



2016 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP634

Facility Name: Northside Hospital

County: Fulton

Street Address: 1000 Johnson Ferry Road NE

City: Atlanta

Zip: 30342-1611

Mailing Address: 1000 Johnson Ferry Road NE

Mailing City: Atlanta

Mailing Zip: 30342-1611

Medicaid Provider Number: 00001405

Medicare Provider Number: 110161

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: Brian J. Toporek

Contact Title: Senior Planner

Phone: 404-851-6821

Fax: 404-303-3820

E-mail: brian.toporek@northside.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
Hospital Authority of Fulton County	Hospital Authority	7/1/1970

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
Northside Hospital. Inc.	Not Applicable	11/1/1991

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not Applicable	11/1/1991

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: Northside Hospital, Inc.

City: Atlanta **State:** GA

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

Name: Northside Health Services, Inc.

City: Atlanta **State:** GA

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: Ga Alliance of Community Health; VHA

City: State:

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

Name: Super Med PPO; NovaNet; others

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(PHO)

4. Provider Service Organization(PSO)

5. Other Managed Care or Prepaid Plan

10b. Managed Care Information: Insurance Products

Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Owner or Owner Parent Based in Another State

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	187	17,003	58,866	16,997	58,304
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	27	1,238	3,955	1,249	4,021
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	284	15,178	81,803	15,142	81,802
Intensive Care	28	2,329	10,478	2,326	10,540
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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	526	35,748	155,102	35,714	154,667

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	161	702
Asian	2,180	8,240
Black/African American	10,585	48,247
Hispanic/Latino	4,349	16,002
Pacific Islander/Hawaiian	6	15
White	16,476	72,613
Multi-Racial	1,991	9,283
Total	35,748	155,102

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,729	42,199
Female	28,019	112,903
Total	35,748	155,102

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,398	39,414
Medicaid	6,124	24,186
Peachare	1	4
Third-Party	19,665	78,941
Self-Pay	2,217	11,285
Other	343	1,272

5. Discharges to Death

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

355

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	1,225
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	7,235
Average Total Charge for an Inpatient Day	11,060

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

58,004

2. Inpatient Admissions from ER

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

10,288

3. Beds Available

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

48

4. Utilization by Specific type of ER bed or room for the report period.

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	0	0
Multipurpose Beds	42	65,560
Holding/Mental Health	6	2,732
	0	0
	0	0

5. Transfers

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

1,267

6. Non-Emergency Visits

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

715,164

7. Observation Visits/Cases

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

9,020

8. Diverted Cases

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

0

9. Ambulance Diversion Hours

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

0

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.

579

Part F : Services and Facilities

1a. Services and Facilities

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

Site Codes

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

Status Codes

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

Service/Facilities	Site Code	Service Status
Podiatric Services	1	1
Renal Dialysis	1	1
ESWL	2	1
Biliary Lithotripter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnostic	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	1	1
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	1,745
Number of Dialysis Treatments	2,471
Number of ESWL Patients	345
Number of ESWL Procedures	345
Number of ESWL Units	2
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	219
Number of Diagnostic X-Ray Procedures	109,161
Number of CTS Units (machines)	27
Number of CTS Procedures	65,484
Number of Diagnostic Radioisotope Procedures	4,746
Number of PET Units (machines)	1
Number of PET Procedures	1,885
Number of Therapeutic Radioisotope Procedures	136
Number of Number of MRI Units	35
Number of Number of MRI Procedures	47,173
Number of Chemotherapy Treatments	60,631
Number of Respiratory Therapy Treatments	202,382
Number of Occupational Therapy Treatments	48,218
Number of Physical Therapy Treatments	102,167
Number of Speech Pathology Patients	3,079
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	16,615
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	42
Number of Ultrasound/Medical Sonography Procedures	46,741
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).

65

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
6	2,743	2 da Vinci Xi, 1 da Vinci Sie, 3 da Vinci Si

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	84.5	6.789999961853	3.5
Physician Assistants Only (not including Licensed Physicians)	27.700000762939	0	0
Registered Nurses (RNs-Advanced Practice*)	2468.8000488281	234.39999389648	36.419998168945
Licensed Practical Nurses (LPNs)	136	11.39999961853	0.5
Pharmacists	143.39999389648	7.199998092651	0
Other Health Services Professionals*	1364.9000244141	150.60000610352	3.799999523163
Administration and Support	2885.1999511719	141.39999389648	5.3000001907349
All Other Hospital Personnel (not included above)	703.20001220703	0	10.39999961853

2. Filling Vacancies

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

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 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	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

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

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

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	59	<input type="checkbox"/>	0	0
General Internal Medicine	194	<input checked="" type="checkbox"/>	0	0
Pediatricians	210	<input checked="" type="checkbox"/>	0	0
Other Medical Specialties	364	<input checked="" type="checkbox"/>	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	156	<input checked="" type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	62	<input type="checkbox"/>	0	0
Ophthalmology Surgery	71	<input type="checkbox"/>	0	0
Orthopedic Surgery	77	<input type="checkbox"/>	0	0
Plastic Surgery	59	<input type="checkbox"/>	0	0
General Surgery	59	<input type="checkbox"/>	0	0
Thoracic Surgery	3	<input type="checkbox"/>	0	0
Other Surgical Specialties	174	<input type="checkbox"/>	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	84	<input checked="" type="checkbox"/>	0	0
Dermatology	10	<input type="checkbox"/>	0	0
Emergency Medicine	64	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	223	<input checked="" type="checkbox"/>	0	0
Pathology	35	<input checked="" type="checkbox"/>	0	0
Psychiatry	14	<input type="checkbox"/>	0	0
Radiology	91	<input checked="" type="checkbox"/>	0	0
Radiation Oncology	28	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeons) with Admitting Privileges	0
Podiatrists	43
Certified Nurse Midwives with Clinical Privileges in the Hospital	58
All Other Staff Affiliates with Clinical Privileges in the Hospital	642

5b. Name of Other Professions

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

CRNA, CAA, NP, PA

Comments and Suggestions:

Oral surgeons are physicians and members of the medical staff and are included under "Other Surgical Specialties". There were 57 on staff at the end of CY 2016.

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	69	87	14	0	0	0	0	0	0	0	0	0	0
Appling	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	4	10	0	0	0	0	0	0	0	0	0	0	0
Banks	4	6	0	0	0	0	0	0	0	0	0	0	0
Barrow	95	103	22	0	0	0	0	0	0	0	0	0	0
Bartow	139	106	50	0	0	0	0	0	0	0	0	0	0
Ben Hill	1	2	0	0	0	0	0	0	0	0	0	0	0
Berrien	3	1	3	0	0	0	0	0	0	0	0	0	0
Bibb	36	34	7	0	0	0	0	0	0	0	0	0	0
Bleckley	7	3	1	0	0	0	0	0	0	0	0	0	0
Brooks	6	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	4	1	0	0	0	0	0	0	0	0	0	0	0
Bulloch	8	3	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	35	35	5	0	0	0	0	0	0	0	0	0	0
Candler	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	154	107	47	0	0	0	0	0	0	0	0	0	0
Catoosa	5	4	1	0	0	0	0	0	0	0	0	0	0
Chatham	18	8	2	0	0	0	0	0	0	0	0	0	0
Chattooga	5	9	2	0	0	0	0	0	0	0	0	0	0
Cherokee	1,612	880	767	0	0	0	0	0	0	0	0	0	0
Clarke	33	38	5	0	0	0	0	0	0	0	0	0	0
Clayton	699	336	243	0	0	0	0	0	0	0	0	0	0
Cobb	5,655	2,551	2,777	0	0	0	0	0	0	0	0	0	0
Coffee	1	3	1	0	0	0	0	0	0	0	0	0	0
Colquitt	3	2	0	0	0	0	0	0	0	0	0	0	0
Columbia	9	5	0	0	0	0	0	0	0	0	0	0	0

Cook	0	2	0	0	0	0	0	0	0	0	0	0	0
Coweta	113	190	41	0	0	0	0	0	0	0	0	0	0
Crisp	14	1	0	0	0	0	0	0	0	0	0	0	0
Dade	1	3	0	0	0	0	0	0	0	0	0	0	0
Dawson	63	79	16	0	0	0	0	0	0	0	0	0	0
Decatur	0	1	0	0	0	0	0	0	0	0	0	0	0
Dekalb	8,014	2,411	4,066	0	0	0	0	0	0	0	0	0	0
Dodge	1	2	0	0	0	0	0	0	0	0	0	0	0
Dooly	2	2	0	0	0	0	0	0	0	0	0	0	0
Dougherty	14	18	1	0	0	0	0	0	0	0	0	0	0
Douglas	447	243	171	0	0	0	0	0	0	0	0	0	0
Effingham	4	0	3	0	0	0	0	0	0	0	0	0	0
Elbert	1	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	45	33	1	0	0	0	0	0	0	0	0	0	0
Fayette	208	193	55	0	0	0	0	0	0	0	0	0	0
Florida	93	131	8	0	0	0	0	0	0	0	0	0	0
Floyd	38	40	15	0	0	0	0	0	0	0	0	0	0
Forsyth	687	659	331	0	0	0	0	0	0	0	0	0	0
Franklin	2	6	0	0	0	0	0	0	0	0	0	0	0
Fulton	8,911	4,760	4,225	0	0	0	0	0	0	0	0	0	0
Gilmer	41	33	3	0	0	0	0	0	0	0	0	0	0
Glynn	3	4	1	0	0	0	0	0	0	0	0	0	0
Gordon	29	21	9	0	0	0	0	0	0	0	0	0	0
Grady	2	0	0	0	0	0	0	0	0	0	0	0	0
Greene	12	40	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	5,276	2,188	3,333	0	0	0	0	0	0	0	0	0	0
Habersham	18	21	3	0	0	0	0	0	0	0	0	0	0
Hall	165	171	37	0	0	0	0	0	0	0	0	0	0
Hancock	4	3	1	0	0	0	0	0	0	0	0	0	0
Haralson	28	30	7	0	0	0	0	0	0	0	0	0	0
Harris	4	8	1	0	0	0	0	0	0	0	0	0	0
Hart	1	6	0	0	0	0	0	0	0	0	0	0	0
Heard	5	8	0	0	0	0	0	0	0	0	0	0	0
Henry	548	437	133	0	0	0	0	0	0	0	0	0	0
Houston	15	31	2	0	0	0	0	0	0	0	0	0	0
Jackson	60	75	16	0	0	0	0	0	0	0	0	0	0
Jasper	9	13	4	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Johnson	0	1	0	0	0	0	0	0	0	0	0	0	0
Jones	2	2	0	0	0	0	0	0	0	0	0	0	0
Lamar	24	10	4	0	0	0	0	0	0	0	0	0	0
Laurens	4	7	1	0	0	0	0	0	0	0	0	0	0
Lee	1	10	1	0	0	0	0	0	0	0	0	0	0
Liberty	4	1	2	0	0	0	0	0	0	0	0	0	0

Lincoln	0	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	20	12	13	0	0	0	0	0	0	0	0	0	0
Lumpkin	17	36	0	0	0	0	0	0	0	0	0	0	0
Macon	4	2	0	0	0	0	0	0	0	0	0	0	0
Madison	8	5	1	0	0	0	0	0	0	0	0	0	0
Marion	1	0	1	0	0	0	0	0	0	0	0	0	0
Mcduffie	0	2	0	0	0	0	0	0	0	0	0	0	0
Meriwether	15	11	0	0	0	0	0	0	0	0	0	0	0
Miller	0	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	1	2	0	0	0	0	0	0	0	0	0	0	0
Monroe	8	8	0	0	0	0	0	0	0	0	0	0	0
Montgomery	0	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	15	12	3	0	0	0	0	0	0	0	0	0	0
Murray	8	15	0	0	0	0	0	0	0	0	0	0	0
Muscogee	41	24	16	0	0	0	0	0	0	0	0	0	0
Newton	207	143	57	0	0	0	0	0	0	0	0	0	0
North Carolina	79	80	6	0	0	0	0	0	0	0	0	0	0
Oconee	13	18	4	0	0	0	0	0	0	0	0	0	0
Oglethorpe	0	3	0	0	0	0	0	0	0	0	0	0	0
Other Out Of State	373	321	86	0	0	0	0	0	0	0	0	0	0
Paulding	317	186	140	0	0	0	0	0	0	0	0	0	0
Peach	12	3	0	0	0	0	0	0	0	0	0	0	0
Pickens	116	100	29	0	0	0	0	0	0	0	0	0	0
Pike	22	18	1	0	0	0	0	0	0	0	0	0	0
Polk	34	18	8	0	0	0	0	0	0	0	0	0	0
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0	0
Putnam	6	17	0	0	0	0	0	0	0	0	0	0	0
Rabun	9	7	1	0	0	0	0	0	0	0	0	0	0
Randolph	0	2	0	0	0	0	0	0	0	0	0	0	0
Richmond	3	9	2	0	0	0	0	0	0	0	0	0	0
Rockdale	266	122	70	0	0	0	0	0	0	0	0	0	0
Schley	0	2	0	0	0	0	0	0	0	0	0	0	0
South Carolina	87	70	8	0	0	0	0	0	0	0	0	0	0
Spalding	77	74	8	0	0	0	0	0	0	0	0	0	0
Stephens	8	8	0	0	0	0	0	0	0	0	0	0	0
Stewart	2	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	3	5	1	0	0	0	0	0	0	0	0	0	0
Talbot	1	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	0	1	0	0	0	0	0	0	0	0	0	0
Taylor	1	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	0	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	48	75	7	0	0	0	0	0	0	0	0	0	0
Terrell	3	2	2	0	0	0	0	0	0	0	0	0	0
Thomas	0	6	0	0	0	0	0	0	0	0	0	0	0

Tift	3	6	0	0	0	0	0	0	0	0	0	0	0
Toombs	1	6	1	0	0	0	0	0	0	0	0	0	0
Towns	17	16	1	0	0	0	0	0	0	0	0	0	0
Troup	31	24	5	0	0	0	0	0	0	0	0	0	0
Turner	1	3	0	0	0	0	0	0	0	0	0	0	0
Union	37	27	2	0	0	0	0	0	0	0	0	0	0
Upson	14	18	0	0	0	0	0	0	0	0	0	0	0
Walker	1	3	1	0	0	0	0	0	0	0	0	0	0
Walton	267	169	88	0	0	0	0	0	0	0	0	0	0
Ware	2	2	0	0	0	0	0	0	0	0	0	0	0
Washington	2	0	0	0	0	0	0	0	0	0	0	0	0
White	5	15	0	0	0	0	0	0	0	0	0	0	0
Whitfield	15	30	2	0	0	0	0	0	0	0	0	0	0
Wilcox	1	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	2	1	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	1	1	0	0	0	0	0	0	0	0	0	0	0
Worth	2	4	0	0	0	0	0	0	0	0	0	0	0
Total	35,748	17,983	17,003	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	11	30
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	11	30

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	14,770	22,402	32,723
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	14,770	22,402	32,723

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	5,300	6,594	12,683
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	5,300	6,594	12,683

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	69
Asian	483
Black/African American	4,150
Hispanic/Latino	934
Pacific Islander/Hawaiian	1
White	11,333
Multi-Racial	1,013
Total	17,983

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	76
Ages 15-64	14,903
Ages 65-74	2,226
Ages 75-85	654
Ages 85 and Up	124
Total	17,983

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,166
Female	13,817
Total	17,983

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,765
Medicaid	608
Third-Party	12,451
Self-Pay	2,159

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 6

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 42
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 6,402
6. Total Live Births: 16,246
7. Total Births (Live and Late Fetal Deaths): 16,398
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 17,536

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)	215	15,076	48,013	1,005
Specialty Care (Intermediate Neonatal Care)	45	841	13,022	536
Subspecialty Care (Intensive Neonatal Care)	30	387	5,911	64

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	91	317
Asian	1,733	5,816
Black/African American	4,898	19,120
Hispanic/Latino	3,361	10,395
Pacific Islander/Hawaiian	4	11
White	6,225	20,862
Multi-Racial	691	2,345
Total	17,003	58,866

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	2	6
Ages 15-44	16,941	58,436
Ages 45 and Up	60	424
Total	17,003	58,866

3. Average Charge for an Uncomplicated Delivery

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

\$12,538.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$35,160.00

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	<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	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? 6.8000001907349 (FTE's)

What languages do they interpret?

Spanish, Portuguese, French, Russian, Mandarin, Cantonese, Vietnamese, and 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 Interpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

1) In-person agency interpreters and 2) video remote interpretation available on demand via 400 iPads throughout the organization

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	1.7	0	0	0
Vietnamese	0.13	0	0	0
Mandarin	0.12	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?

New-hires complete a CBL course prior to orientation. New-hire orientation includes a segment

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
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1. Payers

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

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

2. Uncompensated Indigent and Charity Care

Please report the number of inpatient 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 inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Robert Quattrocchi

Date: 3/3/2017

Title: Chief Executive Officer

Comments:

NOTES ABOUT THIS SURVEY:

Various Areas of the AHQ and Addenda: Race/Ethnicity of Patients: The determination of a patient's race is based on the discretion of the admissions clerk. If the admissions clerk is unsure of the patient's race, the clerk must choose "Multi-racial/Unknown". In addition, "Hispanic" or "Latino" are ethnic characteristics, meaning that Hispanic patients may be of any race. As such, the figures provided should be considered only a very rough approximation of true utilization by race at Northside Hospital.

Part D, Item 1: Utilization of Beds: Critical Care Admissions and Discharges: The figures provided represent direct admissions to and direct discharges from critical care beds only. Length of stay in critical care beds cannot be accurately calculated using direct admissions and discharges because these figures do not represent all patients who spent time in a critical care bed (e.g., patients transferred from other units), while inpatient days and discharge days do reflect all occupied bed days.

Part D, Item 4: Government Payment Source: Medicare admissions and days include Medicare managed care, while Medicaid admissions and days include Medicaid managed care.

Part E, Item 1: Emergency Visits to the Hospital: Consistent with past surveys dating back to 2003, based on instructions from DCH staff, only outpatient visits to the ER are to be included in this figure. Total ER visits thus would equal the sum of Lines E.1. and E.2.

Part E, Item 7: Total Observation Visits: Observation patients seen in the Emergency Department are included as Emergency Room visits are not reflected in this total. Total Observation Visits includes all 23-hour patients (observation and extended recovery) served outside of the ED.

Part E, Item 8: ER Diversions: Northside does not track this information.

Part F, Item 1: Services & Facilities: "ESWL": Northside contracts with two different companies for this service. Each company provides a transportable unit at either Northside Hospital or Northside's Meridian Mark Outpatient Center one or more days per week. No more than one unit is on site at either location on any given day.

Part F, Item 1: Services & Facilities: "Other Organ/Tissues Transplants" represents Bone Marrow Transplants.

Part F, Item 1: Respiratory Therapy Treatments: Beginning with the 2009 survey, Northside began using UB codes to determine the number of respiratory therapy treatments.

Part F, Item 1: Ultrasound units and procedures: Per instructions from DCH staff, ultrasound procedures include only diagnostic ultrasounds and exclude prenatal ultrasounds.

Part F, Item 1: Robotic surgery procedures are determined by ICD-9 and ICD-10 codes.

Part F, Item 2: Medical Ventilators: The figure reported includes both adult and infant ventilators.

Part G, Item 1: Budgeted and vacant budgeted FTE figures are estimated.

Part G, Medical Staff Info.: Please note that the medical staffs of Northside Hospital and Northside Hospital - Forsyth have been merged and are thus identical. Northside Hospital does not maintain data regarding the race/ethnicity of its medical staff. Northside does not have figures on medical staff enrolled in Medicaid or PEHB.

Part G, Item 5: Oral surgeons are members of the medical staff. Consistent with past surveys, these

are included in the "Other Surgical Specialties" category.

Part G, Item 5: Other Staff Affiliates are employed by physicians on staff. None can function independently, and thus do not have "privileges" by Northside's definition. These staff have "clinical functions", not clinical privileges.

Surgical Services Addendum, Part A, Item 1: Consistent with our prior surveys, the operating rooms reported here are sterile rooms only.

Perinatal Addendum, Part A: As we have done on past surveys, we have reported the number of C-section rooms under "Number of Delivery Rooms".

Perinatal Addendum, Part C3: Northside does not assign CPT codes to inpatients. This average charge represents those patients classified under MS-DRG 775.

Minority Health Addendum, Item 3: Northside does not have information on the number of physicians, nurses, and other staff who speak the languages listed.

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