



## 2014 Home Health Survey

### Part A : General Information

#### 1. Identification

UID:HHA113

**Facility Name:** Georgia Home Health

**County:** Harris

**Street Address:** 1031 20th Street

**City:** Columbus

**Zip:** 31901

**Mailing Address:** P.O. 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.

065956260A

#### **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.

11-7318

#### 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
Georgia HomeCare of Harris, LLC	For Profit	02/01/2007

#### 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.
Georgia HomeCare	325 Greenville St., Suite A	Lagrange	Troup	01/17/2011

## 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	8,256	175
Physical Therapy	4,306	200
Home Health Aide	443	110
Occupational Therapy	2,434	200
Medical Social Services	87	200
Speech Pathology	24	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.

81

### 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).

704

### 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	64
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	96
Multi-Racial	524

### 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	229
Female	455

### 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	448	10,609	1,659,508	1,621,291
Medicaid	13	115	17,989	17,575
Other Government Payers	9	114	17,832	17,422
Managed Care (HMO/PPO)	166	3,722	582,212	568,804
Other Third Party Insurers	46	953	149,073	145,640
Self Pay	1	35	5,475	5,349
Other Non Government	1	2	312	305

## 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.

11/01/2013

### 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.

Delli Dorne - Administrator/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	2,432,401
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	17,270
<b>Total Contractual Adjustments</b>	<b>17,270</b>
Bad Debt	37,700
Indigent Care Gross Charges	1,045
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>1,045</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>2,376,386</b>
<b>Adjusted Gross Patient Revenue</b>	<b>2,394,701</b>
Other Revenue	18
<b>Total Net Revenue</b>	<b>2,376,404</b>
Total Expenses	2,029,990
<b>Adjusted Gross Revenue</b>	<b>2,394,719</b>
<b>Total Uncompensated I/C Care</b>	<b>1,045</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>0.04%</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.

1

### **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

<b>Point of Origin</b>	<b>Number of Patients Referred</b>
Hospitals (via discharge planner)	187
Physicians	266
Other Home Health Agencies	8
All Other Healthcare Providers	83

### **7. Referral Hospitals**

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

<b>Hospital Name</b>	<b>Patients Referred</b>
Atlanta Medical Center	1
Carecentrix Tampa	1
Columbus Regional Health	1
Columbus Specialty	1
Doctors Hospital	2
East Alabama Medical Center	4
Emory Crawford Long Hospital	1
Emory Hospital	2
Emory University	1
Emory University Hospital	3
Hughston Orthopedic	1
Hughston Orthopedic Hospital	6
Jack Hughston Memorial Hospital	3
Lanier Health Services	1
Lanier Memorial Hospital	1
Martin Army Hospital	2
Medical Center	21
Midtown Medical Center	10
Patel Paresh	1
Piedmont Atlanta Hospital	2
Piedmont Newnan Hospital	1
Regional Rehab Hospital	13
Southern Orthopaedic Trauma	3
St Francis Hospital	38
St Francis Hospital - Columbus	4
The Medical Center - Columbus	1

Warm Springs Medical Center	1
West Georgia Health Medical CTR	1
West Georgia Health System	60
<b>Total</b>	<b>187</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)	6	0	0
Licensed Practical Nurses (LPNs)	5	0	0
Aides/Assistants	0	0	0
Allied Health/Therapists	3	0	7



## 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	no vacancies in past 6 months
Licensed Practical Nurse	1 month
Aide/Assistant	no vacancies in past 6 months
Allied Health/Therapists	no vacancies in past 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	31	11
February	19	14
March	34	11
April	35	6
May	32	17
June	32	12
July	34	17
August	34	27
September	39	7
October	44	2
November	43	2
December	36	5

### 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
Harris	7	24	558	16	0	0	4	15	10	29
Muscogee	62	232	7,280	135	0	0	65	109	130	304
Troup	76	288	7,712	192	0	0	63	168	120	351
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>132</b>	<b>292</b>	<b>260</b>	<b>684</b>

### 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
Harris	87,285	85,931	38
Muscogee	1,138,770	1,121,112	489
Troup	1,206,346	1,187,658	518
<b>Total</b>	<b>2,432,401</b>	<b>2,394,701</b>	<b>1,045</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:** 03/06/2015

**Title:** President

**Comments:**