GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA142

Facility Name: Gentiva Health Services

County: Fayette

Street Address: 277 Highway 74 North Suite 307

City: Peachtree City

Zip: 30269-1571

Mailing Address: 277 Highway 74 North Suite 307

Mailing City: Peachtree City

Mailing Zip: 30269-1571

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 1,2015 - 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: 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
CHNG 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	40,198	140
Physical Therapy	23,748	165
Home Health Aide	3,682	75
Occupational Therapy	10,270	165
Medical Social Services	437	175
Speech Pathology	7,173	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.

529

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).

878

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	11
Black/African American	615
Hispanic/Latino	18
Pacific Islander/Hawaiian	0
White	1,793
Multi-Racial	576

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	1,175
Female	1,840

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	1,906	55,389	16,414,275	8,829,394
Medicaid	94	2,175	127,019	120,687
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	195	4,298	570,619	504,219
Other Third Party Insurers	328	6,189	882,631	741,988
Self Pay	78	1,378	163,001	38,470
Other Non Government	414	13,079	3,401,297	1,735,208

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.

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 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	21,558,842
Medicare Contractual Adjustments	7,584,883
Medicaid & Peachcare Contractual Adjustments	911
Other Contractual Adjustments	1,862,887
Total Contractual Adjustments	**9,448,681**
Bad Debt	78,953
Indigent Care Gross Charges	61,242
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**61,242**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**11,969,966**
Adjusted Gross Patient Revenue	**13,894,095**
Other Revenue	0
Total Net Revenue	**11,969,966**
Total Expenses	0
Adjusted Gross Revenue	**13,894,095**
Total Uncompensated I/C Care	**61,242**
Percent Uncompensated Indigent/Charity Care	**0.44%**

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.

16

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)	1,745
Physicians	904
Other Home Health Agencies	8
All Other Healthcare Providers	358

7. Referral Hospitals

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

Hospital Name	Patients Referred
COLUMBUS SPECIALTY HOSPITAL	1
EMORY UNIV HOSP-MIDTOWN	20
SPALDING REGIONAL HOSPITAL	199
ST FRANCIS HOSPITAL	1
ST JOSEPHS HOSPITAL ATLANTA	6
SYLVAN GROVE HOSPITAL	26
TANNER MEDICAL CENTER	70
UPSON REGIONAL HOSPITAL	11
VA MEDICAL CENTER	20
WELLSTAR COBB HOSPITAL	44
WELLSTAR DOUGLAS HOSPITAL	89
WELLSTAR KENNESTONE HOSPITAL	19
WELLSTAR PAULDING HOSPITAL	3
WELLSTAR WINDY HILL HOSPITAL	2
WEST GEORGIA MEDICAL CENTER	1
ATLANTA MEDICAL CENTER	31
KINDRED HOSPITAL	19
NORTHSIDE ATLANTA HOSPITAL	9
NORTHSIDE CHEROKEE HOSPITAL	1
NORTHSIDE FORSYTH HOSPITAL	6
NORTHSIDE MEDICAL CENTER COLUMBUS	2
PIEDMONT FAYETTE HOSPITAL	688
PIEDMONT HENRY HOSPITAL	49
PIEDMONT HOSPITAL ATLANTA	130
PIEDMONT NEWNAN HOSPITAL	168
REDMOND REG MED CTR	4

REGENCY HOSPITAL	1
ROCKDALE MEDICAL CENTER	3
SOUTH FULTON MEDICAL CENTER	1
SOUTHERN CRESCENT HOSPITAL	3
FLOYD MEDICAL CTR	7
GWINNETT MED CTR-LAWRENCEVILLE	5
HIGGINS GENERAL HOSPITAL	1
JACK HUGHSTON MEMORIAL HOSPITAL	2
BAPTIST MEDICAL CENTER EAST	1
DEKALB MEDICAL CTR AT DECATUR	17
EASTSIDE MEDICAL CENTER SNELLVILLE	1
EMORY UNIV HOSP-MAIN	51
SOUTHERN REGIONAL HOSPITAL	33
Total	**1,745**

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)	11	0	0
Licensed Practical Nurses (LPNs)	14	0	0
Aides/Assistants	15	0	0
Allied Health/Therapists	17	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	277	38
February	196	27
March	281	39
April	242	34
May	209	29
June	246	34
July	288	40
August	279	39
September	231	32
October	274	38
November	237	33
December	262	36

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
Coweta	64	455	11,161	13	2	0	131	15	317	463
Douglas	42	293	9,187	0	2	0	56	6	226	288
Fayette	70	567	13,293	234	3	0	124	10	418	552
Fulton	68	550	14,066	259	3	0	145	12	391	548
Meriwether	4	16	399	2	0	0	3	2	12	17
Pike	16	97	2,729	1	0	0	21	4	65	90
Spalding	119	576	18,758	10	4	0	149	9	460	618
Upson	12	70	2,109	0	0	0	28	1	39	68
Carroll	24	248	7,326	1	1	0	51	4	185	240

Haralson	22	105	3,132	0	1	0	24	1	92	117
Heard	1	12	241	6	0	0	5	1	5	11
Lamar	0	3	107	1	0	0	3	0	0	3
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**740**	**65**	**2,210**	**3,015**

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	2,926,944	1,886,337	7,655
Douglas	2,409,268	1,552,708	7,655
Fayette	3,486,056	2,246,669	11,483
Fulton	3,688,773	2,377,315	11,483
Meriwether	104,637	67,436	0
Pike	636,999	410,529	0
Spalding	4,919,239	3,170,318	15,310
Upson	553,080	356,445	0
Carroll	1,921,225	1,238,178	3,828
Haralson	821,359	529,344	3,828
Heard	63,202	40,732	0
Lamar	28,060	18,084	0
Total	**21,558,842**	**13,894,095**	**61,242**

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: 02/24/2017

Title: Vice President, Controller and Chief Accounting Officer

Comments: