



2008 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP712

Facility Name: Medical Center of Central Georgia

County: Bibb

Street Address: 777 Hemlock Street

City: Macon

Zip: 31201-2155

Mailing Address: PO Box 6000

Mailing City: Macon

Mailing Zip: 31208-6000

Medicaid Provider Number: 1207A

Medicare Provider Number: 11-0107

2. Report Period

Report Data for the full twelve month period- January 1, 2008 through December 31, 2008.

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: H. Bryan Forlines

Contact Title: Reimbursement Director

Phone: 478-633-6966

Fax: 478-633-5381

E-mail: forlines.bryan@mccg.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
Macon-Bibb County Hospital Authority	Hospital Authority	9/1/1968

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
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: Central Georgia Health System, Inc.

City: Macon **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: Georgia Alliance of Community Hospitals

City: Tifton State: Georgia

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

Name: Central Georgia Health Network

City: Macon 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(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 checked="" type="checkbox"/>	<input checked="" 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)	47	3,345	8,290	3,345	8,290
Pediatrics (Non ICU)	46	953	3,623	953	3,623
Pediatric ICU	12	348	1,407	0	0
Gynecology (No OB)	32	1,510	5,556	1,510	5,556
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	319	17,356	107,345	21,116	128,193
Intensive Care	60	3,412	19,441	0	0
Psychiatry	30	716	4,204	716	4,204
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	546	27,640	149,866	27,640	149,866

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	25	192
Asian	57	235
Black/African American	11,855	66,993
Hispanic/Latino	263	1,305
Pacific Islander/Hawaiian	1	2
White	15,430	81,092
Multi-Racial	9	47
Total	27,640	149,866

3. Gender

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

Gender	Admissions	Inpatient Days
Male	11,886	70,707
Female	15,754	79,159
Total	27,640	149,866

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	12,372	75,240
Medicaid	5,091	27,625
Peachare	7	16
Third-Party	8,224	37,799
Self-Pay	1,945	9,175
Other	1	11

5. Discharges to Death

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

1,070

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2008 (to the nearest whole dollar).

Service	Charge
Private Room Rate	662
Semi-Private Room Rate	662
Operating Room: Average Charge for the First Hour	3,590
Average Total Charge for an Inpatient Day	6,276

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

49,800

2. Inpatient Admissions from ER

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

12,676

3. Beds Available

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

53

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	2	1,513
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	0
General Beds	37	43,572
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

181

6. Non-Emergency Visits

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

341,338

7. Observation Visits/Cases

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

6,903

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

1,844.00

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.

4,138

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	1	1
Biliary Lithotripter	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, Diagnostic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	2	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	1
Hospice	1	1
Respite Care Services	1	1
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	450
Number of Dialysis Treatments	6,074
Number of ESWL Patients	106
Number of ESWL Procedures	106
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	135,734
Number of CTS Units (machines)	0
Number of CTS Procedures	0
Number of Diagnostic Radioisotope Procedures	9,160
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	76
Number of Number of MRI Units	0
Number of Number of MRI Procedures	0
Number of Chemotherapy Treatments	4,503
Number of Respiratory Therapy Treatments	259,152
Number of Occupational Therapy Treatments	16,159
Number of Physical Therapy Treatments	48,163
Number of Speech Pathology Patients	6,155
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	3,482
Number of HIV/AIDS Diagnostic Procedures	2,775
Number of HIV/AIDS Patients	2,775
Number of Ambulance Trips	23,742
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	0
Number of Ultrasound/Medical Sonography Procedures	13,164
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).

79

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
0	0	

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2008. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	11	0	0
Physician Assistants Only (not including Licensed Physicians)	9	0	0
Registered Nurses (RNs-Advanced Practice*)	1139	50	0
Licensed Practical Nurses (LPNs)	67	0	0
Pharmacists	62	2	0
Other Health Services Professionals*	1300	75	0
Administration and Support	0	0	0
All Other Hospital Personnel (not included above)	1825	0	0

2. Filling Vacancies

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

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	Not Applicable
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	40
Black/African American	95
Hispanic/Latino	32
Pacific Islander/Hawaiian	0
White	356
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	55	<input type="checkbox"/>	0	0
General Internal Medicine	74	<input type="checkbox"/>	0	0
Pediatricians	62	<input type="checkbox"/>	0	0
Other Medical Specialties	114	<input 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	42	<input type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	42	<input type="checkbox"/>	0	0
Ophthalmology Surgery	9	<input type="checkbox"/>	0	0
Orthopedic Surgery	14	<input type="checkbox"/>	0	0
Plastic Surgery	5	<input type="checkbox"/>	0	0
General Surgery	20	<input type="checkbox"/>	0	0
Thoracic Surgery	11	<input type="checkbox"/>	0	0
Other Surgical Specialties	37	<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	18	<input checked="" type="checkbox"/>	0	0
Dermatology	0	<input type="checkbox"/>	0	0
Emergency Medicine	31	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	5	<input checked="" type="checkbox"/>	0	0
Psychiatry	24	<input type="checkbox"/>	0	0
Radiology	30	<input checked="" type="checkbox"/>	0	0
	0	<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	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	0

5b. Name of Other Professions

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

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

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
Alabama	28	8	2	2	0	0	0	0	0	0	0	0
Appling	5	3	0	0	0	0	0	0	0	0	0	0
Atkinson	4	5	1	0	0	0	0	0	0	0	0	0
Bacon	1	3	0	0	0	0	0	0	0	0	0	0
Baldwin	1,086	596	102	34	0	0	0	0	0	0	0	0
Barrow	5	0	0	0	0	0	0	0	0	0	0	0
Bartow	2	2	0	0	0	0	0	0	0	0	0	0
Ben Hill	89	25	8	1	0	0	0	0	0	0	0	0
Berrien	25	11	3	0	0	0	0	0	0	0	0	0
Bibb	13,368	8,674	1,953	398	0	0	0	0	0	0	0	0
Bleckley	363	236	26	3	0	0	0	0	0	0	0	0
Brantley	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	6	3	0	0	0	0	0	0	0	0	0	0
Bryan	2	0	0	0	0	0	0	0	0	0	0	0
Bulloch	5	7	1	0	0	0	0	0	0	0	0	0
Burke	1	1	1	0	0	0	0	0	0	0	0	0
Butts	150	88	12	4	0	0	0	0	0	0	0	0
Calhoun	5	1	0	0	0	0	0	0	0	0	0	0
Camden	3	2	1	0	0	0	0	0	0	0	0	0
Candler	2	1	0	0	0	0	0	0	0	0	0	0
Carroll	4	1	1	0	0	0	0	0	0	0	0	0
Charlton	3	0	0	0	0	0	0	0	0	0	0	0
Chatham	4	5	0	0	0	0	0	0	0	0	0	0
Cherokee	1	3	0	0	0	0	0	0	0	0	0	0
Clarke	7	1	0	0	0	0	0	0	0	0	0	0
Clay	0	2	0	0	0	0	0	0	0	0	0	0
Clayton	11	3	1	0	0	0	0	0	0	0	0	0
Clinch	4	4	1	0	0	0	0	0	0	0	0	0

Cobb	14	6	1	1	0	0	0	0	0	0	0	0
Coffee	21	14	1	0	0	0	0	0	0	0	0	0
Colquitt	19	16	0	0	0	0	0	0	0	0	0	0
Columbia	2	1	0	0	0	0	0	0	0	0	0	0
Cook	15	8	2	1	0	0	0	0	0	0	0	0
Coweta	14	6	2	0	0	0	0	0	0	0	0	0
Crawford	413	200	43	7	0	0	0	0	0	0	0	0
Crisp	83	93	6	1	0	0	0	0	0	0	0	0
Dawson	0	1	0	0	0	0	0	0	0	0	0	0
Decatur	8	8	1	0	0	0	0	0	0	0	0	0
DeKalb	14	4	1	0	0	0	0	0	0	0	0	0
Dodge	467	254	22	9	0	0	0	0	0	0	0	0
Dooly	148	114	10	0	0	0	0	0	0	0	0	0
Dougherty	39	52	1	0	0	0	0	0	0	0	0	0
Douglas	3	3	0	0	0	0	0	0	0	0	0	0
Early	3	5	0	0	0	0	0	0	0	0	0	0
Elbert	2	2	0	0	0	0	0	0	0	0	0	0
Emanuel	58	30	1	3	0	0	0	0	0	0	0	0
Evans	2	1	0	0	0	0	0	0	0	0	0	0
Fannin	2	0	0	0	0	0	0	0	0	0	0	0
Fayette	14	4	1	1	0	0	0	0	0	0	0	0
Florida	87	30	3	4	0	0	0	0	0	0	0	0
Floyd	5	1	0	0	0	0	0	0	0	0	0	0
Forsyth	5	5	0	0	0	0	0	0	0	0	0	0
Fulton	28	16	1	0	0	0	0	0	0	0	0	0
Gilmer	1	0	0	0	0	0	0	0	0	0	0	0
Glascocock	5	0	0	0	0	0	0	0	0	0	0	0
Glynn	6	1	0	1	0	0	0	0	0	0	0	0
Gordon	1	0	1	0	0	0	0	0	0	0	0	0
Grady	4	4	0	0	0	0	0	0	0	0	0	0
Greene	16	7	1	1	0	0	0	0	0	0	0	0
Gwinnett	21	7	2	1	0	0	0	0	0	0	0	0
Habersham	1	0	0	0	0	0	0	0	0	0	0	0
Hall	1	1	0	0	0	0	0	0	0	0	0	0
Hancock	212	71	5	2	0	0	0	0	0	0	0	0
Harris	3	2	0	0	0	0	0	0	0	0	0	0
Hart	0	1	0	0	0	0	0	0	0	0	0	0
Heard	1	0	0	0	0	0	0	0	0	0	0	0
Henry	53	25	4	0	0	0	0	0	0	0	0	0
Houston	2,459	1,726	342	33	0	0	0	0	0	0	0	0
Irwin	13	9	1	0	0	0	0	0	0	0	0	0
Jackson	1	1	0	0	0	0	0	0	0	0	0	0
Jasper	104	114	10	0	0	0	0	0	0	0	0	0
Jeff Davis	25	18	1	0	0	0	0	0	0	0	0	0

Jefferson	9	4	0	3	0	0	0	0	0	0	0	0
Johnson	83	48	1	5	0	0	0	0	0	0	0	0
Jones	929	798	107	23	0	0	0	0	0	0	0	0
Lamar	152	86	12	8	0	0	0	0	0	0	0	0
Lanier	5	1	0	0	0	0	0	0	0	0	0	0
Laurens	815	488	48	15	0	0	0	0	0	0	0	0
Lee	19	13	0	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	48	27	13	0	0	0	0	0	0	0	0	0
Lumpkin	1	1	0	0	0	0	0	0	0	0	0	0
Macon	274	134	25	1	0	0	0	0	0	0	0	0
Marion	10	4	0	1	0	0	0	0	0	0	0	0
McDuffie	5	0	0	0	0	0	0	0	0	0	0	0
McIntosh	1	2	0	0	0	0	0	0	0	0	0	0
Meriwether	15	10	0	0	0	0	0	0	0	0	0	0
Mitchell	1	11	0	0	0	0	0	0	0	0	0	0
Monroe	926	799	107	21	0	0	0	0	0	0	0	0
Montgomery	23	13	2	1	0	0	0	0	0	0	0	0
Morgan	5	5	0	0	0	0	0	0	0	0	0	0
Muscogee	15	5	2	0	0	0	0	0	0	0	0	0
Newton	11	9	0	1	0	0	0	0	0	0	0	0
North Carolina	13	4	4	1	0	0	0	0	0	0	0	0
Oconee	1	7	0	0	0	0	0	0	0	0	0	0
Other Out of State	148	44	13	4	0	0	0	0	0	0	0	0
Paulding	4	2	1	0	0	0	0	0	0	0	0	0
Peach	1,240	817	191	29	0	0	0	0	0	0	0	0
Pickens	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	0	1	0	0	0	0	0	0	0	0	0	0
Pike	88	34	2	2	0	0	0	0	0	0	0	0
Polk	1	0	0	0	0	0	0	0	0	0	0	0
Pulaski	276	150	16	3	0	0	0	0	0	0	0	0
Putnam	410	236	35	10	0	0	0	0	0	0	0	0
Quitman	3	1	0	0	0	0	0	0	0	0	0	0
Rabun	0	1	0	0	0	0	0	0	0	0	0	0
Randolph	3	6	0	0	0	0	0	0	0	0	0	0
Richmond	3	3	0	0	0	0	0	0	0	0	0	0
Rockdale	7	2	0	0	0	0	0	0	0	0	0	0
Schley	34	15	0	0	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0
Seminole	5	3	0	0	0	0	0	0	0	0	0	0
South Carolina	11	6	2	0	0	0	0	0	0	0	0	0
Spalding	79	32	5	4	0	0	0	0	0	0	0	0
Stewart	0	1	0	0	0	0	0	0	0	0	0	0
Sumter	69	64	0	2	0	0	0	0	0	0	0	0

Talbot	15	2	0	1	0	0	0	0	0	0	0	0
Tattnall	4	4	0	2	0	0	0	0	0	0	0	0
Taylor	238	138	21	10	0	0	0	0	0	0	0	0
Telfair	162	80	3	6	0	0	0	0	0	0	0	0
Tennessee	26	7	0	1	0	0	0	0	0	0	0	0
Terrell	4	9	0	0	0	0	0	0	0	0	0	0
Thomas	3	2	0	0	0	0	0	0	0	0	0	0
Tift	62	50	6	0	0	0	0	0	0	0	0	0
Toombs	32	23	1	2	0	0	0	0	0	0	0	0
Treutlen	53	36	4	2	0	0	0	0	0	0	0	0
Troup	2	2	0	0	0	0	0	0	0	0	0	0
Turner	16	6	1	0	0	0	0	0	0	0	0	0
Twiggs	492	305	52	12	0	0	0	0	0	0	0	0
Union	4	0	0	0	0	0	0	0	0	0	0	0
Upton	356	130	13	15	0	0	0	0	0	0	0	0
Walker	1	1	0	0	0	0	0	0	0	0	0	0
Walton	11	1	0	0	0	0	0	0	0	0	0	0
Ware	2	5	0	0	0	0	0	0	0	0	0	0
Warren	4	0	1	0	0	0	0	0	0	0	0	0
Washington	125	76	11	4	0	0	0	0	0	0	0	0
Wayne	3	1	1	0	0	0	0	0	0	0	0	0
Webster	1	1	0	0	0	0	0	0	0	0	0	0
Wheeler	49	26	4	0	0	0	0	0	0	0	0	0
Whitfield	2	0	0	0	0	0	0	0	0	0	0	0
Wilcox	142	64	8	0	0	0	0	0	0	0	0	0
Wilkinson	491	397	56	20	0	0	0	0	0	0	0	0
Worth	15	11	1	0	0	0	0	0	0	0	0	0
Total	27,640	17,810	3,345	716	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	8	20
Cystoscopy (OR Suite)	0	0	2
Endoscopy (OR Suite)	0	6	2
	0	0	0
Total	0	14	24

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	7,991	8,059	5,662
Cystoscopy	0	0	155	259
Endoscopy	0	3,369	899	529
	0	0	0	0
Total	0	11,360	9,113	6,450

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	7,991	8,059	5,662
Cystoscopy	0	0	155	259
Endoscopy	0	3,369	899	529
	0	0	0	0
Total	0	11,360	9,113	6,450

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	12
Asian	39
Black/African American	6,548
Hispanic/Latino	100
Pacific Islander/Hawaiian	0
White	11,095
Multi-Racial	16
Total	17,810

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,657
Ages 15-64	11,969
Ages 65-74	2,638
Ages 75-85	1,327
Ages 85 and Up	219
Total	17,810

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	6,896
Female	10,914
Total	17,810

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	5,364
Medicaid	2,308
Third-Party	9,466
Self-Pay	672

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: 0

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 5
4. Number of LDRP Rooms: 21
5. Number of Cesarean Sections: 1,208
6. Total Live Births: 3,276
7. Total Births (Live and Late Fetal Deaths): 3,299
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,388

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	2,888	6,238	0
Specialty Care (Intermediate Neonatal Care)	0	535	10,031	0
Subspecialty Care (Intensive Neonatal Care)	0	656	14,783	0

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	5	10
Asian	25	65
Black/African American	1,834	5,617
Hispanic/Latino	107	308
Pacific Islander/Hawaiian	1	2
White	1,373	3,692
Multi-Racial	0	0
Total	3,345	9,694

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	12	42
Ages 15-44	3,331	9,646
Ages 45 and Up	2	6
Total	3,345	9,694

3. Average Charge for an Uncomplicated Delivery

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

\$9,311.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$15,293.00

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	30	30
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	716	4,204	716	4,204	1,040	<input checked="" 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	241	1,369
Hispanic/Latino	4	54
Pacific Islander/Hawaiian	0	0
White	471	2,781
Multi-Racial	0	0
Total	716	4,204

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	259	1,575
Female	457	2,629
Total	716	4,204

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	267	1,852
Medicaid	194	949
Third Party	158	893
Self-Pay	97	510
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? 1 (FTE's)

What languages do they interpret?

Spanish

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):

Contract Interpreters, Visual aid, Translated consent forms, Deaf Talk Units (3), TTY Relay communications

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	95	0	0	0
Gujdrati	3	0	0	0
Mandarin-Chinese	2	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?

Provide ongoing in-service training on cultural sensitivity on use of different interpreting tools

available and when/how to choose. Staff interpreter visits all LEP patients to insure effective communication and understanding is taking place.

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

Additional in-person interpreters in American sign language and Gujdrati.

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

1. English

2. Spanish

3. Braille

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?

Anderson Health Clinic, Macon, Ga., Macon Free Clinic, Macon, Ga.

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: A. Donald Faulk, Jr.

Date: 9/9/2009

Title: President/CEO

Comments: