GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP622

Facility Name: St Mary's Hospital

County: Clarke

Street Address: 1230 Baxter Street

City: Athens

Zip: 30606-3791

Mailing Address: 1230 Baxter Street

Mailing City: Athens

Mailing Zip: 30606-3791

Medicaid Provider Number: 00001823A

Medicare Provider Number: 110006

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: Martin Hutson

Contact Title: CFO

Phone: 706-389-3938

Fax: 706-389-3931

E-mail: mhutson@stmarysathens.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
St Mary's Health Care System	Not for Profit	10/1/1999

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Catholic Health East	Not for Profit	10/1/1999

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Same as Owner	Not for Profit	10/1/1999

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Same as Parent	Not Applicable	10/1/1999

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
NA	Not Applicable	10/1/1999

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
NA	Not Applicable	10/1/1999

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: Catholic Health East
City: Philadelphia   **State:** PA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: Catholic Health East
City: Philadelphia   **State:** PA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: St Mary's Medical Group, St Mary's Foundations, St
City: Athens **State:** GA

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Georgia Allicance of Commumity Hospitals
City: Atlanta **State:** GA

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

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	33	1,317	3,963	1,327	3,990
Pediatrics (Non ICU)	0	141	334	143	329
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	239	581	237	567
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	103	5,483	22,078	5,957	23,689
Intensive Care	12	853	2,913	366	1,329
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	21	496	6,060	498	6,002
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	**169**	**8,529**	**35,929**	**8,528**	**35,906**

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	64	213
Black/African American	1,863	8,703
Hispanic/Latino	84	328
Pacific Islander/Hawaiian	0	0
White	6,416	26,295
Multi-Racial	102	390
Total	**8,529**	**35,929**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	3,094	14,123
Female	5,435	21,806
Total	**8,529**	**35,929**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	3,985	19,400
Medicaid	911	3,487
Peachare	24	66
Third-Party	2,923	10,196
Self-Pay	663	2,711
Other	23	69

5. Discharges to Death

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

115

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	906
Semi-Private Room Rate	888
Operating Room: Average Charge for the First Hour	5,328
Average Total Charge for an Inpatient Day	6,351

Part E : Emergency Department and Outpatient Services

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

35,950

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

4,773

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

27

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	3	7,093
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	3	604
General Beds	21	28,253
	0	0
	0	0
	0	0
	0	0

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

426

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

0

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

1,384

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

0

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

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

821

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

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

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	129
Number of Dialysis Treatments	87
Number of ESWL Patients	204
Number of ESWL Procedures	244
Number of ESWL Units	0
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	35,314
Number of CTS Units (machines)	3
Number of CTS Procedures	15,208
Number of Diagnostic Radioisotope Procedures	3,537
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	411
Number of Number of MRI Units	2
Number of Number of MRI Procedures	3,528
Number of Chemotherapy Treatments	40
Number of Respiratory Therapy Treatments	35,767
Number of Occupational Therapy Treatments	41,536
Number of Physical Therapy Treatments	85,454
Number of Speech Pathology Patients	19,544
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,083
Number of HIV/AIDS Diagnostic Procedures	186
Number of HIV/AIDS Patients	132
Number of Ambulance Trips	0
Number of Hospice Patients	614
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	13,333
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).

11

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	65	da Vinci

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	10	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	450	19.700000762939	0
Licensed Practical Nurses (LPNs)	30	2.0999999046326	0
Pharmacists	19	1	0
Other Health Services Professionals*	383	2	0
Administration and Support	470	19.200000762939	0
All Other Hospital Personnel (not included above)	31	2	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)	30 Days or Less
Pharmacists	More than 90 Days
Other Health Services Professionals	61-90 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	24
Black/African American	15
Hispanic/Latino	4
Pacific Islander/Hawaiian	0
White	192
Multi-Racial	79

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	11	☐	11	0
General Internal Medicine	26	☐	26	0
Pediatricians	56	☐	20	0
Other Medical Specialties	52	☐	50	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	☐	6	16
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	18	☐	0	0
Ophthalmology Surgery	9	☐	9	0
Orthopedic Surgery	15	☐	13	0
Plastic Surgery	6	☐	6	0
General Surgery	9	☐	8	0
Thoracic Surgery	4	☐	1	0
Other Surgical Specialties	21	☐	25	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	10	☑	9	0
Dermatology	7	☐	0	0
Emergency Medicine	10	☐	10	0
Nuclear Medicine	0	☐	0	0
Pathology	2	☑	2	0
Psychiatry	3	☐	3	0
Radiology	17	☑	17	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	5
Podiatrists	3
Certified Nurse Midwives with Clinical Privileges in the Hospital	2
All Other Staff Affiliates with Clinical Privileges in the Hospital	147

5b. Name of Other Professions

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

too many to mention is such a small space

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	2	1	1	0	0	0	0	0	0	0	0	0
Baldwin	5	8	1	0	0	0	0	0	0	0	0	0
Banks	81	104	10	0	0	0	0	0	0	0	0	0
Barrow	772	535	144	0	0	0	0	0	0	0	0	0
Ben Hill	0	1	0	0	0	0	0	0	0	0	0	0
Bibb	1	0	0	0	0	0	0	0	0	0	0	0
Bryan	0	1	0	0	0	0	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	2	0	0	0	0	0	0	0	0	0	0	0
Chatham	1	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	1	0	0	0	0	0	0	0	0	0	0
Cherokee	3	2	0	0	0	0	0	0	0	0	0	0
Clarke	3,040	2,239	471	0	0	0	0	0	0	0	0	0
Clay	0	4	0	0	0	0	0	0	0	0	0	0
Cobb	5	5	0	0	0	0	0	0	0	0	0	0
Colquitt	1	2	0	0	0	0	0	0	0	0	0	0
Columbia	1	0	1	0	0	0	0	0	0	0	0	0
Crawford	0	1	0	0	0	0	0	0	0	0	0	0
Crisp	0	1	0	0	0	0	0	0	0	0	0	0
Dawson	2	0	0	0	0	0	0	0	0	0	0	0
Decatur	0	1	0	0	0	0	0	0	0	0	0	0
DeKalb	12	20	0	0	0	0	0	0	0	0	0	0
Elbert	227	250	41	0	0	0	0	0	0	0	0	0
Emanuel	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	0	3	0	0	0	0	0	0	0	0	0	0
Fayette	0	1	0	0	0	0	0	0	0	0	0	0
Floyd	1	1	0	0	0	0	0	0	0	0	0	0
Forsyth	2	3	0	0	0	0	0	0	0	0	0	0

Franklin	174	232	22	0	0	0	0	0	0	0	0	0
Fulton	16	16	0	0	0	0	0	0	0	0	0	0
Gilmer	1	1	0	0	0	0	0	0	0	0	0	0
Glynn	3	0	0	0	0	0	0	0	0	0	0	0
Gordon	1	0	0	0	0	0	0	0	0	0	0	0
Greene	255	151	25	0	0	0	0	0	0	0	0	0
Gwinnett	47	64	13	0	0	0	0	0	0	0	0	0
Habersham	24	35	2	0	0	0	0	0	0	0	0	0
Hall	18	24	2	0	0	0	0	0	0	0	0	0
Hancock	0	5	0	0	0	0	0	0	0	0	0	0
Harris	1	0	0	0	0	0	0	0	0	0	0	0
Hart	202	207	35	0	0	0	0	0	0	0	0	0
Henry	2	3	0	0	0	0	0	0	0	0	0	0
Houston	0	2	0	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	695	674	142	0	0	0	0	0	0	0	0	0
Jasper	9	11	1	0	0	0	0	0	0	0	0	0
Jeff Davis	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0
Jones	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	1	0	0	0	0	0	0	0	0	0	0	0
Lee	1	0	0	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	0	0	0	0	0	0	0	0
Lincoln	4	1	0	0	0	0	0	0	0	0	0	0
Lumpkin	0	2	0	0	0	0	0	0	0	0	0	0
Madison	559	557	103	0	0	0	0	0	0	0	0	0
Monroe	6	1	0	0	0	0	0	0	0	0	0	0
Morgan	253	215	34	0	0	0	0	0	0	0	0	0
Muscogee	0	1	0	0	0	0	0	0	0	0	0	0
Newton	55	53	3	0	0	0	0	0	0	0	0	0
Oconee	689	711	125	0	0	0	0	0	0	0	0	0
Oglethorpe	323	291	33	0	0	0	0	0	0	0	0	0
Other Out of State	68	37	2	0	0	0	0	0	0	0	0	0
Pickens	1	2	0	0	0	0	0	0	0	0	0	0
Pierce	0	1	0	0	0	0	0	0	0	0	0	0
Pike	0	1	0	0	0	0	0	0	0	0	0	0
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0
Putnam	89	47	11	0	0	0	0	0	0	0	0	0
Rabun	17	29	1	0	0	0	0	0	0	0	0	0
Richmond	1	2	0	0	0	0	0	0	0	0	0	0
Rockdale	13	23	0	0	0	0	0	0	0	0	0	0
Seminole	1	0	0	0	0	0	0	0	0	0	0	0
Stephens	80	115	3	0	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0

Taliaferro	7	3	0	0	0	0	0	0	0	0	0	0
Thomas	2	0	0	0	0	0	0	0	0	0	0	0
Tift	1	0	0	0	0	0	0	0	0	0	0	0
Towns	1	1	0	0	0	0	0	0	0	0	0	0
Treutlen	1	0	0	0	0	0	0	0	0	0	0	0
Troup	2	2	0	0	0	0	0	0	0	0	0	0
Twiggs	0	1	0	0	0	0	0	0	0	0	0	0
Union	7	3	1	0	0	0	0	0	0	0	0	0
Upson	0	1	0	0	0	0	0	0	0	0	0	0
Walker	1	2	0	0	0	0	0	0	0	0	0	0
Walton	675	261	76	0	0	0	0	0	0	0	0	0
Washington	1	0	0	0	0	0	0	0	0	0	0	0
White	9	6	1	0	0	0	0	0	0	0	0	0
Wilcox	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	46	30	14	0	0	0	0	0	0	0	0	0
Worth	0	1	0	0	0	0	0	0	0	0	0	0
Total	**8,529**	**7,012**	**1,318**	**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	0	0	13
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	1
	0	0	0
Total	**0**	**0**	**15**

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	0	15,331
Cystoscopy	0	0	0	517
Endoscopy	0	0	0	521
	0	0	0	0
Total	**0**	**0**	**0**	**16,369**

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	3,000	6,819
Cystoscopy	0	0	0	338
Endoscopy	0	0	0	345
	0	0	0	0
Total	**0**	**0**	**3,000**	**7,502**

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	54
Black/African American	1,008
Hispanic/Latino	202
Pacific Islander/Hawaiian	0
White	5,645
Multi-Racial	103
Total	**7,012**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,083
Ages 15-64	4,113
Ages 65-74	1,085
Ages 75-85	639
Ages 85 and Up	92
Total	**7,012**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,904
Female	4,108
Total	**7,012**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,018
Medicaid	936
Third-Party	3,879
Self-Pay	179

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: 19

5. Number of Cesarean Sections: 461

6. Total Live Births: 1,336

7. Total Births (Live and Late Fetal Deaths): 1,350

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,355

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)	15	1,197	2,949	54
Specialty Care (Intermediate Neonatal Care)	9	143	1,901	0
Subspecialty Care (Intensive Neonatal Care)	9	143	1,901	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	42	119
Black/African American	211	736
Hispanic/Latino	27	77
Pacific Islander/Hawaiian	0	0
White	1,012	2,951
Multi-Racial	26	75
Total	**1,318**	**3,958**

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	1,318	3,958
Ages 45 and Up	0	0
Total	**1,318**	**3,958**

3. Average Charge for an Uncomplicated Delivery

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

$8,934.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

$11,997.00

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? <u>1</u> (FTE's)
What languages do they interpret?
<u>Spanish, American Sign Language</u>

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):	☑

<u>On call staff - medical interpreter trained</u>

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	36	2	10	7
Korean	.5	0	0	0
Russian	.5	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?

<u>General Orientation for all new employees</u>

Human Resource Department sponsored training

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?

more staff for 24 hour coverage

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

1. English   2. Spanish   3. Braille   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?

Mercy Health Center 767 Oglethrope Athens, GA 30606
 Athens Neighborhood Clininc 675 College Athens, GA 30601
 Athens Nurses Clinic 496 Reese St Athens, GA 30601

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 inccaccurate 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: Don McKenna

Date: 3/23/2011

Title: CEO

Comments: