GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP617

Facility Name: Piedmont Hospital

County: Fulton

Street Address: 1968 Peachtree Road NW

City: Atlanta

Zip: 30309-1285

Mailing Address: 1968 Peachtree Road NW

Mailing City: Atlanta

Mailing Zip: 30309-1285

Medicaid Provider Number: 00001502

Medicare Provider Number: 110083

2. Report Period

Report Data for the full twelve month period- January 1, 2010 through December 31, 2010.
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: Davis Dunbar

Contact Title: Manager, Regulatory Affairs

Phone: 404-788-3638

Fax: 404-609-6724

E-mail: davis.dunbar@piedmont.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
Piedmont Healthcare, Inc.	Not for Profit	6/13/1983

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
Not Applicable	Not Applicable	

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.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Piedmont Healthcare, Inc.
City: Atlanta   **State:** GA

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:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Voluntary Hospitals of America
City: Atlanta   **State:** GA

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

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

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

1. Health Maintenance Organization(HMO)   ☑

2. Preferred Provider Organization(PPO)   ☑

3. Physician Hospital Organization(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)	29	3,509	10,855	3,531	10,998
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	20	95	435	94	378
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	372	20,801	110,570	24,048	122,081
Intensive Care	45	3,554	12,450	0	0
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	15	167	2,165	175	2,311
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	**481**	**28,126**	**136,475**	**27,848**	**135,768**

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	27	121
Asian	300	1,163
Black/African American	9,241	48,181
Hispanic/Latino	555	2,340
Pacific Islander/Hawaiian	1	6
White	17,401	82,190
Multi-Racial	601	2,474
Total	**28,126**	**136,475**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	12,082	62,302
Female	16,044	74,173
Total	**28,126**	**136,475**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	11,744	64,889
Medicaid	1,013	7,603
Peachare	0	0
Third-Party	14,151	59,327
Self-Pay	995	3,724
Other	223	932

5. Discharges to Death

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

493

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2010 (to the nearest whole dollar).

Service	Charge
Private Room Rate	835
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	5,407
Average Total Charge for an Inpatient Day	9,072

Part E : Emergency Department and Outpatient Services

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

50,666

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

10,829

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

45

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	1	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	771
General Beds	42	49,054
	0	0
	0	0
	0	0
	0	0

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

317

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

310,671

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

3,858

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

889.00

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.

748

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	2	1
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	3	4
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	1	1
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
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	6,294
Number of ESWL Patients	225
Number of ESWL Procedures	264
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	155
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	88
Number of Diagnostic X-Ray Procedures	157,275
Number of CTS Units (machines)	7
Number of CTS Procedures	46,706
Number of Diagnostic Radioisotope Procedures	4,774
Number of PET Units (machines)	1
Number of PET Procedures	1,124
Number of Therapeautic Radioisotope Procedures	115
Number of Number of MRI Units	5
Number of Number of MRI Procedures	12,801
Number of Chemotherapy Treatments	3,628
Number of Respiratory Therapy Treatments	732,014
Number of Occupational Therapy Treatments	45,752
Number of Physical Therapy Treatments	136,740
Number of Speech Pathology Patients	1,438
Number of Gamma Ray Knife Procedures	83
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	0
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	3
Number of Ultrasound/Medical Sonography Procedures	4,330
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).

<u>88</u>

3. Robotic Surgery System
Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
1	272	da Vinci si

Part G : Facility Workforce Information

1. Budgeted Staff
Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2010. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2010.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0	0	0
Physician Assistants Only (not including Licensed Physicians)	1	0	0
Registered Nurses (RNs-Advanced Practice*)	1066.5	69	0
Licensed Practical Nurses (LPNs)	14	0	0
Pharmacists	44.200000762939	1	0
Other Health Services Professionals*	555.79998779297	53	0
Administration and Support	278.70001220703	0	0
All Other Hospital Personnel (not included above)	1543.1999511719	15	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	61-90 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
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	66
Black/African American	117
Hispanic/Latino	15
Pacific Islander/Hawaiian	0
White	544
Multi-Racial	14

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	22	☐	0	0
General Internal Medicine	146	☑	0	0
Pediatricians	45	☑	0	0
Other Medical Specialties	243	☐	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	40	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	8	☐	0	0
Ophthalmology Surgery	16	☐	0	0
Orthopedic Surgery	22	☐	0	0
Plastic Surgery	18	☐	0	0
General Surgery	15	☐	0	0
Thoracic Surgery	8	☐	0	0
Other Surgical Specialties	67	☐	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	37	☑	0	0
Dermatology	11	☐	0	0
Emergency Medicine	36	☑	0	0
Nuclear Medicine	0	☐	0	0
Pathology	10	☐	0	0
Psychiatry	0	☐	0	0
Radiology	23	☑	0	0
Radiation Oncology	3	☐	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	0
Podiatrists	6
Certified Nurse Midwives with Clinical Privileges in the Hospital	6
All Other Staff Affiliates with Clinical Privileges in the Hospital	354

5b. Name of Other Professions

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

Psychologist, Surgical First Assistant, Physician Assistant, Nurse Practicioner, RN, Surgical Assistant, Audiologist

Comments and Suggestions:

Part H : Physician Name and License Number

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

Part I : Patient Origin Table

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

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric
P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under

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

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH
Alabama	122	116	1	0	0	0	0	0	0	0	0	0
Appling	2	0	0	0	0	0	0	0	0	0	0	0
Atkinson	2	0	0	0	0	0	0	0	0	0	0	0
Bacon	3	1	0	0	0	0	0	0	0	0	0	0
Baldwin	21	19	0	0	0	0	0	0	0	0	0	0
Banks	5	3	0	0	0	0	0	0	0	0	0	0
Barrow	59	31	4	0	0	0	0	0	0	0	0	0
Bartow	95	108	4	0	0	0	0	0	0	0	0	0
Ben Hill	3	0	0	0	0	0	0	0	0	0	0	0
Berrien	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	46	25	2	0	0	0	0	0	0	0	0	0
Bleckley	2	3	1	0	0	0	0	0	0	0	0	0
Brooks	2	1	0	0	0	0	0	0	0	0	0	0
Bryan	1	2	0	0	0	0	0	0	0	0	0	0
Butts	115	50	5	0	0	0	0	0	0	0	0	0
Calhoun	1	1	0	0	0	0	0	0	0	0	0	0
Candler	4	0	0	0	0	0	0	0	0	0	0	0
Carroll	356	110	11	0	0	0	0	0	0	0	0	0
Catoosa	4	4	0	0	0	0	0	0	0	0	0	0
Chatham	16	10	1	0	0	0	0	0	0	0	0	0
Chattahoochee	0	1	0	0	0	0	0	0	0	0	0	0
Chattooga	12	14	0	0	0	0	0	0	0	0	0	0
Cherokee	558	297	38	0	0	0	0	0	0	0	0	0
Clarke	22	27	1	0	0	0	0	0	0	0	0	0
Clayton	1,219	496	102	0	0	0	0	0	0	0	0	0
Clinch	2	0	0	0	0	0	0	0	0	0	0	0
Cobb	2,720	1,721	489	0	0	0	0	0	0	0	0	0
Coffee	6	1	0	0	0	0	0	0	0	0	0	0

County												
Colquitt	17	6	0	0	0	0	0	0	0	0	0	0
Columbia	6	12	0	0	0	0	0	0	0	0	0	0
Cook	0	1	0	0	0	0	0	0	0	0	0	0
Coweta	773	268	51	0	0	0	0	0	0	0	0	0
Crawford	1	3	0	0	0	0	0	0	0	0	0	0
Crisp	2	1	0	0	0	0	0	0	0	0	0	0
Dawson	66	25	0	0	0	0	0	0	0	0	0	0
Decatur	8	2	0	0	0	0	0	0	0	0	0	0
Dekalb	3,824	2,010	739	0	0	0	0	0	0	0	0	0
Dodge	3	1	0	0	0	0	0	0	0	0	0	0
Dooly	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	18	12	0	0	0	0	0	0	0	0	0	0
Douglas	578	244	53	0	0	0	0	0	0	0	0	0
Early	1	1	0	0	0	0	0	0	0	0	0	0
Effingham	1	5	0	0	0	0	0	0	0	0	0	0
Elbert	3	3	0	0	0	0	0	0	0	0	0	0
Emanuel	6	0	0	0	0	0	0	0	0	0	0	0
Fannin	218	22	0	0	0	0	0	0	0	0	0	0
Fayette	722	409	32	0	0	0	0	0	0	0	0	0
Florida	115	93	2	0	0	0	0	0	0	0	0	0
Floyd	42	56	1	0	0	0	0	0	0	0	0	0
Forsyth	199	132	9	0	0	0	0	0	0	0	0	0
Franklin	8	7	0	0	0	0	0	0	0	0	0	0
Fulton	10,091	4,545	1,642	0	0	0	0	0	0	0	0	0
Gilmer	274	52	1	0	0	0	0	0	0	0	0	0
Glynn	8	6	0	0	0	0	0	0	0	0	0	0
Gordon	28	27	1	0	0	0	0	0	0	0	0	0
Grady	2	0	0	0	0	0	0	0	0	0	0	0
Greene	28	11	1	0	0	0	0	0	0	0	0	0
Gwinnett	1,054	796	99	0	0	0	0	0	0	0	0	0
Habersham	32	10	0	0	0	0	0	0	0	0	0	0
Hall	83	62	0	0	0	0	0	0	0	0	0	0
Hancock	20	5	0	0	0	0	0	0	0	0	0	0
Haralson	59	30	3	0	0	0	0	0	0	0	0	0
Harris	16	8	0	0	0	0	0	0	0	0	0	0
Hart	10	6	1	0	0	0	0	0	0	0	0	0
Heard	51	6	0	0	0	0	0	0	0	0	0	0
Henry	957	535	114	0	0	0	0	0	0	0	0	0
Houston	24	6	0	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	31	26	1	0	0	0	0	0	0	0	0	0
Jasper	90	26	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	1	0	0	0	0	0	0	0	0	0	0
Jefferson	4	3	0	0	0	0	0	0	0	0	0	0

Johnson	1	1	0	0	0	0	0	0	0	0	0	0
Jones	5	2	0	0	0	0	0	0	0	0	0	0
Lamar	40	12	0	0	0	0	0	0	0	0	0	0
Laurens	16	4	0	0	0	0	0	0	0	0	0	0
Lee	7	2	0	0	0	0	0	0	0	0	0	0
Liberty	2	2	0	0	0	0	0	0	0	0	0	0
Lincoln	2	0	0	0	0	0	0	0	0	0	0	0
Long	4	0	0	0	0	0	0	0	0	0	0	0
Lowndes	8	7	0	0	0	0	0	0	0	0	0	0
Lumpkin	36	11	0	0	0	0	0	0	0	0	0	0
Macon	1	1	0	0	0	0	0	0	0	0	0	0
Madison	10	4	0	0	0	0	0	0	0	0	0	0
Mcduffie	3	1	0	0	0	0	0	0	0	0	0	0
Mcintosh	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	52	14	0	0	0	0	0	0	0	0	0	0
Miller	2	0	0	0	0	0	0	0	0	0	0	0
Mitchell	4	1	0	0	0	0	0	0	0	0	0	0
Monroe	19	8	0	0	0	0	0	0	0	0	0	0
Morgan	34	18	0	0	0	0	0	0	0	0	0	0
Murray	15	3	0	0	0	0	0	0	0	0	0	0
Muscogee	24	18	2	0	0	0	0	0	0	0	0	0
Newton	361	153	18	0	0	0	0	0	0	0	0	0
North Carolina	164	73	1	0	0	0	0	0	0	0	0	0
Oconee	10	4	0	0	0	0	0	0	0	0	0	0
Oglethorpe	4	2	0	0	0	0	0	0	0	0	0	0
Other Out of State	295	221	13	0	0	0	0	0	0	0	0	0
Paulding	272	116	10	0	0	0	0	0	0	0	0	0
Peach	6	4	0	0	0	0	0	0	0	0	0	0
Pickens	311	71	1	0	0	0	0	0	0	0	0	0
Pike	54	32	3	0	0	0	0	0	0	0	0	0
Polk	29	22	0	0	0	0	0	0	0	0	0	0
Pulaski	1	4	0	0	0	0	0	0	0	0	0	0
Putnam	181	17	0	0	0	0	0	0	0	0	0	0
Rabun	30	6	0	0	0	0	0	0	0	0	0	0
Richmond	18	5	2	0	0	0	0	0	0	0	0	0
Rockdale	359	197	22	0	0	0	0	0	0	0	0	0
South Carolina	60	40	0	0	0	0	0	0	0	0	0	0
Spalding	235	69	4	0	0	0	0	0	0	0	0	0
Sumter	6	2	1	0	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0
Taylor	2	3	0	0	0	0	0	0	0	0	0	0
Tennessee	67	45	5	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	7	0	0	0	0	0	0	0	0	0	0	0

Tift	10	3	1	0	0	0	0	0	0	0	0	0
Toombs	4	0	0	0	0	0	0	0	0	0	0	0
Towns	60	11	0	0	0	0	0	0	0	0	0	0
Treutlen	0	1	0	0	0	0	0	0	0	0	0	0
Troup	50	16	1	0	0	0	0	0	0	0	0	0
Union	136	21	2	0	0	0	0	0	0	0	0	0
Upson	35	14	0	0	0	0	0	0	0	0	0	0
Walker	5	6	0	0	0	0	0	0	0	0	0	0
Walton	129	100	14	0	0	0	0	0	0	0	0	0
Ware	0	1	0	0	0	0	0	0	0	0	0	0
Warren	2	0	0	0	0	0	0	0	0	0	0	0
Washington	1	1	0	0	0	0	0	0	0	0	0	0
Wayne	1	1	0	0	0	0	0	0	0	0	0	0
Webster	1	0	0	0	0	0	0	0	0	0	0	0
Wheeler	1	0	0	0	0	0	0	0	0	0	0	0
White	14	8	0	0	0	0	0	0	0	0	0	0
Whitfield	33	15	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	1	0	0	0	0	0	0	0	0	0	0
Worth	3	1	0	0	0	0	0	0	0	0	0	0
Total	**28,126**	**13,911**	**3,509**	**0**	**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	4	8	17
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**4**	**8**	**18**

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	1,616	6,180	9,082	3,821
Cystoscopy	0	0	262	1,029
Endoscopy	0	0	0	0
	0	0	0	0
Total	**1,616**	**6,180**	**9,344**	**4,850**

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	1,616	6,180	9,082	3,821
Cystoscopy	0	0	262	1,029
Endoscopy	0	0	0	0
	0	0	0	0
Total	**1,616**	**6,180**	**9,344**	**4,850**

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	11
Asian	125
Black/African American	3,726
Hispanic/Latino	291
Pacific Islander/Hawaiian	3
White	9,241
Multi-Racial	514
Total	**13,911**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	279
Ages 15-64	10,708
Ages 65-74	1,885
Ages 75-85	907
Ages 85 and Up	132
Total	**13,911**

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

Gender	Number of Ambulatory Patients
Male	6,078
Female	7,833
Total	**13,911**

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

Primary Payment Source	Number of Patients
Medicare	2,379
Medicaid	238
Third-Party	10,603
Self-Pay	691

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: 15

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,293

6. Total Live Births: 3,283

7. Total Births (Live and Late Fetal Deaths): 3,306

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,314

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)	28	2,845	8,170	0
Specialty Care (Intermediate Neonatal Care)	19	162	2,764	0
Subspecialty Care (Intensive Neonatal Care)	10	131	2,083	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	2	5
Asian	143	383
Black/African American	917	2,836
Hispanic/Latino	96	303
Pacific Islander/Hawaiian	0	0
White	2,219	6,866
Multi-Racial	132	462
Total	**3,509**	**10,855**

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	3,495	10,808
Ages 45 and Up	14	47
Total	**3,509**	**10,855**

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

$9,916.00

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

$17,053.00

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	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? 3 (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): ☑

Contract interpreter

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	51	6	11	20
Asian	5	2	2	15
Middle Eastern	2	1	1	10

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?

Ongoing inservices

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

None

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

1. English   2. 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, Atlanta, GA

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: Leslie Donahue

Date: 3/26/2011

Title: Chief Executive Officer

Comments:

Piedmont has no way to identify the number of ambulatory surgery patients that were provided services by type of room. As such, ambulatory surgical procedures and patients are the same for Part A: Surgical Services Utilization, Quesstions 1 and 2.