



## 2008 Annual Hospital Questionnaire

### Part A : General Information

#### 1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

Medicaid Provider Number:

Medicare Provider Number:

#### 2. Report Period

Report Data for the full twelve month period- January 1, 2008 through December 31, 2008.  
***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:

Contact Title:

Phone:

Fax:

E-mail:

## 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. Facility Owner

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

#### B. Owner's Parent Organization

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

#### C. Facility Operator

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

#### D. Operator's Parent Organization

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

#### E. Management Contractor

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

#### F. Management's Parent Organization

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

### 2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period.

If checked, please explain in the box below and include effective dates.

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If item 3, 4, 5, 6, or 7 is checked, provide the name and location of the organization.

3. Check the box to the right if your facility is part of a health care system

Name:

City: State:

4. Check the box to the right if your hospital is a division or subsidiary of a holding company.

**Name:**

**City: State:**

**5.** Check the box to the right if the hospital itself operates subsidiary corporations

**Name:**

**City: State:**

**6.** Check the box to the right if your hospital is a member of an alliance.

**Name:**

**City: State:**

**7.** Check the box to the right if your hospital is a participant in a health care network

**Name:**

**City: State:**

**8.** Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors.

**9.** Check the box to the right if the hospital owns or operates a primary care physician group practice.

**10a. Managed Care Information: Formal Written Contract**

Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO)

2. Preferred Provider Organization(PPO)

3. Physician Hospital Organization(PHO)

4. Provider Service Organization(PSO)

**10b. Managed Care Information: Insurance Products**

Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Part D : Inpatient Services

### 1. Utilization of Beds as Set Up and Staffed (SUS):

Please indicate the following information. Do not include newborn and neonatal services. Do not include long-term care units if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

*(Use the blank lines to indicate other categories.)*

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)					
Pediatrics (Non ICU)					
Pediatric ICU					
Gynecology (No OB)					
General Medicine					
General Surgery					
Medical/Surgical					
Intensive Care					
Psychiatry					
Substance Abuse					
Adult Physical Rehabilitation (18 & Up)					
Pediatric Physical Rehabilitation (0-17)					
Burn Care					
Swing Bed (Include All Utilization)					
Long Term Care Hospital (LTCH)					

## **2. Race/Ethnicity**

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		

## **3. Gender**

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

Gender	Admissions	Inpatient Days
Male		
Female		

## **4. Payment Source**

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

Primary Payment Source	Admissions	Inpatient Days
Medicare		
Medicaid		
PeachCare		
Third-Party		
Self-Pay		
Other		

## **5. Discharges to Death**

Please report the total number of discharges during the reporting period due to death.

## **6. Charges for Selected Services**

Please report the hospital's average charges as of 12-31-2008 (to the nearest whole dollar).

Service	Charge
Private Room Rate	
Semi-Private Room Rate	
Operating Room: Average Charge for the First Hour	
Average Total Charge for an Inpatient Day	

## Part E : Emergency Department and Outpatient Services

### **1. Emergency Visits**

Please report the number of emergency visits only.

### **2. Inpatient Admissions**

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

### **3. Beds Available**

Please report the number of beds available in ER as of the last day of the report period.

### **4. Utilization by Specific type of ER bed or room for the report period.**

*(Use the blank lines to indicate other types of ER beds or rooms.)*

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma		
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases		
General Beds		

### **5. Transfers**

Please provide the number of Transfers to another institution from the Emergency Department.

### **6. Non-Emergency Visits**

Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

### **7. Observation Visits/Cases**

Please provide the total number of Observation visits/cases for the entire report period.

### **8. Diverted Cases**

Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

### **9. Ambulance Diversion Hours**

Please provide the total number of Ambulance Diversion hours for your ED for the entire report period.

## 10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

## Part F : Services and Facilities

### 1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

#### Site Codes

- 1 = In-House - Provided by the Hospital
- 2 = Contract - Provided by a contractor but onsite
- 3 = Not Applicable

#### Status Codes

- 1 = On-Going
- 2 = Newly Initiated
- 3 = Discontinued
- 4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podiatric Services		
Renal Dialysis		
ESWL		
Biliary Lithotripter		
Kidney Transplants		
Heart Transplants		
Other-Organ/Tissues Transplants		
Diagnostic X-Ray		
Computerized Tomography Scanner (CTS)		
Radioisotope, Diagnostic		
Positron Emission Tomography (PET)		
Radioisotope, Therapeutic		
Magnetic Resonance Imaging (MRI)		
Chemotherapy		
Respiratory Therapy		
Occupational Therapy		
Physical Therapy		
Speech Pathology Therapy		
Gamma Ray Knife		
Audiology Services		
HIV/AIDS Diagnostic Treatment/Services		
Ambulance Services		
Hospice		
Respite Care Services		
Ultrasound/Medical Sonography		

### **1b. Report Period Workload Totals**

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	
Number of Dialysis Treatments	
Number of ESWL Patients	
Number of ESWL Procedures	
Number of ESWL Units	
Number of Biliary Lithotripter Procedures	
Number of Biliary Lithotripter Units	
Number of Kidney Transplants	
Number of Heart Transplants	
Number of Treatments	
Number of Diagnostic X-Ray Procedures	
Number of CTS Units (machines)	
Number of CTS Procedures	
Number of Diagnostic Radioisotope Procedures	
Number of PET Units (machines)	
Number of PET Procedures	
Number of Therapeutic Radioisotope Procedures	
Number of Number of MRI Units	
Number of Number of MRI Procedures	
Number of Chemotherapy Treatments	
Number of Respiratory Therapy Treatments	
Number of Occupational Therapy Treatments	
Number of Physical Therapy Treatments	
Number of Speech Pathology Patients	
Number of Gamma Ray Knife Procedures	
Number of Gamma Ray Knife Units	
Number of Audiology Patients	
Number of HIV/AIDS Diagnostic Procedures	
Number of HIV/AIDS Patients	
Number of Ambulance Trips	
Number of Hospice Patients	
Number of Respite care Patients	
Number of Ultrasound/Medical Sonography Units	
Number of Ultrasound/Medical Sonography Procedures	
Number of Treatments, Procedures, or Patients (Other 1)	
Number of Treatments, Procedures, or Patients (Other 2)	
Number of Treatments, Procedures, or Patients (Other 3)	

### **2. Medical Ventilators**

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

## Part G : Facility Workforce Information

### 1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2008. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians			
Physician Assistants Only (not including Licensed Physicians)			
Registered Nurses (RNs-Advanced Practice*)			
Licensed Practical Nurses (LPNs)			
Pharmacists			
Other Health Services Professionals*			
Administration and Support			
All Other Hospital Personnel (not included above)			

### 2. Filling Vacancies

Using the drop-down menus, please select 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
Physician's Assistants	
Registered Nurses (RNs-Advance Practice)	
Licensed Practical Nurses (LPNs)	
Pharmacists	
Other Health Services Professionals	
All Other Hospital Personnel (not included above)	

### 3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	
Asian	
Black/African American	
Hispanic/Latino	
Pacific Islander/Hawaiian	
White	
Multi-Racial	

#### 4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plan and/or Board of Regents Benefit Plan).

*(Use the blank lines to indicate other specialties.)*

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice		<input type="checkbox"/>		
General Internal Medicine		<input type="checkbox"/>		
Pediatricians		<input type="checkbox"/>		
Other Medical Specialties		<input type="checkbox"/>		

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics		<input type="checkbox"/>		
Non-OB Physicians Providing OB Services		<input type="checkbox"/>		
Gynecology		<input type="checkbox"/>		
Ophthalmology Surgery		<input type="checkbox"/>		
Orthopedic Surgery		<input type="checkbox"/>		
Plastic Surgery		<input type="checkbox"/>		
General Surgery		<input type="checkbox"/>		
Thoracic Surgery		<input type="checkbox"/>		
Other Surgical Specialties		<input type="checkbox"/>		

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology		<input type="checkbox"/>		
Dermatology		<input type="checkbox"/>		
Emergency Medicine		<input type="checkbox"/>		
Nuclear Medicine		<input type="checkbox"/>		
Pathology		<input type="checkbox"/>		
Psychiatry		<input type="checkbox"/>		
Radiology		<input type="checkbox"/>		
		<input type="checkbox"/>		
		<input type="checkbox"/>		
		<input type="checkbox"/>		

#### 5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based

staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeons) with Admitting Privileges	
Podiatrists	
Certified Nurse Midwives with Clinical Privileges in the Hospital	
All Other Staff Affiliates with Clinical Privileges in the Hospital	

**5b. Name of Other Professions**

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

**Comments and Suggestions:**

**Part H : Physician Name and License Number**

**1. Physicians on Staff**

Please report the full name and license number of each physician on staff.

Full Name	License Number

**Part I : Patient Origin Table**

**1. Patient Origin**

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services  
 Surg=Outpatient Surgical  
 OB=Obstetric  
 P18+=Acute psychiatric adult 18 and over  
 P0-12=Acute psychiatric children 12 and under

S18+=Substance abuse adult 18 and over  
 S13-17=Substance abuse adolescent 13-17  
 E18+=Extended care adult 18 and over  
 E13-17=Extended care adolescent 13-17  
 LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
Alabama												
Appling												
Atkinson												
Bacon												
Baker												
Baldwin												





Macon													
Madison													
Marion													
McDuffie													
McIntosh													
Meriwether													
Miller													
Mitchell													
Monroe													
Montgomery													
Morgan													
Murray													
Muscogee													
Newton													
North Carolina													
Oconee													
Oglethorpe													
Other Out of State													
Paulding													
Peach													
Pickens													
Pierce													
Pike													
Polk													
Pulaski													
Putnam													
Quitman													
Rabun													
Randolph													
Richmond													
Rockdale													
Schley													
Screven													
Seminole													
South Carolina													
Spalding													
Stephens													
Stewart													
Sumter													
Talbot													
Taliaferro													
Tattnall													
Taylor													
Telfair													

Tennessee													
Terrell													
Thomas													
Tift													
Toombs													
Towns													
Treutlen													
Troup													
Turner													
Twiggs													
Union													
Upson													
Walker													
Walton													
Ware													
Warren													
Washington													
Wayne													
Webster													
Wheeler													
White													
Whitfield													
Wilcox													
Wilkes													
Worth													
<b>Total</b>													

# Surgical Services Addendum

## Part A : Surgical Services Utilization

### 1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 290-9-7-.28 .  
(Use the blank line to indicate another type of room.)

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating			
Cystoscopy (OR Suite)			
Endoscopy (OR Suite)			

### 2. Procedures by Type of Room

Please report the number of procedures by type of room.(Use the blank line to indicate another type of room.)

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating				
Cystoscopy				
Endoscopy				

### 3. Patients by Type of Room

Please report the number of patients by type of room.  
(Use the blank line to indicate another type of room.)

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating				
Cystoscopy				
Endoscopy				

## Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

### 1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	
Asian	
Black/African American	
Hispanic/Latino	
Pacific Islander/Hawaiian	
White	
Multi-Racial	

### 2. Age Grouping

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	
Ages 15-64	
Ages 65-74	
Ages 75-85	
Ages 85 and Up	

### 3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	
Female	

### 4. Payment Source

Please report the total number of ambulatory patients by payment source. Report Peachcare for Kids as Third-Party.

Primary Payment Source	Number of Ambulatory Patients
Medicare	
Medicaid	
Third-Party	
Self-Pay	

## Perinatal Services Addendum

### Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of the hospital or anywhere on its grounds.

1. Number of Delivery Rooms:
2. Number of Birthing Rooms:
3. Number of LDR Rooms:
4. Number of LDRP Rooms:
5. Number of Cesarean Sections:
6. Total Live Births:
7. Total Births (Live and Late Fetal Deaths):
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations):

### Part B : Newborn and Neonatal Nursery Services

#### 1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)				
Specialty Care (Intermediate Neonatal Care)				
Subspecialty Care (Intensive Neonatal Care)				

### Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

#### 1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		

## **2. Age Grouping**

Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14		
Ages 15-44		
Ages 45 and Up		

## **3. Average Charge for an Uncomplicated Delivery**

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

## **4. Average Charge for a Premature Delivery**

Please report the average hospital charge for a premature delivery.

## **LTCH Addendum**

### **Part A : General Information**

**1a. Accreditation** Check the box to the right if your Long Term Care Hospital is accredited.   
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

### **1b. Level/Status of Accreditation**

Please provide your organization's level/status of accreditation.

**2. Number of Licensed LTCH Beds:**

**3. Permit Effective Date:**

**4. Permit Designation:**

**5. Number of CON Beds:**

**6. Number of SUS Beds:**

**7. Total Patient Days:**

**8. Total Discharges:**

**9. Total LTCH Admissions:**

### **Part B : Utilization by Race, Age, Gender and Payment Source**

#### **1. Race/Ethnicity**

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		

**2. Age of LTCH Patient**

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-65		
Ages 65-74		
Ages 74-84		
Ages 85 and Up		

**3. Gender**

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male		
Female		

**4. Payment Source**

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare		
Third-Party		
Self-Pay		
Other		

**Psychiatric/Substance Abuse Services Addendum**

**Part A : Psychiatric and Substance Abuse Data by Program**

## 1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example, "AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over		
B- General Acute Psychiatric Adolescents 13-17		
C- General Acute Psychiatric Children 12 and under		
D- Acute Substance Abuse Adults 18 and over		
E- Acute Substance Abuse Adolescents 13-17		
F-Extended Care Adults 18 and over		
G- Extended Care Adolescents 13-17		
H- Extended Care Adolescents 0-12		

## 2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over						<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17						<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under						<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over						<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17						<input type="checkbox"/>
Extended Care Adults 18 and over						<input type="checkbox"/>
Extended Care Adolescents 13-17						<input type="checkbox"/>
Extended Care Adolescents 0-12						<input type="checkbox"/>

## Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

### 1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		

### 2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male		
Female		

### 3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare		
Medicaid		
Third Party		
Self-Pay		
PeachCare		

## Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? (Check the box, if yes.)

**If you checked yes, how many?** (FTE's)

What languages do they interpret?



## 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:**

**Date:**

**Title:**

**Comments:**