



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

**2015 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, 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:** Allison Davis

**Contact Title:** Manager, Strategic Planning

**Phone:** 912-819-7472

**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	03/30/2001

#### 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
US CareNet, LLC.	For Profit	11/01/2015

#### F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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.
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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	17,036	200
Physical Therapy	14,275	170
Home Health Aide	6,048	85
Occupational Therapy	4,229	170
Medical Social Services	382	200
Speech Pathology	427	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, 2015.

248

### **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).

1380

### **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	9
Black/African American	557
Hispanic/Latino	3
Pacific Islander/Hawaiian	1
White	1,151
Multi-Racial	152

### **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	781
Female	1,093

### **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	1,243	36,148	5,525,664	5,212,323
Medicaid	156	1,577	322,020	49,831
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	0	0	0
Other Third Party Insurers	373	3,723	841,663	500,960
Self Pay	0	0	0	0
Other Non Government	102	949	191,349	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.

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 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	6,880,696
Medicare Contractual Adjustments	313,341
Medicaid & Peachcare Contractual Adjustments	272,189
Other Contractual Adjustments	238,626
<b>Total Contractual Adjustments</b>	<b>824,156</b>
Bad Debt	102,077
Indigent Care Gross Charges	191,349
Indigent Care Compensation	0
<b>Uncompensated Indigent Care (Net)</b>	<b>191,349</b>
Charity Care Gross Charges	0
Charity Care Compensation	0
<b>Uncompensated Charity Care (Net)</b>	<b>0</b>
Other Free Care	0
<b>Total Net Patient Revenue</b>	<b>5,763,114</b>
<b>Adjusted Gross Patient Revenue</b>	<b>6,193,089</b>
Other Revenue	0
<b>Total Net Revenue</b>	<b>5,763,114</b>
Total Expenses	5,116,740
<b>Adjusted Gross Revenue</b>	<b>6,193,089</b>
<b>Total Uncompensated I/C Care</b>	<b>191,349</b>
<b>Percent Uncompensated Indigent/Charity Care</b>	<b>3.09%</b>

### 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.

102

## 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)	1,406
Physicians	261
Other Home Health Agencies	1
All Other Healthcare Providers	136

## 7. Referral Hospitals

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

Hospital Name	Patients Referred
Mayo - Waycross	1
Select Specialty	11
Meadows Regional Medical Center	1
Medical College of Georgia	1
Medical Center of Central Georgia	1
Memorial Hospital	173
Northside Medical Center	1
Optim Medical Center	3
Piedmont Healthcare Hospital	2
Savannah Rehab Hospital	34
South Georgia Health System	22
Southeast Georgia Health System	43
Specialty Hospital - Jacksonville	1
St. Joseph's Hospital	621
St. Mary's Healthcare System	1
Camden Medical Center	1
Candler County Hospital	1
Candler Hospital	331
Coffee Regional Medical Center	1
Doctors Hospital	1
Duke Hospital	1
East Georgia Regional	59
Effingham Hospital	13
Emory University Hospital	3
Evans Memorial Hospital	1
Landmark Hospital	1

Liberty Regional Medical Center	10
Mayo - Jacksonville	6
St. Vincent's Riverside	12
VAMC - Augusta	5
VAMC - Charleston	20
VAMC - Dublin	9
VAMC - Gainesville	1
Wayne Memorial Hospital	11
Winn Army Hospital	3
<b>Total</b>	<b>1,406</b>

## 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)	15	3	0
Licensed Practical Nurses (LPNs)	3	0	0
Aides/Assistants	6	2	0
Allied Health/Therapists	0	0	11



## 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	65 days
Licensed Practical Nurse	65 days
Aide/Assistant	30 days
Allied Health/Therapists	65 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	106	57
February	86	46
March	96	52
April	92	49
May	82	44
June	105	56
July	107	57
August	85	46
September	99	53
October	103	56
November	111	60
December	103	55

### 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
Bryan	30	195	4,919	101	12	0	73	75	58	206
Bulloch	7	116	2,318	51	6	0	57	34	26	117
Candler	2	30	455	16	1	0	12	11	5	28
Chatham	75	665	14,144	322	38	0	235	255	209	699
Effingham	22	213	5,115	108	15	0	80	82	52	214
Evans	2	43	994	20	1	0	14	15	14	43
Jeff Davis	1	15	247	3	3	0	11	1	4	16
Liberty	42	250	6,111	140	10	0	95	113	59	267
Long	8	32	745	21	3	0	17	15	8	40

McIntosh	15	135	4,106	76	5	0	39	65	29	133
Toombs	0	8	107	2	0	0	4	1	2	7
Wayne	12	102	3,136	51	8	0	43	39	22	104
<b>Total by Age</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>680</b>	<b>706</b>	<b>488</b>	<b>1,874</b>

## 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	756,363	680,777	22,512
Bulloch	429,585	386,655	11,256
Candler	102,807	92,533	1,876
Chatham	2,566,492	2,310,016	71,287
Effingham	785,736	707,215	28,140
Evans	157,881	142,104	1,876
Jeff Davis	58,747	52,876	5,628
Liberty	980,334	882,366	18,760
Long	146,867	132,190	5,628
McIntosh	488,331	439,531	9,380
Toombs	25,702	23,133	0
Wayne	381,851	343,693	15,006
<b>Total</b>	<b>6,880,696</b>	<b>6,193,089</b>	<b>191,349</b>

## 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:** Kristina Kelly, RN

**Date:** 03/11/2016

**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.