GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA143

Facility Name: Camellia Home Health

County: Cobb

Street Address: Suite 102 1705 Enterprise Way

City: Marietta

Zip: 30067

Mailing Address: 135 Mayfair Road

Mailing City: Hattiesburg

Mailing Zip: 39402

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.
113093084A

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.
11-7149

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: Angie Reynolds

Contact Title: Director of Reimbursement

Phone: 601-544-2903

Fax: 601-582-9553

E-mail: angie@camellia.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

B. Owner's Parent Organization

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

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Camellia of Georgia, LLC	For Profit	02/01/2011

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Medical Systems, Inc.	For Profit	12/15/2006

F. Management's Parent Organization

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

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.
Camellia Home Health	888 Legacy Park Drive, Suite 101	Lawrenceville	Gwinnett	12/14/2007

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	7,875	160
Physical Therapy	8,928	175
Home Health Aide	1,551	75
Occupational Therapy	3,045	175
Medical Social Services	410	200
Speech Pathology	384	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.

160

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).

991

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	63
Black/African American	243
Hispanic/Latino	12
Pacific Islander/Hawaiian	4
White	636
Multi-Racial	19

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	354
Female	626

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	706	16,687	2,760,746	2,676,507
Medicaid	23	409	96,800	93,847
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	115	3,144	0	0
Other Third Party Insurers	119	1,874	948,643	919,698
Self Pay	1	5	73,568	71,323
Other Non Government	18	74	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.

06/01/2006

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.

Wilford A. Payne, III

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	3,879,757
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	95,567
Indigent Care Gross Charges	22,815
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**22,815**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**3,761,375**
Adjusted Gross Patient Revenue	**3,784,190**
Other Revenue	0
Total Net Revenue	**3,761,375**
Total Expenses	0
Adjusted Gross Revenue	**3,784,190**
Total Uncompensated I/C Care	**22,815**
Percent Uncompensated Indigent/Charity Care	**0.60%**

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.

19

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)	322
Physicians	367
Other Home Health Agencies	0
All Other Healthcare Providers	291

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	2
Atlanta VA Medical Center	60
Dekalb Medical Center - Hillandale	14
Dekalb Medical Center - Main Campus	8
Dekalb Medical Center - Wound Center	10
Eastside Medical Center, LLC	2
Eastside Medical Center, - Atlanta	2
Emory Adventist Hospital	3
Emory Eastside Heritage Center	1
Emory Healthcare Wesley Woods Rehab	2
Emory Johns Creek Hospital	2
Emory Medical Center	1
Emory University DBA Emory Crawford Long Hospital	1
Emory University Hospital	2
Grady Hospital	1
Gwinnett Medical Center	19
Kennestone Hospital	1
Northside Hospital	2
Northside Hospital - Canton	2
Northside Hospital - Forsyth	1
Piedmont Atlanta Hospital	4
Piedmont Fayette Hospital	1
Piedmont Fayette Wound Center	1
Peidmont Henry Hospital	1
Saint Joseph Hospital of Atlanta Inc	2
Shepherd Center	2

Sweetwater Springs	6
Tanner Medical Center - Carrollton	2
Wellstar Cobb Hospital	78
Wellstar Cobb Hospital Inpatient Rehab	15
Wellstar Douglas Hospital	9
Wellstar Medical Group Kennestone Inpatient Rehab	33
Wellstar Medical Group Kennestone Wound Clinic	1
Wellstar Medical Group Windy Hill Hospital	1
Wellstar Medical Group Kennestone Hospital	29
Wellstar Paulding Hospital	1
Total	**322**

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	1	0
Licensed Practical Nurses (LPNs)	4	0	0
Aides/Assistants	1	1	0
Allied Health/Therapists	6	1	1

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	4 weeks
Licensed Practical Nurse	2 weeks
Aide/Assistant	1 week
Allied Health/Therapists	2 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	63	3
February	68	5
March	86	7
April	87	9
May	67	10
June	67	6
July	63	10
August	60	11
September	52	10
October	94	20
November	65	8
December	61	15

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
Cobb	82	404	8,725	195	13	0	84	167	188	439
Cherokee	11	73	1,257	46	3	0	9	44	23	76
DeKalb	20	145	3,893	69	1	0	39	56	51	146
Douglas	14	97	1,604	53	2	0	30	43	28	101
Fayette	4	5	101	1	0	0	1	1	6	8
Gwinnett	25	223	6,613	73	0	0	34	63	113	210
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**197**	**374**	**409**	**980**

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
Cobb	1,531,866	1,494,133	15,610
Cherokee	221,542	216,085	3,602
DeKalb	681,640	664,850	1,201
Douglas	278,490	271,630	2,402
Fayette	17,536	17,104	0
Gwinnett	1,148,683	1,120,388	0
Total	**3,879,757**	**3,784,190**	**22,815**

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: Wilford A. Payne, III

Date: 03/06/2015

Title: President / CEO

Comments:

For next year could you please send the letter requesting the survey to our mailing address that is listed on the survey. 135 Mayfair Road, Hattiesburg, MS 39402. Thank you.