



## 2011 Annual Hospital Questionnaire

### Part A : General Information

#### 1. Identification

UID:HOSP240

**Facility Name:** Rockdale Medical Center

**County:** Rockdale

**Street Address:** 1412 Milstead Avenue, NE

**City:** Conyers

**Zip:** 30012-3899

**Mailing Address:** 1412 Milstead Avenue; NE

**Mailing City:** Conyers

**Mailing Zip:** 30012-3899

**Medicaid Provider Number:** 00001603

**Medicare Provider Number:** 110091

#### 2. Report Period

Report Data for the full twelve month period- January 1, 2011 through December 31, 2011.

***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:** GREGORY GIRARD

**Contact Title:** SENIOR ACCOUNTANT

**Phone:** 770-918-3449

**Fax:** 770-918-3805

**E-mail:** GGIRARD@LPNT.NET

## 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
ROCKDALE HOSPITAL, LLC	For Profit	2/1/2009

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
LIFEPOINT HOSPITALS, INC.	For Profit	2/1/2009

#### 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: LIFEPOINT HOSPITALS, INC.

City: BRENTWOOD State: TN

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:

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(PHO)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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)

Brentwood, TN

## Part D : Inpatient Services

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

Please indicate the following information. Do not include newborn and neonatal services. Do not include long-term care units, 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)	23	2,048	5,470	2,097	5,395
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	6	64	225	69	190
General Medicine	0	0	0	0	0
General Surgery	31	1,582	7,522	1,878	7,918
Medical/Surgical	62	4,045	17,678	4,127	18,405
Intensive Care	16	772	4,062	393	3,189
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
<b>Total</b>	<b>138</b>	<b>8,511</b>	<b>34,957</b>	<b>8,564</b>	<b>35,097</b>

## **2. Race/Ethnicity**

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

<b>Race/Ethnicity</b>	<b>Admissions</b>	<b>Inpatient Days</b>
American Indian/Alaska Native	14	124
Asian	34	117
Black/African American	3,449	13,960
Hispanic/Latino	343	983
Pacific Islander/Hawaiian	5	11
White	4,553	19,298
Multi-Racial	113	464
<b>Total</b>	<b>8,511</b>	<b>34,957</b>

## **3. Gender**

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

<b>Gender</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Male	2,737	12,633
Female	5,774	22,324
<b>Total</b>	<b>8,511</b>	<b>34,957</b>

## **4. Payment Source**

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

<b>Primary Payment Source</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Medicare	3,724	17,672
Medicaid	1,712	5,912
Peachare	0	0
Third-Party	2,161	7,849
Self-Pay	860	3,293
Other	54	231

## **5. Discharges to Death**

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

209

## **6. Charges for Selected Services**

Please report the hospital's average charges as of 12-31-2011 (to the nearest whole dollar).

<b>Service</b>	<b>Charge</b>
Private Room Rate	516
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	2,989
Average Total Charge for an Inpatient Day	6,166

## Part E : Emergency Department and Outpatient Services

### **1. Emergency Visits**

Please report the number of emergency visits only.

42,490

### **2. Inpatient Admissions from ER**

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

6,293

### **3. Beds Available**

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

31

### **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	0
General Beds	30	0
	0	0
	0	0
	0	0
	0	0

### **5. Transfers**

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

541

### **6. Non-Emergency Visits**

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

73,043

### **7. Observation Visits/Cases**

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

2,222

### **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

622.00

## 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.

1,435

## 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
Podiatric Services	3	4
Renal Dialysis	2	1
ESWL	2	1
Biliary Lithotripter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnostic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	3
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.

<b>Category</b>	<b>Total</b>
Number of Podiatric Patients	0
Number of Dialysis Treatments	2,033
Number of ESWL Patients	33
Number of ESWL Procedures	33
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	35,908
Number of CTS Units (machines)	3
Number of CTS Procedures	15,204
Number of Diagnostic Radioisotope Procedures	2,229
Number of PET Units (machines)	1
Number of PET Procedures	300
Number of Therapeutic Radioisotope Procedures	24
Number of Number of MRI Units	2
Number of Number of MRI Procedures	4,148
Number of Chemotherapy Treatments	1,720
Number of Respiratory Therapy Treatments	100,762
Number of Occupational Therapy Treatments	4,158
Number of Physical Therapy Treatments	51,699
Number of Speech Pathology Patients	408
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	166
Number of HIV/AIDS Patients	154
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	9
Number of Ultrasound/Medical Sonography Procedures	12,442
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).

20

**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	140	Davinci

## Part G : Facility Workforce Information

### 1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2011. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2011.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	6.0749998092651		
Physician Assistants Only (not including Licensed Physicians)	1		
Registered Nurses (RNs-Advanced Practice*)	268.17999267578	23.35000038147	4.0700001716614
Licensed Practical Nurses (LPNs)	8.3699998855591		
Pharmacists	10.930000305176		
Other Health Services Professionals*	238.47999572754	10.89999961853	0.81000000238419
Administration and Support	308.10998535156	19.299999237061	9.1300001144409
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	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	31-60 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	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	14	<input type="checkbox"/>	0	0
General Internal Medicine	38	<input checked="" type="checkbox"/>	0	0
Pediatricians	13	<input type="checkbox"/>	0	0
Other Medical Specialties	49	<input type="checkbox"/>	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	10	<input type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	13	<input type="checkbox"/>	0	0
Ophthalmology Surgery	4	<input type="checkbox"/>	0	0
Orthopedic Surgery	6	<input type="checkbox"/>	0	0
Plastic Surgery	3	<input type="checkbox"/>	0	0
General Surgery	4	<input type="checkbox"/>	0	0
Thoracic Surgery	1	<input type="checkbox"/>	0	0
Other Surgical Specialties	16	<input type="checkbox"/>	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	10	<input checked="" type="checkbox"/>	0	0
Dermatology	0	<input type="checkbox"/>	0	0
Emergency Medicine	14	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	6	<input checked="" type="checkbox"/>	0	0
Psychiatry	0	<input type="checkbox"/>	0	0
Radiology	15	<input checked="" type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	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 surgeons) with Admitting Privileges	9
Podiatrists	5
Certified Nurse Midwives with Clinical Privileges in the Hospital	3
All Other Staff Affiliates with Clinical Privileges in the Hospital	86

**5b. Name of Other Professions**

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

Interoperative Monitoring, Physician Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetist, Certified Surgical Assistant, Certified Nurse Midwife

**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  
Rehab=Inpatient Rehabilitation

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	Rehab
Alabama	2	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	2	2	2	0	0	0	0	0	0	0	0	0	0
Barrow	7	8	3	0	0	0	0	0	0	0	0	0	0
Bibb	3	3	2	0	0	0	0	0	0	0	0	0	0
Butts	37	33	10	0	0	0	0	0	0	0	0	0	0
Carroll	3	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	2	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	1	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	3	3	0	0	0	0	0	0	0	0	0	0	0
Clarke	2	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	14	26	4	0	0	0	0	0	0	0	0	0	0
Cobb	8	8	4	0	0	0	0	0	0	0	0	0	0
Coweta	0	7	0	0	0	0	0	0	0	0	0	0	0
Dawson	2	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	628	417	231	0	0	0	0	0	0	0	0	0	0
Dougherty	1	1	1	0	0	0	0	0	0	0	0	0	0
Douglas	5	3	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	3	4	1	0	0	0	0	0	0	0	0	0	0
Florida	19	3	0	0	0	0	0	0	0	0	0	0	0
Floyd	2	1	0	0	0	0	0	0	0	0	0	0	0
Forsyth	0	2	0	0	0	0	0	0	0	0	0	0	0
Franklin	2	2	0	0	0	0	0	0	0	0	0	0	0
Fulton	38	36	11	0	0	0	0	0	0	0	0	0	0
Gilmer	1	1	0	0	0	0	0	0	0	0	0	0	0
Glynn	0	1	0	0	0	0	0	0	0	0	0	0	0
Greene	12	15	4	0	0	0	0	0	0	0	0	0	0

Gwinnett	68	72	29	0	0	0	0	0	0	0	0	0	0
Habersham	1	1	0	0	0	0	0	0	0	0	0	0	0
Hancock	0	4	0	0	0	0	0	0	0	0	0	0	0
Harris	2	0	0	0	0	0	0	0	0	0	0	0	0
Hart	1	0	1	0	0	0	0	0	0	0	0	0	0
Henry	203	265	0	0	0	0	0	0	0	0	0	0	0
Jackson	0	5	0	0	0	0	0	0	0	0	0	0	0
Jasper	102	181	37	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	1	0	0	0	0	0	0	0	0	0	0	0
McDuffie	1	0	0	0	0	0	0	0	0	0	0	0	0
Mitchell	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	61	94	26	0	0	0	0	0	0	0	0	0	0
Muscogee	3	2	0	0	0	0	0	0	0	0	0	0	0
Newton	2,357	2,070	743	0	0	0	0	0	0	0	0	0	0
North Carolina	1	1	0	0	0	0	0	0	0	0	0	0	0
Oconee	1	3	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	32	7	1	0	0	0	0	0	0	0	0	0	0
Peach	1	1	0	0	0	0	0	0	0	0	0	0	0
Pike	0	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	12	12	1	0	0	0	0	0	0	0	0	0	0
Richmond	1	0	1	0	0	0	0	0	0	0	0	0	0
Rockdale	4,493	2,949	805	0	0	0	0	0	0	0	0	0	0
South Carolina	9	1	0	0	0	0	0	0	0	0	0	0	0
Spalding	7	3	3	0	0	0	0	0	0	0	0	0	0
Sumter	0	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	4	1	0	0	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	0	2	0	0	0	0	0	0	0	0	0	0	0
Towns	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	0	3	0	0	0	0	0	0	0	0	0	0	0
Union	2	0	1	0	0	0	0	0	0	0	0	0	0
Upson	0	1	0	0	0	0	0	0	0	0	0	0	0
Walton	346	353	125	0	0	0	0	0	0	0	0	0	0
Worth	0	2	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>8,511</b>	<b>6,617</b>	<b>2,046</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	7
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>8</b>

#### 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	1,249	5,137
Cystoscopy	0	0	90	141
Endoscopy	0	0	0	0
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>1,339</b>	<b>5,278</b>

#### 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	1,249	5,137
Cystoscopy	0	0	90	141
Endoscopy	0	0	0	0
	0	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>1,339</b>	<b>5,278</b>

### 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	30
Black/African American	2,208
Hispanic/Latino	152
Pacific Islander/Hawaiian	1
White	4,070
Multi-Racial	145
<b>Total</b>	<b>6,617</b>

## **2. Age Grouping**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	491
Ages 15-64	4,076
Ages 65-74	1,341
Ages 75-85	599
Ages 85 and Up	110
<b>Total</b>	<b>6,617</b>

## **3. Gender**

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,164
Female	2,453
<b>Total</b>	<b>6,617</b>

## **4. Payment Source**

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

Primary Payment Source	Number of Patients
Medicare	2,306
Medicaid	866
Third-Party	3,356
Self-Pay	89

## **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 the hospital or anywhere on its grounds.

#### **1. Number of Delivery Rooms: 0**



2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 17
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 626
6. Total Live Births: 2,027
7. Total Births (Live and Late Fetal Deaths): 2,027
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,064

## 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)	23	1,859	3,734	0
Specialty Care (Intermediate Neonatal Care)	8	164	3,751	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	3	8
Asian	15	33
Black/African American	1,018	2,927
Hispanic/Latino	219	492
Pacific Islander/Hawaiian	1	1
White	742	1,983
Multi-Racial	48	118
<b>Total</b>	<b>2,046</b>	<b>5,562</b>

## **2. Age Grouping**

Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	4	8
Ages 15-44	2,036	5,536
Ages 45 and Up	6	18
<b>Total</b>	<b>2,046</b>	<b>5,562</b>

## **3. Average Charge for an Uncomplicated Delivery**

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

\$3,418.00

## **4. Average Charge for a Premature Delivery**

Please report the average hospital charge for a premature delivery.

\$41,723.00

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

## **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	<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

## 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
<b>Total</b>	<b>0</b>	<b>0</b>

### 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
<b>Total</b>	<b>0</b>	<b>0</b>

### 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?** 0.20000000298023 (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 Intpreter

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		0	0	14
		0	0	0
		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?

Language Courses and Cultural Diversity Policy Annual Assessment through online learning.

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?

Medical Interpreters

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

1. Braille

2.

3.

4.

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

If you checked yes, what is the name and location of that health care center or clinic?

Pharmacy free clinic for minor medical conditions. Mercy Heart Health Clinic 2796 Hwy 20 Conyers, GA 30013. Healing Hands 1733 Lake Rockaway Rd. Conyers, GA 30012

# Comprehensive Inpatient Physical Rehabilitation Addendum

## Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

### 1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

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

### 2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

### 3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

## Part B : Referral Source

### 1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0



	0
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**1. Payers**

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

**2. Uncompensated Indigent and Charity Care**

Please report the number of inpatient physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

**Part D : Admissions by Diagnosis Code**

**1. Admissions by Diagnosis Code**

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

**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 inaccurate 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:** Deborah Armstrong

**Date:** 3/9/2012

**Title:** CEO

**Comments:**