GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 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, 2010 through December 31, 2010.
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

Phone: 706-721-7406

Fax: 706-721-7506

E-mail: soneal@georgiahealth.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 Hospitals
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(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)	38	1,043	4,252	1,162	4,923
Pediatrics (Non ICU)	58	1,344	6,488	1,706	8,126
Pediatric ICU	13	480	3,368	581	4,712
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	196	12,192	62,807	10,898	57,317
Intensive Care	68	2,498	23,462	2,403	23,603
Psychiatry	42	608	2,833	1,402	6,890
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 (Epilipsy/Stem Cell)	26	318	966	325	998
	0	0	0	0	0
	0	0	0	0	0
Total	**441**	**18,483**	**104,176**	**18,477**	**106,569**

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	2	7
Asian	147	778
Black/African American	8,805	50,416
Hispanic/Latino	342	1,868
Pacific Islander/Hawaiian	33	214
White	9,041	50,340
Multi-Racial	113	553
Total	**18,483**	**104,176**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,521	51,215
Female	9,962	52,961
Total	**18,483**	**104,176**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,095	37,300
Medicaid	4,856	28,541
Peachare	5	14
Third-Party	5,226	25,745
Self-Pay	2,301	12,576
Other	0	0

5. Discharges to Death

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

420

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2010 (to the nearest whole dollar).

Service	Charge
Private Room Rate	611
Semi-Private Room Rate	604
Operating Room: Average Charge for the First Hour	3,323
Average Total Charge for an Inpatient Day	5,846

Part E : Emergency Department and Outpatient Services

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

77,393

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

14,530

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

68

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	1,996
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	8	1,269
General Beds	41	63,679
ED Observation Unit	9	3,077
Critical Care	4	7,372
	0	0
	0	0

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

887

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

314,674

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

3,077

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

1

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

66.00

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.

2,083

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	2	1
ESWL	1	1
Billiary Lithotropter	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, 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	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	984
Number of Dialysis Treatments	3,794
Number of ESWL Patients	117
Number of ESWL Procedures	126
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	88
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	59
Number of Diagnostic X-Ray Procedures	99,816
Number of CTS Units (machines)	3
Number of CTS Procedures	34,812
Number of Diagnostic Radioisotope Procedures	3,161
Number of PET Units (machines)	1
Number of PET Procedures	1,901
Number of Therapeautic Radioisotope Procedures	78
Number of Number of MRI Units	3
Number of Number of MRI Procedures	9,104
Number of Chemotherapy Treatments	10,344
Number of Respiratory Therapy Treatments	9,124
Number of Occupational Therapy Treatments	24,445
Number of Physical Therapy Treatments	57,484
Number of Speech Pathology Patients	8,811
Number of Gamma Ray Knife Procedures	95
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	2,493
Number of HIV/AIDS Diagnostic Procedures	4,499
Number of HIV/AIDS Patients	1,180
Number of Ambulance Trips	1,916
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	27
Number of Ultrasound/Medical Sonography Procedures	16,546
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)
1	78	IS2000 da Vinci Surgical System with HD

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2010. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2010.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	6	6	0
Physician Assistants Only (not including Licensed Physicians)	2	0	0
Registered Nurses (RNs-Advanced Practice*)	840.95001220703	101.98999786377	5
Licensed Practical Nurses (LPNs)	90.5	4.1999998092651	
Pharmacists	28.870000839233	2.0499999523163	0
Other Health Services Professionals*	500.29998779297	86.319999694824	2
Administration and Support	103	111.69999694824	2
All Other Hospital Personnel (not included above)	1703.7600097656	25.799999237061	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)	Not Applicable
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

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

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	73
Black/African American	31
Hispanic/Latino	21
Pacific Islander/Hawaiian	0
White	378
Multi-Racial	7

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	36	☑	36	36
General Internal Medicine	56	☑	56	56
Pediatricians	103	☑	103	103
Other Medical Specialties	102	☑	102	102

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	35	☑	35	35
Non-OB Physicians Providing OB Services	24	☑	24	24
Gynecology	36	☑	36	36
Ophthalmology Surgery	14	☑	14	14
Orthopedic Surgery	22	☑	22	22
Plastic Surgery	9	☑	9	9
General Surgery	10	☑	10	10
Thoracic Surgery	12	☑	12	12
Other Surgical Specialties	54	☑	54	54

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	34	☑	34	34
Dermatology	6	☑	6	6
Emergency Medicine	42	☑	42	42
Nuclear Medicine	2	☑	2	2
Pathology	19	☑	19	19
Psychiatry	26	☑	26	26
Radiology	35	☑	35	35
	0	☐	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	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 Practioner, 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	25	16	1	0	0	0	0	0	0	0	0	0
Appling	25	7	0	0	0	0	0	0	0	0	0	0
Atkinson	3	5	0	0	0	0	0	0	0	0	0	0
Bacon	6	6	0	0	0	0	0	0	0	0	0	0
Baker	0	1	0	0	0	0	0	0	0	0	0	0
Baldwin	107	85	1	0	0	0	0	0	0	0	0	0
Banks	5	1	0	0	0	0	0	0	0	0	0	0
Barrow	8	10	0	0	0	0	0	0	0	0	0	0
Bartow	2	3	0	0	0	0	0	0	0	0	0	0
Ben Hill	15	13	0	0	0	0	0	0	0	0	0	0
Berrien	6	4	0	0	1	0	0	0	0	0	0	0
Bibb	50	18	0	0	1	0	0	0	0	0	0	0
Bleckley	16	5	0	0	0	0	0	0	0	0	0	0
Brantley	20	11	0	0	0	0	0	0	0	0	0	0
Brooks	9	7	0	0	0	0	0	0	0	0	0	0
Bryan	17	3	1	0	0	0	0	0	0	0	0	0
Bulloch	152	78	7	0	0	0	0	0	0	0	0	0
Burke	585	247	41	2	2	1	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0
Calhoun	8	2	0	0	0	0	0	0	0	0	0	0
Camden	4	0	0	0	0	0	0	0	0	0	0	0
Candler	36	19	0	1	0	0	0	0	0	0	0	0
Carroll	7	0	0	0	0	0	0	0	0	0	0	0
Catoosa	1	1	0	0	0	0	0	0	0	0	0	0
Charlton	1	2	0	0	0	0	0	0	0	0	0	0
Chatham	50	41	0	0	1	0	0	0	0	0	0	0
Chattahoochee	6	0	0	0	0	0	0	0	0	0	0	0
Cherokee	0	4	0	0	1	0	0	0	0	0	0	0

Clarke	48	66	0	0	0	0	0	0	0	0	0	0
Clayton	8	4	0	0	0	0	0	0	0	0	0	0
Clinch	1	3	0	0	0	0	0	0	0	0	0	0
Cobb	12	8	2	0	0	1	0	0	0	0	0	0
Coffee	26	30	0	0	0	0	0	0	0	0	0	0
Colquitt	14	12	0	0	0	0	0	0	0	0	0	0
Columbia	1,967	1,316	102	40	65	25	0	0	0	0	0	0
Cook	10	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	5	1	0	0	0	0	0	0	0	0	0	0
Crisp	19	1	0	0	0	0	0	0	0	0	0	0
Dawson	1	1	0	0	0	0	0	0	0	0	0	0
Decatur	7	6	0	0	0	0	0	0	0	0	0	0
DeKalb	15	3	0	0	0	0	0	0	0	0	0	0
Dodge	19	21	0	0	0	1	0	0	0	0	0	0
Dooly	7	6	0	0	0	0	0	0	0	0	0	0
Dougherty	39	66	0	0	0	0	0	0	0	0	0	0
Douglas	6	0	0	0	0	0	0	0	0	0	0	0
Early	3	5	0	0	0	0	0	0	0	0	0	0
Echols	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	21	20	0	0	0	0	0	0	0	0	0	0
Elbert	86	52	1	0	0	0	0	0	0	0	0	0
Emanuel	312	131	14	2	2	1	0	0	0	0	0	0
Evans	15	7	1	0	0	0	0	0	0	0	0	0
Fannin	0	1	0	0	0	0	0	0	0	0	0	0
Fayette	1	5	0	0	0	0	0	0	0	0	0	0
Forsyth	4	4	0	0	0	0	0	0	0	0	0	0
Franklin	18	16	0	0	0	0	0	0	0	0	0	0
Fulton	12	13	0	0	0	0	0	0	0	0	0	0
Glascock	59	21	3	0	2	0	0	0	0	0	0	0
Glynn	22	14	0	0	0	0	0	0	0	0	0	0
Gordon	1	2	0	0	0	0	0	0	0	0	0	0
Grady	11	4	0	0	0	0	0	0	0	0	0	0
Greene	102	72	0	0	0	0	0	0	0	0	0	0
Gwinnett	11	6	0	0	1	0	0	0	0	0	0	0
Habersham	6	2	0	0	0	0	0	0	0	0	0	0
Hall	6	9	0	0	0	1	0	0	0	0	0	0
Hancock	76	49	7	1	0	0	0	0	0	0	0	0
Haralson	0	2	0	0	0	0	0	0	0	0	0	0
Harris	3	0	0	0	0	0	0	0	0	0	0	0
Hart	25	18	1	0	0	1	0	0	0	0	0	0
Heard	0	5	0	0	0	0	0	0	0	0	0	0
Henry	5	0	0	0	1	0	0	0	0	0	0	0
Houston	34	16	1	1	0	0	0	0	0	0	0	0

Irwin	3	1	0	0	0	0	0	0	0	0	0	0
Jackson	13	26	110	0	0	0	0	0	0	0	0	0
Jeff Davis	13	8	0	1	0	0	0	0	0	0	0	0
Jefferson	571	196	0	5	4	2	0	0	0	0	0	0
Jenkins	170	63	0	2	0	1	0	0	0	0	0	0
Johnson	62	32	1	0	0	1	0	0	0	0	0	0
Jones	12	6	0	0	0	0	0	0	0	0	0	0
Lamar	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	6	6	0	0	0	0	0	0	0	0	0	0
Laurens	142	91	0	0	1	0	0	0	0	0	0	0
Lee	9	7	0	0	1	0	0	0	0	0	0	0
Liberty	19	14	1	0	0	0	0	0	0	0	0	0
Lincoln	231	79	13	2	0	0	0	0	0	0	0	0
Long	1	2	0	0	0	0	0	0	0	0	0	0
Lowndes	61	30	2	0	0	0	0	0	0	0	0	0
Macon	10	1	0	0	0	0	0	0	0	0	0	0
Madison	28	27	0	0	0	0	0	0	0	0	0	0
Marion	4	1	0	0	0	0	0	0	0	0	0	0
McDuffie	494	272	18	8	4	6	0	0	0	0	0	0
McIntosh	8	3	0	0	0	0	0	0	0	0	0	0
Meriwether	1	0	0	0	0	0	0	0	0	0	0	0
Miller	1	2	0	0	0	0	0	0	0	0	0	0
Mitchell	11	6	0	0	0	0	0	0	0	0	0	0
Monroe	4	0	1	0	0	0	0	0	0	0	0	0
Montgomery	28	5	0	0	0	0	0	0	0	0	0	0
Morgan	36	35	0	0	0	0	0	0	0	0	0	0
Muscogee	6	4	0	0	0	0	0	0	0	0	0	0
Newton	8	8	1	0	0	0	0	0	0	0	0	0
North Carolina	19	19	0	0	0	0	0	0	0	0	0	0
Oconee	26	17	0	0	0	0	0	0	0	0	0	0
Oglethorpe	24	14	0	0	0	1	0	0	0	0	0	0
Other Out of State	167	107	4	0	0	0	0	0	0	0	0	0
Paulding	2	0	0	0	0	0	0	0	0	0	0	0
Peach	17	2	0	0	0	0	0	0	0	0	0	0
Pierce	14	14	0	0	0	0	0	0	0	0	0	0
Pike	2	0	0	0	0	0	0	0	0	0	0	0
Polk	1	1	0	0	0	0	0	0	0	0	0	0
Pulaski	10	15	0	0	0	0	0	0	0	0	0	0
Putnam	37	45	1	3	0	0	0	0	0	0	0	0
Rabun	1	1	0	0	0	0	0	0	0	0	0	0
Randolph	0	1	0	0	0	0	0	0	0	0	0	0
Richmond	6,814	2,986	422	115	137	68	0	0	0	0	0	0
Rockdale	7	5	0	0	0	0	0	0	0	0	0	0
Schley	0	1	0	0	0	0	0	0	0	0	0	0

Screven	144	44	7	1	1	1	0	0	0	0	0	0
Seminole	0	7	0	0	0	0	0	0	0	0	0	0
South Carolina	3,867	2,370	168	28	36	12	0	0	0	0	0	0
Stephens	7	4	0	0	0	0	0	0	0	0	0	0
Sumter	7	8	0	0	0	0	0	0	0	0	0	0
Taliaferro	51	18	3	0	0	0	0	0	0	0	0	0
Tattnall	20	11	0	0	0	0	0	0	0	0	0	0
Taylor	0	1	0	0	0	0	0	0	0	0	0	0
Telfair	43	15	0	0	0	0	0	0	0	0	0	0
Terrell	0	1	0	0	0	0	0	0	0	0	0	0
Thomas	14	12	0	0	0	0	0	0	0	0	0	0
Tift	19	18	0	0	0	0	0	0	0	0	0	0
Toombs	49	34	1	0	0	0	0	0	0	0	0	0
Towns	2	0	0	0	0	0	0	0	0	0	0	0
Treutlen	16	6	0	0	0	0	0	0	0	0	0	0
Troup	6	0	0	0	0	0	0	0	0	0	0	0
Turner	0	3	0	0	0	0	0	0	0	0	0	0
Twiggs	2	2	0	0	0	0	0	0	0	0	0	0
Union	4	2	0	0	0	0	0	0	0	0	0	0
Upson	3	2	0	0	0	0	0	0	0	0	0	0
Walker	1	0	0	0	0	0	0	0	0	0	0	0
Walton	13	12	0	0	0	0	0	0	0	0	0	0
Ware	33	16	0	0	0	0	0	0	0	0	0	0
Warren	197	61	8	2	0	0	0	0	0	0	0	0
Washington	394	189	26	1	5	0	0	0	0	0	0	0
Wayne	21	18	0	0	0	0	0	0	0	0	0	0
Webster	0	1	0	0	0	0	0	0	0	0	0	0
Wheeler	11	6	0	0	0	0	0	0	0	0	0	0
White	1	2	0	0	0	0	0	0	0	0	0	0
Whitfield	2	0	0	0	0	0	0	0	0	0	0	0
Wilcox	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	244	102	3	2	6	0	0	0	0	0	0	0
Wilkinson	9	11	0	0	0	0	0	0	0	0	0	0
Worth	2	2	0	0	0	0	0	0	0	0	0	0
Total	**18,483**	**9,748**	**973**	**217**	**272**	**123**	**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	8,298	10,748
Cystoscopy	0	0	113	215
Endoscopy	0	0	750	2,894
daVinci	0	0	71	70
Total	**0**	**0**	**9,232**	**13,927**

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	6,684	8,674
Cystoscopy	0	0	106	203
Endoscopy	0	0	666	2,511
DaVinci	0	0	51	55
Total	**0**	**0**	**7,507**	**11,443**

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	9
Asian	115
Black/African American	3,952
Hispanic/Latino	285
Pacific Islander/Hawaiian	0
White	5,217
Multi-Racial	170
Total	**9,748**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4,245
Ages 15-64	4,429
Ages 65-74	706
Ages 75-85	312
Ages 85 and Up	56
Total	**9,748**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,829
Female	4,919
Total	**9,748**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,673
Medicaid	3,525
Third-Party	4,147
Self-Pay	403

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 7

4. Number of LDRP Rooms: 3

5. Number of Cesarean Sections: 355

6. Total Live Births: 1,031

7. Total Births (Live and Late Fetal Deaths): 1,050

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 981

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	796	2,078	28
Specialty Care (Intermediate Neonatal Care)	5	29	804	0
Subspecialty Care (Intensive Neonatal Care)	36	434	9,970	67

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	15	94
Black/African American	582	2,509
Hispanic/Latino	49	119
Pacific Islander/Hawaiian	0	0
White	320	1,295
Multi-Racial	7	15
Total	**973**	**4,032**

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	1	3
Ages 15-44	972	4,029
Ages 45 and Up	0	0
Total	**973**	**4,032**

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

$10,731.00

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

$16,213.00

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	217	1,314	1,027	5,542	2,115	☑
General Acute Psychiatric Adolescents 13-17	272	1,055	273	1,059	1,724	☑
General Acute Psychiatric Children 12 and Under	123	491	123	491	1,708	☑
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	5	19
Black/African American	221	1,015
Hispanic/Latino	11	45
Pacific Islander/Hawaiian	0	0
White	356	1,704
Multi-Racial	19	77
Total	**612**	**2,860**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	314	1,481
Female	298	1,379
Total	**612**	**2,860**

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	78	687
Medicaid	268	1,119
Third Party	249	925
Self-Pay	15	124
PeachCare	2	5

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? 5.1999998092651 (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 Intrepreter ☑	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☐

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	.78	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 (NEO), Patient Family Centered Care external and internal learning labs,

CLAS in-services, MCG Strategies (web base training), lectures to students and residents of the Georgia Health Sciences Univeristy.

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?

Collection of “languages spoken” on bilingual employees by Human Resources. Also, the need for more trained medical interpreters (increase FTE’s) to include a variety of languages most commonly encountered.

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

1. English
2. Universal symbols
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?

St. Vincent de Paul Health Center, 1384 Greene Street, Augusta, GA 706-828-3444
Faith Care Clinic, 625 Ronald Reagan Dr., Evans, GA 706-829-2584
Margaret Weston Clinic, Clearwater, SC 803-593-9283
Medical Clinic of Aiken, Aiken, SC 803-641-6825

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: Sandra McVicker

Date: 3/9/2011

Title: Interim COO, MCGHealth, Inc.

Comments: