GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA021

Facility Name: Central Home Health Care, an Amedisys Company

County: Douglas

Street Address: Suite C 3009 Chapel Hill Road

City: Douglasville

Zip: 30135-1777

Mailing Address: Suite C 3009 Chapel Hill Road

Mailing City: Douglasville

Mailing Zip: 30135-1777

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.
0082492A

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.
11-7050

2. Report Period

Report Data for the full twelve month period, January 1,2014 - December 31, 2014 (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: Tonya Woodridge-Jarvis

Contact Title: Regulatory Coordinator

Phone: 225-299-3531

Fax: 225-295-9678

E-mail: tonya.woodridge-jarv@amedisys.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
Amedisys Georgia,LLC d/b/a Central Home Health Care, an Amedisys Company	For Profit	

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	For Profit	01/01/2020

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	For Profit	01/01/2020

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	For Profit	01/01/2020

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	For Profit	01/01/2020

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	For Profit	01/01/2020

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.
Central Home Health Care, an Am	1124 North Park Street Suite 1	Carrolton	Carroll	08/16/2007

Central Home Health Care, an Ame	1825 E Highway 34 Suite 2400	Newnan	Coweta	05/01/2007
Central Home Health Care, an Ame	105 Village Walk Suite 282	Dallas	Paulding	08/01/2006
Central Home Health Care, an Ame	250 Village Center Parkway Suite 2	Stockbridge	Henry	06/29/2006
Central Home Health Care, an Ame	1240 Highway 54 W Suite 601 BLD	Fayetteville	Fayette	12/01/1998

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	80,744	161
Physical Therapy	40,841	204
Home Health Aide	8,195	92
Occupational Therapy	15,101	210
Medical Social Services	2,407	227
Speech Pathology	7,371	234
	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 31,2014.

2925

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).

743

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	8
Asian	25
Black/African American	1,349
Hispanic/Latino	48
Pacific Islander/Hawaiian	1
White	5,155
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	2,409
Female	4,177

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	3,705	101,438	15,726,907	15,112,825
Medicaid	161	2,026	5,209,278	3,447,438
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	2,720	51,195	4,037,793	3,525,439
Self Pay	0	0	0	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 2014. ☑

If you indicated yes above, please indicate the effective date of the policy or policies.

06/01/2006

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.

Jeffrey Jeter, Compliance 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 2014 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	24,973,978
Medicare Contractual Adjustments	384,314
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	2,092,129
Total Contractual Adjustments	**2,476,443**
Bad Debt	371,033
Indigent Care Gross Charges	40,800
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**40,800**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**22,085,702**
Adjusted Gross Patient Revenue	**24,218,631**
Other Revenue	23,173
Total Net Revenue	**22,108,875**
Total Expenses	15,219,601
Adjusted Gross Revenue	**24,241,804**
Total Uncompensated I/C Care	**40,800**
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.

66

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)	0
Physicians	6,586
Other Home Health Agencies	0
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

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 12-31-2014.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	3	2	0
Licensed Practical Nurses (LPNs)	6	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	6	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	12 months
Licensed Practical Nurse	3 months
Aide/Assistant	3 months
Allied Health/Therapists	24 months

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	0	0
February	0	0
March	0	0
April	0	0
May	0	0
June	0	0
July	0	0
August	0	0
September	0	0
October	0	0
November	0	0
December	0	0

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2014. 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
Bartow	0	1	34	0	0	0	0	0	0	0
Bartow	0	1	34	0	0	0	0	0	0	0
Bartow	0	1	34	0	0	0	0	0	0	0
Bartow	0	1	34	0	0	0	0	0	0	0
Carroll	485	913	22,290	78	0	0	238	438	403	1,079
Clayton	34	70	1,318	13	0	0	31	37	30	98
Cobb	168	300	9,825	27	0	0	78	108	163	349
Coweta	392	688	17,329	75	0	0	262	294	259	815
DeKalb	0	3	38	1	0	0	2	1	0	3

Douglas	243	602	16,800	57	0	0	187	266	245	698
Fayette	354	691	17,028	46	0	0	151	213	426	790
Fulton	104	236	5,234	29	0	0	87	91	97	275
Heard	23	82	1,649	12	0	0	34	42	26	102
Henry	412	1,005	22,743	96	0	0	301	460	381	1,142
Paulding	602	758	34,579	58	0	0	191	373	377	941
Spalding	0	1	18	0	0	0	0	1	0	1
Upson	0	0	1	0	0	0	0	0	1	1
Troup	108	251	5,740	24	0	0	81	111	100	292
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**1,643**	**2,435**	**2,508**	**6,586**

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
Bartow	24,973,978	24,218,631	40,800
Bartow	24,973,978	24,218,631	40,800
Bartow	24,973,978	24,218,631	40,800
Bartow	24,973,978	24,218,631	40,800
Carroll	0	0	0
Clayton	0	0	0
Cobb	0	0	0
Coweta	0	0	0
DeKalb	0	0	0
Douglas	0	0	0
Fayette	0	0	0
Fulton	0	0	0
Heard	0	0	0
Henry	0	0	0
Paulding	0	0	0
Spalding	0	0	0
Upson	0	0	0
Troup	0	0	0
Total	**99,895,912**	**96,874,524**	**163,200**

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: Paula Vinson

Date: 02/16/2015

Title: Regulatory Director

Comments: