GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP611

Facility Name: Northeast Georgia Medical Center

County: Hall

Street Address: 743 Spring Street NE

City: Gainesville

Zip: 30501-3899

Mailing Address: 743 Spring Street NE

Mailing City: Gainesville

Mailing Zip: 30501-3899

Medicaid Provider Number: 00000888A

Medicare Provider Number: 110029

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: Chad Bolton

Contact Title: Director, Planning

Phone: 770-219-6630

Fax: 770-219-5437

E-mail: Chad.Bolton@nghs.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. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hosp Authority of Hall Co. & City of Gainesville	Hospital Authority	9/5/1951

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northeast Georgia Medical Center	Not for Profit	10/1/1986

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northeast Georgia Health System	Not for Profit	10/1/1986

E. Management Contractor

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

F. Management's Parent Organization

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

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.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Northeast Georgia Health System, Inc
City: Gainesville **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: Northeast Georgia Health System, Inc
City: Gainesville **State:** GA

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: VHA of GA,Inc/Vol Hosp of Amer/GA Allian Comm Hosp
City: Atlanta/Dallas/Atlanta **State:** GA/TX/GA

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Georgia 1st/MRN, NEGA Health Partners
City: Atlanta/Gainesville **State:** GA/GA

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(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☑

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	☐	☐	☑	☐
Preferred Provider Organization	☐	☑	☑	☑
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State

If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	43	4,088	11,244	4,089	11,259
Pediatrics (Non ICU)	18	633	2,031	631	2,025
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	933	1,928	925	1,907
General Medicine	151	9,416	45,685	9,406	45,659
General Surgery	150	5,110	30,086	5,083	30,097
Medical/Surgical	0	0	0	0	0
Intensive Care	41	3,559	12,708	3,570	12,882
Psychiatry	25	1,790	9,100	1,782	8,951
Substance Abuse	15	746	2,700	747	2,685
Adult Physical Rehabilitation (18 & Up)	25	232	4,062	232	4,003
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
Child/Adol/Psych/SA	14	553	2,379	551	2,382
	0	0	0	0	0
	0	0	0	0	0
Total	**482**	**27,060**	**121,923**	**27,016**	**121,850**

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	13	46
Asian	130	483
Black/African American	1,688	8,649
Hispanic/Latino	2,250	7,378
Pacific Islander/Hawaiian	0	0
White	22,739	104,379
Multi-Racial	240	988
Total	**27,060**	**121,923**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	10,947	54,979
Female	16,113	66,944
Total	**27,060**	**121,923**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	11,459	60,537
Medicaid	4,742	18,335
Peachare	7	23
Third-Party	9,235	35,793
Self-Pay	1,617	7,235
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

598

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	656
Semi-Private Room Rate	634
Operating Room: Average Charge for the First Hour	3,044
Average Total Charge for an Inpatient Day	6,176

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

94,918

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

12,822

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

55

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	10	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	0
General Beds	0	0
Chest	8	0
Fast Track	9	0
SubSpecialty	7	0
Misc	21	0

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

685

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

178,922

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

8,849

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

0

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

0

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.

2,250

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
Podatric Services	1	1
Renal Dialysis	2	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	1
Hospice	1	1
Respite Care Services	1	1
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

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	927
Number of Dialysis Treatments	3,214
Number of ESWL Patients	321
Number of ESWL Procedures	321
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	104,508
Number of CTS Units (machines)	6
Number of CTS Procedures	47,558
Number of Diagnostic Radioisotope Procedures	3,331
Number of PET Units (machines)	1
Number of PET Procedures	878
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	4
Number of Number of MRI Procedures	6,454
Number of Chemotherapy Treatments	868
Number of Respiratory Therapy Treatments	160,481
Number of Occupational Therapy Treatments	49,705
Number of Physical Therapy Treatments	146,171
Number of Speech Pathology Patients	1,252
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	138
Number of HIV/AIDS Patients	29
Number of Ambulance Trips	5,252
Number of Hospice Patients	809
Number of Respite care Patients	19
Number of Ultrasound/Medical Sonography Units	6
Number of Ultrasound/Medical Sonography Procedures	17,660
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

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).

65

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
0	0	

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	0	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	889.34002685547	21.930000305176	3.2300000190735
Licensed Practical Nurses (LPNs)	115.44000244141	3.2999999523163	1.1599999666214
Pharmacists	25.879999160767	0	0
Other Health Services Professionals*	277	17.069999694824	6.789999961853
Administration and Support	106.19000244141	4	0
All Other Hospital Personnel (not included above)	1608.6400146484	52.5	4.1799998283386

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	Not Applicable
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 Days
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	31-60 Days

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	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

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 Plant and/or Board of Regents Benefit Plan).

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	14	☐	14	10
General Internal Medicine	52	☐	24	18
Pediatricians	28	☐	26	11
Other Medical Specialties	96	☐	0	0

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	21	☐	15	19
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	27	☐	3	2
Ophthalmology Surgery	9	☐	6	5
Orthopedic Surgery	15	☐	12	5
Plastic Surgery	5	☐	5	0
General Surgery	16	☐	16	8
Thoracic Surgery	3	☐	1	0
Other Surgical Specialties	11	☐	24	18

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	24	☑	24	0
Dermatology	4	☐	4	4
Emergency Medicine	22	☑	22	0
Nuclear Medicine	0	☐	0	0
Pathology	6	☑	6	0
Psychiatry	7	☐	6	2
Radiology	20	☑	20	0
Neonatology	3	☑	5	0
	0	☐	0	0
	0	☐	0	0

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 surgeions) with Admitting Privleges	10
Podiatrists	11
Certified Nurse Midwives with Clinical Privileges in the Hospital	11
All Other Staff Affiliates with Clinical Privileges in the Hospital	122

5b. Name of Other Professions

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

NPs, PAs, AAs, & CRNAs

Comments and Suggestions:

The data presented in the AHQ and related addendum reflects the beds and services of both NGMC's Main Campus and Lanier Park Campus, which are licensed and operated as a single hospital.
D.1. Set up and Staffed bed totals are less than NGMC's approved complement of 557.
D.1 and Perinatal Services Addendum Part A.3 and B.1 - Increase through CON project 2005120.
D.1.a - Inpatient and discharge days include LDR and C-section room days; LDRs are not acute care beds.
D.4. Most Peachcare admissions and patient days are now included in the Medicaid category because the payment source for both classes of patients are the Medicaid CMOs.
F.1B. Additional CT unit through CON project 2008015.
G.3. Physician Race information is not captured during the medical staff application process.
G.4. Note 1: Medical Staff numbers as of November 2009, 2008 data not available.
Note 2: NGMC physicians do not report Medicaid/PeachCare/PEHB plan provider status to the hospital. NGMC has attempted to gather data regarding physician enrollment in those programs, but recognizes that its data are likely incomplete. NGMC also recognizes that it is very likely that a greater number of its medical staff are
enrolled providers in those programs than reflected in the data reported here.
G.5.a. Dentists and oral surgeons had co-admitting privileges as of 12/31/2008.
H.1. 2008 data not available. Data as of May 2009.
E.4. NGMC is not able to track visits by type of ED bed.
Surgical Services Addendum - Northeast Georgia Medical Center has 4 dedicated endoscopy suites adjacent to the main campus OR suite.
Part B - patient counts for this section come from a
different source than patient counts in Part A and were adjusted to tie to Part A figures.
Perinatal Addendum - Part B.1. Specialty Care (Intermediate Neonatal Care) days represent the entire length of stay of the neonate.
Minority Health Addendum - Part 6. Signage on the hospital campus utilizes universal symbols and numbers to direct non-English speaking patients to the appropriate locations. Signs are marked with braille lettering to assist the sight-impaired in locating their intended destination.
Minority Health Addendum - Part 3. While the medical center does collect Preferred Language from patients, it does not believe the data is reliable, and has chosen not to include it here. The hospital

will try to collect more accurate information in the future. Data on languages spoken by physicians is not collected.

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

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
P13-17=Acute psychiatric adolescent 13-17
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
E0-12=Extended care children 0-12
LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
Alabama	20	3	2	0	1	0	1	0	0	0	0	0
Appling	0	1	0	0	0	0	0	0	0	0	0	0
Baldwin	1	0	0	0	0	0	0	0	0	0	0	0
Banks	635	275	91	47	10	1	11	0	0	0	0	0
Barrow	236	95	33	31	8	0	14	0	0	0	0	0
Bartow	30	1	1	12	8	2	2	0	0	0	0	0
Bibb	4	0	0	0	0	0	1	0	0	0	0	0
Bulloch	1	2	0	0	0	0	0	0	0	0	0	0
Butts	2	0	0	0	0	0	0	0	0	0	0	0
Carroll	18	2	0	5	9	0	2	0	0	0	0	0
Catoosa	1	0	0	0	1	0	0	0	0	0	0	0
Chatham	0	1	0	0	0	0	0	0	0	0	0	0
Chattooga	2	1	0	0	1	0	0	0	0	0	0	0
Cherokee	77	13	8	13	14	1	5	0	0	0	0	0
Clarke	120	15	3	62	17	2	11	0	0	0	0	0
Clayton	11	1	1	0	2	0	1	0	0	0	0	0
Cobb	53	7	5	7	9	2	0	0	0	0	0	0
Columbia	2	0	0	0	0	0	1	0	0	0	0	0
Coweta	8	0	1	3	2	0	0	0	0	0	0	0
Dade	0	1	0	0	0	0	0	0	0	0	0	0
Dawson	720	246	80	51	5	1	28	0	0	0	0	0
DeKalb	71	14	7	8	13	1	4	0	0	0	0	0
Dodge	0	1	0	0	0	0	0	0	0	0	0	0
Douglas	14	9	0	2	5	0	0	0	0	0	0	0
Elbert	50	3	1	13	7	1	6	0	0	0	0	0
Emanuel	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	68	26	1	10	5	0	3	1	0	0	0	0
Fayette	4	2	0	0	0	0	0	0	0	0	0	0

Florida	63	9	1	6	0	0	0	0	0	0	0	0
Floyd	10	1	0	1	7	0	0	0	0	0	0	0
Forsyth	510	117	43	114	36	4	77	2	0	0	0	0
Franklin	222	54	10	72	11	1	19	0	0	0	0	0
Fulton	129	23	7	37	19	0	8	1	0	0	0	0
Gilmer	62	28	8	5	2	0	1	0	0	0	0	0
Glynn	2	0	0	0	0	0	0	0	0	0	0	0
Gordon	10	0	0	1	6	1	0	0	0	0	0	0
Grady	1	0	0	0	0	0	0	0	0	0	0	0
Greene	5	0	0	3	0	0	0	0	0	0	0	0
Gwinnett	878	321	145	64	27	0	33	0	0	0	0	0
Habersham	2,090	914	270	98	32	4	33	1	0	0	0	0
Hall	13,548	5,251	2,703	581	97	14	272	3	0	0	0	0
Hancock	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	9	0	0	2	3	2	0	0	0	0	0	0
Hart	95	21	2	36	8	0	17	0	0	0	0	0
Henry	11	5	0	0	5	0	0	0	0	0	0	0
Houston	6	2	0	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	1,495	695	230	69	16	2	27	0	0	0	0	0
Jefferson	1	1	0	0	0	0	0	0	0	0	0	0
Laurens	1	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	1	0	0	0	0	0	0	0	0	0	0
Lowndes	2	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	1,008	407	100	57	16	4	20	0	0	0	0	0
Macon	1	0	0	0	0	0	0	0	0	0	0	0
Madison	59	9	4	22	6	1	1	0	0	0	0	0
McDuffie	1	0	0	0	0	0	0	0	0	0	0	0
McIntosh	1	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	0	0	1	0	0	0	0	0	0	0	0
Montgomery	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	6	0	1	2	1	0	0	1	0	0	0	0
Murray	4	0	1	2	1	0	0	0	0	0	0	0
Muscogee	9	1	0	0	0	0	0	0	0	0	0	0
Newton	25	0	0	7	8	0	3	0	0	0	0	0
North Carolina	172	64	3	12	0	0	4	0	0	0	0	0
Oconee	25	6	2	7	5	0	7	0	0	0	0	0
Oglethorpe	11	1	0	6	2	0	1	0	0	0	0	0
Other Out of State	106	21	4	12	1	0	3	0	0	0	0	0
Paulding	10	1	0	5	0	1	0	0	0	0	0	0
Peach	1	0	0	0	0	0	1	0	0	0	0	0
Pickens	40	7	1	6	9	0	3	0	0	0	0	0
Pierce	1	0	0	0	0	0	0	0	0	0	0	0
Polk	7	0	0	3	1	0	1	0	0	0	0	0

Pulaski	1	0	0	0	1	0	0	0	0	0	0	0
Putnam	3	0	0	0	0	0	0	0	0	0	0	0
Rabun	738	265	38	31	3	1	18	0	0	0	0	0
Richmond	7	0	0	3	0	0	1	0	0	0	0	0
Rockdale	11	1	0	3	1	0	1	1	0	0	0	0
South Carolina	47	9	2	7	0	0	3	0	0	0	0	0
Spalding	4	0	0	0	0	1	0	0	0	0	0	0
Stephens	726	251	37	94	23	3	41	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0
Tattnall	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	13	4	0	3	0	0	0	0	0	0	0	0
Thomas	1	0	0	0	0	0	0	0	0	0	0	0
Towns	277	130	24	19	0	0	6	0	0	0	0	0
Treutlen	2	0	0	0	0	0	0	0	0	0	0	0
Troup	6	0	0	3	3	0	0	0	0	0	0	0
Union	420	184	21	41	11	1	11	0	0	0	0	0
Upson	1	0	0	0	0	0	0	0	0	0	0	0
Walker	3	0	1	1	1	0	0	0	0	0	0	0
Walton	55	14	6	17	4	1	6	0	0	0	0	0
Wayne	1	0	0	0	0	0	0	0	0	0	0	0
White	1,940	786	190	69	7	0	35	0	0	0	0	0
Whitfield	9	1	0	4	1	0	2	0	0	0	0	0
Wilcox	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	2	0	0	0	0	0	1	0	0	0	0	0
Total	**27,060**	**10,325**	**4,088**	**1,790**	**491**	**52**	**746**	**10**	**0**	**0**	**0**	**0**

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 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	2	19
Cystoscopy (OR Suite)	0	0	2
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**2**	**21**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	1,690	8,207	8,614
Cystoscopy	0	0	119	773
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**1,690**	**8,326**	**9,387**

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	1,676	7,679	7,876
Cystoscopy	0	0	119	773
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**1,676**	**7,798**	**8,649**

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	2
Asian	44
Black/African American	437
Hispanic/Latino	783
Pacific Islander/Hawaiian	0
White	9,026
Multi-Racial	33
Total	**10,325**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,157
Ages 15-64	7,213
Ages 65-74	1,236
Ages 75-85	633
Ages 85 and Up	86
Total	**10,325**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,207
Female	6,118
Total	**10,325**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	2,222
Medicaid	1,068
Third-Party	6,464
Self-Pay	571

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 th hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 18

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,120

6. Total Live Births: 3,842

7. Total Births (Live and Late Fetal Deaths): 3,850

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 4,436

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)	59	3,729	8,918	209
Specialty Care (Intermediate Neonatal Care)	10	239	4,911	52
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

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	4	10
Asian	58	134
Black/African American	244	737
Hispanic/Latino	1,368	3,437
Pacific Islander/Hawaiian	0	0
White	2,395	6,876
Multi-Racial	19	50
Total	**4,088**	**11,244**

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	6	17
Ages 15-44	4,077	11,188
Ages 45 and Up	5	39
Total	**4,088**	**11,244**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$7,078.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$14,239.00

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: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

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	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

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 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

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	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

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	25	25
B- General Acute Psychiatric Adolescents 13-17	7	7
C- General Acute Psychiatric Children 12 and under	4	4
D- Acute Substance Abuse Adults 18 and over	15	15
E- Acute Substance Abuse Adolescents 13-17	3	3
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

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	1,790	9,100	1,782	8,951	1,523	☑
General Acute Psychiatric Adolescents 13-17	491	2,050	489	2,053	1,236	☑
General Acute Psychiatric Children 12 and Under	52	297	52	297	1,183	☑
Acute Substance Abuse Adults 18 and over	746	2,700	747	2,685	1,936	☑
Acute Substance Abuse Adolescents 13-17	10	32	10	32	1,376	☑
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

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	1	5
Asian	10	66
Black/African American	269	1,439
Hispanic/Latino	49	268
Pacific Islander/Hawaiian	0	0
White	2,703	12,165
Multi-Racial	57	236
Total	**3,089**	**14,179**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,544	6,955
Female	1,545	7,224
Total	**3,089**	**14,179**

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	605	3,598
Medicaid	942	4,649
Third Party	1,484	5,691
Self-Pay	58	241
PeachCare	0	0

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? 7.2600002288818 (FTE's)
What languages do they interpret?
Spanish

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☑	Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☐

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish		0	40	203
Vietnamese		0	0	11
Korean		0	4	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

Every employee received an educational component on cultural diversity which includes how to

access translation services.

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

none

6. In what languages are the signs written that direct patients within your facility?

1. English
2.
3.
4.

7. If an uninsured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? *(Check the box, if yes)* ☑
If you checked yes, what is the name and location of that health care center or clinic?

Hall County Health Department, Good News Clinic, Medlink

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: Carol H. Burrell

Date: 1/13/2010

Title: Chief Operating Officer

Comments: