GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:hosp541

Facility Name: Northside Hospital - Cherokee

County: Cherokee

Street Address: 450 Northside Cherokee Boulevard

City: Canton

Zip: 30115

Mailing Address: 450 Northside Cherokee Boulevard

Mailing City: Canton

Mailing Zip: 30115

Medicaid Provider Number: 00001108

Medicare Provider Number: 110008

2. Report Period

Report Data for the full twelve month period- January 1, 2019 through December 31, 2019.
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: 404-250-3102

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
Northside Hospital, Inc.	Not for Profit	1/1/2010

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Hospital, Inc.	Not for Profit	1/1/2010

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Northside Health Services, Inc.	Not for Profit	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 Hospitals; VHA
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: SuperMed 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(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)	18	2,192	6,491	2,189	6,512
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	125	6,833	40,465	6,818	40,682
Intensive Care	15	2,044	8,690	2,070	8,887
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	**158**	**11,069**	**55,646**	**11,077**	**56,081**

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	81	351
Asian	50	200
Black/African American	658	3,242
Hispanic/Latino	646	2,547
Pacific Islander/Hawaiian	2	6
White	8,989	45,511
Multi-Racial	643	3,789
Total	**11,069**	**55,646**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	4,183	22,538
Female	6,886	33,108
Total	**11,069**	**55,646**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,514	31,622
Medicaid	1,341	5,782
Peachare	0	0
Third-Party	3,113	12,920
Self-Pay	999	4,934
Other	102	388

5. Discharges to Death

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

237

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2019 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,439
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	9,929
Average Total Charge for an Inpatient Day	12,952

Part E : Emergency Department and Outpatient Services

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

53,419

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

8,006

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

33

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	33	61,425
	0	0
	0	0
	0	0

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

1,598

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

139,097

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

1,362

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

12.00

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.

762

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	1	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	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	666
Number of Dialysis Treatments	1,375
Number of ESWL Patients	110
Number of ESWL Procedures	110
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	57,889
Number of CTS Units (machines)	8
Number of CTS Procedures	41,822
Number of Diagnostic Radioisotope Procedures	1,555
Number of PET Units (machines)	1
Number of PET Procedures	1,775
Number of Therapeautic Radioisotope Procedures	30
Number of Number of MRI Units	6
Number of Number of MRI Procedures	11,529
Number of Chemotherapy Treatments	1,792
Number of Respiratory Therapy Treatments	66,853
Number of Occupational Therapy Treatments	27,290
Number of Physical Therapy Treatments	58,630
Number of Speech Pathology Patients	2,170
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,117
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	14
Number of Ultrasound/Medical Sonography Procedures	19,094
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).

45

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
3	884	3 da Vinci 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 12-31-2019. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2019.

Profession	Profession	Profession	Profession
Licensed Physicians	43.40	1.00	1.73
Physician Assistants Only (not including Licensed Physicians)	5.00	0.50	0.00
Registered Nurses (RNs-Advanced Practice*)	724.85	80.13	14.69
Licensed Practical Nurses (LPNs)	26.25	0.00	0.00
Pharmacists	36.90	2.00	0.00
Other Health Services Professionals*	522.80	77.52	5.41
Administration and Support	493.80	33.20	4.75
All Other Hospital Personnel (not included above)	174.90	7.60	0.69

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	61-90 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 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	90	☐	0	0
General Internal Medicine	251	☑	0	0
Pediatricians	176	☑	0	0
Other Medical Specialties	405	☐	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	186	☑	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	60	☐	0	0
Ophthalmology Surgery	79	☐	0	0
Orthopedic Surgery	94	☐	0	0
Plastic Surgery	53	☐	0	0
General Surgery	78	☑	0	0
Thoracic Surgery	5	☐	0	0
Other Surgical Specialties	144	☐	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	81	☑	0	0
Dermatology	12	☐	0	0
Emergency Medicine	67	☑	0	0
Nuclear Medicine	145	☑	0	0
Pathology	29	☑	0	0
Psychiatry	9	☐	0	0
Radiology	92	☑	0	0
Radiation Oncology	21	☐	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	40
Podiatrists	35
Certified Nurse Midwives with Clinical Privileges in the Hospital	76
All Other Staff Affiliates with Clinical Privileges in the Hospital	948

5b. Name of Other Professions

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

CAA/CRNA; CNP; PAC

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	17	14	0	0	0	0	0	0	0	0	0	0	0
Baldwin	1	2	0	0	0	0	0	0	0	0	0	0	0
Banks	2	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	2	0	0	0	0	0	0	0	0	0	0	0	0
Bartow	237	246	69	0	0	0	0	0	0	0	0	0	0
Ben Hill	0	1	0	0	0	0	0	0	0	0	0	0	0
Berrien	0	2	0	0	0	0	0	0	0	0	0	0	0
Bibb	1	3	1	0	0	0	0	0	0	0	0	0	0
Carroll	23	25	0	0	0	0	0	0	0	0	0	0	0
Catoosa	3	2	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	3	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	4	3	1	0	0	0	0	0	0	0	0	0	0
Cherokee	7,685	4,939	1,447	0	0	0	0	0	0	0	0	0	0
Clarke	3	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	3	7	2	0	0	0	0	0	0	0	0	0	0
Cobb	762	865	181	0	0	0	0	0	0	0	0	0	0
Coffee	1	1	0	0	0	0	0	0	0	0	0	0	0
Colquitt	1	0	0	0	0	0	0	0	0	0	0	0	0
Cook	0	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	7	7	2	0	0	0	0	0	0	0	0	0	0
Crisp	1	1	1	0	0	0	0	0	0	0	0	0	0
Dawson	45	29	10	0	0	0	0	0	0	0	0	0	0
Dekalb	37	23	3	0	0	0	0	0	0	0	0	0	0
Dodge	1	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	0	2	0	0	0	0	0	0	0	0	0	0	0
Douglas	17	33	3	0	0	0	0	0	0	0	0	0	0

Effingham	0	1	0	0	0	0	0	0	0	0	0	0	0
Elbert	0	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	192	186	37	0	0	0	0	0	0	0	0	0	0
Fayette	4	13	1	0	0	0	0	0	0	0	0	0	0
Florida	45	20	2	0	0	0	0	0	0	0	0	0	0
Floyd	19	36	3	0	0	0	0	0	0	0	0	0	0
Forsyth	52	89	8	0	0	0	0	0	0	0	0	0	0
Fulton	176	202	17	0	0	0	0	0	0	0	0	0	0
Gilmer	445	445	141	0	0	0	0	0	0	0	0	0	0
Glynn	1	0	0	0	0	0	0	0	0	0	0	0	0
Gordon	67	77	11	0	0	0	0	0	0	0	0	0	0
Grady	0	1	0	0	0	0	0	0	0	0	0	0	0
Greene	1	0	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	25	59	3	0	0	0	0	0	0	0	0	0	0
Habersham	2	7	0	0	0	0	0	0	0	0	0	0	0
Hall	13	18	2	0	0	0	0	0	0	0	0	0	0
Haralson	1	2	0	0	0	0	0	0	0	0	0	0	0
Harris	1	2	0	0	0	0	0	0	0	0	0	0	0
Hart	1	0	0	0	0	0	0	0	0	0	0	0	0
Henry	7	9	3	0	0	0	0	0	0	0	0	0	0
Houston	1	1	1	0	0	0	0	0	0	0	0	0	0
Jackson	4	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Jones	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	1	1	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	6	9	0	0	0	0	0	0	0	0	0	0	0
Marion	0	1	0	0	0	0	0	0	0	0	0	0	0
Mcduffie	0	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	1	0	1	0	0	0	0	0	0	0	0	0	0
Montgomery	1	0	1	0	0	0	0	0	0	0	0	0	0
Morgan	1	0	0	0	0	0	0	0	0	0	0	0	0
Murray	17	12	7	0	0	0	0	0	0	0	0	0	0
Muscogee	3	0	0	0	0	0	0	0	0	0	0	0	0
Newton	4	3	0	0	0	0	0	0	0	0	0	0	0
North Carolina	41	35	6	0	0	0	0	0	0	0	0	0	0
Oglethorpe	1	1	0	0	0	0	0	0	0	0	0	0	0
Other Out Of State	88	39	11	0	0	0	0	0	0	0	0	0	0
Paulding	77	106	19	0	0	0	0	0	0	0	0	0	0
Peach	0	1	0	0	0	0	0	0	0	0	0	0	0
Pickens	778	668	178	0	0	0	0	0	0	0	0	0	0
Pierce	0	1	0	0	0	0	0	0	0	0	0	0	0
Pike	1	1	0	0	0	0	0	0	0	0	0	0	0
Polk	22	30	5	0	0	0	0	0	0	0	0	0	0
Rabun	0	2	0	0	0	0	0	0	0	0	0	0	0

Richmond	0	2	0	0	0	0	0	0	0	0	0	0	0
Rockdale	3	2	0	0	0	0	0	0	0	0	0	0	0
South Carolina	13	6	4	0	0	0	0	0	0	0	0	0	0
Spalding	0	1	0	0	0	0	0	0	0	0	0	0	0
Stephens	2	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	2	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	27	27	0	0	0	0	0	0	0	0	0	0	0
Tift	2	1	0	0	0	0	0	0	0	0	0	0	0
Towns	21	12	0	0	0	0	0	0	0	0	0	0	0
Troup	0	1	0	0	0	0	0	0	0	0	0	0	0
Turner	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	31	58	7	0	0	0	0	0	0	0	0	0	0
Walker	2	1	1	0	0	0	0	0	0	0	0	0	0
Walton	2	5	2	0	0	0	0	0	0	0	0	0	0
Ware	0	1	0	0	0	0	0	0	0	0	0	0	0
White	2	5	0	0	0	0	0	0	0	0	0	0	0
Whitfield	6	7	1	0	0	0	0	0	0	0	0	0	0
Wilkinson	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**11,069**	**8,421**	**2,192**	**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	3	15
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**3**	**15**

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	2,760	6,089	14,916
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**2,760**	**6,089**	**14,916**

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	1,694	1,946	6,727
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**1,694**	**1,946**	**6,727**

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	33
Asian	44
Black/African American	491
Hispanic/Latino	394
Pacific Islander/Hawaiian	1
White	7,082
Multi-Racial	376
Total	**8,421**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	324
Ages 15-64	5,125
Ages 65-74	1,854
Ages 75-85	975
Ages 85 and Up	143
Total	**8,421**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	3,275
Female	5,146
Total	**8,421**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,037
Medicaid	671
Third-Party	4,198
Self-Pay	515

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 11

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 705

6. Total Live Births: 2,104

7. Total Births (Live and Late Fetal Deaths): 2,128

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,387

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)	16	2,000	5,601	92
Specialty Care (Intermediate Neonatal Care)	4	102	629	46
Subspecialty Care (Intensive Neonatal Care)	4	7	38	4

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	36	95
Asian	19	55
Black/African American	188	626
Hispanic/Latino	390	1,048
Pacific Islander/Hawaiian	2	6
White	1,492	4,479
Multi-Racial	65	182
Total	**2,192**	**6,491**

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	4
Ages 15-44	2,186	6,472
Ages 45 and Up	4	15
Total	**2,192**	**6,491**

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

$12,937.00

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

$28,630.00

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? 2 (FTE's)
What languages do they interpret?
Spanish; In addition to FTEs, there are also 5 PRN interpreters.

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): ☑

Video remote Ipads; Contact outside agencies to obtain interpreter as soon as possible.

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	2.79	0	0	0
Arabic	0.04	0	0	0
Vietnamese	0.03	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?

All new hires must complete a computer based learning (CBL) course; annual mandatory CBL for

cultural competence; language census automatically generated twice a day to every nursing unit, manager of Interpretation Services and Staff Interpreters; daily rounding by staff interpreters on all patients listing non-English as language preference or primary to offer services, ensure signage in place and staff are aware education on interpretation services and options done by staff interpreters periodically throughout hospital and for physician practices affiliated with the hospital. Insights to cultural differences done by staff interpreters on a case by case basis with staff involved with the patients as well as formal inservices through out hospital for the most commonly encountered cultural items.

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?

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

1. English
2. Limited Spanish
3.
4.

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

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: William Hayes

Date: 3/6/2020

Title: CEO

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, Northside Hospital - Forsyth, and Northside Hospital - Cherokee 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 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. Oral surgeons are members of the medical staff. Consistent with past surveys, these are included in the "Other Surgical Specialties" category.