



2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP611

Facility Name: Northeast Georgia Medical Center

County: Hall

Street Address: 743 Spring Street NE

City: Gainesville

Zip: 30501-3899

Mailing Address: 743 Spring Street NE

Mailing City: Gainesville

Mailing Zip: 30501-3899

Medicaid Provider Number: 00000888A

Medicare Provider Number: 110029

2. Report Period

Report Data for the full twelve month period- January 1, 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: Chad Bolton

Contact Title: Director, Planning

Phone: 770-219-6630

Fax: 770-219-5437

E-mail: Chad.Bolton@nghs.com

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

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

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

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

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

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

Name: Northeast Georgia Health System, Inc

City: Gainesville **State:** GA

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

Name: Northeast Georgia Health System, Inc

City: Gainesville **State:** GA

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

Name:

City: State:

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

Name: VHA of GA, Inc/Vol Hosp of Amer/GA Allian Comm Hosp

City: Atlanta/Dallas/Atlanta State: GA/TX/GA

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

Name: Georgia 1st/MRN, NEGA Health Partners

City: Atlanta/Gainesville State: GA/GA

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

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

10a. Managed Care Information: Formal Written Contract

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

1. Health Maintenance Organization(HMO)

2. Preferred Provider Organization(PPO)

3. Physician Hospital Organization(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 checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" 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)	44	3,822	10,744	3,825	10,753
Pediatrics (Non ICU)	18	616	1,884	619	1,886
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	665	1,452	674	1,474
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	315	15,024	71,912	15,058	72,210
Intensive Care	58	3,943	14,853	3,935	14,686
Psychiatry	25	1,932	8,792	1,929	8,852
Substance Abuse	15	802	2,699	803	2,715
Adult Physical Rehabilitation (18 & Up)	24	251	4,062	248	4,004
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
Child/Adol/Psych/SA	14	518	2,350	521	2,333
	0	0	0	0	0
	0	0	0	0	0
Total	513	27,573	118,748	27,612	118,913

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	8	45
Asian	140	621
Black/African American	1,845	8,696
Hispanic/Latino	2,047	7,147
Pacific Islander/Hawaiian	0	0
White	23,322	101,330
Multi-Racial	211	909
Total	27,573	118,748

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,461	54,068
Female	16,112	64,680
Total	27,573	118,748

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	12,193	58,102
Medicaid	4,789	19,156
Peachare	3	21
Third-Party	8,849	33,978
Self-Pay	1,739	7,491
Other	0	0

5. Discharges to Death

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

643

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	656
Semi-Private Room Rate	634
Operating Room: Average Charge for the First Hour	3,139
Average Total Charge for an Inpatient Day	6,399

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

96,964

2. Inpatient Admissions from ER

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

13,462

3. Beds Available

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

72

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	10	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	5	0
General Beds	17	0
Chest	10	0
Fast Track	9	0
SubSpecialty	7	0
Overflow	18	0

5. Transfers

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

699

6. Non-Emergency Visits

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

192,987

7. Observation Visits/Cases

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

8,844

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.

1,728

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	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnostic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	1
Hospice	1	1
Respite Care Services	1	1
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	881
Number of Dialysis Treatments	3,217
Number of ESWL Patients	394
Number of ESWL Procedures	394
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	104,917
Number of CTS Units (machines)	6
Number of CTS Procedures	49,016
Number of Diagnostic Radioisotope Procedures	3,225
Number of PET Units (machines)	1
Number of PET Procedures	964
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	5
Number of Number of MRI Procedures	10,675
Number of Chemotherapy Treatments	1,126
Number of Respiratory Therapy Treatments	182,535
Number of Occupational Therapy Treatments	47,471
Number of Physical Therapy Treatments	141,967
Number of Speech Pathology Patients	1,347
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	127
Number of HIV/AIDS Patients	33
Number of Ambulance Trips	5,575
Number of Hospice Patients	836
Number of Respite care Patients	24
Number of Ultrasound/Medical Sonography Units	8
Number of Ultrasound/Medical Sonography Procedures	18,186
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

2. Medical Ventilators

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

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

65

3. Robotic Surgery System

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

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

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2009. 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*)	909.04998779297	55	0.93000000715256
Licensed Practical Nurses (LPNs)	106.01999664307	2	0
Pharmacists	27.860000610352	1	0
Other Health Services Professionals*	282.26998901367	11	8.5900001525879
Administration and Support	110.05999755859	5	0
All Other Hospital Personnel (not included above)	1712.5799560547	87	3.5899999141693

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)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	More than 90 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	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	14	<input type="checkbox"/>	14	13
General Internal Medicine	65	<input checked="" type="checkbox"/>	24	18
Pediatricians	28	<input type="checkbox"/>	22	10
Other Medical Specialties	96	<input type="checkbox"/>	96	54

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	21	<input type="checkbox"/>	20	19
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	28	<input type="checkbox"/>	23	21
Ophthalmology Surgery	10	<input type="checkbox"/>	7	5
Orthopedic Surgery	14	<input type="checkbox"/>	13	5
Plastic Surgery	5	<input type="checkbox"/>	5	1
General Surgery	15	<input type="checkbox"/>	15	8
Thoracic Surgery	3	<input type="checkbox"/>	0	0
Other Surgical Specialties	12	<input type="checkbox"/>	12	8

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	24	<input checked="" type="checkbox"/>	24	0
Dermatology	4	<input type="checkbox"/>	5	4
Emergency Medicine	23	<input checked="" type="checkbox"/>	23	0
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	6	<input checked="" type="checkbox"/>	6	0
Psychiatry	5	<input type="checkbox"/>	3	1
Radiology	13	<input checked="" type="checkbox"/>	13	0
Neonatology	5	<input checked="" type="checkbox"/>	5	0
	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	8
Podiatrists	12
Certified Nurse Midwives with Clinical Privileges in the Hospital	11
All Other Staff Affiliates with Clinical Privileges in the Hospital	134

5b. Name of Other Professions

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

CRNA, NP, AA, PA

Comments and Suggestions:

The data presented in the AHQ and related addendum reflects the beds and services of both NGMC's Main Campus and Lanier Park Campus, which are licensed and operated as a single hospital.

D.1. Set up and Staffed bed totals are less than NGMC's approved complement of 557. D.1.a - Inpatient and discharge days include inpatient LDR and C-section room days; LDRs are not acute care beds.

D.4. Most Peachcare admissions and patient days are now included in the Medicaid category because the payment source for both classes of patients are the Medicaid CMOs.

E.4. Note 1: NGMC is not able to track visits by type of ED bed.

Note 2: The ER beds for psych/substance abuse cases include 4 emergency beds housed in the Laurelwood building.

F.1b. Reported PET procedures include both PET scans and other corresponding non-scan PET procedures.

Additional MRI unit authorized by CON for Project No. GA 2008-015 became operational during 2009.

MRI Procedures. NGMC has discovered that prior years reported volumes were incorrect due to a data retrieval issues. Corrected volumes for years 2005-2008 are as follows:

2005 - 7,350

2006 - 9,046

2007 - 10,584

2008 - 10,845

G.3. Physician Race information is not captured during the medical staff application process.

G.4. Note 1: Medical Staff numbers as of April 2010; end-of-year 2009 data not currently available.

Note 2: NGMC physicians do not report Medicaid/PeachCare/PEHB plan provider status to the hospital. NGMC has attempted to gather data regarding physician enrollment in those programs, but recognizes that its data are likely incomplete. NGMC also recognizes that it is very likely that a greater number of its medical staff are enrolled providers in those programs than reflected in the data reported here.

G.5.a. Dentists and oral surgeons had co-admitting privileges as of 12/31/2008.

H.1. Medical Staff numbers as of April 2010; end-of-year 2009 data not currently available.

Surgical Services Addendum - Northeast Georgia Medical Center has 4 dedicated endoscopy suites adjacent to the main campus OR suite.

Part B - patient counts for this section come from a different source than patient counts in Part A and were adjusted to tie to Part A figures.

Perinatal Addendum - Part B.1. Specialty Care (Intermediate Neonatal Care) days represent the entire length of stay of the neonate.

Perinatal Addendum - Part C.4 - The reported Average Charge for a Premature Delivery includes all outliers, which accounted for 53% of all cases in this category in 2009. The average charge for non-outlier premature deliveries in 2009 was \$11,868.

Minority Health Addendum - Part 6. Signage on the hospital campus utilizes universal symbols and numbers to direct non-English speaking patients to the appropriate locations. Signs are marked with braille lettering to assist the sight-impaired in locating their intended destination.

Minority Health Addendum - Part 3. While the medical center does collect Preferred Language from patients, it does not believe the data is reliable, and has chosen not to include it here. The hospital will try to collect more accurate information in the future. Data on languages spoken by physicians is not collected.

Part H : Physician Name and License Number

1. Physicians on Staff

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

Part I : Patient Origin Table

1. Patient Origin

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

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric

P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under

S18+=Substance abuse adult 18 and over
S13-17=Substance abuse adolescent 13-17
E18+=Extended care adult 18 and over
E13-17=Extended care adolescent 13-17
E0-12=Extended care children 0-12
LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
Alabama	13	7	1	1	0	0	0	0	0	0	0	0
Appling	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	2	0	0	0	0	0	0	0	0	0	0	0
Banks	655	270	85	44	2	0	18	1	0	0	0	0
Barrow	242	98	36	34	5	4	9	1	0	0	0	0
Bartow	24	4	0	12	7	0	1	0	0	0	0	0
Ben Hill	1	0	0	0	1	0	0	0	0	0	0	0
Bulloch	1	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	2	0	0	0	0	0	0	0	0	0	0	0
Candler	0	2	0	0	0	0	0	0	0	0	0	0
Carroll	12	3	0	6	1	0	2	0	0	0	0	0
Catoosa	3	0	0	1	0	0	1	0	0	0	0	0
Chatham	1	2	0	0	0	0	1	0	0	0	0	0
Chattahoochee	2	2	0	2	0	0	0	0	0	0	0	0
Cherokee	48	15	6	7	6	2	6	0	0	0	0	0
Clarke	145	16	6	71	11	0	26	0	0	0	0	0
Clayton	11	0	0	4	4	0	1	0	0	0	0	0
Cobb	45	10	3	9	7	2	1	0	0	0	0	0
Colquitt	0	2	0	0	0	0	0	0	0	0	0	0
Columbia	5	3	1	0	0	0	0	1	0	0	0	0
Cook	0	2	0	0	0	0	0	0	0	0	0	0
Coweta	3	3	0	0	1	0	0	0	0	0	0	0
Dawson	746	261	80	61	6	1	27	1	0	0	0	0
Decatur	1	0	0	0	0	0	0	0	0	0	0	0
DeKalb	86	21	7	16	19	1	5	0	0	0	0	0
Dodge	1	0	0	0	0	0	0	0	0	0	0	0
Dougherty	2	0	0	0	0	0	0	0	0	0	0	0

Douglas	10	3	0	2	1	2	1	0	0	0	0	0
Elbert	38	3	2	16	2	0	4	0	0	0	0	0
Fannin	53	28	2	8	2	0	2	0	0	0	0	0
Fayette	11	3	0	1	2	0	1	0	0	0	0	0
Florida	93	14	2	3	1	0	2	0	0	0	0	0
Floyd	20	2	0	10	5	1	2	1	0	0	0	0
Forsyth	549	138	39	144	34	2	64	1	0	0	0	0
Franklin	235	77	17	68	9	1	21	0	0	0	0	0
Fulton	130	30	5	46	19	3	14	0	0	0	0	0
Gilmer	66	28	2	6	4	0	6	0	0	0	0	0
Gordon	11	0	1	4	0	0	2	0	0	0	0	0
Greene	8	0	0	7	0	0	1	0	0	0	0	0
Gwinnett	1,011	412	148	87	43	1	53	1	0	0	0	0
Habersham	2,129	851	220	99	28	3	44	0	0	0	0	0
Hall	13,285	5,220	2,463	588	64	16	277	3	0	0	0	0
Hancock	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	9	0	0	5	2	0	1	0	0	0	0	0
Harris	0	1	0	0	0	0	0	0	0	0	0	0
Hart	105	12	3	35	8	1	13	0	0	0	0	0
Heard	1	0	0	0	1	0	0	0	0	0	0	0
Henry	21	2	2	1	5	0	2	1	0	0	0	0
Houston	6	3	2	0	0	0	0	0	0	0	0	0
Jackson	1,705	757	244	80	21	1	34	0	0	0	0	0
Jasper	0	1	0	0	0	0	0	0	0	0	0	0
Jefferson	2	1	0	0	0	0	0	0	0	0	0	0
Johnson	1	0	0	0	0	0	0	0	0	0	0	0
Jones	1	0	0	0	1	0	0	0	0	0	0	0
Laurens	1	0	0	1	0	0	0	0	0	0	0	0
Lowndes	0	2	0	0	0	0	0	0	0	0	0	0
Lumpkin	1,038	430	109	67	18	3	20	1	0	0	0	0
Madison	88	17	3	31	10	0	8	1	0	0	0	0
McDuffie	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	3	0	0	0	0	0	1	0	0	0	0	0
Monroe	2	1	0	0	0	0	0	0	0	0	0	0
Montgomery	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	10	0	1	3	2	0	0	1	0	0	0	0
Murray	7	1	0	4	2	0	1	0	0	0	0	0
Muscogee	9	0	0	0	0	0	0	0	0	0	0	0
Newton	29	4	1	6	8	1	3	0	0	0	0	0
North Carolina	185	92	6	9	1	0	4	0	0	0	0	0
Oconee	25	8	1	5	6	0	2	0	0	0	0	0
Oglethorpe	9	2	0	3	2	0	1	0	0	0	0	0
Other Out of State	104	23	1	6	2	0	1	0	0	0	0	0
Paulding	8	0	0	1	1	1	0	0	0	0	0	0

Peach	1	0	0	1	0	0	0	0	0	0	0	0
Pickens	46	9	1	14	5	0	4	0	0	0	0	0
Polk	1	0	0	1	0	0	0	0	0	0	0	0
Putnam	4	1	0	2	0	0	0	0	0	0	0	0
Rabun	735	292	37	30	4	1	22	0	0	0	0	0
Richmond	8	2	0	5	0	0	2	0	0	0	0	0
Rockdale	8	2	0	2	1	0	1	0	0	0	0	0
South Carolina	46	11	2	4	0	0	3	0	0	0	0	0
Spalding	7	2	0	0	2	0	0	0	0	0	0	0
Stephens	826	315	47	94	21	3	32	1	0	0	0	0
Taliaferro	3	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	0	0	1	0	0	0	0	0	0	0	0
Tennessee	14	7	1	0	0	0	0	0	0	0	0	0
Thomas	1	0	0	0	0	0	0	0	0	0	0	0
Tift	1	1	0	0	0	0	0	0	0	0	0	0
Toombs	1	0	0	0	0	0	0	0	0	0	0	0
Towns	304	133	19	21	2	0	7	0	0	0	0	0
Troup	8	1	0	3	3	0	0	0	0	0	0	0
Union	403	161	22	37	9	0	10	0	0	0	0	0
Upson	2	1	0	0	1	0	0	0	0	0	0	0
Walker	3	0	1	1	0	0	0	0	0	0	0	0
Walton	58	15	1	19	16	1	3	1	0	0	0	0
Wayne	1	0	0	0	0	0	0	0	0	0	0	0
White	2,009	806	192	80	12	0	34	0	0	0	0	0
Whitfield	6	1	0	3	1	0	1	0	0	0	0	0
Wilcox	2	1	0	0	0	0	0	0	0	0	0	0
Wilkes	0	1	0	0	0	0	0	0	0	0	0	0
Total	27,573	10,651	3,822	1,932	451	51	802	16	0	0	0	0

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

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

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	1,699	7,989	9,270
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	1,699	7,989	9,270

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	1,682	7,707	8,969
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	1,682	7,707	8,969

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	3
Asian	62
Black/African American	501
Hispanic/Latino	726
Pacific Islander/Hawaiian	0
White	9,291
Multi-Racial	68
Total	10,651

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,009
Ages 15-64	7,612
Ages 65-74	1,337
Ages 75-85	613
Ages 85 and Up	80
Total	10,651

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,168
Female	6,483
Total	10,651

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,383
Medicaid	1,127
Third-Party	6,468
Self-Pay	673

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 18
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 1,053
6. Total Live Births: 3,562
7. Total Births (Live and Late Fetal Deaths): 3,577
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 4,071

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)	52	3,411	8,200	247
Specialty Care (Intermediate Neonatal Care)	10	270	4,776	31
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	1	2
Asian	47	125
Black/African American	257	879
Hispanic/Latino	1,139	2,935
Pacific Islander/Hawaiian	0	0
White	2,341	6,711
Multi-Racial	37	92
Total	3,822	10,744

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	7	19
Ages 15-44	3,812	10,719
Ages 45 and Up	3	6
Total	3,822	10,744

3. Average Charge for an Uncomplicated Delivery

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

\$7,953.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$17,559.00

LTCH Addendum

Part A : General Information

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

1b. Level/Status of Accreditation

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

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	0	0

2. Age of LTCH Patient

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

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	0	0

3. Gender

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

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

4. Payment Source

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

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

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

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	25	25
B- General Acute Psychiatric Adolescents 13-17	7	7
C- General Acute Psychiatric Children 12 and under	4	4
D- Acute Substance Abuse Adults 18 and over	15	15
E- Acute Substance Abuse Adolescents 13-17	3	3
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	1,932	8,792	1,929	8,852	1,589	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	451	2,045	455	2,031	1,238	<input checked="" type="checkbox"/>
General Acute Psychiatric Children 12 and Under	51	243	50	240	1,413	<input checked="" type="checkbox"/>
Acute Substance Abuse Adults 18 and over	802	2,699	803	2,715	1,979	<input checked="" type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	16	62	16	62	1,420	<input checked="" 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	1	4
Asian	21	126
Black/African American	341	1,806
Hispanic/Latino	87	327
Pacific Islander/Hawaiian	0	0
White	2,715	11,212
Multi-Racial	87	366
Total	3,252	13,841

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,557	6,563
Female	1,695	7,278
Total	3,252	13,841

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	590	3,078
Medicaid	1,075	5,150
Third Party	1,543	5,450
Self-Pay	44	163
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

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

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

If you checked yes, how many? 7.2600002288818 (FTE's)

What languages do they interpret?

Spanish

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

Bilingual Hospital Staff Member

Bilingual Member of Patient's Family

Community Volunteer 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		0	48	268
Vietnamese		0	1	12
Laotian/Mandarin Chinese		0	1	4

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

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

access translation services

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

none

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

1. English

2.

3.

4.

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

If you checked yes, what is the name and location of that health care center or clinic?

Hall County Health Department, Good News Clinic, Medlink

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or 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: Carol H. Burrell

Date: 5/14/2010

Title: Chief Operating Officer

Comments: