GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 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: 31403

Mailing Address: P O Box 23089

Mailing City: Savannah

Mailing Zip: 31403-8089

Medicaid Provider Number: 00001273

Medicare Provider Number: 110036

2. Report Period

Report Data for the full twelve month period- January 1, 2013 through December 31, 2013.
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

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: Memorial Health
City: Savannah **State:** 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)	32	2,939	8,907	2,961	8,749
Pediatrics (Non ICU)	42	2,362	7,989	2,543	8,895
Pediatric ICU	12	235	2,084	222	1,204
Gynecology (No OB)	0	0	0	0	0
General Medicine	77	13,347	17,141	3,919	16,252
General Surgery	45	3,819	15,700	3,690	17,317
Medical/Surgical	0	0	0	0	0
Intensive Care	55	412	18,475	767	5,100
Psychiatry	35	792	9,387	1,180	9,193
Substance Abuse	1	40	443	40	443
Adult Physical Rehabilitation (18 & Up)	50	769	12,177	766	11,348
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	30	218	9,889	2,092	12,067
Ortho/Neuro	58	268	18,746	4,635	23,332
Stepdown	36	251	11,782	2,548	13,188
Total	**473**	**25,452**	**132,720**	**25,363**	**127,088**

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	61	207
Asian	182	814
Black/African American	8,141	46,433
Hispanic/Latino	840	3,582
Pacific Islander/Hawaiian	0	0
White	15,405	76,791
Multi-Racial	823	4,893
Total	**25,452**	**132,720**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,251	62,489
Female	14,201	70,231
Total	**25,452**	**132,720**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	8,527	48,547
Medicaid	5,994	33,919
Peachare	142	832
Third-Party	8,412	39,114
Self-Pay	747	2,662
Other	1,630	7,646

5. Discharges to Death

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

521

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2013 (to the nearest whole dollar).

Service	Charge
Private Room Rate	932
Semi-Private Room Rate	843
Operating Room: Average Charge for the First Hour	5,467
Average Total Charge for an Inpatient Day	7,276

Part E : Emergency Department and Outpatient Services

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

95,018

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

14,003

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	15	0
Express Care	7	0
Pediatric Beds	10	0
Cardiac	4	0
Clinical Decision Unit	8	0

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

1,055

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

151,263

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

13,165

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

32

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

276.00

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.

3,010

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	1	1
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	4
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	340
Number of Dialysis Treatments	4,663
Number of ESWL Patients	137
Number of ESWL Procedures	137
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	83
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	122,316
Number of CTS Units (machines)	4
Number of CTS Procedures	31,173
Number of Diagnostic Radioisotope Procedures	3,950
Number of PET Units (machines)	1
Number of PET Procedures	845
Number of Therapeautic Radioisotope Procedures	50
Number of Number of MRI Units	2
Number of Number of MRI Procedures	9,552
Number of Chemotherapy Treatments	1,304
Number of Respiratory Therapy Treatments	15,069
Number of Occupational Therapy Treatments	15,130
Number of Physical Therapy Treatments	26,254
Number of Speech Pathology Patients	6,995
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	142
Number of HIV/AIDS Patients	89
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	16,387
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	253	Intuitive Davinci S model VS3000

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2013. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2013.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	14.300000190735		
Physician Assistants Only (not including Licensed Physicians)	0		
Registered Nurses (RNs-Advanced Practice*)	973.59997558594		
Licensed Practical Nurses (LPNs)	18.89999961853		
Pharmacists	38.700000762939		
Other Health Services Professionals*	50		
Administration and Support	138.69999694824		0
All Other Hospital Personnel (not included above)	1802.6999511719		

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	
Registered Nurses (RNs-Advance Practice)	
Licensed Practical Nurses (LPNs)	
Pharmacists	
Other Health Services Professionals	
All Other Hospital Personnel (not included above)	

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	34	☐	0	0
General Internal Medicine	50	☐	0	0
Pediatricians	90	☐	0	0
Other Medical Specialties	261	☐	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	36	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	4	☐	0	0
Ophthalmology Surgery	18	☐	0	0
Orthopedic Surgery	35	☐	0	0
Plastic Surgery	19	☐	0	0
General Surgery	19	☐	0	0
Thoracic Surgery	5	☐	0	0
Other Surgical Specialties	119	☐	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	21	☑	0	0
Nuclear Medicine	1	☑	0	0
Pathology	4	☑	0	0
Psychiatry	7	☐	0	0
Radiology	13	☑	0	0
Rad/Onc	4	☑	0	0
Psychology	15	☐	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	17
Certified Nurse Midwives with Clinical Privileges in the Hospital	4
All Other Staff Affiliates with Clinical Privileges in the Hospital	223

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
Memorial Health University Medical Center, Inc.
Memorial Health Foundation, Inc.
MPPG, Inc.
Provident Health Services, Inc.
Provident Professional Building Condominium Association, Inc.
Savannah Mid-Town Properties, Inc.
Memorial Professional Assurance Co.
Memorial Health Corporate Services, Inc.
Memorial Health 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 36 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 36 beds for patient type AD.

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	19	5	0	0	0	0	1	0	0	0	0	0	1
Appling	253	84	5	1	0	0	1	0	0	0	0	0	14
Atkinson	26	7	2	0	0	0	0	0	0	0	0	0	0
Bacon	109	39	7	1	0	0	0	0	0	0	0	0	5
Baldwin	3	2	0	0	0	0	0	0	0	0	0	0	1
Barrow	1	0	0	0	0	0	0	0	0	0	0	0	0
Bartow	2	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	10	1	1	0	0	0	0	0	0	0	0	0	0
Berrien	4	4	0	0	0	0	0	0	0	0	0	0	0
Bibb	9	4	1	0	0	0	0	0	0	0	0	0	0
Bleckley	2	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	81	28	1	3	0	0	0	0	0	0	0	0	4
Bryan	1,170	838	193	38	0	0	3	0	0	0	0	0	30
Bulloch	657	414	48	19	0	0	0	0	0	0	0	0	36
Burke	20	6	1	5	0	0	0	0	0	0	0	0	0
Camden	68	23	13	3	0	0	0	0	0	0	0	0	1
Candler	177	51	9	3	0	0	0	0	0	0	0	0	9
Carroll	1	3	0	0	0	0	0	0	0	0	0	0	0
Catoosa	0	1	0	0	0	0	0	0	0	0	0	0	0
Charlton	11	11	1	1	0	0	0	0	0	0	0	0	0
Chatham	13,919	5,629	1,809	482	0	0	23	0	0	0	0	0	324
Cherokee	2	1	0	0	0	0	0	0	0	0	0	0	0
Clarke	4	2	0	1	0	0	0	0	0	0	0	0	0
Clayton	5	1	1	1	0	0	0	0	0	0	0	0	0
Clinch	6	5	3	0	0	0	0	0	0	0	0	0	0
Cobb	14	4	1	0	0	0	0	0	0	0	0	0	0
Coffee	231	57	8	3	0	0	0	0	0	0	0	0	15

Colquitt	4	4	0	0	0	0	0	0	0	0	0	0	0
Columbia	8	2	0	1	0	0	0	0	0	0	0	0	0
Cook	1	0	0	0	0	0	0	0	0	0	0	0	0
Coweta	1	1	1	0	0	0	0	0	0	0	0	0	0
Crisp	1	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	1	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	18	2	0	0	0	0	0	0	0	0	0	0	0
Dodge	10	4	0	1	0	0	0	0	0	0	0	0	0
Dougherty	8	2	1	1	0	0	0	0	0	0	0	0	0
Douglas	2	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	1,919	1,184	352	27	0	0	3	0	0	0	0	0	62
Emanuel	136	56	9	7	0	0	0	0	0	0	0	0	4
Evans	220	74	13	10	0	0	0	0	0	0	0	0	14
Fannin	3	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	107	46	1	3	0	0	0	0	0	0	0	0	4
Floyd	3	0	0	1	0	0	0	0	0	0	0	0	1
Forsyth	3	1	0	1	0	0	0	0	0	0	0	0	0
Franklin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	21	7	1	1	0	0	0	0	0	0	0	0	0
Gilmer	0	2	0	0	0	0	0	0	0	0	0	0	0
Glascock	1	0	0	1	0	0	0	0	0	0	0	0	0
Glynn	344	144	21	12	0	0	1	0	0	0	0	0	17
Gordon	3	1	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	19	3	1	1	0	0	1	0	0	0	0	0	1
Hall	3	0	0	0	0	0	0	0	0	0	0	0	0
Hancock	0	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	1	0	0	0	0	0	0	0	0	0	0	0	0
Harris	0	1	0	0	0	0	0	0	0	0	0	0	0
Hart	1	0	0	0	0	0	0	0	0	0	0	0	0
Henry	6	0	0	0	0	0	0	0	0	0	0	0	1
Houston	11	4	0	3	0	0	0	0	0	0	0	0	0
Irwin	9	2	0	0	0	0	0	0	0	0	0	0	1
Jackson	2	3	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	177	74	11	3	0	0	1	0	0	0	0	0	7
Jefferson	5	1	0	3	0	0	0	0	0	0	0	0	0
Jenkins	28	13	1	3	0	0	0	0	0	0	0	0	1
Johnson	12	7	0	1	0	0	0	0	0	0	0	0	0
Jones	1	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	4	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	62	29	0	10	0	0	0	0	0	0	0	0	3
Lee	0	1	0	0	0	0	0	0	0	0	0	0	0
Liberty	1,277	734	193	25	0	0	3	0	0	0	0	0	37
Long	198	105	22	3	0	0	0	0	0	0	0	0	6

Lowndes	19	4	0	3	0	0	0	0	0	0	0	0	0
Lumpkin	0	1	0	0	0	0	0	0	0	0	0	0	0
Macon	1	0	0	0	0	0	0	0	0	0	0	0	0
Madison	2	0	0	0	0	0	0	0	0	0	0	0	0
McDuffie	6	0	0	3	0	0	0	0	0	0	0	0	0
McIntosh	154	66	21	2	0	0	0	0	0	0	0	0	10
Mitchell	1	2	0	0	0	0	0	0	0	0	0	0	0
Montgomery	106	45	3	0	0	0	0	0	0	0	0	0	7
Muscogee	4	0	0	0	0	0	0	0	0	0	0	0	0
North Carolina	34	9	1	1	0	0	0	0	0	0	0	0	0
Other Out of State	227	47	8	8	0	0	1	0	0	0	0	0	15
Paulding	2	0	0	0	0	0	0	0	0	0	0	0	0
Peach	2	1	0	1	0	0	0	0	0	0	0	0	0
Pierce	95	61	8	1	0	0	0	0	0	0	0	0	2
Pulaski	1	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	3	1	0	0	0	0	0	0	0	0	0	0	1
Rabun	1	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	47	3	1	23	0	0	0	0	0	0	0	0	2
Rockdale	3	0	1	0	0	0	0	0	0	0	0	0	0
Screven	190	115	13	10	0	0	0	0	0	0	0	0	8
South Carolina	1,306	568	110	18	0	0	0	0	0	0	0	0	54
Spalding	2	0	0	0	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	1	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	400	171	15	7	0	0	1	0	0	0	0	0	15
Telfair	49	15	1	1	0	0	0	0	0	0	0	0	3
Tennessee	20	2	3	1	0	0	0	0	0	0	0	0	0
Thomas	4	2	0	0	0	0	0	0	0	0	0	0	0
Tift	9	3	0	0	0	0	0	0	0	0	0	0	0
Toombs	511	202	13	11	0	0	0	0	0	0	0	0	23
Treutlen	46	13	3	2	0	0	0	0	0	0	0	0	1
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	1
Upson	2	0	0	0	0	0	0	0	0	0	0	0	0
Walton	4	0	0	1	0	0	0	0	0	0	0	0	0
Ware	174	81	14	6	0	0	0	0	0	0	0	0	7
Warren	2	0	0	1	0	0	0	0	0	0	0	0	0
Washington	7	5	1	1	0	0	0	0	0	0	0	0	0
Wayne	527	197	13	10	0	0	1	0	0	0	0	0	18
Wheeler	44	10	1	1	0	0	0	0	0	0	0	0	3
White	2	0	0	0	0	0	0	0	0	0	0	0	0
Wilcox	2	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	1	0	0	0	0	0	0	0	0	0
Worth	3	0	0	0	0	0	0	0	0	0	0	0	0
Total	**25,452**	**11,358**	**2,961**	**792**	**0**	**0**	**40**	**0**	**0**	**0**	**0**	**0**	**769**

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	7	13
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**5**	**7**	**13**

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	4,628	6,391	3,663	4,896
Cystoscopy	0	0	130	179
Endoscopy	0	0	68	95
	0	0	0	0
Total	**4,628**	**6,391**	**3,861**	**5,170**

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	4,524	6,247	3,503	4,837
Cystoscopy	0	0	130	179
Endoscopy	0	0	68	95
	0	0	0	0
Total	**4,524**	**6,247**	**3,701**	**5,111**

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	13
Asian	92
Black/African American	2,930
Hispanic/Latino	264
Pacific Islander/Hawaiian	0
White	7,776
Multi-Racial	283
Total	**11,358**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	2,810
Ages 15-64	6,748
Ages 65-74	1,196
Ages 75-85	503
Ages 85 and Up	101
Total	**11,358**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,001
Female	6,357
Total	**11,358**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,249
Medicaid	2,300
Third-Party	6,223
Self-Pay	586

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: 1,050

6. Total Live Births: 2,656

7. Total Births (Live and Late Fetal Deaths): 2,736

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,637

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	2,123	4,609	26
Specialty Care (Intermediate Neonatal Care)	28	0	8,559	174
Subspecialty Care (Intensive Neonatal Care)	28	742	8,524	681

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	9	67
Asian	29	79
Black/African American	1,050	2,735
Hispanic/Latino	210	774
Pacific Islander/Hawaiian	0	0
White	1,553	4,790
Multi-Racial	110	462
Total	**2,961**	**8,907**

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	9	13
Ages 15-44	2,950	8,887
Ages 45 and Up	2	7
Total	**2,961**	**8,907**

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

$12,210.00

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

$83,204.00

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	792	9,387	1,180	9,193	2,262	☐
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	40	443	40	443	3,008	☐
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	1	4
Asian	4	43
Black/African American	324	3,912
Hispanic/Latino	5	81
Pacific Islander/Hawaiian	0	0
White	466	5,427
Multi-Racial	32	363
Total	**832**	**9,830**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	333	3,858
Female	499	5,972
Total	**832**	**9,830**

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	294	4,104
Medicaid	297	3,349
Third Party	206	2,011
Self-Pay	35	367
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		0	0	0
Vietnamese		0	0	0
Korean		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. Spanish
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 Street, 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	6	111
Black/African American	239	3,928
Hispanic/Latino	8	96
Pacific Islander/Hawaiian	0	0
White	503	7,855
Multi-Racial	13	187

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	409	6,595
Female	360	5,582

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	390	6,502
65-84	311	4,690
85 Up	68	985

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	744
Long Term Care Hospital	3
Skilled Nursing Facility	2
Traumatic Brain Injury Facility	0

Other	20

1. Payers

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

Primary Payment Source	Admissions
Medicare	409
Third Party/Commercial	208
Self Pay	40
Other	112

2. Uncompensated Indigent and Charity Care

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

26

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	195
2. Brain Injury	88
3. Amputation	54
4. Spinal Cord	60
5. Fracture of the femur	68
6. Neurological disorders	25
7. Multiple Trauma	89
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	3
12. Systemic vasculidities	0
13. Joint replacement	10
All Other	177

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: 5/22/2015

Title: President and Chief Executive Officer

Comments: