



2009 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP719

Facility Name: Medical College of Georgia Hospitals and Clinics

County: Richmond

Street Address: 1120 Fifteenth Street

City: Augusta

Zip: 30912-0006

Mailing Address: 1120 Fifteenth Street

Mailing City: Augusta

Mailing Zip: 30912-0006

Medicaid Provider Number: 00000723

Medicare Provider Number: 110034

2. Report Period

Report Data for the full twelve month period- January 1, 2009 through December 31, 2009.
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: Sheila O'Neal

Contact Title: VP, Strategic Support and Philanthropy

Phone: 706-721-7406

Fax: 706-721-7506

E-mail: soneal@mcg.edu

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
University System of GA Board of Regents	State	1/1/1956

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
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:

City: State:

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: MCG Health, Inc. Insurance Company

City: Grand Cayman **State:** CI

6. Check the box to the right if your hospital is a member of an alliance.

Name: Georgia Alliance of Community Hospital

City: Tifton **State:** GA

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

Name: First Medical Network

City: Atlanta **State:** GA

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 checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input 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)	38	1,062	3,806	1,210	4,593
Pediatrics (Non ICU)	58	1,320	6,425	1,601	7,529
Pediatric ICU	13	477	3,845	578	5,304
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	190	11,750	56,696	10,510	51,889
Intensive Care	76	2,816	24,849	2,756	27,471
Psychiatry	42	594	2,495	1,398	6,111
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
Other Epilepsy/Stem Cell	26	319	913	346	1,012
	0	0	0	0	0
	0	0	0	0	0
Total	443	18,338	99,029	18,399	103,909

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	10	39
Asian	116	641
Black/African American	8,762	47,951
Hispanic/Latino	375	2,027
Pacific Islander/Hawaiian	0	0
White	8,938	47,851
Multi-Racial	137	520
Total	18,338	99,029

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,485	48,331
Female	9,853	50,698
Total	18,338	99,029

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,230	36,232
Medicaid	4,398	24,369
Peachare	14	63
Third-Party	5,329	26,957
Self-Pay	2,367	11,408
Other	0	0

5. Discharges to Death

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

432

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2009 (to the nearest whole dollar).

Service	Charge
Private Room Rate	611
Semi-Private Room Rate	604
Operating Room: Average Charge for the First Hour	3,134
Average Total Charge for an Inpatient Day	5,462

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

79,085

2. Inpatient Admissions from ER

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

16,048

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	6	1,994
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	1,445
General Beds	32	66,607
ED Observation Unit	10	3,828
Critical Care	4	5,211
	0	0
	0	0

5. Transfers

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

881

6. Non-Emergency Visits

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

315,552

7. Observation Visits/Cases

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

3,828

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

32.00

10. Untreated Cases

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

2,450

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	2	1
ESWL	1	1
Biliary Lithotripter	3	4
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, Diagnostic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	1	1
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	2	1
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	294
Number of Dialysis Treatments	3,744
Number of ESWL Patients	86
Number of ESWL Procedures	90
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	66
Number of Heart Transplants	1
Number of Other-Organ/Tissues Treatments	21
Number of Diagnostic X-Ray Procedures	97,529
Number of CTS Units (machines)	3
Number of CTS Procedures	35,847
Number of Diagnostic Radioisotope Procedures	3,408
Number of PET Units (machines)	1
Number of PET Procedures	1,877
Number of Therapeutic Radioisotope Procedures	87
Number of Number of MRI Units	3
Number of Number of MRI Procedures	8,354
Number of Chemotherapy Treatments	10,353
Number of Respiratory Therapy Treatments	8,247
Number of Occupational Therapy Treatments	30,838
Number of Physical Therapy Treatments	67,171
Number of Speech Pathology Patients	12,467
Number of Gamma Ray Knife Procedures	117
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	2,266
Number of HIV/AIDS Diagnostic Procedures	4,382
Number of HIV/AIDS Patients	1,128
Number of Ambulance Trips	1,651
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	27
Number of Ultrasound/Medical Sonography Procedures	15,053
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).

10

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 12-31-2009. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2009.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0	0	0
Physician Assistants Only (not including Licensed Physicians)	1	0	0
Registered Nurses (RNs-Advanced Practice*)	724.34997558594	80.199996948242	15
Licensed Practical Nurses (LPNs)	108.09999847412	8.4799995422363	0
Pharmacists	39.970001220703	0.11999999731779	0
Other Health Services Professionals*	798.72998046875	101.69999694824	9
Administration and Support	362.98999023438	83.419998168945	3
All Other Hospital Personnel (not included above)	1236.4300537109	37.799999237061	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	61-90 Days
Other Health Services Professionals	30 Days or Less
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	67
Black/African American	33
Hispanic/Latino	23
Pacific Islander/Hawaiian	0
White	374
Multi-Racial	5

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	43	<input checked="" type="checkbox"/>	23	23
General Internal Medicine	26	<input checked="" type="checkbox"/>	26	26
Pediatricians	91	<input checked="" type="checkbox"/>	27	27
Other Medical Specialties	116	<input checked="" type="checkbox"/>	145	145

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	37	<input checked="" type="checkbox"/>	15	15
Non-OB Physicians Providing OB Services	31	<input checked="" type="checkbox"/>	11	11
Gynecology	38	<input checked="" type="checkbox"/>	6	6
Ophthalmology Surgery	12	<input checked="" type="checkbox"/>	14	14
Orthopedic Surgery	26	<input checked="" type="checkbox"/>	17	17
Plastic Surgery	9	<input checked="" type="checkbox"/>	5	5
General Surgery	10	<input checked="" type="checkbox"/>	3	3
Thoracic Surgery	19	<input checked="" type="checkbox"/>	5	5
Other Surgical Specialties	51	<input checked="" type="checkbox"/>	51	51

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	32	<input checked="" type="checkbox"/>	26	26
Dermatology	6	<input checked="" type="checkbox"/>	4	4
Emergency Medicine	38	<input checked="" type="checkbox"/>	38	38
Nuclear Medicine	4	<input checked="" type="checkbox"/>	4	4
Pathology	21	<input checked="" type="checkbox"/>	16	16
Psychiatry	32	<input checked="" type="checkbox"/>	32	32
Radiology	38	<input checked="" type="checkbox"/>	27	27
	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	24
Podiatrists	2
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	107

5b. Name of Other Professions

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

Physician Assistant, PH.D Psychology, Optometry, Advanced Nurse Practitioner, CRNA

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	32	26	1	0	0	0	0	0	0	0	0	0
Appling	25	4	1	0	1	0	0	0	0	0	0	0
Atkinson	5	4	0	0	0	0	0	0	0	0	0	0
Bacon	6	5	0	0	0	0	0	0	0	0	0	0
Baker	2	1	0	0	0	0	0	0	0	0	0	0
Baldwin	108	68	2	2	0	0	0	0	0	0	0	0
Banks	4	4	0	0	0	0	0	0	0	0	0	0
Barrow	11	13	0	0	0	0	0	0	0	0	0	0
Bartow	8	2	0	0	0	1	0	0	0	0	0	0
Ben Hill	32	7	0	0	0	0	0	0	0	0	0	0
Berrien	7	9	0	0	0	0	0	0	0	0	0	0
Bibb	33	13	1	0	0	0	0	0	0	0	0	0
Bleckley	8	3	0	0	0	0	0	0	0	0	0	0
Brantley	8	6	0	0	0	0	0	0	0	0	0	0
Brooks	5	6	0	0	0	0	0	0	0	0	0	0
Bryan	16	12	0	0	0	0	0	0	0	0	0	0
Bulloch	163	48	4	1	0	1	0	0	0	0	0	0
Burke	569	223	28	3	3	0	0	0	0	0	0	0
Butts	4	0	0	0	0	0	0	0	0	0	0	0
Calhoun	7	4	0	0	0	0	0	0	0	0	0	0
Camden	4	5	0	0	0	0	0	0	0	0	0	0
Candler	49	18	1	0	1	0	0	0	0	0	0	0
Carroll	5	3	0	0	0	0	0	0	0	0	0	0
Catoosa	1	0	0	0	0	0	0	0	0	0	0	0
Charlton	2	1	0	0	0	0	0	0	0	0	0	0
Chatham	52	50	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	0	0	0	0	0	0	0	0	0	0
Clarke	42	59	1	0	0	0	0	0	0	0	0	0

Clay	6	0	0	0	0	0	0	0	0	0	0	0
Clayton	3	2	1	0	0	0	0	0	0	0	0	0
Clinch	7	3	0	0	0	0	0	0	0	0	0	0
Cobb	16	1	1	0	0	0	0	0	0	0	0	0
Coffee	35	19	0	0	0	0	0	0	0	0	0	0
Colquitt	14	6	0	0	0	0	0	0	0	0	0	0
Columbia	1,890	1,244	120	51	59	20	0	0	0	0	0	0
Cook	5	9	0	0	0	0	0	0	0	0	0	0
Coweta	3	1	0	0	0	0	0	0	0	0	0	0
Crawford	1	1	0	0	0	0	0	0	0	0	0	0
Crisp	9	4	0	0	0	0	0	0	0	0	0	0
Dawson	3	1	0	0	0	0	0	0	0	0	0	0
Decatur	6	4	0	0	0	0	0	0	0	0	0	0
DeKalb	19	4	0	1	1	0	0	0	0	0	0	0
Dodge	22	8	0	0	0	0	0	0	0	0	0	0
Dooly	3	6	0	0	0	0	0	0	0	0	0	0
Dougherty	43	25	1	0	1	1	0	0	0	0	0	0
Douglas	5	1	0	0	0	0	0	0	0	0	0	0
Early	2	1	0	0	0	0	0	0	0	0	0	0
Echols	0	2	0	0	0	0	0	0	0	0	0	0
Effingham	27	12	1	0	1	0	0	0	0	0	0	0
Elbert	98	51	0	0	0	1	0	0	0	0	0	0
Emanuel	259	69	8	4	1	1	0	0	0	0	0	0
Evans	19	11	1	1	0	0	0	0	0	0	0	0
Fayette	2	2	0	0	0	0	0	0	0	0	0	0
Florida	24	20	1	0	0	0	0	0	0	0	0	0
Floyd	3	1	0	0	0	0	0	0	0	0	0	0
Forsyth	6	6	0	0	0	0	0	0	0	0	0	0
Franklin	14	10	0	0	0	0	0	0	0	0	0	0
Fulton	16	14	1	1	0	0	0	0	0	0	0	0
Gilmer	1	0	0	0	0	0	0	0	0	0	0	0
Glascocock	90	26	2	1	1	0	0	0	0	0	0	0
Glynn	36	9	0	0	0	0	0	0	0	0	0	0
Gordon	1	0	0	0	0	0	0	0	0	0	0	0
Grady	3	2	0	0	0	0	0	0	0	0	0	0
Greene	66	88	1	0	0	0	0	0	0	0	0	0
Gwinnett	22	5	1	0	0	1	0	0	0	0	0	0
Habersham	3	4	0	0	0	0	0	0	0	0	0	0
Hall	4	6	0	0	0	0	0	0	0	0	0	0
Hancock	74	34	10	0	0	0	0	0	0	0	0	0
Harris	1	1	0	0	0	0	0	0	0	0	0	0
Hart	19	19	1	0	0	0	0	0	0	0	0	0
Henry	4	0	0	1	0	0	0	0	0	0	0	0
Houston	35	13	0	0	0	0	0	0	0	0	0	0

Irwin	4	4	0	0	0	0	0	0	0	0	0	0
Jackson	16	22	1	0	0	0	0	0	0	0	0	0
Jeff Davis	11	6	0	1	0	0	0	0	0	0	0	0
Jefferson	585	184	123	3	2	4	0	0	0	0	0	0
Jenkins	178	54	3	2	0	3	0	0	0	0	0	0
Johnson	83	24	1	0	0	0	0	0	0	0	0	0
Jones	6	7	0	0	0	0	0	0	0	0	0	0
Lamar	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	4	2	1	0	0	0	0	0	0	0	0	0
Laurens	115	88	0	0	0	0	0	0	0	0	0	0
Lee	9	4	0	0	0	0	0	0	0	0	0	0
Liberty	22	11	2	0	0	0	0	0	0	0	0	0
Lincoln	198	84	4	3	2	0	0	0	0	0	0	0
Long	3	0	0	0	0	0	0	0	0	0	0	0
Lowndes	48	31	0	0	0	0	0	0	0	0	0	0
Lumpkin	3	3	0	0	0	0	0	0	0	0	0	0
Macon	6	0	0	0	0	0	0	0	0	0	0	0
Madison	28	17	0	0	0	0	0	0	0	0	0	0
McDuffie	537	194	16	19	6	2	0	0	0	0	0	0
McIntosh	4	5	0	0	0	0	0	0	0	0	0	0
Miller	1	1	0	0	0	0	0	0	0	0	0	0
Mitchell	5	7	0	0	0	0	0	0	0	0	0	0
Monroe	4	3	0	0	0	0	0	0	0	0	0	0
Montgomery	10	6	0	0	0	0	0	0	0	0	0	0
Morgan	20	21	0	0	0	0	0	0	0	0	0	0
Murray	1	0	0	0	0	0	0	0	0	0	0	0
Muscogee	6	2	0	0	0	1	0	0	0	0	0	0
Newton	12	7	1	0	0	0	0	0	0	0	0	0
North Carolina	33	22	2	2	1	0	0	0	0	0	0	0
Oconee	31	20	0	1	0	0	0	0	0	0	0	0
Oglethorpe	17	15	0	0	0	0	0	0	0	0	0	0
Other Out of State	179	77	7	2	0	1	0	0	0	0	0	0
Peach	5	1	0	0	0	0	0	0	0	0	0	0
Pierce	17	18	0	0	0	0	0	0	0	0	0	0
Pike	3	0	0	0	0	0	0	0	0	0	0	0
Pulaski	12	2	0	0	0	0	0	0	0	0	0	0
Putnam	48	42	0	0	0	1	0	0	0	0	0	0
Rabun	0	1	0	0	0	0	0	0	0	0	0	0
Richmond	6,927	2,719	459	147	78	69	0	0	0	0	0	0
Rockdale	4	3	0	0	0	0	0	0	0	0	0	0
Screven	102	40	1	2	0	2	0	0	0	0	0	0
Seminole	2	5	0	0	0	0	0	0	0	0	0	0
South Carolina	3,781	2,131	163	27	14	26	0	0	0	0	0	0
Spalding	2	0	0	0	0	0	0	0	0	0	0	0

Stephens	9	4	0	0	0	0	0	0	0	0	0	0
Taliaferro	59	23	4	0	0	0	0	0	0	0	0	0
Tattnall	22	11	0	0	0	0	0	0	0	0	0	0
Telfair	33	4	0	0	0	0	0	0	0	0	0	0
Terrell	1	5	0	0	0	0	0	0	0	0	0	0
Thomas	11	15	0	0	0	0	0	0	0	0	0	0
Tift	22	13	0	0	0	0	0	0	0	0	0	0
Toombs	55	26	0	0	0	0	0	0	0	0	0	0
Treutlen	20	18	0	0	0	0	0	0	0	0	0	0
Troup	2	0	0	0	0	0	0	0	0	0	0	0
Turner	5	1	0	0	0	0	0	0	0	0	0	0
Twiggs	3	0	0	0	0	0	0	0	0	0	0	0
Union	5	0	0	0	0	0	0	0	0	0	0	0
Upson	4	0	0	0	0	0	0	0	0	0	0	0
Walker	2	0	0	0	0	0	0	0	0	0	0	0
Walton	13	7	0	0	0	0	0	0	0	0	0	0
Ware	29	24	0	0	0	0	0	0	0	0	0	0
Warren	199	58	14	1	0	0	0	0	0	0	0	0
Washington	334	165	30	1	4	2	0	0	0	0	0	0
Wayne	32	14	0	0	0	0	0	0	0	0	0	0
Wheeler	10	5	0	0	0	0	0	0	0	0	0	0
White	0	1	0	0	0	0	0	0	0	0	0	0
Whitfield	2	0	0	0	0	0	0	0	0	0	0	0
Wilcox	3	4	0	0	0	0	0	0	0	0	0	0
Wilkes	238	104	5	2	3	1	0	0	0	0	0	0
Wilkinson	10	12	0	0	0	0	0	0	0	0	0	0
Worth	4	4	0	0	0	0	0	0	0	0	0	0
Total	18,338	8,740	1,026	279	179	138	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	0	29
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	5
DaVinci	0	0	1
Total	0	0	36

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	8,326	9,322
Cystoscopy	0	0	106	158
Endoscopy	0	0	603	2,869
DaVinci	0	0	101	56
Total	0	0	9,136	12,405

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	6,736	7,868
Cystoscopy	0	0	100	157
Endoscopy	0	0	674	3,297
DaVinci	0	0	76	50
Total	0	0	7,586	11,372

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	4
Asian	93
Black/African American	3,467
Hispanic/Latino	236
Pacific Islander/Hawaiian	0
White	4,826
Multi-Racial	114
Total	8,740

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	3,733
Ages 15-64	3,919
Ages 65-74	708
Ages 75-85	330
Ages 85 and Up	50
Total	8,740

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,319
Female	4,421
Total	8,740

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,592
Medicaid	2,917
Third-Party	3,942
Self-Pay	289

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: 7
4. Number of LDRP Rooms: 3
5. Number of Cesarean Sections: 428
6. Total Live Births: 1,119
7. Total Births (Live and Late Fetal Deaths): 1,132
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,026

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)	25	892	2,500	21
Specialty Care (Intermediate Neonatal Care)	5	49	920	0
Subspecialty Care (Intensive Neonatal Care)	36	383	9,421	108

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	2	4
Asian	27	98
Black/African American	600	2,207
Hispanic/Latino	56	150
Pacific Islander/Hawaiian	0	0
White	325	1,321
Multi-Racial	16	51
Total	1,026	3,831

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	5	13
Ages 15-44	1,020	3,815
Ages 45 and Up	1	3
Total	1,026	3,831

3. Average Charge for an Uncomplicated Delivery

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

\$8,750.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$13,076.00

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	28	28
B- General Acute Psychiatric Adolescents 13-17	7	7
C- General Acute Psychiatric Children 12 and under	7	7
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	279	1,293	1,081	4,854	2,013	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	179	648	180	653	1,658	<input checked="" type="checkbox"/>
General Acute Psychiatric Children 12 and Under	138	561	138	561	1,584	<input checked="" 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	1	4
Asian	4	21
Black/African American	218	911
Hispanic/Latino	10	48
Pacific Islander/Hawaiian	0	0
White	348	1,453
Multi-Racial	15	65
Total	596	2,502

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	278	1,236
Female	318	1,266
Total	596	2,502

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	112	686
Medicaid	198	781
Third Party	275	999
Self-Pay	9	30
PeachCare	2	6

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? 4 (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):

Telephone Interpreter Service

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	.63	0	0	0
ASL	.10	0	0	0
Chinese	.07	0	0	0

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

New employee orientation, Mandatory Web-based training and on-going CLAS in-service training.

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?

Training for trainers courses and additional interpreters.

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

1. English 2. Implementing universal 3. Implementing English/Spanish 4.
symbols signs signs

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?

St. Vincent de Paul Health Center - 1384 Green Street, Augusta, GA 30901 and
Christ Community Health Services 1226 D'Antignac Street, Augusta, GA 30901

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: Sandra McVicker

Date: 3/11/2010

Title: Interim, President and CEO MCGHealth, Inc.

Comments: