GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP626

Facility Name: Candler Hospital

County: Chatham

Street Address: 5353 Reynolds Street

City: Savannah

Zip: 31405

Mailing Address: 5353 Reynolds Street

Mailing City: Savannah

Mailing Zip: 31405

Medicaid Provider Number: 32700000

Medicare Provider Number: 110024

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: Elizabeth Medo

Contact Title: Manager, Decision Support

Phone: 912-819-8202

Fax: 912-819-8664

E-mail: medoe@sjchs.org

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
Candler Hospital, Inc.	Not for Profit	7/26/1934

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
St. Joseph's / Candler Health System, Inc.	Not for Profit	4/1/1997

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Candler Hospital, Inc.	Not for Profit	7/26/1934

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
St. Joseph's / Candler Health System, Inc.	Not for Profit	4/1/1997

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: St. Joseph's/Candler Health System, Inc.
City: Savannah   **State:** Georgia

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: Premier
City: Charlotte   **State:** NC

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: The Care Network
City: Savannah   **State:** 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)	42	3,346	9,145	3,337	9,122
Pediatrics (Non ICU)	20	657	1,892	661	1,937
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	160	7,012	35,868	7,062	36,416
Intensive Care	20	1,221	13,016	1,221	13,375
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	23	396	5,227	393	4,804
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)	40	376	10,272	376	10,272
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**305**	**13,008**	**75,420**	**13,050**	**75,926**

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	9	18
Asian	103	414
Black/African American	5,433	29,176
Hispanic/Latino	142	558
Pacific Islander/Hawaiian	0	0
White	6,913	34,845
Multi-Racial	32	137
Total	**12,632**	**65,148**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	3,818	23,305
Female	8,814	41,843
Total	**12,632**	**65,148**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,267	34,648
Medicaid	2,460	11,093
Peachare	0	0
Third-Party	4,383	17,023
Self-Pay	498	2,306
Other	24	78

5. Discharges to Death

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

276

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	800
Semi-Private Room Rate	800
Operating Room: Average Charge for the First Hour	3,117
Average Total Charge for an Inpatient Day	4,304

Part E : Emergency Department and Outpatient Services

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

50,470

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

4,483

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

34

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	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	34	50,470
	0	0
	0	0
	0	0
	0	0

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

356

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

117,582

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

2,889

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.

1,528

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	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	2	1
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
Otoneurology	1	1
	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	205
Number of Dialysis Treatments	1,941
Number of ESWL Patients	69
Number of ESWL Procedures	73
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	53,306
Number of CTS Units (machines)	3
Number of CTS Procedures	26,509
Number of Diagnostic Radioisotope Procedures	2,627
Number of PET Units (machines)	1
Number of PET Procedures	570
Number of Therapeautic Radioisotope Procedures	75
Number of Number of MRI Units	2
Number of Number of MRI Procedures	5,681
Number of Chemotherapy Treatments	2,252
Number of Respiratory Therapy Treatments	132,511
Number of Occupational Therapy Treatments	60,803
Number of Physical Therapy Treatments	99,817
Number of Speech Pathology Patients	6,771
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	3,174
Number of HIV/AIDS Patients	2,718
Number of Ambulance Trips	0
Number of Hospice Patients	156
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	17,366
Number of Treatments, Procedures, or Patients (Other 1)	1,616
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).

60

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	0.14000000059605	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	434.88000488281	1.2200000286102	3.9000000953674
Licensed Practical Nurses (LPNs)	22.729999542236	0	0
Pharmacists	12.14999961853	0	0
Other Health Services Professionals*	406.48999023438	0	4.5999999046326
Administration and Support	184.03999328613	11.840000152588	0
All Other Hospital Personnel (not included above)	325.04998779297	11.050000190735	26.879999160767

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	31-60 Days
Registered Nurses (RNs-Advance Practice)	30 Days or Less
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	31-60 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

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	10
Black/African American	25
Hispanic/Latino	14
Pacific Islander/Hawaiian	0
White	414
Multi-Racial	15

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	30	☑	28	0
General Internal Medicine	45	☑	34	0
Pediatricians	39	☐	38	0
Other Medical Specialties	116	☐	110	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	29	☐	25	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	7	☐	5	0
Ophthalmology Surgery	23	☐	20	0
Orthopedic Surgery	31	☐	28	0
Plastic Surgery	16	☐	11	0
General Surgery	15	☐	14	0
Thoracic Surgery	6	☐	6	0
Other Surgical Specialties	41	☐	39	0

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	27	☑	26	0
Dermatology	9	☐	5	0
Emergency Medicine	26	☑	26	0
Nuclear Medicine	0	☐	0	0
Pathology	5	☑	5	0
Psychiatry	1	☐	0	0
Radiology	10	☑	10	0
Radiation Oncology	2	☐	2	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	20
Podiatrists	8
Certified Nurse Midwives with Clinical Privileges in the Hospital	2
All Other Staff Affiliates with Clinical Privileges in the Hospital	4

5b. Name of Other Professions

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

Psychologist

Comments and Suggestions:

Section G, 4: # Enrolled as Providers in Medicaid/Peachcare and PEHB Plan: The Candler Medical Staff Office does not track this information. We determined participation in Medicaid/Peachcare by looking each physician up on the Medicaid physician search tool on the Georgia Health Partnership portal (http://www.ghp.georgia.gov/wps/portal). The PEHB plan participant information is no longer available on this site.

 LTCH Addendum: The LTCH numbers were provided to us by Select Specialty, the LTCH operator and license holder, and could not be verified by Candler Hospital.

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	4	1	0	0	0	0	0	0	0	0	0	0
Appling	59	38	5	0	0	0	0	0	0	0	0	6
Atkinson	2	1	0	0	0	0	0	0	0	0	0	1
Bacon	5	13	0	0	0	0	0	0	0	0	0	1
Baldwin	0	1	0	0	0	0	0	0	0	0	0	0
Ben Hill	4	1	0	0	0	0	0	0	0	0	0	1
Bibb	1	2	0	0	0	0	0	0	0	0	0	0
Brantley	8	11	0	0	0	0	0	0	0	0	0	2
Bryan	568	678	214	0	0	0	0	0	0	0	0	11
Bulloch	199	290	45	0	0	0	0	0	0	0	0	7
Burke	3	2	0	0	0	0	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0
Camden	5	12	2	0	0	0	0	0	0	0	0	2
Candler	58	50	4	0	0	0	0	0	0	0	0	2
Charlton	0	1	0	0	0	0	0	0	0	0	0	0
Chatham	8,844	4,337	2,503	0	0	0	0	0	0	0	0	165
Clarke	0	1	0	0	0	0	0	0	0	0	0	0
Clayton	1	1	0	0	0	0	0	0	0	0	0	0
Clinch	0	1	0	0	0	0	0	0	0	0	0	0
Cobb	5	1	0	0	0	0	0	0	0	0	0	0
Coffee	5	27	0	0	0	0	0	0	0	0	0	9
Colquitt	1	0	0	0	0	0	0	0	0	0	0	0
Columbia	1	0	1	0	0	0	0	0	0	0	0	0
Coweta	0	1	0	0	0	0	0	0	0	0	0	0
DeKalb	1	3	1	0	0	0	0	0	0	0	0	0
Dodge	1	3	0	0	0	0	0	0	0	0	0	0
Dougherty	1	0	0	0	0	0	0	0	0	0	0	0
Douglas	0	1	0	0	0	0	0	0	0	0	0	0

Effingham	989	838	336	0	0	0	0	0	0	0	0	15
Emanuel	45	77	3	0	0	0	0	0	0	0	0	4
Evans	98	117	11	0	0	0	0	0	0	0	0	4
Florida	0	21	1	0	0	0	0	0	0	0	0	0
Fulton	6	2	2	0	0	0	0	0	0	0	0	1
Glynn	19	52	2	0	0	0	0	0	0	0	0	12
Gwinnett	2	3	0	0	0	0	0	0	0	0	0	0
Habersham	2	0	0	0	0	0	0	0	0	0	0	0
Houston	2	4	1	0	0	0	0	0	0	0	0	0
Jeff Davis	25	22	0	0	0	0	0	0	0	0	0	4
Jefferson	1	0	0	0	0	0	0	0	0	0	0	0
Jenkins	12	8	3	0	0	0	0	0	0	0	0	2
Johnson	7	4	0	0	0	0	0	0	0	0	0	0
Laurens	7	15	1	0	0	0	0	0	0	0	0	2
Lee	1	0	0	0	0	0	0	0	0	0	0	0
Liberty	461	427	156	0	0	0	0	0	0	0	0	24
Long	54	50	18	0	0	0	0	0	0	0	0	1
Lowndes	0	1	0	0	0	0	0	0	0	0	0	0
McIntosh	49	55	12	0	0	0	0	0	0	0	0	6
Mitchell	2	1	0	0	0	0	0	0	0	0	0	0
Monroe	1	0	0	0	0	0	0	0	0	0	0	0
Montgomery	15	21	1	0	0	0	0	0	0	0	0	2
Murray	2	0	0	0	0	0	0	0	0	0	0	0
Muscogee	1	0	0	0	0	0	0	0	0	0	0	1
North Carolina	11	3	0	0	0	0	0	0	0	0	0	0
Oconee	0	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	90	18	5	0	0	0	0	0	0	0	0	40
Paulding	1	0	0	0	0	0	0	0	0	0	0	0
Peach	0	1	0	0	0	0	0	0	0	0	0	0
Pickens	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	12	15	0	0	0	0	0	0	0	0	0	0
Polk	0	1	0	0	0	0	0	0	0	0	0	0
Richmond	1	1	0	0	0	0	0	0	0	0	0	0
Screven	183	99	13	0	0	0	0	0	0	0	0	11
South Carolina	381	404	68	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	203	231	31	0	0	0	0	0	0	0	0	13
Telfair	11	8	1	0	0	0	0	0	0	0	0	2
Tennessee	0	2	0	0	0	0	0	0	0	0	0	0
Toombs	98	84	7	0	0	0	0	0	0	0	0	11
Treutlen	2	5	0	0	0	0	0	0	0	0	0	0
Turner	0	1	0	0	0	0	0	0	0	0	0	0
Upson	0	2	0	0	0	0	0	0	0	0	0	0
Ware	4	13	0	0	0	0	0	0	0	0	0	2

Wayne	48	111	6	0	0	0	0	0	0	0	0	11
Wheeler	6	6	0	0	0	0	0	0	0	0	0	1
Whitfield	0	2	0	0	0	0	0	0	0	0	0	0
Wilcox	0	1	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0
Total	**12,632**	**8,204**	**3,453**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**376**

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	0	17
Cystoscopy (OR Suite)	0	0	2
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	0	19

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	0	2,093	7,799
Cystoscopy	0	0	97	440
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	2,190	8,239

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	0	1,940	7,765
Cystoscopy	0	0	81	439
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	2,021	8,204

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	8
Asian	70
Black/African American	1,895
Hispanic/Latino	113
Pacific Islander/Hawaiian	0
White	6,082
Multi-Racial	36
Total	**8,204**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	663
Ages 15-64	5,824
Ages 65-74	1,114
Ages 75-85	523
Ages 85 and Up	80
Total	**8,204**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,533
Female	5,671
Total	**8,204**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,862
Medicaid	670
Third-Party	5,420
Self-Pay	252

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: 0

4. Number of LDRP Rooms: 14

5. Number of Cesarean Sections: 1,382

6. Total Live Births: 3,162

7. Total Births (Live and Late Fetal Deaths): 3,177

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,203

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)	35	2,687	5,447	0
Specialty Care (Intermediate Neonatal Care)	18	359	3,190	440
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	2	4
Asian	41	98
Black/African American	1,596	4,696
Hispanic/Latino	73	196
Pacific Islander/Hawaiian	0	0
White	1,726	4,437
Multi-Racial	15	42
Total	**3,453**	**9,473**

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	10	29
Ages 15-44	3,438	9,429
Ages 45 and Up	5	15
Total	**3,453**	**9,473**

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

$8,427.00

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

$13,181.00

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.

JCAHO

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

Fully Accredited

2. Number of Licensed LTCH Beds: 40

3. Permit Effective Date: 10/29/2002

4. Permit Designation: LTACH

5. Number of CON Beds: 40

6. Number of SUS Beds: 40

7. Total Patient Days: 10,272

8. Total Discharges: 364

9. Total LTCH Admissions: 376

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	1	17
Black/African American	144	4,021
Hispanic/Latino	5	116
Pacific Islander/Hawaiian	0	0
White	226	6,118
Multi-Racial	0	0
Total	**376**	**10,272**

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	129	3,572
Ages 65-74	114	3,331
Ages 75-84	97	2,332
Ages 85 and Up	36	1,037
Total	**376**	**10,272**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	169	4,586
Female	207	5,686
Total	**376**	**10,272**

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	269	7,133
Third-Party	96	2,734
Self-Pay	0	0
Other	11	405

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	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
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	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
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	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. 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**

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	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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? 0 (FTE's)
What languages do they interpret?
"Contracted" interpreters translate for Hispanic patients only.

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	Unknown	0	0	0
Vietnamese	Unknown	0	0	0
Korean	Unknown	0	0	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?

Computer based learning (CBLS) class required for all clinical and non-clinical personnel annually.

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?

Cultural competency education fairs, seminars and learning events.

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?

Affiliated:
St. Joseph's/Candler St. Mary's Health Clinic
1302 Drayton St., Savannah, GA 31404

The Good Samaritan Clinic, A Partnership Clinic of St. Joseph's Candler
Our Lady of Lourdes Catholic Church and the Department of Community Health
4704 August Rd.
Garden City, GA 31408

Non-Affiliated:
Community Health Mission, 310 Eisenhower Dr., Bldg., #5, Savannah, GA 31405
Curtis V. Cooper Primary Care, Inc.-Savannah, 840 A Hitch Dr., Savannah, GA 31401
Curtis V. Coooper Primary Care, Inc.-Garden City, 106 E. Broad St., Savannah, GA 31408
Union Mission J.C. Lewis Health Center, 107 Fahm St., Savannah, GA 31401

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: Paul P. Hinchey

Date: 9/18/2009

Title: President & CEO

Comments:

Part D, 1: 14 PCU beds were reported as ICU beds in previous years' surveys. After internal review, these PCU beds were moved to the Med/Surg category for the 2008 survey.

Part D, 1: Inpatient days and discharge days associated with ICU include all days associated with the patient stay. In many instances, this would include days where the patient was in a Med/Surg bed.

Part D, 2, 3 and 4 - Patient Origin: Admissions and patient days in the race, gender, payment source and patient origin sections do not include numbers from the LTCH, a separately licensed provider. Those numbers are reported on the LTCH addendum.

Part E, 4: SJH does not dedicate ER beds to specific services.

Part E, 8 and 9: Candler did not experience a general ambulance diversion in 2008. In the rare instance when it is necessary, Candler diverts ambulances to SJH, its sister facility. Candler does not track the ED cases that are "diverted" in those instances; so the most accurate response to E.8 is "not available".

Part F, 1b: Number of Treatments, Procedures or Patients (Other1) = Otoneurology Procedures.

Part G, 4 - Number of Medical Staff: The data reflected in Part G, 4 is the most accurate data available, but may not precisely reflect the physician staff database as of December 31, 2008.

Part G, 4 - #Enrolled as Providers in Medicaid/Peachcare and PEHB Plan: The SJC Medical Staff Office does not track this information. We determined participation by looking each physician on staff up on the Medicaid physician search tool on http://www.ghp.georgia.gov/wps/portal (the Georgia Health Partnership portal). The PEHB plan participant information is no longer available on this site.

Surgical Services Addendum, Part B1: The figures reported on the 2007 AHQ for 1) Pacific Islander Hawaiian; 2) White; and 3) Multi-racial categories were incorrect. The correct numbers should be:

Pacific Islander/Hawaiian = 0; White = 7,265; and Multi-Racial = 47

LTCH Addendum: The LTCH numbers were provided to us by Select Specialty, the LTCH operator and license holder, and could not be verified by Candler Hospital.

Georgia Minority Advisory Council Addendum- Q3: SJC does not track information regarding languages spoken by physicians, nurses and other employed staff. The accurate response would be "unknown".