Georgia Department of Community Health

2011 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP703

Facility Name: Memorial Health University Medical Center

County: Chatham

Street Address: 4700 Waters Avenue

City: Savannah

Zip: 31404

Mailing Address: P O Box 23089

Mailing City: Savannah

Mailing Zip: 31403

Medicaid Provider Number: 00001273

Medicare Provider Number: 110036

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: Chris Rowell

Contact Title: Senior Financial Analyst

Phone: 912-350-8606

Fax: 912-350-8126

E-mail: rowelch1@memorialhealth.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
Chatham County Hospital Authority	Local Govt	1/1/1955

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
Memorial Health University Medical Center	Not for Profit	1/1/1955

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: Memorial Health
City: Savannah **State:** GA

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

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: See List in Comments Section G
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Premier Group Purchasing Organization
City: Charlotte **State:** NC

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	2,975	9,443	2,969	9,167
Pediatrics (Non ICU)	48	2,447	8,009	2,685	8,946
Pediatric ICU	12	285	2,121	169	1,040
Gynecology (No OB)	0	0	0	0	0
General Medicine	77	13,735	15,488	4,221	15,289
General Surgery	45	3,534	14,360	3,324	16,366
Medical/Surgical	0	0	0	0	0
Intensive Care	55	724	16,874	911	5,232
Psychiatry	35	913	10,045	1,157	9,838
Substance Abuse	1	5	18	6	18
Adult Physical Rehabilitation (18 & Up)	50	858	12,612	842	11,523
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
Med/Onc	28	219	9,291	2,042	10,781
Ortho/Neuro	62	423	19,864	5,102	23,628
Step Down	36	292	11,101	2,819	12,403
Total	**482**	**26,410**	**129,226**	**26,247**	**124,231**

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	42	214
Asian	135	524
Black/African American	7,961	38,725
Hispanic/Latino	560	2,090
Pacific Islander/Hawaiian	0	0
White	16,998	84,442
Multi-Racial	714	3,231
Total	**26,410**	**129,226**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	15,175	70,481
Female	11,235	58,745
Total	**26,410**	**129,226**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10,191	56,599
Medicaid	5,234	25,082
Peachare	10	37
Third-Party	8,403	36,766
Self-Pay	674	2,475
Other	1,897	8,267

5. Discharges to Death

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

451

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	896
Semi-Private Room Rate	795
Operating Room: Average Charge for the First Hour	5,153
Average Total Charge for an Inpatient Day	8,301

Part E : Emergency Department and Outpatient Services

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

94,519

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

12,451

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

51

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	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	4	0
General Beds	27	0
Express Care	7	0
Pediatric	10	0
	0	0
	0	0

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

1,060

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

176,623

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

10,688

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

20

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

139.00

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.

2,413

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	1	1
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)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	3
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	495
Number of Dialysis Treatments	6,177
Number of ESWL Patients	153
Number of ESWL Procedures	177
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	2
Number of Biliary Lithotripter Units	3
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	114,882
Number of CTS Units (machines)	4
Number of CTS Procedures	30,317
Number of Diagnostic Radioisotope Procedures	4,052
Number of PET Units (machines)	1
Number of PET Procedures	978
Number of Therapeautic Radioisotope Procedures	50
Number of Number of MRI Units	2
Number of Number of MRI Procedures	8,901
Number of Chemotherapy Treatments	1,182
Number of Respiratory Therapy Treatments	14,801
Number of Occupational Therapy Treatments	13,807
Number of Physical Therapy Treatments	25,722
Number of Speech Pathology Patients	7,836
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	123
Number of HIV/AIDS Patients	89
Number of Ambulance Trips	7,688
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	15,836
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).

135

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	217	Intuituive DaVinci SI - Model #VS 3000

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)	7.5999999046326	0	0
Registered Nurses (RNs-Advanced Practice*)	960.35998535156	55.209999084473	20
Licensed Practical Nurses (LPNs)	24.5	0	0
Pharmacists	35.200000762939	0	0
Other Health Services Professionals*			
Administration and Support			0
All Other Hospital Personnel (not included above)	2676.3000488281	196.69999694824	0

2. Filling Vacancies

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

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	61-90 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	30 Days or Less
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	41	☐	0	0
General Internal Medicine	53	☐	0	0
Pediatricians	75	☐	0	0
Other Medical Specialties	165	☐	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	37	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	4	☐	0	0
Ophthalmology Surgery	23	☐	0	0
Orthopedic Surgery	34	☐	0	0
Plastic Surgery	19	☐	0	0
General Surgery	19	☐	0	0
Thoracic Surgery	6	☐	0	0
Other Surgical Specialties	65	☐	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	14	☑	0	0
Dermatology	8	☐	0	0
Emergency Medicine	16	☑	0	0
Nuclear Medicine	1	☑	0	0
Pathology	4	☑	0	0
Psychiatry	9	☑	0	0
Radiology	9	☑	0	0
Rad Onc	3	☑	0	0
Psychology	19	☐	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	7
Podiatrists	14
Certified Nurse Midwives with Clinical Privileges in the Hospital	4
All Other Staff Affiliates with Clinical Privileges in the Hospital	222

5b. Name of Other Professions

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

Comments and Suggestions:

The Following is a list of subsidiary corporations owned by Memorial Health, Inc.:
Memorial Health Partners, Inc.
Memorial Health Anesthetists, Inc.
Memorial Health University Medical Center, Inc.
Memorial Health University Medical Center Foundation, Inc.
Memorial Health UrgentOne, Inc.
MPPG, Inc.
Provident Health Services, Inc.
Provident Professional Building Condominium Association, Inc.
Savannah Midtown Properties, Inc.
Memorial Professional Assurance Co.
Provident Health Surgical Associates, Inc.
Memorial Health Corporate Services, Inc
4600 Waters Avenue Condominium, Inc.

Please Note that anywhere it asks for both admissions and inpatient days, we reported discharge days instead of inpatient days, as this is what we have available in our reporting system.
Part D#1: Substance Abuse patients are treated in Psychiatry. The 1 SUS bed for substance abuse patients resides in psychiatry and was placed in substance abuse to prevent an error message.
Part G#1: Like previous years, we are reporting budgeted staff for the hospital only.
Part G#3: We do not track ethnicity of our physicians.
Surgical Services Addendum Part B #2: The age grouping contains the age of 85 in two lines; Therefore, MHUMC patients of age 85 have been accounted for within ages 85 and up.
Psych/SA Addendum Part A#1: The number of Con-Authorized Beds and SUS Beds within patient types A & D should be disregarded because we do not breakout the 42 beds in Psych. The numbers in patient types A&D were only placed there to bypass the critical errors message; therefore please disregard the numbers in A&D and accept the 42 beds for patient type AD.
Part G#4: We do not track the payplan enrollment status of all active physicians.

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	14	4	1	0	0	0	0	0	0	0	0	0	0
APPLING	196	92	11	2	0	0	0	0	0	0	0	0	5
ATKINSON	46	16	1	0	0	0	0	0	0	0	0	0	3
BACON	85	36	3	0	0	0	0	0	0	0	0	0	2
BALDWIN	6	1	0	0	0	0	0	0	0	0	0	0	0
BARROW	2	0	0	0	0	0	0	0	0	0	0	0	0
BARTOW	2	1	0	0	0	0	0	0	0	0	0	0	0
BEN HILL	14	2	0	0	0	0	0	0	0	0	0	0	0
BERRIEN	5	1	0	2	0	0	0	0	0	0	0	0	0
BIBB	9	0	1	0	0	0	0	0	0	0	0	0	1
BLECKLEY	4	0	0	1	0	0	0	0	0	0	0	0	1
BRANTLEY	112	54	4	1	0	0	0	0	0	0	0	0	5
BROOKS	1	0	0	0	0	0	0	0	0	0	0	0	0
BRYAN	1,260	1,005	195	42	0	0	0	0	0	0	0	0	27
BULLOCH	610	341	43	12	0	0	0	0	0	0	0	0	46
BURKE	20	10	2	7	0	0	0	0	0	0	0	0	2
BUTTS	1	0	0	0	0	0	0	0	0	0	0	0	0
CAMDEN	60	31	13	0	0	0	0	0	0	0	0	0	0
CANDLER	107	53	3	3	0	0	0	0	0	0	0	0	4
CARROLL	2	0	0	0	0	0	0	0	0	0	0	0	0
CATOOSA	2	0	0	2	0	0	0	0	0	0	0	0	0
CHARLTON	22	9	5	0	0	0	0	0	0	0	0	0	1
CHATHAM	14,948	6,289	1,913	599	0	0	4	0	0	0	0	0	401
CHEROKEE	3	0	0	0	0	0	0	0	0	0	0	0	0
CLARKE	3	0	1	1	0	0	0	0	0	0	0	0	0
CLAYTON	4	1	0	0	0	0	0	0	0	0	0	0	1
CLINCH	5	2	1	1	0	0	0	0	0	0	0	0	1

COBB	13	7	1	0	0	0	0	0	0	0	0	0	0
COFFEE	186	86	4	2	0	0	0	0	0	0	0	0	8
COLQUITT	2	0	1	0	0	0	0	0	0	0	0	0	0
COLUMBIA	8	2	2	1	0	0	0	0	0	0	0	0	0
COOK	2	2	0	0	0	0	0	0	0	0	0	0	0
COWETA	4	1	0	0	0	0	0	0	0	0	0	0	0
CRISP	2	0	0	0	0	0	0	0	0	0	0	0	0
DAWSON	1	0	0	0	0	0	0	0	0	0	0	0	0
DECATUR	0	1	0	0	0	0	0	0	0	0	0	0	0
DEKALB	16	3	3	2	0	0	0	0	0	0	0	0	1
DODGE	22	8	1	1	0	0	0	0	0	0	0	0	3
DOUGHERTY	6	1	0	1	0	0	0	0	0	0	0	0	0
DOUGLAS	1	1	0	0	0	0	0	0	0	0	0	0	0
EFFINGHAM	1,941	1,327	272	36	0	0	1	0	0	0	0	0	47
ELBERT	0	1	0	0	0	0	0	0	0	0	0	0	0
EMANUEL	128	69	1	10	0	0	0	0	0	0	0	0	7
EVANS	176	109	14	5	0	0	0	0	0	0	0	0	8
FAYETTE	7	6	1	0	0	0	0	0	0	0	0	0	0
FLORIDA	118	70	5	7	0	0	0	0	0	0	0	0	8
FLOYD	1	1	0	0	0	0	0	0	0	0	0	0	0
FORSYTH	1	1	0	0	0	0	0	0	0	0	0	0	0
FULTON	37	11	1	13	0	0	0	0	0	0	0	0	0
GILMER	1	0	1	0	0	0	0	0	0	0	0	0	0
GLYNN	333	186	27	8	0	0	0	0	0	0	0	0	20
GREENE	0	1	0	0	0	0	0	0	0	0	0	0	0
GWINNETT	19	0	1	0	0	0	0	0	0	0	0	0	1
HALL	5	0	0	1	0	0	0	0	0	0	0	0	0
HANCOCK	1	3	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
HENRY	6	2	1	0	0	0	0	0	0	0	0	0	0
HOUSTON	3	2	1	0	0	0	0	0	0	0	0	0	0
IRWIN	4	5	0	0	0	0	0	0	0	0	0	0	0
JACKSON	1	0	0	0	0	0	0	0	0	0	0	0	0
JEFF DAVIS	211	97	8	2	0	0	0	0	0	0	0	0	7
JEFFERSON	9	0	0	5	0	0	0	0	0	0	0	0	0
JENKINS	23	11	1	3	0	0	0	0	0	0	0	0	1
JOHNSON	14	4	1	2	0	0	0	0	0	0	0	0	1
JONES	0	1	0	0	0	0	0	0	0	0	0	0	0
LAURENS	36	15	2	9	0	0	0	0	0	0	0	0	0
LEE	4	0	0	0	0	0	0	0	0	0	0	0	0
LIBERTY	1,307	923	200	29	0	0	0	0	0	0	0	0	39
LINCOLN	0	1	0	0	0	0	0	0	0	0	0	0	0
LONG	164	95	18	5	0	0	0	0	0	0	0	0	2
LOWNDES	14	8	2	0	0	0	0	0	0	0	0	0	2

LUMPKIN	1	0	0	1	0	0	0	0	0	0	0	0	0
MCDUFFIE	6	0	0	1	0	0	0	0	0	0	0	0	0
MCINTOSH	133	84	7	2	0	0	0	0	0	0	0	0	7
MILLER	1	0	0	0	0	0	0	0	0	0	0	0	0
MITCHELL	1	1	0	0	0	0	0	0	0	0	0	0	0
MONROE	0	1	0	0	0	0	0	0	0	0	0	0	0
MONTGOMERY	101	54	7	2	0	0	0	0	0	0	0	0	3
MORGAN	1	0	0	0	0	0	0	0	0	0	0	0	0
MUSCOGEE	6	5	1	1	0	0	0	0	0	0	0	0	0
NEWTON	3	0	0	0	0	0	0	0	0	0	0	0	0
NORTH CAROLINA	51	7	2	2	0	0	0	0	0	0	0	0	2
OTHER OUT OF STAT	355	55	13	20	0	0	0	0	0	0	0	0	24
PEACH	1	1	0	0	0	0	0	0	0	0	0	0	0
PICKENS	0	1	0	0	0	0	0	0	0	0	0	0	0
PIERCE	137	58	9	2	0	0	0	0	0	0	0	0	10
PUTNAM	3	2	0	1	0	0	0	0	0	0	0	0	1
RANDOLPH	0	1	0	0	0	0	0	0	0	0	0	0	0
RICHMOND	23	4	0	10	0	0	0	0	0	0	0	0	1
SCREVEN	267	136	8	5	0	0	0	0	0	0	0	0	17
SOUTH CAROLINA	1,254	612	78	15	0	0	0	0	0	0	0	0	69
STEWART	1	0	0	0	0	0	0	0	0	0	0	0	0
TATTNALL	385	190	17	13	0	0	0	0	0	0	0	0	19
TELFAIR	41	20	1	1	0	0	0	0	0	0	0	0	2
TENNESSEE	23	5	1	1	0	0	0	0	0	0	0	0	1
THOMAS	1	1	0	0	0	0	0	0	0	0	0	0	0
TIFT	2	1	1	0	0	0	0	0	0	0	0	0	0
TOOMBS	426	224	13	6	0	0	0	0	0	0	0	0	20
TOWNS	1	0	0	0	0	0	0	0	0	0	0	0	0
TREUTLEN	33	8	0	1	0	0	0	0	0	0	0	0	3
TROUP	2	0	0	0	0	0	0	0	0	0	0	0	0
TURNER	1	0	0	0	0	0	0	0	0	0	0	0	0
TWIGGS	1	1	0	0	0	0	0	0	0	0	0	0	0
UPSON	1	0	0	0	0	0	0	0	0	0	0	0	0
WALKER	1	0	0	0	0	0	0	0	0	0	0	0	0
WARE	202	83	16	5	0	0	0	0	0	0	0	0	1
WASHINGTON	4	4	0	1	0	0	0	0	0	0	0	0	0
WAYNE	536	215	34	4	0	0	0	0	0	0	0	0	22
WHEELER	27	10	0	4	0	0	0	0	0	0	0	0	1
WHITFIELD	1	0	0	0	0	0	0	0	0	0	0	0	0
WILCOX	1	0	0	0	0	0	0	0	0	0	0	0	0
WILKINSON	2	0	0	0	0	0	0	0	0	0	0	0	0
WORTH	2	1	0	0	0	0	0	0	0	0	0	0	0
Total	**26,410**	**12,794**	**2,974**	**913**	**0**	**0**	**5**	**0**	**0**	**0**	**0**	**0**	**858**

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	5	11	9
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**5**	**11**	**9**

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	4,553	8,682	3,435	4,372
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**4,553**	**8,682**	**3,435**	**4,372**

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	4,440	8,531	3,349	4,263
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**4,440**	**8,531**	**3,349**	**4,263**

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	26
Asian	83
Black/African American	3,027
Hispanic/Latino	320
Pacific Islander/Hawaiian	0
White	9,033
Multi-Racial	305
Total	**12,794**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	2,899
Ages 15-64	7,896
Ages 65-74	1,308
Ages 75-85	563
Ages 85 and Up	128
Total	**12,794**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,847
Female	6,947
Total	**12,794**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,449
Medicaid	2,422
Third-Party	7,418
Self-Pay	505

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: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 12

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,006

6. Total Live Births: 2,688

7. Total Births (Live and Late Fetal Deaths): 2,759

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,759

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)	36	2,166	4,522	145
Specialty Care (Intermediate Neonatal Care)	24	2	8,667	898
Subspecialty Care (Intensive Neonatal Care)	20	757	6,719	255

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	4	19
Asian	40	96
Black/African American	1,018	2,822
Hispanic/Latino	217	589
Pacific Islander/Hawaiian	0	0
White	1,582	5,426
Multi-Racial	113	490
Total	**2,974**	**9,442**

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	17	34
Ages 15-44	2,956	9,389
Ages 45 and Up	1	19
Total	**2,974**	**9,442**

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

$11,388.00

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

$65,338.00

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	1	1
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	1	1
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
AD-P/SA18+	34	34

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	913	10,045	1,157	9,838	2,338	☑
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	5	18	6	18	2,994	☑
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	4	30
Black/African American	311	3,335
Hispanic/Latino	2	18
Pacific Islander/Hawaiian	0	0
White	534	6,038
Multi-Racial	67	642
Total	**918**	**10,063**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	370	4,359
Female	548	5,704
Total	**918**	**10,063**

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	375	5,121
Medicaid	290	2,908
Third Party	220	1,734
Self-Pay	33	300
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? 2 (FTE's)
What languages do they interpret?
SPANISH

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

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

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

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
SPANISH	91	0	0	0
VIETNAMESE	4	0	0	0
KOREAN	1.5	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?

MEDICAL INTERPRETER TRAINING-BRIDGING

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?

HOSPITAL COVERAGE FOR AFTER HOURS

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?

CURTIS V. COOPER HEALTH SYSTEM: 106 EAST BROAD ST. , SAVANNAH, GA. 31401

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	2	19
Black/African American	233	3,388
Hispanic/Latino	10	197
Pacific Islander/Hawaiian	0	0
White	584	8,559
Multi-Racial	29	449

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	426	6,113
Female	432	6,499

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	2	57
18-64	420	6,292
65-84	371	5,283
85 Up	65	980

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	851
Long Term Care Hospital	1
Skilled Nursing Facility	3
Traumatic Brain Injury Facility	0

Home	3

1. Payers

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

Primary Payment Source	Admissions
Medicare	484
Third Party/Commercial	311
Self Pay	63
Other	0

2. Uncompensated Indigent and Charity Care

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

48

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	265
2. Brain Injury	104
3. Amputation	59
4. Spinal Cord	95
5. Fracture of the femur	113
6. Neurological disorders	23
7. Multiple Trauma	82
8. Congenital deformity	0
9. Burns	1
10. Osteoarthritis	0
11. Rheumatoid arthritis	3
12. Systemic vasculidities	1
13. Joint replacement	21
All Other	91

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: Margaret Gill

Date: 10/1/2012

Title: President and Chief Executive Officer

Comments:

Revised NICU bed count 9/21/2012