GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2015 Home Health Survey

Part A : General Information

1. Identification

UID:HHA152

Facility Name: CareOne Health Services

County: DeKalb

Street Address: 778 Rays RoadSuite 105

City: Stone Mountain

Zip: 30083

Mailing Address: 778 Rays Road Suite 105

Mailing City: Stone Mountain

Mailing Zip: 30083

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.
00310507074B

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.
117157

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: Osman Dirie

Contact Title: Adminstrator

Phone: 404-228-8563

Fax: 404-254-1831

E-mail: osmandirie@outlook.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
Osman Dirie	For Profit	

B. Owner's Parent Organization

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

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.

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	127	0
Physical Therapy	198	0
Home Health Aide	283	0
Occupational Therapy	82	0
Medical Social Services	4	0
Speech Pathology	0	0
	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.

247

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).

232

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	7
Black/African American	280
Hispanic/Latino	1
Pacific Islander/Hawaiian	0
White	8
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	161
Female	136

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	0	6,194	792,340	800,313
Medicaid	0	0	0	0
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	0	1,475	100,473	80,000
Other Third Party Insurers	0	0	0	0
Self Pay	0	0	0	0
Other Non Government	0	0	0	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.

02/06/2015

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.

Osman Dirie

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	892,813
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	0
Indigent Care Gross Charges	12,500
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**12,500**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**880,313**
Adjusted Gross Patient Revenue	**892,813**
Other Revenue	0
Total Net Revenue	**880,313**
Total Expenses	0
Adjusted Gross Revenue	**892,813**
Total Uncompensated I/C Care	**12,500**
Percent Uncompensated Indigent/Charity Care	**1.40%**

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.

5

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)	4
Physicians	8
Other Home Health Agencies	0
All Other Healthcare Providers	0

7. Referral Hospitals

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

Hospital Name	Patients Referred
Signature Health Care	1
Dekalb medical at Hillandale	1
Emory Hospital	1
Golden Living	1
North East Atlanta Rehab Center	1
Total	**5**

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)	1	1	8
Licensed Practical Nurses (LPNs)	0	1	4
Aides/Assistants	4	1	2
Allied Health/Therapists	1	0	5

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	3
Licensed Practical Nurse	2
Aide/Assistant	3
Allied Health/Therapists	5

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	17	3
February	23	2
March	22	4
April	11	2
May	28	5
June	14	3
July	12	6
August	23	4
September	19	1
October	15	6
November	11	2
December	16	3

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
DeKalb	297	297	6,194	0	0	0	32	250	15	297
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**32**	**250**	**15**	**297**

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
DeKalb	892,813	892,813	12,500

Total	**892,813**	**892,813**	**12,500**

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: osman dirie

Date: 09/14/2016

Title: adminstrator

Comments: