



2011 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: 777 Hemlock St.

Mailing City: Macon

Mailing Zip: 31201-2155

Medicaid Provider Number: 1207A

Medicare Provider Number: 110107

2. Report Period

Report Data for the full twelve month period- January 1, 2011 through December 31, 2011.

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: Director of Reimbursement

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:

City: State:

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 type="checkbox"/>	<input 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	4,670	8,361	4,670	8,361
Pediatrics (Non ICU)	46	1,435	4,555	1,435	4,555
Pediatric ICU	12	531	2,354	531	2,354
Gynecology (No OB)	32	1,341	4,431	1,341	4,431
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	319	16,450	110,650	16,450	110,650
Intensive Care	60	4,287	18,716	4,287	18,716
Psychiatry	30	982	4,386	982	4,386
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	29,696	153,453	29,696	153,453

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	44	217
Asian	74	431
Black/African American	12,845	69,908
Hispanic/Latino	128	535
Pacific Islander/Hawaiian	6	24
White	16,594	82,326
Multi-Racial	5	12
Total	29,696	153,453

3. Gender

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

Gender	Admissions	Inpatient Days
Male	13,265	73,475
Female	16,431	79,978
Total	29,696	153,453

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	14,091	78,913
Medicaid	5,074	27,124
Peachare	4	19
Third-Party	7,815	34,059
Self-Pay	2,658	13,035
Other	54	303

5. Discharges to Death

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

999

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2011 (to the nearest whole dollar).

Service	Charge
Private Room Rate	685
Semi-Private Room Rate	685
Operating Room: Average Charge for the First Hour	4,773
Average Total Charge for an Inpatient Day	7,502

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

57,247

2. Inpatient Admissions from ER

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

16,497

3. Beds Available

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

0

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	1,693
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	0
General Beds	37	55,554
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

219

6. Non-Emergency Visits

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

305,210

7. Observation Visits/Cases

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

5,049

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

0

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.

2,319

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	3	4
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)	2	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	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	316
Number of Dialysis Treatments	6,831
Number of ESWL Patients	72
Number of ESWL Procedures	72
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	139,944
Number of CTS Units (machines)	6
Number of CTS Procedures	36,987
Number of Diagnostic Radioisotope Procedures	9,735
Number of PET Units (machines)	1
Number of PET Procedures	1,993
Number of Therapeutic Radioisotope Procedures	23
Number of Number of MRI Units	2
Number of Number of MRI Procedures	7,575
Number of Chemotherapy Treatments	4,994
Number of Respiratory Therapy Treatments	485,294
Number of Occupational Therapy Treatments	20,617
Number of Physical Therapy Treatments	58,386
Number of Speech Pathology Patients	6,808
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	52
Number of HIV/AIDS Diagnostic Procedures	1,716
Number of HIV/AIDS Patients	1,716
Number of Ambulance Trips	24,949
Number of Hospice Patients	6
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	0
Number of Ultrasound/Medical Sonography Procedures	15,984
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).

64

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	198	Robotic Hysterectomies-94;Robotic Nephrectomies-8;Robotic Prostatectomies-90;Robotic Sacrocolpopexies-6

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2011. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2011.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	125.51000213623		
Physician Assistants Only (not including Licensed Physicians)	7.8000001907349		
Registered Nurses (RNs-Advanced Practice*)	1347.0699462891		
Licensed Practical Nurses (LPNs)	45.020000457764		
Pharmacists	57.520000457764		
Other Health Services Professionals*	1469.0100097656		
Administration and Support	1366.0500488281		0
All Other Hospital Personnel (not included above)	4417.9799804688		

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	More than 90 Days
Registered Nurses (RNs-Advance Practice)	30 Days or Less
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	31-60 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	Not Applicable

3. Race/Ethnicity of Physicians

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

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

4. Medical Staff

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

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit 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	64	<input checked="" type="checkbox"/>	0	0
General Internal Medicine	65	<input checked="" type="checkbox"/>	0	0
Pediatricians	51	<input checked="" type="checkbox"/>	0	0
Other Medical Specialties	140	<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 checked="" type="checkbox"/>	0	0
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	0	<input type="checkbox"/>	0	0
Ophthalmology Surgery	10	<input type="checkbox"/>	0	0
Orthopedic Surgery	19	<input type="checkbox"/>	0	0
Plastic Surgery	7	<input type="checkbox"/>	0	0
General Surgery	15	<input type="checkbox"/>	0	0
Thoracic Surgery	7	<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	17	<input checked="" type="checkbox"/>	0	0
Dermatology	5	<input type="checkbox"/>	0	0
Emergency Medicine	35	<input checked="" type="checkbox"/>	0	0
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	5	<input checked="" type="checkbox"/>	0	0
Psychiatry	9	<input type="checkbox"/>	0	0
Radiology	62	<input checked="" type="checkbox"/>	0	0
Psychology	6	<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	15
Podiatrists	6
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.

Psychology

Comments and Suggestions:

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services

Surg=Outpatient Surgical

OB=Obstetric

P18+=Acute psychiatric adult 18 and over

P13-17=Acute psychiatric adolescent 13-17

P0-12=Acute psychiatric children 12 and under

Rehab=Inpatient Rehabilitation

S18+=Substance abuse adult 18 and over

S13-17=Substance abuse adolescent 13-17

E18+=Extended care adult 18 and over

E13-17=Extended care adolescent 13-17

E0-12=Extended care children 0-12

LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	12	6	0	1	0	0	0	0	0	0	0	0	0
Appling	4	7	0	0	0	0	0	0	0	0	0	0	0
Atkinson	5	0	1	0	0	0	0	0	0	0	0	0	0
Bacon	5	5	2	0	0	0	0	0	0	0	0	0	0
Baker	1	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	1,283	473	57	31	0	0	0	0	0	0	0	0	0
Banks	1	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	5	2	0	0	0	0	0	0	0	0	0	0	0
Bartow	1	1	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	117	28	1	0	0	0	0	0	0	0	0	0	0
Berrien	32	20	1	0	0	0	0	0	0	0	0	0	0
Bibb	14,308	6,833	1,558	642	0	0	0	0	0	0	0	0	0
Bleckley	343	226	25	6	0	0	0	0	0	0	0	0	0
Brantley	2	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	7	2	1	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0	0
Bulloch	1	2	1	0	0	0	0	0	0	0	0	0	0
Burke	6	0	0	0	0	0	0	0	0	0	0	0	0
Butts	129	79	14	4	0	0	0	0	0	0	0	0	0
Calhoun	4	3	0	0	0	0	0	0	0	0	0	0	0
Camden	1	1	0	0	0	0	0	0	0	0	0	0	0
Candler	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	2	1	0	0	0	0	0	0	0	0	0	0	0
Catoosa	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	14	4	1	1	0	0	0	0	0	0	0	0	0
Chattahoochee	0	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	2	0	0	0	0	0	0	0	0	0	0	0	0

Cherokee	7	1	1	0	0	0	0	0	0	0	0	0	0
Clarke	4	1	0	0	0	0	0	0	0	0	0	0	0
Clay	0	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	12	7	4	0	0	0	0	0	0	0	0	0	0
Clinch	2	1	0	0	0	0	0	0	0	0	0	0	0
Cobb	10	6	2	1	0	0	0	0	0	0	0	0	0
Coffee	49	20	9	1	0	0	0	0	0	0	0	0	0
Colquitt	30	29	0	0	0	0	0	0	0	0	0	0	0
Columbia	1	3	0	0	0	0	0	0	0	0	0	0	0
Cook	19	10	0	0	0	0	0	0	0	0	0	0	0
Coweta	5	5	1	0	0	0	0	0	0	0	0	0	0
Crawford	456	178	21	18	0	0	0	0	0	0	0	0	0
Crisp	246	83	11	2	0	0	0	0	0	0	0	0	0
Decatur	6	6	0	0	0	0	0	0	0	0	0	0	0
DeKalb	32	12	1	2	0	0	0	0	0	0	0	0	0
Dodge	589	260	18	3	0	0	0	0	0	0	0	0	0
Dooly	200	70	7	0	0	0	0	0	0	0	0	0	0
Dougherty	69	42	0	0	0	0	0	0	0	0	0	0	0
Douglas	3	0	0	0	0	0	0	0	0	0	0	0	0
Early	6	2	0	0	0	0	0	0	0	0	0	0	0
Effingham	3	0	0	0	0	0	0	0	0	0	0	0	0
Emanuel	40	20	0	4	0	0	0	0	0	0	0	0	0
Evans	1	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	0	0	1	0	0	0	0	0	0	0	0	0
Fayette	2	4	0	0	0	0	0	0	0	0	0	0	0
Florida	74	15	2	3	0	0	0	0	0	0	0	0	0
Floyd	2	0	0	0	0	0	0	0	0	0	0	0	0
Forsyth	4	1	1	0	0	0	0	0	0	0	0	0	0
Fulton	23	11	1	3	0	0	0	0	0	0	0	0	0
Gilmer	1	1	0	0	0	0	0	0	0	0	0	0	0
Glascocock	4	1	0	0	0	0	0	0	0	0	0	0	0
Glynn	8	0	1	0	0	0	0	0	0	0	0	0	0
Gordon	1	2	0	0	0	0	0	0	0	0	0	0	0
Grady	8	15	1	0	0	0	0	0	0	0	0	0	0
Greene	8	9	0	1	0	0	0	0	0	0	0	0	0
Gwinnett	22	6	2	2	0	0	0	0	0	0	0	0	0
Habersham	1	0	0	0	0	0	0	0	0	0	0	0	0
Hall	2	0	0	0	0	0	0	0	0	0	0	0	0
Hancock	207	55	6	5	0	0	0	0	0	0	0	0	0
Harris	1	4	0	0	0	0	0	0	0	0	0	0	0
Henry	43	35	2	0	0	0	0	0	0	0	0	0	0
Houston	2,552	1,661	275	53	0	0	0	0	0	0	0	0	0
Irwin	29	8	2	1	0	0	0	0	0	0	0	0	0
Jackson	1	1	0	0	0	0	0	0	0	0	0	0	0

Jasper	172	84	13	2	0	0	0	0	0	0	0	0	0
Jeff Davis	26	7	2	0	0	0	0	0	0	0	0	0	0
Jefferson	4	2	1	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	84	39	5	1	0	0	0	0	0	0	0	0	0
Jones	955	584	93	28	0	0	0	0	0	0	0	0	0
Lamar	221	108	9	5	0	0	0	0	0	0	0	0	0
Lanier	6	1	2	0	0	0	0	0	0	0	0	0	0
Laurens	595	380	51	6	0	0	0	0	0	0	0	0	0
Lee	26	22	0	0	0	0	0	0	0	0	0	0	0
Liberty	7	0	0	0	0	0	0	0	0	0	0	0	0
Long	1	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	53	38	16	0	0	0	0	0	0	0	0	0	0
Macon	244	105	3	7	0	0	0	0	0	0	0	0	0
Madison	2	0	0	0	0	0	0	0	0	0	0	0	0
Marion	16	3	0	0	0	0	0	0	0	0	0	0	0
McIntosh	1	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	23	7	0	1	0	0	0	0	0	0	0	0	0
Miller	3	0	0	0	0	0	0	0	0	0	0	0	0
Mitchell	7	9	0	1	0	0	0	0	0	0	0	0	0
Monroe	1,004	785	110	21	0	0	0	0	0	0	0	0	0
Montgomery	19	15	0	0	0	0	0	0	0	0	0	0	0
Morgan	8	5	1	1	0	0	0	0	0	0	0	0	0
Muscogee	14	12	0	0	0	0	0	0	0	0	0	0	0
Newton	14	4	2	0	0	0	0	0	0	0	0	0	0
North Carolina	11	6	1	0	0	0	0	0	0	0	0	0	0
Oconee	0	1	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	1	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	140	29	7	1	0	0	0	0	0	0	0	0	0
Peach	1,300	724	109	39	0	0	0	0	0	0	0	0	0
Pickens	0	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	2	0	0	0	0	0	0	0	0	0	0	0	0
Pike	92	46	1	3	0	0	0	0	0	0	0	0	0
Pulaski	275	139	3	2	0	0	0	0	0	0	0	0	0
Putnam	446	170	24	13	0	0	0	0	0	0	0	0	0
Rabun	1	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	3	4	0	0	0	0	0	0	0	0	0	0	0
Richmond	8	1	1	0	0	0	0	0	0	0	0	0	0
Rockdale	9	1	3	1	0	0	0	0	0	0	0	0	0
Schley	17	8	2	0	0	0	0	0	0	0	0	0	0
Screven	0	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	13	5	0	0	0	0	0	0	0	0	0	0	0
Spalding	69	44	9	3	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0

Sumter	93	46	3	3	0	0	0	0	0	0	0	0	0
Talbot	8	2	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	5	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	336	118	17	3	0	0	0	0	0	0	0	0	0
Telfair	152	56	4	3	0	0	0	0	0	0	0	0	0
Tennessee	21	1	1	1	0	0	0	0	0	0	0	0	0
Terrell	16	4	0	0	0	0	0	0	0	0	0	0	0
Thomas	9	13	0	0	0	0	0	0	0	0	0	0	0
Tift	92	58	1	2	0	0	0	0	0	0	0	0	0
Toombs	30	13	2	0	0	0	0	0	0	0	0	0	0
Treutlen	48	12	6	1	0	0	0	0	0	0	0	0	0
Troup	7	2	0	1	0	0	0	0	0	0	0	0	0
Turner	30	21	1	1	0	0	0	0	0	0	0	0	0
Twiggs	503	250	22	25	0	0	0	0	0	0	0	0	0
Upson	466	147	11	2	0	0	0	0	0	0	0	0	0
Walker	2	2	0	0	0	0	0	0	0	0	0	0	0
Walton	6	2	0	0	0	0	0	0	0	0	0	0	0
Ware	2	1	0	0	0	0	0	0	0	0	0	0	0
Washington	128	56	2	2	0	0	0	0	0	0	0	0	0
Wayne	5	3	0	0	0	0	0	0	0	0	0	0	0
Webster	2	2	0	0	0	0	0	0	0	0	0	0	0
Wheeler	35	19	2	0	0	0	0	0	0	0	0	0	0
Whitfield	4	0	0	1	0	0	0	0	0	0	0	0	0
Wilcox	145	74	2	1	0	0	0	0	0	0	0	0	0
Wilkinson	569	291	41	16	0	0	0	0	0	0	0	0	0
Worth	15	23	1	0	0	0	0	0	0	0	0	0	0
Total	29,696	14,890	2,614	982	0	0	0	0	0	0	0	0	0

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	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	5,016	8,080	5,714
Cystoscopy	0	0	144	112
Endoscopy	0	3,380	910	668
	0	0	0	0
Total	0	8,396	9,134	6,494

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	5,016	8,080	5,714
Cystoscopy	0	0	144	112
Endoscopy	0	3,380	910	668
	0	0	0	0
Total	0	8,396	9,134	6,494

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	29
Asian	65
Black/African American	5,752
Hispanic/Latino	73
Pacific Islander/Hawaiian	1
White	8,951
Multi-Racial	19
Total	14,890

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,969
Ages 15-64	9,671
Ages 65-74	2,124
Ages 75-85	989
Ages 85 and Up	137
Total	14,890

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	6,182
Female	8,708
Total	14,890

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	4,259
Medicaid	2,467
Third-Party	7,534
Self-Pay	630

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: 9
4. Number of LDRP Rooms: 21
5. Number of Cesarean Sections: 960
6. Total Live Births: 2,587
7. Total Births (Live and Late Fetal Deaths): 2,607
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,618

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)	30	2,234	4,587	0
Specialty Care (Intermediate Neonatal Care)	14	231	4,623	0
Subspecialty Care (Intensive Neonatal Care)	42	662	13,941	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	11	63
Asian	16	32
Black/African American	1,283	3,615
Hispanic/Latino	28	65
Pacific Islander/Hawaiian	1	7
White	1,275	3,315
Multi-Racial	0	0
Total	2,614	7,097

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	3	6
Ages 15-44	2,607	7,084
Ages 45 and Up	4	7
Total	2,614	7,097

3. Average Charge for an Uncomplicated Delivery

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

\$10,955.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$15,573.00

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	26	26
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	982	0	982	4,386	1,077	<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	2	7
Asian	0	0
Black/African American	463	2,081
Hispanic/Latino	2	11
Pacific Islander/Hawaiian	0	0
White	515	2,287
Multi-Racial	0	0
Total	982	4,386

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	471	2,035
Female	511	2,351
Total	982	4,386

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	289	1,537
Medicaid	259	1,537
Third Party	143	433
Self-Pay	291	879
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? (Check the box, if yes.)

If you checked yes, how many? 2 (FTE's)

What languages do they interpret?

Spanish, Hindi

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):

Deaf Talk Video Conferencing System

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	85	28	0	0
Mandarin Chinese	9	0	0	0
Hindi	1	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 Corners Cultural Understanding during orientation. Ongoing Inservice Training on Interpreting

Services/Cultural Understanding for all departments. Carenotes available in Spanish provided during visit and upon discharge.

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 Deaf Talk Unit

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

1. English

2. Spanish

3.

4.

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

If you checked yes, what is the name and location of that health care center or clinic?

Anderson Health Clinic, department of MCCG located on hospital campus. Macon Volunteer Clinic 376 Rogers Ave. First Choice Primary Care Clinic 770 Walnut St. Bibb County Health Department 171 Emery Highway.

Comprehensive Inpatient Physical Rehabilitation Addendum

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

1. Admissions and Days of Care by Race

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

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

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0
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1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care

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

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or 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: 3/23/2012

Title: President/CEO

Comments: