



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2016 Home Health Survey**

**Part A : General Information**

**1. Identification**

**UID:HHA052**

**Facility Name:** CareSouth - An Affiliate of Crisp Regional Hospital

**County:** Crisp

**Street Address:** 906 5th Streen North, Suite F-6

**City:** Cordele

**Zip:** 31015-3224

**Mailing Address:** 906 5th Street North Suite F-6

**Mailing City:** Cordele

**Mailing Zip:** 31015-3224

**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.

00696429

**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.

117309

**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:** Jessica Holshouser

**Contact Title:** Supervisor, Business Services

**Phone:** 706-854-7583

**Fax:** 706-228-6825

**E-mail:** jholshouser@uscarenet.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
Crisp Reginoal Hospital	Hospital Authority	11/01/1995

#### B. Owner's Parent Organization

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

#### 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
US CareNet, LLC	For Profit	11/01/2015

#### 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.
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## 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	6,810	165
Physical Therapy	3,634	195
Home Health Aide	524	70
Occupational Therapy	1,378	195
Medical Social Services	27	190
Speech Pathology	163	195
	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.

87

### **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).

507

### **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	281
Hispanic/Latino	4
Pacific Islander/Hawaiian	0
White	379
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	243
Female	423

### **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	543	10,792	1,749,938	1,749,938
Medicaid	60	1,134	145,423	47,696
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	48	587	119,266	67,569
Self Pay	3	24	3,905	3,905
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.

12-11-2000

### 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.

Jimmie Smith, RN-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	2,018,532
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	50,261
Other Contractual Adjustments	78,118
<b>Total Contractual Adjustments</b>	<b>128,379</b>
Bad Debt	18,494
Indigent Care Gross Charges	2,551
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>2,551</b>
Charity Care Gross Charges	0
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>0</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>1,869,108</b>
<b>Adjusted Gross Patient Revenue</b>	<b>1,949,777</b>
Other Revenue	99
<b>Total Net Revenue</b>	<b>1,869,207</b>
Total Expenses	0
<b>Adjusted Gross Revenue</b>	<b>1,949,876</b>
<b>Total Uncompensated I/C Care</b>	<b>2,551</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>0.13%</b>

### 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)	501
Physicians	160
Other Home Health Agencies	0
All Other Healthcare Providers	238

## **7. Referral Hospitals**

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

Hospital Name	Patients Referred
AUGUSTA UNIVERSITY MEDICAL CENTER	1
BLECKLEY MEMORIAL HOSPITAL	9
CARL VINSON VAMC	4
CENTRAL GEORGIA REHAB HOSPITAL	3
CHARLIE NORWOOD VAMC	2
COLISEUM MEDICAL CENTER	16
CRISP REGIONAL HOSPITAL	250
DODGE COUNTY HOSPITAL	3
DORMINY MEDICAL CENTER	3
EMORY UNIVERSITY HOSPITAL	16
GEORGIA REGENTS MEDICAL CENTER (MCG)	2
GWINNETT COUNTY HOSPITAL	1
HOUSTON MEDICAL CENTER	16
JACK HUGHSTON MEMORIAL HOSPITAL	2
MAYO CLINIC HOSPITAL	2
MEDICAL CENTER OF CENTRAL GA	66
MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER	1
MIDTOWN MEDICAL CENTER	1
NORTHSIDE MEDICAL CENTER	1
PEACH REGIONAL MEDICAL CENTER	1
PERRY HOSPITAL	4
PHOEBE PUTNEY MEMORIAL HOSPITAL	71
PIEDMONT HOSPITAL	1
REGENCY HOSPITAL	1
ST JOSEPH HOSPITAL	1
TAYLOR REGIONAL HOSPITAL	13

COLUMBUS REGIONAL MEDICAL CENTER	1
TIFT REGIONAL MEDICAL CENTER	8
COLUMBUS REGIONAL HOSPITAL	1
<b>Total</b>	<b>501</b>

## 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)	6	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	0	0	1
Allied Health/Therapists	0	0	4



## **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	
Aide/Assistant	
Allied Health/Therapists	

## **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	70	2
February	67	0
March	63	3
April	56	0
May	68	1
June	63	3
July	60	1
August	60	0
September	48	2
October	52	1
November	55	1
December	57	1

### **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
Crisp	55	435	7,756	199	6	0	116	143	144	403
Dooly	17	149	2,480	67	2	0	47	53	30	130
Macon	7	62	851	25	1	0	20	22	11	53
Sumter	1	13	181	7	0	0	6	5	1	12
Pulaski	0	2	113	1	0	0	1	0	16	17
Wilcox	10	73	1,155	37	3	0	26	25	0	51
Total by Age	0	0	0	0	0	0	216	248	202	666

### **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
Crisp	1,221,424	1,179,821	2,551
Dooly	394,008	380,586	0
Macon	160,634	155,163	0
Sumter	36,370	35,131	0
Pulaski	51,524	49,769	0
Wilcox	154,572	149,307	0
<b>Total</b>	<b>2,018,532</b>	<b>1,949,777</b>	<b>2,551</b>

## 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:** Jimmie Smith, RN Administrator

**Date:** 02/24/2017

**Title:** Administrator

**Comments:**