GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA079

Facility Name: United Home Care of Griffin

County: Spalding

Street Address: Suites B & C 147 West Ellis Road

City: Griffin

Zip: 30223

Mailing Address: 147 West Ellis Road

Mailing City: Griffin

Mailing Zip: 30223

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.
000709816A

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.
117092

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: Rita Southworth

Contact Title: Vice President of Home Care

Phone: 770-279-6200

Fax: 770-510-2459

E-mail: RSouthworth@pruitthealth.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
Not applicable	Not Applicable	

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	Not Applicable	

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Home Care of South Atlanta, Inc.	For Profit	10/14/2004

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Health Services of Georigia, Inc.	For Profit	10/14/2004

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Pruitt Corporation d/b/a UHS- Pruitt Corporation	For Profit	10/12/2004

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Health Services, Inc.	For Profit	10/12/2004

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.
United Home Care of Warm Spring	6597 Spring Street PO Box 412	Warm Springs	Meriwether	10/12/2004

United Home Care	7345 Red Oak Rd Bldg 25	Union City	Fulton	10/12/2004

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	16,078	165
Physical Therapy	10,017	175
Home Health Aide	1,791	65
Occupational Therapy	4,667	175
Medical Social Services	460	165
Speech Pathology	1,005	175
	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.

279

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).

1359

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	7
Black/African American	914
Hispanic/Latino	9
Pacific Islander/Hawaiian	0
White	782
Multi-Racial	2

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	630
Female	1,088

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	975	22,522	3,831,719	3,591,872
Medicaid	28	202	31,585	9,091
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	358	6,233	1,122,482	1,084,498
Other Third Party Insurers	337	4,977	738,563	574,936
Self Pay	0	0	0	0
Other Non Government	20	84	13,570	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.

10/24/2004

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.

Rita Southworth- Vice President of Home 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	5,737,919
Medicare Contractual Adjustments	51,746
Medicaid & Peachcare Contractual Adjustments	22,494
Other Contractual Adjustments	201,611
Total Contractual Adjustments	**275,851**
Bad Debt	188,101
Indigent Care Gross Charges	13,570
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**13,570**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**5,260,397**
Adjusted Gross Patient Revenue	**5,475,578**
Other Revenue	0
Total Net Revenue	**5,260,397**
Total Expenses	0
Adjusted Gross Revenue	**5,475,578**
Total Uncompensated I/C Care	**13,570**
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 reproted in Part E, Question 4 above.

20

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)	547
Physicians	403
Other Home Health Agencies	1
All Other Healthcare Providers	767

7. Referral Hospitals

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

Hospital Name	Patients Referred
Henry Hospital	135
Northside Hospital	6
South Reginal Hospital	116
Athens Regional Medical Center	1
VA Hospital	40
Columbus Regional Medical Center	1
Community Mission Hospital	1
Crawford Long Hospital	1
Dekalb Medical Center	9
Fayette Community Hospital	1
Grady Memorial Hospital	2
Gwinnett Medical Center	1
Houstonm Medical Center	1
Hughston Sports Hospital	1
Medical Center of Central Georgia Downtown	1
Piedmont Hospital of Atlanta	46
Piedmont Hospital of Fayette	36
Piedmont Hospital of Newnan	8
Regency Hospital	1
Rockdale Medical Center	1
Southern Regional Hospital	113
South Fulton Medical	1
Southwest Hospital	2
Southside Medical Center	2
Spalding Regional Hospital	10
St Mary Hospital	1

Sylvan Grove Hospital	15
Upson Regional	5
Warm Springs Medical Center	6
Wellstar Health Systems	7
West Georgia Medical Center	2
Emory Hospital	32
Hospital	1
Atlanta Medical Center	27
Total	**633**

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)	7	2	0
Licensed Practical Nurses (LPNs)	3	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	0	1	11

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	1-3 months
Licensed Practical Nurse	1-3 months
Aide/Assistant	1 month
Allied Health/Therapists	6-8 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	138	0
February	125	0
March	176	0
April	172	0
May	164	0
June	126	0
July	144	0
August	148	0
September	168	0
October	186	0
November	173	0
December	143	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
Carroll	6	47	841	23	0	0	11	19	17	47
Coweta	15	79	2,471	36	1	0	26	32	21	79
Fayette	21	76	1,312	39	0	0	23	26	27	76
Fulton	74	447	8,636	250	2	0	100	204	143	447
Henry	66	400	8,347	221	6	0	111	177	112	400
Meriwether	3	63	887	31	1	0	27	20	16	63
Pike	0	13	236	7	0	0	1	6	6	13
Spalding	13	100	1,689	51	0	0	33	42	25	100
Troup	3	18	419	11	0	0	5	7	6	18

Upson	3	37	793	21	0	0	13	17	7	37
Clayton	75	438	8,504	236	10	0	135	191	112	438
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**485**	**741**	**492**	**1,718**

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
Carroll	135,734	129,528	0
Coweta	384,545	366,963	1,155
Fayette	232,634	221,998	0
Fulton	1,491,638	1,423,441	1,040
Henry	1,492,297	1,424,068	4,370
Meriwether	192,181	183,394	875
Pike	52,157	49,772	0
Spalding	314,335	299,963	0
Troup	21,460	20,479	0
Upson	44,112	42,095	0
Clayton	1,376,826	1,313,877	6,130
Total	**5,737,919**	**5,475,578**	**13,570**

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: Rita Southworth

Date: 05/15/2015

Title: Vice President of Home Care

Comments: