GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA060

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

County: Liberty

Street Address: 401 N. Main Street

City: Hinesville

Zip: 31313

Mailing Address: 401 N. Main Street

Mailing City: Hinesville

Mailing Zip: 31313

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.
00696418A

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.
117082

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 Services, 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.

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	15,464	200
Physical Therapy	10,720	170
Home Health Aide	4,837	85
Occupational Therapy	2,494	170
Medical Social Services	276	200
Speech Pathology	370	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.

224

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).

1175

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	5
Asian	7
Black/African American	586
Hispanic/Latino	21
Pacific Islander/Hawaiian	1
White	1,232
Multi-Racial	130

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	809
Female	1,173

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	1,561	29,367	4,134,082	4,134,082
Medicaid	81	974	262,180	110,208
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	218	3,394	664,079	403,060
Self Pay	0	0	0	0
Other Non Government	122	426	172,098	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.

Kristina Kelly, 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	5,232,439
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	151,972
Other Contractual Adjustments	193,435
Total Contractual Adjustments	**345,407**
Bad Debt	67,584
Indigent Care Gross Charges	172,098
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**172,098**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**4,647,350**
Adjusted Gross Patient Revenue	**5,012,883**
Other Revenue	19,642
Total Net Revenue	**4,666,992**
Total Expenses	4,198,200
Adjusted Gross Revenue	**5,032,525**
Total Uncompensated I/C Care	**172,098**
Percent Uncompensated Indigent/Charity Care	**3.42%**

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)	1,182
Physicians	235
Other Home Health Agencies	7
All Other Healthcare Providers	266

7. Referral Hospitals

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

Hospital Name	Patients Referred
Appling Healthcare System	1
Coffee Regional Medical Center	2
Meadows Regional Medical Center	1
Doctors Hospital	2
Emory Hospital	2
Evans Memorial Hospital	5
Liberty Regional Medical Center	12
St. Vincent's	1
Wayne Memorial Hospital	9
Effingham Hospital	1
Memorial Hospital	152
Southeast Georgia Health System	48
VAMC - Charleston	21
St. Vincent's, Riverside	7
Select Specialty	11
East Georgia Regional Medical Center	27
Mayo, Jacksonville	2
Piedmont Hospital	2
Candler Hospital	270
Shepherd	1
St Joseph's Hospital	605
Total	**1,182**

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)	16	2	0
Licensed Practical Nurses (LPNs)	3	0	0
Aides/Assistants	5	0	0
Allied Health/Therapists	11	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	60 days
Licensed Practical Nurse	90 days
Aide/Assistant	30 days
Allied Health/Therapists	90 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	131	70
February	112	60
March	125	67
April	85	46
May	83	44
June	76	41
July	59	32
August	66	36
September	84	45
October	90	48
November	79	43
December	109	59

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
Bryan	29	166	3,870	103	13	0	69	75	61	205
Bulloch	17	55	994	37	7	0	37	27	9	73
Candler	4	11	324	8	0	0	2	8	7	17
Chatham	72	655	11,212	365	40	0	220	301	237	758
Effingham	32	211	4,261	85	9	0	87	100	61	248
Evans	7	44	1,035	26	6	0	18	21	14	53
Jeff Davis	4	16	218	13	1	0	7	9	4	20
Liberty	33	248	5,464	165	24	0	105	131	55	291
Long	7	47	724	25	1	0	20	18	16	54

McIntosh	18	124	3,120	81	8	0	39	71	32	142
Toombs	2	11	123	7	0	0	3	6	4	13
Wayne	17	102	2,278	66	13	0	46	55	7	108
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**653**	**822**	**507**	**1,982**

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
Bryan	541,196	518,487	18,338
Bulloch	192,718	184,632	9,874
Candler	44,880	42,996	0
Chatham	2,001,104	1,917,137	56,426
Effingham	654,715	627,243	12,696
Evans	139,919	134,048	8,464
Jeff Davis	52,800	50,584	1,411
Liberty	768,234	735,998	33,855
Long	142,559	136,577	1,411
McIntosh	374,877	359,147	11,285
Toombs	34,320	32,880	0
Wayne	285,117	273,154	18,338
Total	**5,232,439**	**5,012,883**	**172,098**

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: Kristina Kelly

Date: 02/21/2024

Title: Administrator

Comments:

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

categories.