



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2015 Home Health Survey**

**Part A : General Information**

**1. Identification**

UID:HHA011

**Facility Name:** Intrepid USA Healthcare Services

**County:** Lowndes

**Street Address:** 355 Northside Drive Suite 1

**City:** Valdosta

**Zip:** 31602-1724

**Mailing Address:** 355 Northside Drive Suite 1

**Mailing City:** Valdosta

**Mailing Zip:** 31602-1724

**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.

000775541A

**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.

117073

**2. Report Period**

Report Data for the full twelve month period, January 1, 2015 - December 31, 2015 (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:** Kelly Whitaker

**Contact Title:** Regional Director of Operations

**Phone:** 229-247-7760

**Fax:** 229-241-9806

**E-mail:** kelly.whitaker@intrepidusa.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
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

#### C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

#### 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.
F.C. of GA, Inc. d/b/a Intrepid USA	360 Courtland Avenue, Suite A	Homerville	Clinch	06/30/2003

## 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	12,735	165
Physical Therapy	4,550	185
Home Health Aide	2,018	90
Occupational Therapy	773	185
Medical Social Services	226	185
Speech Pathology	568	185
	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, 2015.

174

### 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).

1269

### 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	0
Black/African American	303
Hispanic/Latino	6
Pacific Islander/Hawaiian	0
White	532
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	298
Female	543

### 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	546	13,817	2,212,888	2,143,720
Medicaid	32	904	30,817	8,683
Other Government Payers	23	301	0	0
Managed Care (HMO/PPO)	181	5,217	667,325	556,080
Other Third Party Insurers	52	584	114,635	27,493
Self Pay	7	47	680	0
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 2015. ☒

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

04/01/2012

### 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.

Cindy Godfrey, Director of Regulatory Compliance

### 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 2015 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	3,026,345
Medicare Contractual Adjustments	180,411
Medicaid & Peachcare Contractual Adjustments	22,124
Other Contractual Adjustments	31,998
<b>Total Contractual Adjustments</b>	<b>234,533</b>
Bad Debt	55,836
Indigent Care Gross Charges	0
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>0</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>2,735,976</b>
<b>Adjusted Gross Patient Revenue</b>	<b>2,767,974</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>2,735,976</b>
Total Expenses	0
<b>Adjusted Gross Revenue</b>	<b>2,767,974</b>
<b>Total Uncompensated I/C Care</b>	<b>0</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>0.00%</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.

0

## **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)	318
Physicians	303
Other Home Health Agencies	10
All Other Healthcare Providers	48

## **7. Referral Hospitals**

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

Hospital Name	Patients Referred
ARCHBOLD MEMORIAL HOSPITAL	9
BERRIEN COUNTY HOSPITAL	3
BROOKS COUNTY HOSPITAL	2
CLINCH MEMORIAL HOSPITAL	27
COFFEE REGIONAL MEDICAL CENTER	2
COLQUITT REGIONAL MED CENTER	1
COLUMBUS REGIONAL HEALTH	1
EMORY HOSPITAL	4
LOUIS SMITH MEMORIAL HOSPITAL	3
PHOEBE PUTNEY HOSPITAL	1
SELECT SPECIALTY HOSPITAL	2
SHANDS TEACHING HOSPITAL	2
SMITH NORTHVIEW HOSPITAL	26
ST FRANCIS HOSPITAL	1
TIFT GENERAL HOSPITAL	2
SOUTH GEORGIA MEDICAL CENTER	211
VA MEDICAL CENTER GAINESVILLE FLORIDA	21
<b>Total</b>	<b>318</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 12-31-2015.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	9	0	0
Licensed Practical Nurses (LPNs)	6	0	0
Aides/Assistants	3	0	0
Allied Health/Therapists	11	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	60
Licensed Practical Nurse	63
Aide/Assistant	10
Allied Health/Therapists	80

## 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	79	4
February	55	3
March	84	2
April	56	4
May	54	3
June	58	4
July	60	2
August	77	2
September	67	3
October	51	1
November	42	1
December	52	1

### 2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2015. 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
Berrien	28	70	2,221	52	0	0	30	35	28	93
Brooks	23	69	2,599	38	0	0	12	34	40	86
Clinch	47	115	4,354	69	0	0	29	63	50	142
Cook	12	28	1,111	20	0	0	7	19	11	37
Echols	3	8	495	4	0	0	1	4	6	11
Lowndes	113	378	1,535	34	0	0	21	29	18	68
Lanier	10	60	13,271	215	0	0	74	164	166	404
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>174</b>	<b>348</b>	<b>319</b>	<b>841</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
Berrien	316,493	274,682	0
Brooks	286,836	289,793	0
Clinch	517,489	582,984	0
Cook	115,545	133,116	0
Echols	40,485	27,542	0
Lowndes	1,551,210	1,217,007	0
Lanier	198,287	242,850	0
<b>Total</b>	<b>3,026,345</b>	<b>2,767,974</b>	<b>0</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:** Kelly Whitaker

**Date:** 06/08/2016

**Title:** Regional Director of Operations

**Comments:**