GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA030

Facility Name: Georgia Home Health Services- Valdosta

County: Lowndes

Street Address: 3404 Greystone Way

City: Valdosta

Zip: 31605-1048

Mailing Address: 3404 Greystone Way

Mailing City: Valdosta

Mailing Zip: 31605-1048

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.
000335057A

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.
117058

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: Lisa Scott

Contact Title: Business Office Manager

Phone: 423-309-4347

Fax: 423-886-4028

E-mail: lscott@triviumhealthcare.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
Ghhs Healthcare, LLC	For Profit	09/01/2011

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
GHHS Healthcare, LLC	For Profit	09/01/2011

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
GHHS Healthcare	For Profit	09/01/2011

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Ghhs Healthcare, LLC	For Profit	09/01/2011

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
GHHS Healthcare, LLC	For Profit	09/01/2011

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Ghhs Healthcare, LLC	For Profit	09/01/2011

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.
Nashville	111 South Davis Street	Nashville	Berrien	09/01/2011

Tifton	1017 North Central Ave	Tifton	Tift	09/01/2011

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	46,401	160
Physical Therapy	10,530	165
Home Health Aide	5,492	85
Occupational Therapy	4,016	165
Medical Social Services	1,171	185
Speech Pathology	2,287	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 31,2015.

677

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).

1953

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	645
Hispanic/Latino	15
Pacific Islander/Hawaiian	0
White	1,444
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	792
Female	1,314

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	1,168	43,999	6,883,571	5,982,438
Medicaid	104	2,270	305,462	122,879
Other Government Payers	28	862	116,986	81,251
Managed Care (HMO/PPO)	570	19,005	3,039,247	2,991,587
Other Third Party Insurers	49	770	401,436	253,398
Self Pay	27	247	2,084	1,848
Other Non Government	160	2,744	342,250	375,252

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.

09/01/2011

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.

Lori McGuire 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 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	11,091,036
Medicare Contractual Adjustments	263,027
Medicaid & Peachcare Contractual Adjustments	102,164
Other Contractual Adjustments	501,702
Total Contractual Adjustments	**866,893**
Bad Debt	91,166
Indigent Care Gross Charges	305,462
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**305,462**
Charity Care Gross Charges	18,862
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**18,862**
Other Free Care	0
Total Net Patient Revenue	**9,808,653**
Adjusted Gross Patient Revenue	**10,634,679**
Other Revenue	0
Total Net Revenue	**9,808,653**
Total Expenses	1,589,280
Adjusted Gross Revenue	**10,634,679**
Total Uncompensated I/C Care	**324,324**
Percent Uncompensated Indigent/Charity Care	**3.05%**

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.

31

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)	522
Physicians	1,377
Other Home Health Agencies	17
All Other Healthcare Providers	190

7. Referral Hospitals

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

Hospital Name	Patients Referred
Saint Francis Hospital	2
VA Gainesville	44
Cook Medical Center	4
Shephard Center	2
The Hughston Clinic	5
Select Specialty Hospital	8
Egleston	1
Archilbold Memorial Hospital	14
Brook County Hospital	7
Childrens Healthcare of Atlanta	1
Colquitt Regional Medical Center	2
Dorminy Medical Center	20
Emory University Hospital	12
Medical Center Of Central Georgia	5
Phoebe Putney Hospital	24
Memorial Hospital of Adel	1
Saint Joseph's Hospital	1
Shanda Gainesville	7
Smith Northview	58
Tallahasee Memorial Hospital	6
Regional Medical Center	0
South Georgia Medical Center	241
Northside Hospital	0
Irwin Coutny Hospital	0
Jack Hughston Memorial Hospital	6
Select Specialty Hospital	0

Coffee Regional Medical Center	6
Baptist Medical Center	0
Childrens Medical Center	1
Columbus Regional Hughston Hospital	2
Dotcots Hosptial of Augusta	0
Mayo Clinic Jacksonville Florida	11
Medical Center Navient Health	2
Optim Medical Center	1
Pearlman Cancer Center	0
Phoebe Worth Medical Center	1
Veterans Administrator Gainesville	0
Total	**495**

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)	26	0	0
Licensed Practical Nurses (LPNs)	22	0	0
Aides/Assistants	4	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	20 days
Licensed Practical Nurse	17 days
Aide/Assistant	28 days
Allied Health/Therapists	40 days

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	253	0
February	181	3
March	180	8
April	212	3
May	196	20
June	183	22
July	188	23
August	208	27
September	221	32
October	169	36
November	149	19
December	197	38

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
Ben Hill	39	164	5,536	141	0	0	48	103	80	231
Berrien	63	285	9,877	279	6	1	18	117	126	262
Brooks	26	106	2,599	94	0	1	33	108	41	183
Cook	6	76	2,233	73	0	1	36	110	30	177
Echols	4	12	534	10	0	1	8	7	6	22
Irwin	15	63	2,262	46	0	1	18	95	41	155
Lanier	15	80	2,513	78	0	0	47	86	25	158
Lowndes	225	918	27,353	802	15	15	78	346	26	465
Tift	79	299	11,547	256	5	2	6	237	53	298

Turner	28	103	5,443	108	1	0	46	72	37	155
Total by Age	**0**	**0**	**0**	**0**	**0**	**22**	**338**	**1,281**	**465**	**2,106**

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
Ben Hill	854,800	819,906	6,025
Berrien	1,373,543	1,260,802	7,225
Brooks	2,104,164	1,999,352	4,534
Cook	363,136	302,517	5,424
Echols	9,337	66,828	5,125
Irwin	360,724	360,486	4,585
Lanier	401,638	387,210	6,112
Lowndes	3,119,022	3,016,894	257,167
Tift	1,658,039	1,689,785	25,553
Turner	846,633	730,899	2,574
Total	**11,091,036**	**10,634,679**	**324,324**

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: Lisa Scott

Date: 03/04/2016

Title: Business Office Manager

Comments: