GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2013 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP719

Facility Name: Georgia Regents Medical Center

County: Richmond

Street Address: 1120 15th Street

City: Augusta

Zip: 30912

Mailing Address: 1120 15th Street

Mailing City: Augusta

Mailing Zip: 30912

Medicaid Provider Number: 00000723

Medicare Provider Number: 110034

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: Stacie Pankow

Contact Title: Institutional Research Analyst

Phone: 706-721-2553

Fax: 706-434-6181

E-mail: spankow@gru.edu

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management
As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
University System of Georgia Board of Regents	State	1/1/1956

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management
Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☐
Name:
City: **State:**

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: MCG Health Inc. Insurance Company
City: Grand Cayman   **State:** CI

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

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: First Medical Network
City: Atlanta   **State:** GA

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

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

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☑	☐
Preferred Provider Organization	☐	☐	☑	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	30	1,122	3,117	1,119	3,156
Pediatrics (Non ICU)	45	839	3,511	1,003	4,652
Pediatric ICU	13	322	2,461	101	343
Gynecology (No OB)	0	446	2,241	445	2,210
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	203	10,799	59,315	12,625	76,195
Intensive Care	70	2,975	23,763	1,143	6,657
Psychiatry	41	1,088	6,399	1,095	6,534
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
Epilepsy	6	235	598	235	593
	0	0	0	0	0
	0	0	0	0	0
Total	**408**	**17,826**	**101,405**	**17,766**	**100,340**

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	15	55
Asian	55	308
Black/African American	8,176	47,342
Hispanic/Latino	451	1,946
Pacific Islander/Hawaiian	106	717
White	8,865	50,403
Multi-Racial	158	634
Total	**17,826**	**101,405**

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

Gender	Admissions	Inpatient Days
Male	8,509	50,689
Female	9,317	50,716
Total	**17,826**	**101,405**

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,804	37,728
Medicaid	4,830	26,287
Peachare	8	31
Third-Party	5,273	27,321
Self-Pay	1,911	10,038
Other	0	0

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

522

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	706
Semi-Private Room Rate	706
Operating Room: Average Charge for the First Hour	3,213
Average Total Charge for an Inpatient Day	8,005

Part E : Emergency Department and Outpatient Services

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

87,464

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

9,636

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

72

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	10	2,176
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	9	2,126
General Beds	45	83,162
	0	0
	0	0
	0	0
	0	0

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

1,367

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

470,431

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

5,923

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

88.00

10. Untreated Cases

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

2,949

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	2	1
ESWL	1	1
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	1	1
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	2	1
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	4,353
Number of ESWL Patients	107
Number of ESWL Procedures	124
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	71
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	2
Number of Diagnostic X-Ray Procedures	114,051
Number of CTS Units (machines)	2
Number of CTS Procedures	28,391
Number of Diagnostic Radioisotope Procedures	3,270
Number of PET Units (machines)	1
Number of PET Procedures	1,588
Number of Therapeautic Radioisotope Procedures	10
Number of Number of MRI Units	3
Number of Number of MRI Procedures	10,714
Number of Chemotherapy Treatments	10,166
Number of Respiratory Therapy Treatments	141,533
Number of Occupational Therapy Treatments	24,630
Number of Physical Therapy Treatments	60,995
Number of Speech Pathology Patients	8,907
Number of Gamma Ray Knife Procedures	303
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	2,109
Number of HIV/AIDS Diagnostic Procedures	6,921
Number of HIV/AIDS Patients	2,307
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	84
Number of Ultrasound/Medical Sonography Procedures	13,078
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).

95

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	357	daVinci 4-Arm Robot

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	3.4800000190735	0	0
Physician Assistants Only (not including Licensed Physicians)	1	0	0
Registered Nurses (RNs-Advanced Practice*)	1012.4000244141	89.25	0
Licensed Practical Nurses (LPNs)	85.919998168945	5	0
Pharmacists	29.879999160767	2.7999999523163	0
Other Health Services Professionals*	835.86999511719	88.98999786377	9.0600004196167
Administration and Support	202.94999694824	32.099998474121	0
All Other Hospital Personnel (not included above)	1162	143.94999694824	69.220001220703

2. Filling Vacancies
Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians
Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	25
Asian	72
Black/African American	44
Hispanic/Latino	30
Pacific Islander/Hawaiian	0
White	414
Multi-Racial	21

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	29	☑	13	13
General Internal Medicine	45	☑	45	45
Pediatricians	104	☑	27	27
Other Medical Specialties	130	☑	130	130

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	☑	28	28
Non-OB Physicians Providing OB Services	16	☑	10	10
Gynecology	40	☑	6	6
Ophthalmology Surgery	16	☑	14	14
Orthopedic Surgery	27	☑	20	20
Plastic Surgery	10	☑	5	5
General Surgery	7	☑	2	2
Thoracic Surgery	7	☑	3	3
Other Surgical Specialties	73	☑	69	69

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	57	☑	38	38
Dermatology	8	☑	6	6
Emergency Medicine	71	☑	53	53
Nuclear Medicine	2	☑	1	1
Pathology	23	☑	21	21
Psychiatry	35	☑	35	35
Radiology	52	☑	39	39
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	17
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	2
All Other Staff Affiliates with Clinical Privileges in the Hospital	168

5b. Name of Other Professions

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

PA, PhD, NP, CRNA, Dental Assistant, Optometry

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
Appling	18	9	0	0	0	0	0	0	0	0	0	0	0
Atkinson	10	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	8	6	0	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	78	64	1	0	0	2	0	0	0	0	0	0	0
Banks	2	3	0	0	0	0	0	0	0	0	0	0	0
Barrow	10	11	0	0	0	0	0	0	0	0	0	0	0
Bartow	6	1	0	2	0	0	0	0	0	0	0	0	0
Ben Hill	18	9	1	0	1	0	0	0	0	0	0	0	0
Berrien	17	9	0	0	0	0	0	0	0	0	0	0	0
Bibb	36	24	0	1	0	0	0	0	0	0	0	0	0
Bleckley	5	3	0	0	0	0	0	0	0	0	0	0	0
Brantley	10	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	8	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	17	16	0	0	0	0	0	0	0	0	0	0	0
Bulloch	184	69	5	1	0	0	0	0	0	0	0	0	0
Burke	596	255	92	12	3	0	0	0	0	0	0	0	0
Butts	1	3	0	0	0	0	0	0	0	0	0	0	0
Calhoun	0	4	0	0	0	0	0	0	0	0	0	0	0
Camden	3	2	0	0	0	0	0	0	0	0	0	0	0
Candler	36	16	0	0	0	0	0	0	0	0	0	0	0
Carroll	2	3	0	0	0	0	0	0	0	0	0	0	0
Chatham	49	36	1	1	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	1	0	0	1	0	0	0	0	0	0	0	0	0
Cherokee	3	0	0	1	0	0	0	0	0	0	0	0	0
Clarke	35	53	0	0	0	0	0	0	0	0	0	0	0

County												
Clay	0	3	0	0	0	0	0	0	0	0	0	0	0
Clayton	3	0	0	1	0	0	0	0	0	0	0	0	0
Clinch	8	0	1	0	0	0	0	0	0	0	0	0	0
Cobb	6	14	0	0	0	0	0	0	0	0	0	0	0
Coffee	45	35	0	0	0	0	0	0	0	0	0	0	0
Colquitt	24	22	1	1	0	0	0	0	0	0	0	0	0
Columbia	2,383	1,631	145	151	72	23	0	0	0	0	0	0	0
Cook	12	11	0	0	0	0	0	0	0	0	0	0	0
Coweta	0	1	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	9	6	0	0	0	0	0	0	0	0	0	0	0
Dawson	8	1	0	0	0	0	0	0	0	0	0	0	0
Decatur	7	3	0	0	0	0	0	0	0	0	0	0	0
Dekalb	12	7	0	0	0	0	0	0	0	0	0	0	0
Dodge	20	16	0	0	0	0	0	0	0	0	0	0	0
Dooly	7	2	1	0	0	0	0	0	0	0	0	0	0
Dougherty	63	66	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	2	3	0	0	0	0	0	0	0	0	0	0	0
Effingham	28	35	2	0	0	3	0	0	0	0	0	0	0
Elbert	79	50	1	0	0	0	0	0	0	0	0	0	0
Emanuel	284	132	10	2	0	0	0	0	0	0	0	0	0
Evans	39	14	1	0	0	0	0	0	0	0	0	0	0
Fannin	4	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	4	3	0	0	0	0	0	0	0	0	0	0	0
Florida	37	36	0	2	0	0	0	0	0	0	0	0	0
Floyd	3	5	1	0	0	0	0	0	0	0	0	0	0
Forsyth	5	4	0	0	0	0	0	0	0	0	0	0	0
Franklin	12	8	0	0	0	0	0	0	0	0	0	0	0
Fulton	10	21	2	1	0	0	0	0	0	0	0	0	0
Gilmer	0	2	0	0	0	0	0	0	0	0	0	0	0
Glascock	94	29	6	3	0	0	0	0	0	0	0	0	0
Glynn	30	9	1	1	0	1	0	0	0	0	0	0	0
Gordon	1	0	0	1	0	0	0	0	0	0	0	0	0
Grady	7	4	0	0	0	0	0	0	0	0	0	0	0
Greene	49	58	1	0	0	0	0	0	0	0	0	0	0
Gwinnett	21	18	1	0	0	0	0	0	0	0	0	0	0
Habersham	1	2	0	0	0	0	0	0	0	0	0	0	0
Hall	10	10	0	0	0	0	0	0	0	0	0	0	0
Hancock	56	52	5	1	0	0	0	0	0	0	0	0	0
Haralson	0	1	0	0	0	0	0	0	0	0	0	0	0
Harris	4	4	0	0	0	0	0	0	0	0	0	0	0
Hart	13	19	0	0	0	0	0	0	0	0	0	0	0
Henry	10	5	0	0	0	0	0	0	0	0	0	0	0

Houston	27	35	0	0	0	0	0	0	0	0	0	0	0
Irwin	5	2	0	0	0	0	0	0	0	0	0	0	0
Jackson	15	7	0	0	0	0	0	0	0	0	0	0	0
Jasper	7	8	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	10	9	0	0	0	0	0	0	0	0	0	0	0
Jefferson	487	187	102	12	2	1	0	0	0	0	0	0	0
Jenkins	162	64	12	1	1	0	0	0	0	0	0	0	0
Johnson	72	48	2	0	0	0	0	0	0	0	0	0	0
Jones	9	13	0	0	0	0	0	0	0	0	0	0	0
Lamar	0	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	8	3	0	0	0	0	0	0	0	0	0	0	0
Laurens	118	77	1	0	0	0	0	0	0	0	0	0	0
Lee	9	13	0	0	0	0	0	0	0	0	0	0	0
Liberty	31	18	0	1	0	0	0	0	0	0	0	0	0
Lincoln	209	77	6	11	2	1	0	0	0	0	0	0	0
Long	2	6	0	0	0	0	0	0	0	0	0	0	0
Lowndes	66	63	1	0	0	0	0	0	0	0	0	0	0
Macon	2	4	0	0	0	0	0	0	0	0	0	0	0
Madison	32	19	0	0	0	0	0	0	0	0	0	0	0
Marion	0	1	0	0	0	0	0	0	0	0	0	0	0
McDuffie	453	225	14	20	4	0	0	0	0	0	0	0	0
McIntosh	2	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	1	0	0	0	0	0	0	0	0	0	0	0	0
Mitchell	4	8	0	0	0	0	0	0	0	0	0	0	0
Monroe	8	2	0	0	0	0	0	0	0	0	0	0	0
Montgomery	13	6	0	1	0	1	0	0	0	0	0	0	0
Morgan	34	26	0	0	0	0	0	0	0	0	0	0	0
Murray	4	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	10	9	0	0	0	0	0	0	0	0	0	0	0
Newton	12	6	0	0	2	0	0	0	0	0	0	0	0
Oconee	22	19	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	12	36	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	152	60	5	3	0	0	0	0	0	0	0	0	0
Paulding	1	1	0	0	0	0	0	0	0	0	0	0	0
Peach	9	4	0	1	0	0	0	0	0	0	0	0	0
Pickens	2	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	7	8	0	0	0	0	0	0	0	0	0	0	0
Pike	2	1	0	0	0	0	0	0	0	0	0	0	0
Polk	1	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	12	4	0	0	0	0	0	0	0	0	0	0	0
Putnam	32	61	0	0	0	0	0	0	0	0	0	0	0
Quitman	1	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	1	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	4	0	0	0	0	0	0	0	0	0	0	0

Richmond	6,140	2,974	426	457	99	40	0	0	0	0	0	0	0
Rockdale	8	7	0	0	0	0	0	0	0	0	0	0	0
Screven	103	54	4	2	0	0	0	0	0	0	0	0	0
Seminole	1	3	0	0	0	0	0	0	0	0	0	0	0
South Carolina	3,981	2,706	224	82	33	7	0	0	0	0	0	0	0
Spalding	5	9	0	0	0	0	0	0	0	0	0	0	0
Stephens	3	11	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	9	5	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	45	11	2	0	0	0	0	0	0	0	0	0	0
Tattnall	26	12	1	0	0	0	0	0	0	0	0	0	0
Taylor	1	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	20	14	0	0	0	0	0	0	0	0	0	0	0
Tennessee	10	9	0	1	0	0	0	0	0	0	0	0	0
Terrell	7	10	0	0	1	0	0	0	0	0	0	0	0
Thomas	9	11	2	0	0	0	0	0	0	0	0	0	0
Tift	22	16	3	0	0	0	0	0	0	0	0	0	0
Toombs	33	18	0	0	0	0	0	0	0	0	0	0	0
Treutlen	13	10	0	0	0	0	0	0	0	0	0	0	0
Troup	2	0	0	0	0	0	0	0	0	0	0	0	0
Turner	4	1	0	0	0	0	0	0	0	0	0	0	0
Twiggs	3	1	0	0	0	0	0	0	0	0	0	0	0
Union	6	4	0	0	0	0	0	0	0	0	0	0	0
Upson	1	2	0	0	0	0	0	0	0	0	0	0	0
Walker	1	0	0	0	0	0	0	0	0	0	0	0	0
Walton	15	11	0	0	0	0	0	0	0	0	0	0	0
Ware	15	14	0	0	0	0	0	0	0	0	0	0	0
Warren	113	40	3	2	1	0	0	0	0	0	0	0	0
Washington	335	171	26	3	0	0	0	0	0	0	0	0	0
Wayne	23	14	0	0	0	1	0	0	0	0	0	0	0
Wheeler	14	3	0	0	0	0	0	0	0	0	0	0	0
White	3	0	0	0	0	0	0	0	0	0	0	0	0
Whitfield	1	2	0	0	0	0	0	0	0	0	0	0	0
Wilcox	3	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	196	135	6	6	3	0	0	0	0	0	0	0	0
Wilkinson	12	11	0	0	0	0	0	0	0	0	0	0	0
Worth	7	5	0	0	0	0	0	0	0	0	0	0	0
Total	**17,826**	**10,385**	**1,120**	**786**	**224**	**80**	**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	0	27
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	7
	0	0	0
Total	**0**	**0**	**35**

2. Procedures by Type of Room
Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	6,725	11,751
Cystoscopy	0	0	114	247
Endoscopy	0	0	830	3,614
	0	0	0	0
Total	**0**	**0**	**7,669**	**15,612**

3. Patients by Type of Room
Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	7,046	9,504
Cystoscopy	0	0	103	236
Endoscopy	0	0	833	3,133
	0	0	0	0
Total	**0**	**0**	**7,982**	**12,873**

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	7
Asian	50
Black/African American	4,221
Hispanic/Latino	329
Pacific Islander/Hawaiian	7
White	5,628
Multi-Racial	143
Total	**10,385**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	3,899
Ages 15-64	4,978
Ages 65-74	1,069
Ages 75-85	379
Ages 85 and Up	60
Total	**10,385**

3. Gender
Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,083
Female	5,302
Total	**10,385**

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

Primary Payment Source	Number of Patients
Medicare	2,155
Medicaid	3,442
Third-Party	4,182
Self-Pay	614

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 8

4. Number of LDRP Rooms: 3

5. Number of Cesarean Sections: 406

6. Total Live Births: 1,238

7. Total Births (Live and Late Fetal Deaths): 1,250

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,126

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services
Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	25	931	3,481	0
Specialty Care (Intermediate Neonatal Care)	5	26	611	0
Subspecialty Care (Intensive Neonatal Care)	36	409	8,994	1

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

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

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	2	7
Asian	12	36
Black/African American	570	1,726
Hispanic/Latino	97	243
Pacific Islander/Hawaiian	1	2
White	423	1,032
Multi-Racial	15	35
Total	**1,120**	**3,081**

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	4	10
Ages 15-44	1,112	3,064
Ages 45 and Up	4	7
Total	**1,120**	**3,081**

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

$12,068.00

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

$18,296.00

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	27	27
B- General Acute Psychiatric Adolescents 13-17	7	7
C- General Acute Psychiatric Children 12 and under	7	7
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	786	5,118	844	5,464	2,472	☑
General Acute Psychiatric Adolescents 13-17	224	921	224	921	2,059	☑
General Acute Psychiatric Children 12 and Under	80	371	80	371	2,024	☑
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	2	9
Black/African American	389	2,311
Hispanic/Latino	28	168
Pacific Islander/Hawaiian	6	22
White	646	3,799
Multi-Racial	19	101
Total	**1,090**	**6,410**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	483	2,824
Female	607	3,586
Total	**1,090**	**6,410**

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	222	1,869
Medicaid	403	2,239
Third Party	429	2,113
Self-Pay	36	189
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? 5.1999998092651 (FTE's)
What languages do they interpret?
Spanish and ASL

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): ☑

video conferencing equipment

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	0.83%	0	0	0
Chinese	0.05%	0	0	0
American Sign Language	0.05%	0	0	0

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

New Employee Orientation (NEO), Patient and Family Centered-Care External and Internal Learning

Labs, CLAS in-services to hospital & clinic staff, MC Strategies (web-based mandatory training for hospital staff), Healthy Perspective (web-based mandatory training for students of the academic medical center), In-person lectures/workshops to students and residents of the academic medical center and Community outreach.

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?

Data collection by Human Resources on "primary language spoken at home" by bilingual employees and students. Also, the need for more trained medical interpreters (increase FTE's) to include a variety of languages (the most commonly encountered) and to ensure coverage 24/7. Continuum of CLAS training to staff, students, patients and their families.

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

1. English
2. Universal Symbols
3.
4.

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

We are participants of the Georgia Indigent Care Trust Fund. Other sources are: St. Vincent de Paul Health Center, 1384 Greene St., Augusta, GA 706-828-3444; Faith Care Clinic, 625 Ronald Reagan Dr., Evans, GA 706-829-2584; Margaret Weston Clinic, Clearwater, SC 803-593-9283; Medical Clinic of Aiken, Aiken, SC 803-641-6825; Ministerio Catholico for Hispanic Americano, 706-231-2547 or 706-793-5688; Association of Latino Services in CSRA, 706-877-7707; Harrisburg Family Healthcare Clinic (423 Crawford Ave., Augusta, GA, 30904, 706-496-3885); Druid Park Community Health Center (1125 Druid Park Ave., Augusta, GA, 30904, 706-738-0455); Christ Community Health Services (D'Antignac St. Augusta, GA 30901, 706-922-0600); Belle Terrace Health and Wellness Center (2467 Golden Camp Rd., Augusta, GA, 30901, 706-790-4440); Lamar Medical Center (1448 Lee Beard Way, Augusta, GA, 30901-3414, 706-828-7468).

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

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 inpatietn 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 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: David S. Hefner

Date: 5/1/2014

Title: Chief Executive Officer

Comments: