GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA117

Facility Name: Amicita Home Health

County: Dougherty

Street Address: 507 North Jefferson Street

City: Albany

Zip: 31701

Mailing Address: 507 North Jefferson Street

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.
000812864C

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.
117147

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: Robin Leake, RN, MSN, MBA, MHA

Contact Title: President

Phone: 478-621-4841

Fax: 478-621-4843

E-mail: rleake@shs-ga.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
Steward Health Services	Not for Profit	03/01/2012

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Community Health Systems Inc. D/b/a Community Health	Not for Profit	03/01/2012

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Amicita Home Health, LLC	Not for Profit	03/01/2012

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Steward Health, LLC	Not for Profit	03/01/2012

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.

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	4,856	175
Physical Therapy	2,862	185
Home Health Aide	473	75
Occupational Therapy	1,621	185
Medical Social Services	44	150
Speech Pathology	179	185
	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.

69

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).

476

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	2
Black/African American	316
Hispanic/Latino	2
Pacific Islander/Hawaiian	0
White	170
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	181
Female	310

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	248	5,275	849,639	774,502
Medicaid	63	1,269	54,590	21,235
Other Government Payers	5	86	8,470	8,471
Managed Care (HMO/PPO)	137	2,913	396,161	327,280
Other Third Party Insurers	3	35	22,408	0
Self Pay	0	0	51,974	41,899
Other Non Government	35	457	54,913	35,842

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.

03/01/2012

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.

Joseph Marta- Administrator

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	1,438,155
Medicare Contractual Adjustments	22,325
Medicaid & Peachcare Contractual Adjustments	33,355
Other Contractual Adjustments	40,435
Total Contractual Adjustments	**96,115**
Bad Debt	110,403
Indigent Care Gross Charges	22,408
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**22,408**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**1,209,229**
Adjusted Gross Patient Revenue	**1,272,072**
Other Revenue	45,592
Total Net Revenue	**1,254,821**
Total Expenses	1,820,223
Adjusted Gross Revenue	**1,317,664**
Total Uncompensated I/C Care	**22,408**
Percent Uncompensated Indigent/Charity Care	**1.70%**

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.

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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)	238
Physicians	135
Other Home Health Agencies	0
All Other Healthcare Providers	102

7. Referral Hospitals

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

Hospital Name	Patients Referred
Archbold Hospital	4
Colquitt Regional Medical Center	1
Crisp Regional Hospital	1
Emory University Hospital	2
Georgia Regents University Augusta Medical Center	1
Houston Healthcare	1
Hughston Clinic	1
Lake City VAMC	1
Medical Center Navicent Health	1
Phoebe North	31
Phoebe Putney Memorial	167
Phoebe Worth Medical Center	7
Piedmont Hospital	1
Shands Hospital at the University of Florida	1
Southwest Georgia Regional Medical Center	16
Wellstar Kennestone Hospital	2
Total	**238**

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)	5	0	0
Licensed Practical Nurses (LPNs)	2	0	0
Aides/Assistants	1	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	30 days
Licensed Practical Nurse	30 days
Aide/Assistant	15 days
Allied Health/Therapists	45days

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	33	5
February	23	3
March	29	6
April	33	3
May	30	4
June	25	4
July	35	6
August	44	4
September	41	8
October	49	6
November	30	11
December	35	5

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
Colquitt	2	8	137	2	0	0	4	1	5	10
Thomas	0	9	148	4	0	0	3	4	2	9
Baker	2	4	212	3	0	0	3	1	2	6
Calhoun	3	11	302	7	1	0	5	4	4	13
Clay	0	0	0	0	0	0	0	0	0	0
Dougherty	35	330	7,903	151	6	0	103	115	115	333
Mitchell	5	28	574	14	1	0	20	8	5	33
Randolph	6	31	888	21	0	0	11	17	8	36
Terrell	6	47	1,094	18	0	0	12	16	19	47

Decatur	0	1	15	0	0	0	1	0	0	1
Early	0	2	29	1	0	0	0	1	1	2
Grady	0	1	19	0	0	0	0	0	1	1
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**162**	**167**	**162**	**491**

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
Colquitt	17,790	12,073	0
Thomas	29,513	29,283	0
Baker	23,894	23,119	0
Calhoun	39,393	37,519	0
Clay	181	208	0
Dougherty	1,015,010	914,381	20,703
Mitchell	70,036	57,870	1,705
Randolph	95,566	82,533	0
Terrell	138,114	106,722	0
Decatur	1,724	1,430	0
Early	4,059	4,059	0
Grady	2,875	2,875	0
Total	**1,438,155**	**1,272,072**	**22,408**

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: Robin Leake

Date: 03/04/2016

Title: President

Comments: