GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2015 Annual Hospital Questionnaire

Part A : General Information

1. Identification   UID:HOSP636

Facility Name: Coliseum Medical Centers

County: Bibb

Street Address: 350 Hospital Drive

City: Macon

Zip: 31217-3871

Mailing Address: 350 Hospital Drive

Mailing City: Macon

Mailing Zip: 31217-3871

Medicaid Provider Number: 00000459

Medicare Provider Number: 110164

2. Report Period

Report Data for the full twelve month period- January 1, 2015 through December 31, 2015.
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: June Dickerson

Contact Title: Assistant Controller - CHS

Phone: 478-464-5443

Fax: 478-765-4500

E-mail: june.dickerson@hcahealthcare.com

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
Coliseum Medical Center, LLC	For Profit	5/1/1998

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Macon Healthcare, LLC	For Profit	5/1/1998

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coliseum Medical Center, LLC	For Profit	5/1/1998

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Macon Healthcare, LLC	For Profit	5/1/1998

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Coliseum Park Hospital, Inc.	For Profit	5/1/1998

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
HCA, Inc.	For Profit	5/1/1998

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: Macon Healthcare, LLC
City: Macon   **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: Macon Healthcare, LLC
City: Macon   **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:
City: State:

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: HCA, Inc./Macon Healthcare, LLC
City: Nashville/Macon   **State:** TN/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)	28	1,077	2,449	1,075	2,444
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	9	307	698	306	696
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	133	7,286	35,027	7,299	35,026
Intensive Care	27	1,229	5,604	1,229	5,604
Psychiatry	38	1,370	8,171	1,362	8,123
Substance Abuse	4	436	2,266	438	2,276
Adult Physical Rehabilitation (18 & Up)	29	562	7,483	570	7,589
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	**268**	**12,267**	**61,698**	**12,279**	**61,758**

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	2	6
Asian	65	246
Black/African American	4,979	24,782
Hispanic/Latino	53	261
Pacific Islander/Hawaiian	0	0
White	7,166	36,392
Multi-Racial	2	11
Total	12,267	61,698

3. Gender

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

Gender	Admissions	Inpatient Days
Male	4,974	26,922
Female	7,293	34,776
Total	12,267	61,698

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,147	34,766
Medicaid	1,912	7,918
Peachare	0	0
Third-Party	3,478	15,579
Self-Pay	730	3,435
Other	0	0

5. Discharges to Death

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

337

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2015 (to the nearest whole dollar).

Service	Charge
Private Room Rate	968
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	6,500
Average Total Charge for an Inpatient Day	9,191

Part E : Emergency Department and Outpatient Services

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

49,815

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

6,467

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

25

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	25	49,815
	0	0
	0	0
	0	0
	0	0

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

651

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

39,909

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

2,960

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.

378

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	2	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)	3	4
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	4
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	2	1
Respite Care Services	2	1
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	1
Number of Dialysis Treatments	2,491
Number of ESWL Patients	73
Number of ESWL Procedures	82
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	63,900
Number of CTS Units (machines)	2
Number of CTS Procedures	14,844
Number of Diagnostic Radioisotope Procedures	3,016
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	33
Number of Number of MRI Units	1
Number of Number of MRI Procedures	1,964
Number of Chemotherapy Treatments	967
Number of Respiratory Therapy Treatments	144,258
Number of Occupational Therapy Treatments	49,685
Number of Physical Therapy Treatments	57,753
Number of Speech Pathology Patients	1,776
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	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	262
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	9,437
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).

<u>71</u>

3. Robotic Surgery System
Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
2	555	DaVinci Robotic Surgical System XI & DaVinci Robotic Surgical System SI-E w/HD

Part G : Facility Workforce Information

1. Budgeted Staff
Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2015. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2015.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	1	1	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	316	41	27
Licensed Practical Nurses (LPNs)	14	0	0
Pharmacists	13	0	0
Other Health Services Professionals*	239	10	2
Administration and Support	15	1	0
All Other Hospital Personnel (not included above)	325	13	0

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)	Not Applicable
Pharmacists	More than 90 Days
Other Health Services Professionals	More than 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	19	☐	19	19
General Internal Medicine	60	☐	40	60
Pediatricians	20	☐	20	14
Other Medical Specialties	158	☐	59	58

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	21	☐	21	21
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	3	☐	0	3
Ophthalmology Surgery	7	☐	6	4
Orthopedic Surgery	9	☐	9	9
Plastic Surgery	7	☐	4	6
General Surgery	11	☐	7	9
Thoracic Surgery	7	☐	4	3
Other Surgical Specialties	24	☐	15	12

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	10	☑	10	10
Dermatology	3	☐	0	2
Emergency Medicine	32	☑	32	32
Nuclear Medicine	0	☐	0	0
Pathology	2	☑	2	2
Psychiatry	5	☐	5	5
Radiology	31	☑	31	31
	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	5
Podiatrists	12
Certified Nurse Midwives with Clinical Privileges in the Hospital	5
All Other Staff Affiliates with Clinical Privileges in the Hospital	191

5b. Name of Other Professions

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

NP, CRNA, CNM, PA, FNP, PhD, RN, CNOR, Anes Asst, Surg Tech, Litho Tech, Audiologist, Auto Transfusionist, Perfusionist, Intraoperative Neuromonitor Tech, Laser Tech, Neurophysiologist, Sonographer, Physicist, Prosthetist, Cardio Tech, Resp Therapist

Comments and Suggestions:

Part G. 3. - We no longer request or maintain Race/Ethnicity of Physicians. Part G. 4. - Due to Hospitalists admitting most patients, we have changed the reporting status for Internal Medicine physicians in 2015.

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	10	1	0	1	0	0	0	0	0	0	0	0	1
Appling	4	3	0	0	0	0	1	0	0	0	0	0	0
Bacon	3	1	0	0	0	0	2	0	0	0	0	0	0
Baker	0	2	0	0	0	0	0	0	0	0	0	0	0
Baldwin	330	146	28	26	0	0	8	0	0	0	0	0	16
Banks	5	0	0	3	0	0	0	0	0	0	0	0	0
Bartow	4	0	0	2	0	0	0	0	0	0	0	0	0
Ben Hill	28	2	0	1	0	0	0	0	0	0	0	0	2
Berrien	3	2	1	1	0	0	0	0	0	0	0	0	0
Bibb	6,207	1,246	673	526	0	0	163	0	0	0	0	0	222
Bleckley	162	53	5	26	0	0	4	0	0	0	0	0	12
Brantley	1	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	1	0	0	0	0	0	0
Bulloch	7	0	0	5	0	0	0	0	0	0	0	0	0
Burke	2	0	0	1	0	0	1	0	0	0	0	0	0
Butts	55	14	3	10	0	0	6	0	0	0	0	0	4
Calhoun	3	0	0	1	0	0	0	0	0	0	0	0	0
Camden	1	0	0	0	0	0	0	0	0	0	0	0	0
Candler	4	0	0	1	0	0	1	0	0	0	0	0	0
Carroll	3	1	0	3	0	0	0	0	0	0	0	0	0
Chatham	9	0	0	0	0	0	2	0	0	0	0	0	1
Chattahoochee	1	0	0	1	0	0	0	0	0	0	0	0	0
Cherokee	6	1	0	1	0	0	2	0	0	0	0	0	0
Clarke	9	0	0	8	0	0	1	0	0	0	0	0	0
Clay	0	0	1	0	0	0	0	0	0	0	0	0	0
Clayton	12	1	0	7	0	0	0	0	0	0	0	0	0
Cobb	9	0	0	3	0	0	2	0	0	0	0	0	0

County												
Coffee	16	6	0	5	0	0	2	0	0	0	0	0	0
Colquitt	8	2	0	0	0	0	1	0	0	0	0	0	0
Columbia	10	0	0	7	0	0	1	0	0	0	0	0	0
Cook	4	0	0	0	0	0	0	0	0	0	0	0	1
Coweta	4	0	0	3	0	0	1	0	0	0	0	0	0
Crawford	106	32	12	3	0	0	2	0	0	0	0	0	3
Crisp	46	14	1	7	0	0	2	0	0	0	0	0	3
Dawson	1	0	0	1	0	0	0	0	0	0	0	0	0
Decatur	1	0	0	1	0	0	0	0	0	0	0	0	0
DeKalb	13	0	1	3	0	0	2	0	0	0	0	0	2
Dodge	277	39	6	41	0	0	9	0	0	0	0	0	8
Dooly	54	14	2	5	0	0	1	0	0	0	0	0	5
Dougherty	15	3	0	7	0	0	1	0	0	0	0	0	0
Douglas	6	0	0	2	0	0	0	0	0	0	0	0	0
Effingham	1	0	0	1	0	0	0	0	0	0	0	0	0
Elbert	2	0	0	2	0	0	0	0	0	0	0	0	0
Emanuel	43	6	0	9	0	0	4	0	0	0	0	0	2
Evans	3	0	0	1	0	0	0	0	0	0	0	0	0
Fannin	2	0	0	1	0	0	0	0	0	0	0	0	0
Fayette	3	1	0	2	0	0	0	0	0	0	0	0	0
Florida	33	5	0	4	0	0	0	0	0	0	0	0	4
Floyd	5	0	0	1	0	0	0	0	0	0	0	0	0
Forsyth	3	1	0	2	0	0	0	0	0	0	0	0	0
Fulton	22	3	0	6	0	0	2	0	0	0	0	0	2
Gilmer	1	0	0	1	0	0	0	0	0	0	0	0	0
Glynn	5	1	0	4	0	0	0	0	0	0	0	0	1
Greene	4	3	0	2	0	0	0	0	0	0	0	0	0
Gwinnett	20	0	0	6	0	0	3	0	0	0	0	0	0
Habersham	2	0	0	1	0	0	0	0	0	0	0	0	0
Hall	4	0	0	0	0	0	0	0	0	0	0	0	0
Hancock	41	9	0	2	0	0	1	0	0	0	0	0	4
Harris	1	1	0	1	0	0	0	0	0	0	0	0	0
Hart	1	0	0	1	0	0	0	0	0	0	0	0	0
Henry	19	10	2	4	0	0	4	0	0	0	0	0	1
Houston	933	482	100	139	0	0	51	0	0	0	0	0	118
Irwin	5	1	0	0	0	0	0	0	0	0	0	0	1
Jackson	5	0	0	1	0	0	0	0	0	0	0	0	0
Jasper	82	16	5	6	0	0	4	0	0	0	0	0	3
Jeff Davis	7	13	0	1	0	0	2	0	0	0	0	0	0
Jefferson	2	0	0	2	0	0	0	0	0	0	0	0	0
Johnson	64	16	0	7	0	0	1	0	0	0	0	0	4
Jones	562	174	51	29	0	0	15	0	0	0	0	0	21
Lamar	52	13	1	12	0	0	8	0	0	0	0	0	2
Lanier	2	0	0	0	0	0	0	0	0	0	0	0	0

Laurens	500	106	11	106	0	0	23	0	0	0	0	0	10
Lee	3	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	7	1	0	1	0	0	0	0	0	0	0	0	1
Macon	62	22	0	4	0	0	1	0	0	0	0	0	4
Marion	1	1	0	1	0	0	0	0	0	0	0	0	0
McDuffie	3	0	0	3	0	0	0	0	0	0	0	0	0
McIntosh	1	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	6	0	0	3	0	0	1	0	0	0	0	0	0
Miller	1	0	0	0	0	0	0	0	0	0	0	0	0
Mitchell	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	369	105	41	40	0	0	14	0	0	0	0	0	13
Montgomery	7	2	1	1	0	0	0	0	0	0	0	0	0
Morgan	5	3	0	1	0	0	1	0	0	0	0	0	0
Muscogee	9	0	0	4	0	0	0	0	0	0	0	0	0
Newton	11	1	0	2	0	0	3	0	0	0	0	0	1
North Carolina	10	1	1	1	0	0	1	0	0	0	0	0	1
Oglethorpe	0	1	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	45	6	2	12	0	0	2	0	0	0	0	0	4
Paulding	2	0	0	2	0	0	0	0	0	0	0	0	0
Peach	423	143	33	45	0	0	20	0	0	0	0	0	31
Pierce	1	0	0	1	0	0	0	0	0	0	0	0	0
Pike	14	3	1	5	0	0	0	0	0	0	0	0	1
Polk	1	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	78	37	2	8	0	0	6	0	0	0	0	0	4
Putnam	87	48	2	10	0	0	3	0	0	0	0	0	3
Rabun	3	0	0	2	0	0	0	0	0	0	0	0	0
Richmond	20	3	0	12	0	0	3	0	0	0	0	0	0
Rockdale	1	0	0	1	0	0	0	0	0	0	0	0	0
Schley	3	0	0	1	0	0	0	0	0	0	0	0	0
Screven	2	0	0	2	0	0	0	0	0	0	0	0	0
South Carolina	13	0	0	4	0	0	2	0	0	0	0	0	2
Spalding	20	9	0	5	0	0	1	0	0	0	0	0	1
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	13	7	0	1	0	0	2	0	0	0	0	0	1
Tattnall	2	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	76	22	3	6	0	0	1	0	0	0	0	0	5
Telfair	88	16	0	9	0	0	6	0	0	0	0	0	4
Tennessee	4	1	1	1	0	0	0	0	0	0	0	0	0
Terrell	0	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	11	3	1	0	0	0	1	0	0	0	0	0	0
Toombs	14	2	0	1	0	0	3	0	0	0	0	0	0
Treutlen	30	34	1	8	0	0	1	0	0	0	0	0	1
Troup	0	1	0	0	0	0	0	0	0	0	0	0	0

Turner	3	2	0	1	0	0	0	0	0	0	0	0	0
Twiggs	325	39	27	13	0	0	7	0	0	0	0	0	11
Upson	66	5	4	37	0	0	4	0	0	0	0	0	1
Walton	6	0	2	4	0	0	1	0	0	0	0	0	0
Ware	1	1	0	0	0	0	0	0	0	0	0	0	0
Warren	1	0	0	0	0	0	0	0	0	0	0	0	0
Washington	68	16	2	20	0	0	5	0	0	0	0	0	3
Wayne	1	0	0	0	0	0	1	0	0	0	0	0	0
Wheeler	26	7	1	2	0	0	0	0	0	0	0	0	0
White	1	1	0	0	0	0	0	0	0	0	0	0	0
Wilcox	56	16	1	2	0	0	2	0	0	0	0	0	5
Wilkes	2	2	0	2	0	0	0	0	0	0	0	0	0
Wilkinson	391	85	30	26	0	0	9	0	0	0	0	0	12
Worth	2	0	0	0	0	0	1	0	0	0	0	0	0
Total	**12,267**	**3,092**	**1,059**	**1,370**	**0**	**0**	**436**	**0**	**0**	**0**	**0**	**0**	**562**

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	13
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	0	14

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	1,850	2,841
Cystoscopy	0	0	121	251
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	1,971	3,092

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	1,850	2,841
Cystoscopy	0	0	121	251
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	1,971	3,092

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	1
Asian	18
Black/African American	895
Hispanic/Latino	25
Pacific Islander/Hawaiian	0
White	2,153
Multi-Racial	0
Total	**3,092**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	118
Ages 15-64	2,005
Ages 65-74	640
Ages 75-85	270
Ages 85 and Up	59
Total	**3,092**

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

Gender	Number of Ambulatory Patients
Male	1,012
Female	2,080
Total	**3,092**

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

Primary Payment Source	Number of Patients
Medicare	1,104
Medicaid	339
Third-Party	1,588
Self-Pay	61

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: 6

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 400

6. Total Live Births: 1,068

7. Total Births (Live and Late Fetal Deaths): 1,071

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,086

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)	22	1,008	1,945	19
Specialty Care (Intermediate Neonatal Care)	8	16	279	51
Subspecialty Care (Intensive Neonatal Care)	5	94	1,629	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	1	1
Asian	7	14
Black/African American	626	1,486
Hispanic/Latino	15	36
Pacific Islander/Hawaiian	0	0
White	410	888
Multi-Racial	0	0
Total	**1,059**	**2,425**

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	2	6
Ages 15-44	1,056	2,415
Ages 45 and Up	1	4
Total	**1,059**	**2,425**

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

$16,453.00

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

$18,687.00

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.

0

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation: 0

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	40	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	20	4
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	1,370	8,171	1,362	8,123	3,485	☑
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	436	2,266	438	2,276	3,610	☑
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	9	52
Black/African American	616	3,697
Hispanic/Latino	11	57
Pacific Islander/Hawaiian	0	0
White	1,170	6,631
Multi-Racial	0	0
Total	**1,806**	**10,437**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	876	5,018
Female	930	5,419
Total	**1,806**	**10,437**

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	466	3,263
Medicaid	320	1,789
Third Party	770	4,055
Self-Pay	250	1,330
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? <u>0</u> (FTE's)
What languages do they interpret?
<u>0</u>

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
Japanese	.0053	0	0	0
Spanish	.0043	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?

<u>Orientation</u>

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?

None. We use Language Service Interpreter phones.

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

1. English   2. Spanish   3. 0   4. 0

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?

Macon Volunteer Clinic; Anderson Clinic

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	3	32
Black/African American	176	2,488
Hispanic/Latino	3	62
Pacific Islander/Hawaiian	0	0
White	380	4,901
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	242	3,338
Female	320	4,145

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	205	2,869
65-84	298	3,780
85 Up	59	834

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	528
Long Term Care Hospital	34
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	395
Third Party/Commercial	163
Self Pay	4
Other	0

2. Uncompensated Indigent and Charity Care

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

2

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	137
2. Brain Injury	16
3. Amputation	11
4. Spinal Cord	61
5. Fracture of the femur	83
6. Neurological disorders	48
7. Multiple Trauma	9
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	37
All Other	160

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: Lance W. Jones

Date: 3/10/2016

Title: Chief Executive Officer

Comments:

Part F. 1b. Number of Radioisotope Procedures: We changed from using stats reported by the department in 2014 to collecting stats from the procedure analysis and adding the multipliers to applicable stats in 2015.