



2011 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP706

Facility Name: Emory University Hospital

County: DeKalb

Street Address: 1364 Clifton Road NE

City: Atlanta

Zip: 30322-1061

Mailing Address: 1364 Clifton Road NE

Mailing City: Atlanta

Mailing Zip: 30322-1061

Medicaid Provider Number: 0000712

Medicare Provider Number: 110010

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: Toni Wimby

Contact Title: Associate Administrator

Phone: 404-686-2818

Fax: 404-686-2848

E-mail: toni.wimby@emoryhealthcare.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Universityd/b/a Emory University Hospital	Not for Profit	1/1/1922

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
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: Emory Healthcare

City: Atlanta **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company.

Name:

City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations

Name:

City: State:

6. Check the box to the right if your hospital is a member of an alliance.

Name: University Healthsystem Consortium

City: Chicago State: Illinois

7. Check the box to the right if your hospital is a participant in a health care network

Name: Emory Healthcare

City: Atlanta State: Georgia

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)

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)	0	0	0	0	0
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	264	13,937	72,740	13,957	73,429
General Surgery	0	0	0	0	0
Medical/Surgical	117	5,858	42,448	5,867	42,873
Intensive Care	93	1,577	28,299	1,579	28,582
Psychiatry	18	493	2,610	494	2,646
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	46	665	11,119	667	11,261
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	538	22,530	157,216	22,564	158,791

2. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	7,293	54,031
Hispanic/Latino	355	2,584
Pacific Islander/Hawaiian	0	0
White	12,676	84,253
Multi-Racial	2,206	16,348
Total	22,530	157,216

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,349	76,349
Female	11,181	80,867
Total	22,530	157,216

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10,552	72,109
Medicaid	2,005	16,495
Peachare	0	0
Third-Party	8,732	58,711
Self-Pay	1,241	9,901
Other	0	0

5. Discharges to Death

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

512

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	1,165
Semi-Private Room Rate	1,160
Operating Room: Average Charge for the First Hour	3,480
Average Total Charge for an Inpatient Day	7,546

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

35,668

2. Inpatient Admissions from ER

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

12,097

3. Beds Available

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

21

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	193
General Beds	21	35,475
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

660

6. Non-Emergency Visits

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

103,124

7. Observation Visits/Cases

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

6,435

8. Diverted Cases

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

231

9. Ambulance Diversion Hours

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

518.00

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.

977

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

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	6,488
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	215
Number of Heart Transplants	22
Number of Other-Organ/Tissues Treatments	132
Number of Diagnostic X-Ray Procedures	185,191
Number of CTS Units (machines)	7
Number of CTS Procedures	47,313
Number of Diagnostic Radioisotope Procedures	6,435
Number of PET Units (machines)	3
Number of PET Procedures	4,611
Number of Therapeutic Radioisotope Procedures	2,721
Number of Number of MRI Units	9
Number of Number of MRI Procedures	39,083
Number of Chemotherapy Treatments	12,120
Number of Respiratory Therapy Treatments	233,564
Number of Occupational Therapy Treatments	30,248
Number of Physical Therapy Treatments	41,332
Number of Speech Pathology Patients	22,510
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	4,282
Number of HIV/AIDS Patients	98
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	21,385
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).

67

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	165	DaVinci Surgery System

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			
Physician Assistants Only (not including Licensed Physicians)			
Registered Nurses (RNs-Advanced Practice*)	1170.2800292969		
Licensed Practical Nurses (LPNs)	0.83999997377396		
Pharmacists	59.669998168945		
Other Health Services Professionals*	968.10998535156		
Administration and Support	1110.5		0
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	31-60 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	61-90 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 Plan 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	2	<input type="checkbox"/>	0	0
General Internal Medicine	40	<input type="checkbox"/>	0	0
Pediatricians	47	<input type="checkbox"/>	0	0
Other Medical Specialties	366	<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	17	<input type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	11	<input type="checkbox"/>	0	0
Ophthalmology Surgery	35	<input type="checkbox"/>	0	0
Orthopedic Surgery	0	<input type="checkbox"/>	0	0
Plastic Surgery	5	<input type="checkbox"/>	0	0
General Surgery	41	<input type="checkbox"/>	0	0
Thoracic Surgery	24	<input type="checkbox"/>	0	0
Other Surgical Specialties	29	<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	122	<input checked="" type="checkbox"/>	0	0
Dermatology	19	<input type="checkbox"/>	0	0
Emergency Medicine	91	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	12	<input checked="" type="checkbox"/>	0	0
Pathology	52	<input checked="" type="checkbox"/>	0	0
Psychiatry	45	<input type="checkbox"/>	0	0
Radiology	93	<input checked="" type="checkbox"/>	0	0
Rad Oncology	18	<input checked="" type="checkbox"/>	0	0
Rehab	10	<input type="checkbox"/>	0	0
Hospitalist	98	<input checked="" 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	2
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	381

5b. Name of Other Professions

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

Physician Assistants, Nurse Practitioners, Registered Nurses, Certified Registered Nurses

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
Appling	15	3	0	0	0	0	0	0	0	0	0	0	0
Atkinson	6	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	3	0	0	0	0	0	0	0	0	0	0	0	0
Baker	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	83	10	0	0	0	0	0	0	0	0	0	0	2
Banks	7	0	0	1	0	0	0	0	0	0	0	0	0
Barrow	161	31	0	0	0	0	0	0	0	0	0	0	1
Bartow	132	30	0	2	0	0	0	0	0	0	0	0	2
Ben Hill	38	8	0	0	0	0	0	0	0	0	0	0	1
Berrien	22	5	0	0	0	0	0	0	0	0	0	0	0
Bibb	188	29	0	1	0	0	0	0	0	0	0	0	3
Bleckley	9	0	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	9	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	4	0	0	0	0	0	0	0	0	0	0	0	0
Bulloch	19	1	0	2	0	0	0	0	0	0	0	0	0
Burke	10	0	0	0	0	0	0	0	0	0	0	0	0
Butts	62	7	0	1	0	0	0	0	0	0	0	0	1
Calhoun	15	0	0	0	0	0	0	0	0	0	0	0	0
Camden	17	1	0	5	0	0	0	0	0	0	0	0	0
Carroll	228	33	0	0	0	0	0	0	0	0	0	0	6
Catoosa	17	7	0	0	0	0	0	0	0	0	0	0	0
Chatham	72	8	0	2	0	0	0	0	0	0	0	0	2
Chattahoochee	10	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	15	5	0	2	0	0	0	0	0	0	0	0	0
Cherokee	321	72	0	7	0	0	0	0	0	0	0	0	4
Clarke	123	18	0	6	0	0	0	0	0	0	0	0	1

Clay	22	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	579	64	0	5	0	0	0	0	0	0	0	0	23
Clinch	2	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	979	179	0	24	0	0	0	0	0	0	0	0	25
Coffee	30	4	0	2	0	0	0	0	0	0	0	0	0
Colquitt	20	8	0	0	0	0	0	0	0	0	0	0	2
Columbia	30	5	0	0	0	0	0	0	0	0	0	0	0
Cook	25	1	0	0	0	0	0	0	0	0	0	0	1
Coweta	289	48	0	2	0	0	0	0	0	0	0	0	9
Crawford	11	0	0	0	0	0	0	0	0	0	0	0	1
Crisp	23	3	0	0	0	0	0	0	0	0	0	0	0
Dade	6	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	40	5	0	0	0	0	0	0	0	0	0	0	2
Decatur	17	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	4,993	466	0	107	0	0	0	0	0	0	0	0	187
Dodge	26	1	0	0	0	0	0	0	0	0	0	0	0
Dooly	14	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	60	10	0	0	0	0	0	0	0	0	0	0	1
Douglas	223	45	0	4	0	0	0	0	0	0	0	0	6
Early	13	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	16	1	0	1	0	0	0	0	0	0	0	0	0
Elbert	39	7	0	0	0	0	0	0	0	0	0	0	0
Emanuel	10	4	0	0	0	0	0	0	0	0	0	0	0
Evans	3	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	55	14	0	2	0	0	0	0	0	0	0	0	0
Fayette	235	40	0	8	0	0	0	0	0	0	0	0	9
Floyd	104	16	0	1	0	0	0	0	0	0	0	0	1
Forsyth	177	40	0	2	0	0	0	0	0	0	0	0	3
Franklin	63	5	0	0	0	0	0	0	0	0	0	0	0
Fulton	2,526	421	0	113	0	0	0	0	0	0	0	0	148
Gilmer	33	1	0	1	0	0	0	0	0	0	0	0	1
Glascocock	1	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	25	4	0	0	0	0	0	0	0	0	0	0	0
Gordon	87	7	0	4	0	0	0	0	0	0	0	0	2
Grady	16	0	0	0	0	0	0	0	0	0	0	0	0
Greene	58	5	0	2	0	0	0	0	0	0	0	0	0
Gwinnett	1,945	280	0	29	0	0	0	0	0	0	0	0	51
Habersham	74	8	0	0	0	0	0	0	0	0	0	0	2
Hall	181	51	0	5	0	0	0	0	0	0	0	0	2
Hancock	11	3	0	0	0	0	0	0	0	0	0	0	0
Haralson	62	3	0	1	0	0	0	0	0	0	0	0	0
Harris	55	5	0	1	0	0	0	0	0	0	0	0	1
Hart	40	4	0	0	0	0	0	0	0	0	0	0	0
Heard	28	5	0	0	0	0	0	0	0	0	0	0	0

Henry	771	113	0	7	0	0	0	0	0	0	0	0	28
Houston	177	19	0	1	0	0	0	0	0	0	0	0	10
Irwin	23	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	189	12	0	2	0	0	0	0	0	0	0	0	4
Jasper	63	3	0	1	0	0	0	0	0	0	0	0	0
Jeff Davis	6	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	24	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	6	0	0	0	0	0	0	0	0	0	0	0	0
Jones	6	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	41	8	0	1	0	0	0	0	0	0	0	0	0
Lanier	10	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	54	14	0	0	0	0	0	0	0	0	0	0	1
Lee	66	1	0	0	0	0	0	0	0	0	0	0	0
Liberty	10	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	8	0	0	0	0	0	0	0	0	0	0	0	0
Long	3	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	70	5	0	1	0	0	0	0	0	0	0	0	0
Lumpkin	35	4	0	0	0	0	0	0	0	0	0	0	1
Macon	32	4	0	0	0	0	0	0	0	0	0	0	0
Madison	76	5	0	1	0	0	0	0	0	0	0	0	0
Marion	14	4	0	0	0	0	0	0	0	0	0	0	0
McDuffie	8	0	0	2	0	0	0	0	0	0	0	0	0
McIntosh	2	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	64	7	0	1	0	0	0	0	0	0	0	0	2
Miller	2	1	0	1	0	0	0	0	0	0	0	0	0
Mitchell	22	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	42	4	0	0	0	0	0	0	0	0	0	0	1
Montgomery	23	0	0	0	0	0	0	0	0	0	0	0	1
Morgan	60	4	0	1	0	0	0	0	0	0	0	0	1
Murray	47	3	0	1	0	0	0	0	0	0	0	0	0
Muscogee	202	26	0	3	0	0	0	0	0	0	0	0	2
Newton	366	44	0	8	0	0	0	0	0	0	0	0	13
Oconee	83	11	0	1	0	0	0	0	0	0	0	0	0
Oglethorpe	12	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	2,664	779	0	95	0	0	0	0	0	0	0	0	54
Paulding	136	19	0	0	0	0	0	0	0	0	0	0	5
Peach	34	7	0	0	0	0	0	0	0	0	0	0	0
Pickens	65	8	0	1	0	0	0	0	0	0	0	0	1
Pierce	10	0	0	0	0	0	0	0	0	0	0	0	0
Pike	63	4	0	0	0	0	0	0	0	0	0	0	1
Polk	91	7	0	2	0	0	0	0	0	0	0	0	2
Pulaski	14	3	0	0	0	0	0	0	0	0	0	0	0
Putnam	37	1	0	1	0	0	0	0	0	0	0	0	1
Quitman	3	0	0	0	0	0	0	0	0	0	0	0	0

Rabun	44	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	30	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	54	8	0	0	0	0	0	0	0	0	0	0	0
Rockdale	363	49	0	10	0	0	0	0	0	0	0	0	6
Schley	3	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	15	0	0	0	0	0	0	0	0	0	0	0	0
Spalding	175	31	0	2	0	0	0	0	0	0	0	0	4
Stephens	75	7	0	0	0	0	0	0	0	0	0	0	0
Stewart	5	1	0	1	0	0	0	0	0	0	0	0	0
Sumter	41	5	0	0	0	0	0	0	0	0	0	0	1
Talbot	14	1	0	0	0	0	0	0	0	0	0	0	1
Taliaferro	9	0	0	0	0	0	0	0	0	0	0	0	1
Tattnall	10	0	0	0	0	0	0	0	0	0	0	0	1
Taylor	16	1	0	0	0	0	0	0	0	0	0	0	1
Telfair	10	1	0	0	0	0	0	0	0	0	0	0	0
Terrell	15	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	33	3	0	0	0	0	0	0	0	0	0	0	0
Tift	44	4	0	1	0	0	0	0	0	0	0	0	0
Toombs	20	3	0	0	0	0	0	0	0	0	0	0	0
Towns	48	1	0	0	0	0	0	0	0	0	0	0	0
Treutlen	9	0	0	0	0	0	0	0	0	0	0	0	0
Troup	272	42	0	2	0	0	0	0	0	0	0	0	6
Turner	12	0	0	0	0	0	0	0	0	0	0	0	0
Twiggs	6	3	0	0	0	0	0	0	0	0	0	0	0
Union	45	8	0	0	0	0	0	0	0	0	0	0	0
Upson	68	12	0	0	0	0	0	0	0	0	0	0	1
Walker	44	1	0	0	0	0	0	0	0	0	0	0	1
Walton	200	19	0	1	0	0	0	0	0	0	0	0	7
Ware	5	0	0	0	0	0	0	0	0	0	0	0	1
Warren	2	0	0	0	0	0	0	0	0	0	0	0	0
Washington	27	3	0	0	0	0	0	0	0	0	0	0	1
Wayne	22	1	0	0	0	0	0	0	0	0	0	0	1
Webster	4	0	0	0	0	0	0	0	0	0	0	0	0
White	47	8	0	0	0	0	0	0	0	0	0	0	0
Whitfield	113	21	0	1	0	0	0	0	0	0	0	0	1
Wilcox	5	3	0	0	0	0	0	0	0	0	0	0	0
Wilkes	8	1	0	0	0	0	0	0	0	0	0	0	1
Wilkinson	20	4	0	0	0	0	0	0	0	0	0	0	0
Worth	28	1	0	1	0	0	0	0	0	0	0	0	2
Total	22,530	3,403	0	493	0	0	0	0	0	0	0	0	665

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	21
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	0	22

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	7,299	2,901
Cystoscopy	0	0	103	502
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	7,402	3,403

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	7,299	2,901
Cystoscopy	0	0	103	502
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	7,402	3,403

Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	837
Hispanic/Latino	48
Pacific Islander/Hawaiian	0
White	2,140
Multi-Racial	378
Total	3,403

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	11
Ages 15-64	2,361
Ages 65-74	710
Ages 75-85	279
Ages 85 and Up	42
Total	3,403

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,614
Female	1,789
Total	3,403

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,256
Medicaid	317
Third-Party	1,743
Self-Pay	87

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: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

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)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	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	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 Grouping

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

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	0	0
Ages 15-44	0	0
Ages 45 and Up	0	0
Total	0	0

3. Average Charge for an Uncomplicated Delivery

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

\$0.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$0.00

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	47	18
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	493	2,610	494	2,646	2,888	<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	139	684
Hispanic/Latino	5	42
Pacific Islander/Hawaiian	0	0
White	303	1,665
Multi-Racial	46	219
Total	493	2,610

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	213	1,086
Female	280	1,524
Total	493	2,610

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	212	1,176
Medicaid	121	675
Third Party	148	718
Self-Pay	12	41
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? 1 (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 Interpreter

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	72	0	0	0
Korean	14	0	0	0
Vietnamese	14	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?

EMITS covers the CLAS standards briefly in the Patient Services Orientation. EMITS does

in-services on linguistically appropriate services on units at EUH as requested.

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?

The EMITS coordinator would be able to do much more staff education on CLAS if the interpreter services department had additional staffing to assist with Spanish interpretation and interpreter scheduling.

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

1. English

2. Spanish

3. Braille

4.

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

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

Grady Health System, 80 Jesse Hill Jr. Drive SE, Atlanta, GA 30303

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	329	5,649
Hispanic/Latino	11	174
Pacific Islander/Hawaiian	0	0
White	281	4,551
Multi-Racial	44	745

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	360	6,312
Female	305	4,807

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	458	7,739
65-84	184	3,027
85 Up	23	353

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	659
Long Term Care Hospital	0
Skilled Nursing Facility	6
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	294
Third Party/Commercial	302
Self Pay	69
Other	0

2. Uncompensated Indigent and Charity Care

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

113

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	250
2. Brain Injury	95
3. Amputation	42
4. Spinal Cord	62
5. Fracture of the femur	5
6. Neurological disorders	49
7. Multiple Trauma	6
8. Congenital deformity	1
9. Burns	1
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	9
All Other	145

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: Robert Bachman

Date: 3/9/2012

Title: Chief Operating Officer

Comments: