GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP703

Facility Name: Memorial Health University Medical Center

County: Chatham

Street Address: 4700 Waters Avenue

City: Savannah

Zip: 31404

Mailing Address: P O Box 23089

Mailing City: Savannah

Mailing Zip: 31403

Medicaid Provider Number: 00001273

Medicare Provider Number: 110036

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: Chris Rowell

Contact Title: Senior Financial Analyst

Phone: 912-350-8606

Fax: 912-350-8126

E-mail: RowelCh1@memorialhealth.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
Chatham County Hospital Authority	Local Govt	1/1/1955

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Memorial Health University Medical Center	Not for Profit	1/1/1955

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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.

From May 1, 2008, Chuck Neumann served as the interim CEO until a permanent replacement was hired. Phillip S. Schaengold, J.D., M.B.A. was named as the permanent President and CEO, effective June 1, 2009.

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

Name: Memorial Health

City: Savannah **State:** GA

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

Name: Memorial Health, Inc.
City: Savannah **State:** GA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: See list in Comments section of Part G
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Premier Group Purchasing Organization
City: Charlotte **State:** NC

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

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)	33	3,149	9,278	3,191	9,170
Pediatrics (Non ICU)	48	2,056	7,894	2,506	9,106
Pediatric ICU	12	348	2,089	250	769
Gynecology (No OB)	0	0	0	0	0
General Medicine	83	12,639	14,333	3,701	14,374
General Surgery	45	3,379	13,746	3,002	16,048
Medical/Surgical	0	0	0	0	0
Intensive Care	55	853	17,516	753	4,675
Psychiatry	41	1,001	9,378	1,149	9,277
Substance Abuse	1	4	10	4	10
Adult Physical Rehabilitation (18 & Up)	50	823	13,971	803	13,079
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
Med/Onc	28	177	9,048	1,913	10,975
Ortho/Neuro	63	327	19,588	4,876	24,263
Stepdown	36	268	11,144	2,759	12,031
Total	**495**	**25,024**	**127,995**	**24,907**	**123,777**

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	31	126
Asian	151	546
Black/African American	8,662	47,672
Hispanic/Latino	746	2,754
Pacific Islander/Hawaiian	0	0
White	14,748	73,175
Multi-Racial	686	3,722
Total	**25,024**	**127,995**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	10,748	59,865
Female	14,276	68,130
Total	**25,024**	**127,995**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,292	56,910
Medicaid	5,076	24,921
Peachare	20	162
Third-Party	8,356	36,855
Self-Pay	655	1,878
Other	1,625	7,269

5. Discharges to Death

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

464

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	706
Semi-Private Room Rate	706
Operating Room: Average Charge for the First Hour	5,533
Average Total Charge for an Inpatient Day	7,543

Part E : Emergency Department and Outpatient Services

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

94,640

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

13,471

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

51

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	3	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	4	0
General Beds	27	0
Express Care	7	0
Pediatric	10	0
	0	0
	0	0

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

969

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

195,779

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

11,664

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

46

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

401.00

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.

1,473

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	1	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	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	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	317
Number of Dialysis Treatments	6,149
Number of ESWL Patients	208
Number of ESWL Procedures	244
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	4
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	103,354
Number of CTS Units (machines)	4
Number of CTS Procedures	29,319
Number of Diagnostic Radioisotope Procedures	6,177
Number of PET Units (machines)	1
Number of PET Procedures	800
Number of Therapeautic Radioisotope Procedures	56
Number of Number of MRI Units	2
Number of Number of MRI Procedures	9,194
Number of Chemotherapy Treatments	1,118
Number of Respiratory Therapy Treatments	14,885
Number of Occupational Therapy Treatments	12,875
Number of Physical Therapy Treatments	23,502
Number of Speech Pathology Patients	6,874
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	175
Number of HIV/AIDS Patients	117
Number of Ambulance Trips	47,161
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	15,037
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).

135

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*)	1023.5	88.25	10
Licensed Practical Nurses (LPNs)	24	3.3499999046326	0
Pharmacists	24.25	0	0
Other Health Services Professionals*	355.45001220703	44.270000457764	0
Administration and Support	1470.0100097656	99.690002441406	0
All Other Hospital Personnel (not included above)	498.79000854492	58.979999542236	2

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	61-90 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	30 Days or Less
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	46	☐	46	46
General Internal Medicine	66	☑	64	64
Pediatricians	52	☑	52	52
Other Medical Specialties	158	☑	147	143

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	34	☐	34	34
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	5	☐	5	5
Ophthalmology Surgery	23	☐	22	22
Orthopedic Surgery	33	☐	23	23
Plastic Surgery	16	☐	14	14
General Surgery	21	☐	17	17
Thoracic Surgery	6	☐	6	6
Other Surgical Specialties	63	☐	53	46

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	13	☑	13	13
Dermatology	9	☐	6	5
Emergency Medicine	19	☑	19	19
Nuclear Medicine	2	☑	2	2
Pathology	3	☑	3	3
Psychiatry	9	☑	4	4
Radiology	10	☑	10	10
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	7
Podiatrists	11
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	174

5b. Name of Other Professions

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

Comments and Suggestions:

The following is a list of subsidary corporations owned by Memorial Health, Inc.:
Memorial Healthcare Partnership
Memorial Health Anesthetists, Inc.
Memorial Health TransportOne, Inc.
Memorial Health University Medical Center, Inc.
Memorial Health University Medical Center Foundation, Inc.
Memorial Health UrgentOne, Inc.
Memorial Professional Assurance Company, Inc.
MPPG, Inc.
Provident Health Services, Inc.
Provident Professional Building Condominium Association, Inc.
Savannah Midtown Properties, Inc.

Please note that anywhere it asks for both Admissions and Inpatient Days, we reported Discharge Days instead of Inpatient Days, as this is what we have available in our reporting system.
Part D #1: Substance abuse patients are treated in Psychiatry. The 1 SUS bed for substance abuse patients resides in Psychiatry and was placed in Substance Abuse to prevent an error message.
Part G #1: Like 2008, we are reporting budgeted staff for the hospital only.
Part G #3: We do not track the ethnicity of our physicians
Surgical Services Addendum Part B #2: The age grouping contains the age of 85 in two lines; therefore, MHUMC patients of age 85 have been accounted for within Ages 85 and Up.
Psych/SA Addendum Part A #1: The number of CON-Authorized Beds and SUS Beds within Patient Types A & D should be disregarded because we do not breakout of the 42 beds in Psych. The numbers in Patient Types A & D were only placed there to bypass the critical errors message; therefore, please disregard the numbers in A & D and accept the 42 beds for Patient Type AD.

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	25	6	0	3	0	0	0	0	0	0	0	0
Appling	176	108	8	3	0	0	0	0	0	0	0	0
Atkinson	34	20	3	0	0	0	0	0	0	0	0	0
Bacon	86	33	4	1	0	0	0	0	0	0	0	0
Baldwin	2	2	0	0	0	0	0	0	0	0	0	0
Bartow	0	1	0	0	0	0	0	0	0	0	0	0
Ben Hill	17	8	3	0	0	0	0	0	0	0	0	0
Bibb	10	4	2	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	82	57	5	2	0	0	0	0	0	0	0	0
Bryan	1,198	1,115	186	65	0	0	1	0	0	0	0	0
Bulloch	665	490	40	11	0	0	0	0	0	0	0	0
Burke	5	8	0	0	0	0	0	0	0	0	0	0
Butts	3	0	0	0	0	0	0	0	0	0	0	0
Calhoun	1	0	0	0	0	0	0	0	0	0	0	0
Camden	52	36	15	2	0	0	0	0	0	0	0	0
Candler	143	113	8	3	0	0	0	0	0	0	0	0
Carroll	4	0	1	0	0	0	0	0	0	0	0	0
Catoosa	2	0	1	0	0	0	0	0	0	0	0	0
Charlton	15	12	2	2	0	0	0	0	0	0	0	0
Chatham	13,965	7,651	2,035	806	0	0	3	0	0	0	0	0
Cherokee	3	1	0	0	0	0	0	0	0	0	0	0
Clarke	3	3	0	1	0	0	0	0	0	0	0	0
Clayton	5	2	1	0	0	0	0	0	0	0	0	0
Clinch	5	3	1	0	0	0	0	0	0	0	0	0
Cobb	8	7	1	2	0	0	0	0	0	0	0	0
Coffee	242	84	15	1	0	0	0	0	0	0	0	0
Colquitt	6	2	0	0	0	0	0	0	0	0	0	0

Columbia	12	2	1	1	0	0	0	0	0	0	0	0
Cook	0	1	0	0	0	0	0	0	0	0	0	0
Coweta	2	1	0	0	0	0	0	0	0	0	0	0
Crawford	2	0	0	0	0	0	0	0	0	0	0	0
Crisp	3	0	0	0	0	0	0	0	0	0	0	0
Decatur	2	0	0	0	0	0	0	0	0	0	0	0
DeKalb	12	11	1	2	0	0	0	0	0	0	0	0
Dodge	12	2	0	0	0	0	0	0	0	0	0	0
Dougherty	5	2	0	0	0	0	0	0	0	0	0	0
Douglas	5	1	0	0	0	0	0	0	0	0	0	0
Effingham	1,918	1,546	298	59	0	0	0	0	0	0	0	0
Elbert	0	1	0	0	0	0	0	0	0	0	0	0
Emanuel	117	88	3	5	0	0	0	0	0	0	0	0
Evans	157	121	8	2	0	0	0	0	0	0	0	0
Fayette	2	0	0	0	0	0	0	0	0	0	0	0
Florida	125	55	6	13	0	0	0	0	0	0	0	0
Floyd	2	0	0	0	0	0	0	0	0	0	0	0
Forsyth	4	0	0	0	0	0	0	0	0	0	0	0
Franklin	1	0	0	1	0	0	0	0	0	0	0	0
Fulton	22	14	0	8	0	0	0	0	0	0	0	0
Gilmer	0	1	0	0	0	0	0	0	0	0	0	0
Glynn	324	207	35	3	0	0	0	0	0	0	0	0
Gordon	1	0	0	0	0	0	0	0	0	0	0	0
Grady	1	1	0	0	0	0	0	0	0	0	0	0
Greene	1	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	9	5	1	0	0	0	0	0	0	0	0	0
Habersham	2	0	0	0	0	0	0	0	0	0	0	0
Hall	3	2	1	0	0	0	0	0	0	0	0	0
Hancock	2	3	0	0	0	0	0	0	0	0	0	0
Henry	2	3	1	0	0	0	0	0	0	0	0	0
Houston	10	1	1	1	0	0	0	0	0	0	0	0
Irwin	3	6	0	0	0	0	0	0	0	0	0	0
Jackson	0	1	0	0	0	0	0	0	0	0	0	0
Jeff Davis	137	59	9	5	0	0	0	0	0	0	0	0
Jefferson	4	1	0	1	0	0	0	0	0	0	0	0
Jenkins	28	16	3	1	0	0	0	0	0	0	0	0
Johnson	4	2	0	0	0	0	0	0	0	0	0	0
Jones	1	1	0	0	0	0	0	0	0	0	0	0
Lanier	0	2	0	0	0	0	0	0	0	0	0	0
Laurens	58	29	0	1	0	0	0	0	0	0	0	0
Liberty	1,449	1,125	223	41	0	0	0	0	0	0	0	0
Long	185	93	22	3	0	0	0	0	0	0	0	0
Lowndes	5	7	0	0	0	0	0	0	0	0	0	0
Lumpkin	9	0	0	0	0	0	0	0	0	0	0	0

McIntosh	121	129	9	2	0	0	0	0	0	0	0	0
Meriwether	1	0	0	0	0	0	0	0	0	0	0	0
Montgomery	82	52	3	0	0	0	0	0	0	0	0	0
Morgan	2	0	0	0	0	0	0	0	0	0	0	0
Muscogee	5	4	0	1	0	0	0	0	0	0	0	0
Newton	3	0	0	0	0	0	0	0	0	0	0	0
North Carolina	44	11	5	5	0	0	0	0	0	0	0	0
Oconee	3	0	0	1	0	0	0	0	0	0	0	0
Oglethorpe	2	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	287	85	20	31	0	0	0	0	0	0	0	0
Paulding	2	3	0	0	0	0	0	0	0	0	0	0
Pickens	0	1	0	0	0	0	0	0	0	0	0	0
Pierce	117	58	8	2	0	0	0	0	0	0	0	0
Pike	2	0	0	0	0	0	0	0	0	0	0	0
Polk	0	1	0	0	0	0	0	0	0	0	0	0
Pulaski	1	1	0	0	0	0	0	0	0	0	0	0
Putnam	2	0	0	0	0	0	0	0	0	0	0	0
Richmond	9	7	0	0	0	0	0	0	0	0	0	0
Rockdale	3	0	1	0	0	0	0	0	0	0	0	0
Screven	202	154	10	5	0	0	0	0	0	0	0	0
South Carolina	1,170	878	62	18	0	0	0	0	0	0	0	0
Spalding	5	0	1	0	0	0	0	0	0	0	0	0
Stephens	2	0	1	0	0	0	0	0	0	0	0	0
Talbot	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	352	263	17	14	0	0	0	0	0	0	0	0
Taylor	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	38	15	1	0	0	0	0	0	0	0	0	0
Tennessee	29	9	5	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	4	4	0	0	0	0	0	0	0	0	0	0
Tift	4	3	1	0	0	0	0	0	0	0	0	0
Toombs	394	238	17	10	0	0	0	0	0	0	0	0
Treutlen	22	12	0	0	0	0	0	0	0	0	0	0
Troup	0	1	0	0	0	0	0	0	0	0	0	0
Turner	3	0	0	0	0	0	0	0	0	0	0	0
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0
Union	0	1	0	0	0	0	0	0	0	0	0	0
Upson	2	0	1	0	0	0	0	0	0	0	0	0
Walton	4	0	0	2	0	0	0	0	0	0	0	0
Ware	191	76	17	3	0	0	0	0	0	0	0	0
Washington	2	3	0	0	0	0	0	0	0	0	0	0
Wayne	487	235	26	6	0	0	0	0	0	0	0	0
Wheeler	17	8	0	0	0	0	0	0	0	0	0	0
White	2	0	0	0	0	0	0	0	0	0	0	0

Whitfield	1	1	0	0	0	0	0	0	0	0	0	0
Wilcox	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	1	0	0	0	0	0	0	0	0	0	0	0
Worth	0	2	0	0	0	0	0	0	0	0	0	0
Total	**25,024**	**15,431**	**3,149**	**1,149**	**0**	**0**	**4**	**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	5	11	9
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**5**	**11**	**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	1,344	2,958	3,237	15,294
Cystoscopy	0	0	220	303
Endoscopy	0	0	59	82
	0	0	0	0
Total	**1,344**	**2,958**	**3,516**	**15,679**

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	1,312	2,888	3,161	15,047
Cystoscopy	0	0	219	302
Endoscopy	0	0	59	82
	0	0	0	0
Total	**1,312**	**2,888**	**3,439**	**15,431**

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	16
Asian	96
Black/African American	3,898
Hispanic/Latino	338
Pacific Islander/Hawaiian	0
White	10,751
Multi-Racial	332
Total	**15,431**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	3,132
Ages 15-64	8,763
Ages 65-74	2,182
Ages 75-85	1,172
Ages 85 and Up	182
Total	**15,431**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	7,064
Female	8,367
Total	**15,431**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,978
Medicaid	2,402
Third-Party	8,285
Self-Pay	766

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: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 12

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,120

6. Total Live Births: 2,854

7. Total Births (Live and Late Fetal Deaths): 2,912

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,912

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)	36	2,342	4,977	82
Specialty Care (Intermediate Neonatal Care)	24	603	9,269	49
Subspecialty Care (Intensive Neonatal Care)	20	120	6,887	61

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	3
Asian	44	84
Black/African American	1,138	3,349
Hispanic/Latino	246	472
Pacific Islander/Hawaiian	0	0
White	1,589	4,402
Multi-Racial	131	968
Total	**3,149**	**9,278**

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	12
Ages 15-44	3,140	9,266
Ages 45 and Up	2	0
Total	**3,149**	**9,278**

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

$9,141.00

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

$35,691.00

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	1	1
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	1	1
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
AD-P/SA18+	42	42

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	1,149	9,378	1,149	9,277	1,902	☑
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	4	10	4	10	2,696	☑
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	2	15
Asian	4	26
Black/African American	448	3,814
Hispanic/Latino	16	101
Pacific Islander/Hawaiian	0	0
White	631	5,014
Multi-Racial	52	418
Total	**1,153**	**9,388**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	515	4,274
Female	638	5,114
Total	**1,153**	**9,388**

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	479	4,675
Medicaid	288	2,457
Third Party	325	1,749
Self-Pay	61	507
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? 2 (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): ☐

If hospital-hired FTE is not available to interpret due to non-office hours or a language is different than Spanish, the hospital has an appointed company for interpreter services for patients, via telephone.

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	91.28	0	0	0
Vietnamese	3.85	0	0	0
Korean	1.55	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?

Medical Interpreter Training - Bridging the Gap training as well as weekly medical reviews

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?

Hospital coverage for after-hours

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?

Curtis V. Cooper Health System: 106 East Broad Street, Savannah, GA 31401

Electronic Signature

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

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

Date: 10/1/2012

Title: President & Chief Executive Officer

Comments:

Updated NICU bed count 10/1/2012