GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP706

Facility Name: Emory University Hospital

County: DeKalb

Street Address: 1364 Clifton Road NE

City: Atlanta

Zip: 30322-1061

Mailing Address: 1364 Clifton Road NE

Mailing City: Atlanta

Mailing Zip: 30322-1061

Medicaid Provider Number: 0000712

Medicare Provider Number: 110010

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: Toni Wimby

Contact Title: Associate Administrator

Phone: 404-686-2818

Fax: 404-686-2848

E-mail: toni.wimby@emoryhealthcare.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
Emory University d/b/a Emory University Hospital	Not for Profit	1/1/1922

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
N/A	Not Applicable	

D. Operator's Parent Organization

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

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: Emory Healthcare

City: Atlanta **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: University Healthcare Consortium
City: Chicago **State:** Illinois

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Emory Healthcare
City: Atlanta **State:** Georgia

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)	0	0	0	0	0
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	274	14,309	79,251	14,769	79,911
General Surgery	0	0	0	0	0
Medical/Surgical	117	6,503	36,907	6,507	36,419
Intensive Care	93	1,685	29,003	1,158	28,990
Psychiatry	18	585	3,841	590	3,969
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	46	758	10,847	756	10,951
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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**548**	**23,840**	**159,849**	**23,780**	**160,240**

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	0	0
Asian	0	0
Black/African American	6,695	49,823
Hispanic/Latino	351	2,673
Pacific Islander/Hawaiian	0	0
White	14,933	95,602
Multi-Racial	1,861	11,751
Total	**23,840**	**159,849**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,695	79,915
Female	12,145	79,934
Total	**23,840**	**159,849**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10,412	69,005
Medicaid	1,818	17,658
Peachare	0	0
Third-Party	10,446	65,021
Self-Pay	1,164	8,165
Other	0	0

5. Discharges to Death

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

799

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	1,000
Semi-Private Room Rate	995
Operating Room: Average Charge for the First Hour	2,940
Average Total Charge for an Inpatient Day	6,795

Part E : Emergency Department and Outpatient Services

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

31,363

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

7,251

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

21

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	1	186
General Beds	20	31,177
	0	0
	0	0
	0	0
	0	0

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

1,084

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

45,299

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

4,940

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

210

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

303.00

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.

878

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	3	4
Renal Dialysis	1	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
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	1	1
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	2	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
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	0
Number of Dialysis Treatments	5,141
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	163
Number of Heart Transplants	23
Number of Other-Organ/Tissues Treatments	303
Number of Diagnostic X-Ray Procedures	133,658
Number of CTS Units (machines)	2
Number of CTS Procedures	29,842
Number of Diagnostic Radioisotope Procedures	8,560
Number of PET Units (machines)	1
Number of PET Procedures	2,516
Number of Therapeautic Radioisotope Procedures	1,211
Number of Number of MRI Units	2
Number of Number of MRI Procedures	9,046
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	297,896
Number of Occupational Therapy Treatments	35,496
Number of Physical Therapy Treatments	50,521
Number of Speech Pathology Patients	21,814
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	10,827
Number of HIV/AIDS Patients	213
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	3
Number of Ultrasound/Medical Sonography Procedures	10,052
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).

64

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			
Physician Assistants Only (not including Licensed Physicians)			
Registered Nurses (RNs-Advanced Practice*)	1108		
Licensed Practical Nurses (LPNs)	0.80000001192093		
Pharmacists	56.5		
Other Health Services Professionals*	916.59997558594		
Administration and Support	1051.4000244141		0
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	31-60 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 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	3	☐	3	0
General Internal Medicine	46	☐	46	0
Pediatricians	35	☐	35	0
Other Medical Specialties	331	☐	331	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	15	☐	15	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	14	☐	14	0
Ophthalmology Surgery	35	☐	35	0
Orthopedic Surgery	23	☐	23	0
Plastic Surgery	4	☐	4	0
General Surgery	29	☐	29	0
Thoracic Surgery	20	☐	20	0
Other Surgical Specialties	30	☐	30	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	93	☑	93	0
Dermatology	13	☐	13	0
Emergency Medicine	70	☑	70	0
Nuclear Medicine	14	☑	14	0
Pathology	58	☑	58	0
Psychiatry	56	☐	56	0
Radiology	72	☑	72	0
Rad Oncology	16	☑	16	0
Rehab	7	☐	7	0
Hospitalists	67	☑	67	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	2
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	278

5b. Name of Other Professions

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

Physician Assistants, Nurse Practitioners, Registered Nurses, Certified Registered Nurses

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. **(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
Appling	1	0	0	0	0	0	0	0	0	0	0	0
Atkinson	8	1	0	0	0	0	0	0	0	0	0	0
Bacon	3	1	0	0	0	0	0	0	0	0	0	0
Baker	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	90	5	0	1	0	0	0	0	0	0	0	0
Banks	24	2	0	0	0	0	0	0	0	0	0	0
Barrow	154	13	0	3	0	0	0	0	0	0	0	0
Bartow	189	40	0	6	0	0	0	0	0	0	0	0
Ben Hill	22	3	0	0	0	0	0	0	0	0	0	0
Berrien	22	3	0	0	0	0	0	0	0	0	0	0
Bibb	236	38	0	1	0	0	0	0	0	0	0	0
Bleckley	11	0	0	0	0	0	0	0	0	0	0	0
Brantley	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	9	2	0	1	0	0	0	0	0	0	0	0
Bryan	12	0	0	1	0	0	0	0	0	0	0	0
Bulloch	9	2	0	1	0	0	0	0	0	0	0	0
Burke	7	0	0	0	0	0	0	0	0	0	0	0
Butts	89	16	0	1	0	0	0	0	0	0	0	0
Calhoun	12	0	0	0	0	0	0	0	0	0	0	0
Camden	6	0	0	0	0	0	0	0	0	0	0	0
Candler	5	1	0	1	0	0	0	0	0	0	0	0
Carroll	386	49	0	5	0	0	0	0	0	0	0	0
Catoosa	32	1	0	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	77	4	0	0	0	0	0	0	0	0	0	0
Chattahoochee	11	2	0	0	0	0	0	0	0	0	0	0
Chattooga	32	5	0	0	0	0	0	0	0	0	0	0
Cherokee	370	50	0	5	0	0	0	0	0	0	0	0

Clarke	138	18	0	2	0	0	0	0	0	0	0	0
Clay	27	1	0	0	0	0	0	0	0	0	0	0
Clayton	503	48	0	6	0	0	0	0	0	0	0	0
Clinch	1	3	0	0	0	0	0	0	0	0	0	0
Cobb	1,182	176	0	24	0	0	0	0	0	0	0	0
Coffee	40	6	0	1	0	0	0	0	0	0	0	0
Colquitt	74	12	0	0	0	0	0	0	0	0	0	0
Columbia	39	3	0	1	0	0	0	0	0	0	0	0
Cook	25	4	0	0	0	0	0	0	0	0	0	0
Coweta	302	46	0	5	0	0	0	0	0	0	0	0
Crawford	4	1	0	0	0	0	0	0	0	0	0	0
Crisp	32	3	0	0	0	0	0	0	0	0	0	0
Dade	3	2	0	0	0	0	0	0	0	0	0	0
Dawson	54	8	0	0	0	0	0	0	0	0	0	0
Decatur	8	3	0	0	0	0	0	0	0	0	0	0
DeKalb	5,388	503	0	166	0	0	0	0	0	0	0	0
Dodge	21	3	0	1	0	0	0	0	0	0	0	0
Dooly	17	6	0	0	0	0	0	0	0	0	0	0
Dougherty	84	8	0	1	0	0	0	0	0	0	0	0
Douglas	283	44	0	2	0	0	0	0	0	0	0	0
Early	9	0	0	0	0	0	0	0	0	0	0	0
Echols	1	1	0	0	0	0	0	0	0	0	0	0
Effingham	13	0	0	2	0	0	0	0	0	0	0	0
Elbert	49	8	0	0	0	0	0	0	0	0	0	0
Emanuel	9	0	0	0	0	0	0	0	0	0	0	0
Fannin	34	8	0	0	0	0	0	0	0	0	0	0
Fayette	228	41	0	7	0	0	0	0	0	0	0	0
Floyd	128	11	0	4	0	0	0	0	0	0	0	0
Forsyth	184	46	0	3	0	0	0	0	0	0	0	0
Franklin	55	3	0	0	0	0	0	0	0	0	0	0
Fulton	2,869	376	0	172	0	0	0	0	0	0	0	0
Gilmer	46	6	0	0	0	0	0	0	0	0	0	0
Glascock	2	0	0	0	0	0	0	0	0	0	0	0
Glynn	40	2	0	0	0	0	0	0	0	0	0	0
Gordon	100	9	0	0	0	0	0	0	0	0	0	0
Grady	10	2	0	0	0	0	0	0	0	0	0	0
Greene	36	6	0	1	0	0	0	0	0	0	0	0
Gwinnett	2,040	306	0	36	0	0	0	0	0	0	0	0
Habersham	89	15	0	1	0	0	0	0	0	0	0	0
Hall	254	61	0	5	0	0	0	0	0	0	0	0
Hancock	26	3	0	0	0	0	0	0	0	0	0	0
Haralson	80	11	0	0	0	0	0	0	0	0	0	0
Harris	68	9	0	0	0	0	0	0	0	0	0	0
Hart	61	7	0	0	0	0	0	0	0	0	0	0

Heard	35	4	0	0	0	0	0	0	0	0	0	0
Henry	744	93	0	15	0	0	0	0	0	0	0	0
Houston	219	20	0	0	0	0	0	0	0	0	0	0
Irwin	19	3	0	0	0	0	0	0	0	0	0	0
Jackson	140	13	0	1	0	0	0	0	0	0	0	0
Jasper	46	7	0	0	0	0	0	0	0	0	0	0
Jeff Davis	3	3	0	0	0	0	0	0	0	0	0	0
Jefferson	14	2	0	1	0	0	0	0	0	0	0	0
Jenkins	3	0	0	0	0	0	0	0	0	0	0	0
Johnson	8	0	0	0	0	0	0	0	0	0	0	0
Jones	17	1	0	0	0	0	0	0	0	0	0	0
Lamar	48	3	0	2	0	0	0	0	0	0	0	0
Lanier	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	62	11	0	2	0	0	0	0	0	0	0	0
Lee	56	7	0	0	0	0	0	0	0	0	0	0
Liberty	8	1	0	0	0	0	0	0	0	0	0	0
Lincoln	7	0	0	0	0	0	0	0	0	0	0	0
Long	1	1	0	0	0	0	0	0	0	0	0	0
Lowndes	133	5	0	1	0	0	0	0	0	0	0	0
Lumpkin	39	5	0	0	0	0	0	0	0	0	0	0
Macon	38	1	0	0	0	0	0	0	0	0	0	0
Madison	59	6	0	1	0	0	0	0	0	0	0	0
Marion	8	1	0	0	0	0	0	0	0	0	0	0
McDuffie	18	1	0	0	0	0	0	0	0	0	0	0
McIntosh	2	0	0	0	0	0	0	0	0	0	0	0
Meriwether	75	10	0	0	0	0	0	0	0	0	0	0
Miller	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	23	1	0	0	0	0	0	0	0	0	0	0
Monroe	31	4	0	0	0	0	0	0	0	0	0	0
Montgomery	20	9	0	0	0	0	0	0	0	0	0	0
Morgan	51	10	0	3	0	0	0	0	0	0	0	0
Murray	86	10	0	0	0	0	0	0	0	0	0	0
Muscogee	265	27	0	5	0	0	0	0	0	0	0	0
Newton	422	47	0	9	0	0	0	0	0	0	0	0
Oconee	103	11	0	1	0	0	0	0	0	0	0	0
Oglethorpe	12	3	0	0	0	0	0	0	0	0	0	0
Other Out of State	1,730	215	0	45	0	0	0	0	0	0	0	0
Paulding	148	28	0	0	0	0	0	0	0	0	0	0
Peach	56	6	0	0	0	0	0	0	0	0	0	0
Pickens	75	15	0	0	0	0	0	0	0	0	0	0
Pierce	12	2	0	1	0	0	0	0	0	0	0	0
Pike	64	5	0	0	0	0	0	0	0	0	0	0
Polk	87	14	0	1	0	0	0	0	0	0	0	0
Pulaski	24	3	0	0	0	0	0	0	0	0	0	0

Putnam	48	8	0	0	0	0	0	0	0	0	0	0
Rabun	32	7	0	1	0	0	0	0	0	0	0	0
Randolph	15	1	0	0	0	0	0	0	0	0	0	0
Richmond	81	15	0	2	0	0	0	0	0	0	0	0
Rockdale	402	44	0	7	0	0	0	0	0	0	0	0
Schley	4	1	0	0	0	0	0	0	0	0	0	0
Screven	5	1	0	0	0	0	0	0	0	0	0	0
Seminole	6	0	0	0	0	0	0	0	0	0	0	0
Spalding	215	24	0	5	0	0	0	0	0	0	0	0
Stephens	109	8	0	0	0	0	0	0	0	0	0	0
Stewart	2	1	0	0	0	0	0	0	0	0	0	0
Sumter	53	3	0	0	0	0	0	0	0	0	0	0
Talbot	25	2	0	0	0	0	0	0	0	0	0	0
Tattnall	11	1	0	0	0	0	0	0	0	0	0	0
Taylor	30	0	0	0	0	0	0	0	0	0	0	0
Telfair	24	5	0	0	0	0	0	0	0	0	0	0
Terrell	7	2	0	0	0	0	0	0	0	0	0	0
Thomas	31	7	0	0	0	0	0	0	0	0	0	0
Tift	84	6	0	1	0	0	0	0	0	0	0	0
Toombs	17	5	0	0	0	0	0	0	0	0	0	0
Towns	57	8	0	1	0	0	0	0	0	0	0	0
Treutlen	9	0	0	0	0	0	0	0	0	0	0	0
Troup	317	27	0	5	0	0	0	0	0	0	0	0
Turner	13	1	0	0	0	0	0	0	0	0	0	0
Twiggs	7	2	0	0	0	0	0	0	0	0	0	0
Union	59	6	0	0	0	0	0	0	0	0	0	0
Upson	54	10	0	0	0	0	0	0	0	0	0	0
Walker	37	4	0	0	0	0	0	0	0	0	0	0
Walton	287	50	0	1	0	0	0	0	0	0	0	0
Ware	9	0	0	0	0	0	0	0	0	0	0	0
Warren	6	0	0	0	0	0	0	0	0	0	0	0
Washington	19	2	0	0	0	0	0	0	0	0	0	0
Wayne	13	4	0	1	0	0	0	0	0	0	0	0
Wheeler	3	0	0	0	0	0	0	0	0	0	0	0
White	46	8	0	2	0	0	0	0	0	0	0	0
Whitfield	153	16	0	5	0	0	0	0	0	0	0	0
Wilcox	13	2	0	0	0	0	0	0	0	0	0	0
Wilkes	5	1	0	0	0	0	0	0	0	0	0	0
Wilkinson	19	1	0	0	0	0	0	0	0	0	0	0
Worth	24	1	0	0	0	0	0	0	0	0	0	0
Total	**23,840**	**2,959**	**0**	**585**	**0**	**0**	**0**	**0**	**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	0	21
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**22**

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	9,089	2,602
Cystoscopy	0	0	142	357
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**9,231**	**2,959**

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	9,089	2,602
Cystoscopy	0	0	142	357
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**9,231**	**2,959**

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	0
Asian	0
Black/African American	583
Hispanic/Latino	35
Pacific Islander/Hawaiian	0
White	2,074
Multi-Racial	267
Total	**2,959**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	6
Ages 15-64	2,225
Ages 65-74	473
Ages 75-85	223
Ages 85 and Up	32
Total	**2,959**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,409
Female	1,550
Total	**2,959**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	874
Medicaid	156
Third-Party	1,876
Self-Pay	53

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: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

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)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
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	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 Grouping
Please provide the number of admissions by the following age groupings.

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

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

$0.00

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

$0.00

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	47	18
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	585	3,841	590	3,969	2,177	☑
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	219	1,297
Hispanic/Latino	5	67
Pacific Islander/Hawaiian	0	0
White	298	2,088
Multi-Racial	63	389
Total	**585**	**3,841**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	255	1,695
Female	330	2,146
Total	**585**	**3,841**

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	224	1,506
Medicaid	149	1,061
Third Party	195	1,168
Self-Pay	17	106
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? 1 (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	73	0	0	0
Chinese	14	0	0	0
Vietnamese	13	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?

Emory University Hospital's leadership received a brief orientation to cultural competency and

diversity durin their annual planning/goal-setting retreat.

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?

The recommendation to purchase Culture Vision and the Diversity Toolkit have been made and approved for purchase

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

1. English
2. Braille
3. Spanish
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?

Good Samaritan Health Center, 239 Ivan Allen Jr. Blvd. NW, Atlanta, GA 30313 and Grady Clinics 80 Jessie hill Jr. Drive, Atlanta, GA 30303, County Health Services in the county of residenc for patients residing outside of Fulton/Dekalb

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: Robert Bachman

Date: 10/5/2009

Title: Chief Operating Officer

Comments: