GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA030

Facility Name: Georgia Home Health Services Valdosta

County: Lowndes

Street Address: 4380 Kings Way

City: Valdosta

Zip: 31602

Mailing Address: 4380 Kings Way

Mailing City: Valdosta

Mailing Zip: 31602

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 1,2016 - 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 Scott

Contact Title: Business Office Manager

Phone: 4233094347

Fax: 4238864028

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, LLC	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 St	Nashville	Berrien	09/01/2011

Tifton	1823 Old Ocilla Rd	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	42,657	160
Physical Therapy	10,294	165
Home Health Aide	4,573	85
Occupational Therapy	5,410	165
Medical Social Services	994	185
Speech Pathology	2,414	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 31,2016.

731

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).

1474

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	9
Asian	5
Black/African American	904
Hispanic/Latino	48
Pacific Islander/Hawaiian	0
White	1,144
Multi-Racial	29

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	813
Female	1,326

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	1,209	39,463	9,278,879	8,194,252
Medicaid	100	1,774	262,782	102,220
Other Government Payers	21	535	10,000	5,235
Managed Care (HMO/PPO)	585	20,869	473,571	902,882
Other Third Party Insurers	29	466	447,286	350,060
Self Pay	10	58	14,907	63,547
Other Non Government	185	3,185	205,000	98,250

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.

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 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	10,692,425
Medicare Contractual Adjustments	20,026
Medicaid & Peachcare Contractual Adjustments	170,562
Other Contractual Adjustments	632,686
Total Contractual Adjustments	**823,274**
Bad Debt	42,052
Indigent Care Gross Charges	74,104
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**74,104**
Charity Care Gross Charges	36,549
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**36,549**
Other Free Care	0
Total Net Patient Revenue	**9,716,446**
Adjusted Gross Patient Revenue	**10,459,785**
Other Revenue	0
Total Net Revenue	**9,716,446**
Total Expenses	0
Adjusted Gross Revenue	**10,459,785**
Total Uncompensated I/C Care	**110,653**
Percent Uncompensated Indigent/Charity Care	**1.06%**

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.

57

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)	950
Physicians	992
Other Home Health Agencies	8
All Other Healthcare Providers	189

7. Referral Hospitals

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

Hospital Name	Patients Referred
St Francis Hospital	1
Cook Medical Center	7
Select Specialty Hospital	3
Egleston	2
Archibold Memorial Hospital	6
Brook County Hospital	1
Childrens Hospital	2
Colquitt Regional Medical Center	5
Dorminey Medical Center	28
Emory University Hospital	7
Medical Center of Central Georgia	3
Phoebe Putney Hospital	17
Tallahasee Memorial Hospital	4
South Georgia Medical Center	486
Northside Hospital	1
Irwin County Hospital	7
Jack Hughstone Memorial Hospital	2
Coffee Regional Medical Center	3
Baptist Medical Center	3
Columbus Region Hughston Hospital	2
Dotcots Hospital of August	4
Mayo Clinic Jacksonville	6
Medical Center Navient Health	11
Pearlman Cancer Center	2
VA Gainesville	46
Doctors Memorial	1

Duke Univiersity Hospital	1
Memorial Health	2
Tift Regional	292
University Med Ctr Memorial Hospital	1
Williiamsburg Regional Medical Center	1
Childrens Hospital of August	2
Coliseum Medical Center	2
Emory Rehab	1
Florida Hospital	2
University Healthcare System	1
North Florida Regional Medical Center	1
UAB Hospital	1
St. Vincent- Riverside	1
Total	**968**

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)	25	0	0
Licensed Practical Nurses (LPNs)	22	0	0
Aides/Assistants	3	0	0
Allied Health/Therapists	15	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	30
Licensed Practical Nurse	25
Aide/Assistant	14
Allied Health/Therapists	35

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	313	0
February	183	4
March	187	4
April	196	15
May	214	16
June	179	21
July	209	25
August	185	23
September	161	29
October	173	27
November	179	39
December	210	47

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
Ben Hill	59	156	3,990	63	1	1	42	53	59	155
Brooks	24	82	1,953	37	0	1	21	34	29	85
Cook	20	78	2,121	41	2	3	21	36	20	80
Echols	9	20	1,047	6	0	0	4	4	8	16
Irwin	18	60	1,704	29	1	1	24	15	19	59
Lanier	18	90	2,367	62	1	2	34	44	28	108
Lowndes	266	890	22,622	426	11	22	237	355	296	910
Tift	110	338	9,889	157	2	7	81	135	117	340
Turner	55	121	3,369	57	0	0	40	42	36	118

Berrien	85	304	10,794	169	2	3	24	130	111	268
Total by Age	**0**	**0**	**0**	**0**	**0**	**40**	**528**	**848**	**723**	**2,139**

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	902,500	820,250	6,025
Brooks	1,393,554	1,260,802	22,250
Cook	473,957	199,800	4,534
Echols	10,500	15,250	2,500
Irwin	365,720	360,466	1,550
Lanier	406,720	326,710	3,040
Lowndes	3,154,052	3,014,950	55,254
Tift	1,695,035	1,734,210	10,500
Turner	896,833	733,589	1,500
Berrien	1,393,554	1,250,420	3,500
Total	**10,692,425**	**9,716,447**	**110,653**

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: 03/03/2017

Title: Business Office Manager

Comments: