



2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA024

Facility Name: Caresouth Homecare Professionals - Washington

County: Elbert

Street Address: 333 B Heard Street

City: Elberton

Zip: 30636-1601

Mailing Address: 333 B Heard Street

Mailing City: Elberton

Mailing Zip: 30636-1601

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.

00814811

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.

117069

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: Jessica Holshouser

Contact Title: Statistical Reporting Supervisor

Phone: 706-854-7583

Fax: 706-228-6825

E-mail: jholshouser@caresouth.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
CareSouth HHA Holdings, Inc.	For Profit	03/01/1998

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/01/1998

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
CareSouth Home Health Services, Inc.	For Profit	03/01/1998

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/01/1998

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.
Statesboro	1601 Fair Rd, Suite 100	Statesboro	Bulloch	10/15/2012

Athens	624 S Milledge Ave, Suite 101	Athens	Clarke	03/01/1998
Augusta	231 Fury's Ferry Rd, Suite 212	Augusta	Richmond	03/01/1998
Eatonton	1023 Lake Oconee Pkwy, Suite F	Eatonton	Putnam	03/01/1998
Hartwell	1087 E Franklin St	Hartwell	Hart	03/01/1998
Sandersville	318 S Harris St, Suite A	Sandersville	Washington	05/01/2010
Commerce	201 Mercer Place, Bldg 2	Commerce	Jackson	10/23/2007

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	34,973	170
Physical Therapy	37,827	180
Home Health Aide	2,999	100
Occupational Therapy	6,972	180
Medical Social Services	679	195
Speech Pathology	1,225	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, 2014.

730

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).

3728

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	4
Asian	19
Black/African American	1,184
Hispanic/Latino	20
Pacific Islander/Hawaiian	1
White	2,964
Multi-Racial	670

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	1,916
Female	2,946

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	2,904	52,878	9,635,715	9,635,715
Medicaid	185	2,529	286,801	93,437
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	1,738	29,268	5,454,595	5,212,481
Self Pay	0	0	0	0
Other Non Government	35	136	38,173	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.

11/01/1995

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.

Kathy McKissick, RN - Regional Director of Operations

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	15,415,284
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	188,450
Other Contractual Adjustments	228,273
Total Contractual Adjustments	416,723
Bad Debt	18,755
Indigent Care Gross Charges	38,173
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	38,173
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	14,941,633
Adjusted Gross Patient Revenue	15,208,079
Other Revenue	804
Total Net Revenue	14,942,437
Total Expenses	11,229,178
Adjusted Gross Revenue	15,208,883
Total Uncompensated I/C Care	38,173
Percent Uncompensated Indigent/Charity Care	0.25%

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.

35

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)	2,383
Physicians	1,658
Other Home Health Agencies	70
All Other Healthcare Providers	751

7. Referral Hospitals

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

Hospital Name	Patients Referred
Anderson Area Medical Center	11
Anmed Health Rehab Hospital	34
Athens Regional Medical Center	437
Atlanta Medical Center	1
Barrow Medical Center	1
Burke Medical Center	6
Brooks Rehab Hospital	1
Candler County Hospital	2
VAMC - Athens	3
Coliseum Medical Center	16
CRH - Northside Medical Center	3
Crisp Regional Hospital	1
Dekalb Medical Center	1
Doctors Hospital Augusta	146
East Central Regional Hospital	1
East Georgia Regional Medical Center	176
Eastside Medical Center	1
Eisenhower Medical Center	49
Elbert Memorial Hospital	63
Emory Hospital	27
Fairview Park Hospital	13
Good Samaritan Hospital	21
Gwinnett Medical Center	10
Jack Hughston Memorial Hospital	1
Jasper Memorial Hospital	25
Jefferson Hospital	35

Kindred Hospital - Atlanta	1
Landmark Hospital	13
Medical Center of Central Georgia	55
Georgia Regents Medical Center	141
Medical University of South Carolina	1
Memorial Health University Medical Center	9
Morgan Memorial Hospital	21
Newton Medical Center	1
Northeast Georgia Health Systems, Inc	56
Northridge Medical Center	73
Oconee Medical Center of Seneca, SC	1
Oconee Regional Medical Center	58
Optim Medical Center Screven	2
Optim Medical Center Tattnall	7
Piedmont Atlanta Hospital	12
Putnam General Hospital	55
Regency Hospital - Macon	4
Regional Rehab Hospital	1
St Joseph Hospital - Savannah	1
Scottish Rite	1
Select Specialty	34
Self Regional	1
Southeast Georgia Health System	1
St Francis	1
St Joseph Hospital - Atlanta	5
St Mary's Hospital	463
Stephens County Hospital	1
Trinity Hospital - Augusta	12
Ty Cobb Regional Medical Center	37
University Hospital	90
University Hospital - McDuffie	27
Wills Memorial Hospital	18
VAMC - Atlanta	3
VAMC - Augusta	52
Washington County Regional Medical	40
Total	2,383

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)	31	9	0
Licensed Practical Nurses (LPNs)	11	0	0
Aides/Assistants	4	0	0
Allied Health/Therapists	32	1	4

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 days
Licensed Practical Nurse	30 days
Aide/Assistant	270 days
Allied Health/Therapists	180 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	465	1
February	366	9
March	427	20
April	378	31
May	413	51
June	359	63
July	361	62
August	342	85
September	354	92
October	381	103
November	332	78
December	328	101

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
Bulloch	33	230	3,597	128	1	0	69	98	66	233
Burke	10	78	1,348	37	1	0	23	29	23	75
Clarke	45	514	8,448	233	1	0	88	205	189	482
Columbia	16	198	2,560	106	2	0	41	93	66	200
Elbert	50	447	7,658	191	1	0	109	157	138	404
Glascock	3	34	464	18	0	0	5	15	10	30
Greene	9	156	2,011	92	1	0	41	79	34	154
Hancock	23	147	2,739	69	2	0	38	56	41	135
Hart	48	534	9,078	207	2	0	111	166	159	436

Jackson	85	675	12,687	325	4	0	152	268	204	624
Jasper	9	104	1,876	45	1	0	19	37	40	96
Jefferson	16	196	3,151	81	2	0	31	69	74	174
Jenkins	3	28	504	17	0	0	10	14	6	30
Lincoln	5	40	499	25	2	0	14	20	9	43
Madison	32	206	3,586	120	4	0	40	102	58	200
Morgan	20	11	1,719	67	0	0	23	60	29	112
Oconee	4	101	1,268	54	0	0	15	47	32	94
Oglethorpe	27	160	2,576	95	1	0	40	82	28	150
Putnam	33	304	4,470	151	3	0	68	128	93	289
Richmond	51	519	8,174	268	3	0	135	217	138	490
Screven	5	51	737	28	1	0	21	21	5	47
Taliaferro	3	30	343	18	0	0	8	14	6	28
Warren	6	36	555	13	1	0	13	9	15	37
Washington	27	224	3,307	108	0	0	62	89	69	220
Wilkes	8	79	1,320	38	2	0	27	31	21	79
Total by Age	0	0	0	0	0	0	1,203	2,106	1,553	4,862

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
Bulloch	738,741	728,812	1,091
Burke	237,792	234,596	1,091
Clarke	1,528,212	1,507,670	1,091
Columbia	634,113	625,589	2,181
Elbert	1,280,908	1,263,691	1,091
Glascocok	95,117	93,838	0
Greene	488,267	481,704	1,091
Hancock	428,026	422,273	2,181
Hart	1,382,366	1,363,785	2,181
Jackson	1,978,432	1,951,839	4,363
Jasper	304,374	300,283	1,091
Jefferson	551,678	544,263	2,181
Jenkins	95,117	93,838	0
Lincoln	136,334	134,502	2,181
Madison	634,113	625,589	4,363
Morgan	355,103	350,330	0
Oconee	298,033	294,027	0
Oglethorpe	475,585	469,192	1,091
Putnam	916,293	903,977	3,272
Richmond	1,553,577	1,532,694	3,272

Screven	149,017	147,014	1,091
Taliaferro	88,776	87,583	0
Warren	117,311	115,734	1,091
Washington	697,524	688,148	0
Wilkes	250,475	247,108	2,179
Total	15,415,284	15,208,079	38,173

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: Kathy McKissick

Date: 03/03/2016

Title: Regional Director of Operations

Comments: