GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2011 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP611

Facility Name: Northeast Georgia Medical Center

County: Hall

Street Address: 743 Spring Street NE

City: Gainesville

Zip: 30501-3899

Mailing Address: 743 Spring Street NE

Mailing City: Gainesville

Mailing Zip: 30501-3899

Medicaid Provider Number: 00000888A

Medicare Provider Number: 110029

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: Chad Bolton

Contact Title: Director, Planning

Phone: 770-219-6630

Fax: 770-219-5437

E-mail: Chad.Bolton@nghs.com

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
Hosp Authority of Hall Co. & City of Gainesville	Hospital Authority	9/5/1951

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northeast Georgia Medical Center, Inc.	Not for Profit	10/1/1986

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northeast Georgia Health System, Inc.	Not for Profit	10/1/1986

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: Northeast Georgia Health System, Inc.
City: Gainesville **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: Northeast Georgia Health System, Inc.
City: Gainesville **State:** GA

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: VHA of GA,Inc/Vol Hosp of Amer/GA Allian Comm Hosp
City: Atlanta/Dallas/Atlanta **State:** GA/TX/GA

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: SuperMed PPO network, NEGA Health Partners
City: Atlanta/Gainesville **State:** GA/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)	44	3,665	10,308	3,661	10,244
Pediatrics (Non ICU)	18	346	1,119	357	1,159
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	296	853	299	856
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	315	15,357	73,012	15,419	73,623
Intensive Care	58	4,420	15,273	4,441	15,580
Psychiatry	25	1,695	8,621	1,686	8,513
Substance Abuse	15	836	3,179	845	3,219
Adult Physical Rehabilitation (18 & Up)	24	235	3,128	234	3,128
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
Child/Adol/Pshy/SA	14	511	2,331	510	2,314
	0	0	0	0	0
	0	0	0	0	0
Total	**513**	**27,361**	**117,824**	**27,452**	**118,636**

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	28	161
Asian	128	455
Black/African American	1,762	8,689
Hispanic/Latino	1,612	5,651
Pacific Islander/Hawaiian	0	0
White	22,916	99,323
Multi-Racial	915	3,545
Total	**27,361**	**117,824**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,393	52,887
Female	15,968	64,937
Total	**27,361**	**117,824**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	13,028	62,014
Medicaid	4,749	18,893
Peachare	0	0
Third-Party	7,824	29,639
Self-Pay	1,760	7,278
Other	0	0

5. Discharges to Death

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

670

6. Charges for Selected Services

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

Service	Charge
Private Room Rate	705
Semi-Private Room Rate	665
Operating Room: Average Charge for the First Hour	3,889
Average Total Charge for an Inpatient Day	7,498

Part E : Emergency Department and Outpatient Services

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

98,846

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

12,857

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

100

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	2	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	5	0
General Beds	57	0
Overflow	14	0
Minor Acuity	9	0
OBS	12	0
Sexual Assualt	1	0

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

976

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

197,348

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

10,471

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.

902

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	2	1
ESWL	2	1
Billiary Lithotropter	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, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
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	1	1
Ambulance Services	1	1
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	1,314
Number of Dialysis Treatments	3,373
Number of ESWL Patients	385
Number of ESWL Procedures	385
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	103,013
Number of CTS Units (machines)	6
Number of CTS Procedures	42,094
Number of Diagnostic Radioisotope Procedures	3,043
Number of PET Units (machines)	1
Number of PET Procedures	975
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	5
Number of Number of MRI Procedures	12,922
Number of Chemotherapy Treatments	1,795
Number of Respiratory Therapy Treatments	189,517
Number of Occupational Therapy Treatments	45,988
Number of Physical Therapy Treatments	167,555
Number of Speech Pathology Patients	1,402
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	157
Number of HIV/AIDS Patients	28
Number of Ambulance Trips	6,079
Number of Hospice Patients	920
Number of Respite care Patients	25
Number of Ultrasound/Medical Sonography Units	8
Number of Ultrasound/Medical Sonography Procedures	20,777
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).

60

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	245	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 12-31-2011. 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	0	0	0
Physician Assistants Only (not including Licensed Physicians)	0	1	0
Registered Nurses (RNs-Advanced Practice*)	998.03997802734	66.150001525879	1.5900000333786
Licensed Practical Nurses (LPNs)	130.71000671387	6.3499999046326	1.4500000476837
Pharmacists	37.209999084473	0.0099999997764826	0
Other Health Services Professionals*	396.41000366211	58.759998321533	9.9499998092651
Administration and Support	121.69999694824	12.319999694824	0
All Other Hospital Personnel (not included above)	1923.0600585938	51.069999694824	7.0700001716614

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)	30 Days or Less
Pharmacists	More than 90 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	30 Days or Less

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	26	☐	19	24
General Internal Medicine	70	☑	13	65
Pediatricians	32	☐	32	32
Other Medical Specialties	173	☐	50	133

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	22	☐	15	22
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	3	☐	1	3
Ophthalmology Surgery	11	☐	1	7
Orthopedic Surgery	14	☐	12	13
Plastic Surgery	5	☐	4	5
General Surgery	18	☐	15	17
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	13	☐	4	10

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	26	☑	26	1
Dermatology	4	☐	1	1
Emergency Medicine	21	☑	21	21
Nuclear Medicine	0	☐	0	0
Pathology	6	☑	6	0
Psychiatry	9	☐	4	3
Radiology	13	☑	13	10
Neonatology	3	☑	3	3
	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	13
Podiatrists	12
Certified Nurse Midwives with Clinical Privileges in the Hospital	11
All Other Staff Affiliates with Clinical Privileges in the Hospital	145

5b. Name of Other Professions

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

NP, PA, AA, CRNA

Comments and Suggestions:

The data presented in the AHQ and related addendum reflects the beds and services of both NGMC's Main Campus and Lanier Park Campus, which are licensed and operated as a single hospital.
D.1. Set up and Staffed bed totals are less than NGMC's approved complement of 557, the number of beds combined on the Main Campus and Lanier Park Campus.
D.1.a -Inpatient and discharge days include inpatient LDR and C-section room days; LDRs are not acute care beds.
D.2 - The multi-racial category includes patients who declined to indicate their race and were included in an "other" category on the hospital's records. The same is true for payor breakdowns in the Psych, Surgical and Perinatal Addendums.
D.4. Most Peachcare admissions and patient days are now included in the Medicaid category because the payment source for both classes of patients are the Medicaid CMOs.
E.4. Note 1: NGMC is not able to track visits by type of ED bed.
Note 2: The ER beds for psych/substance abuse cases include 4 emergency beds housed in the Laurelwood building.
F.1b.Reported PET procedures include both PET scans and other corresponding non-scan PET procedures.
G.3. Physician Race information is not captured during the medical staff application process.
G.4.Note 1: NGMC physicians do not report Medicaid/PeachCare/PEHB plan provider status to the hospital. NGMC has attempted to gather data regarding physician enrollment in those programs, but recognizes that its data are likely incomplete. NGMC also recognizes that it is very likely that a greater number of its medical staff are enrolled providers in those programs than reflected in the data reported here.
G.5.a. Dentists and oral surgeons had co-admitting privileges as of 12/31/2008.
Surgical Services Addendum - Northeast Georgia Medical Center has 4 dedicated endoscopy suites adjacent to the main campus OR suite.
Part B - patient counts for this section come from a different source than patient counts in Part A and were adjusted to tie to Part A figures.
Minority Health Addendum - Part 3. While the medical center does collect Preferred Language from patients, it does not believe the data is reliable, and has chosen not to include it here. Data on languages spoken by physicians is not collected.

Minority Health Addendum - Part 6. Signage on the hospital campus utilizes universal symbols and numbers to direct non-English speaking patients to the appropriate locations. Signs are marked with braille lettering to assist the sight-impaired in locating their intended destination.

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	23	5	2	0	0	0	3	0	0	0	0	0	0
Appling	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	3	1	0	1	2	0	0	0	0	0	0	0	0
Banks	689	278	74	35	7	0	21	1	0	0	0	0	7
Barrow	284	124	51	30	13	1	14	0	0	0	0	0	7
Bartow	25	1	0	14	1	1	4	0	0	0	0	0	0
Bibb	3	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0	0
Candler	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	4	1	0	1	1	1	1	0	0	0	0	0	0
Catoosa	6	0	0	3	1	0	1	0	0	0	0	0	0
Chatham	3	1	0	0	1	0	0	0	0	0	0	0	0
Chattooga	3	0	0	2	1	0	0	0	0	0	0	0	0
Cherokee	72	13	6	16	10	0	13	0	0	0	0	0	0
Clarke	129	33	8	60	3	2	14	0	0	0	0	0	2
Clayton	11	0	0	0	6	1	1	0	0	0	0	0	0
Clinch	1	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	57	8	2	17	6	1	11	0	0	0	0	0	1
Colquitt	2	1	0	0	0	0	0	0	0	0	0	0	0
Columbia	1	2	0	0	0	0	0	0	0	0	0	0	0
Cook	2	0	0	2	0	0	0	0	0	0	0	0	0
Coweta	6	2	0	3	2	0	0	0	0	0	0	0	0
Crisp	5	0	0	2	0	0	1	1	0	0	0	0	0
Dade	2	0	0	1	0	0	0	0	0	0	0	0	0
Dawson	770	267	83	46	11	1	20	1	0	0	0	0	7
Dekalb	64	10	2	6	14	2	3	0	0	0	0	0	1

Dooly	1	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	1	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	18	0	1	3	2	0	1	0	0	0	0	0	0
Effingham	1	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	43	8	0	11	3	0	4	0	0	0	0	0	3
Emanuel	1	0	0	0	0	0	0	0	0	0	0	0	0
Evans	0	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	73	28	0	10	3	0	0	0	0	0	0	0	0
Fayette	10	5	0	0	1	0	2	0	0	0	0	0	0
Florida	85	14	1	3	2	0	8	0	0	0	0	0	2
Floyd	21	0	0	12	1	0	3	0	0	0	0	0	0
Forsyth	444	121	35	92	29	0	55	0	0	0	0	0	3
Franklin	284	62	17	70	7	5	19	0	0	0	0	0	4
Fulton	138	23	5	31	15	2	16	1	0	0	0	0	0
Gilmer	50	23	4	6	6	0	3	0	0	0	0	0	0
Glynn	4	1	0	2	0	0	1	0	0	0	0	0	0
Gordon	6	1	0	4	0	0	0	1	0	0	0	0	0
Greene	16	1	1	8	1	0	1	0	0	0	0	0	0
Gwinnett	1,090	477	188	88	49	2	40	3	0	0	0	0	9
Habersham	2,074	877	186	97	26	1	41	0	0	0	0	0	11
Hall	12,770	5,033	2,278	497	86	13	318	9	0	0	0	0	76
Hancock	2	0	0	0	2	0	0	0	0	0	0	0	0
Haralson	5	0	0	2	2	0	0	0	0	0	0	0	0
Hart	133	16	3	59	4	0	16	0	0	0	0	0	0
Heard	1	0	0	0	0	0	0	0	0	0	0	0	0
Henry	4	0	1	0	0	0	1	0	0	0	0	0	0
Houston	4	2	0	1	1	0	0	0	0	0	0	0	0
Jackson	1,769	875	297	65	19	1	38	1	0	0	0	0	27
Jasper	1	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	2	0	0	1	1	0	0	0	0	0	0	0	0
Laurens	1	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	1	0	0	0	0	0	0	0	0
Lincoln	1	0	0	1	0	0	0	0	0	0	0	0	0
Lowndes	1	1	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	1,239	463	135	78	22	1	29	0	0	0	0	0	23
Madison	81	17	1	21	4	1	8	0	0	0	0	0	2
Mcduffie	3	0	0	0	0	0	1	0	0	0	0	0	0
Mcintosh	1	0	0	0	0	0	1	0	0	0	0	0	0
Monroe	3	0	0	1	0	0	0	0	0	0	0	0	0
Morgan	8	2	0	1	3	0	0	0	0	0	0	0	1
Murray	14	0	0	10	2	0	1	0	0	0	0	0	0
Muscogee	4	1	0	1	0	0	0	0	0	0	0	0	0
Newton	17	3	0	9	1	0	3	0	0	0	0	0	0
North Carolina	181	89	6	3	0	0	2	1	0	0	0	0	0

Oconee	25	7	1	8	2	0	4	0	0	0	0	0	2
Oglethorpe	11	5	0	2	0	0	3	0	0	0	0	0	2
Other Out Of State	136	46	7	11	4	0	9	1	0	0	0	0	2
Paulding	9	0	0	4	3	0	0	0	0	0	0	0	0
Pickens	40	8	2	9	6	0	2	0	0	0	0	0	0
Pike	5	0	0	2	0	0	0	0	0	0	0	0	0
Polk	4	0	0	0	0	1	3	0	0	0	0	0	0
Pulaski	1	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	4	1	0	0	0	1	0	0	0	0	0	0	0
Rabun	743	310	25	21	12	1	15	0	0	0	0	0	9
Richmond	2	2	0	0	0	0	0	0	0	0	0	0	0
Rockdale	8	1	0	1	4	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	1	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	38	10	4	2	0	0	5	0	0	0	0	0	0
Spalding	9	0	0	3	0	0	2	0	0	0	0	0	0
Stephens	779	263	41	74	13	1	18	0	0	0	0	0	11
Sumter	1	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	2	0	0	1	0	0	0	0	0	0	0	0	0
Telfair	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	29	4	1	1	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	2	0	0	1	0	0	0	0	0	0	0	0	0
Towns	327	139	10	16	2	2	8	0	0	0	0	0	5
Troup	2	0	0	0	1	0	0	0	0	0	0	0	0
Union	419	147	10	43	5	1	8	0	0	0	0	0	7
Upson	1	0	0	0	1	0	0	0	0	0	0	0	0
Walker	11	0	0	4	2	0	1	0	0	0	0	0	0
Walton	47	14	4	13	4	0	3	0	0	0	0	0	0
Ware	0	1	0	0	0	0	0	0	0	0	0	0	0
Warren	1	0	1	0	0	0	0	0	0	0	0	0	0
Washington	3	1	0	1	0	0	0	0	0	0	0	0	0
White	1,909	802	172	49	11	3	34	0	0	0	0	0	11
Whitfield	8	0	0	1	3	0	2	0	0	0	0	0	0
Wilkes	4	1	0	2	0	0	0	0	0	0	0	0	0
Wilkinson	0	1	0	0	0	0	0	0	0	0	0	0	0
Total	**27,361**	**10,656**	**3,665**	**1,695**	**445**	**46**	**836**	**20**	**0**	**0**	**0**	**0**	**235**

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	2	21
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**2**	**21**

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	2,221	7,635	9,501
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**2,221**	**7,635**	**9,501**

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	2,019	7,280	8,637
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**2,019**	**7,280**	**8,637**

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	19
Asian	67
Black/African American	461
Hispanic/Latino	690
Pacific Islander/Hawaiian	0
White	9,039
Multi-Racial	380
Total	**10,656**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	866
Ages 15-64	7,343
Ages 65-74	1,574
Ages 75-85	758
Ages 85 and Up	115
Total	**10,656**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,127
Female	6,529
Total	**10,656**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,818
Medicaid	1,325
Third-Party	5,921
Self-Pay	592

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: 18

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,127

6. Total Live Births: 3,432

7. Total Births (Live and Late Fetal Deaths): 3,442

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

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

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

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	52	2,856	7,682	452
Specialty Care (Intermediate Neonatal Care)	10	328	3,855	474
Subspecialty Care (Intensive Neonatal Care)	4	306	1,946	79

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	1	1
Asian	43	98
Black/African American	235	945
Hispanic/Latino	845	2,170
Pacific Islander/Hawaiian	0	0
White	2,252	6,325
Multi-Racial	289	769
Total	**3,665**	**10,308**

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	3	8
Ages 15-44	3,660	10,296
Ages 45 and Up	2	4
Total	**3,665**	**10,308**

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

$8,889.00

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

$18,431.00

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	25	25
B- General Acute Psychiatric Adolescents 13-17	7	7
C- General Acute Psychiatric Children 12 and under	4	4
D- Acute Substance Abuse Adults 18 and over	15	15
E- Acute Substance Abuse Adolescents 13-17	3	3
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	1,695	8,621	1,686	8,513	1,668	☑
General Acute Psychiatric Adolescents 13-17	445	2,018	443	1,991	1,338	☑
General Acute Psychiatric Children 12 and Under	46	222	46	222	1,315	☑
Acute Substance Abuse Adults 18 and over	836	3,179	845	3,219	4,059	☑
Acute Substance Abuse Adolescents 13-17	20	91	21	101	2,320	☑
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	6	29
Asian	24	109
Black/African American	274	1,581
Hispanic/Latino	72	333
Pacific Islander/Hawaiian	0	0
White	2,500	11,328
Multi-Racial	166	751
Total	**3,042**	**14,131**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,476	6,746
Female	1,566	7,385
Total	**3,042**	**14,131**

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	728	4,109
Medicaid	1,071	4,994
Third Party	1,140	4,554
Self-Pay	103	474
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? 8.2200002670288 (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): ☑

Language Access Network is a video interpreting device for hard of hearing patients.

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	5.2	0	0	319
Vietnamese	0.1	0	0	14
German	0	0	0	9

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?

Classes on cultural competency awareness are provided for existing staff. Several staff members

have been identified and trained as certified interpreters. Each year, during the annual mandatory education, an employee's cultural awareness is discussed including the usage of interpreters and their importance in communicating with non-English speaking patients.

In general orientation our new staff are trained about the Interpreter Program. Discussion involves how to access interpreters and usage of the language line for various types of languages.
New staff receive information that incorporates cultural awareness in communicating and providing care to patients and their families.

The organization offers Interpreter skills training classes which include medical terminology.

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 needed. We offer a web page for LEP patient needs, badges to identify all assessed interpreters, wireless interpreting device for LEP and hearing impaired patients, as well as telephonic interpreting line and document translation program.

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

1. English
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?

Hall County Health Department, Good News Clinic, Medlink

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	19	306
Hispanic/Latino	7	70
Pacific Islander/Hawaiian	0	0
White	205	2,703
Multi-Racial	4	49

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	128	1,742
Female	107	1,386

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	1	7
18-64	110	1,441
65-84	112	1,534
85 Up	12	146

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	234
Long Term Care Hospital	0
Skilled Nursing Facility	1
Traumatic Brain Injury Facility	0

	0

1. Payers

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

Primary Payment Source	Admissions
Medicare	141
Third Party/Commercial	76
Self Pay	8
Other	10

2. Uncompensated Indigent and Charity Care

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

5

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	99
2. Brain Injury	23
3. Amputation	18
4. Spinal Cord	9
5. Fracture of the femur	3
6. Neurological disorders	4
7. Multiple Trauma	14
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	8
All Other	57

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: Carol Burrell

Date: 8/16/2012

Title: Chief Executive Officer

Comments: