





**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:**

**City:** **State:**

**8.** Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☒

**9.** Check the box to the right if the hospital owns or operates a primary care physician group practice. ☒

**10a. Managed Care Information: Formal Written Contract**

Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☒

2. Preferred Provider Organization(PPO) ☒

3. Physician Hospital Organization(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)	0	676	1,767	676	1,767
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	1,894	6,818	1,894	6,818
General Surgery	0	0	0	0	0
Medical/Surgical	0	2,287	6,516	2,287	6,516
Intensive Care	0	507	2,028	507	2,028
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
<b>Total</b>	<b>0</b>	<b>5,364</b>	<b>17,129</b>	<b>5,364</b>	<b>17,129</b>







### **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	69
Number of Dialysis Treatments	108
Number of ESWL Patients	0
Number of ESWL Procedures	32
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	43,111
Number of CTS Units (machines)	2
Number of CTS Procedures	15,780
Number of Diagnostic Radioisotope Procedures	2,901
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	2
Number of Number of MRI Procedures	3,616
Number of Chemotherapy Treatments	886
Number of Respiratory Therapy Treatments	23,505
Number of Occupational Therapy Treatments	0
Number of Physical Therapy Treatments	51,006
Number of Speech Pathology Patients	276
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	144
Number of HIV/AIDS Patients	73
Number of Ambulance Trips	11,176
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	3
Number of Ultrasound/Medical Sonography Procedures	9,076
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).

5

**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	





**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	13
Podiatrists	4
Certified Nurse Midwives with Clinical Privileges in the Hospital	4
All Other Staff Affiliates with Clinical Privileges in the Hospital	36

**5b. Name of Other Professions**

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

Physicians Assistant, Nurse Practitioners, CRNA

**Comments and Suggestions:**







Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	6
Asian	6
Black/African American	907
Hispanic/Latino	63
Pacific Islander/Hawaiian	0
White	3,380
Multi-Racial	58
<b>Total</b>	<b>4,420</b>

## **2. Age Grouping**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	575
Ages 15-64	2,444
Ages 65-74	658
Ages 75-85	623
Ages 85 and Up	120
<b>Total</b>	<b>4,420</b>

## **3. Gender**

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,801
Female	2,619
<b>Total</b>	<b>4,420</b>

## **4. Payment Source**

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

Primary Payment Source	Number of Patients
Medicare	1,747
Medicaid	870
Third-Party	1,685
Self-Pay	118

## **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: 2**

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 0
4. Number of LDRP Rooms: 12
5. Number of Cesarean Sections: 245
6. Total Live Births: 675
7. Total Births (Live and Late Fetal Deaths): 682
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 676

## 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)	12	634	1,203	0
Specialty Care (Intermediate Neonatal Care)	4	0	0	0
Subspecialty Care (Intensive Neonatal Care)	4	41	1,496	84

## 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	1	3
Asian	2	5
Black/African American	229	574
Hispanic/Latino	33	86
Pacific Islander/Hawaiian	0	0
White	433	1,109
Multi-Racial	9	23
<b>Total</b>	<b>707</b>	<b>1,800</b>

## **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	703	1,787
Ages 45 and Up	3	10
<b>Total</b>	<b>707</b>	<b>1,800</b>

## **3. Average Charge for an Uncomplicated Delivery**

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

\$5,225.00

## **4. Average Charge for a Premature Delivery**

Please report the average hospital charge for a premature delivery.

\$13,068.00

## **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.



## 1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example, "AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

## 2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

## Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

### 1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

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

### 2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
<b>Total</b>	<b>0</b>	<b>0</b>

### 3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
PeachCare	0	0

## Georgia Minority Health Advisory Council Addendum

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

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

If you checked yes, how many? 0 (FTE's)

What languages do they interpret?

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): ☐

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	1	3	2	3
Russian	<.1	0	1	0
Norwegian	<.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?

We train frontline staff to recognize language differences and to utilize the telephonic language line

service to identify the language and interpret the conversatin as required.

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?

NA

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?

Willing Helpers clinic at Solid Rock Baptist Church

Brown Bridge Road

Covington, Georgia

## 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:** James F. Weadick

**Date:** 2/24/2014

**Title:** CEO

**Comments:**