GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA100

Facility Name: Pruitthealth Home Health - Atlanta

County: Gwinnett

Street Address: 1626 Jeurgens Court

City: Norcross

Zip: 30093

Mailing Address: 1626 Jeurgens Court

Mailing City: Norcross

Mailing Zip: 30093

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.
008479274A

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.
117118

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: Preston Rylee

Contact Title: Executive Director of Finance Health Services

Phone: 770-806-6879

Fax: 770-806-6869

E-mail: prrylee@pruitthealth.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
PruittHealth Home Health, Inc.	For Profit	06/24/1999

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Health Services of Georgia, Inc.	For Profit	06/24/1999

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
PruittHealth Home Health, Inc.	For Profit	06/24/1999

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Health Services of Georgia, Inc.	For Profit	06/24/1999

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
PruittHealth, Inc.	For Profit	06/24/1999

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
United Health Services, Inc.	For Profit	06/24/1999

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.
United Home Care of Winder	349 Resource Pkwy	Winder	Barrow	08/01/2008

United Home Care of Monroe	500 Great Oaks Drive	Monroe	Walton	02/01/2002

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	26,403	165
Physical Therapy	19,757	175
Home Health Aide	2,918	65
Occupational Therapy	7,639	175
Medical Social Services	910	165
Speech Pathology	590	175
	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.

412

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).

128

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	6
Asian	22
Black/African American	861
Hispanic/Latino	14
Pacific Islander/Hawaiian	0
White	1,862
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	1,038
Female	1,727

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	1,318	32,917	6,047,172	5,705,426
Medicaid	88	1,222	173,266	67,899
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	342	7,041	1,396,417	1,293,735
Other Third Party Insurers	946	16,398	2,478,571	2,044,170
Self Pay	0	0	0	0
Other Non Government	71	639	107,685	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.

08/01/1999

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.

Mickey Thomas- Senior Vice President of Home Health

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	10,203,111
Medicare Contractual Adjustments	190,877
Medicaid & Peachcare Contractual Adjustments	105,367
Other Contractual Adjustments	537,083
Total Contractual Adjustments	**833,327**
Bad Debt	150,869
Indigent Care Gross Charges	107,685
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**107,685**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**9,111,230**
Adjusted Gross Patient Revenue	**9,755,998**
Other Revenue	0
Total Net Revenue	**9,111,230**
Total Expenses	0
Adjusted Gross Revenue	**9,755,998**
Total Uncompensated I/C Care	**107,685**
Percent Uncompensated Indigent/Charity Care	**1.10%**

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.

71

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)	1,324
Physicians	592
Other Home Health Agencies	1
All Other Healthcare Providers	848

7. Referral Hospitals

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

Hospital Name	Patients Referred
BJC Medical	1
Grady Memorial	2
North Georgia Med	2
Walton Regional Med	2
Athens Regional Medical Center	71
Atlanta Medical Center	10
Barrow Regional Medical Center	79
Clearview Regional Medical Center	191
Dekalb Medical Medical	332
Eastside Medical Center	125
Emory Hospital	57
Gwinnett Medical Center	32
North Fulton Regional Hospital	12
Northside Hospital	97
VA Hospital	6
Piedmont Hospital	38
Rockdale Medical Center	37
St Mary's Hospital	62
Landmark, Hospital	9
Newton General Hospital	14
Northeast Georgia Medical Center	87
South Regional Hospital	1
Regency Med	1
Saint Josephs Hospital	47
Wellstar Health Systems	8
Georgia Medical Center	1

Total	**1,324**

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)	17	5	0
Licensed Practical Nurses (LPNs)	11	0	0
Aides/Assistants	4	0	0
Allied Health/Therapists	0	3	19

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	3 months
Licensed Practical Nurse	1 month
Aide/Assistant	1 month
Allied Health/Therapists	3 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	372	0
February	301	0
March	261	0
April	273	0
May	299	0
June	266	0
July	268	0
August	216	0
September	215	0
October	242	0
November	210	0
December	218	0

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
Barrow	77	401	11,696	218	5	0	104	179	118	401
Greene	3	15	443	9	1	0	5	6	4	15
Madison	15	60	1,873	32	2	0	10	28	22	60
Oconee	8	41	474	16	1	0	7	14	20	41
Oglethorpe	2	24	622	15	0	0	8	12	4	24
Rockdale	31	129	3,071	74	0	0	40	55	34	129
Jasper	1	9	167	4	0	0	3	4	2	9
Fulton	27	268	6,849	132	6	0	73	113	82	268
Franklin	0	17	279	8	0	0	7	7	3	17

Walton	64	477	13,571	214	8	0	118	173	186	477
Gwinnett	40	328	11,098	173	10	0	110	137	81	328
DeKalb	68	649	12,574	304	32	0	226	240	183	649
Jackson	54	215	6,549	103	5	0	50	85	80	215
Newton	22	132	3,256	72	1	0	51	56	25	132
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**812**	**1,109**	**844**	**2,765**

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
Barrow	1,779,782	1,701,790	9,145
Greene	76,207	72,868	1,775
Madison	331,936	317,390	4,620
Oconee	144,733	138,391	1,155
Oglethorpe	84,134	80,447	0
Rockdale	605,753	579,208	0
Jasper	20,944	20,026	0
Fulton	772,632	738,774	7,115
Franklin	54,393	52,009	2,225
Walton	1,886,422	1,803,757	14,630
Gwinnett	955,450	913,581	11,755
DeKalb	2,154,102	2,059,707	47,770
Jackson	826,082	789,882	6,505
Newton	510,541	488,168	990
Total	**10,203,111**	**9,755,998**	**107,685**

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: Preston Rylee

Date: 02/22/2016

Title: Executive Director of Finance Health Services

Comments: