GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA138

Facility Name: Guardian Home Care, LLC

County: Fulton

Street Address: Suite 440 11660 Alpharetta

City: Roswell

Zip: 30076

Mailing Address: Suite 440 11660 Alpharetta

Mailing City: Roswell

Mailing Zip: 30076

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.
00975917a

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.
11-7131

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: Jerry Huggler

Contact Title: Senior Vice President

Phone: 972-201-3800

Fax: 972-267-1116

E-mail: jhuggler@accentcare.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
Guardian Home Care, LLC	For Profit	10/30/2001

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Guardian Home Care Holdings, Inc.	For Profit	05/01/2006

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

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.
Guardian Home Care, LLC-College	1895 Phoenix Blvd, #250	College Park	Clayton	

Guardian Home Care, LLC-Canton	1558 Marietta Highway, #210	Canton	Cherokee	
Guardian Home Care, LLC-Decatu	484 Irvin Court, #220	Decatur	DeKalb	
Guardian Home Care, LLC-Mariett	900 Circle 75 Parkway SE, #1360	Atlanta	Cobb	

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	31,833	140
Physical Therapy	26,018	160
Home Health Aide	2,337	90
Occupational Therapy	12,098	160
Medical Social Services	1,076	160
Speech Pathology	2,768	160
	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.

548

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).

3000

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	1
Black/African American	32
Hispanic/Latino	1
Pacific Islander/Hawaiian	0
White	65
Multi-Racial	3,449

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	1,165
Female	2,383

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	3,293	62,180	11,916,149	11,916,149
Medicaid	17	273	15,226	15,226
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	49	723	1,944,074	1,944,074
Other Third Party Insurers	795	12,782	394,486	379,763
Self Pay	9	75	0	0
Other Non Government	22	97	3,983	3,986

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.

10/01/2004

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.

Charlotte Patterson

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	14,273,918
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	0
Indigent Care Gross Charges	14,720
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**14,720**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**14,259,198**
Adjusted Gross Patient Revenue	**14,273,918**
Other Revenue	0
Total Net Revenue	**14,259,198**
Total Expenses	0
Adjusted Gross Revenue	**14,273,918**
Total Uncompensated I/C Care	**14,720**
Percent Uncompensated Indigent/Charity Care	**0.10%**

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.

22

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)	712
Physicians	941
Other Home Health Agencies	26
All Other Healthcare Providers	1,869

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	70
Atlanta VA Medical Center	32
Dekalb Medical Center	49
Emory Johns Creek Hospital	16
Emory St. Joseph Hospital	27
Emory University Hospital	12
North Fulton Hospital	117
Northside Cherokee Hospital	15
Northside Hospital Atlanta	11
Piedmont Henry Hospital	188
Piedmont Hospital Atlanta	32
Southern Regional Medical Center	11
Wellstar Cobb Hospital	21
Wellstar Kennestone Hospital	38
Total	**639**

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)	15	0	0
Licensed Practical Nurses (LPNs)	2	0	0
Aides/Assistants	2	0	0
Allied Health/Therapists	10	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	1 month
Licensed Practical Nurse	1 month
Aide/Assistant	1 month
Allied Health/Therapists	3 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	339	112
February	304	86
March	321	87
April	309	81
May	285	52
June	306	75
July	273	62
August	332	70
September	264	63
October	319	73
November	238	41
December	258	19

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
Alabama	1	0	0	0	0	0	0	0	0	0
Cherokee	44	219	4,699	102	0	0	19	94	106	219
Clayton	15	155	3,326	84	0	0	27	77	51	155
Cobb	127	457	9,806	164	0	0	54	149	254	457
DeKalb	198	951	20,406	379	0	0	146	321	484	951
Fayette	7	18	386	6	0	0	1	6	11	18
Fulton	386	1,486	31,885	523	0	0	136	474	876	1,486
Henry	19	207	4,442	104	0	0	52	94	61	207
Paulding	5	40	858	26	0	0	2	26	12	40

Wayne	0	1	21	1	0	0	0	1	0	1
Dawson	0	2	43	1	0	0	0	1	1	2
Forsyth	0	3	64	2	0	0	1	1	1	3
Gwinnett	0	9	196	5	0	0	0	5	4	9
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**438**	**1,249**	**1,861**	**3,548**

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
Alabama	0	0	0
Cherokee	880,528	880,528	380
Clayton	624,276	624,276	1,340
Cobb	1,840,776	1,840,776	4,120
DeKalb	3,824,862	3,824,862	2,850
Fayette	72,341	72,341	0
Fulton	5,974,789	5,974,789	2,645
Henry	835,306	835,306	3,385
Paulding	160,757	160,757	0
Wayne	4,019	4,019	0
Dawson	8,038	8,038	0
Forsyth	12,056	12,056	0
Gwinnett	36,170	36,170	0
Total	**14,273,918**	**14,273,918**	**14,720**

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: Jerry Huggler

Date: 02/26/2015

Title: SVP Finance

Comments: