GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP706

Facility Name: Emory University Hospital

County: DeKalb

Street Address: 1364 Clifton Road, NE

City: Atlanta

Zip: 30322-1061

Mailing Address: 1364 Clifton Road, NE

Mailing City: Atlanta

Mailing Zip: 30322-1061

Medicaid Provider Number: 0000712

Medicare Provider Number: 110010

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
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: Miranda Chennault

Contact Title: Controller

Phone: 404-686-6015

Fax: 404-686-6030

E-mail: Miranda.Chennault@emoryhealthcare.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

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

A. Facility Owner

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

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Healthcare, Inc.	Not for Profit	1/1/1922

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Emory Healthcare
City: Atlanta **State:** 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: Vizient
City: Irving **State:** Texas

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Emory Healthcare
City: Atlanta **State:** Georgia

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(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)

N/A

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)	0	0	0	0	0
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	408	22,780	155,197	22,799	158,409
Intensive Care	120	1,658	18,206	1,645	18,768
Psychiatry	44	1,130	8,456	1,116	8,054
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	16	1	15	1	15
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	**588**	**25,569**	**181,874**	**25,561**	**185,246**

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	52	537
Asian	538	3,911
Black/African American	10,781	78,262
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	37	279
White	13,312	91,253
Multi-Racial	849	7,632
Total	**25,569**	**181,874**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	12,274	90,066
Female	13,295	91,808
Total	**25,569**	**181,874**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	12,805	90,471
Medicaid	2,516	19,889
Peachare	0	0
Third-Party	8,529	58,447
Self-Pay	1,422	11,420
Other	297	1,647

5. Discharges to Death

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

589

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,657
Semi-Private Room Rate	1,651
Operating Room: Average Charge for the First Hour	6,540
Average Total Charge for an Inpatient Day	10,481

Part E : Emergency Department and Outpatient Services

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

50,812

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

12,763

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

45

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	2	1,025
General Beds	43	49,787
	0	0
	0	0
	0	0
	0	0

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

708

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

136,287

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

6,040

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

723.00

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.

562

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	1	1
ESWL	1	1
Billiary Lithotropter	1	1
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	2	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	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	0
Number of Dialysis Treatments	6,817
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	294
Number of Heart Transplants	31
Number of Other-Organ/Tissues Treatments	365
Number of Diagnostic X-Ray Procedures	194,915
Number of CTS Units (machines)	8
Number of CTS Procedures	56,694
Number of Diagnostic Radioisotope Procedures	5,434
Number of PET Units (machines)	2
Number of PET Procedures	5,453
Number of Therapeautic Radioisotope Procedures	45,143
Number of Number of MRI Units	9
Number of Number of MRI Procedures	40,436
Number of Chemotherapy Treatments	216
Number of Respiratory Therapy Treatments	212,738
Number of Occupational Therapy Treatments	14,761
Number of Physical Therapy Treatments	25,337
Number of Speech Pathology Patients	8,711
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	6,981
Number of HIV/AIDS Patients	99
Number of Ambulance Trips	0
Number of Hospice Patients	599
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	27,159
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).

110

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
2	470	Davinci SI and Davinci XI

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,528.90	219.60	51.00
Licensed Practical Nurses (LPNs)	36.10	2.00	0.00
Pharmacists	82.00	0.50	0.00
Other Health Services Professionals*	1,401.20	92.40	14.00
Administration and Support	222.60	9.00	0.00
All Other Hospital Personnel (not included above)	646.70	38.40	0.00

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)	More than 90 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	30 Days or Less
Other Health Services Professionals	More than 90 Days
All Other Hospital Personnel (not included above)	61-90 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

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

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit 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	0	☐	0	0
General Internal Medicine	35	☐	0	0
Pediatricians	1	☐	0	0
Other Medical Specialties	533	☑	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	36	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	7	☐	0	0
Ophthalmology Surgery	42	☐	0	0
Orthopedic Surgery	36	☐	0	0
Plastic Surgery	11	☐	0	0
General Surgery	56	☐	0	0
Thoracic Surgery	22	☐	0	0
Other Surgical Specialties	56	☑	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	147	☑	0	0
Dermatology	18	☐	0	0
Emergency Medicine	121	☑	0	0
Nuclear Medicine	9	☑	0	0
Pathology	51	☑	0	0
Psychiatry	46	☐	0	0
Radiology	133	☑	0	0
Hopsitalists	89	☑	0	0
Radiation Oncology	25	☐	0	0
Cardiovascular Disease	50	☐	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	9
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	676

5b. Name of Other Professions

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

Physician Assistants, Nurse Practitioners, Surgical Assistants, Certified Registered Nurse Anesthetist

Comments and Suggestions:

Part G: #3 Physician race/ethnicity is not tracked.
Part G: #4 Emory University Hospital and Emory Orthopedics & Spine Hospital share the same medical roster.

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	487	63	0	13	0	0	0	0	0	0	0	0	0
Appling	15	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	11	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	3	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	70	13	0	3	0	0	0	0	0	0	0	0	0
Banks	11	5	0	0	0	0	0	0	0	0	0	0	0
Barrow	152	23	0	3	0	0	0	0	0	0	0	0	0
Bartow	155	31	0	5	0	0	0	0	0	0	0	0	0
Ben Hill	24	1	0	0	0	0	0	0	0	0	0	0	0
Berrien	25	4	0	0	0	0	0	0	0	0	0	0	0
Bibb	219	22	0	5	0	0	0	0	0	0	0	0	0
Bleckley	11	2	0	1	0	0	0	0	0	0	0	0	0
Brantley	6	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	5	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	20	1	0	1	0	0	0	0	0	0	0	0	0
Bulloch	26	6	0	0	0	0	0	0	0	0	0	0	0
Burke	4	1	0	0	0	0	0	0	0	0	0	0	0
Butts	92	14	0	1	0	0	0	0	0	0	0	0	0
Calhoun	16	2	0	0	0	0	0	0	0	0	0	0	0
Camden	3	0	0	1	0	0	0	0	0	0	0	0	0
Candler	2	0	0	1	0	0	0	0	0	0	0	0	0
Carroll	335	43	0	7	0	0	0	0	0	0	0	0	0
Catoosa	22	5	0	2	0	0	0	0	0	0	0	0	0
Charlton	5	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	79	10	0	3	0	0	0	0	0	0	0	0	0
Chattahoochee	5	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	16	5	0	0	0	0	0	0	0	0	0	0	0

Cherokee	335	62	0	10	0	0	0	0	0	0	0	0	0
Clarke	149	21	0	9	0	0	0	0	0	0	0	0	0
Clay	4	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	839	131	0	48	0	0	0	0	0	0	0	0	0
Clinch	3	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,151	211	0	67	0	0	0	0	0	0	0	0	0
Coffee	38	3	0	0	0	0	0	0	0	0	0	0	0
Colquitt	24	5	0	2	0	0	0	0	0	0	0	0	0
Columbia	54	6	0	0	0	0	0	0	0	0	0	0	0
Cook	24	3	0	0	0	0	0	0	0	0	0	0	0
Coweta	275	59	0	16	0	0	0	0	0	0	0	0	0
Crawford	2	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	28	4	0	4	0	0	0	0	0	0	0	0	0
Dade	5	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	43	13	0	0	0	0	0	0	0	0	0	0	0
Decatur	16	10	0	1	0	0	0	0	0	0	0	0	0
DeKalb	7,380	1,141	0	280	0	0	0	0	0	0	0	0	0
Dodge	19	1	0	3	0	0	0	0	0	0	0	0	0
Dooly	11	1	0	1	0	0	0	0	0	0	0	0	0
Dougherty	94	12	0	0	0	0	0	0	0	0	0	0	0
Douglas	302	52	0	9	0	0	0	0	0	0	0	0	0
Early	2	4	0	0	0	0	0	0	0	0	0	0	0
Effingham	14	1	0	0	0	0	0	0	0	0	0	0	0
Elbert	22	5	0	1	0	0	0	0	0	0	0	0	0
Emanuel	3	1	0	0	0	0	0	0	0	0	0	0	0
Evans	3	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	47	8	0	2	0	0	0	0	0	0	0	0	0
Fayette	257	66	0	13	0	0	0	0	0	0	0	0	0
Florida	191	28	0	6	0	0	0	0	0	0	0	0	0
Floyd	141	21	0	9	0	0	0	0	0	0	0	0	0
Forsyth	161	48	0	12	0	0	0	0	0	0	0	0	0
Franklin	41	4	0	0	0	0	0	0	0	0	0	0	0
Fulton	3,173	610	0	360	0	0	0	0	0	0	0	0	0
Gilmer	22	4	0	1	0	0	0	0	0	0	0	0	0
Glynn	33	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	75	11	0	3	0	0	0	0	0	0	0	0	0
Grady	14	3	0	0	0	0	0	0	0	0	0	0	0
Greene	47	7	0	3	0	0	0	0	0	0	0	0	0
Gwinnett	2,033	383	0	59	0	0	0	0	0	0	0	0	0
Habersham	74	21	0	0	0	0	0	0	0	0	0	0	0
Hall	291	49	0	6	0	0	0	0	0	0	0	0	0
Hancock	15	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	89	5	0	2	0	0	0	0	0	0	0	0	0
Harris	59	8	0	3	0	0	0	0	0	0	0	0	0

Hart	37	3	0	2	0	0	0	0	0	0	0	0	0
Heard	22	3	0	0	0	0	0	0	0	0	0	0	0
Henry	866	171	0	21	0	0	0	0	0	0	0	0	0
Houston	236	20	0	0	0	0	0	0	0	0	0	0	0
Irwin	14	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	186	38	0	3	0	0	0	0	0	0	0	0	0
Jasper	25	5	0	1	0	0	0	0	0	0	0	0	0
Jeff Davis	10	3	0	0	0	0	0	0	0	0	0	0	0
Jefferson	7	1	0	1	0	0	0	0	0	0	0	0	0
Jenkins	6	1	0	1	0	0	0	0	0	0	0	0	0
Johnson	10	0	0	0	0	0	0	0	0	0	0	0	0
Jones	21	5	0	1	0	0	0	0	0	0	0	0	0
Lamar	50	13	0	0	0	0	0	0	0	0	0	0	0
Lanier	4	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	56	10	0	0	0	0	0	0	0	0	0	0	0
Lee	33	3	0	1	0	0	0	0	0	0	0	0	0
Liberty	8	0	0	0	0	0	0	0	0	0	0	0	0
Long	2	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	64	9	0	1	0	0	0	0	0	0	0	0	0
Lumpkin	41	16	0	2	0	0	0	0	0	0	0	0	0
Macon	15	1	0	1	0	0	0	0	0	0	0	0	0
Madison	35	5	0	0	0	0	0	0	0	0	0	0	0
Marion	13	5	0	0	0	0	0	0	0	0	0	0	0
McDuffie	5	1	0	0	0	0	0	0	0	0	0	0	0
McIntosh	8	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	59	6	0	2	0	0	0	0	0	0	0	0	0
Miller	3	2	0	0	0	0	0	0	0	0	0	0	0
Mitchell	26	1	0	0	0	0	0	0	0	0	0	0	0
Monroe	37	3	0	0	0	0	0	0	0	0	0	0	0
Montgomery	7	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	45	11	0	1	0	0	0	0	0	0	0	0	0
Murray	60	9	0	1	0	0	0	0	0	0	0	0	0
Muscogee	276	40	0	5	0	0	0	0	0	0	0	0	0
Newton	393	69	0	9	0	0	0	0	0	0	0	0	0
North Carolina	129	19	0	6	0	0	0	0	0	0	0	0	0
Oconee	41	7	0	1	0	0	0	0	0	0	0	0	0
Oglethorpe	11	4	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	337	38	0	36	0	0	0	0	0	0	0	0	0
Paulding	151	24	0	0	0	0	0	0	0	0	0	0	0
Peach	52	7	0	0	0	0	0	0	0	0	0	0	0
Pickens	45	8	0	2	0	0	0	0	0	0	0	0	0
Pierce	5	0	0	0	0	0	0	0	0	0	0	0	0
Pike	55	10	0	1	0	0	0	0	0	0	0	0	0
Polk	77	8	0	1	0	0	0	0	0	0	0	0	0

Pulaski	10	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	34	6	0	0	0	0	0	0	0	0	0	0	0
Quitman	2	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	27	2	0	5	0	0	0	0	0	0	0	0	0
Randolph	6	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	50	7	0	2	0	0	0	0	0	0	0	0	0
Rockdale	408	62	0	9	0	0	0	0	0	0	0	0	0
Schley	6	2	0	0	0	0	0	0	0	0	0	0	0
Screven	16	0	0	2	0	0	0	0	0	0	0	0	0
Seminole	3	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	254	36	0	3	0	0	0	0	0	0	0	0	0
Spalding	204	32	0	5	0	0	0	0	0	0	0	0	1
Stephens	56	5	0	2	0	0	0	0	0	0	0	0	0
Stewart	6	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	39	3	0	0	0	0	0	0	0	0	0	0	0
Talbot	9	1	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	4	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	30	0	0	2	0	0	0	0	0	0	0	0	0
Telfair	22	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	150	18	0	3	0	0	0	0	0	0	0	0	0
Terrell	8	0	0	1	0	0	0	0	0	0	0	0	0
Thomas	32	1	0	1	0	0	0	0	0	0	0	0	0
Tift	81	3	0	1	0	0	0	0	0	0	0	0	0
Toombs	12	1	0	0	0	0	0	0	0	0	0	0	0
Towns	24	4	0	0	0	0	0	0	0	0	0	0	0
Treutlen	3	0	0	0	0	0	0	0	0	0	0	0	0
Troup	188	36	0	7	0	0	0	0	0	0	0	0	0
Turner	30	5	0	0	0	0	0	0	0	0	0	0	0
Twiggs	11	1	0	0	0	0	0	0	0	0	0	0	0
Union	37	5	0	0	0	0	0	0	0	0	0	0	0
Upson	77	12	0	1	0	0	0	0	0	0	0	0	0
Walker	31	6	0	0	0	0	0	0	0	0	0	0	0
Walton	436	71	0	6	0	0	0	0	0	0	0	0	0
Ware	8	0	0	0	0	0	0	0	0	0	0	0	0
Warren	6	0	0	0	0	0	0	0	0	0	0	0	0
Washington	12	2	0	0	0	0	0	0	0	0	0	0	0
Wayne	13	2	0	0	0	0	0	0	0	0	0	0	0
Webster	2	1	0	0	0	0	0	0	0	0	0	0	0
Wheeler	6	0	0	0	0	0	0	0	0	0	0	0	0
White	42	14	0	1	0	0	0	0	0	0	0	0	0
Whitfield	111	14	0	3	0	0	0	0	0	0	0	0	0
Wilcox	13	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	9	2	0	0	0	0	0	0	0	0	0	0	0

Wilkinson	12	0	0	0	0	0	0	0	0	0	0	0	0
Worth	23	3	0	0	0	0	0	0	0	0	0	0	0
Total	**25,569**	**4,223**	**0**	**1,130**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**

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	25
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**26**

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	6,986	3,582
Cystoscopy	0	0	147	660
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**7,133**	**4,242**

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	6,131	3,563
Cystoscopy	0	0	133	660
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**6,264**	**4,223**

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	10
Asian	116
Black/African American	1,518
Hispanic/Latino	0
Pacific Islander/Hawaiian	15
White	2,386
Multi-Racial	178
Total	**4,223**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	2
Ages 15-64	2,829
Ages 65-74	857
Ages 75-85	465
Ages 85 and Up	70
Total	**4,223**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,644
Female	2,579
Total	**4,223**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,690
Medicaid	387
Third-Party	2,058
Self-Pay	88

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: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

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

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

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

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

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

$0.00

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

$0.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

0

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation: 0

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	64	44
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	1,130	8,456	1,116	8,054	3,036	☑
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	1	4
Asian	23	192
Black/African American	517	3,802
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	2	6
White	459	3,422
Multi-Racial	128	1,030
Total	**1,130**	**8,456**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	550	4,135
Female	580	4,321
Total	**1,130**	**8,456**

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	382	3,391
Medicaid	410	3,212
Third Party	329	1,768
Self-Pay	9	85
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 2.5999999046326 (FTE's)
What languages do they interpret?
Spanish, Korean, Vietnamese

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): ☑

Cyracom Language Services over the phone offers 310 Languages 24/7. Video Remote Interpreter. Laptop offer 39l languages with 8 that are 24/7 Agency Interpreters (we have contracts with several agencies that provide several languages).

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	1.09	0	0	0
Korean	0.18	0	0	0
Veitnamese	0.14	0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

Emory Staff receives In-Services twice a year. New employees receive the information during their orientation. There are groups at EHC that are working on how to increase Cultural Competence and Diversity. There also is an HLC online class for Cultural competency and there is an Interpretation Services HLC online class as part of the yearly regulatory modules that all employees have to complete.

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?

Awareness across the system of the new law ACA section 1557 , for Administration to relate to all leaders how important it is to provide and comply with these services, to centralize the interpretation department in order to provide the same services across the system, add staff and other auxiliary aids to the interpretation department.

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

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

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

Grady Walk-In Center
56 Jesse Hill Jr Drive SE
Atlanta, GA 30303

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	1	15
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	1	15

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	1	15
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	1
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	1

2. Uncompensated Indigent and Charity Care

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

1

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	1
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: Bryce Gartland, MD

Date: 3/12/2019

Title: CEO, EUH

Comments: