673,684	28,693
Bibb	638,161	632,178	26,925
Burke	3,223	3,193	136
Columbia	460,894	456,573	19,446
Crawford	38,676	38,314	1,632
Glascocock	6,446	6,386	272
Hancock	132,145	130,905	5,574
Houston	1,640,526	1,625,144	69,218
Jefferson	3,223	3,193	136
Jenkins	0	0	0
Jones	64,461	63,856	2,720
Lincoln	64,461	63,856	2,720
Monroe	45,123	44,699	1,904
Peach	325,527	322,475	13,736
Putnam	203,051	201,147	8,567
Twiggs	248,174	245,847	10,471
Washington	6,446	6,386	272
Wilkinson	286,850	284,161	12,103
<b>Total</b>	<b>4,847,448</b>	<b>4,801,997</b>	<b>204,525</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:** Hal M. Smith, Jr.

**Date:** 11/09/2015

**Title:** Executive Director

**Comments:**