



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA149

Facility Name: Caresouth Homecare Professionals - Macon

County: Bibb

Street Address: 5233 Riverside Drive, Suite C

City: Macon

Zip: 31210

Mailing Address: 6688 North Central Expressway, Suite 1300

Mailing City: Dallas

Mailing Zip: 75206

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.

979465743A

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.

117152

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: Brenda Riordan

Contact Title: Regional President

Phone: 978-834-7135

Fax: 413-732-5560

E-mail: briordan@ehhi.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
CareSouth HHA Holdings of Middle Georgia, LLC	For Profit	03/25/2009

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/25/2009

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth HHA Holdings of Middle Georgia, LLC	For Profit	03/25/2009

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/25/2009

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.
Warner Robins	122 Byrd Way, Suite 3	Warner Robins	Houston	03/25/2009

Milledgeville	345 N Cobb St, Suite A	Milledgeville	Baldwin	01/01/2011
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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	31,564	170
Physical Therapy	31,199	180
Home Health Aide	1,962	100
Occupational Therapy	13,380	180
Medical Social Services	675	195
Speech Pathology	2,183	180
	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.

590

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).

4215

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	14
Black/African American	1,069
Hispanic/Latino	22
Pacific Islander/Hawaiian	6
White	2,137
Multi-Racial	768

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	1,541
Female	2,476

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	3,238	68,450	8,937,243	8,937,243
Medicaid	188	2,869	289,245	102,708
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	527	9,388	5,066,298	4,468,090
Self Pay	0	0	0	0
Other Non Government	64	346	67,941	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.

01/01/2006

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.

Brenda Riordan, Regional President

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	14,360,727
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	186,537
Other Contractual Adjustments	546,120
Total Contractual Adjustments	732,657
Bad Debt	52,088
Indigent Care Gross Charges	67,941
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	67,941
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	13,508,041
Adjusted Gross Patient Revenue	14,122,102
Other Revenue	1,199
Total Net Revenue	13,509,240
Total Expenses	9,559,179
Adjusted Gross Revenue	14,123,301
Total Uncompensated I/C Care	67,941
Percent Uncompensated Indigent/Charity Care	0.48%

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 reported in Part E, Question 4 above.

62

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)	2,199
Physicians	1,258
Other Home Health Agencies	12
All Other Healthcare Providers	548

7. Referral Hospitals

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

Hospital Name	Patients Referred
Crisp Regional	3
East Cooper Medical Center	1
Grady Memorial	1
Gwinnett Medical Center	5
HealthSouth	1
Middle Georgia Hospital	1
Navicent Health	77
Parkridge Medical Center	1
Putnam General Hospital	2
Roberta Healthcare Center	1
St Francis Hospital	4
Sylvan Grove Hospital	1
VAMC Dublin	2
VAMC Decatur	1
Bleckley Memorial Hospital	1
Carl Vinson VAMC	2
Central Georgia Rehab	30
Archbold Medical Center	0
Athens Regional Medical Center	4
Atlanta VAMC	7
Coliseum Medical Center	392
CRH Medical Center	10
Doctors Hospital Augusta	2
Emory Hospital	33
Gulf Coast Medical Center	0
Houston Healthcare	1,151

Jack Hughston Memorial Hospital	18
Jasper Memorial Hospital	0
Medical Center of Central Georgia	164
Medical Center of Peach County	18
Georgia Regents Medical Center	3
Monroe County Hospital	3
Northside Hospital - Forsyth	3
Oconee Regional Medical Center	181
Palm Bay Community Hospital	0
Peach Regional Medical Cneter	0
Phoebe Putney Memorial Hospital	0
Piedmont Hospital	12
Regency Hospital - Macon	41
St Joseph's Hospital - Atlanta	1
St Mary's Hospital	10
Spalding Regional Medical Center	2
Tallahassee Memorial Hospital	0
University Hospital	1
Upson Regional Medical Center	8
Washington County Regional Medical Center	0
Wellstar Douglas Hospital	0
Wellstar Cobb Hospital	1
Total	2,199

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	1	0
Licensed Practical Nurses (LPNs)	1	1	0
Aides/Assistants	3	1	0
Allied Health/Therapists	7	1	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	50 Days
Licensed Practical Nurse	50 Days
Aide/Assistant	50 Days
Allied Health/Therapists	50 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	358	60
February	332	65
March	346	79
April	355	51
May	346	74
June	358	69
July	377	65
August	358	71
September	372	72
October	347	69
November	355	62
December	367	84

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
Baldwin	33	563	11,199	239	0	0	140	196	148	484
Bibb	126	1,086	22,014	503	0	0	286	398	384	1,068
Crawford	5	61	1,013	29	0	0	15	25	18	58
Houston	219	1,789	32,332	834	0	0	454	710	527	1,691
Jones	10	140	2,723	65	0	0	45	50	34	129
Monroe	14	129	2,614	73	0	0	33	63	32	128
Peach	50	439	7,952	198	0	0	105	160	131	396
Pulaski	6	52	932	25	0	0	22	20	11	53
Butts	0	1	4	1	0	0	0	1	0	1

Hancock	1	6	100	3	0	0	1	2	2	5
Putnam	0	1	6	1	0	0	0	1	0	1
Upson	0	2	24	2	0	0	1	1	0	2
Wilkinson	0	1	18	0	0	0	1	0	0	1
Total by Age	0	0	0	0	0	0	1,103	1,627	1,287	4,017

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
Baldwin	1,986,411	1,953,404	9,398
Bibb	3,904,710	3,839,827	18,473
Crawford	179,680	176,694	850
Houston	5,734,854	5,639,561	27,132
Jones	482,989	474,964	2,285
Monroe	463,656	455,951	2,194
Peach	1,410,478	1,387,040	6,673
Pulaski	165,313	162,566	782
Butts	6,385	6,279	30
Hancock	17,737	17,443	84
Putnam	1,064	1,047	5
Upson	4,257	4,186	20
Wilkinson	3,193	3,140	15
Total	14,360,727	14,122,102	67,941

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 inaccurate 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: Tracey Kruse

Date: 03/03/2016

Title: Chief Operating Officer

Comments: