Georgia Department of Community Health

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA028

Facility Name: Floyd HomeCare, LLC d/b/a Floyd HomeCare

County: Floyd

Street Address: 508 Riverside Pkwy NE, Suite 300

City: Rome

Zip: 30161-2985

Mailing Address: PO 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.
000041302A

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.
11-7010

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: Rachel Brown

Contact Title: Licensure & Regulatory Paralegal

Phone: 337-233-1307

Fax: 337-233-5764

E-mail: LRA@LHCGROUP.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
Floyd HomeCare, LLC	For Profit	01/01/2007

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.
Floyd HomeCare of Cedartown	117 John Phillips Road	Cedartown	Polk	09/17/2007

Floyd HomeCare of Summerville	10891 Commerce St, Suite A	Summerville	Chattooga	10/10/2007
Floyd HomeCare of Cartersville	775 West Ave, Suite B	Cartersville	Bartow	03/05/2008

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	30,211	175
Physical Therapy	17,426	200
Home Health Aide	1,514	110
Occupational Therapy	8,043	200
Medical Social Services	1,634	200
Speech Pathology	1,542	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.

628

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).

2400

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	1
Black/African American	284
Hispanic/Latino	18
Pacific Islander/Hawaiian	1
White	1,904
Multi-Racial	239

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	949
Female	1,499

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	1,536	39,769	5,957,154	5,826,436
Medicaid	134	2,214	331,644	324,366
Other Government Payers	16	262	39,246	38,385
Managed Care (HMO/PPO)	742	17,960	2,690,299	2,631,265
Other Third Party Insurers	2	84	12,583	12,307
Self Pay	4	25	3,745	3,663
Other Non Government	14	56	8,388	8,204

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.

11/01/2014

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.

Kerrigan Lebeouf - 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 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	9,043,059
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	2,723
Total Contractual Adjustments	**2,723**
Bad Debt	176,685
Indigent Care Gross Charges	19,025
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**19,025**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**8,844,626**
Adjusted Gross Patient Revenue	**8,866,374**
Other Revenue	919
Total Net Revenue	**8,845,545**
Total Expenses	0
Adjusted Gross Revenue	**8,867,293**
Total Uncompensated I/C Care	**19,025**
Percent Uncompensated Indigent/Charity Care	**0.21%**

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.

18

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)	1,137
Physicians	957
Other Home Health Agencies	2
All Other Healthcare Providers	352

7. Referral Hospitals

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

Hospital Name	Patients Referred
Cartersville Medical Center	87
Cerner Medical Center	3
Atlanta Medical Center	6
Cancer Treatment Centers of America	2
East Alabama Medical Center	1
Emory Healthcare	16
Emory Johns Creek	1
Emory University Hospital Midtown	4
Erlanger Hospital	3
Floyd Behavioral Health Center	1
Floyd Medical Center	488
Floyd Memorial Hospital	1
Jack Hughston Memorial Hospital	1
Kennestone Wellstar Hospital	3
Kindred Hospital - Rome	16
Northside Hospital	1
Northside Hospital Cherokee	3
Parkridge Medical Center	1
Piedmont Hospital	9
Piedmont Mountainside Hospital	37
Polk Medical Center	109
Redmond Regional Medical Center	156
Saint Josephs Hospital	1
Shephard Center	4
Southeastern Regional Medical Center	1
Tanner Medical Center	7

Tanner Medical Center - Carrolton	10
VA Medical Center - Atlanta	24
Veterans Administration - Decatur	4
Wellstar Cobb Hospital	3
Wellstar Kennestone Hospital	6
Wellstar Paulding Hospital	10
Total	**1,019**

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)	26	4	1
Licensed Practical Nurses (LPNs)	19	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	24	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	2 months
Aide/Assistant	0
Allied Health/Therapists	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	173	25
February	112	22
March	148	29
April	143	31
May	130	31
June	151	30
July	168	43
August	150	36
September	150	48
October	183	36
November	133	47
December	120	44

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
Bartow	58	351	9,272	182	0	0	130	146	110	386
Chattooga	53	219	6,506	124	0	0	56	110	80	246
Floyd	189	886	26,715	453	0	0	235	383	378	996
Gordon	21	88	2,332	53	0	0	24	46	33	103
Haralson	19	131	3,328	74	0	0	33	61	49	143
Paulding	3	24	539	19	0	0	5	18	4	27
Pickens	7	77	1,211	35	0	0	26	27	29	82
Polk	76	407	10,467	236	0	0	135	189	141	465
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**644**	**980**	**824**	**2,448**

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
Bartow	1,388,890	1,361,754	2,921
Chattooga	974,559	955,518	2,050
Floyd	4,001,745	3,923,558	8,419
Gordon	349,319	342,494	735
Haralson	498,514	488,774	1,049
Paulding	80,739	79,161	170
Pickens	181,400	177,856	382
Polk	1,567,893	1,537,259	3,299
Total	**9,043,059**	**8,866,374**	**19,025**

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: Donald D. Stelly

Date: 02/29/2016

Title: President

Comments: