GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification   UID:HHA070

Facility Name: VNA of Greater Tift, Inc.

County: Tift

Street Address: 2014 US Hwy 41 N

City: Tifton

Zip: 31794

Mailing Address: 2014 US Hwy. 41 N

Mailing City: Tifton

Mailing Zip: 31794

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.
NA

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.
117046

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: Sandy Albertson

Contact Title: CFO

Phone: 229-386-8571

Fax: 229-386-1525

E-mail: visitingnurses@hotmail.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
Eva Fletcher	Not for Profit	06/01/1978

B. Owner's Parent Organization

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

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Eva Fletcher	Not for Profit	06/01/1978

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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	5,313	150
Physical Therapy	2,538	200
Home Health Aide	2,503	120
Occupational Therapy	451	200
Medical Social Services	0	0
Speech Pathology	64	200
	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.

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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).

409

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	1
Black/African American	102
Hispanic/Latino	6
Pacific Islander/Hawaiian	0
White	332
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	197
Female	245

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	234	7,533	1,286,712	793,520
Medicaid	0	0	0	0
Other Government Payers	26	883	139,110	100,593
Managed Care (HMO/PPO)	81	1,944	310,110	190,045
Other Third Party Insurers	16	204	35,050	33,537
Self Pay	57	305	46,460	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.
12/01/1996

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.

Eva Fletcher, 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	1,817,442
Medicare Contractual Adjustments	471,278
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	165,289
Total Contractual Adjustments	**636,567**
Bad Debt	16,720
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	46,460
Total Net Patient Revenue	**1,117,695**
Adjusted Gross Patient Revenue	**1,329,444**
Other Revenue	218
Total Net Revenue	**1,117,913**
Total Expenses	1,244,095
Adjusted Gross Revenue	**1,329,662**
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.

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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)	237
Physicians	67
Other Home Health Agencies	4
All Other Healthcare Providers	63

7. Referral Hospitals

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

Hospital Name	Patients Referred
Columbus Regional Hospital	2
Crisp Regional Hospital	10
Emory University Hospital	5
Navicent	4
Phebe Putney Memorial Hospital	16
Shands Hospital	3
TRMC	186
VA	7
Other	4
Total	**237**

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)	5	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	0	0	3

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	0
Licensed Practical Nurse	0
Aide/Assistant	0
Allied Health/Therapists	0

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	0
February	37	3
March	35	0
April	21	0
May	25	3
June	20	2
July	19	5
August	25	3
September	25	4
October	29	6
November	28	3
December	30	7

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	9	30	1,080	0	0	0	14	16	9	39
Berrien	2	17	217	0	0	0	10	5	4	19
Cook	2	10	168	0	0	0	5	6	1	12
Crisp	2	9	310	0	0	0	1	8	2	11
Irwin	0	17	288	0	0	1	8	7	1	17
Tift	38	194	5,486	0	0	0	42	92	98	232
Turner	14	67	2,417	0	0	0	15	36	30	81
Wilcox	0	7	134	0	0	0	0	4	3	7
Worth	4	20	769	0	0	0	5	8	11	24

Total by Age	0	0	0	0	0	1	100	182	159	442

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	172,640	132,944	0
Berrien	35,140	26,589	0
Cook	29,080	23,896	0
Crisp	43,450	34,369	0
Irwin	47,480	39,883	0
Tift	954,262	667,455	0
Turner	392,230	292,478	0
Wilcox	22,170	18,769	0
Worth	120,990	93,061	0
Total	**1,817,442**	**1,329,444**	**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 inccaurate 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: Sandy Albertson

Date: 02/22/2017

Title: CFO

Comments: