GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA149

Facility Name: Caresouth Homecare Professionals - Macon

County: Bibb

Street Address: 5233 Riverside Drive, Suite C

City: Macon

Zip: 31210

Mailing Address: 5233 Riverside Drive, Suite C

Mailing City: Macon

Mailing Zip: 31210

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.
979465743A

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.
117152

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: Jessica Holshouser

Contact Title: Statistical Reporting Supervisor

Phone: 706-854-7583

Fax: 706-228-6825

E-mail: jholshouser@caresouth.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
CareSouth HHA Holdings of Middle Georgia, Inc.	For Profit	03/25/2009

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth HHA Holdings of Georgia, Inc.	For Profit	03/25/2009

C. Agency Operator

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

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
CareSouth Home Health Services, Inc.	For Profit	03/25/2009

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/25/2009

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.
Warner Robins	1532 Watson Blvd	Warner Robins	Houston	03/25/2009

Milledgeville	345 N Cobb St	Milledgeville	Baldwin	01/01/2011

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	23,340	170
Physical Therapy	23,066	180
Home Health Aide	1,995	100
Occupational Therapy	8,483	180
Medical Social Services	372	195
Speech Pathology	1,051	180
	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.

488

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).

2364

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	11
Black/African American	858
Hispanic/Latino	18
Pacific Islander/Hawaiian	5
White	1,715
Multi-Racial	616

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	1,194
Female	2,030

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	1,935	36,626	6,492,589	6,492,589
Medicaid	162	2,744	263,956	89,067
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	1,062	18,478	3,334,703	3,145,250
Self Pay	0	0	0	0
Other Non Government	65	459	99,704	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.

01/01/2006

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.

Paula Layfield, RN - Director of Operations

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	10,190,952
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	172,126
Other Contractual Adjustments	186,285
Total Contractual Adjustments	**358,411**
Bad Debt	5,931
Indigent Care Gross Charges	99,704
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**99,704**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**9,726,906**
Adjusted Gross Patient Revenue	**10,012,895**
Other Revenue	329
Total Net Revenue	**9,727,235**
Total Expenses	7,299,167
Adjusted Gross Revenue	**10,013,224**
Total Uncompensated I/C Care	**99,704**
Percent Uncompensated Indigent/Charity Care	**1.00%**

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 reproted in Part E, Question 4 above.

65

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)	1,749
Physicians	1,052
Other Home Health Agencies	9
All Other Healthcare Providers	414

7. Referral Hospitals

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

Hospital Name	Patients Referred
Archbold Medical Center	1
Athens Regional Medical Center	1
Charlie Norwood VAMC - Augusta	2
Coliseum Medical Center	352
CRH Medical Center	10
Doctors Hospital Augusta	2
Emory Hospital	14
Gulf Coast Medical Center	1
Houston Healthcare	1,021
Jack Hughston Memorial Hospital	12
Jasper Memorial Hospital	2
Medical Center of Central Georgia	147
Medical Center of Peach County	10
Georgia Regents Medical Center	5
Monroe County Hospital	3
Northside Hospital - Forsyth	1
Oconee Regional Medical Center	107
Palm Bay Community Hospital	1
Peach Regional Medical Cneter	2
Phoebe Putney Memorial Hospital	1
Piedmont Hospital	5
Regency Hospital - Macon	35
St Joseph's Hospital - Atlanta	2
St Mary's Hospital - Athens	3
Shepherd Center	1
Tallahassee Memorial Hospital	1

Tift Regional Medical Center	1
Upson Regional Medical Center	2
Washington County Regional Medical Center	2
Wellstar Douglas Hospital	1
Wellstar Cobb Hospital	1
Total	**1,749**

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)	20	0	0
Licensed Practical Nurses (LPNs)	13	0	0
Aides/Assistants	10	2	0
Allied Health/Therapists	17	2	0

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	30 days
Licensed Practical Nurse	30 days
Aide/Assistant	120 days
Allied Health/Therapists	120 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	276	0
February	248	4
March	259	11
April	273	17
May	247	22
June	249	33
July	242	45
August	250	44
September	252	44
October	247	63
November	233	55
December	234	73

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
Baldwin	36	389	7,063	171	5	0	100	144	102	346
Bibb	87	912	15,837	394	9	0	208	323	345	876
Crawford	7	43	699	21	1	0	12	17	13	42
Houston	162	1,513	25,092	703	35	0	391	579	443	1,413
Jones	10	85	1,331	47	1	0	24	40	24	88
Monroe	13	105	2,007	62	3	0	30	49	31	110
Peach	30	338	5,792	146	10	0	96	121	97	314
Pulaski	5	36	486	21	1	0	12	19	4	35
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**873**	**1,292**	**1,059**	**3,224**

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
Baldwin	1,093,694	1,074,585	7,670
Bibb	2,769,006	2,720,625	13,805
Crawford	132,761	130,441	1,534
Houston	4,466,444	4,388,406	53,687
Jones	278,165	273,305	1,534
Monroe	347,706	341,631	4,602
Peach	992,543	975,201	15,339
Pulaski	110,633	108,701	1,533
Total	**10,190,952**	**10,012,895**	**99,704**

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: Paula Layfield

Date: 02/22/2023

Title: Director of Operations

Comments: