GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA004

Facility Name: Intrepid USA Healthcare Services

County: Glynn

Street Address: Suites G & H 650 Scranton Road

City: Brunswick

Zip: 31520-1930

Mailing Address: 650 Scranton Road, Suites G & H

Mailing City: Brunswick

Mailing Zip: 31520-1930

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.
392849492C

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.
11-7144

2. Report Period

Report Data for the full twelve month period, January 1,2014 - December 31, 2014 (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: Sherry Schusterman

Contact Title: Administrator

Phone: 912-264-3640

Fax: 912-262-0014

E-mail: Sherry.Schusterman@intrepidusa.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
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Intrepid U.S.A., Inc.	For Profit	06/30/2003

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
F.C. of Georgia, Inc. d/b/a Intrepid USA Healthcare Services	For Profit	06/30/2003

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
not applicable		

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
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.
F.C. of Georgia, Inc. d/b/a Intrepid	140 Lakes Blvd., Suite 211	Kingsland	Camden	12/01/2011

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	11,827	165
Physical Therapy	6,509	185
Home Health Aide	3,662	90
Occupational Therapy	1,057	185
Medical Social Services	0	0
Speech Pathology	92	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 31,2014.

143

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).

2150

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	3
Black/African American	318
Hispanic/Latino	5
Pacific Islander/Hawaiian	0
White	603
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	346
Female	583

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	669	17,660	2,322,041	2,245,411
Medicaid	5	167	6,082	1,894
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	155	7,000	565,382	483,718
Other Third Party Insurers	100	753	205,431	123,485
Self Pay	5	4	9,728	9,848
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 2014. ☑

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

04/01/2012

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.

Sherry Schusterman, 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 2014 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	3,108,664
Medicare Contractual Adjustments	158,295
Medicaid & Peachcare Contractual Adjustments	4,187
Other Contractual Adjustments	52,886
Total Contractual Adjustments	**215,368**
Bad Debt	28,940
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	**2,864,356**
Adjusted Gross Patient Revenue	**2,917,242**
Other Revenue	0
Total Net Revenue	**2,864,356**
Total Expenses	2,631,883
Adjusted Gross Revenue	**2,917,242**
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)	449
Physicians	385
Other Home Health Agencies	4
All Other Healthcare Providers	145

7. Referral Hospitals

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

Hospital Name	Patients Referred
BAPTIST MEDICAL CENTER	13
BROOKS REHAB	7
CANDLER ST JOSEPHS HOSPITAL	1
CANDLER HOSPITAL	4
EMORY HOSPITAL	4
HEALTH SOUTH REHAB	1
HEARTLAND HOSPICE OF BRUNSWICK	1
JESUP HEALTH CENTER	1
MAYO CLINIC	31
MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER	8
MEMORIAL HOSPITAL OF JAX	2
MEMORIAL HOSPITAL	1
PIEDMONT HOSPITAL	1
SELECT SPECIALTY HOSPITAL	1
SHANDS TEACHING HOSPITAL	2
SOUTH GEORGIA MEDICAL CENTER	1
SOUTHEAST GEORGIA HEALTH SYSTEM SENIOR CARE CENTER	11
SOUTHEAST GEORGIA HEALTH SYSTEM ST MARYS	36
SOUTHEAST GEORGIA HEALTH SYSTEM WOUND CLINIC	2
SOUTHEAST GEORGIA SENIOR CARE CENTER ST MARYS	1
SPECIALTY HOSPITAL	1
ST VINCENTS HOSPITAL	55
UNIVERSITY OF FLORIDA ST MARYS MULTISPECIALTY CENTER	1
VA CLINIC OF KINGSLAND	8
VA MEDICAL CENTER GAINSVILLE FLA	5
SHANDS OF JAX	7

SOUTHEAST GEORGIA HEALTH SYSTEM BRUNSWICK CAMPUS	243
Total	**449**

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 12-31-2014.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	9	0	0
Licensed Practical Nurses (LPNs)	2	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	4	2	1

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	1-2 MONTHS
Licensed Practical Nurse	1 MONTH
Aide/Assistant	1 MONTH
Allied Health/Therapists	6-8 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	70	7
February	81	7
March	81	8
April	82	8
May	72	7
June	88	9
July	100	12
August	63	8
September	67	8
October	78	10
November	75	8
December	69	8

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2014. 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
Brantley	6	28	615	19	0	0	8	18	8	34
Camden	42	226	6,247	121	0	0	75	90	79	244
Charlton	12	17	682	12	0	0	4	10	4	18
McIntosh	12	50	1,242	26	0	0	15	20	19	54
Glynn	76	509	14,362	255	0	0	100	254	225	579
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**202**	**392**	**335**	**929**

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
Brantley	87,200	85,662	0
Camden	799,856	795,919	0
Charlton	84,103	82,119	0
McIntosh	161,501	155,538	0
Glynn	1,976,004	1,798,004	0
Total	**3,108,664**	**2,917,242**	**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: SHERRY SCHUSTERMAN

Date: 02/25/2016

Title: ADMINISTRATOR

Comments: