GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA049

Facility Name: Northwest Georgia Home Health, LLC d/b/a Home Care Solutions

County: Catoosa

Street Address: 7409 Nashville Street, Suite B

City: Ringgold

Zip: 30736

Mailing Address: Post Office Box 51266

Mailing City: Lafayette

Mailing Zip: 70505

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.
000185523A

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.
11-7308

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: Jodi B. Bordelon

Contact Title: Licensure & Regulatory Paralegal

Phone: 337-233-1307

Fax: 337-233-5764

E-mail: LRA@LHCGROUP.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
Northwest Georgia Home Health, LLC	For Profit	03/01/2010

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
LHC Group, Inc.	For Profit	01/20/2005

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Georgia Health Care Group, LLC	For Profit	03/14/2005

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.

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	7,014	300
Physical Therapy	3,640	300
Home Health Aide	816	185
Occupational Therapy	1,548	300
Medical Social Services	77	300
Speech Pathology	444	300
	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.

157

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).

567

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	0
Asian	2
Black/African American	17
Hispanic/Latino	3
Pacific Islander/Hawaiian	0
White	639
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	291
Female	370

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	419	9,527	1,350,784	1,334,830
Medicaid	22	283	40,125	39,651
Other Government Payers	26	201	28,499	28,162
Managed Care (HMO/PPO)	191	3,507	497,240	491,366
Other Third Party Insurers	2	15	2,127	2,102
Self Pay	1	6	851	841
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.

11/01/2013

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.

Kathryn M. Wade - Administrator/Director of Nursing

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	1,919,626
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	22,674
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**1,896,952**
Adjusted Gross Patient Revenue	**1,896,952**
Other Revenue	0
Total Net Revenue	**1,896,952**
Total Expenses	0
Adjusted Gross Revenue	**1,896,952**
Total Uncompensated I/C Care	**0**
Percent Uncompensated Indigent/Charity Care	**0.00%**

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.

1

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)	219
Physicians	193
Other Home Health Agencies	0
All Other Healthcare Providers	165

7. Referral Hospitals

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

Hospital Name	Patients Referred
EASTSIDE MEDICAL CENTER	1
EMORY HEALTHCARE	1
ERLANGER HEALTH SYSTEM	8
ERLANGER HEALTH SYSTEMS	3
ERLANGER HOSPITAL	41
FLOYD MEDICAL CENTER	1
HEALTHSOUTH	1
HEALTHSOUTH CHATTANOOGA REHABILITATION HOSPITAL	8
HEALTHSOUTH REHABILITATION HOSPITAL	1
HEALTHSOUTH REHABILITATION HOSPITAL OF NEWNAN	1
KENNESTONE WELLSTAR HOSPITAL	1
KINDRED HOSPITAL CHATTANOOGA	2
LIFE CARE CENTER OF OOLTEWAH	1
MEMORIAL HEALTH CARE SYSTEM	1
MEMORIAL HOSPITAL - CHATTANOOGA	20
MEMORIAL HOSPITAL OF CHATTANOOGA	6
NHC HEALTHCARE - ROSSVILLE	20
NHC HEALTHCARE ROSSVILLE	1
NORTHSIDE HOSPITAL CHEROKEE	1
NOVANT HEALTH MEDICAL PARK HOSPITAL	1
OAKVIEW HEALTH & REHABILITIATION CTR	1
OAKVIEW NURSING AND REHAB CENTER	1
PARKRIDGE EAST HOSPITAL	5
PARKRIDGE MEDICAL CENTER	32
PIEDMONT HOSPITAL	1
REDMOND REGIONAL MEDICAL CENTER	1

REGENCY HOSPITAL	1
REGENCY AT THE PARK-REHAB CENTER	1
RIDGEWOOD MANOR	2
SISKIN REHABILITATION HOSPITAL	36
TENN VALLEY HEALTHCARE-ALVIN C YORK CAMPUS	1
TENNESSEE VALLEY VA MEDICAL CENTER	1
VA ALVIN C YORK CAMPUS	1
VA ALVIN YORK CAMPUS	1
VANDERBILT HOSPITAL	1
VANDERBILT MEDICAL CENTER	1
VANDERBILT UMC	1
VANDERBILT UNIVERSITY MEDICAL CENTER	1
ALVIN C YORK VA MEDICAL CENTER	5
AMEDISYS - CHATTANOOGA OFFICE	1
BUCHANAN GENERAL HOSPITAL	1
CONSULATE HEALTH CARE OF CHATTANOOGA	2
CORNERSTONE HOSPITAL	1
Total	**219**

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)	2	0	0
Licensed Practical Nurses (LPNs)	3	0	0
Aides/Assistants	0	0	0
Allied Health/Therapists	3	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	N/A
Licensed Practical Nurse	1 month
Aide/Assistant	1 month
Allied Health/Therapists	N/A

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	30	14
February	18	9
March	32	11
April	36	11
May	35	13
June	32	10
July	39	18
August	41	11
September	38	14
October	35	9
November	46	19
December	45	11

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
Catoosa	32	170	3,913	109	0	0	41	97	60	198
Dade	11	62	1,167	35	0	0	24	30	16	70
Gordon	0	2	11	0	0	0	1	0	1	2
Murray	2	21	399	10	0	0	5	9	8	22
Walker	34	222	5,292	129	0	0	56	105	96	257
Whitfield	12	100	2,757	54	0	0	26	43	43	112
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**153**	**284**	**224**	**661**

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
Catoosa	554,804	548,251	0
Dade	165,463	163,509	0
Gordon	1,560	1,541	0
Murray	56,572	55,904	0
Walker	750,326	741,463	0
Whitfield	390,901	386,284	0
Total	**1,919,626**	**1,896,952**	**0**

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: Donald D. Stelly

Date: 03/03/2017

Title: President

Comments: