



## 2016 Home Health Survey

### Part A : General Information

#### 1. Identification

UID:HHA073

**Facility Name:** West Georgia Home Care

**County:** Troup

**Street Address:** 120 Glenn Bass Road

**City:** LaGrange

**Zip:** 30240

**Mailing Address:** 120 Glenn Bass Rd

**Mailing City:** LaGrange

**Mailing Zip:** 30240-5809

#### **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.

00145681A

#### **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.

117032

#### 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:** Phyllis Gentry, RN, BSN

**Contact Title:** Director

Phone: 706-845-3291

Fax: 706-845-1041

E-mail: gentryp@wghealth.org

## 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
LaGrange-Troup County Hospital Authority	Hospital Authority	08/24/2006

#### 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
West Georgia Medical Center, Inc	Not for Profit	08/24/2006

#### D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
WellStar Health System, Inc	Not for Profit	04/01/2016

#### 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.
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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	12,088	178
Physical Therapy	6,813	178
Home Health Aide	4,744	135
Occupational Therapy	2,725	178
Medical Social Services	323	178
Speech Pathology	72	178
	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.

189

### 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).

1445

### 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	3
Black/African American	349
Hispanic/Latino	4
Pacific Islander/Hawaiian	0
White	806
Multi-Racial	12

### 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	486
Female	688

### 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	833	21,401	2,982,269	2,652,348
Medicaid	87	1,680	336,195	81,469
Other Government Payers	29	423	89,840	29,906
Managed Care (HMO/PPO)	115	1,972	329,019	96,778
Other Third Party Insurers	35	427	81,302	23,845
Self Pay	64	791	168,661	168,661
Other Non Government	11	71	14,170	4,702

## 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.

12/31/2005

### 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.

Phyllis Gentry, RN, BSN, Director

### 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	4,001,456
Medicare Contractual Adjustments	329,921
Medicaid & Peachcare Contractual Adjustments	254,726
Other Contractual Adjustments	233,693
<b>Total Contractual Adjustments</b>	<b>818,340</b>
Bad Debt	111,237
Indigent Care Gross Charges	0
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>0</b>
Charity Care Gross Charges	14,170
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>14,170</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>3,057,709</b>
<b>Adjusted Gross Patient Revenue</b>	<b>3,305,572</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>3,057,709</b>
Total Expenses	3,474,826
<b>Adjusted Gross Revenue</b>	<b>3,305,572</b>
<b>Total Uncompensated I/C Care</b>	<b>14,170</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>0.43%</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.

11

**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)	1,123
Physicians	339
Other Home Health Agencies	6
All Other Healthcare Providers	296

**7. Referral Hospitals**

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

Hospital Name	Patients Referred
Central Alabama Veterans Health Care System	1
Columbus Specialty Hospital	4
Columbus Medical Center	16
Columbus VA	1
Crawford Long Hospital	1
East Alabama Medical Center	11
Childrens Healthcare of Atlanta	2
Emory University Hospital Midtown	54
Emory University Orthopedics and Spine Hospital	2
Emory Hospital	8
Grady Memorial Hospital	3
Health South Lakeshore Rehabilitation Hospital	4
Health South Rehabilitation Hospital of Newnan	59
Jack Hughston Memorial Hospital	31
Kindred Hospital	1
Lanier Health Services	18
Midwestern Regional Medical Center	1
Northside Medical Center	1
Northside Hospital	6
Piedmont Hospital	10
Piedmont Fayette Hospital	4
Piedmont Newnan Hospital	41
Regional Rehabilitation Hospital	6
Rockdale Medical Center	1
Select Specialty Hospital	1
Shepherd Spinal Center	2

Southern Crescent Hospital For Specialty Care	1
Southern Regional Medical Center	2
St Francis Hospital	26
St Josephs Hospital of Atlanta	4
Summit Ridge Hospital	1
Tanner Medical Center	18
University of Alabama Birmingham	6
Upton Regional Medical Center	3
VA Hospital Decatur	16
VA Hospital Montgomery	2
VA Hospital Tuskegee	3
Warm Springs Medical Center	10
Wellstar Cobb Hospital	2
Wellstar Kenneston Hospital	11
Wellstar Health System	1
West Georgia Medical Center	727
West Paces Medical Center	1
<b>Total</b>	<b>1,123</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)	12	2	0
Licensed Practical Nurses (LPNs)	6	2	0
Aides/Assistants	5	0	0
Allied Health/Therapists	12	1	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	90 plus days
Licensed Practical Nurse	78 days
Aide/Assistant	60 days
Allied Health/Therapists	90 plus days

## 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	114	0
February	80	2
March	90	4
April	93	14
May	82	13
June	92	13
July	81	14
August	81	16
September	86	13
October	80	26
November	70	27
December	67	16

### 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
Harris	16	55	1,590	35	0	0	21	24	26	71
Heard	14	52	1,334	37	0	0	30	27	9	66
Meriwether	26	131	3,192	92	0	0	47	57	51	155
Troup	174	706	20,649	376	0	0	274	333	275	882
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>372</b>	<b>441</b>	<b>361</b>	<b>1,174</b>

### 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
Harris	252,636	226,252	0
Heard	256,193	237,051	0
Meriwether	516,877	479,684	0
Troup	2,975,750	2,362,585	14,170
<b>Total</b>	<b>4,001,456</b>	<b>3,305,572</b>	<b>14,170</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:** Phyllis Gentry, RN, BSN

**Date:** 03/07/2017

**Title:** Director

**Comments:**

Part D: 1. Charge Per Visit Start of Care Visits for Skilled Nursing and Physical Therapists are \$250.00. All other visits for clinical are \$178.00 each; all Home Health Aide visits are \$135.00 each. Thank you.