



## 2016 Home Health Survey

### Part A : General Information

#### 1. Identification

UID:HHA128

**Facility Name:** Three Rivers Home Health

**County:** Toombs

**Street Address:** 115 Northwest Main Street

**City:** Vidalia

**Zip:** 30474

**Mailing Address:** 115 Northwest Main Street

**Mailing City:** Vidalia

**Mailing Zip:** 30474

#### **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.

000821026A

#### **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.

117123

#### 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	10/08/1998

#### 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.
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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	1,960	170
Physical Therapy	2,162	180
Home Health Aide	34	90
Occupational Therapy	316	180
Medical Social Services	4	190
Speech Pathology	58	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.

26

### **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).

147

### **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	1
Black/African American	64
Hispanic/Latino	2
Pacific Islander/Hawaiian	0
White	197
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	129
Female	135

### **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	113	2,095	362,117	354,262
Medicaid	25	257	12,921	12,611
Other Government Payers	30	766	134,122	93,106
Managed Care (HMO/PPO)	64	982	177,445	147,424
Other Third Party Insurers	31	428	72,512	66,647
Self Pay	1	6	1,760	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.

### 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	760,877
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	52,888
<b>Total Contractual Adjustments</b>	<b>52,888</b>
Bad Debt	12,887
Indigent Care Gross Charges	310
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>310</b>
Charity Care Gross Charges	20,742
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>20,742</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>674,050</b>
<b>Adjusted Gross Patient Revenue</b>	<b>747,990</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>674,050</b>
Total Expenses	546,929
<b>Adjusted Gross Revenue</b>	<b>747,990</b>
<b>Total Uncompensated I/C Care</b>	<b>21,052</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>2.81%</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)	148
Physicians	84
Other Home Health Agencies	3
All Other Healthcare Providers	29

## **7. Referral Hospitals**

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

Hospital Name	Patients Referred
Augusta University Healthcare System	1
Camellia Health and Rehab	1
Charlie Norwood VAMC - Augusta	1
Coliseum Rehab Center	5
Dodge County Hospital	1
East Georgia Regional Medical Center	5
Emanuel Medical Center	3
Emory University Hospital	1
Emory University Hospital - Midtown	2
Fairview Park Hospital	69
Georgia Regents Medical Center	4
Healthsouth Walton Rehabilitation Hospital	2
Jack Hughston Memorial Hospital	2
Meadows Regional Medical Center	9
Medical Center Navicent Health	17
Memorial Health	8
Optim Medical Center Tattnall	7
Rehabilitation Hospital of Savannah	1
Scott Health and Rehabilitation	1
Select Specialtiy Hospital	2
Shepherd Center	1
Southland Healthcare and Rehab	1
St Joseph / Candler	2
University Health Care System	1
Washington County Regional Medical Center	1
<b>Total</b>	<b>148</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)	2	1	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	0	0	0
Allied Health/Therapists	2	0	1

## 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 months
Licensed Practical Nurse	6-8 weeks
Aide/Assistant	
Allied Health/Therapists	4-6 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	28	0
February	21	2
March	22	2
April	19	0
May	20	1
June	14	0
July	20	0
August	16	0
September	16	0
October	18	2
November	16	1
December	9	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
Candler	0	1	9	1	0	0	0	1	0	1
Emanuel	7	42	806	28	0	0	10	22	17	49
Evans	0	0	0	0	0	0	0	0	0	0
Jeff Davis	0	1	16	0	0	0	0	0	1	1
Johnson	16	64	1,260	39	0	0	29	32	19	80
Laurens	1	0	19	1	0	0	0	1	0	1
Montgomery	4	15	265	10	0	0	10	7	2	19
Tattnall	1	0	61	0	0	0	0	0	1	1
Toombs	9	43	1,104	24	0	0	23	17	12	52



Treutlen	7	53	994	30	0	0	15	28	17	60
Wayne	0	0	0	0	0	0	0	0	0	0
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>87</b>	<b>108</b>	<b>69</b>	<b>264</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
Candler	2,882	2,833	80
Emanuel	141,223	138,831	3,907
Evans	0	0	0
Jeff Davis	2,882	2,833	80
Johnson	230,569	226,664	6,379
Laurens	2,882	2,833	80
Montgomery	54,760	53,833	1,515
Tattnall	2,882	2,833	80
Toombs	149,870	147,332	4,146
Treutlen	172,927	169,998	4,785
Wayne	0	0	0
<b>Total</b>	<b>760,877</b>	<b>747,990</b>	<b>21,052</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:** Hal M. Smith, Jr.

**Date:** 03/07/2017

**Title:** Executive Director

**Comments:**