GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA057

Facility Name: Three Rivers Home Health

County: Dodge

Street Address: 205 Foster Street

City: Eastman

Zip: 31023

Mailing Address: PO Box 640

Mailing City: Eastman

Mailing Zip: 31023-0640

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.
000186766A

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.
117053

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: Wanda Daniels

Contact Title: Executive Administrator

Phone: 478-374-3468

Fax: 478-374-6741

E-mail: wdaniels@123rivers.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
Three Rivers Home Health Services, Inc.	For Profit	06/01/1979

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
Not Applicable		

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.
Dublin	205 Industrial Blvd	Dublin	Laurens	01/01/1981

Cochran	147 East Dykes Street	Cochran	Bleckley	01/01/1984
Telfair	167 8th Street	Helena	Telfair	02/01/1994

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	14,056	170
Physical Therapy	17,520	180
Home Health Aide	2,519	90
Occupational Therapy	4,237	180
Medical Social Services	10	190
Speech Pathology	845	180
	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.

206

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).

1224

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	1
Asian	0
Black/African American	429
Hispanic/Latino	2
Pacific Islander/Hawaiian	1
White	1,220
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	648
Female	1,005

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	856	21,772	3,439,882	3,436,909
Medicaid	103	1,968	114,298	2,058
Other Government Payers	83	2,393	448,890	347,409
Managed Care (HMO/PPO)	421	10,074	1,607,903	1,434,536
Other Third Party Insurers	181	2,914	521,201	504,471
Self Pay	9	66	10,242	3,272
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.

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	6,142,416
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	12,613
Other Contractual Adjustments	122,061
Total Contractual Adjustments	**134,674**
Bad Debt	88,244
Indigent Care Gross Charges	99,717
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**99,717**
Charity Care Gross Charges	91,126
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**91,126**
Other Free Care	0
Total Net Patient Revenue	**5,728,655**
Adjusted Gross Patient Revenue	**6,041,559**
Other Revenue	0
Total Net Revenue	**5,728,655**
Total Expenses	4,103,337
Adjusted Gross Revenue	**6,041,559**
Total Uncompensated I/C Care	**190,843**
Percent Uncompensated Indigent/Charity Care	**3.16%**

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.

27

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)	988
Physicians	544
Other Home Health Agencies	7
All Other Healthcare Providers	114

7. Referral Hospitals

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

Hospital Name	Patients Referred
ATLANTA VA MEDICAL CENTER	3
AUGUSTA UNIVERSITY	4
BLECKLEY MEMORIAL HOSPITAL	52
CANDLER COUNTY HOSPITAL	1
CARL VINSON VA MEDICAL CENTER	6
CEMTRAL GEORGIA REHABILITATION HOSPITAL	7
CHARLIE NORWOOD VAMC - AUGUSTA	4
CHILDREN'S HEALTHCARE OF ATLANTA AT EGLESTON	1
COFFEE REGIONAL HSOPITAL	5
COLISEUM MEDICAL CENTER	73
COLISEUM NORTHSIDE HSOPITAL	11
COLISEUM REHABILITATION HOSPITAL	6
COLUMBUS REGIONAL HOSPITAL	2
COOK MEDICAL CENTER	1
CRISP REGIONAL HOSPITAL	6
DEKALB MEDICAL	1
DOCTORS HOSPITAL OF AUGUSTA	3
DODGE COUNTY HOSPITAL	60
DORMINY MEDICAL CENTER	2
EAST GEORGIA REGIONAL MEDICAL CENTER	2
EISENHOWER ARMY MEDICAL CENTER	1
EMANUEL MEDICAL CENTER	1
EMORY REHABILITATION HOSPITAL	1
EMORY UNIVERSITY HOSPITAL	12
EMORY UNIVERSITY HOSPITAL MIDTOWN	3
FAIRVIEW PARK HOSPITAL	417

GEORGIA REGENTS MEDICAL CENTER	6
GRADY HEALTH SYSTEM	1
GWINNETT MEDICAL CENTER	1
HOUSTON MEDICAL CENTER	30
HOUSTON MEDICAL CENTER PERRY	3
JACK HUGHSTON MEMORIAL HOSPITAL	2
JASPER MEMORIAL HOSPITAL	1
JEFF DAVIS	4
KINDRED HOSPITAL	1
MAYO CLINIC	1
MEADOWS REGIONAL MEDICAL CENTER	12
MEDICAL COLLEGE OF GEORGIA	1
MEMORIAL HEALTH	17
NAVICENT HEALTH / MEDICAL CENTER OF CENTRAL GEORGIA	142
NORTHSIDE MEDICAL CENTER	1
OPTIM MEDICAL CENTER TATTNALL	7
PERRY HOSPITAL	2
PIEDMONT ATLANTA HOSPITAL	1
REGENCY HOSPITAL OF CENTRAL GEORGIA	8
REHABILITATION HOSPITAL OF SAVANNAH	2
SCOTT HEALTH AND REHABILITATION	1
SELECT SPECIALITY HOSPITAL	2
SHEPHERD CENTER	1
SOUTHEASTERN REGIONAL MEDICAL CENTER	2
ST JOSEPH'S HOSPITAL	1
ST JOSEPH'S CANDLER	1
ST VINCENT'S MEDICAL CENTER	1
TAYLOR REGIONAL HOSPITAL	37
THE LODGE	5
TIFT REGIONAL MEDICAL CENTER	4
UNIVERSITY HEALTH	3
WALTON REHABILITATION HOSPITAL	1
WASHINGTON COUNTY REGIONAL MEDICAL CENTER	1
Total	**988**

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)	14	0	0
Licensed Practical Nurses (LPNs)	6	0	0
Aides/Assistants	4	1	0
Allied Health/Therapists	8	0	5

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	4-6 weeks
Licensed Practical Nurse	4-6 weeks
Aide/Assistant	4-6 weeks
Allied Health/Therapists	6-8 weeks

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	120	5
February	125	7
March	142	13
April	102	3
May	130	16
June	104	14
July	123	20
August	128	15
September	101	12
October	119	10
November	116	9
December	110	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
Bleckley	20	149	3,209	72	0	0	53	60	56	169
Dodge	70	276	10,850	186	0	1	92	159	94	346
Laurens	85	641	15,972	338	0	1	185	272	268	726
Pulaski	9	36	869	22	0	0	22	16	7	45
Telfair	24	171	4,582	93	0	1	68	68	58	195
Wheeler	6	67	1,186	39	0	0	27	31	15	73
Wilcox	19	80	2,519	41	0	0	24	32	43	99
Total by Age	**0**	**0**	**0**	**0**	**0**	**3**	**471**	**638**	**541**	**1,653**

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
Bleckley	627,992	617,679	19,511
Dodge	1,285,708	1,264,597	39,947
Laurens	2,697,758	2,653,461	83,819
Pulaski	167,216	164,471	5,195
Telfair	724,604	712,707	22,513
Wheeler	271,262	266,808	8,428
Wilcox	367,876	361,836	11,430
Total	**6,142,416**	**6,041,559**	**190,843**

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: Hal M. Smith, Jr.

Date: 03/07/2017

Title: Executive Director

Comments:

The Abbeville branch office reported in previous years was closed 06/30/2016. Form 855A was filed and approved by CMS however the State has not received notification from CMS. We have contacted CMS and they will be sending appropriate notification to the State.