GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA142

Facility Name: Gentiva Health Services

County: Fayette

Street Address: 277 Hwy 74 North Suite 307

City: Peachtree City

Zip: 30269

Mailing Address: 277 Hwy 74 North Suite 307

Mailing City: Peachtree City

Mailing Zip: 30269

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.
614408124A

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.
11-7137

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: Terry Linboom

Contact Title: Reimbursement Accountant

Phone: 913-814-2937

Fax: 913-814-4752

E-mail: Terry.Linboom@gentiva.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
CHMG of Griffin Inc.	For Profit	03/03/2002

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gentiva Health Services	For Profit	09/07/2001

C. Agency Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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.
Griffin	246 O'Dell Road Unit 5	Griffin	Spalding	03/03/2002

Villa Rica	845 South Carroll Rd. Suite C	Villa Rica	Carroll	04/01/2008

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	30,907	140
Physical Therapy	17,662	165
Home Health Aide	3,558	75
Occupational Therapy	8,604	165
Medical Social Services	306	175
Speech Pathology	2,100	165
	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.

489

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).

812

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	3
Asian	0
Black/African American	621
Hispanic/Latino	11
Pacific Islander/Hawaiian	2
White	1,576
Multi-Racial	351

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	1,020
Female	1,544

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	1,655	43,464	12,612,924	6,766,661
Medicaid	52	735	47,774	46,772
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	62	1,435	137,454	120,056
Other Third Party Insurers	226	3,313	473,788	413,522
Self Pay	84	1,090	94,120	13,109
Other Non Government	485	13,100	3,997,365	2,146,188

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	17,363,425
Medicare Contractual Adjustments	5,846,264
Medicaid & Peachcare Contractual Adjustments	414
Other Contractual Adjustments	1,916,578
Total Contractual Adjustments	**7,763,256**
Bad Debt	80,871
Indigent Care Gross Charges	12,990
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**12,990**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**9,506,308**
Adjusted Gross Patient Revenue	**11,435,876**
Other Revenue	0
Total Net Revenue	**9,506,308**
Total Expenses	0
Adjusted Gross Revenue	**11,435,876**
Total Uncompensated I/C Care	**12,990**
Percent Uncompensated Indigent/Charity Care	**0.11%**

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.

10

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)	1,444
Physicians	789
Other Home Health Agencies	14
All Other Healthcare Providers	317

7. Referral Hospitals

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

Hospital Name	Patients Referred
ATLANTA MEDICAL CENTER	17
CARTERSVILLE MEDICAL CENTER	1
CENTRAL GEORGIA MEDICAL CENTER	1
DEKALB MEDICAL CTR AT DECATUR	10
EMORY ADVENTIST HOSP	2
EMORY CRAWFORD LONG HOSPITAL GA PEACHTREE	1
EMORY UNIV HOSP-MAIN	11
EMORY UNIV HOSP-MIDTOWN	25
FAIRBURN HEALTH CARE CENTER	3
FAYETTE COMMUNITY HOSPITAL	237
FLOYD MEDICAL CTR	3
GWINNETT MED CTR-LAWRENCEVILLE	6
JACK HUGHSTON MEMORIAL HOSPITAL	5
KINDRED HOSPITAL	8
MEDICAL CTR OF CENTRAL GA	2
NEWNAN HOSPITAL	74
NORTHSIDE ATLANTA HOSPITAL	7
NORTHSIDE FORSYTH HOSPITAL	2
PHOEBE PUTNEY MEMORIAL HOSPITAl	1
PIEDMONT HENRY HOSPITAL	38
PIEDMONT HOSPITAL ATLANTA	135
PIEDMONT NEWNAN HOSPITAL	97
REDMOND REG MED CTR	3
REGENCY HOSPITAL	3
ROCKDALE MEDICAL CENTER	2
SELECT SPECIALTY HOSPITAL	1

SOUTH FULTON MEDICAL CENTER	2
SOUTHERN CRESCENT HOSPITAL	3
SOUTHERN REGIONAL HOSPITAL	27
SOUTHSIDE MEDICAL CENTER	1
SPALDING REGIONAL HOSPITAL	144
ST JOSEPHS HOSPITAL ATLANTA	1
SYLVAN GROVE HOSPITAL	22
TANNER MEDICAL CARROLLTON	46
TANNER MEDICAL CENTER	12
UPSON REGIONAL HOSPITAL	6
VA MEDICAL CENTER	40
WELLSTAR COBB HOSPITAL	30
WELLSTAR DOUGLAS HOSPITAL	96
WELLSTAR KENNESTONE HOSPITAL	15
WELLSTAR PAULDING HOSPITAL	5
WEST GEORGIA MEDICAL CENTER	1
PIEDMONT FAYETTE HOSPITAL	298
Total	**1,444**

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)	14	0	0
Licensed Practical Nurses (LPNs)	0	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	13	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	6 weeks
Licensed Practical Nurse	4 weeks
Aide/Assistant	2 weeks
Allied Health/Therapists	12 weeks

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	215	26
February	179	22
March	210	25
April	193	23
May	203	24
June	218	26
July	216	26
August	245	29
September	213	26
October	242	29
November	198	24
December	232	28

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
Coweta	64	426	10,409	224	2	0	107	11	318	436
Douglas	35	229	6,858	89	1	1	48	7	179	235
Fayette	60	450	9,602	218	2	0	93	24	338	455
Fulton	60	556	11,173	269	2	0	128	19	392	539
Meriwether	0	12	464	5	0	0	3	0	6	9
Pike	4	62	1,817	37	0	0	13	0	49	62
Spalding	47	449	13,914	202	2	0	133	10	298	441
Upson	4	42	1,007	21	0	0	21	1	22	44
Carroll	28	217	5,278	113	1	0	46	5	175	226

Haralson	5	102	2,294	55	0	0	25	1	72	98
Heard	1	19	321	10	0	0	5	0	14	19
Total by Age	**0**	**0**	**0**	**0**	**0**	**1**	**622**	**78**	**1,863**	**2,564**

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
Coweta	2,862,599	1,885,361	2,598
Douglas	1,886,031	1,242,176	1,299
Fayette	2,640,664	1,739,191	2,598
Fulton	3,072,708	2,023,743	2,598
Meriwether	127,606	84,043	0
Pike	499,697	329,110	0
Spalding	3,826,514	2,520,213	2,598
Upson	276,937	182,396	0
Carroll	1,451,513	955,993	1,299
Haralson	630,877	415,508	0
Heard	88,279	58,142	0
Total	**17,363,425**	**11,435,876**	**12,990**

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: David L. Gieringer

Date: 02/16/2015

Title: Sr. VP, Controller and Chief Accounting Officer

Comments: