Georgia Department of Community Health

# 2014 Annual Hospital Questionnaire

## Part A : General Information

### 1. Identification

**UID:HOSP519**

**Facility Name:** Taylor Regional Hospital

**County:** Pulaski

**Street Address:** 222 Perry Hwy

**City:** Hawkinsville

**Zip:** 31036-7297

**Mailing Address:** 222 Perry Highway PO Box 1297

**Mailing City:** Hawkinsville

**Mailing Zip:** 31036-7297

**Medicaid Provider Number:** 00001548A

**Medicare Provider Number:** 110135

### 2. Report Period

Report Data for the full twelve month period- January 1, 2014 through December 31, 2014.
***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:** Dawn Warnock

**Contact Title:** Director, Health Information Services, Risk Mgr

**Phone:** 478-783-0401

**Fax:** 478-783-1153

**E-mail:** dawn.warnock@taylorregional.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 |
|---|---|---|
| Board of Trustees of Taylor Regional Hospital | Not for Profit | 9/9/1999 |

**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 |
|---|---|---|
| Board of Trustees of Taylor Regional Hospital | Not for Profit | 9/9/1999 |

**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:**
**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(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) | 4 | 162 | 393 | 163 | 396 |
| Pediatrics (Non ICU) | 2 | 40 | 143 | 41 | 103 |
| Pediatric ICU | 0 | 0 | 0 | 0 | 0 |
| Gynecology (No OB) | 0 | 0 | 0 | 0 | 0 |
| General Medicine | 0 | 0 | 0 | 0 | 0 |
| General Surgery | 0 | 0 | 0 | 0 | 0 |
| Medical/Surgical | 36 | 577 | 2,612 | 560 | 2,586 |
| Intensive Care | 5 | 395 | 777 | 399 | 769 |
| 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) | 10 | 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** | **57** | **1,174** | **3,925** | **1,163** | **3,854** |

## 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 | 0 | 0 |
| Asian | 2 | 4 |
| Black/African American | 342 | 1,151 |
| Hispanic/Latino | 7 | 18 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 821 | 2,747 |
| Multi-Racial | 2 | 5 |
| **Total** | **1,174** | **3,925** |

## 3. Gender

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

| Gender | Admissions | Inpatient Days |
|---|---|---|
| Male | 424 | 1,413 |
| Female | 750 | 2,512 |
| **Total** | **1,174** | **3,925** |

## 4. Payment Source

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

| Primary Payment Source | Admissions | Inpatient Days |
|---|---|---|
| Medicare | 575 | 1,852 |
| Medicaid | 234 | 785 |
| Peachare | 15 | 70 |
| Third-Party | 251 | 863 |
| Self-Pay | 92 | 314 |
| Other | 7 | 41 |

## 5. Discharges to Death

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

32

## 6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2014 (to the nearest whole dollar).

| Service | Charge |
|---|---|
| Private Room Rate | 530 |
| Semi-Private Room Rate | 520 |
| Operating Room: Average Charge for the First Hour | 1,200 |
| Average Total Charge for an Inpatient Day | 3,117 |

## Part E : Emergency Department and Outpatient Services

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

10,028

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

1,177

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

6

**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 | 0 | 0 |
| Beds or Rooms dedicated for Psychiatric /Substance Abuse cases | 0 | 0 |
| General Beds | 6 | 10,028 |
| | 0 | 0 |
| | 0 | 0 |
| | 0 | 0 |
| | 0 | 0 |

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

362

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

62

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

491

**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.

132

# Part F : Services and Facilities

## 1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

| Service/Facilities | Site Code | Service Status |
|---|---|---|
| Podatric Services | 1 | 1 |
| Renal Dialysis | 3 | 4 |
| ESWL | 2 | 3 |
| 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) | 3 | 4 |
| Radioisotope, Therapeutic | 1 | 1 |
| Magnetic Resonance Imaging (MRI) | 1 | 1 |
| Chemotherapy | 3 | 4 |
| Respiratory Therapy | 1 | 1 |
| Occupational Therapy | 2 | 1 |
| Physical Therapy | 2 | 1 |
| Speech Pathology Therapy | 2 | 1 |
| Gamma Ray Knife | 3 | 4 |
| Audiology Services | 3 | 4 |
| HIV/AIDS Diagnostic Treatment/Services | 3 | 4 |
| Ambulance Services | 1 | 1 |
| Hospice | 2 | 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 | 253 |
| Number of Dialysis Treatments | 0 |
| Number of ESWL Patients | 6 |
| Number of ESWL Procedures | 6 |
| 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 | 13,649 |
| Number of CTS Units (machines) | 1 |
| Number of CTS Procedures | 3,461 |
| Number of Diagnostic Radioisotope Procedures | 629 |
| Number of PET Units (machines) | 0 |
| Number of PET Procedures | 0 |
| Number of Therapeautic Radioisotope Procedures | 3 |
| Number of Number of MRI Units | 1 |
| Number of Number of MRI Procedures | 1,032 |
| Number of Chemotherapy Treatments | 0 |
| Number of Respiratory Therapy Treatments | 16,472 |
| Number of Occupational Therapy Treatments | 0 |
| Number of Physical Therapy Treatments | 27,378 |
| Number of Speech Pathology Patients | 78 |
| 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 | 169 |
| Number of HIV/AIDS Patients | 17 |
| Number of Ambulance Trips | 842 |
| Number of Hospice Patients | 12 |
| Number of Respite care Patients | 0 |
| Number of Ultrasound/Medical Sonography Units | 1 |
| Number of Ultrasound/Medical Sonography Procedures | 3,654 |
| 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).

3

**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 | |

## Part G : Facility Workforce Information

### 1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2014. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2014.

| Profession | Budgeted FTEs | Vacant Budgeted FTEs | Contract/Temporary Staff FTEs |
|---|---|---|---|
| Licensed Physicians | 17 | 1 | |
| Physician Assistants Only (not including Licensed Physicians) | 0 | | |
| Registered Nurses (RNs-Advanced Practice*) | 90 | 1 | 1 |
| Licensed Practical Nurses (LPNs) | 40 | | |
| Pharmacists | 1.5 | | |
| Other Health Services Professionals* | 103 | | |
| Administration and Support | 19 | | 0 |
| All Other Hospital Personnel (not included above) | 113.5 | | |

### 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) | More than 90 Days |
| Licensed Practical Nurses (LPNs) | 61-90 Days |
| Pharmacists | More than 90 Days |
| Other Health Services Professionals | 61-90 Days |
| All Other Hospital Personnel (not included above) | 61-90 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 | 1 |
| Black/African American | 2 |
| Hispanic/Latino | 0 |
| Pacific Islander/Hawaiian | 0 |
| White | 20 |
| Multi-Racial | 1 |

### 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 | 9 | ☑ | 9 | 9 |
| General Internal Medicine | 13 | ☑ | 13 | 13 |
| Pediatricians | 4 | ☑ | 4 | 4 |
| Other Medical Specialties | 10 | ☑ | 10 | 10 |

| 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 | 4 | ☑ | 4 | 4 |
| Non-OB Physicians Providing OB Services | 0 | ☐ | 0 | 0 |
| Gynecology | 4 | ☑ | 4 | 4 |
| Ophthalmology Surgery | 2 | ☐ | 2 | 2 |
| Orthopedic Surgery | 7 | ☑ | 7 | 7 |
| Plastic Surgery | 0 | ☐ | 0 | 0 |
| General Surgery | 5 | ☑ | 5 | 5 |
| Thoracic Surgery | 0 | ☐ | 0 | 0 |
| Other Surgical Specialties | 9 | ☑ | 9 | 9 |

| 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 | 3 | ☐ | 3 | 3 |
| Dermatology | 0 | ☐ | 0 | 0 |
| Emergency Medicine | 26 | ☐ | 26 | 26 |
| Nuclear Medicine | 4 | ☐ | 4 | 4 |
| Pathology | 6 | ☐ | 6 | 6 |
| Psychiatry | 0 | ☐ | 0 | 0 |
| Radiology | 42 | ☐ | 42 | 42 |
| | 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 | 0 |
| Podiatrists | 1 |
| Certified Nurse Midwives with Clinical Privileges in the Hospital | 0 |
| All Other Staff Affiliates with Clinical Privileges in the Hospital | 30 |

## 5b. Name of Other Professions

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

LPC, MS, NP, RN, PA, CRNA

**Comments and Suggestions:**

## Part H : Physician Name and License Number

### 1. Physicians on Staff

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

## Part I : Patient Origin Table

### 1. Patient Origin

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

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric
P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under
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 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Baker | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Bibb | 2 | 7 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Bleckley | 222 | 284 | 23 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Brooks | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Bulloch | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Carroll | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Coffee | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Columbia | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Coweta | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Crisp | 10 | 17 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dodge | 77 | 190 | 17 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Dooly | 115 | 113 | 15 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Forsyth | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Glynn | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Gwinnett | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Henry | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Houston | 50 | 180 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Irwin | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jeff Davis | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jones | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Laurens | 8 | 12 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lee | 1 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Lowndes | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Macon | 5 | 10 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Marion | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Out of State | 7 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Peach | 1 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pike | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Pulaski | 459 | 514 | 41 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Spalding | 3 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Sumter | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Telfair | 8 | 33 | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Turner | 1 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Twiggs | 10 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Wheeler | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Wilcox | 186 | 110 | 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Wilkinson | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **1,174** | **1,511** | **160** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |

# Surgical Services Addendum

## Part A : Surgical Services Utilization

### 1. Surgery Rooms in the OR Suite

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

| Room Type | Dedicated Inpatient Rooms | Dedicated Outpatient Rooms | Shared Rooms |
|---|---|---|---|
| General Operating | 0 | 0 | 3 |
| Cystoscopy (OR Suite) | 0 | 0 | 0 |
| Endoscopy (OR Suite) | 0 | 0 | 1 |
| | 0 | 0 | 0 |
| **Total** | **0** | **0** | **4** |

### 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 | 560 | 1,059 |
| Cystoscopy | 0 | 0 | 9 | 52 |
| Endoscopy | 0 | 0 | 108 | 1,255 |
| | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **677** | **2,366** |

### 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 | 420 | 811 |
| Cystoscopy | 0 | 0 | 4 | 30 |
| Endoscopy | 0 | 0 | 61 | 670 |
| | 0 | 0 | 0 | 0 |
| **Total** | **0** | **0** | **485** | **1,511** |

## 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 | 0 |
| Asian | 1 |
| Black/African American | 440 |
| Hispanic/Latino | 5 |
| Pacific Islander/Hawaiian | 0 |
| White | 1,060 |
| Multi-Racial | 5 |
| **Total** | **1,511** |

### 2. Age Grouping

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

| Age of Patient | Number of Ambulatory Patients |
|---|---|
| Ages 0-14 | 60 |
| Ages 15-64 | 939 |
| Ages 65-74 | 395 |
| Ages 75-85 | 94 |
| Ages 85 and Up | 23 |
| **Total** | **1,511** |

### 3. Gender

Please report the total number of ambulatory patients by gender.

| Gender | Number of Ambulatory Patients |
|---|---|
| Male | 650 |
| Female | 861 |
| **Total** | **1,511** |

### 4. Payment Source

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

| Primary Payment Source | Number of Patients |
|---|---|
| Medicare | 563 |
| Medicaid | 220 |
| Third-Party | 683 |
| Self-Pay | 45 |

## 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:** 4

**4. Number of LDRP Rooms:** 0

**5. Number of Cesarean Sections:** 84

**6. Total Live Births:** 160

**7. Total Births (Live and Late Fetal Deaths):** 165

**8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations):** 165

## 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) | 10 | 160 | 358 | 0 |
| Specialty Care (Intermediate Neonatal Care) | 0 | 0 | 0 | 0 |
| Subspecialty Care (Intensive Neonatal Care) | 0 | 0 | 0 | 0 |

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

### 1. Race/Ethnicity

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

| Race/Ethnicity | Admissions by Mother's Race | Inpatient Days |
|---|---|---|
| American Indian/Alaska Native | 0 | 0 |
| Asian | 1 | 2 |
| Black/African American | 77 | 168 |
| Hispanic/Latino | 2 | 7 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 80 | 181 |
| Multi-Racial | 0 | 0 |
| **Total** | **160** | **358** |

**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 | 4 |
| Ages 15-44 | 159 | 354 |
| Ages 45 and Up | 0 | 0 |
| **Total** | **160** | **358** |

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

$4,500.00

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

$5,500.00

## 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 | 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 | ☐ |
| 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 | 0 | 0 |
| Hispanic/Latino | 0 | 0 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 0 | 0 |
| Multi-Racial | 0 | 0 |
| **Total** | **0** | **0** |

### 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 |
| **Total** | **0** | **0** |

### 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 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 | 2 | 2 | 4 | 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?

Annual training in culture diversity

**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?

Ability of staff to speak Spanish proficiently

**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?

Southwest Georgia Health Care

# 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:** Nikki Paulk, RN

**Date:** 3/6/2017

**Title:** President

**Comments:**

this survey was completed on 3/5/2015 and electronically signed by Nikki Paulk, President of Taylor Regional Hospital on that date.  Dawn Warnock