GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA037

Facility Name: SJC Home Health Services, Inc. - Brunswick

County: Glynn

Street Address: 4635 New Jesup Hwy

City: Brunswick

Zip: 31520

Mailing Address: 4635 New Jesup Hwy

Mailing City: Brunswick

Mailing Zip: 31520

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.
00696451

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.
117088

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: Allison Davis

Contact Title: Manager, Strategic Planning

Phone: 912-819-5422

Fax: 912-819-5449

E-mail: davisalli@sjchs.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
SJC Home Health Services, Inc.	Not for Profit	06/30/2001

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
St. Joseph's/Candler Health System, Inc.	Not for Profit	06/30/2001

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SJC Home Health Service, Inc.	Not for Profit	06/30/2001

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
St. Joseph's/Candler Health System, Inc.	Not for Profit	06/30/2001

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Home Health Services, Inc.	For Profit	11/01/1995

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
CareSouth Health System, Inc.	For Profit	03/01/1998

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.
Alma	111 W 12th St, Suite 1	Alma	Bacon	08/01/2013

Waycross	1711 City Blvd Square	Waycross	Ware	08/01/2013

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	14,356	200
Physical Therapy	8,569	170
Home Health Aide	4,520	85
Occupational Therapy	1,764	170
Medical Social Services	10	200
Speech Pathology	115	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 31,2014.

217

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).

972

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	2
Asian	3
Black/African American	345
Hispanic/Latino	8
Pacific Islander/Hawaiian	0
White	1,101
Multi-Racial	193

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	655
Female	997

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	1,355	25,879	3,584,806	3,584,806
Medicaid	81	1,142	260,062	61,772
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	176	2,249	429,286	237,680
Self Pay	0	0	0	0
Other Non Government	40	64	37,066	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.

11/01/1995

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.

Cheryl Tyson, 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	4,311,220
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	198,290
Other Contractual Adjustments	157,457
Total Contractual Adjustments	**355,747**
Bad Debt	34,149
Indigent Care Gross Charges	37,066
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**37,066**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**3,884,258**
Adjusted Gross Patient Revenue	**4,078,781**
Other Revenue	39,943
Total Net Revenue	**3,924,201**
Total Expenses	3,973,029
Adjusted Gross Revenue	**4,118,724**
Total Uncompensated I/C Care	**37,066**
Percent Uncompensated Indigent/Charity Care	**0.90%**

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.

40

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)	935
Physicians	305
Other Home Health Agencies	0
All Other Healthcare Providers	229

7. Referral Hospitals

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

Hospital Name	Patients Referred
Bacon County Hospital	49
Baptist Downtown, Jacksonville	7
Baptist Nassau, Jacksonville	1
Baptist, Jacksonville	11
Candler Hospital	3
Clinch Memorial Hospital	1
Camden Medical Center	38
Coffee Regional Medical Center	66
Doctors Hospital	2
Emory Hospital	4
Irwin County Hospital	2
Hughston Ortho Hospital	2
Mayo Jacksonville	38
Mayo Waycross	108
Georgia Regents University	1
Memorial Jacksonville	2
Memorial Hospital	24
Optim Medical Center	3
Orange Park Medical Center	2
Palm Bay Community Hospital	1
Satilla Regional Medical Center	2
Select Specialty	1
South Georgia Medical Center	4
Southeast Georgia Health System	347
Shands, Jacksonville	8
St Joseph's Hospital	13

Specialty Hospital, Jacksonville	3
St Vincent's	15
St Vincent's, Riverside	139
St Vincent's, Southside	3
TIft Regional	1
University of Florida, St Mary's	2
VAMC - Atlanta	1
VAMC - Augusta	2
VAMC - Dublin	4
VAMC - Gainesville	23
Wayne Memorial Hospital	2
Total	**935**

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)	18	3	0
Licensed Practical Nurses (LPNs)	4	2	0
Aides/Assistants	9	4	0
Allied Health/Therapists	8	8	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	30 days
Allied Health/Therapists	30 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	94	51
February	90	49
March	90	48
April	84	45
May	77	41
June	61	33
July	58	31
August	73	40
September	88	47
October	87	47
November	69	37
December	84	45

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
Atkinson	1	8	135	6	1	0	2	6	1	9
Bacon	20	137	5,192	85	4	0	41	65	58	164
Brantley	5	71	1,393	48	3	0	32	36	8	76
Camden	30	230	4,536	130	3	0	100	95	65	260
Charlton	16	55	1,284	30	3	0	23	24	19	66
Clinch	6	18	608	12	1	0	8	9	5	22
Coffee	26	114	2,642	78	4	0	44	60	32	136
Glynn	56	564	9,083	318	19	0	178	242	203	623
Ware	26	272	4,461	141	2	0	76	116	104	296

Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**504**	**653**	**495**	**1,652**

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
Atkinson	23,487	22,221	927
Bacon	427,990	404,915	3,707
Brantley	198,337	187,644	2,780
Camden	678,521	641,939	2,780
Charlton	172,240	162,954	2,780
Clinch	57,413	54,318	927
Coffee	354,919	335,783	3,707
Glynn	1,625,841	1,538,184	17,606
Ware	772,472	730,823	1,852
Total	**4,311,220**	**4,078,781**	**37,066**

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: Cheryl Tyson, RN

Date: 03/07/2016

Title: Administrator

Comments:

Part F.7: The "Other Non Governmental" line includes self pay patients, self pay visits, and gross revenue with both self pay patients and other indigent patients who fall within other payer categories.