Georgia Department of Community Health

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA093

Facility Name: SunCrest Home Health of Georgia

County: Clayton

Street Address: 29 Upper Riverdale Rd Southwest Suite 130

City: Riverdale

Zip: 30274

Mailing Address: 29 Upper Riverdale Rd Southwest Suite 130

Mailing City: Riverdale

Mailing Zip: 30274

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.
000770272B

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.
11-7105

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: Julie LeMon

Contact Title: Compliance Coordinator

Phone: 502-891-1187

Fax: 502-891-8067

E-mail: julielemon@almostfamily.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
SunCrest Home Health of Georgia, Inc.	For Profit	09/02/2008

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SunCrest Healthcare, Inc.	For Profit	09/02/2008

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SunCrest Home Health of Georgia, inc.	For Profit	09/02/2008

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
SunCrest Healthcare, Inc.	For Profit	09/02/2008

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.
SunCrest Home Health	315 S. 9th Street	Griffin	Spalding	

SunCrest Home Health	246 Bullsboro Drive Ste D&E	Newnan	Coweta	

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

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1. Health-Related by PayerVisits

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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	625	16,661	2,597,168	2,406,803
Medicaid	86	1,266	178,129	139,274
Other Government Payers	56	727	128,962	79,750
Managed Care (HMO/PPO)	169	3,469	21,440	27,168
Other Third Party Insurers	0	0	0	0
Self Pay	27	108	55,972	12,435
Other Non Government	149	1,880	343,406	207,252

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.

10/01/2008

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.

Raj Kaushal, MD, Chief Clinical Officer

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	3,325,077
Medicare Contractual Adjustments	129,553
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	267,758
Total Contractual Adjustments	**397,311**
Bad Debt	55,084
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	**2,872,682**
Adjusted Gross Patient Revenue	**3,140,440**
Other Revenue	0
Total Net Revenue	**2,872,682**
Total Expenses	3,672,768
Adjusted Gross Revenue	**3,140,440**
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.

10

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)	354
Physicians	376
Other Home Health Agencies	0
All Other Healthcare Providers	381

7. Referral Hospitals

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

Hospital Name	Patients Referred
Atlanta Medical Center	23
Atlanta VA Medical Center	71
Charles George Veterans Affairs Medical Center	1
Charlie Norwood VAMC Augusta	2
Cancer Treatment Centers of America SERMC	2
Christian City	1
Dekalb Medical Center Main Campus	1
Grady Memorial Hospital	2
Emory University Hospital	5
Piedmont Fayette Hospital	21
Piedmont Henry Hospital	41
Piedmont Hospital Atlanta	4
Piedmont Hospital Newnan	61
Rockdale Medical Center	2
Roosevelt Warm Spring Institute	1
Southern Crescent Hospital	5
Southern Regional Medical	92
Spalding Regional Medical Center	10
Sylvan Grove Hospital	1
VA Medical Center Atlanta	4
Wellstar Cobb Hospital	1
Wellstar Windy Hill Hospital	1
Wesley Woods Geriatric Hospital	1
West Georgia Medical Center	1
Total	**354**

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)	5	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	6	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	5 months
Licensed Practical Nurse	1 month
Aide/Assistant	2 weeks
Allied Health/Therapists	6 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	166	43
February	110	43
March	72	42
April	89	41
May	82	22
June	99	35
July	110	26
August	107	38
September	89	27
October	89	38
November	96	26
December	84	31

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
Clayton	77	435	6,812	0	0	29	270	74	31	404
Fayette	31	131	3,080	0	0	8	57	32	26	123
Henry	38	216	5,056	0	0	20	122	39	22	203
Coweta	53	305	6,337	0	0	19	153	63	49	284
DeKalb	0	2	48	0	0	0	1	0	0	1
Fulton	0	13	210	0	0	3	5	1	2	11
Pike	2	10	183	0	0	1	5	2	1	9
Spalding	25	78	2,365	0	0	12	44	17	4	77
Total by Age	**0**	**0**	**0**	**0**	**0**	**92**	**657**	**228**	**135**	**1,112**

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
Clayton	933,412	870,216	0
Fayette	435,683	409,845	0
Henry	708,522	662,416	0
Coweta	913,460	885,626	0
DeKalb	2,301	2,145	0
Fulton	25,307	23,593	0
Pike	32,518	30,407	0
Spalding	273,874	256,192	0
Total	**3,325,077**	**3,140,440**	**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: Patrick Todd Lyles

Date: 02/16/2016

Title: Sr. Vice President

Comments: