GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA077

Facility Name: Gentiva Health Services - Savannah

County: Chatham

Street Address: 2280 E Victory Dr. Suite B

City: Savannah

Zip: 31404-3957

Mailing Address: 2280 E Victory Dr. Suite B

Mailing City: Savannah

Mailing Zip: 31404-3957

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.
000702292A

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.
11-7090

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: Terry Linboom

Contact Title: Sr. Reimbursement Accountant

Phone: 913-814-2937

Fax: 913-814-4752

E-mail: Terry.Linboom@gentiva.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
Gentiva Certified Health Care Corp.	For Profit	09/21/1988

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gentiva Health Services	For Profit	12/31/2000

C. Agency Operator

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

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	11,349	140
Physical Therapy	8,556	165
Home Health Aide	1,169	75
Occupational Therapy	4,610	165
Medical Social Services	401	175
Speech Pathology	570	165
	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.

211

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).

291

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	4
Black/African American	346
Hispanic/Latino	8
Pacific Islander/Hawaiian	0
White	563
Multi-Racial	1

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	327
Female	596

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	609	19,521	5,717,007	3,008,578
Medicaid	46	937	62,598	58,653
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	85	2,747	307,096	265,699
Other Third Party Insurers	76	1,187	172,623	147,080
Self Pay	20	182	22,232	0
Other Non Government	87	2,181	844,244	451,344

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.

None

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	7,125,800
Medicare Contractual Adjustments	2,708,430
Medicaid & Peachcare Contractual Adjustments	3,580
Other Contractual Adjustments	455,885
Total Contractual Adjustments	**3,167,895**
Bad Debt	19,171
Indigent Care Gross Charges	7,380
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**7,380**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**3,931,354**
Adjusted Gross Patient Revenue	**4,394,619**
Other Revenue	0
Total Net Revenue	**3,931,354**
Total Expenses	0
Adjusted Gross Revenue	**4,394,619**
Total Uncompensated I/C Care	**7,380**
Percent Uncompensated Indigent/Charity Care	**0.17%**

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.

6

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)	4
Physicians	903
Other Home Health Agencies	16
All Other Healthcare Providers	0

7. Referral Hospitals

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

Hospital Name	Patients Referred
MEMORIAL HEALTH UNIV MED CTR	3
ST JOSEPH HOSPITAL SAVANNAH	1
Total	**4**

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)	7	0	0
Licensed Practical Nurses (LPNs)	4	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	12	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	6 weeks
Licensed Practical Nurse	4 weeks
Aide/Assistant	2 weeks
Allied Health/Therapists	12 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	73	12
February	67	12
March	81	14
April	72	13
May	67	12
June	79	14
July	70	12
August	89	16
September	76	13
October	83	15
November	70	12
December	91	17

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
Chatham	155	831	24,526	354	6	0	195	283	359	837
Effingham	12	87	2,239	38	0	0	30	30	26	86
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**225**	**313**	**385**	**923**

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

Chatham	6,532,139	4,028,497	7,380
Effingham	593,661	366,122	0
Total	**7,125,800**	**4,394,619**	**7,380**

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: David L. Gieringer

Date: 02/24/2017

Title: Vice President, Controller and Chief Accounting Officer

Comments: