



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2015 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, 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: 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 Service, Inc. 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 Service, Inc. 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	5,708	150
Physical Therapy	5,054	180
Home Health Aide	1,662	55
Occupational Therapy	0	0
Medical Social Services	0	0
Speech Pathology	171	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, 2015.

74

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).

576

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	2
Black/African American	139
Hispanic/Latino	14
Pacific Islander/Hawaiian	2
White	592
Multi-Racial	1

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	335
Female	416

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	496	8,801	1,395,386	1,393,220
Medicaid	1	11	1,650	576
Other Government Payers	18	312	50,528	48,182
Managed Care (HMO/PPO)	130	2,477	372,256	361,771
Other Third Party Insurers	76	711	116,897	106,339
Self Pay	21	165	28,047	0
Other Non Government	9	118	20,440	16,906

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.

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 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	1,985,204
Medicare Contractual Adjustments	1,395
Medicaid & Peachcare Contractual Adjustments	1,074
Other Contractual Adjustments	4,654
Total Contractual Adjustments	7,123
Bad Debt	23,040
Indigent Care Gross Charges	28,047
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	28,047
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	1,926,994
Adjusted Gross Patient Revenue	1,959,695
Other Revenue	1,308
Total Net Revenue	1,928,302
Total Expenses	1,926,396
Adjusted Gross Revenue	1,961,003
Total Uncompensated I/C Care	28,047
Percent Uncompensated Indigent/Charity Care	1.43%

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.

21

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)	368
Physicians	171
Other Home Health Agencies	35
All Other Healthcare Providers	86

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	1
Baptist Health Center - Fernandina	6
Baptists Health Systems	14
Alaris at Hamilton Park	1
Candler Hospital	2
Coffee Regional Medical Center	1
Department of Veterans Affairs	1
East Georgia Regional Hospital	3
Ed Frasier Memorial Hospital	1
Emory Hospital	1
HealthSouth Walton Rehab Hospital	1
Mayo Clinic Jacksonville	31
Mayo Health System of Waycross	7
Mayo Health Systems of Waycross	9
Memorial Medical Center - Jacksonville	2
Memorial University Medical Center	46
Orange Park Medical Center	1
Ralph H Johnson VA Medical Ceneter	17
SEGHS - Brunswick Campus	126
SEGHS - Camden Campus	8
Select Specialty	2
Specialty Hospital	3
St. Joseph's/ Candler Health System	9
St.Vincent's Medical Center	54
VA Medical Center Gainesville	6
VAMC - Charleston	8

Wayne Memorial Hospital	1
VA Medical Center	2
Saint Simons by the Sea	1
UF Health Jacksonville	1
University Healthcare System	1
Southeastern Regional Medical Center	1
Total	368

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)	9	0	0
Licensed Practical Nurses (LPNs)	2	0	0
Aides/Assistants	1	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	14 days
Licensed Practical Nurse	14 days
Aide/Assistant	7 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	56	19
February	36	14
March	44	15
April	49	10
May	34	7
June	42	12
July	51	12
August	38	10
September	31	14
October	50	15
November	31	10
December	43	17

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
Brantley	22	142	3,277	96	1	0	35	85	44	164
Camden	10	106	1,852	82	3	0	37	65	14	116
Charlton	17	84	1,650	59	1	0	25	42	34	101
Glynn	16	205	3,181	118	2	0	51	99	71	221
Bryan	0	8	161	10	1	0	2	3	3	8
Bulloch	4	7	68	14	3	0	6	5	0	11
Chatham	15	74	1,773	55	9	0	32	34	23	89
Effingham	3	10	142	16	0	1	5	6	1	13
Long	0	2	6	2	0	0	0	2	0	2

McIntosh	4	22	485	22	1	0	9	12	5	26
Total by Age	0	0	0	0	0	1	202	353	195	751

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	476,961	472,179	1,224
Camden	307,630	303,720	6,745
Charlton	266,340	261,042	999
Glynn	516,587	511,940	1,500
Bryan	28,203	28,203	1,260
Bulloch	12,138	12,139	4,172
Chatham	279,375	275,562	11,846
Effingham	31,150	30,006	0
Long	1,027	1,027	0
McIntosh	65,793	63,877	301
Total	1,985,204	1,959,695	28,047

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: John P. Johnson

Date: 03/01/2016

Title: CEO

Comments: