



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2014 Home Health Survey**

**Part A : General Information**

**1. Identification**

UID:HHA028

**Facility Name:** Floyd HomeCare

**County:** Floyd

**Street Address:** Suite 300 508 Riverside Pkwy NE

**City:** Rome

**Zip:** 30161

**Mailing Address:** PO Box 51266

**Mailing City:** Lafayette

**Mailing Zip:** 70505

**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.

000041302A

**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.

11-7010

**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:** Rachel Brown

**Contact Title:** Licensure & Regulatory Paralegal

**Phone:** 337-233-1307

**Fax:** 337-233-5764

**E-mail:** LRA@lhcgroupp.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
Floyd HomeCare, LLC	For Profit	01/01/2007

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
LHC Group, Inc.	For Profit	01/20/2005

#### C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Georgia Health Care Group, LLC	For Profit	03/14/2005

#### 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.
Floyd HomeCare of Cedartown	1000 N. Main St	Cedartown	Polk	09/17/2007

Floyd HomeCare of Summerville	10891 Commerce St, Suite A	Summerville	Chattooga	10/10/2007
Floyd HomeCare of Cartersville	775 West Ave, Suite B	Cartersville	Bartow	03/05/2008

## 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	26,258	175
Physical Therapy	15,772	200
Home Health Aide	1,548	110
Occupational Therapy	5,930	200
Medical Social Services	1,145	200
Speech Pathology	1,222	200
	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.

425

### **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).

2281

### **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	3
Asian	1
Black/African American	222
Hispanic/Latino	11
Pacific Islander/Hawaiian	0
White	1,524
Multi-Racial	601

### **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	919
Female	1,443

### **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	1,552	35,099	5,385,438	5,147,877
Medicaid	119	1,869	286,771	274,121
Other Government Payers	2	19	2,915	2,787
Managed Care (HMO/PPO)	492	10,623	1,629,947	1,558,047
Other Third Party Insurers	177	4,141	635,377	607,349
Self Pay	2	13	1,995	1,907
Other Non Government	18	111	17,031	16,280

## 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.

11/01/2014

### 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.

Kerrigan Lebeouf - Administrator and Director of Nursing

### 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	7,959,474
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	73,090
<b>Total Contractual Adjustments</b>	<b>73,090</b>
Bad Debt	253,911
Indigent Care Gross Charges	24,105
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>24,105</b>
Charity Care Gross Charges	0
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>0</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>7,608,368</b>
<b>Adjusted Gross Patient Revenue</b>	<b>7,705,563</b>
Other Revenue	77
<b>Total Net Revenue</b>	<b>7,608,445</b>
Total Expenses	0
<b>Adjusted Gross Revenue</b>	<b>7,705,640</b>
<b>Total Uncompensated I/C Care</b>	<b>24,105</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>0.31%</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)	934
Physicians	757
Other Home Health Agencies	8
All Other Healthcare Providers	271

## **7. Referral Hospitals**

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

Hospital Name	Patients Referred
Atlanta Medical Center	3
Atlanta VA Community Health Nursing	1
Cartersville Medical Center	38
Emory Hospital	4
Emory University Hospital	5
Emory University Hospital Midtown	3
Erlanger Health Systems	1
Erlanger Hospital	5
Floyd Behavioral Health Center	3
Wellstart Kennestone Hospital	14
Floyd Pre-Op	3
Floyd Rehab And	4
Golden Living Center - Denise	26
Gordon Hospital	2
Hamilton Medical Center	1
Hutchenson Medical Center	1
Northside Hospital	2
Parkridge Medical Center	1
Piedmont Mountainside Hospital	12
Piedmont Atlanta Hospital	5
Piedmont Hospital	2
Polk Medical Center	53
St. Joseph's Health System	1
Tanner Medical Center	9
Tanner Medical Higgins	5
UAB Hospital	1

VA Atlanta Medical Center	2
Wellstar Cobb Hospital	5
Wellstar Douglasville Hospital	2
Wellstar Health System Referral Cent	1
Wellstar Windy Hospital	1
McCord Mary	1
Floyd Hospital	518
Redmond Regional Medical Center	165
Kindred Hospital - Rome	20
Shepherd Center	6
Wellstar Paulding Hospital	8
<b>Total</b>	<b>934</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 12-31-2014.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	19	1	0
Licensed Practical Nurses (LPNs)	13	0	0
Aides/Assistants	2	1	0
Allied Health/Therapists	16	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	3 months
Licensed Practical Nurse	1 month
Aide/Assistant	0
Allied Health/Therapists	6 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	98	88
February	87	43
March	110	61
April	118	52
May	117	66
June	140	61
July	113	68
August	81	49
September	91	58
October	161	14
November	148	12
December	120	14

### 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	58	276	8,863	169	0	0	99	139	109	347
Chattooga	53	205	6,027	133	0	0	52	117	87	256
Floyd	188	881	23,091	469	0	0	228	386	420	1,034
Gordon	21	78	2,353	57	0	0	21	48	28	97
Haralson	19	102	2,270	66	0	0	28	56	39	123
Paulding	3	16	362	17	0	0	1	17	3	21
Pickens	7	40	867	25	0	0	7	23	16	46
Polk	76	372	8,042	212	0	0	139	157	142	438
Total by Age	0	0	0	0	0	0	575	943	844	2,362

## **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	1,335,196	1,292,599	4,043
Chattooga	924,757	895,257	2,801
Floyd	3,541,755	3,428,746	10,726
Gordon	362,262	350,712	1,097
Haralson	348,299	337,195	1,055
Paulding	80,247	77,696	243
Pickens	133,029	128,794	403
Polk	1,233,929	1,194,564	3,737
<b>Total</b>	<b>7,959,474</b>	<b>7,705,563</b>	<b>24,105</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:** Donald D. Stelly

**Date:** 03/04/2015

**Title:** President

**Comments:**