GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA065

Facility Name: Charlton Visiting Nurses Services

County: Brantley

Street Address: 59 Brantley Street

City: Nahunta

Zip: 31553

Mailing Address: 59 Brantley Street

Mailing City: Nahunta

Mailing Zip: 31553

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.
00240083

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.
117317

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: John P. Johnson

Contact Title: President/CEO

Phone: 912-283-1262

Fax: 912-283-5374

E-mail: jjohnson@ahce.net

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
Ware Visiting Nurses d.b.a. Charlton Visiting Nurses Service	For Profit	09/01/1982

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlantic Homecare, Inc.	For Profit	11/01/1988

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Ware Visiting Nurses d.b.a. Charlton Visiting Nurses Service	For Profit	09/01/1982

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlantic Homecare, Inc.	For Profit	11/01/1988

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlantic Homecare, Inc.	For Profit	11/01/1988

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Atlantic Homecare, Inc.	For Profit	11/01/1988

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.
Folkston Office	308 Main Street	Folkston	Charlton	09/01/1982

St. Marys Office	4445 Highway 40 East Suite 401	St. Marys	Camden	07/28/2006
Pooler Office- Subunit	138 Canal Street, Suite 505	Pooler	Chatham	11/15/2006
Brunswick Office	3023 Altama Avenue	Brunswick	Glynn	02/01/1997

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	6,636	150
Physical Therapy	5,959	180
Home Health Aide	2,351	55
Occupational Therapy	35	180
Medical Social Services	0	0
Speech Pathology	244	180
	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.

110

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).

660

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	4
Black/African American	191
Hispanic/Latino	4
Pacific Islander/Hawaiian	1
White	673
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	376
Female	497

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	587	11,023	1,677,062	1,670,628
Medicaid	17	115	18,114	5,754
Other Government Payers	25	318	52,919	37,322
Managed Care (HMO/PPO)	139	2,511	407,854	404,623
Other Third Party Insurers	97	944	162,056	137,748
Self Pay	7	272	38,373	0
Other Non Government	1	42	3,260	3,260

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.

09/01/1982

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.

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	2,359,638
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	12,360
Other Contractual Adjustments	39,905
Total Contractual Adjustments	**52,265**
Bad Debt	9,665
Indigent Care Gross Charges	38,373
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**38,373**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**2,259,335**
Adjusted Gross Patient Revenue	**2,337,613**
Other Revenue	262
Total Net Revenue	**2,259,597**
Total Expenses	2,251,246
Adjusted Gross Revenue	**2,337,875**
Total Uncompensated I/C Care	**38,373**
Percent Uncompensated Indigent/Charity Care	**1.64%**

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.

7

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)	436
Physicians	199
Other Home Health Agencies	17
All Other Healthcare Providers	117

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	2
Baptist Health Center - Fernandina	6
Baptists Health Systems	8
Cancer Treatment Centers of America	1
Charlie Norwood VAMC	1
Columbus Regional Hughston Hospital	1
Doctors Hospital of Augusta	1
East Georgia Regional Hospital	5
Ed Frasier Memorial Hospital	1
Effingham Hospital	6
Emory Hospital	1
HealthSouth Walton Rehab Hospital	1
Mayo Clinic Jacksonville	15
Mayo Health System of Waycross	22
Mayo Health Systems of Waycross	1
Memorial Medical Center - Jacksonville	3
Memorial University Medical Center	58
North Florida Regional Medical Center	1
Piedmont Hospital	1
Ralph H Johnson VA Medical Ceneter	18
SEGHS - Brunswick Campus	153
SEGHS - Camden Campus	19
Select Specialty	10
Shands Hospital - Jacksonville	3
South Georgia Medical Center	2
Specialty Hospital	2

St. Joseph's/ Candler Health System	21
St.Vincent's Medical Center	25
VA Medical Center Gainsville	17
VAMC - Charleston	2
Wayne Memorial Hospital	3
St. Joseph's/ Candlet Health Systems	7
Candler County Hospital	1
Candler hopital	18
Total	**436**

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)	10	0	0
Licensed Practical Nurses (LPNs)	1	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	4	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	30 days
Licensed Practical Nurse	30 days
Aide/Assistant	14 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	53	1
February	58	3
March	60	3
April	56	1
May	68	7
June	80	7
July	52	11
August	78	5
September	43	11
October	50	13
November	40	6
December	53	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	25	138	3,224	96	0	0	39	86	38	163
Camden	24	126	3,020	82	1	0	45	69	36	150
Charlton	7	105	1,784	59	1	0	27	49	36	112
Glynn	34	202	3,837	118	5	0	53	98	85	236
Bryan	1	18	291	10	0	1	8	7	3	19
Bulloch	6	14	312	14	0	0	3	14	3	20
Chatham	5	113	1,861	55	0	2	49	38	29	118
Effingham	1	21	253	16	0	1	12	9	0	22
Long	0	3	41	2	0	0	2	1	0	3

McIntosh	3	27	602	22	0	0	8	19	3	30
Total by Age	**0**	**0**	**0**	**0**	**0**	**4**	**246**	**390**	**233**	**873**

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	500,634	500,244	0
Camden	456,458	456,225	22,159
Charlton	280,968	280,968	300
Glynn	605,267	600,207	15,914
Bryan	45,339	41,627	0
Bulloch	49,863	48,265	0
Chatham	287,110	278,619	0
Effingham	44,976	44,166	0
Long	7,767	7,767	0
McIntosh	81,256	79,525	0
Total	**2,359,638**	**2,337,613**	**38,373**

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: John P. Johnson

Date: 02/27/2017

Title: CEO

Comments: