GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA051

Facility Name: Phoebe Home Care

County: Dougherty

Street Address: 804 14th Avenue

City: Albany

Zip: 31701

Mailing Address: 804 14th Avenue

Mailing City: Albany

Mailing Zip: 31701

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.
00723709

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.
117100

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: Lori Jenkins

Contact Title: DIrector, Strategy & Planning

Phone: 229-312-1432

Fax: 229-312-7100

E-mail: ljenkins@ppmh.org

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
Phoebe Putney Memorial Hospital, Inc.	Not for Profit	09/01/1996

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	09/01/1996

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Memorial Hospital, Inc.	Not for Profit	09/01/1996

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	09/01/1996

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.
Americus	804 Oglethorpe Avenue	Americus	Sumter	09/01/1996

Cuthbert	91 East Dawson Street	Cuthbert	Calhoun	09/01/1997

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	35,212	120
Physical Therapy	15,331	150
Home Health Aide	5,206	80
Occupational Therapy	3,946	150
Medical Social Services	0	180
Speech Pathology	632	150
	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.

326

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).

2686

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	5
Black/African American	1,605
Hispanic/Latino	9
Pacific Islander/Hawaiian	0
White	1,293
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	1,127
Female	1,786

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	2,039	45,346	6,506,495	6,438,917
Medicaid	290	5,257	630,702	331,209
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	382	5,845	738,247	593,687
Self Pay	202	3,879	738,958	17,823
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.

01/01/2004

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.

Teddrick Brown, Director, Post Acute Care

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	8,614,402
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	252,069
Other Contractual Adjustments	128,854
Total Contractual Adjustments	**380,923**
Bad Debt	366,506
Indigent Care Gross Charges	435,539
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**435,539**
Charity Care Gross Charges	50,591
Charity Care Compensation	793
Uncompensated Charity Care (Net)	**49,798**
Other Free Care	0
Total Net Patient Revenue	**7,381,636**
Adjusted Gross Patient Revenue	**7,995,827**
Other Revenue	0
Total Net Revenue	**7,381,636**
Total Expenses	6,326,594
Adjusted Gross Revenue	**7,995,827**
Total Uncompensated I/C Care	**485,337**
Percent Uncompensated Indigent/Charity Care	**6.07%**

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.

175

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)	2,237
Physicians	616
Other Home Health Agencies	0
All Other Healthcare Providers	60

7. Referral Hospitals

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

Hospital Name	Patients Referred
Archibold Memorial Hospital	2
Central GA Rehabilitation Hospital	1
Children's Healthcare of Atlanta	3
Coffee Regional Medical Center	1
Coliseum Medical Center	2
Colquitt Regional Medical Center	1
Columbus Regional Medical Center	29
Columbus Specialty Hospital, Inc.	4
Crisp Regional Hospital	4
Doctor's Hospital of Augusta	1
East Albany Medical Center	1
Emory University Hospital	17
Houston Medical Center	1
Hughston Sports Hospital	5
Jack Hughston Memorial Hospital	30
Medical Center of Central GA	3
Miller County Hospital	1
Northside Hospital	1
Phoebe Worth	101
Piedmont Medical Center	6
Phoebe Putney Memorial Hospital	1,865
Select Specialy Hospital	1
Shands Hospital	4
St Francis Hospital	18
Phoebe Sumter Medical Center	77
Southwest GA Regional Medical Center	40

Tift Regional Medical Center	12
University of AL Birmingham Medical Center	1
VA Medical Center	5
Total	**2,237**

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)	35	4	0
Licensed Practical Nurses (LPNs)	6	3	0
Aides/Assistants	5	0	0
Allied Health/Therapists	12	1	2

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	90-120 Days
Licensed Practical Nurse	60-90 Days
Aide/Assistant	0-30 Days
Allied Health/Therapists	30-60 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	286	0
February	259	4
March	269	11
April	224	28
May	242	35
June	205	34
July	204	45
August	201	53
September	180	46
October	218	51
November	186	40
December	198	58

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
Baker	2	38	609	21	2	0	19	12	5	36
Calhoun	9	83	1,472	37	4	0	36	27	18	81
Clay	0	22	356	9	2	0	9	6	4	19
Colquitt	1	23	314	14	0	0	11	10	1	22
Crisp	4	20	332	14	1	0	10	10	2	22
Dougherty	210	1,734	34,988	698	98	6	704	503	406	1,619
Early	3	12	199	8	1	0	9	5	1	15
Lee	23	295	6,009	135	14	1	121	102	58	282
Miller	1	9	115	4	0	0	4	3	1	8

Mitchell	0	8	139	2	2	0	3	2	2	7
Quitman	0	10	187	1	0	0	7	0	2	9
Randolph	16	140	2,920	59	6	0	48	48	35	131
Sumter	29	209	4,018	96	23	1	96	66	55	218
Terrell	21	209	4,066	91	6	1	75	72	44	192
Worth	25	265	4,603	127	16	2	93	97	60	252
Total by Age	**0**	**0**	**0**	**0**	**0**	**11**	**1,245**	**963**	**694**	**2,913**

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
Baker	86,905	80,665	4,896
Calhoun	210,034	194,952	11,833
Clay	50,437	46,815	2,842
Colquitt	44,758	41,544	2,522
Crisp	47,803	44,371	2,693
Dougherty	4,997,312	4,638,470	281,550
Early	28,148	26,126	1,586
Lee	857,684	796,096	48,322
Miller	16,221	15,056	914
Mitchell	20,071	18,630	1,131
Quitman	26,529	24,624	1,495
Randolph	417,330	387,363	23,512
Sumter	574,028	532,809	32,341
Terrell	580,201	538,538	32,688
Worth	656,941	609,768	37,012
Total	**8,614,402**	**7,995,827**	**485,337**

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: Joel Wernick

Date: 08/10/2015

Title: CEO

Comments: