GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP705

Facility Name: Emory University Hospital Midtown

County: Fulton

Street Address: 550 Peachtree Street NE

City: Atlanta

Zip: 30308

Mailing Address: 550 Peachtree Street NE

Mailing City: Atlanta

Mailing Zip: 30308

Medicaid Provider Number: 00000503

Medicare Provider Number: 110078

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: Toni Wimby, FACHE

Contact Title: Associate Administrator, Emory Hospitals

Phone: 404-686-2450

Fax: 404-686-2848

E-mail: toni.wimby@emoryhealthcare.org

Part C : Ownership, Operation and Management

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

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory University	Not for Profit	1/1/1944

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	9/9/1999

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	9/9/1999

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	9/9/1999

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	9/9/1999

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	9/9/1999

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: Emory Healthcare
City: Atlanta   **State:** Georgia

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: State:

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: State:

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: University Healthcare Consortium
City: Chicage   **State:** Illinois

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

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

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

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO)   ☑

2. Preferred Provider Organization(PPO)   ☑

3. Physician Hospital Organization(PH0)   ☐

4. Provider Service Organization(PSO)   ☐

5. Other Managed Care or Prepaid Plan   ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	43	3,836	12,912	4,108	13,828
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	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	330	16,266	85,723	17,576	92,627
Intensive Care	66	2,216	17,315	679	5,305
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
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)	30	243	8,172	235	7,903
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**469**	**22,561**	**124,122**	**22,598**	**119,663**

2. Race/Ethnicity

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	1	30
Black/African American	15,141	84,721
Hispanic/Latino	373	1,504
Pacific Islander/Hawaiian	0	0
White	6,442	34,094
Multi-Racial	604	3,773
Total	22,561	124,122

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,640	52,513
Female	13,921	71,609
Total	22,561	124,122

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,005	60,672
Medicaid	3,913	18,214
Peachare	0	0
Third-Party	7,062	33,804
Self-Pay	2,332	10,141
Other	249	1,291

5. Discharges to Death

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

447

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	1,050
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	3,030
Average Total Charge for an Inpatient Day	10,140

Part E : Emergency Department and Outpatient Services

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

56,698

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

8,695

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

29

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	29	56,698
	0	0
	0	0
	0	0
	0	0

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

538

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

109,078

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

8,328

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

265.00

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.

4,065

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	2	1
ESWL	1	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)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	3	4
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	2	1
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
Rehabilitation Therapy	1	1
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	10,162
Number of ESWL Patients	78
Number of ESWL Procedures	86
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	158,369
Number of CTS Units (machines)	2
Number of CTS Procedures	35,254
Number of Diagnostic Radioisotope Procedures	9,051
Number of PET Units (machines)	2
Number of PET Procedures	2,964
Number of Therapeautic Radioisotope Procedures	9,051
Number of Number of MRI Units	3
Number of Number of MRI Procedures	7,719
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	214,772
Number of Occupational Therapy Treatments	4,683
Number of Physical Therapy Treatments	24,881
Number of Speech Pathology Patients	4,353
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	421
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	1
Number of Ultrasound/Medical Sonography Procedures	17,827
Number of Treatments, Procedures, or Patients (Other 1)	66,195
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).

58

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*)	857.70001220703	0	0
Licensed Practical Nurses (LPNs)	12.130000114441	0	0
Pharmacists	47.680000305176	0	0
Other Health Services Professionals*	891.34002685547	0	0
Administration and Support	15.069999694824	0	0
All Other Hospital Personnel (not included above)	651.79998779297	0	0

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)	Not Applicable
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	61-90 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	24	☐	24	0
General Internal Medicine	92	☐	92	0
Pediatricians	81	☑	81	0
Other Medical Specialties	313	☐	313	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	70	☐	70	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	21	☐	21	0
Ophthalmology Surgery	44	☐	44	0
Orthopedic Surgery	39	☐	39	0
Plastic Surgery	10	☐	10	0
General Surgery	60	☐	60	0
Thoracic Surgery	23	☐	23	0
Other Surgical Specialties	72	☐	72	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	95	☑	95	0
Dermatology	21	☐	21	0
Emergency Medicine	83	☑	83	0
Nuclear Medicine	4	☑	4	0
Pathology	56	☑	56	0
Psychiatry	32	☐	32	0
Radiology	135	☑	135	0
Rehabilitation	12	☐	12	0
Radiation Oncology	15	☑	15	0
Hospitalists	98	☑	98	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	21
Podiatrists	7
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	320

5b. Name of Other Professions

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

Optometry, Psychology, Speech Therapy

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	S18+=Substance abuse adult 18 and over
Surg=Outpatient Surgical	S13-17=Substance abuse adolescent 13-17
OB=Obstetric	E18+=Extended care adult 18 and over
P18+=Acute psychiatric adult 18 and over	E13-17=Extended care adolescent 13-17
P13-17=Acute psychiatric adolescent 13-17	E0-12=Extended care children 0-12
P0-12=Acute psychiatric children 12 and under	LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
ALABAMA	103	26	2	0	0	0	0	0	0	0	0	0
APPLING	0	1	0	0	0	0	0	0	0	0	0	0
ATKINSON	1	1	0	0	0	0	0	0	0	0	0	0
BACON	2	0	0	0	0	0	0	0	0	0	0	0
BALDWIN	21	4	0	0	0	0	0	0	0	0	0	0
BANKS	3	0	0	0	0	0	0	0	0	0	0	0
BARROW	56	28	4	0	0	0	0	0	0	0	0	0
BARTOW	111	79	4	0	0	0	0	0	0	0	0	0
BEN HILL	5	3	0	0	0	0	0	0	0	0	0	0
BERRIEN	2	3	0	0	0	0	0	0	0	0	0	0
BIBB	41	17	4	0	0	0	0	0	0	0	0	0
BLECKLEY	5	4	0	0	0	0	0	0	0	0	0	0
BRANTLEY	0	1	0	0	0	0	0	0	0	0	0	0
BROOKS	3	1	0	0	0	0	0	0	0	0	0	0
BRYAN	1	0	0	0	0	0	0	0	0	0	0	0
BULLOCH	7	2	0	0	0	0	0	0	0	0	0	0
BUTTS	120	29	2	0	0	0	0	0	0	0	0	0
CALHOUN	5	1	0	0	0	0	0	0	0	0	0	0
CANDLER	1	0	0	0	0	0	0	0	0	0	0	0
CARROLL	340	135	6	0	0	0	0	0	0	0	0	0
CATOOSA	5	1	1	0	0	0	0	0	0	0	0	0
CHATHAM	17	1	0	0	0	0	0	0	0	0	0	0
CHATTAHOOCHEE	2	1	0	0	0	0	0	0	0	0	0	0
CHATTOOGA	7	7	0	0	0	0	0	0	0	0	0	0
CHEROKEE	126	84	13	0	0	0	0	0	0	0	0	0
CLARKE	27	14	0	0	0	0	0	0	0	0	0	0
CLAY	1	0	0	0	0	0	0	0	0	0	0	0
CLAYTON	1,137	294	272	0	0	0	0	0	0	0	0	0

County												
CLINCH	2	2	0	0	0	0	0	0	0	0	0	0
COBB	900	440	175	0	0	0	0	0	0	0	0	0
COFFEE	7	2	0	0	0	0	0	0	0	0	0	0
COLQUITT	9	5	0	0	0	0	0	0	0	0	0	0
COLUMBIA	6	4	0	0	0	0	0	0	0	0	0	0
COOK	5	1	1	0	0	0	0	0	0	0	0	0
COWETA	110	71	11	0	0	0	0	0	0	0	0	0
CRAWFORD	2	1	0	0	0	0	0	0	0	0	0	0
CRISP	4	2	0	0	0	0	0	0	0	0	0	0
DADE	1	0	0	0	0	0	0	0	0	0	0	0
DAWSON	24	13	0	0	0	0	0	0	0	0	0	0
DECATUR	3	1	0	0	0	0	0	0	0	0	0	0
DEKALB	3,862	1,167	1,118	0	0	0	0	0	0	0	0	0
DODGE	8	3	1	0	0	0	0	0	0	0	0	0
DOOLY	2	4	0	0	0	0	0	0	0	0	0	0
DOUGHERTY	20	14	0	0	0	0	0	0	0	0	0	0
DOUGLAS	280	114	54	0	0	0	0	0	0	0	0	0
EFFINGHAM	4	0	0	0	0	0	0	0	0	0	0	0
ELBERT	17	3	0	0	0	0	0	0	0	0	0	0
Emanuel	8	1	0	0	0	0	0	0	0	0	0	0
EVANS	1	0	0	0	0	0	0	0	0	0	0	0
FANNIN	16	17	0	0	0	0	0	0	0	0	0	0
FAYETTE	187	92	30	0	0	0	0	0	0	0	0	0
FLORIDA	80	22	0	0	0	0	0	0	0	0	0	0
FLOYD	33	13	0	0	0	0	0	0	0	0	0	0
FORSYTH	104	52	8	0	0	0	0	0	0	0	0	0
FRANKLIN	11	7	0	0	0	0	0	0	0	0	0	0
FULTON	10,352	2,067	1,700	0	0	0	0	0	0	0	0	243
GILMER	19	10	0	0	0	0	0	0	0	0	0	0
GLYNN	9	2	0	0	0	0	0	0	0	0	0	0
GORDON	29	14	0	0	0	0	0	0	0	0	0	0
GRADY	2	0	0	0	0	0	0	0	0	0	0	0
GREENE	16	6	0	0	0	0	0	0	0	0	0	0
GWINNETT	860	437	234	0	0	0	0	0	0	0	0	0
HABERSHAM	20	15	2	0	0	0	0	0	0	0	0	0
HALL	63	47	5	0	0	0	0	0	0	0	0	0
HANCOCK	1	0	0	0	0	0	0	0	0	0	0	0
HARALSON	48	18	0	0	0	0	0	0	0	0	0	0
HARRIS	22	13	0	0	0	0	0	0	0	0	0	0
HART	8	4	0	0	0	0	0	0	0	0	0	0
HEARD	19	6	1	0	0	0	0	0	0	0	0	0
HENRY	897	341	96	0	0	0	0	0	0	0	0	0
HOUSTON	51	16	0	0	0	0	0	0	0	0	0	0
IRWIN	3	0	0	0	0	0	0	0	0	0	0	0

JACKSON	41	17	1	0	0	0	0	0	0	0	0	0
JASPER	27	11	0	0	0	0	0	0	0	0	0	0
JEFF DAVIS	1	0	1	0	0	0	0	0	0	0	0	0
JEFFERSON	1	0	1	0	0	0	0	0	0	0	0	0
JOHNSON	6	1	0	0	0	0	0	0	0	0	0	0
JONES	6	4	0	0	0	0	0	0	0	0	0	0
LAMAR	61	17	0	0	0	0	0	0	0	0	0	0
LANIER	1	0	0	0	0	0	0	0	0	0	0	0
LAURENS	16	11	0	0	0	0	0	0	0	0	0	0
LEE	6	3	0	0	0	0	0	0	0	0	0	0
LIBERTY	0	1	0	0	0	0	0	0	0	0	0	0
LINCOLN	1	0	0	0	0	0	0	0	0	0	0	0
LOWNDES	14	9	0	0	0	0	0	0	0	0	0	0
LUMPKIN	14	6	0	0	0	0	0	0	0	0	0	0
MACON	0	1	0	0	0	0	0	0	0	0	0	0
MADISON	8	5	1	0	0	0	0	0	0	0	0	0
MARION	1	1	0	0	0	0	0	0	0	0	0	0
MCDUFFIE	1	0	0	0	0	0	0	0	0	0	0	0
MCINTOSH	2	1	0	0	0	0	0	0	0	0	0	0
MERIWETHER	35	6	0	0	0	0	0	0	0	0	0	0
MITCHELL	9	1	0	0	0	0	0	0	0	0	0	0
MONROE	9	6	1	0	0	0	0	0	0	0	0	0
MONTGOMERY	6	2	0	0	0	0	0	0	0	0	0	0
MORGAN	17	8	0	0	0	0	0	0	0	0	0	0
MURRAY	10	4	0	0	0	0	0	0	0	0	0	0
MUSCOGEE	67	22	2	0	0	0	0	0	0	0	0	0
NEWTON	325	83	14	0	0	0	0	0	0	0	0	0
North Carolina	47	26	3	0	0	0	0	0	0	0	0	0
OCONEE	8	6	0	0	0	0	0	0	0	0	0	0
OGLETHORPE	2	1	0	0	0	0	0	0	0	0	0	0
OTHER OUT OF STAT	227	39	8	0	0	0	0	0	0	0	0	0
PAULDING	84	39	11	0	0	0	0	0	0	0	0	0
PEACH	13	6	1	0	0	0	0	0	0	0	0	0
PICKENS	34	14	2	0	0	0	0	0	0	0	0	0
PIERCE	2	1	0	0	0	0	0	0	0	0	0	0
PIKE	60	19	0	0	0	0	0	0	0	0	0	0
POLK	32	14	4	0	0	0	0	0	0	0	0	0
PULASKI	2	2	0	0	0	0	0	0	0	0	0	0
PUTNAM	18	12	0	0	0	0	0	0	0	0	0	0
RABUN	13	7	0	0	0	0	0	0	0	0	0	0
RANDOLPH	1	0	0	0	0	0	0	0	0	0	0	0
RICHMOND	10	4	1	0	0	0	0	0	0	0	0	0
ROCKDALE	182	79	26	0	0	0	0	0	0	0	0	0
SCHLEY	3	1	0	0	0	0	0	0	0	0	0	0

SCREVEN	1	0	0	0	0	0	0	0	0	0	0	0
SEMINOLE	1	0	0	0	0	0	0	0	0	0	0	0
SOUTH CAROLINA	59	14	1	0	0	0	0	0	0	0	0	0
SPALDING	332	70	6	0	0	0	0	0	0	0	0	0
STEPHENS	8	8	0	0	0	0	0	0	0	0	0	0
STEWART	3	1	0	0	0	0	0	0	0	0	0	0
SUMTER	13	4	0	0	0	0	0	0	0	0	0	0
TALBOT	2	3	0	0	0	0	0	0	0	0	0	0
TAYLOR	6	0	0	0	0	0	0	0	0	0	0	0
TELFAIR	11	6	0	0	0	0	0	0	0	0	0	0
TENNESSEE	26	12	1	0	0	0	0	0	0	0	0	0
TERRELL	2	2	0	0	0	0	0	0	0	0	0	0
THOMAS	18	4	1	0	0	0	0	0	0	0	0	0
TIFT	12	5	0	0	0	0	0	0	0	0	0	0
TOOMBS	9	0	0	0	0	0	0	0	0	0	0	0
TOWNS	10	4	0	0	0	0	0	0	0	0	0	0
TREUTLEN	1	0	0	0	0	0	0	0	0	0	0	0
TROUP	180	52	4	0	0	0	0	0	0	0	0	0
TURNER	7	1	0	0	0	0	0	0	0	0	0	0
TWIGGS	1	0	0	0	0	0	0	0	0	0	0	0
UNION	16	9	0	0	0	0	0	0	0	0	0	0
UPSON	33	11	0	0	0	0	0	0	0	0	0	0
WALKER	3	1	0	0	0	0	0	0	0	0	0	0
WALTON	56	18	2	0	0	0	0	0	0	0	0	0
WARE	0	2	0	0	0	0	0	0	0	0	0	0
WARREN	1	0	0	0	0	0	0	0	0	0	0	0
WASHINGTON	4	4	0	0	0	0	0	0	0	0	0	0
WAYNE	1	3	0	0	0	0	0	0	0	0	0	0
WHEELER	0	1	0	0	0	0	0	0	0	0	0	0
WHITE	11	9	0	0	0	0	0	0	0	0	0	0
WHITFIELD	23	13	0	0	0	0	0	0	0	0	0	0
WILCOX	1	1	0	0	0	0	0	0	0	0	0	0
WILKES	1	2	0	0	0	0	0	0	0	0	0	0
Wilkinson	7	0	0	0	0	0	0	0	0	0	0	0
WORTH	5	3	0	0	0	0	0	0	0	0	0	0
Total	**22,561**	**6,537**	**3,836**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**243**

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	23
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**24**

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	6,366	6,075
Cystoscopy	0	0	119	462
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**6,485**	**6,537**

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	6,366	6,075
Cystoscopy	0	0	119	462
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**6,485**	**6,537**

Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

1. Race/Ethnicity of Ambulatory Patients
Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	3,980
Hispanic/Latino	73
Pacific Islander/Hawaiian	0
White	2,298
Multi-Racial	186
Total	**6,537**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	56
Ages 15-64	5,078
Ages 65-74	868
Ages 75-85	447
Ages 85 and Up	88
Total	**6,537**

3. Gender
Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,319
Female	4,218
Total	**6,537**

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

Primary Payment Source	Number of Patients
Medicare	1,959
Medicaid	662
Third-Party	3,730
Self-Pay	186

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: 11

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,203

6. Total Live Births: 3,862

7. Total Births (Live and Late Fetal Deaths): 3,879

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,879

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)	25	3,678	8,039	0
Specialty Care (Intermediate Neonatal Care)	16	140	6,920	83
Subspecialty Care (Intensive Neonatal Care)	8	124	2,600	1

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	2,918	9,989
Hispanic/Latino	172	694
Pacific Islander/Hawaiian	0	0
White	524	1,574
Multi-Racial	222	655
Total	**3,836**	**12,912**

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	4	12
Ages 15-44	3,829	12,890
Ages 45 and Up	3	10
Total	**3,836**	**12,912**

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

$11,457.00

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

$13,123.00

LTCH Addendum

Part A : General Information

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

JCAHO

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

Full

2. Number of Licensed LTCH Beds: 30

3. Permit Effective Date: 6/20/2001

4. Permit Designation: LTAH

5. Number of CON Beds: 30

6. Number of SUS Beds: 30

7. Total Patient Days: 8,172

8. Total Discharges: 235

9. Total LTCH Admissions: 243

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

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	1	30
Black/African American	123	4,136
Hispanic/Latino	1	38
Pacific Islander/Hawaiian	0	0
White	81	2,724
Multi-Racial	37	1,244
Total	**243**	**8,172**

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	154	5,179
Ages 65-74	47	1,581
Ages 75-84	36	1,210
Ages 85 and Up	6	202
Total	**243**	**8,172**

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

Gender of Patient	Admissions	Inpatient Days
Male	138	4,641
Female	105	3,531
Total	**243**	**8,172**

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	121	4,069
Third-Party	117	3,935
Self-Pay	5	168
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	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

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

1. Race/Ethnicity

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

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

2. Gender

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

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

3. Payment Source

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

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

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 1.5 (FTE's)
What languages do they interpret?
Spanish, Korean

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

Bilingual Hospital Staff Member ☑   Bilingual Member of Patient's Family ☑

Community Volunteer Intrepreter ☐   Telephone Interpreter Service ☑

Refer Patient to Outside Agency ☑   Other (please describe): ☐

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	80	0	0	0
Korean	10	0	0	0
Vietnamese	10	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?

None

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?

Dedicated Staff Person

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

1. English	2. Braille	3. N/A	4. N/A

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

Good Samaritan Health Center 239 Ivan Allen Jr. BLVD.,NE Atlanta, GA 30313
 Grady Clinic 80 Jessie Hill Jr. Drive Atlanta, GA 30303

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: Dane Peterson

Date: 3/19/2010

Title: COO

Comments: