GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA017

Facility Name: Central Georgia Home Health- Macon

County: Bibb

Street Address: 3780 Eisenhower Parkway Suite 4

City: Macon

Zip: 31206

Mailing Address: 3780 Eisenhower Parkway Suite 4

Mailing City: Macon

Mailing Zip: 31206

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.
00697232A

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.
117023

2. Report Period

Report Data for the full twelve month period, January 1,2015 - December 31, 2015 (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: Denise Cauley

Contact Title: Director

Phone: 478-633-5604

Fax: 478-633-4318

E-mail: cauley.denise@navicenthealth.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
Medical Center of Central Georgia, Inc dba The Medical Center Navicent Health	Not for Profit	11/01/1995

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Navicent Health	Not for Profit	02/14/1995

C. Agency Operator

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

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

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.

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	32,734	200
Physical Therapy	18,757	200
Home Health Aide	4,735	85
Occupational Therapy	4,767	200
Medical Social Services	770	200
Speech Pathology	1,210	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 31,2015.

343

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).

3245

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	5
Black/African American	1,564
Hispanic/Latino	24
Pacific Islander/Hawaiian	0
White	1,999
Multi-Racial	1

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	1,519
Female	2,078

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	921	32,072	7,982,305	7,626,928
Medicaid	132	3,270	713,887	238,577
Other Government Payers	13	663	54,545	18,293
Managed Care (HMO/PPO)	475	14,592	1,200,484	402,604
Other Third Party Insurers	520	9,570	787,324	264,043
Self Pay	1	118	28,827	0
Other Non Government	174	2,332	460,258	154,355

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 2015. ☑

If you indicated yes above, please indicate the effective date of the policy or policies.

01/23/2007

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.

Denise Cauley, Director

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 2015 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	11,227,630
Medicare Contractual Adjustments	229,345
Medicaid & Peachcare Contractual Adjustments	475,310
Other Contractual Adjustments	1,386,648
Total Contractual Adjustments	**2,091,303**
Bad Debt	15,104
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	416,423
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**416,423**
Other Free Care	0
Total Net Patient Revenue	**8,704,800**
Adjusted Gross Patient Revenue	**10,507,871**
Other Revenue	234
Total Net Revenue	**8,705,034**
Total Expenses	0
Adjusted Gross Revenue	**10,508,105**
Total Uncompensated I/C Care	**416,423**
Percent Uncompensated Indigent/Charity Care	**3.96%**

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.

216

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)	3,070
Physicians	469
Other Home Health Agencies	11
All Other Healthcare Providers	243

7. Referral Hospitals

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

Hospital Name	Patients Referred
Athen Regional Medical Center	3
Emory Crawford Long/Midtown	1
Emory Saint Josephs Hospital	2
Perry Hospital	11
Dodge County Hospital	2
Kenneston Hospital	1
Sylvan Grove Hospital	1
Gwinnett Medical Center	1
Northside Medical	6
Atlanta VA Med Center	1
Bleckley County Hospital	1
Monroe County	1
VA Augusta	3
Coliseum Rehab Hospital	10
Emory Hospital	8
Grady Memorial	1
Houston Medical Center	56
Jack Hughston	4
Medical Center Peach co.	31
Macon Northside	35
Oconee Regional	3
Piedmont Fayette Hospital	5
Regency Hospital	434
Carl Vinson VA	5
Fairview Park	16
Coliseum Med Center	83

Rehab Hospital Navicent Health	436
Medical Center Navicent Health	1,898
Putnam General Hospital	1
Roosevelt Rehab Hospital	2
Spalding Regional Hospital	1
Warm Springs Rehab Hospital	1
Emory Rehab Hospital	1
St Josephs Hospital	3
Piedmont Henry Hospital	1
UPMC Shadyside Hospital	1
Total	**3,070**

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 12-31-2015.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	41	1	0
Licensed Practical Nurses (LPNs)	4	0	0
Aides/Assistants	4	0	0
Allied Health/Therapists	25	0	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	6 months
Licensed Practical Nurse	no vacancies
Aide/Assistant	no vacancies
Allied Health/Therapists	no vacancies

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	199	146
February	169	122
March	186	111
April	179	129
May	197	125
June	161	129
July	188	112
August	195	124
September	203	118
October	191	115
November	188	119
December	179	119

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2015. 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
Bibb	174	1,886	32,072	791	73	0	702	610	502	1,814
Bleckley	5	50	840	21	0	0	35	13	8	56
Butts	2	16	280	8	1	0	12	6	1	19
Crawford	10	108	1,838	47	2	0	34	41	25	100
Houston	49	531	9,033	238	17	0	199	183	108	490
Jones	17	181	3,081	93	5	0	57	80	45	182
Lamar	3	31	525	15	1	0	44	29	1	74
Peach	20	215	3,659	109	6	0	63	105	42	210
Twiggs	12	126	2,136	57	6	0	40	48	24	112

Wilkinson	8	82	1,401	39	2	0	33	43	18	94
Laurens	13	142	2,416	52	5	0	50	55	16	121
Monroe	18	190	3,239	84	6	0	57	61	68	186
Baldwin	11	135	1,813	62	3	0	60	46	33	139
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**1,386**	**1,320**	**891**	**3,597**

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
Bibb	5,724,631	5,216,612	212,322
Bleckley	149,776	144,020	5,555
Butts	49,963	48,043	1,853
Crawford	327,735	315,138	12,155
Houston	1,610,604	1,548,467	59,736
Jones	549,368	528,253	20,376
Lamar	93,638	90,039	3,473
Peach	652,325	627,254	24,194
Twiggs	380,841	366,204	14,125
Wilkinson	249,702	240,105	9,261
Laurens	430,806	414,246	15,978
Monroe	577,437	555,244	21,417
Baldwin	430,804	414,246	15,978
Total	**11,227,630**	**10,507,871**	**416,423**

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: Denise Cauley

Date: 03/03/2016

Title: Director

Comments: