GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA017

Facility Name: Central Georgia Home Health

County: Bibb

Street Address: 3780 Eisenhower Parkway, Suite 4

City: Macon

Zip: 31206

Mailing Address: 3780 Eisenhower Parkway Suite 4

Mailing City: Macon

Mailing Zip: 31206

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.
00697232A

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.
117023

2. Report Period

Report Data for the full twelve month period, January 1,2016 - December 31, 2016 (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: Scott Jones

Contact Title: Director

Phone: 478-633-5627

Fax: 478-633-4381

E-mail: jones.scott@navicenthealth.org

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
Medical Center of Central Georgia, inc dba The Medical Center Navicent Health	Not for Profit	11/01/1995

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Navicent Health	Not for Profit	02/14/1995

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

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.

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	29,822	200
Physical Therapy	20,003	200
Home Health Aide	4,200	85
Occupational Therapy	4,591	200
Medical Social Services	630	200
Speech Pathology	1,748	200
	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 31,2016.

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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).

3219

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	7
Asian	12
Black/African American	1,450
Hispanic/Latino	27
Pacific Islander/Hawaiian	2
White	1,878
Multi-Racial	1

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	1,499
Female	1,878

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	1,267	31,000	5,355,533	5,187,000
Medicaid	140	2,999	703,003	236,627
Other Government Payers	85	2,100	102,400	34,208
Managed Care (HMO/PPO)	299	9,586	3,000,337	1,790,650
Other Third Party Insurers	466	9,452	1,615,341	642,343
Self Pay	5	102	147,307	0
Other Non Government	17	98	410,002	171,037

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 2016. ☑

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

01/23/2007

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.

Scott Jones, Director

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 2016 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	11,333,923
Medicare Contractual Adjustments	241,688
Medicaid & Peachcare Contractual Adjustments	477,649
Other Contractual Adjustments	2,089,305
Total Contractual Adjustments	**2,808,642**
Bad Debt	55,414
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	408,002
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**408,002**
Other Free Care	0
Total Net Patient Revenue	**8,061,865**
Adjusted Gross Patient Revenue	**10,559,172**
Other Revenue	0
Total Net Revenue	**8,061,865**
Total Expenses	0
Adjusted Gross Revenue	**10,559,172**
Total Uncompensated I/C Care	**408,002**
Percent Uncompensated Indigent/Charity Care	**3.86%**

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.

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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)	2,995
Physicians	432
Other Home Health Agencies	13
All Other Healthcare Providers	240

7. Referral Hospitals

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

Hospital Name	Patients Referred
Coliseum Rehab Hospital	6
Fariview Park	26
Gwinett Medical Center	1
Houston Medical Center	40
Jack Hughston	3
Medical Center Peach County	51
Monroe County Hospital	12
Northside Hospital	4
Oconee Regional	4
Perry Hospital	9
Piedmont	5
St Josephs Hospital	1
Taylor Regional	3
Coliseum Medical Center	103
Emory	15
Macon Northside	50
Medical Center Navicent Health	1,901
Rehab Hospital Navicent Health	401
VA Augusta	1
Atlanta Va Med Center	2
Atlanta Va Med Center	2
Bleckley Memorial Hospital	1
Bleckley Memorial Hospital	1
Bleckley	2
Grady Memorial	1
Regency Hospital	6

Shands	1
Carl Vinson VA	12
Total	**2,664**

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 12-31-2016.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	40	3	0
Licensed Practical Nurses (LPNs)	4	0	0
Aides/Assistants	4	0	0
Allied Health/Therapists	25	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 months
Licensed Practical Nurse	no vacancies
Aide/Assistant	no vacancies
Allied Health/Therapists	no vacancies

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	204	141
February	201	123
March	211	138
April	189	112
May	187	125
June	186	122
July	165	89
August	186	150
September	200	138
October	184	133
November	148	110
December	179	105

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2016. 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	7	159	2,354	70	3	0	50	0	32	82
Bibb	185	1,886	31,901	785	73	0	700	600	496	1,796
Bleckley	6	36	773	18	0	0	33	12	7	52
Butts	2	14	245	7	0	0	11	5	1	17
Crawford	10	146	2,302	55	1	0	33	38	22	93
Houston	49	505	7,510	199	12	0	125	179	107	411
Jones	15	186	2,992	91	3	0	54	80	44	178
Lamar	4	32	424	13	0	0	41	25	0	66
Peach	28	229	1,999	98	4	0	61	104	40	205

Twiggs	14	116	1,642	54	5	0	33	48	22	103
Wilkinson	8	101	1,545	41	1	0	29	42	17	88
Laurens	15	93	1,851	48	4	0	44	52	15	111
Monroe	18	222	3,479	81	3	0	52	58	65	175
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**1,266**	**1,243**	**868**	**3,377**

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
Baldwin	272,001	253,414	9,792
Bibb	6,009,507	5,598,328	216,275
Bleckley	170,000	158,383	6,120
Butts	56,666	52,794	2,040
Crawford	317,334	295,649	11,429
Houston	1,380,405	1,286,074	49,712
Jones	600,668	559,662	21,624
Lamar	226,667	211,178	8,160
Peach	691,336	644,093	24,888
Twiggs	351,335	327,520	12,668
Wilkinson	294,667	274,570	10,612
Laurens	374,001	348,444	13,464
Monroe	589,336	549,063	21,218
Total	**11,333,923**	**10,559,172**	**408,002**

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: Scott Jones

Date: 03/03/2017

Title: Director

Comments: