GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP616

Facility Name: Phoebe Putney Memorial Hospital

County: Dougherty

Street Address: 417 West Third Avenue

City: Albany

Zip: 31701-1960

Mailing Address: PO Box 3770

Mailing City: Albany

Mailing Zip: 31706

Medicaid Provider Number: 000001482A

Medicare Provider Number: 110007

2. Report Period

Report Data for the full twelve month period- January 1, 2013 through December 31, 2013.
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: Lori Jenkins

Contact Title: Manager of Planning Department

Phone: 229-312-1432

Fax: 229-312-7100

E-mail: ljenkins@ppmh.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
Hospital Authority of Albany-Dougherty County	Hospital Authority	7/1/1941

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Memorial Hospital, Inc.	Not for Profit	9/1/1991

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	9/1/1991

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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: Phoebe Putney Health System, Inc.
City: Albany **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: Phoebe Putney Health System, Inc.
City: Albany **State:** GA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Georgia Alliance of Community Hospitals
City: Tifton **State:** GA

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(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)

Not Applicable

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)	42	2,859	8,531	2,850	8,448
Pediatrics (Non ICU)	26	546	1,674	541	1,649
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	14	352	1,024	353	1,033
General Medicine	173	8,688	40,486	10,779	53,998
General Surgery	131	3,660	20,705	4,427	27,337
Medical/Surgical	0	0	0	0	0
Intensive Care	50	3,268	23,261	449	3,166
Psychiatry	38	1,560	8,220	1,545	8,120
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	25	366	4,803	366	4,702
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	**499**	**21,299**	**108,704**	**21,310**	**108,453**

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	7	22
Asian	49	238
Black/African American	10,906	57,065
Hispanic/Latino	69	276
Pacific Islander/Hawaiian	0	0
White	9,687	48,361
Multi-Racial	581	2,742
Total	**21,299**	**108,704**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,676	47,242
Female	12,623	61,462
Total	**21,299**	**108,704**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,781	56,999
Medicaid	5,095	24,695
Peachare	0	0
Third-Party	4,301	18,081
Self-Pay	1,576	6,415
Other	546	2,514

5. Discharges to Death

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

485

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2013 (to the nearest whole dollar).

Service	Charge
Private Room Rate	480
Semi-Private Room Rate	480
Operating Room: Average Charge for the First Hour	3,364
Average Total Charge for an Inpatient Day	5,136

Part E : Emergency Department and Outpatient Services

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

102,221

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

10,568

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

49

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	4	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	0
General Beds	27	0
Chest Pain	6	0
Fast Track and Obersvation/holding	9	0
Resuscitation/seclusion	1	0
	0	0

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

707

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

1,164,761

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

8,312

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.

680

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	3	4
Renal Dialysis	1	1
ESWL	2	1
Billiary Lithotropter	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, 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	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
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	0
Number of Dialysis Treatments	3,230
Number of ESWL Patients	319
Number of ESWL Procedures	319
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	101,194
Number of CTS Units (machines)	6
Number of CTS Procedures	38,728
Number of Diagnostic Radioisotope Procedures	2,822
Number of PET Units (machines)	1
Number of PET Procedures	984
Number of Therapeautic Radioisotope Procedures	42
Number of Number of MRI Units	4
Number of Number of MRI Procedures	10,413
Number of Chemotherapy Treatments	27,216
Number of Respiratory Therapy Treatments	201,770
Number of Occupational Therapy Treatments	47,543
Number of Physical Therapy Treatments	85,456
Number of Speech Pathology Patients	2,140
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,992
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	849
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	9
Number of Ultrasound/Medical Sonography Procedures	15,824
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).

47

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	320	IS2000 da Vinci Surgical System

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2013. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2013.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0	0	
Physician Assistants Only (not including Licensed Physicians)	1.3700000047684	0.37000000476837	
Registered Nurses (RNs-Advanced Practice*)	796.89001464844	110.54000091553	
Licensed Practical Nurses (LPNs)	70.319999694824	14.420000076294	
Pharmacists	38.930000305176	3.7799999713898	
Other Health Services Professionals*	544.95001220703	93.430000305176	
Administration and Support	231.71000671387	27.360000610352	
All Other Hospital Personnel (not included above)	1382.1199951172	159.30000305176	

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	61-90 Days
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	61-90 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	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 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	30	☑	30	30
General Internal Medicine	43	☑	39	43
Pediatricians	22	☐	22	22
Other Medical Specialties	32	☑	32	32

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	20	☐	20	20
Non-OB Physicians Providing OB Services	2	☑	2	2
Gynecology	25	☐	20	25
Ophthalmology Surgery	8	☐	8	8
Orthopedic Surgery	11	☑	11	11
Plastic Surgery	2	☐	0	2
General Surgery	12	☑	12	12
Thoracic Surgery	2	☑	2	2
Other Surgical Specialties	25	☑	25	25

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	12	☑	12	12
Dermatology	2	☐	2	2
Emergency Medicine	31	☑	31	31
Nuclear Medicine	17	☑	17	17
Pathology	5	☑	5	5
Psychiatry	3	☑	3	3
Radiology	17	☑	17	17
Hematology/Oncology	10	☑	10	10
Neonatology	4	☑	4	4
Radiation Oncology	3	☑	3	3

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	5
Podiatrists	5
Certified Nurse Midwives with Clinical Privileges in the Hospital	7
All Other Staff Affiliates with Clinical Privileges in the Hospital	195

5b. Name of Other Professions

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

Physician Assistants, Surgical Technologists, Orthopedic Technologists, Dental Assistants, Ophthalmic Technologists, Nurse Practitioners

Comments and Suggestions:

Data reported is for all beds/services/other categories for both Phoebe Main Campus and North Campus.
D.1.(a) Reported OB inpatient days include obstetric, labor and delivery, c-section, ante- and post-partum days.
D.2. Multiracial categories include patients whose race/ethnicity is unknown.
E.4. Pheobe Putney information systems are unable to capture the type of Emergency Room visit by type of bed.
E.5. Transfer data includes intra-facility transfers from Phoebe's North Campus to the Main Campus. Transfer data also includes transfers back to non-hospital institutions (e.g., nursing homes).
E.6. Visits reported here include visits provided under the auspices of Phoebe Physician Group.
E.10. Includes all patients (i) who registered but left against medical advice; or (ii) who left before being discharged. Some of these patients likely received some care before leaving.
F.1. Number of MRI units: Phoebe Putney operates 2 MRI units on its main campus, one on its north campus and 1 on its Meredyth Drive campus.
F.1. Number of CT units: Phoebe Putney operates 4 CT units on its main campus, 1 on its north campus and 1 on its Meredyth Drive campus.
F.1. Phoebe Putney has a critical care transport service that uses critical care ambulances for the transports. These ambulances are not part of the county's Emergency Medical System.
F.1.b. Respiratory treatments reflect all procedures with attached CPT code.
F.2. The breakdown of ventilators reported here is as follows: 34 adult, 12 neonatal and 1 transport.
G.1: Contract/temporary staff data not available.
G.3. Phoebe Putney does not capture the race/ethnicity of its medical staff.
G.4. Reported hospital-based physicians include both physicians with hospital-based practices and Phoebe Physician Group-employed physicians.
G.4. Some physicians are reported in both the Obstetrics and Gynecology categories.
G.4. The number of providers enrolled in Medicaid/PeachCare and/or Public Employee Health Benefits Plan was derived from hospital records. Any physician whose patient generated a charge where the financial class was Medicaid, State Health Benefit Plan or Board of Regents Health Plan

is counted in the report. Additional physicians on staff may be Medicaid and/or State Health Benefit enrolled providers.

Surgical Services Addendum B.2. Mulitracial categories include patients whose race/ethnicity is unknown.

Perinatal Services Addendum C.1. Mulitracial categories include patients whose race/ethnicity is unknown.

Perinatal Services Addendum C.3. Average hospital charge for an uncomplicated delivery is based on charges for MS-DRG 775 (mothers' charges).

Perinatal Services Addendum C.4. Average charge for a premature delivery excludes outliers.

Psychiatric/Substance Abuse Addendum A.2:Phoebe Putney Memorial Hospital, including its inpatient psychiatric services, is accredited by DNV.

Psychiatric/Substance Abuse Addendum B.1: Multiracial categories include patients whose race/ethnicity is unknown.

Minority Health Addendum Part 3: Although Phoebe does have physicians, nurses, and employed staff who speak languages other than English, Phoebe does not have reliable data responsive to the survey request.

Comprehensive Inpatient Physical Rehabilitation Addendum A.1. Multiracial categories include patients whose race/ethnicity is unknown.

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	24	1	0	3	0	0	0	0	0	0	0	0	0
Appling	0	1	0	0	0	0	0	0	0	0	0	0	0
Atkinson	9	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	1	0	0	0	0	0	0	0	0	0	0	0	0
Baker	185	88	24	11	0	0	0	0	0	0	0	0	5
Bartow	1	0	0	1	0	0	0	0	0	0	0	0	0
Ben Hill	241	81	9	53	0	0	0	0	0	0	0	0	5
Berrien	37	27	10	2	0	0	0	0	0	0	0	0	0
Bibb	7	7	0	5	0	0	0	0	0	0	0	0	0
Bleckley	0	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	0	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	13	10	6	0	0	0	0	0	0	0	0	0	0
Bryan	0	1	0	0	0	0	0	0	0	0	0	0	0
Bulloch	1	0	1	0	0	0	0	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0	0
Calhoun	417	257	48	28	0	0	0	0	0	0	0	0	12
Camden	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	3	2	1	0	0	0	0	0	0	0	0	0	0
Chatham	2	1	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	6	1	0	0	0	0	0	0	0	0	0	0	1
Chattooga	1	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	0	1	0	0	0	0	0	0	0	0	0	0	0
Clarke	3	0	0	0	0	0	0	0	0	0	0	0	0
Clay	85	48	32	7	0	0	0	0	0	0	0	0	1
Clayton	5	3	0	2	0	0	0	0	0	0	0	0	0
Clinch	2	5	0	0	0	0	0	0	0	0	0	0	0
Cobb	8	8	1	0	0	0	0	0	0	0	0	0	0

Coffee	56	27	4	6	0	0	0	0	0	0	0	0	0
Colquitt	503	215	62	48	0	0	0	0	0	0	0	0	2
Cook	32	19	10	2	0	0	0	0	0	0	0	0	0
Coweta	2	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	412	284	20	59	0	0	0	0	0	0	0	0	9
Dawson	1	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	65	65	17	7	0	0	0	0	0	0	0	0	0
DeKalb	7	1	1	2	0	0	0	0	0	0	0	0	0
Dodge	0	7	0	0	0	0	0	0	0	0	0	0	0
Dooly	93	47	5	13	0	0	0	0	0	0	0	0	3
Dougherty	11,102	4,664	1,530	739	0	0	0	0	0	0	0	0	183
Douglas	3	0	0	0	0	0	0	0	0	0	0	0	0
Early	156	117	23	7	0	0	0	0	0	0	0	0	5
Echols	0	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	1	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	69	9	5	10	0	0	0	0	0	0	0	0	2
Forsyth	2	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	12	1	1	4	0	0	0	0	0	0	0	0	0
Gilmer	1	2	0	0	0	0	0	0	0	0	0	0	0
Glynn	4	4	1	0	0	0	0	0	0	0	0	0	0
Grady	42	24	22	1	0	0	0	0	0	0	0	0	1
Greene	0	1	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	8	3	2	1	0	0	0	0	0	0	0	0	0
Habersham	1	1	0	0	0	0	0	0	0	0	0	0	0
Hall	2	0	0	1	0	0	0	0	0	0	0	0	0
Harris	0	1	0	0	0	0	0	0	0	0	0	0	0
Henry	5	0	1	0	0	0	0	0	0	0	0	0	0
Houston	11	17	1	2	0	0	0	0	0	0	0	0	0
Irwin	32	16	1	7	0	0	0	0	0	0	0	0	0
Jackson	1	2	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	3	0	1	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	3	1	1	0	0	0	0	0	0	0	0	0
Laurens	0	1	0	0	0	0	0	0	0	0	0	0	0
Lee	2,015	1,304	320	117	0	0	0	0	0	0	0	0	23
Liberty	2	1	1	0	0	0	0	0	0	0	0	0	0
Lincoln	1	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	63	69	33	15	0	0	0	0	0	0	0	0	0
Macon	87	25	4	10	0	0	0	0	0	0	0	0	3
Marion	25	11	0	3	0	0	0	0	0	0	0	0	2
McIntosh	2	0	1	0	0	0	0	0	0	0	0	0	0
Miller	153	96	5	11	0	0	0	0	0	0	0	0	1

Mitchell	925	562	142	20	0	0	0	0	0	0	0	0	15
Morgan	0	1	0	0	0	0	0	0	0	0	0	0	0
Murray	1	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	21	3	4	4	0	0	0	0	0	0	0	0	0
Newton	1	1	1	0	0	0	0	0	0	0	0	0	0
North Carolina	7	1	0	0	0	0	0	0	0	0	0	0	0
Oconee	1	0	0	1	0	0	0	0	0	0	0	0	0
Other Out of State	84	19	0	12	0	0	0	0	0	0	0	0	1
Paulding	3	1	0	3	0	0	0	0	0	0	0	0	0
Peach	7	2	0	2	0	0	0	0	0	0	0	0	0
Pickens	3	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	0	1	0	0	0	0	0	0	0	0	0	0
Polk	2	1	0	0	0	0	0	0	0	0	0	0	0
Pulaski	1	0	0	1	0	0	0	0	0	0	0	0	0
Putnam	1	0	0	0	0	0	0	0	0	0	0	0	0
Quitman	30	19	5	0	0	0	0	0	0	0	0	0	1
Rabun	1	0	0	0	0	0	0	0	0	0	0	0	0
Randolph	483	285	97	19	0	0	0	0	0	0	0	0	9
Richmond	2	0	0	0	0	0	0	0	0	0	0	0	0
Rockdale	1	1	0	0	0	0	0	0	0	0	0	0	0
Schley	61	51	3	4	0	0	0	0	0	0	0	0	1
Screven	2	0	0	2	0	0	0	0	0	0	0	0	0
Seminole	22	29	4	1	0	0	0	0	0	0	0	0	0
South Carolina	9	0	0	3	0	0	0	0	0	0	0	0	0
Spalding	1	0	0	1	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	52	20	4	6	0	0	0	0	0	0	0	0	1
Sumter	759	441	59	78	0	0	0	0	0	0	0	0	31
Talbot	2	1	0	0	0	0	0	0	0	0	0	0	1
Taylor	5	3	0	2	0	0	0	0	0	0	0	0	0
Telfair	2	2	0	0	0	0	0	0	0	0	0	0	1
Tennessee	15	0	0	2	0	0	0	0	0	0	0	0	0
Terrell	1,107	452	134	71	0	0	0	0	0	0	0	0	18
Thomas	81	38	29	7	0	0	0	0	0	0	0	0	1
Tift	164	112	26	40	0	0	0	0	0	0	0	0	1
Treutlen	1	0	0	0	0	0	0	0	0	0	0	0	0
Troup	2	0	1	1	0	0	0	0	0	0	0	0	0
Turner	135	80	5	20	0	0	0	0	0	0	0	0	4
Twiggs	0	1	0	0	0	0	0	0	0	0	0	0	0
Upson	1	0	0	0	0	0	0	0	0	0	0	0	0
Walton	0	2	0	0	0	0	0	0	0	0	0	0	0
Ware	3	1	1	0	0	0	0	0	0	0	0	0	0
Washington	2	0	0	0	0	0	0	0	0	0	0	0	1
Wayne	0	1	0	0	0	0	0	0	0	0	0	0	0

Webster	48	24	3	2	0	0	0	0	0	0	0	0	0
Wheeler	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilcox	68	42	4	11	0	0	0	0	0	0	0	0	2
Worth	1,149	678	133	69	0	0	0	0	0	0	0	0	20
Total	**21,299**	**10,460**	**2,860**	**1,560**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**366**

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	16
Cystoscopy (OR Suite)	0	0	3
Endoscopy (OR Suite)	0	0	0
Open Heart	1	0	0
Total	**1**	**8**	**19**

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	35	3,558	4,223	6,520
Cystoscopy	0	0	160	901
Endoscopy	0	0	0	0
	0	0	0	0
Total	**35**	**3,558**	**4,383**	**7,421**

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	34	3,523	3,777	6,049
Cystoscopy	0	0	132	888
Endoscopy	0	0	0	0
	0	0	0	0
Total	**34**	**3,523**	**3,909**	**6,937**

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	6
Asian	26
Black/African American	4,602
Hispanic/Latino	48
Pacific Islander/Hawaiian	2
White	5,498
Multi-Racial	278
Total	**10,460**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,491
Ages 15-64	6,333
Ages 65-74	1,755
Ages 75-85	756
Ages 85 and Up	125
Total	**10,460**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,399
Female	6,061
Total	**10,460**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,242
Medicaid	2,065
Third-Party	4,844
Self-Pay	309

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: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 12

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,030

6. Total Live Births: 2,611

7. Total Births (Live and Late Fetal Deaths): 2,636

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,994

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)	44	2,186	4,434	229
Specialty Care (Intermediate Neonatal Care)	12	5	4,631	466
Subspecialty Care (Intensive Neonatal Care)	15	537	7,422	166

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	4	16
Asian	21	51
Black/African American	1,770	5,532
Hispanic/Latino	33	75
Pacific Islander/Hawaiian	0	0
White	936	2,510
Multi-Racial	96	349
Total	**2,860**	**8,533**

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	10	35
Ages 15-44	2,849	8,493
Ages 45 and Up	1	5
Total	**2,860**	**8,533**

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

$7,775.00

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

$16,494.00

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	38	38
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	1,560	8,220	1,545	8,120	1,944	☑
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
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	0	0
Black/African American	835	4,473
Hispanic/Latino	3	13
Pacific Islander/Hawaiian	0	0
White	692	3,588
Multi-Racial	30	146
Total	**1,560**	**8,220**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	722	3,814
Female	838	4,406
Total	**1,560**	**8,220**

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	590	3,716
Medicaid	533	2,825
Third Party	229	961
Self-Pay	208	718
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 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	n/a	0	0	0
		0	0	0
		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?

Cultural diversity module included in the annual employee update and new employee orientation.

Nursing internship course includes diversity 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?

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?

Albany Area Primary Health Care. Locations in Dougherty, Lee, Baker, Calhoun and Terrell counties.

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	2	22
Black/African American	176	2,437
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	184	2,297
Multi-Racial	4	47

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	191	2,598
Female	175	2,205

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	167	2,187
65-84	173	2,258
85 Up	26	358

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	366
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

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

Primary Payment Source	Admissions
Medicare	248
Third Party/Commercial	101
Self Pay	9
Other	8

2. Uncompensated Indigent and Charity Care

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

10

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	145
2. Brain Injury	20
3. Amputation	34
4. Spinal Cord	31
5. Fracture of the femur	34
6. Neurological disorders	5
7. Multiple Trauma	6
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	17
All Other	74

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: Joel Wernick

Date: 4/15/2014

Title: CEO

Comments: