GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP709

Facility Name: Atlanta Medical Center

County: Fulton

Street Address: 303 Parkway Drive

City: Atlanta

Zip: 30312-1212

Mailing Address: 303 Parkway Drive

Mailing City: Atlanta

Mailing Zip: 30312-1212

Medicaid Provider Number: 00000789A

Medicare Provider Number: 110115

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 Williams

Contact Title: Assistant Chief Financial Officer

Phone: 404-265-6377

Fax: 404-265-4763

E-mail: Christine2.Williams@tenethealth.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
Tenet Healthcare Corporation	For Profit	9/5/1997

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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: Tenet Healthcare Corporation
City: Dallas **State:** Texas

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☑

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☑

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(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)

Dallas, Texas

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)	30	3,384	8,984	3,344	8,902
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	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	315	8,711	53,316	10,530	58,038
Intensive Care	75	3,347	21,405	1,478	16,336
Psychiatry	63	2,725	14,191	2,732	14,332
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	141	2,102	139	2,104
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	**503**	**18,308**	**99,998**	**18,223**	**99,712**

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	6	22
Asian	102	369
Black/African American	12,384	68,232
Hispanic/Latino	1,045	3,902
Pacific Islander/Hawaiian	25	137
White	4,224	24,273
Multi-Racial	522	3,063
Total	**18,308**	**99,998**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,183	45,914
Female	11,125	54,084
Total	**18,308**	**99,998**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,862	38,254
Medicaid	6,471	32,934
Peachare	0	0
Third-Party	3,448	2,956
Self-Pay	1,980	8,681
Other	547	17,173

5. Discharges to Death

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

577

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	1,475
Semi-Private Room Rate	1,475
Operating Room: Average Charge for the First Hour	7,031
Average Total Charge for an Inpatient Day	12,186

Part E : Emergency Department and Outpatient Services

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

117,023

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

11,565

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

62

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	4	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	9	0
General Beds	49	0
	0	0
	0	0
	0	0
	0	0

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

1,068

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

53,747

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

3,062

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

170

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

453.00

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.

3,267

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	2	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	2	1
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	178
Number of Dialysis Treatments	1,602
Number of ESWL Patients	242
Number of ESWL Procedures	242
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	80,578
Number of CTS Units (machines)	6
Number of CTS Procedures	29,319
Number of Diagnostic Radioisotope Procedures	5,052
Number of PET Units (machines)	0
Number of PET Procedures	101
Number of Therapeautic Radioisotope Procedures	20
Number of Number of MRI Units	3
Number of Number of MRI Procedures	6,420
Number of Chemotherapy Treatments	44
Number of Respiratory Therapy Treatments	185,976
Number of Occupational Therapy Treatments	21,080
Number of Physical Therapy Treatments	35,895
Number of Speech Pathology Patients	5,577
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	3,450
Number of HIV/AIDS Diagnostic Procedures	1,297
Number of HIV/AIDS Patients	1,265
Number of Ambulance Trips	0
Number of Hospice Patients	136
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	20
Number of Ultrasound/Medical Sonography Procedures	17,532
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).

59

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	25	MAKO

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	21	0	0
Physician Assistants Only (not including Licensed Physicians)	1	0	0
Registered Nurses (RNs-Advanced Practice*)	708	100	51.790000915527
Licensed Practical Nurses (LPNs)	11	0	0
Pharmacists	24	0	0
Other Health Services Professionals*	686	23	20.530000686646
Administration and Support	260	27	1.2699999809265
All Other Hospital Personnel (not included above)	27	0	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	Not Applicable
Pharmacists	61-90 Days
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	12
Black/African American	89
Hispanic/Latino	3
Pacific Islander/Hawaiian	0
White	73
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	32	☑	0	0
General Internal Medicine	41	☑	0	0
Pediatricians	17	☐	0	0
Other Medical Specialties	19	☐	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	28	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	2	☑	0	0
Ophthalmology Surgery	7	☐	0	0
Orthopedic Surgery	14	☑	0	0
Plastic Surgery	3	☐	0	0
General Surgery	15	☑	0	0
Thoracic Surgery	3	☐	0	0
Other Surgical Specialties	10	☑	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	18	☑	0	0
Dermatology	0	☐	0	0
Emergency Medicine	37	☑	0	0
Nuclear Medicine	2	☑	0	0
Pathology	3	☑	0	0
Psychiatry	8	☐	0	0
Radiology	64	☑	0	0
Cardiology	20	☐	0	0
Neurology	12	☐	0	0
Other	56	☐	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	0
Podiatrists	8
Certified Nurse Midwives with Clinical Privileges in the Hospital	20
All Other Staff Affiliates with Clinical Privileges in the Hospital	151

5b. Name of Other Professions

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

Advanced Practice Reg Nurse, Anesthesia Asst, Autotransfusionist, Cert Reg Nurse Anesthetist, Cert Surgical Technologist, Certified Nurse Midwife, Clinical Cardiac Electronphysiology, Medical Physics, Nurse Practitioner, Physician Assistant, RN, Research Only, and Surgical Assistant.

Comments and Suggestions:

Question 3: Physicians are not required to record their race. Only 177 of the 419 doctors recorded their race.

Question 4: AMC does not capture the number of medical staff enrolled as Medicaid / Peachcare or PEHB Providers

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	75	16	0	1	0	0	0	0	0	0	0	0	3
Appling	2	0	0	0	0	0	0	0	0	0	0	0	0
Baker	2	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	25	6	1	11	0	0	0	0	0	0	0	0	0
Banks	4	3	0	1	0	0	0	0	0	0	0	0	0
Barrow	32	15	1	8	0	0	0	0	0	0	0	0	1
Bartow	54	10	3	14	0	0	0	0	0	0	0	0	0
Ben Hill	1	0	0	0	0	0	0	0	0	0	0	0	0
Berrien	1	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	22	16	0	10	0	0	0	0	0	0	0	0	0
Bleckley	2	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	1	0	0	0	0	0	0	0	0	0	0	0
Bulloch	3	0	1	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	1	0	0	0	0	0	0	0	0	0
Butts	159	24	2	8	0	0	0	0	0	0	0	0	2
Calhoun	3	3	0	0	0	0	0	0	0	0	0	0	0
Candler	1	0	0	1	0	0	0	0	0	0	0	0	0
Carroll	186	40	15	17	0	0	0	0	0	0	0	0	1
Catoosa	7	0	0	3	0	0	0	0	0	0	0	0	0
Chatham	9	6	1	0	0	0	0	0	0	0	0	0	0
Chattooga	3	4	0	1	0	0	0	0	0	0	0	0	0
Cherokee	112	43	36	25	0	0	0	0	0	0	0	0	4
Clarke	49	2	5	32	0	0	0	0	0	0	0	0	0
Clayton	1,166	504	308	169	0	0	0	0	0	0	0	0	6
Clinch	1	5	0	0	0	0	0	0	0	0	0	0	0
Cobb	558	206	210	91	0	0	0	0	0	0	0	0	5
Coffee	5	0	0	0	0	0	0	0	0	0	0	0	0

Colquitt	1	0	0	0	0	0	0	0	0	0	0	0	0
Columbia	10	4	0	3	0	0	0	0	0	0	0	0	0
Coweta	339	65	45	12	0	0	0	0	0	0	0	0	13
Crisp	3	2	0	0	0	0	0	0	0	0	0	0	0
Dade	1	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	10	8	0	3	0	0	0	0	0	0	0	0	0
Decatur	1	1	0	0	0	0	0	0	0	0	0	0	0
DeKalb	2,067	625	517	356	0	0	0	0	0	0	0	0	14
Dodge	6	2	0	0	0	0	0	0	0	0	0	0	0
Dooly	16	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	10	5	0	1	0	0	0	0	0	0	0	0	4
Douglas	228	73	56	20	0	0	0	0	0	0	0	0	4
Early	1	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	5	2	0	2	0	0	0	0	0	0	0	0	0
Emanuel	2	0	0	0	0	0	0	0	0	0	0	0	0
Evans	2	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	11	6	0	3	0	0	0	0	0	0	0	0	0
Fayette	186	81	42	16	0	0	0	0	0	0	0	0	5
Florida	74	5	0	11	0	0	0	0	0	0	0	0	0
Floyd	37	10	1	20	0	0	0	0	0	0	0	0	0
Forsyth	32	13	5	6	0	0	0	0	0	0	0	0	0
Franklin	1	0	0	1	0	0	0	0	0	0	0	0	0
Fulton	9,906	2,923	1,623	1,314	0	0	0	0	0	0	0	0	52
Gilmer	22	7	0	5	0	0	0	0	0	0	0	0	2
Glynn	1	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	25	10	0	19	0	0	0	0	0	0	0	0	0
Greene	2	0	0	1	0	0	0	0	0	0	0	0	0
Gwinnett	570	127	302	92	0	0	0	0	0	0	0	0	0
Habersham	24	8	0	1	0	0	0	0	0	0	0	0	1
Hall	45	12	2	8	0	0	0	0	0	0	0	0	0
Hancock	4	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	38	8	4	0	0	0	0	0	0	0	0	0	0
Harris	6	1	0	0	0	0	0	0	0	0	0	0	0
Hart	2	5	0	0	0	0	0	0	0	0	0	0	0
Heard	18	4	0	1	0	0	0	0	0	0	0	0	1
Henry	414	178	63	66	0	0	0	0	0	0	0	0	6
Houston	29	15	3	6	0	0	0	0	0	0	0	0	0
Jackson	27	2	3	10	0	0	0	0	0	0	0	0	1
Jasper	19	6	0	2	0	0	0	0	0	0	0	0	1
Jeff Davis	1	2	0	0	0	0	0	0	0	0	0	0	0
Jefferson	1	0	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	1	0	0	0	0	0	0	0	0	0
Johnson	14	4	0	0	0	0	0	0	0	0	0	0	0
Jones	5	0	1	3	0	0	0	0	0	0	0	0	0

Lamar	26	8	2	2	0	0	0	0	0	0	0	0	0
Lanier	4	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	8	1	1	1	0	0	0	0	0	0	0	0	0
Lee	3	2	0	0	0	0	0	0	0	0	0	0	0
Liberty	1	1	0	1	0	0	0	0	0	0	0	0	0
Lowndes	8	1	0	1	0	0	0	0	0	0	0	0	0
Lumpkin	8	3	0	1	0	0	0	0	0	0	0	0	1
Macon	34	6	0	0	0	0	0	0	0	0	0	0	0
Madison	8	0	0	6	0	0	0	0	0	0	0	0	0
McDuffie	2	1	0	2	0	0	0	0	0	0	0	0	0
Meriwether	32	5	4	4	0	0	0	0	0	0	0	0	0
Mitchell	3	2	0	0	0	0	0	0	0	0	0	0	0
Monroe	9	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	9	1	0	3	0	0	0	0	0	0	0	0	0
Murray	19	4	0	16	0	0	0	0	0	0	0	0	0
Muscogee	77	13	4	25	0	0	0	0	0	0	0	0	0
Newton	196	49	8	29	0	0	0	0	0	0	0	0	4
North Carolina	30	6	0	0	0	0	0	0	0	0	0	0	0
Oconee	11	0	0	3	0	0	0	0	0	0	0	0	0
Oglethorpe	7	0	0	6	0	0	0	0	0	0	0	0	0
Other Out of State	244	24	14	33	0	0	0	0	0	0	0	0	5
Paulding	66	18	22	15	0	0	0	0	0	0	0	0	1
Peach	6	4	0	3	0	0	0	0	0	0	0	0	0
Pickens	17	8	1	9	0	0	0	0	0	0	0	0	0
Pike	22	1	0	2	0	0	0	0	0	0	0	0	2
Polk	24	1	1	10	0	0	0	0	0	0	0	0	0
Pulaski	11	5	0	1	0	0	0	0	0	0	0	0	0
Putnam	1	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	0	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	18	3	0	17	0	0	0	0	0	0	0	0	0
Rockdale	175	55	11	39	0	0	0	0	0	0	0	0	5
Schley	1	0	0	0	0	0	0	0	0	0	0	0	1
Seminole	2	0	0	2	0	0	0	0	0	0	0	0	0
South Carolina	15	3	0	0	0	0	0	0	0	0	0	0	0
Spalding	199	46	13	34	0	0	0	0	0	0	0	0	6
Stephens	7	0	0	1	0	0	0	0	0	0	0	0	0
Stewart	1	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	2	0	0	0	0	0	0	0	0	0	0	0
Talbot	2	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	15	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	8	3	0	0	0	0	0	0	0	0	0	0	0
Tennessee	21	4	0	3	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0	0

Thomas	2	1	0	3	0	0	0	0	0	0	0	0	0
Toombs	3	2	0	1	0	0	0	0	0	0	0	0	0
Towns	2	6	0	0	0	0	0	0	0	0	0	0	0
Treutlen	2	0	0	0	0	0	0	0	0	0	0	0	0
Troup	95	8	7	33	0	0	0	0	0	0	0	0	1
Union	5	4	0	0	0	0	0	0	0	0	0	0	0
Upson	19	11	0	13	0	0	0	0	0	0	0	0	0
Walker	12	0	0	5	0	0	0	0	0	0	0	0	0
Walton	64	20	6	11	0	0	0	0	0	0	0	0	1
Ware	4	1	0	2	0	0	0	0	0	0	0	0	0
Washington	4	3	0	1	0	0	0	0	0	0	0	0	0
Wayne	1	0	0	0	0	0	0	0	0	0	0	0	0
Wheeler	2	0	0	0	0	0	0	0	0	0	0	0	0
White	7	1	0	1	0	0	0	0	0	0	0	0	0
Whitfield	17	6	0	6	0	0	0	0	0	0	0	0	0
Wilcox	6	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	4	0	2	2	0	0	0	0	0	0	0	0	0
Wilkinson	3	0	0	2	0	0	0	0	0	0	0	0	0
Worth	3	2	0	0	0	0	0	0	0	0	0	0	0
Total	**18,308**	**5,476**	**3,346**	**2,725**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**153**

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	27
Cystoscopy (OR Suite)	0	0	2
Endoscopy (OR Suite)	0	0	7
	0	0	0
Total	**0**	**0**	**36**

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	4,178	3,833
Cystoscopy	0	0	91	651
Endoscopy	0	0	835	992
	0	0	0	0
Total	**0**	**0**	**5,104**	**5,476**

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	3,770	3,833
Cystoscopy	0	0	91	651
Endoscopy	0	0	836	992
	0	0	0	0
Total	**0**	**0**	**4,697**	**5,476**

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	9
Asian	40
Black/African American	4,022
Hispanic/Latino	180
Pacific Islander/Hawaiian	4
White	1,054
Multi-Racial	167
Total	**5,476**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	500
Ages 15-64	3,586
Ages 65-74	943
Ages 75-85	377
Ages 85 and Up	70
Total	**5,476**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,154
Female	3,322
Total	**5,476**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,845
Medicaid	1,609
Third-Party	169
Self-Pay	1,853

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of th hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 13

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 851

6. Total Live Births: 3,270

7. Total Births (Live and Late Fetal Deaths): 3,293

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,412

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)	32	2,963	6,140	31
Specialty Care (Intermediate Neonatal Care)	17	161	2,373	146
Subspecialty Care (Intensive Neonatal Care)	16	146	1,860	229

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	1	6
Asian	46	125
Black/African American	1,827	5,333
Hispanic/Latino	663	1,816
Pacific Islander/Hawaiian	1	1
White	688	1,633
Multi-Racial	120	411
Total	**3,346**	**9,325**

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	11	30
Ages 15-44	3,330	9,282
Ages 45 and Up	5	13
Total	**3,346**	**9,325**

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

$17,491.00

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

$32,621.00

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	66	63
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	2,725	14,216	2,732	14,263	1,410	☐
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	0	0	0	0	0	☐
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	11	63
Black/African American	1,853	9,715
Hispanic/Latino	29	155
Pacific Islander/Hawaiian	3	20
White	675	3,575
Multi-Racial	154	688
Total	**2,725**	**14,216**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,431	7,142
Female	1,294	7,074
Total	**2,725**	**14,216**

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	787	4,939
Medicaid	1,669	8,150
Third Party	167	800
Self-Pay	102	327
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? 0 (FTE's)
What languages do they interpret?

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	2%	7	16	12
French	<1%	4	7	6
Arabic	<1%	0	0	14

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?

Annual cultural competency courses are required for staff via computer based training.

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?

More multi-lingual clinical staff.

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?

Southside Medical Center, Corporate office & Main Facility. 1046 Reidge Avenue SW, Atlanta, GA 30315 Phone: 404-688-1350 Fax: 404-688-2962

Sheffield Healthcare Clinic, 265 Boulevard NE 2nd Floo, Atlanta, GA 30312
Phone: 404-265-4940

Grady Health System, 80 Jesse Hill Jr Drive SE, Atlanta, GA 30303
Phone: 404-616-1000

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	81	1,099
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	69	956
Multi-Racial	3	47

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	75	1,016
Female	78	1,086

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	89	1,128
65-84	57	864
85 Up	7	110

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	153
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

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

Primary Payment Source	Admissions
Medicare	117
Third Party/Commercial	34
Self Pay	1
Other	1

2. Uncompensated Indigent and Charity Care

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

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

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

Diagnosis	Admissions
1. Stroke	5
2. Brain Injury	9
3. Amputation	12
4. Spinal Cord	1
5. Fracture of the femur	1
6. Neurological disorders	1
7. Multiple Trauma	13
8. Congenital deformity	1
9. Burns	0
10. Osteoarthritis	6
11. Rheumatoid arthritis	1
12. Systemic vasculidities	0
13. Joint replacement	9
All Other	94

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: Lisa Napier

Date: 3/19/2014

Title: Chief Financial Officer

Comments: