GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA051

Facility Name: Phoebe Home Care

County: Dougherty

Street Address: 804 14th Avenue

City: Albany

Zip: 31701

Mailing Address: 804 14th Avenue

Mailing City: Albany

Mailing Zip: 31701

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.
00723709

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.
117100

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: Lori Jenkins

Contact Title: Director, Strategy & Planning

Phone: 229-312-1432

Fax: 229-312-7100

E-mail: ljenkins@ppmh.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
Phobe Putney Memorial Hospital, Inc.	Not for Profit	09/01/1996

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	09/01/1996

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Memorial Hospital, Inc.	Not for Profit	09/01/1996

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	09/01/1996

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.
Americus	804 Oglethorpe Avenue	Americus	Sumter	09/01/1996

Cuthbert	91 East Dawson Street	Cuthbert	Randolph	09/01/1997

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	34,919	120
Physical Therapy	14,840	150
Home Health Aide	4,510	80
Occupational Therapy	3,822	150
Medical Social Services	0	180
Speech Pathology	405	150
	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.

360

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).

2716

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	5
Black/African American	1,562
Hispanic/Latino	3
Pacific Islander/Hawaiian	0
White	1,308
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	1,185
Female	1,694

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	1,959	42,995	5,980,454	5,713,351
Medicaid	285	5,222	625,103	317,364
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	428	6,825	875,457	685,485
Self Pay	207	3,454	637,686	26,455
Other Non Government	0	0	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 2015. ☑

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

01/01/2004

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.

Teddrick Brown, Director, Post Acute Care

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	8,118,700
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	258,183
Other Contractual Adjustments	171,012
Total Contractual Adjustments	**429,195**
Bad Debt	509,708
Indigent Care Gross Charges	373,638
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**373,638**
Charity Care Gross Charges	73,470
Charity Care Compensation	9,966
Uncompensated Charity Care (Net)	**63,504**
Other Free Care	0
Total Net Patient Revenue	**6,742,655**
Adjusted Gross Patient Revenue	**7,350,809**
Other Revenue	0
Total Net Revenue	**6,742,655**
Total Expenses	6,197,064
Adjusted Gross Revenue	**7,350,809**
Total Uncompensated I/C Care	**437,142**
Percent Uncompensated Indigent/Charity Care	**5.95%**

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.

176

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)	2,180
Physicians	684
Other Home Health Agencies	0
All Other Healthcare Providers	15

7. Referral Hospitals

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

Hospital Name	Patients Referred
Fairview Park Hospital	1
Regency Hospital of South Atlanta	1
SE AL Medical Center	2
Archibold Memorial Hospital	2
Children's Healthcare of Atlanta	3
Coliseum Medical Center	2
Colquitt Regional Medical Center	1
Columbus Regional Medical Center	29
Columbus Specialty Hospital, Inc.	4
Crisp Regional Hospital	4
Doctor's Hospital of Augusta	1
Emory University Hospital	17
Houston Medical Center	1
Hughston Sports Hospital	5
Jack Hughston Memorial Hospital	30
Medical Center of Central GA	3
Miller County Hospital	1
Northside Hospital	1
Phoebe Worth	101
Piedmont Medical Center	6
Phoebe Putney Memorial Hospital	1,811
Select Specialy Hospital	1
St Francis Hospital	18
Phoebe Sumter Medical Center	77
Southwest GA Regional Medical Center	38
Tift Regional Medical Center	14

VA Medical Center	5
Dekalb Medical Center	1
Total	**2,180**

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)	35	1	0
Licensed Practical Nurses (LPNs)	5	1	0
Aides/Assistants	5	1	0
Allied Health/Therapists	13	1	2

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	90-120 Days
Licensed Practical Nurse	60-90 Days
Aide/Assistant	60-90 Days
Allied Health/Therapists	90-120 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	291	0
February	247	0
March	284	12
April	243	27
May	205	33
June	197	40
July	231	60
August	183	45
September	177	54
October	200	32
November	182	38
December	206	46

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
Baker	1	28	540	15	3	0	10	10	5	25
Calhoun	7	74	1,427	31	1	0	29	24	14	67
Clay	5	13	239	4	1	0	10	3	4	17
Colquitt	2	15	289	8	0	0	6	7	3	16
Crisp	2	26	501	12	2	0	15	8	3	26
Dougherty	194	1,669	32,189	748	86	4	648	545	389	1,586
Early	1	13	263	5	0	0	4	4	3	11
Lee	21	346	6,673	154	17	5	136	120	59	320
Miller	1	9	174	8	1	0	5	5	0	10

Mitchell	0	10	189	4	4	0	7	3	0	10
Quitman	0	10	198	4	0	0	5	3	2	10
Randolph	15	154	2,970	58	9	1	49	44	44	138
Sumter	29	204	3,934	80	26	5	111	49	42	207
Terrell	20	201	3,876	87	9	1	72	67	51	191
Worth	19	261	5,034	132	17	2	97	96	50	245
Total by Age	**0**	**0**	**0**	**0**	**0**	**18**	**1,204**	**988**	**669**	**2,879**

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
Baker	53,176	48,146	2,863
Calhoun	173,182	156,802	9,325
Clay	67,356	60,985	3,627
Colquitt	31,512	28,531	1,697
Crisp	51,338	46,482	2,764
Dougherty	4,570,888	4,138,561	246,113
Early	21,402	19,377	1,152
Lee	765,207	692,831	41,202
Miller	61,710	55,873	3,324
Mitchell	15,756	14,266	848
Quitman	13,392	12,126	721
Randolph	450,878	408,233	24,277
Sumter	609,487	551,840	32,817
Terrell	647,038	585,839	34,839
Worth	586,378	530,917	31,573
Total	**8,118,700**	**7,350,809**	**437,142**

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: Joel Wernick

Date: 03/23/2016

Title: CEO

Comments: