GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP706

Facility Name: Emory University Hospital

County: DeKalb

Street Address: 1364 Clifton Road NE

City: Atlanta

Zip: 30322-1061

Mailing Address: 1364 Clifton Road NE

Mailing City: Atlanta

Mailing Zip: 30322-1061

Medicaid Provider Number: 0000712

Medicare Provider Number: 110010

2. Report Period

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

Contact Title: Associate Administrator

Phone: 404-686-2818

Fax: 404-686-2848

E-mail: toni.wimby@emoryhealthcare.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

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

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory University d/b/a Emory University Hospital	Not for Profit	1/1/1922

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

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

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

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

Name: Emory Healthcare

City: Atlanta **State:** Georgia

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

Name:

City: **State:**

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

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

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

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☑

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	0	0	0	0	0
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	269	14,319	72,799	14,474	73,538
General Surgery	0	0	0	0	0
Medical/Surgical	117	6,097	41,171	6,087	37,200
Intensive Care	93	1,646	28,497	1,190	30,704
Psychiatry	18	592	3,519	590	3,482
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	46	766	11,529	761	11,400
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**543**	**23,420**	**157,515**	**23,102**	**156,324**

2. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	7,381	52,746
Hispanic/Latino	383	2,657
Pacific Islander/Hawaiian	0	0
White	13,902	90,777
Multi-Racial	1,754	11,335
Total	**23,420**	**157,515**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,767	77,915
Female	11,653	79,600
Total	**23,420**	**157,515**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10,584	70,709
Medicaid	1,829	16,958
Peachare	0	0
Third-Party	9,583	58,677
Self-Pay	1,424	11,171
Other	0	0

5. Discharges to Death

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

833

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	1,045
Operating Room: Average Charge for the First Hour	3,120
Average Total Charge for an Inpatient Day	6,977

Part E : Emergency Department and Outpatient Services

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

33,011

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

7,418

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

21

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	193
General Beds	20	32,259
	0	0
	0	0
	0	0
	0	0

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

1,178

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

65,406

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

6,428

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

217

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

218.00

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.

1,162

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	1	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	2	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	5,405
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	188
Number of Heart Transplants	26
Number of Other-Organ/Tissues Treatments	161
Number of Diagnostic X-Ray Procedures	170,330
Number of CTS Units (machines)	8
Number of CTS Procedures	39,215
Number of Diagnostic Radioisotope Procedures	18,297
Number of PET Units (machines)	1
Number of PET Procedures	2,709
Number of Therapeautic Radioisotope Procedures	2,080
Number of Number of MRI Units	8
Number of Number of MRI Procedures	19,621
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	310,844
Number of Occupational Therapy Treatments	31,796
Number of Physical Therapy Treatments	44,632
Number of Speech Pathology Patients	20,578
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	9,594
Number of HIV/AIDS Patients	219
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	3
Number of Ultrasound/Medical Sonography Procedures	12,796
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).

69

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			
Physician Assistants Only (not including Licensed Physicians)			
Registered Nurses (RNs-Advanced Practice*)	1119.8199462891		
Licensed Practical Nurses (LPNs)	0.80000001192093		
Pharmacists	57.090000152588		
Other Health Services Professionals*	926.16998291016		
Administration and Support	1062.3699951172		0
All Other Hospital Personnel (not included above)			

2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
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	2	☐	0	0
General Internal Medicine	48	☐	0	0
Pediatricians	37	☐	0	0
Other Medical Specialties	318	☐	0	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	17	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	15	☐	0	0
Ophthalmology Surgery	38	☐	0	0
Orthopedic Surgery	2	☐	0	0
Plastic Surgery	4	☐	0	0
General Surgery	35	☐	0	0
Thoracic Surgery	21	☐	0	0
Other Surgical Specialties	18	☐	0	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	97	☑	0	0
Dermatology	12	☐	0	0
Emergency Medicine	78	☑	0	0
Nuclear Medicine	13	☑	0	0
Pathology	59	☑	0	0
Psychiatry	57	☐	0	0
Radiology	89	☑	0	0
Rad Oncology	16	☑	0	0
Rehab	7	☐	0	0
Hospitalist	82	☑	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	2
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	316

5b. Name of Other Professions

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

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

Comments and Suggestions:

Part H : Physician Name and License Number

1. Physicians on Staff

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

Part I : Patient Origin Table

1. Patient Origin

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

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

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
Appling	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	2	0	0	0	0	0	0	0	0	0	0	0
Baldwin	69	14	0	1	0	0	0	0	0	0	0	0
Banks	23	1	0	0	0	0	0	0	0	0	0	0
Barrow	134	17	0	3	0	0	0	0	0	0	0	0
Bartow	185	33	0	6	0	0	0	0	0	0	0	0
Ben Hill	27	2	0	0	0	0	0	0	0	0	0	0
Berrien	20	2	0	0	0	0	0	0	0	0	0	0
Bibb	209	37	0	1	0	0	0	0	0	0	0	0
Bleckley	11	2	0	0	0	0	0	0	0	0	0	0
Brantley	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	7	3	0	0	0	0	0	0	0	0	0	0
Bryan	14	3	0	0	0	0	0	0	0	0	0	0
Bulloch	2	0	0	0	0	0	0	0	0	0	0	0
Burke	7	0	0	0	0	0	0	0	0	0	0	0
Butts	86	12	0	2	0	0	0	0	0	0	0	0
Calhoun	19	4	0	1	0	0	0	0	0	0	0	0
Camden	7	1	0	0	0	0	0	0	0	0	0	0
Candler	3	0	0	1	0	0	0	0	0	0	0	0
Carroll	344	45	0	6	0	0	0	0	0	0	0	0
Catoosa	23	3	0	2	0	0	0	0	0	0	0	0
Chatham	71	7	0	4	0	0	0	0	0	0	0	0
Chattahoochee	3	0	0	0	0	0	0	0	0	0	0	0
Chattooga	32	5	0	0	0	0	0	0	0	0	0	0
Cherokee	356	75	0	4	0	0	0	0	0	0	0	0
Clarke	125	31	0	3	0	0	0	0	0	0	0	0
Clay	36	4	0	0	0	0	0	0	0	0	0	0
Clayton	541	53	0	9	0	0	0	0	0	0	0	0

Clinch	9	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,071	215	0	13	0	0	0	0	0	0	0	0
Coffee	49	3	0	1	0	0	0	0	0	0	0	0
Colquitt	50	18	0	1	0	0	0	0	0	0	0	0
Columbia	41	2	0	1	0	0	0	0	0	0	0	0
Cook	34	4	0	0	0	0	0	0	0	0	0	0
Coweta	283	59	0	3	0	0	0	0	0	0	0	0
Crawford	5	2	0	0	0	0	0	0	0	0	0	0
Crisp	14	5	0	0	0	0	0	0	0	0	0	0
Dade	9	0	0	1	0	0	0	0	0	0	0	0
Dawson	57	16	0	1	0	0	0	0	0	0	0	0
Decatur	11	1	0	0	0	0	0	0	0	0	0	0
DeKalb	5,328	536	0	152	0	0	0	0	0	0	0	0
Dodge	17	0	0	0	0	0	0	0	0	0	0	0
Dooly	15	5	0	0	0	0	0	0	0	0	0	0
Dougherty	86	11	0	0	0	0	0	0	0	0	0	0
Douglas	286	38	0	2	0	0	0	0	0	0	0	0
Early	9	0	0	0	0	0	0	0	0	0	0	0
Effingham	7	1	0	0	0	0	0	0	0	0	0	0
Elbert	42	4	0	1	0	0	0	0	0	0	0	0
Emanuel	15	0	0	0	0	0	0	0	0	0	0	0
Evans	13	0	0	0	0	0	0	0	0	0	0	0
Fannin	32	16	0	0	0	0	0	0	0	0	0	0
Fayette	214	45	0	8	0	0	0	0	0	0	0	0
Floyd	108	20	0	3	0	0	0	0	0	0	0	0
Forsyth	189	36	0	4	0	0	0	0	0	0	0	0
Franklin	68	11	0	0	0	0	0	0	0	0	0	0
Fulton	2,716	457	0	172	0	0	0	0	0	0	0	0
Gilmer	49	12	0	2	0	0	0	0	0	0	0	0
Glascock	3	0	0	0	0	0	0	0	0	0	0	0
Glynn	41	5	0	0	0	0	0	0	0	0	0	0
Gordon	66	3	0	2	0	0	0	0	0	0	0	0
Grady	8	1	0	0	0	0	0	0	0	0	0	0
Greene	44	6	0	1	0	0	0	0	0	0	0	0
Gwinnett	2,030	327	0	39	0	0	0	0	0	0	0	0
Habersham	62	20	0	1	0	0	0	0	0	0	0	0
Hall	240	42	0	3	0	0	0	0	0	0	0	0
Hancock	16	1	0	1	0	0	0	0	0	0	0	0
Haralson	87	16	0	0	0	0	0	0	0	0	0	0
Harris	86	10	0	0	0	0	0	0	0	0	0	0
Hart	45	1	0	0	0	0	0	0	0	0	0	0
Heard	29	0	0	2	0	0	0	0	0	0	0	0
Henry	830	123	0	14	0	0	0	0	0	0	0	0
Houston	232	42	0	2	0	0	0	0	0	0	0	0

Irwin	19	6	0	0	0	0	0	0	0	0	0	0
Jackson	133	22	0	1	0	0	0	0	0	0	0	0
Jasper	52	5	0	2	0	0	0	0	0	0	0	0
Jeff Davis	14	2	0	0	0	0	0	0	0	0	0	0
Jefferson	28	2	0	1	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0
Johnson	15	2	0	0	0	0	0	0	0	0	0	0
Jones	15	4	0	0	0	0	0	0	0	0	0	0
Lamar	38	9	0	0	0	0	0	0	0	0	0	0
Lanier	3	0	0	0	0	0	0	0	0	0	0	0
Laurens	62	20	0	0	0	0	0	0	0	0	0	0
Lee	67	13	0	2	0	0	0	0	0	0	0	0
Liberty	16	1	0	1	0	0	0	0	0	0	0	0
Lincoln	3	0	0	0	0	0	0	0	0	0	0	0
Long	5	0	0	0	0	0	0	0	0	0	0	0
Lowndes	100	4	0	0	0	0	0	0	0	0	0	0
Lumpkin	35	7	0	0	0	0	0	0	0	0	0	0
Macon	17	1	0	0	0	0	0	0	0	0	0	0
Madison	55	4	0	1	0	0	0	0	0	0	0	0
Marion	8	0	0	0	0	0	0	0	0	0	0	0
McDuffie	14	1	0	0	0	0	0	0	0	0	0	0
McIntosh	2	1	0	0	0	0	0	0	0	0	0	0
Meriwether	67	9	0	0	0	0	0	0	0	0	0	0
Miller	5	0	0	0	0	0	0	0	0	0	0	0
Mitchell	19	0	0	0	0	0	0	0	0	0	0	0
Monroe	46	6	0	0	0	0	0	0	0	0	0	0
Montgomery	26	6	0	0	0	0	0	0	0	0	0	0
Morgan	63	18	0	0	0	0	0	0	0	0	0	0
Murray	48	4	0	0	0	0	0	0	0	0	0	0
Muscogee	249	39	0	2	0	0	0	0	0	0	0	0
Newton	387	40	0	6	0	0	0	0	0	0	0	0
Oconee	95	15	0	2	0	0	0	0	0	0	0	0
Oglethorpe	17	2	0	1	0	0	0	0	0	0	0	0
Other Out of State	2,016	214	0	68	0	0	0	0	0	0	0	0
Paulding	152	23	0	1	0	0	0	0	0	0	0	0
Peach	44	4	0	1	0	0	0	0	0	0	0	0
Pickens	85	20	0	1	0	0	0	0	0	0	0	0
Pierce	6	1	0	0	0	0	0	0	0	0	0	0
Pike	53	10	0	1	0	0	0	0	0	0	0	0
Polk	62	13	0	0	0	0	0	0	0	0	0	0
Pulaski	20	2	0	0	0	0	0	0	0	0	0	0
Putnam	71	6	0	0	0	0	0	0	0	0	0	0
Quitman	6	0	0	0	0	0	0	0	0	0	0	0
Rabun	29	5	0	0	0	0	0	0	0	0	0	0

Randolph	20	2	0	0	0	0	0	0	0	0	0	0
Richmond	80	5	0	2	0	0	0	0	0	0	0	0
Rockdale	357	45	0	2	0	0	0	0	0	0	0	0
Schley	3	4	0	0	0	0	0	0	0	0	0	0
Seminole	8	0	0	0	0	0	0	0	0	0	0	0
Spalding	234	43	0	5	0	0	0	0	0	0	0	0
Stephens	94	16	0	1	0	0	0	0	0	0	0	0
Stewart	5	2	0	0	0	0	0	0	0	0	0	0
Sumter	41	4	0	0	0	0	0	0	0	0	0	0
Talbot	13	1	0	0	0	0	0	0	0	0	0	0
Tattnall	8	2	0	0	0	0	0	0	0	0	0	0
Taylor	18	3	0	0	0	0	0	0	0	0	0	0
Telfair	9	4	0	0	0	0	0	0	0	0	0	0
Terrell	15	0	0	0	0	0	0	0	0	0	0	0
Thomas	50	7	0	0	0	0	0	0	0	0	0	0
Tift	86	7	0	0	0	0	0	0	0	0	0	0
Toombs	16	1	0	1	0	0	0	0	0	0	0	0
Towns	49	5	0	3	0	0	0	0	0	0	0	0
Treutlen	9	0	0	3	0	0	0	0	0	0	0	0
Troup	364	35	0	0	0	0	0	0	0	0	0	0
Turner	24	0	0	0	0	0	0	0	0	0	0	0
Twiggs	11	2	0	0	0	0	0	0	0	0	0	0
Union	51	15	0	1	0	0	0	0	0	0	0	0
Upson	52	9	0	0	0	0	0	0	0	0	0	0
Walker	28	10	0	1	0	0	0	0	0	0	0	0
Walton	237	33	0	4	0	0	0	0	0	0	0	0
Ware	6	2	0	0	0	0	0	0	0	0	0	0
Warren	5	0	0	0	0	0	0	0	0	0	0	0
Washington	23	5	0	0	0	0	0	0	0	0	0	0
Wayne	18	2	0	2	0	0	0	0	0	0	0	0
Webster	3	0	0	0	0	0	0	0	0	0	0	0
Wheeler	7	1	0	0	0	0	0	0	0	0	0	0
White	34	3	0	1	0	0	0	0	0	0	0	0
Whitfield	103	14	0	2	0	0	0	0	0	0	0	0
Wilcox	9	2	0	0	0	0	0	0	0	0	0	0
Wilkes	7	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	27	2	0	0	0	0	0	0	0	0	0	0
Worth	19	0	0	0	0	0	0	0	0	0	0	0
Total	**23,420**	**3,295**	**0**	**592**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

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

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	0	21
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**22**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	7,922	2,949
Cystoscopy	0	0	144	382
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**8,066**	**3,331**

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	7,922	2,913
Cystoscopy	0	0	144	382
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**8,066**	**3,295**

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	672
Hispanic/Latino	42
Pacific Islander/Hawaiian	0
White	2,291
Multi-Racial	290
Total	**3,295**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4
Ages 15-64	2,446
Ages 65-74	569
Ages 75-85	239
Ages 85 and Up	37
Total	**3,295**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,617
Female	1,678
Total	**3,295**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,003
Medicaid	220
Third-Party	1,980
Self-Pay	92

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

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

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

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

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

1. Race/Ethnicity

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

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

2. Age Grouping
Please provide the number of admissions by the following age groupings.

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

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

$0.00

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

$0.00

LTCH Addendum

Part A : General Information

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

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

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

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

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

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

2. Age of LTCH Patient

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

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

3. Gender

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

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

4. Payment Source

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

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

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

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

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	47	18
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	592	3,519	590	3,482	2,038	☑
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	218	1,167
Hispanic/Latino	3	46
Pacific Islander/Hawaiian	0	0
White	295	1,882
Multi-Racial	76	424
Total	**592**	**3,519**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	307	1,734
Female	285	1,785
Total	**592**	**3,519**

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	241	1,555
Medicaid	161	947
Third Party	177	963
Self-Pay	13	54
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

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

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

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

Bilingual Hospital Staff Member ☑	Bilingual Member of Patient's Family ☑
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☐

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

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	72	0	0	0
Korean	14	0	0	0
Vietnamese	14	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?

Cultural Competency and Diversity is one of our Care Transformation attributes. Sr. and Exec

leadership have already received training on this; and over the next several months, all EHC employees will receive training/orientation on this attribute.

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

The most urgently needed tool is inservicing on cultural diversity - what does it mean? How do we understand our own culture? What is our understanding of our biases and assumptions and how do these impact our peer relationships and patient/family relationships. I know the cultural competency and diversity work group through the CT office is working on rolling out a culture vision tool on the intranet. This of course needs to come after converations have begun so that staff kow the person who knows the most of about his/her cultural needs is not a document on a computer screen but the patient/family. Having a conversation - asking someone what will best meet their needs is far more important than reading something about a particular vulture which can be transferred too easily into stereotyping.

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

1. English
2. Spanish
3.
4.

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

Grady Health System - 80 Jesse Hill Jr Drive SE, 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: Robert Bachman

Date: 3/11/2010

Title: Chief Operating Officer

Comments: