GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# 2015 Home Health Survey

## Part A : General Information

### 1. Identification

**UID:HHA085**

**Facility Name:** Appalachian Home Health Care

**County:** Union

**Street Address:** 129 Gowder Drive

**City:** Blairsville

**Zip:** 30512

**Mailing Address:** 129 Gowder Drive

**Mailing City:** Blairsville

**Mailing Zip:** 30512

**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.
NA

**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.
11-7095

### 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:** Bobbie Hoodenpyle

**Contact Title:** Administrator

**Phone:** 706-745-5101

**Fax:** 706-745-5139

**E-mail:** bhoodenpyle2000@yahoo.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 |
|---|---|---|
| Appalachian Home Health Care Inc | For Profit | |

**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 |
|---|---|---|
| | For Profit | |

**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 | 4,722 | 200 |
| Physical Therapy | 3,770 | 250 |
| Home Health Aide | 3,414 | 120 |
| Occupational Therapy | 1,892 | 250 |
| Medical Social Services | 0 | 0 |
| Speech Pathology | 63 | 250 |
| | 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.

68

### 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).

441

### 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 | 0 |
| Black/African American | 0 |
| Hispanic/Latino | 1 |
| Pacific Islander/Hawaiian | 0 |
| White | 370 |
| Multi-Racial | 0 |

### 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 | 139 |
| Female | 232 |

### 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 | 371 | 13,861 | 1,518,218 | 1,483,954 |
| Medicaid | 0 | 0 | 0 | 0 |
| Other Government Payers | 0 | 0 | 0 | 0 |
| Managed Care (HMO/PPO) | 0 | 0 | 0 | 0 |
| Other Third Party Insurers | 0 | 0 | 0 | 0 |
| Self Pay | 0 | 0 | 0 | 0 |
| 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.

12/05/2013

**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.

Bobbie Hoodenpyle

**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 | 1,518,218 |
| Medicare Contractual Adjustments | 34,264 |
| Medicaid & Peachcare Contractual Adjustments | 0 |
| Other Contractual Adjustments | 0 |
| **Total Contractual Adjustments** | **34,264** |
| Bad Debt | 0 |
| Indigent Care Gross Charges | 0 |
| Indigent Care Compensation | 0 |
| **Uncompensated Indigent Care (Net)** | **0** |
| Charity Care Gross Charges | 0 |
| Charity Care Compensation | 0 |
| **Uncompensated Charity Care (Net)** | **0** |
| Other Free Care | 0 |
| **Total Net Patient Revenue** | **1,483,954** |
| **Adjusted Gross Patient Revenue** | **1,483,954** |
| Other Revenue | 0 |
| **Total Net Revenue** | **1,483,954** |
| Total Expenses | 0 |
| **Adjusted Gross Revenue** | **1,483,954** |
| **Total Uncompensated I/C Care** | **0** |
| **Percent Uncompensated Indigent/Charity Care** | **0.00%** |

**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.

0

## 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) | 0 |
| Physicians | 344 |
| Other Home Health Agencies | 0 |
| All Other Healthcare Providers | 0 |

## 7. Referral Hospitals

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

| Hospital Name | Patients Referred |
|---|---|
| | 0 |
| **Total** | **0** |

## 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) | 0 | 0 | 0 |
| Licensed Practical Nurses (LPNs) | 0 | 0 | 0 |
| Aides/Assistants | 0 | 0 | 0 |
| Allied Health/Therapists | 0 | 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 | 0 |
| Licensed Practical Nurse | 0 |
| Aide/Assistant | 0 |
| Allied Health/Therapists | 0 |

# 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 | 46 | 0 |
| February | 24 | 1 |
| March | 26 | 4 |
| April | 33 | 4 |
| May | 27 | 3 |
| June | 35 | 5 |
| July | 31 | 6 |
| August | 22 | 5 |
| September | 22 | 7 |
| October | 25 | 3 |
| November | 25 | 7 |
| December | 28 | 4 |

## 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 |
|---|---|---|---|---|---|---|---|---|---|---|
| Union | 68 | 344 | 13,861 | 0 | 0 | 0 | 17 | 146 | 208 | 371 |
| **Total by Age** | **0** | **0** | **0** | **0** | **0** | **0** | **17** | **146** | **208** | **371** |

## 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 |
|---|---|---|---|
| Union | 1,518,218 | 1,483,954 | 0 |

| | | | |
|---|---|---|---|
| **Total** | **1,518,218** | **1,483,954** | **0** |

## 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:** Bobbie Hoodenpyle

**Date:** 09/08/2016

**Title:** Administrator

**Comments:**

We do not have any medicaid patients.