



2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP534

Facility Name: Emory Eastside Medical Center

County: Gwinnett

Street Address: 1700 Medical Way

City: Snellville

Zip: 30078-2195

Mailing Address: P O Box 587

Mailing City: Snellville

Mailing Zip: 30078-0587

Medicaid Provider Number: 0019088

Medicare Provider Number: 110192

2. Report Period

Report Data for the full twelve month period- January 1, 2009 through December 31, 2009.
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: Charles McKinney

Contact Title: Controller

Phone: 770-736-2495

Fax: 770-736-2395

E-mail: Charles.McKinney@HCAHealthcare.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
Atlanta Healthcare Management, L.P.	For Profit	2/1/1999

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
HCA, Inc	For Profit	2/1/1999

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
EHCA Eastside, LLC	For Profit	2/1/1999

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
EHCA, LLC	For Profit	2/1/1999

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
HCA, Inc	For Profit	2/1/1999

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
HCA, Inc	For Profit	2/1/1999

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: HCA, Inc

City: Nashville State: TN

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

Name: EHCA, LLC

City: Atlanta 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:

City: State:

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

Name: Emory / HCA, Inc

City: Atlanta / Nashville State: GA / TN

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

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

10a. Managed Care Information: Formal Written Contract

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

1. Health Maintenance Organization(HMO)

2. Preferred Provider Organization(PPO)

3. Physician Hospital Organization(PHO)

4. Provider Service Organization(PSO)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. Do not include newborn and neonatal services. Do not include long-term care units, 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)	22	2,420	5,921	2,432	5,983
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	30	2,576	11,148	2,829	11,217
General Surgery	43	1,975	10,615	2,475	10,617
Medical/Surgical	0	0	0	0	0
Intensive Care	20	959	5,575	418	5,642
Psychiatry	61	1,430	15,970	1,452	16,175
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	259	4,075	260	4,097
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
PCU	18	1,440	6,163	1,223	6,190
Ortho/Spine Unit	17	635	1,975	649	1,962
	0	0	0	0	0
Total	231	11,694	61,442	11,738	61,883

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	5	18
Asian	490	1,922
Black/African American	2,623	13,422
Hispanic/Latino	383	1,561
Pacific Islander/Hawaiian	0	0
White	8,126	44,152
Multi-Racial	67	367
Total	11,694	61,442

3. Gender

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

Gender	Admissions	Inpatient Days
Male	3,772	22,572
Female	7,922	38,870
Total	11,694	61,442

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,638	39,056
Medicaid	1,201	4,669
Peachare	0	0
Third-Party	4,046	14,265
Self-Pay	809	3,452
Other	0	0

5. Discharges to Death

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

188

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2009 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,069
Semi-Private Room Rate	1,069
Operating Room: Average Charge for the First Hour	3,490
Average Total Charge for an Inpatient Day	6,642

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

59,083

2. Inpatient Admissions from ER

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

6,484

3. Beds Available

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

31

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	31	50,154
Pediatric Urgent Care (shares with Day Surgery)	5	8,929
	0	0
	0	0
	0	0

5. Transfers

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

779

6. Non-Emergency Visits

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

80,651

7. Observation Visits/Cases

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

4,495

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.

1,301

Part F : Services and Facilities

1a. Services and Facilities

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

Site Codes

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

Status Codes

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

Service/Facilities	Site Code	Service Status
Podiatric Services	1	1
Renal Dialysis	2	1
ESWL	2	1
Biliary Lithotripter	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, Diagnostic	1	1
Positron Emission Tomography (PET)	3	3
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	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	2	1
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	3	4
	3	4
	3	4

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	1,619
Number of Dialysis Treatments	1,162
Number of ESWL Patients	23
Number of ESWL Procedures	27
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	54,923
Number of CTS Units (machines)	3
Number of CTS Procedures	23,858
Number of Diagnostic Radioisotope Procedures	5,034
Number of PET Units (machines)	1
Number of PET Procedures	11
Number of Therapeutic Radioisotope Procedures	29
Number of Number of MRI Units	1
Number of Number of MRI Procedures	4,020
Number of Chemotherapy Treatments	190
Number of Respiratory Therapy Treatments	132,070
Number of Occupational Therapy Treatments	24,132
Number of Physical Therapy Treatments	42,590
Number of Speech Pathology Patients	1,447
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,269
Number of HIV/AIDS Diagnostic Procedures	2,119
Number of HIV/AIDS Patients	76
Number of Ambulance Trips	626
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	13,561
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).

20

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 12-31-2009. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2009.

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*)	360	30	4
Licensed Practical Nurses (LPNs)	39	0	2
Pharmacists	11	1	0
Other Health Services Professionals*	316	6	0
Administration and Support	137	2	0
All Other Hospital Personnel (not included above)	167	21	1

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)	30 Days or Less
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)	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	95
Black/African American	47
Hispanic/Latino	4
Pacific Islander/Hawaiian	1
White	212
Multi-Racial	1

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	34	<input type="checkbox"/>	18	34
General Internal Medicine	39	<input checked="" type="checkbox"/>	11	36
Pediatricians	32	<input type="checkbox"/>	22	27
Other Medical Specialties	160	<input type="checkbox"/>	81	99

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	24	<input type="checkbox"/>	18	14
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	5	<input type="checkbox"/>	3	5
Ophthalmology Surgery	7	<input type="checkbox"/>	6	6
Orthopedic Surgery	12	<input type="checkbox"/>	11	12
Plastic Surgery	4	<input type="checkbox"/>	0	1
General Surgery	8	<input type="checkbox"/>	7	8
Thoracic Surgery	1	<input type="checkbox"/>	1	1
Other Surgical Specialties	26	<input type="checkbox"/>	20	17

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	10	<input checked="" type="checkbox"/>	10	10
Dermatology	5	<input type="checkbox"/>	0	1
Emergency Medicine	18	<input checked="" type="checkbox"/>	18	18
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	11	<input checked="" type="checkbox"/>	11	11
Psychiatry	3	<input type="checkbox"/>	3	3
Radiology	41	<input checked="" type="checkbox"/>	41	6
Neonatology	3	<input checked="" type="checkbox"/>	3	3
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	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 surgeons) with Admitting Privileges	4
Podiatrists	5
Certified Nurse Midwives with Clinical Privileges in the Hospital	5
All Other Staff Affiliates with Clinical Privileges in the Hospital	98

5b. Name of Other Professions

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

NP, CRNA, RN, PA, Certified Surgical Assistant, PhD (Psychologist), RNFA, Cardiac Sonographer, LPN, Dental Assistant, MSW

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
Alabama	12	2	0	0	0	0	0	0	0	0	0	0
Baldwin	2	1	0	2	0	0	0	0	0	0	0	0
Banks	6	2	1	3	0	0	0	0	0	0	0	0
Barrow	238	130	90	31	0	0	0	0	0	0	0	0
Bartow	2	0	1	1	0	0	0	0	0	0	0	0
Berrien	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	2	2	0	0	0	0	0	0	0	0	0	0
Bulloch	0	1	0	0	0	0	0	0	0	0	0	0
Butts	2	1	0	2	0	0	0	0	0	0	0	0
Carroll	5	3	0	5	0	0	0	0	0	0	0	0
Chatham	4	1	0	0	0	0	0	0	0	0	0	0
Cherokee	25	1	1	20	0	0	0	0	0	0	0	0
Clarke	45	9	1	31	0	0	0	0	0	0	0	0
Clayton	26	7	1	17	0	0	0	0	0	0	0	0
Cobb	64	19	5	46	0	0	0	0	0	0	0	0
Columbia	4	0	1	0	0	0	0	0	0	0	0	0
Coweta	5	0	2	2	0	0	0	0	0	0	0	0
Dawson	8	0	0	4	0	0	0	0	0	0	0	0
DeKalb	944	371	96	208	0	0	0	0	0	0	0	0
Dooly	1	0	0	0	0	0	0	0	0	0	0	0
Dougherty	0	1	0	0	0	0	0	0	0	0	0	0
Douglas	10	7	0	2	0	0	0	0	0	0	0	0
Effingham	0	2	0	0	0	0	0	0	0	0	0	0
Elbert	1	1	0	1	0	0	0	0	0	0	0	0
Evans	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	3	0	0	1	0	0	0	0	0	0	0	0
Fayette	10	4	0	9	0	0	0	0	0	0	0	0
Florida	41	8	0	3	0	0	0	0	0	0	0	0

Floyd	4	0	0	3	0	0	0	0	0	0	0	0
Forsyth	39	10	2	29	0	0	0	0	0	0	0	0
Franklin	3	2	0	0	0	0	0	0	0	0	0	0
Fulton	270	42	8	206	0	0	0	0	0	0	0	0
Gilmer	3	2	0	1	0	0	0	0	0	0	0	0
Greene	2	2	0	2	0	0	0	0	0	0	0	0
Gwinnett	6,937	3,165	1,502	444	0	0	0	0	0	0	0	0
Habersham	5	7	0	4	0	0	0	0	0	0	0	0
Hall	66	31	18	28	0	0	0	0	0	0	0	0
Hancock	1	0	1	0	0	0	0	0	0	0	0	0
Haralson	1	0	0	0	0	0	0	0	0	0	0	0
Harris	1	0	0	1	0	0	0	0	0	0	0	0
Hart	4	2	0	3	0	0	0	0	0	0	0	0
Henry	24	13	1	9	0	0	0	0	0	0	0	0
Houston	2	0	0	2	0	0	0	0	0	0	0	0
Jackson	74	53	30	17	0	0	0	0	0	0	0	0
Jasper	13	3	3	0	0	0	0	0	0	0	0	0
Jefferson	1	0	0	1	0	0	0	0	0	0	0	0
Jones	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	3	0	0	1	0	0	0	0	0	0	0	0
Laurens	1	0	1	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	0	0	0	0	0	0	0	0
Lincoln	2	0	1	0	0	0	0	0	0	0	0	0
Lowndes	3	0	1	0	0	0	0	0	0	0	0	0
Lumpkin	7	2	0	7	0	0	0	0	0	0	0	0
Macon	1	0	1	0	0	0	0	0	0	0	0	0
Madison	5	3	0	2	0	0	0	0	0	0	0	0
McDuffie	0	1	0	0	0	0	0	0	0	0	0	0
Meriwether	2	0	0	1	0	0	0	0	0	0	0	0
Morgan	10	8	1	6	0	0	0	0	0	0	0	0
Murray	2	0	0	2	0	0	0	0	0	0	0	0
Muscogee	2	0	0	1	0	0	0	0	0	0	0	0
Newton	187	97	25	28	0	0	0	0	0	0	0	0
North Carolina	14	3	0	1	0	0	0	0	0	0	0	0
Oconee	11	5	0	4	0	0	0	0	0	0	0	0
Oglethorpe	3	2	0	2	0	0	0	0	0	0	0	0
Other Out of State	92	26	0	14	0	0	0	0	0	0	0	0
Paulding	4	0	2	1	0	0	0	0	0	0	0	0
Pickens	4	1	0	2	0	0	0	0	0	0	0	0
Polk	2	0	0	1	0	0	0	0	0	0	0	0
Putnam	5	3	0	3	0	0	0	0	0	0	0	0
Rabun	13	2	0	9	0	0	0	0	0	0	0	0
Richmond	1	0	0	1	0	0	0	0	0	0	0	0
Rockdale	178	87	9	48	0	0	0	0	0	0	0	0

South Carolina	12	1	0	4	0	0	0	0	0	0	0	0
Spalding	5	0	1	2	0	0	0	0	0	0	0	0
Stephens	9	2	1	3	0	0	0	0	0	0	0	0
Taliaferro	2	0	0	2	0	0	0	0	0	0	0	0
Tattnall	3	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	0	0	1	0	0	0	0	0	0	0	0
Tennessee	10	1	0	1	0	0	0	0	0	0	0	0
Towns	1	4	0	0	0	0	0	0	0	0	0	0
Troup	1	0	0	1	0	0	0	0	0	0	0	0
Twiggs	2	0	0	1	0	0	0	0	0	0	0	0
Union	2	2	1	1	0	0	0	0	0	0	0	0
Walker	0	1	0	0	0	0	0	0	0	0	0	0
Walton	2,156	1,151	448	123	0	0	0	0	0	0	0	0
Washington	1	0	0	1	0	0	0	0	0	0	0	0
Wheeler	1	0	0	1	0	0	0	0	0	0	0	0
White	20	2	0	15	0	0	0	0	0	0	0	0
Whitfield	2	0	0	2	0	0	0	0	0	0	0	0
Wilkes	0	1	0	0	0	0	0	0	0	0	0	0
Wilkinson	0	1	0	0	0	0	0	0	0	0	0	0
Total	11,694	5,311	2,256	1,430	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	8
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	0	9

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	2,033	5,143
Cystoscopy	0	0	61	186
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	2,094	5,329

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	1,998	5,125
Cystoscopy	0	0	61	186
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	2,059	5,311

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	4
Asian	164
Black/African American	897
Hispanic/Latino	166
Pacific Islander/Hawaiian	0
White	4,059
Multi-Racial	21
Total	5,311

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	124
Ages 15-64	3,870
Ages 65-74	817
Ages 75-85	424
Ages 85 and Up	76
Total	5,311

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,759
Female	3,552
Total	5,311

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,358
Medicaid	251
Third-Party	3,503
Self-Pay	199

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: 13
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 829
6. Total Live Births: 2,269
7. Total Births (Live and Late Fetal Deaths): 2,298
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,416

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)	20	1,965	3,886	133
Specialty Care (Intermediate Neonatal Care)	10	233	2,115	110
Subspecialty Care (Intensive Neonatal Care)	8	92	661	474

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	6	14
Asian	232	574
Black/African American	595	1,582
Hispanic/Latino	127	294
Pacific Islander/Hawaiian	0	0
White	1,278	3,012
Multi-Racial	18	50
Total	2,256	5,526

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	2	6
Ages 15-44	2,248	5,508
Ages 45 and Up	6	12
Total	2,256	5,526

3. Average Charge for an Uncomplicated Delivery

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

\$7,994.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$18,849.00

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	61	61
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	1,430	15,970	1,452	16,175	2,437	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	15	100
Black/African American	237	2,570
Hispanic/Latino	19	191
Pacific Islander/Hawaiian	0	0
White	1,155	13,047
Multi-Racial	4	62
Total	1,430	15,970

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	516	5,745
Female	914	10,225
Total	1,430	15,970

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	1,344	15,164
Medicaid	57	507
Third Party	24	220
Self-Pay	5	79
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?

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 Interpreter

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	5	4	0	0
Farsi/Urdu	1	3	0	0
Vietnamese	1	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?

In 2009, the Emory Eastside CEO facilitated The Standards of Service Excellence education for

every current employee and since has provided every new hire coming through Orientation with the same education. Included in this message are the shared values of Integrity, Compassion, A Positive Attitude, Respect, & Exceptional Quality ("ICARE"). Employee Behavioral Expectations are introduced by the CEO and ingrained by a facility specific video depicting facility leadership and staff role playing scenarios. Also, each new employee receives a booklet that gives specific definitions and examples of appropriate behaviors. The booklet includes an "ICARE" acknowledgement card which each new employee signs. The acknowledgement card is on record for each employee in Human Resources and the employee is evaluated for performance of these indicators in their quarterly Performance Management Program. Ongoing monitoring is provided by employees at all levels, Occurrence Reporting and the Ethics and Compliance Program / Facility Ethics Compliance Officer.

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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?**

Currently, the following 3 resources are the key to Emory Eastside Medical Center providing CLAS to our patients:

- a.) Admission Assessment electronic screens for cultural/spiritual beliefs which could impede patient care. Based on this information, staff use the Internet to research culture and/or religious beliefs.
- b.) Conference call phones with multi-line capability for ATT Language Line calls allow off-site physicians to talk with patients.
- c.) Spanish speaking diabetes instructor.

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

1. English

2. Spanish

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?

Gwinnett Community Clinic, 2160 Fountain Drive, Snellville, GA 30078

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: Kimberly Ryan

Date: 3/11/2010

Title: Chief Executive Officer

Comments: