GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 Home Health Survey

Part A : General Information

1. Identification

UID:HHA138

Facility Name: Guardian Home Care LLC

County: Fulton

Street Address: 11660 Alpharetta, Suite 440

City: Roswell

Zip: 30076

Mailing Address: 11660 Alpharetta Suite 440

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 1,2016 - 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: Jerry Huggler

Contact Title: Controller

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
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.
Guardian Home Care, LLC-College	1895 Phoenix Boulevard	College Park	Clayton	10/30/2001

Guardian Home Care, LLC-Canton	1558 Marietta Highway	Canton	Cherokee	10/30/2001
Guardian Home Care, LLC-Decatu	484 Irvin Court	Decatur	DeKalb	10/30/2001
Guardian Home Care, LLC-Mariett	900 Circle 75 Parkway SE	Atlanta	Cobb	10/30/2001

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	38,405	140
Physical Therapy	31,640	160
Home Health Aide	3,422	90
Occupational Therapy	14,930	160
Medical Social Services	1,010	160
Speech Pathology	2,829	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 31,2016.

682

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).

2394

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	7
Black/African American	120
Hispanic/Latino	1
Pacific Islander/Hawaiian	0
White	200
Multi-Racial	3,765

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	1,511
Female	2,584

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	3,540	69,300	13,060,999	13,060,999
Medicaid	39	648	40,394	40,394
Other Government Payers	0	0	0	0
Managed Care (HMO/PPO)	1,015	18,171	3,171,857	3,171,857
Other Third Party Insurers	383	4,114	588,658	557,893
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 2016. ☑

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.

Valerie Witmer

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	16,861,908
Medicare Contractual Adjustments	0
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	0
Total Contractual Adjustments	**0**
Bad Debt	0
Indigent Care Gross Charges	30,765
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**30,765**
Charity Care Gross Charges	0
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**0**
Other Free Care	0
Total Net Patient Revenue	**16,831,143**
Adjusted Gross Patient Revenue	**16,861,908**
Other Revenue	0
Total Net Revenue	**16,831,143**
Total Expenses	0
Adjusted Gross Revenue	**16,861,908**
Total Uncompensated I/C Care	**30,765**
Percent Uncompensated Indigent/Charity Care	**0.18%**

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.

18

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)	1,258
Physicians	743
Other Home Health Agencies	66
All Other Healthcare Providers	2,028

7. Referral Hospitals

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

Hospital Name	Patients Referred
EMORY UNIVERSITY HOSPITAL	56
NORTHSIDE HOSPITAL ATLANTA	80
PIEDMONT FAYETTE HOSPITAL	40
PIEDMONT HENRY HOSPITAL	70
PIEDMONT HOSPITAL ATLANTA	152
VA MEDICAL CENTER - DECATUR	23
WELLSTAR HOSPITAL	392
ATLANTA VA MEDICAL CENTER	223
DEKALB MEDICAL CENTER - NORTH DECATUR	45
EMORY SAINT JOSEPH HOSPITAL	96
Total	**1,177**

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)	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	1 month

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	399	70
February	412	62
March	407	70
April	308	51
May	328	56
June	290	49
July	244	41
August	338	47
September	330	58
October	320	46
November	309	34
December	410	34

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
Cherokee	23	322	7,253	136	0	0	28	125	169	322
Clayton	30	179	4,032	109	0	0	50	89	40	179
Cobb	53	561	12,636	248	0	0	75	213	273	561
DeKalb	150	910	20,496	395	0	0	165	337	408	910
Fayette	8	79	1,779	40	0	0	12	37	30	79
Forsyth	1	5	113	1	0	0	0	1	4	5
Fulton	220	1,771	39,889	681	0	0	202	616	953	1,771
Gwinnett	1	17	3,964	3	0	0	2	3	12	17
Henry	18	176	1,667	103	0	0	45	86	45	176

Paulding	13	74	1,644	39	0	0	22	29	23	74
Rockdale	0	1	23	1	0	0	0	1	0	1
Total by Age	**0**	**0**	**0**	**0**	**0**	**0**	**601**	**1,537**	**1,957**	**4,095**

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
Cherokee	1,325,894	1,325,894	0
Clayton	737,065	737,065	2,770
Cobb	2,310,020	2,310,020	825
DeKalb	3,747,091	3,747,091	18,720
Fayette	325,297	325,297	0
Forsyth	20,588	20,588	0
Fulton	7,292,415	7,292,415	7,900
Gwinnett	70,001	70,001	0
Henry	724,712	724,712	0
Paulding	304,708	304,708	550
Rockdale	4,117	4,117	0
Total	**16,861,908**	**16,861,908**	**30,765**

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 D Huggler

Date: 03/01/2017

Title: Controller

Comments: