Georgia Department of Community Health

2016 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP366

Facility Name: Gwinnett Medical Center

County: Gwinnett

Street Address: 1000 Medical Center Boulevard

City: Lawrenceville

Zip: 30046

Mailing Address: PO Box 348

Mailing City: Lawrenceville

Mailing Zip: 30046

Medicaid Provider Number: 00000294

Medicare Provider Number: 110087

2. Report Period

Report Data for the full twelve month period- January 1, 2016 through December 31, 2016.
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: Heather Boyce

Contact Title: Planning Analyst

Phone: 678-312-3757

Fax: 678-312-2310

E-mail: hboyce@gwinnettmedicalcenter.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
Hospital Authority of Gwinnett County	Hospital Authority	1/1/1957

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gwinnett Hospital System, Inc.	Not for Profit	1/1/1959

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Gwinnett Health System, Inc.	Not for Profit	12/1/1992

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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: Gwinnett Health System, Inc.
City: Lawrenceville **State:** Georgia

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: VHA
City: Dallas **State:** Texas

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

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☑

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	49	5,513	15,388	5,529	15,435
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	167	16,098	53,096	10,645	55,776
General Surgery	62	1,165	20,275	4,713	24,694
Medical/Surgical	31	415	10,123	1,894	9,925
Intensive Care	20	216	6,356	348	1,821
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
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
CVICU	16	362	4,769	650	3,406
	0	0	0	0	0
	0	0	0	0	0
Total	**345**	**23,769**	**110,007**	**23,779**	**111,057**

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	20	88
Asian	1,277	5,236
Black/African American	5,721	28,510
Hispanic/Latino	3,200	11,267
Pacific Islander/Hawaiian	8	15
White	12,608	60,944
Multi-Racial	935	3,947
Total	**23,769**	**110,007**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,566	45,968
Female	15,203	64,039
Total	**23,769**	**110,007**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,654	52,056
Medicaid	4,524	18,211
Peachare	0	0
Third-Party	7,403	30,200
Self-Pay	1,906	8,367
Other	282	1,173

5. Discharges to Death

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

422

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2016 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,507
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	9,221
Average Total Charge for an Inpatient Day	8,745

Part E : Emergency Department and Outpatient Services

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

109,970

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

14,872

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

65

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	1,192
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	2,640
General Beds	51	82,974
Pediatric Beds	10	26,997
	0	0
	0	0
	0	0

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

2,432

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

184,901

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

22,208

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

49

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

909.00

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

2,906

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	3	4
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)	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	3	4
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	0
Number of Dialysis Treatments	4,577
Number of ESWL Patients	377
Number of ESWL Procedures	377
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	197,602
Number of CTS Units (machines)	5
Number of CTS Procedures	61,200
Number of Diagnostic Radioisotope Procedures	10,203
Number of PET Units (machines)	1
Number of PET Procedures	1,292
Number of Therapeautic Radioisotope Procedures	146
Number of Number of MRI Units	3
Number of Number of MRI Procedures	12,792
Number of Chemotherapy Treatments	53,092
Number of Respiratory Therapy Treatments	882,335
Number of Occupational Therapy Treatments	24,920
Number of Physical Therapy Treatments	95,645
Number of Speech Pathology Patients	28,116
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	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	52
Number of Ultrasound/Medical Sonography Procedures	40,843
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).

58

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	239	Intuitive Surgical daVinci Si Firefly Fluoroscence 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 12-31-2016. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2016.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	47.909999847412	3.6099998950958	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	1031.6099853516	107.73000335693	24.329999923706
Licensed Practical Nurses (LPNs)	4.9499998092651	1.4500000476837	0
Pharmacists	33.169998168945	5.710000038147	0
Other Health Services Professionals*	779.89001464844	81.300003051758	20.790000915527
Administration and Support	16	0	0
All Other Hospital Personnel (not included above)	1167.1899414062	117.91999816895	36.860000610352

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	30 Days or Less
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	31-60 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	317
Black/African American	149
Hispanic/Latino	22
Pacific Islander/Hawaiian	0
White	456
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	14	☐	5	0
General Internal Medicine	81	☑	25	0
Pediatricians	48	☐	18	0
Other Medical Specialties	159	☐	100	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	45	☐	21	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	4	☐	2	0
Ophthalmology Surgery	7	☐	2	0
Orthopedic Surgery	30	☐	17	0
Plastic Surgery	8	☐	5	0
General Surgery	22	☐	11	0
Thoracic Surgery	2	☐	2	0
Other Surgical Specialties	27	☐	8	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	26	☑	22	0
Dermatology	0	☐	0	0
Emergency Medicine	46	☑	14	0
Nuclear Medicine	0	☐	0	0
Pathology	7	☑	5	0
Psychiatry	3	☐	2	0
Radiology	41	☑	32	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	13
Podiatrists	11
Certified Nurse Midwives with Clinical Privileges in the Hospital	17
All Other Staff Affiliates with Clinical Privileges in the Hospital	407

5b. Name of Other Professions

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

Acute Care Nurse Practitioner, Adult Nurse Practitioner, Certified Nurse Practitioner, Certified Registered Nurse Anesthesist, Certified Surgical Assistant, Clinical Nurse Specialist, Family Nurse Practitioner, Gerontological Nurse Practitioner, Licensed Associate Professional Counselor, Licensed Clinical Social Worker, Licensed Clinical Psychologist, Licensed Master Social Worker, Licensed Practical Nurse, Licensed Professional Counselor, Medical Radiation Physicist, Neonatal Nurse Practitioner, Nurse Practitioner, Oncology Certified Nurse, Oral Assistant, Oral Surgical Assistant, Pathologist's Assistant, Pediatric Nurse Practitioner, Physician Assistant, Psychologist, Registered Nurse, Sexual Assault Nurse Examiner, Surgical Assistant, Surgical Technician, Ultrasound Technician, Women's Health Care Nurse Practitioner

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
Alabama	26	0	2	0	0	0	0	0	0	0	0	0	0
Appling	2	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	4	1	0	0	0	0	0	0	0	0	0	0	0
Banks	16	18	3	0	0	0	0	0	0	0	0	0	0
Barrow	1,221	541	356	0	0	0	0	0	0	0	0	0	0
Bartow	9	4	1	0	0	0	0	0	0	0	0	0	0
Berrien	0	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	11	1	2	0	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	2	1	2	0	0	0	0	0	0	0	0	0	0
Bulloch	1	0	0	0	0	0	0	0	0	0	0	0	0
Burke	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	6	2	0	0	0	0	0	0	0	0	0	0	0
Calhoun	1	0	0	0	0	0	0	0	0	0	0	0	0
Camden	1	0	1	0	0	0	0	0	0	0	0	0	0
Candler	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	3	4	0	0	0	0	0	0	0	0	0	0	0
Chatham	5	2	1	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	25	11	4	0	0	0	0	0	0	0	0	0	0
Clarke	33	24	4	0	0	0	0	0	0	0	0	0	0
Clayton	35	12	7	0	0	0	0	0	0	0	0	0	0
Clinch	1	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	90	57	24	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	4	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	8	3	3	0	0	0	0	0	0	0	0	0	0

Crisp	1	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	13	15	0	0	0	0	0	0	0	0	0	0	0
DeKalb	979	446	250	0	0	0	0	0	0	0	0	0	0
Dodge	0	1	0	0	0	0	0	0	0	0	0	0	0
Dougherty	6	0	0	0	0	0	0	0	0	0	0	0	0
Douglas	19	6	5	0	0	0	0	0	0	0	0	0	0
Effingham	1	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	7	3	0	0	0	0	0	0	0	0	0	0	0
Fannin	6	4	0	0	0	0	0	0	0	0	0	0	0
Fayette	9	2	1	0	0	0	0	0	0	0	0	0	0
Florida	48	0	3	0	0	0	0	0	0	0	0	0	0
Floyd	2	0	0	0	0	0	0	0	0	0	0	0	0
Forsyth	70	82	12	0	0	0	0	0	0	0	0	0	0
Franklin	9	10	0	0	0	0	0	0	0	0	0	0	0
Fulton	501	388	100	0	0	0	0	0	0	0	0	0	0
Gilmer	3	5	0	0	0	0	0	0	0	0	0	0	0
Gordon	2	0	0	0	0	0	0	0	0	0	0	0	0
Grady	1	0	0	0	0	0	0	0	0	0	0	0	0
Greene	3	6	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	18,997	7,756	4,408	0	0	0	0	0	0	0	0	0	0
Habersham	22	16	4	0	0	0	0	0	0	0	0	0	0
Hall	240	221	91	0	0	0	0	0	0	0	0	0	0
Harris	1	1	0	0	0	0	0	0	0	0	0	0	0
Hart	7	7	0	0	0	0	0	0	0	0	0	0	0
Henry	33	14	5	0	0	0	0	0	0	0	0	0	0
Houston	0	3	0	0	0	0	0	0	0	0	0	0	0
Jackson	300	243	89	0	0	0	0	0	0	0	0	0	0
Jasper	4	4	1	0	0	0	0	0	0	0	0	0	0
Johnson	1	0	0	0	0	0	0	0	0	0	0	0	0
Jones	1	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	3	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	4	0	0	0	0	0	0	0	0	0	0	0	0
Lee	1	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	2	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	1	0	1	0	0	0	0	0	0	0	0	0	0
Lumpkin	9	23	1	0	0	0	0	0	0	0	0	0	0
Madison	10	11	3	0	0	0	0	0	0	0	0	0	0
Meriwether	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	3	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	7	6	1	0	0	0	0	0	0	0	0	0	0
Murray	1	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	7	2	0	0	0	0	0	0	0	0	0	0	0
Newton	114	64	24	0	0	0	0	0	0	0	0	0	0

North Carolina	35	0	0	0	0	0	0	0	0	0	0	0	0
Oconee	8	16	3	0	0	0	0	0	0	0	0	0	0
Oglethorpe	2	5	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	181	134	6	0	0	0	0	0	0	0	0	0	0
Paulding	3	1	1	0	0	0	0	0	0	0	0	0	0
Peach	1	0	0	0	0	0	0	0	0	0	0	0	0
Pickens	10	2	1	0	0	0	0	0	0	0	0	0	0
Pike	0	1	0	0	0	0	0	0	0	0	0	0	0
Putnam	5	0	1	0	0	0	0	0	0	0	0	0	0
Rabun	14	6	2	0	0	0	0	0	0	0	0	0	0
Randolph	2	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	3	1	0	0	0	0	0	0	0	0	0	0	0
Rockdale	111	42	17	0	0	0	0	0	0	0	0	0	0
Schley	0	2	0	0	0	0	0	0	0	0	0	0	0
Seminole	1	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	30	0	2	0	0	0	0	0	0	0	0	0	0
Spalding	5	2	1	0	0	0	0	0	0	0	0	0	0
Stephens	12	9	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	1	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	2	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	18	0	1	0	0	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	2	2	0	0	0	0	0	0	0	0	0	0	0
Towns	6	1	0	0	0	0	0	0	0	0	0	0	0
Troup	4	2	1	0	0	0	0	0	0	0	0	0	0
Turner	1	0	0	0	0	0	0	0	0	0	0	0	0
Twiggs	2	0	0	0	0	0	0	0	0	0	0	0	0
Union	6	3	0	0	0	0	0	0	0	0	0	0	0
Upson	1	0	0	0	0	0	0	0	0	0	0	0	0
Walker	3	0	0	0	0	0	0	0	0	0	0	0	0
Walton	318	717	66	0	0	0	0	0	0	0	0	0	0
Washington	1	0	0	0	0	0	0	0	0	0	0	0	0
White	12	17	1	0	0	0	0	0	0	0	0	0	0
Whitfield	3	1	1	0	0	0	0	0	0	0	0	0	0
Wilcox	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	3	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	4	0	0	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**23,769**	**10,994**	**5,513**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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	7	15
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
CVOR	2	0	0
Total	**2**	**7**	**16**

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	6,115	4,763	4,043
Cystoscopy	0	0	142	1,029
Endoscopy	0	0	0	0
CVOR	445	0	0	0
Total	**445**	**6,115**	**4,905**	**5,072**

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	6,079	4,561	3,891
Cystoscopy	0	0	139	1,024
Endoscopy	0	0	0	0
CVOR	441	0	0	0
Total	**441**	**6,079**	**4,700**	**4,915**

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	570
Black/African American	2,284
Hispanic/Latino	1,049
Pacific Islander/Hawaiian	5
White	6,504
Multi-Racial	573
Total	**10,994**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	412
Ages 15-64	7,614
Ages 65-74	1,945
Ages 75-85	894
Ages 85 and Up	129
Total	**10,994**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,411
Female	6,583
Total	**10,994**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,554
Medicaid	505
Third-Party	7,388
Self-Pay	547

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: 19

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,807

6. Total Live Births: 5,167

7. Total Births (Live and Late Fetal Deaths): 5,216

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,528

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)	40	4,422	9,381	387
Specialty Care (Intermediate Neonatal Care)	8	773	10,038	382
Subspecialty Care (Intensive Neonatal Care)	16	142	1,227	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	5	11
Asian	428	1,056
Black/African American	1,554	5,066
Hispanic/Latino	1,473	3,474
Pacific Islander/Hawaiian	6	12
White	1,755	4,992
Multi-Racial	292	777
Total	**5,513**	**15,388**

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	1	3
Ages 15-44	5,487	15,270
Ages 45 and Up	25	115
Total	**5,513**	**15,388**

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

$8,705.00

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

$29,368.00

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	0	0
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	0	0	0	0	0	☐
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	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. 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**

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	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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? 14 (FTE's)
What languages do they interpret?
Spanish, Korean

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): ☑

Contract Interpretation Service. Video Relay, Telephonic via language line.

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	14,211 contacts	0	0	0
Vietnamese	801 contacts	0	0	0
Korean	1,750 contacts	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?

Interpreter workshops: medical interpreter training; standards and practices of interpretation; code of

ethics; "Breaking Down Medical Vocabulary"; skill set techniques and training. Annual medical interpreter re-testing: National Board of Certification for Medical Interpreters

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?

Additional Video Conferencing

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

1. Spanish
2. Korean
3. Braille
4. English

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?

AID Gwinnett; AIDS Coalition Athens; Alzheimer's Association; American Cancer Society; American Diabetic Association; Athens Neighborhood Health Center; Atlanta VA Medical Center; Babies Can't Wait; Ben Massell Dental Clinic; Breast Friends; Center for the Visually Impaired; Community Care Services Program-Agency on Aging; Diabetes Association of Atlanta; Friends of Disabled Adults & Children; Georgia Partnership for Caring Foundation; Georgia Perimeter College Dental Clinic; Good News; Good Samaritan Health Center Duluth and Atlanta; Gwinnett Community Clinic; Health Departments: Buford, Lawrenceville, Norcross; Hebron Community Health Center; Hope Clinic; Kid's Clinic; Mercy Clinic North; Mason Pediatrics; Oakhurst Community Health Center; Peachcare for Kids; Promina Health Call; Regain; Sheffield Health Care Clinic; St. Joseph Mercy Care Services Dental Clinic

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	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

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	0	0
Female	0	0

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	0	0
65-84	0	0
85 Up	0	0

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	0
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	0
Third Party/Commercial	0
Self Pay	0
Other	0

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

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: Philip R. Wolfe

Date: 3/24/2017

Title: President & Chief Executive Officer

Comments:

Part D. Inpatient Services
1. Utilization of Beds as Set up and Staffed (SUS) - The number of set up and staffed beds represents the current number of operational beds in both patient towers.
5. Discharges to Death - Deaths are adult only.
6. Charges for Selected Services - Operating Room: Average Charge for the First Hour - The Gwinnett Hospital System maintains numerous levels for initial hour operating room charges based on the resource intensity of anesthesia, staff, and equipment involved in the case. The average provided is based on one hour of Level 3 OR Charges.

Part E. Emergency Department and Outpatient Services.
5. Transfers - Transfers to another institution include transfers to other acute care facilities, SNF, as well as other institutions.
9. Diversion Hours - Diversion hours represent the number of hours on Total Diversion.
10. Untreated Cases - Untreated cases include all patients that left the facility prior to triage or prior to physician assessment.

Part F. Services and Facilities
1b. Report Period Workload Totals - HIV/AIDS patients are treated and receive services, but a formal program for these patients does not exist.
1b. Report Period Workload Totals - Ultrasound Units and procedures include Gwinnett Cardiac Imaging.

Part G. Facility Workforce Information
4. Medical Staff enrolled as providers in Medicaid/Peachcare is based solely on licensed information on record with Gwinnett Health System. These numbers may not represent all physicians enrolled as providers in Medicaid and Peachcare.
4. General Internal Medicine includes Hospitalists.
4. Pediatricians include all Pediatrics.
4. Other Medical Specialties includes Allergy, Cardiology, Endocrinology, Gastroenterology, Hematology/Oncology, Infectious Disease, Nephrology, Neurology, Oncology, Orthopedics, Otolaryngology, Perinatology, Physical Rehab, Pulmonology, Rheumatology, and Urology.
4. Other Surgical Specialties includes Colon/Rectal Surgery, Neurosurgery, and Oral Surgery.
4. Emergency Medicine includes Emergency Medicine - Pediatrics.
4. PEHB Plan Enrollment is currently not available.

Part H. Physician Name and License Number
Physicians include only those with admitting privileges. This includes those with a Medical Staff Status of Active, Courtesy, or Provisional, as defined by the Medical Staff bylaws.

Part I. Patient Origin Table.

1. Outpatient Surgery reports all out of state patients as "Other Out of State," including Alabama, Florida, North Carolina, South Carolina, and Tennessee.

Perinatal Services Addendum

C3. Average charge for an uncomplicated delivery based on MSDRG 755.

C4. Average charge for a premature delivery based on MSDRGs 791 and 792.