



2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA078

Facility Name: Taylor Home Health Care

County: Pulaski

Street Address: 188 Perry Highway Suite 1

City: Hawkinsville

Zip: 31036

Mailing Address: PO Box 1297

Mailing City: Hawkinsville

Mailing Zip: 31036-7297

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.

000383215

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.

117091

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: Julie Martin, RN, BSN, CMP

Contact Title: Director

Phone: 478-783-0327

Fax: 478-783-3129

E-mail: julie.martin@taylorregional.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
Taylor Regional Hospital	Not for Profit	10/01/1988

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
Taylor Regional Hospital	Not for Profit	10/01/1988

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	2,915	175
Physical Therapy	2,858	200
Home Health Aide	1,846	115
Occupational Therapy	114	200
Medical Social Services	0	0
Speech Pathology	27	225
	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.

29

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).

167

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	0
Black/African American	33
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	152
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	62
Female	123

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	125	5,698	1,267,225	361,324
Medicaid	9	624	77,136	27,755
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	32	1,083	0	0
Other Third Party Insurers	17	341	73,099	24,791
Self Pay	2	14	2,474	1,474
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.

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 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	1,419,934
Medicare Contractual Adjustments	621,405
Medicaid & Peachcare Contractual Adjustments	25,776
Other Contractual Adjustments	37,409
Total Contractual Adjustments	684,590
Bad Debt	320,000
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	0
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	415,344
Adjusted Gross Patient Revenue	452,753
Other Revenue	0
Total Net Revenue	415,344
Total Expenses	0
Adjusted Gross Revenue	452,753
Total Uncompensated I/C Care	0
Percent Uncompensated Indigent/Charity Care	0.00%

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.

0

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)	106
Physicians	41
Other Home Health Agencies	0
All Other Healthcare Providers	15

7. Referral Hospitals

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

Hospital Name	Patients Referred
EMORY UNIVERSITY HOSPITAL	1
TAYLOR REGIONAL HOSPITAL	50
NAVICENT HEALTH (MCCG)	11
BLECKLEY MEMORIAL HOSPITAL	29
HCA COLISEUM HOSPITAL	2
HOUSTON MEDICAL CENTER	8
PIEDMONT HOSPITAL	1
KENNESTONE HOSPITAL	1
DODGE COUNTY HOSPITAL	2
VAMC OF AUGUSTA	1
Total	106

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)	4	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	0	0	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	
Licensed Practical Nurse	
Aide/Assistant	
Allied Health/Therapists	

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	7	1
February	15	2
March	13	3
April	12	2
May	8	1
June	12	1
July	12	2
August	18	2
September	17	3
October	11	1
November	11	1
December	4	4

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
Bleckley	10	65	2,021	24	0	0	16	24	22	62
Houston	5	12	549	9	0	0	1	8	5	14
Pulaski	30	95	5,020	0	0	0	17	49	43	109
Total by Age	0	0	0	0	0	0	34	81	70	185

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
Bleckley	352,176	112,293	0
Houston	151,818	48,408	0
Pulaski	915,940	292,052	0
Total	1,419,934	452,753	0

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: JULIE M. MARTIN, RN, BSN, CMP

Date: 02/18/2015

Title: DIRECTOR

Comments: