GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA131

Facility Name: MedSide Healthcare

County: Fulton

Street Address: 1120 Hope Road

City: Sandy Springs

Zip: 30350

Mailing Address: 1120 Hope Road

Mailing City: Sandy Springs

Mailing Zip: 30350

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.
00849527A

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.
117126

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: Victor Vaysman

Contact Title: CEO

Phone: 404-633-7433

Fax: 888-829-7626

E-mail: victor@medside.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
1120 Hope Road LLC	For Profit	12/28/2009

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
MedSide Corporation	For Profit	01/01/2004

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	8,039	220
Physical Therapy	11,760	280
Home Health Aide	3,256	150
Occupational Therapy	5,094	280
Medical Social Services	250	280
Speech Pathology	748	280
	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.

305

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).

493

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	58
Black/African American	869
Hispanic/Latino	13
Pacific Islander/Hawaiian	2
White	611
Multi-Racial	116

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	688
Female	981

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	418	7,598	1,900,340	1,344,405
Medicaid	37	370	91,770	23,020
Other Government Payers	51	570	145,020	71,280
Managed Care (HMO/PPO)	1,136	19,185	4,765,480	2,457,690
Other Third Party Insurers	11	126	34,500	13,114
Self Pay	272	1,298	318,430	2,240
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 2016. ☑

If you indicated yes above, please indicate the effective date of the policy or policies.

01/01/2003

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.

Victor Vaysman

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	7,255,540
Medicare Contractual Adjustments	553,744
Medicaid & Peachcare Contractual Adjustments	68,100
Other Contractual Adjustments	2,353,802
Total Contractual Adjustments	**2,975,646**
Bad Debt	51,955
Indigent Care Gross Charges	0
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**0**
Charity Care Gross Charges	316,190
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**316,190**
Other Free Care	0
Total Net Patient Revenue	**3,911,749**
Adjusted Gross Patient Revenue	**6,581,741**
Other Revenue	0
Total Net Revenue	**3,911,749**
Total Expenses	0
Adjusted Gross Revenue	**6,581,741**
Total Uncompensated I/C Care	**316,190**
Percent Uncompensated Indigent/Charity Care	**4.80%**

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.

270

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)	1,803
Physicians	381
Other Home Health Agencies	849
All Other Healthcare Providers	1,416

7. Referral Hospitals

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

Hospital Name	Patients Referred
AMERICAN TRANSITIONAL HOSPITALS LLC	3
ATLANTA MEDICAL CENTERR	95
CANCER TREATMENT CENTERS OF AMERICA	8
DEKALB MEDICAL CENTER INC.	252
EASTSIDE MEDICAL CENTER, LLC	88
EHCA JOHNS CREEK, LLC	39
EMORY CLINIC, INC.	45
EMORY CRAWFORD LONG HOSPITAL	20
EMORY HEALTHCARE	9
EMORY UNIVERSITY HOSPITAL	315
GRADY MEMORIAL HOSPITAL CORPORATION	67
GWINNETT HOSPITAL SYSTEM, INC	84
KENNESTONE HOSPITAL, INC.	160
KINDRED HOSPITALS LIMITED PARTNERSHIP	12
NORTH FULTON MEDICAL CENTER, INC.	94
NORTHEAST GEORGIA MEDICAL CENTER, INC.	4
NORTHSIDE HOSPITAL, INC. NORTHSIDE HOSPITAL	53
PIEDMONT HOSPITAL	55
PIEDMONT HOSPITAL, INC	94
REGENCY HOSPITAL COMPANY OF SOUTH ATLANTA, LLC	1
SAINT JOSEPHS HOSPITAL OF ATLANTA INC	156
SAINT JOSEPHS MEDICAL GROUP	1
SHEPHERD CENTER INC	11
SOUTHERN REGIONAL HEALTH SYSTEM, INC SOUTHERN REGIONAL MEDICA	9
VA MEDICAL CENTER	128
Total	**1,803**

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)	5	3	0
Licensed Practical Nurses (LPNs)	5	4	0
Aides/Assistants	6	2	0
Allied Health/Therapists	12	2	2

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	5 weeks
Licensed Practical Nurse	4 weeks
Aide/Assistant	3 weeks
Allied Health/Therapists	10 weeks

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	98	4
February	74	7
March	124	12
April	93	11
May	109	13
June	135	14
July	139	18
August	119	31
September	132	20
October	146	15
November	150	16
December	178	19

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2016. 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
Cobb	11	225	3,686	117	29	1	81	88	49	219
DeKalb	62	530	8,692	284	90	0	150	233	151	534
Fulton	78	574	10,416	286	89	1	161	231	185	578
Gwinnett	39	347	6,287	167	61	0	113	130	94	337
Clayton	0	1	66	1	1	0	0	1	0	1
Total by Age	**0**	**0**	**0**	**0**	**0**	**2**	**505**	**683**	**479**	**1,669**

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
Cobb	922,830	818,341	28,280
DeKalb	2,164,380	1,985,664	91,810
Fulton	2,563,520	2,332,986	119,320
Gwinnett	1,586,390	1,426,330	76,220
Clayton	18,420	18,420	560
Total	**7,255,540**	**6,581,741**	**316,190**

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: Victor Vaysman

Date: 02/28/2017

Title: CEO

Comments: