



2016 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: 31551

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 1,2016 - December 31, 2016 (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 Nurse Services, Inc. d.b.a Charlton Visiting	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 Nurse Services, Inc. d.b.a Charlton Visiting	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	4,314	150
Physical Therapy	4,445	180
Home Health Aide	1,282	55
Occupational Therapy	69	180
Medical Social Services	0	0
Speech Pathology	145	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, 2016.

70

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).

651

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	2
Asian	1
Black/African American	128
Hispanic/Latino	4
Pacific Islander/Hawaiian	0
White	491
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	273
Female	353

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	395	6,842	1,117,781	1,116,224
Medicaid	1	4	605	197
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	144	2,564	415,859	410,759
Other Third Party Insurers	72	740	125,300	74,845
Self Pay	9	46	7,509	0
Other Non Government	5	59	10,054	9,754

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 2016.

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 2016 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	1,677,108
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	408
Other Contractual Adjustments	28,805
Total Contractual Adjustments	29,213
Bad Debt	28,607
Indigent Care Gross Charges	7,509
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	7,509
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	0
Other Free Care	0
Total Net Patient Revenue	1,611,779
Adjusted Gross Patient Revenue	1,648,093
Other Revenue	212
Total Net Revenue	1,611,991
Total Expenses	1,725,643
Adjusted Gross Revenue	1,648,305
Total Uncompensated I/C Care	7,509
Percent Uncompensated Indigent/Charity Care	0.46%

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.

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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)	321
Physicians	132
Other Home Health Agencies	22
All Other Healthcare Providers	74

7. Referral Hospitals

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

Hospital Name	Patients Referred
St Joseph's/ Candler Health Systems	1
Brooks Rehab - Jacksonville	1
Mayo Health System	46
Memorial Health University Medical Center	12
Memorial Hospital	1
Memorial University Medical Center	24
Orange Park Medcial Center	1
Saint Simons by the Sea	1
SEGHS - Brunswick Campus	110
SEGHS - Camden Campus	9
Shands Hospital at the University of Florida	3
Ralph H. Johnson/ VA Medical Center	1
Ralph Johnson VAMC	1
Specialty Hospital	1
St Joseph's/ Candler Health Systems	4
St Vincents Riverside Medical Center	30
VA Medical Center Gainesville	1
Wayne Memorial Hospital	5
Candler Hospital	2
Optim Medical Center Tattnell	1
St Vincent's Medical Center	8
St Vincents Riverside Medical Center	12
UF Health Jacksonville - University of florida	1
VAMC - Charleston	1
WACH	1
Department of Veterans Affairs	2

Landmark Hospital	1
Bacon County Hospital	1
Baptist Health System	32
Baptist Medical Center - Nassau	6
St Francis Hospital	1
Total	321

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 12-31-2016.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	8	0	0
Licensed Practical Nurses (LPNs)	3	0	0
Aides/Assistants	1	0	0
Allied Health/Therapists	3	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 or less
Licensed Practical Nurse	30 days or less
Aide/Assistant	14 days or less
Allied Health/Therapists	30 days or less

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	46	18
February	45	12
March	41	5
April	37	14
May	35	5
June	30	11
July	24	16
August	37	17
September	28	9
October	32	11
November	32	7
December	25	12

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2016. 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	119	2,664	66	0	0	35	67	39	141
Camden	12	105	2,048	59	1	0	24	55	38	117
Charlton	11	75	1,915	34	0	0	16	37	33	86
Glynn	17	178	2,681	94	2	0	51	87	57	195
Chatham	11	40	584	21	5	0	15	22	14	51
Effingham	1	9	101	3	0	0	5	3	2	10
McIntosh	1	18	196	11	1	0	10	7	2	19
Bulloch	1	2	28	2	0	0	0	3	0	3
Bryan	1	1	30	0	0	0	0	0	2	2

Long	0	2	8	0	0	0	2	0	0	2
Total by Age	0	0	0	0	0	0	158	281	187	626

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	424,327	422,712	0
Camden	300,233	296,697	1,379
Charlton	294,325	290,327	0
Glynn	483,486	479,889	1,770
Chatham	102,531	93,078	4,060
Effingham	19,370	17,360	0
McIntosh	41,071	38,063	300
Bulloch	5,074	4,774	0
Bryan	5,435	3,937	0
Long	1,256	1,256	0
Total	1,677,108	1,648,093	7,509

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: 02/27/2017

Title: CEO

Comments: