



2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA029

Facility Name: Amicita Home Health LLC

County: Toombs

Street Address: 806 Maple Drive

City: Vidalia

Zip: 30474-7208

Mailing Address: 806 Maple Drive

Mailing City: Vidalia

Mailing Zip: 30474-7208

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.

000186062A

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.

11-7054

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: Lisa Gorge

Contact Title: Compliance Reporting Analyst

Phone: 478-621-2291

Fax: 478-744-0481

E-mail: lgorge@ethicahealth.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
Community Ancillary Services, Inc.	Not for Profit	02/01/2017

B. Owner's Parent Organization

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

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.
Jesup	248 NE Broad Street	Jesup	Wayne	08/02/2015

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	9,011	175
Physical Therapy	4,483	185
Home Health Aide	929	75
Occupational Therapy	2,203	185
Medical Social Services	282	150
Speech Pathology	321	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, 2016.

141

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).

1083

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	3
Black/African American	176
Hispanic/Latino	16
Pacific Islander/Hawaiian	0
White	638
Multi-Racial	6

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	329
Female	512

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	531	11,465	2,062,788	1,783,103
Medicaid	32	406	3,990	3,160
Other Government Payers	3	131	2,362	2,102
Managed Care (HMO/PPO)	273	5,201	625,238	539,744
Other Third Party Insurers	2	26	6,030	1,999
Self Pay	0	0	0	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 2016. ☐

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.

Sarah Thompson - President

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	2,700,408
Medicare Contractual Adjustments	56,561
Medicaid & Peachcare Contractual Adjustments	439
Other Contractual Adjustments	19,571
Total Contractual Adjustments	76,571
Bad Debt	291,814
Indigent Care Gross Charges	1,915
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	1,915
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	2,330,108
Adjusted Gross Patient Revenue	2,351,594
Other Revenue	26,715
Total Net Revenue	2,356,823
Total Expenses	2,911,759
Adjusted Gross Revenue	2,378,309
Total Uncompensated I/C Care	1,915
Percent Uncompensated Indigent/Charity Care	0.08%

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.

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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)	298
Physicians	370
Other Home Health Agencies	0
All Other Healthcare Providers	173

7. Referral Hospitals

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

Hospital Name	Patients Referred
Appling Health Care Systems	2
Appling Healthcare Systems	5
Augusta University	1
Bacon County Hospital	1
Baptist Health Jacksonville	1
Candler County Hospital	4
Candler Hospital	9
Coffee Regional Medical Center	1
East Georgia Regional Medical Center	20
Emanuel Medical Center	17
Emory University Hospital	2
Evans Memorial Hospital	5
Fairview Park Hospital	3
Jeff Davis Hospital	2
Landmark Hospital	5
Liberty Regional Medical Center	4
Mayo Clinic Health System in Waycross	1
Mayo Clinic in Florida	2
Meadows Regional	57
Medical Center Navicent Health	1
Memorial Health	2
Memorial University Medical Center	57
Midtown Medical Center	1
Optim Medical Center	1
Optim Medical Center Tatttnal	4
Savannah Rehab Hospital	5

Select Specialty Hospital	1
Select Specialty in Augusta	1
Shands Jacksonville Medical Center	1
Southeast Georgia Health System	9
St. Joseph Hospital	32
St. Vincents Medical Center	1
Tift Regional Medical Center	1
University Nursing and Rehab	1
VA Clinic	2
Wayne Memorial Hospital	36
Total	298

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)	8	0	0
Licensed Practical Nurses (LPNs)	2	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	0	0	6

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	45 days
Licensed Practical Nurse	30 days
Aide/Assistant	15 days
Allied Health/Therapists	45 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	41	27
February	48	7
March	46	16
April	39	12
May	39	24
June	42	20
July	36	18
August	33	14
September	42	14
October	37	19
November	26	13
December	35	15

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
Appling	11	34	1,425	20	0	0	12	20	13	45
Candler	2	15	196	11	0	0	4	9	4	17
Emanuel	10	47	1,099	35	1	0	16	26	15	57
Jeff Davis	12	32	948	27	0	0	13	23	8	44
Long	5	12	391	10	1	0	7	7	3	17
Montgomery	7	32	684	17	0	0	10	16	13	39
Tattnall	24	90	2,656	65	1	0	31	52	31	114
Toombs	44	220	4,660	140	1	0	59	112	93	264
Wayne	37	140	4,241	99	0	0	37	82	58	177

Evans	6	26	581	12	0	0	10	10	12	32
Liberty	9	26	639	10	1	0	13	8	14	35
Total by Age	0	0	0	0	0	0	212	365	264	841

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
Appling	181,975	158,830	0
Candler	47,502	39,619	0
Emanuel	168,586	146,061	0
Jeff Davis	164,343	143,996	0
Long	88,869	77,137	585
Montgomery	125,137	107,484	0
Tattnall	332,032	287,797	0
Toombs	714,762	624,755	1,330
Wayne	629,113	551,193	0
Evans	94,397	84,269	0
Liberty	153,692	130,453	0
Total	2,700,408	2,351,594	1,915

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: Sarah Thompson

Date: 03/03/2017

Title: President

Comments: