



## 2015 Annual Hospital Questionnaire

### Part A : General Information

#### 1. Identification

UID:HOSP719

**Facility Name:** Augusta University 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, 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:** 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
Not Applicable		

#### C. Facility Operator

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

#### D. Operator's Parent Organization

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

#### E. Management Contractor

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

#### F. Management's Parent Organization

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

### 2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period.

If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system

Name:

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(PHO)

4. Provider Service Organization(PSO)

5. Other Managed Care or Prepaid Plan

**10b. Managed Care Information: Insurance Products**

Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**11. Owner or Owner Parent Based in Another State**

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

## Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	30	1,288	3,641	1,480	4,519
Pediatrics (Non ICU)	45	788	3,477	2,182	10,319
Pediatric ICU	13	268	1,673	269	1,161
Gynecology (No OB)	0	435	2,059	432	2,197
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	218	10,360	55,043	10,597	64,294
Intensive Care	70	3,757	29,866	1,714	13,969
Psychiatry	27	909	4,171	977	4,652
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	7	12	251	623
	0	0	0	0	0
	0	0	0	0	0
<b>Total</b>	<b>409</b>	<b>17,812</b>	<b>99,942</b>	<b>17,902</b>	<b>101,734</b>

## **2. Race/Ethnicity**

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

<b>Race/Ethnicity</b>	<b>Admissions</b>	<b>Inpatient Days</b>
American Indian/Alaska Native	15	102
Asian	177	747
Black/African American	8,341	47,578
Hispanic/Latino	481	2,284
Pacific Islander/Hawaiian	0	0
White	8,676	48,772
Multi-Racial	122	459
<b>Total</b>	<b>17,812</b>	<b>99,942</b>

## **3. Gender**

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

<b>Gender</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Male	8,128	49,078
Female	9,684	50,864
<b>Total</b>	<b>17,812</b>	<b>99,942</b>

## **4. Payment Source**

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

<b>Primary Payment Source</b>	<b>Admissions</b>	<b>Inpatient Days</b>
Medicare	5,915	38,199
Medicaid	4,691	25,169
Peachare	1	3
Third-Party	5,471	27,762
Self-Pay	1,734	8,809
Other	0	0

## **5. Discharges to Death**

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

433

## **6. Charges for Selected Services**

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

<b>Service</b>	<b>Charge</b>
Private Room Rate	792
Semi-Private Room Rate	792
Operating Room: Average Charge for the First Hour	3,763
Average Total Charge for an Inpatient Day	9,890

## Part E : Emergency Department and Outpatient Services

### **1. Emergency Visits**

Please report the number of emergency visits only.

72,421

### **2. Inpatient Admissions from ER**

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

9,894

### **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	2,636
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	9	2,386
General Beds	45	82,818
	0	0
	0	0
	0	0
	0	0

### **5. Transfers**

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

1,164

### **6. Non-Emergency Visits**

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

495,637

### **7. Observation Visits/Cases**

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

7,083

### **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

424.00

## 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.

3,374

## 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
Podiatric Services	3	4
Renal Dialysis	2	1
ESWL	1	1
Biliary Lithotripter	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, Diagnostic	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.

<b>Category</b>	<b>Total</b>
Number of Podiatric Patients	0
Number of Dialysis Treatments	3,624
Number of ESWL Patients	49
Number of ESWL Procedures	54
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	65
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	4
Number of Diagnostic X-Ray Procedures	125,382
Number of CTS Units (machines)	3
Number of CTS Procedures	34,736
Number of Diagnostic Radioisotope Procedures	9,159
Number of PET Units (machines)	1
Number of PET Procedures	1,581
Number of Therapeutic Radioisotope Procedures	1,270
Number of Number of MRI Units	3
Number of Number of MRI Procedures	13,004
Number of Chemotherapy Treatments	10,314
Number of Respiratory Therapy Treatments	199,153
Number of Occupational Therapy Treatments	48,395
Number of Physical Therapy Treatments	84,893
Number of Speech Pathology Patients	12,809
Number of Gamma Ray Knife Procedures	135
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	2,289
Number of HIV/AIDS Diagnostic Procedures	5,843
Number of HIV/AIDS Patients	1,399
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	28,569
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).

0

### **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	439	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 12-31-2015. 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	0	0	0
Physician Assistants Only (not including Licensed Physicians)	2.2000000476837	0	0
Registered Nurses (RNs-Advanced Practice*)	1260.8299560547	161.39999389648	19
Licensed Practical Nurses (LPNs)	92	6.9000000953674	0
Pharmacists	63.919998168945	8.5	0
Other Health Services Professionals*	948.70001220703	113	14
Administration and Support	227.89999389648	21.89999961853	4
All Other Hospital Personnel (not included above)	1164.25	97.5	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)	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	0
Asian	88
Black/African American	38
Hispanic/Latino	23
Pacific Islander/Hawaiian	0
White	456
Multi-Racial	14

### 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	22	<input type="checkbox"/>	22	22
General Internal Medicine	44	<input type="checkbox"/>	44	44
Pediatricians	86	<input type="checkbox"/>	86	86
Other Medical Specialties	121	<input type="checkbox"/>	121	121

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	45	<input type="checkbox"/>	45	45
Non-OB Physicians Providing OB Services	11	<input type="checkbox"/>	11	11
Gynecology	47	<input type="checkbox"/>	47	47
Ophthalmology Surgery	13	<input type="checkbox"/>	13	13
Orthopedic Surgery	20	<input type="checkbox"/>	20	20
Plastic Surgery	9	<input type="checkbox"/>	9	9
General Surgery	12	<input type="checkbox"/>	12	12
Thoracic Surgery	7	<input type="checkbox"/>	7	7
Other Surgical Specialties	63	<input type="checkbox"/>	63	63

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	63	<input type="checkbox"/>	63	63
Dermatology	7	<input type="checkbox"/>	7	7
Emergency Medicine	54	<input type="checkbox"/>	54	54
Nuclear Medicine	1	<input type="checkbox"/>	1	1
Pathology	18	<input type="checkbox"/>	18	18
Psychiatry	30	<input type="checkbox"/>	30	30
Radiology	38	<input type="checkbox"/>	38	38
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0

**5a. Non-Physicians**

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

Profession	Number
Dentists (include oral surgeons) with Admitting Privileges	25
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	2
All Other Staff Affiliates with Clinical Privileges in the Hospital	190

**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
Alabama	20	10	0	5	0	0	0	0	0	0	0	0	0
Appling	16	7	1	0	0	0	0	0	0	0	0	0	0
Atkinson	5	14	1	0	0	0	0	0	0	0	0	0	0
Bacon	7	7	0	0	0	0	0	0	0	0	0	0	0
Baker	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	94	72	2	0	0	0	0	0	0	0	0	0	0
Banks	4	8	0	0	0	0	0	0	0	0	0	0	0
Barrow	11	10	0	1	0	0	0	0	0	0	0	0	0
Bartow	4	6	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	19	10	1	0	0	0	0	0	0	0	0	0	0
Berrien	7	9	0	0	0	0	0	0	0	0	0	0	0
Bibb	29	31	0	0	0	0	0	0	0	0	0	0	0
Bleckley	5	8	0	0	0	0	0	0	0	0	0	0	0
Brantley	7	10	2	0	0	0	0	0	0	0	0	0	0
Brooks	10	9	0	0	0	0	0	0	0	0	0	0	0
Bryan	23	18	1	0	0	0	0	0	0	0	0	0	0
Bulloch	114	81	8	2	0	0	0	0	0	0	0	0	0
Burke	575	282	94	24	0	0	0	0	0	0	0	0	0
Butts	7	4	0	0	0	0	0	0	0	0	0	0	0
Calhoun	13	8	0	0	0	0	0	0	0	0	0	0	0
Camden	4	2	0	0	0	0	0	0	0	0	0	0	0
Candler	31	12	0	0	0	0	0	0	0	0	0	0	0
Carroll	3	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	58	36	1	3	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	3	6	0	0	0	0	0	0	0	0	0	0	0
Cherokee	6	2	0	1	0	0	0	0	0	0	0	0	0

Clarke	30	52	4	0	0	0	0	0	0	0	0	0	0
Clay	0	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	8	5	1	1	0	0	0	0	0	0	0	0	0
Clinch	4	0	1	0	0	0	0	0	0	0	0	0	0
Cobb	18	10	0	3	0	0	0	0	0	0	0	0	0
Coffee	39	20	0	0	0	0	0	0	0	0	0	0	0
Colquitt	23	14	0	0	0	0	0	0	0	0	0	0	0
Columbia	2,377	1,968	231	185	0	0	0	0	0	0	0	0	0
Cook	5	7	0	0	0	0	0	0	0	0	0	0	0
Coweta	3	0	0	1	0	0	0	0	0	0	0	0	0
Crawford	1	2	0	0	0	0	0	0	0	0	0	0	0
Crisp	14	11	0	0	0	0	0	0	0	0	0	0	0
Dawson	0	1	0	0	0	0	0	0	0	0	0	0	0
Decatur	7	7	1	0	0	0	0	0	0	0	0	0	0
DeKalb	14	11	0	2	0	0	0	0	0	0	0	0	0
Dodge	19	16	1	0	0	0	0	0	0	0	0	0	0
Dooly	12	2	0	0	0	0	0	0	0	0	0	0	0
Dougherty	64	68	1	0	0	0	0	0	0	0	0	0	0
Douglas	0	1	0	0	0	0	0	0	0	0	0	0	0
Early	3	2	1	0	0	0	0	0	0	0	0	0	0
Effingham	15	19	1	0	0	0	0	0	0	0	0	0	0
Elbert	39	65	0	1	0	0	0	0	0	0	0	0	0
Emanuel	255	94	4	2	0	0	0	0	0	0	0	0	0
Evans	23	10	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	2	2	0	0	0	0	0	0	0	0	0	0	0
Florida	40	45	1	5	0	0	0	0	0	0	0	0	0
Floyd	6	2	0	0	0	0	0	0	0	0	0	0	0
Forsyth	3	0	0	1	0	0	0	0	0	0	0	0	0
Franklin	5	15	0	0	0	0	0	0	0	0	0	0	0
Fulton	27	19	0	6	0	0	0	0	0	0	0	0	0
Gilmer	1	0	0	0	0	0	0	0	0	0	0	0	0
Glascocock	61	22	3	4	0	0	0	0	0	0	0	0	0
Glynn	20	11	0	0	0	0	0	0	0	0	0	0	0
Grady	9	6	1	0	0	0	0	0	0	0	0	0	0
Greene	47	51	2	0	0	0	0	0	0	0	0	0	0
Gwinnett	22	16	1	1	0	0	0	0	0	0	0	0	0
Habersham	4	3	0	0	0	0	0	0	0	0	0	0	0
Hall	8	8	0	0	0	0	0	0	0	0	0	0	0
Hancock	68	48	8	0	0	0	0	0	0	0	0	0	0
Harris	0	1	0	0	0	0	0	0	0	0	0	0	0
Hart	18	12	0	1	0	0	0	0	0	0	0	0	0
Henry	6	4	0	1	0	0	0	0	0	0	0	0	0
Houston	33	19	1	2	0	0	0	0	0	0	0	0	0

Irwin	3	7	0	0	0	0	0	0	0	0	0	0	0
Jackson	16	16	0	1	0	0	0	0	0	0	0	0	0
Jasper	8	7	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	14	18	0	0	0	0	0	0	0	0	0	0	0
Jefferson	480	229	101	8	0	0	0	0	0	0	0	0	0
Jenkins	155	69	5	1	0	0	0	0	0	0	0	0	0
Johnson	72	34	3	0	0	0	0	0	0	0	0	0	0
Jones	13	13	0	0	0	0	0	0	0	0	0	0	0
Lamar	0	2	0	0	0	0	0	0	0	0	0	0	0
Lanier	9	2	0	0	0	0	0	0	0	0	0	0	0
Laurens	111	89	4	1	0	0	0	0	0	0	0	0	0
Lee	16	13	1	0	0	0	0	0	0	0	0	0	0
Liberty	23	17	3	0	0	0	0	0	0	0	0	0	0
Lincoln	142	92	4	7	0	0	0	0	0	0	0	0	0
Long	5	5	0	0	0	0	0	0	0	0	0	0	0
Lowndes	50	59	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	1	1	0	0	0	0	0	0	0	0	0	0	0
Macon	3	0	0	0	0	0	0	0	0	0	0	0	0
Madison	13	17	0	0	0	0	0	0	0	0	0	0	0
McDuffie	397	247	17	31	0	0	0	0	0	0	0	0	0
McIntosh	2	9	0	0	0	0	0	0	0	0	0	0	0
Meriwether	0	3	0	0	0	0	0	0	0	0	0	0	0
Miller	2	8	0	0	0	0	0	0	0	0	0	0	0
Mitchell	10	12	0	0	0	0	0	0	0	0	0	0	0
Monroe	5	2	0	0	0	0	0	0	0	0	0	0	0
Montgomery	23	14	3	0	0	0	0	0	0	0	0	0	0
Morgan	27	25	1	0	0	0	0	0	0	0	0	0	0
Murray	2	2	0	0	0	0	0	0	0	0	0	0	0
Muscogee	8	7	0	0	0	0	0	0	0	0	0	0	0
Newton	17	16	0	1	0	0	0	0	0	0	0	0	0
North Carolina	20	21	0	1	0	0	0	0	0	0	0	0	0
Oconee	10	20	2	1	0	0	0	0	0	0	0	0	0
Oglethorpe	9	19	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	128	39	6	13	0	0	0	0	0	0	0	0	0
Paulding	6	4	0	0	0	0	0	0	0	0	0	0	0
Peach	10	11	0	0	0	0	0	0	0	0	0	0	0
Pickens	0	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	14	3	0	0	0	0	0	0	0	0	0	0	0
Pike	0	1	0	0	0	0	0	0	0	0	0	0	0
Polk	2	5	0	0	0	0	0	0	0	0	0	0	0
Pulaski	10	12	0	0	0	0	0	0	0	0	0	0	0
Putnam	27	31	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	3	0	0	0	0	0	0	0	0	0	0	0
Randolph	2	5	0	0	0	0	0	0	0	0	0	0	0

Richmond	6,119	3,305	463	467	0	0	0	0	0	0	0	0	0
Rockdale	8	6	1	0	0	0	0	0	0	0	0	0	0
Schley	2	0	0	0	0	0	0	0	0	0	0	0	0
Screven	123	47	1	8	0	0	0	0	0	0	0	0	0
Seminole	3	2	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4,223	3,193	269	106	0	0	0	0	0	0	0	0	0
Spalding	3	7	0	0	0	0	0	0	0	0	0	0	0
Stephens	8	2	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	7	2	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	57	26	3	0	0	0	0	0	0	0	0	0	0
Tattnall	48	18	0	0	0	0	0	0	0	0	0	0	0
Taylor	4	2	0	0	0	0	0	0	0	0	0	0	0
Telfair	25	10	1	0	0	0	0	0	0	0	0	0	0
Tennessee	7	9	1	0	0	0	0	0	0	0	0	0	0
Terrell	5	7	0	0	0	0	0	0	0	0	0	0	0
Thomas	12	5	0	0	0	0	0	0	0	0	0	0	0
Tift	19	21	0	0	0	0	0	0	0	0	0	0	0
Toombs	39	38	0	1	0	0	0	0	0	0	0	0	0
Treutlen	29	13	0	0	0	0	0	0	0	0	0	0	0
Troup	5	1	0	0	0	0	0	0	0	0	0	0	0
Turner	6	4	0	0	0	0	0	0	0	0	0	0	0
Twiggs	2	3	0	0	0	0	0	0	0	0	0	0	0
Union	3	0	0	0	0	0	0	0	0	0	0	0	0
Upson	2	1	0	1	0	0	0	0	0	0	0	0	0
Walton	15	16	0	1	0	0	0	0	0	0	0	0	0
Ware	11	15	0	0	0	0	0	0	0	0	0	0	0
Warren	139	45	2	1	0	0	0	0	0	0	0	0	0
Washington	313	193	25	4	0	0	0	0	0	0	0	0	0
Wayne	22	8	1	0	0	0	0	0	0	0	0	0	0
Wheeler	10	7	0	0	0	0	0	0	0	0	0	0	0
White	0	1	0	0	0	0	0	0	0	0	0	0	0
Whitfield	6	4	0	0	0	0	0	0	0	0	0	0	0
Wilcox	1	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	222	153	4	3	0	0	0	0	0	0	0	0	0
Wilkinson	7	14	0	0	0	0	0	0	0	0	0	0	0
Worth	8	2	0	0	0	0	0	0	0	0	0	0	0
<b>Total</b>	<b>17,812</b>	<b>11,726</b>	<b>1,295</b>	<b>909</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>



## 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	29
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	12
daVinci Robot	0	0	1
<b>Total</b>	<b>0</b>	<b>0</b>	<b>43</b>

#### 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	9,168	15,400
Cystoscopy	0	0	79	429
Endoscopy	0	0	1,153	4,362
daVinci Robot	0	0	224	503
<b>Total</b>	<b>0</b>	<b>0</b>	<b>10,624</b>	<b>20,694</b>

#### 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	6,121	11,339
Cystoscopy	0	0	66	337
Endoscopy	0	0	991	3,670
	0	0	193	246
<b>Total</b>	<b>0</b>	<b>0</b>	<b>7,371</b>	<b>15,592</b>

### 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	8
Asian	161
Black/African American	4,675
Hispanic/Latino	365
Pacific Islander/Hawaiian	0
White	6,365
Multi-Racial	152
<b>Total</b>	<b>11,726</b>

## **2. Age Grouping**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4,235
Ages 15-64	5,769
Ages 65-74	1,179
Ages 75-85	485
Ages 85 and Up	58
<b>Total</b>	<b>11,726</b>

## **3. Gender**

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,422
Female	6,304
<b>Total</b>	<b>11,726</b>

## **4. Payment Source**

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

Primary Payment Source	Number of Patients
Medicare	2,336
Medicaid	3,705
Third-Party	5,187
Self-Pay	498

## **Perinatal Services Addendum**

### **Part A : Obstetrical Services Utilization**

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

#### **1. Number of Delivery Rooms: 0**

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 10
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 474
6. Total Live Births: 1,458
7. Total Births (Live and Late Fetal Deaths): 1,480
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,301

## 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	1,086	3,360	0
Specialty Care (Intermediate Neonatal Care)	9	2	9	0
Subspecialty Care (Intensive Neonatal Care)	36	515	11,754	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	2	5
Asian	40	90
Black/African American	698	2,306
Hispanic/Latino	93	206
Pacific Islander/Hawaiian	0	0
White	447	1,126
Multi-Racial	15	57
<b>Total</b>	<b>1,295</b>	<b>3,790</b>

## **2. Age Grouping**

Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	2	4
Ages 15-44	1,292	3,737
Ages 45 and Up	1	49
<b>Total</b>	<b>1,295</b>	<b>3,790</b>

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

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

\$12,547.00

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

Please report the average hospital charge for a premature delivery.

\$24,344.00

## **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
<b>Total</b>	<b>0</b>	<b>0</b>

**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
<b>Total</b>	<b>0</b>	<b>0</b>

**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
<b>Total</b>	<b>0</b>	<b>0</b>

**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	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	909	4,171	978	4,654	2,781	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input checked="" type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input checked="" type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

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

### 1. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	4	18
Black/African American	351	1,720
Hispanic/Latino	22	85
Pacific Islander/Hawaiian	0	0
White	524	2,319
Multi-Racial	8	29
<b>Total</b>	<b>909</b>	<b>4,171</b>

### 2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	429	2,000
Female	480	2,171
<b>Total</b>	<b>909</b>	<b>4,171</b>

### 3. Payment Source

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

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	231	1,404
Medicaid	271	1,197
Third Party	364	1,411
Self-Pay	43	159
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? 7.5 (FTE's)

What languages do they interpret?

Spanish and American Sign Language

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 Intpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

Video remote interpreters

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	1.11	0	0	0
Chinese	0.07	0	0	0
American Sign Language	0.08	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





# Comprehensive Inpatient Physical Rehabilitation Addendum

## Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

### 1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

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

### 2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

### 3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

## Part B : Referral Source

### 1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0
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**1. Payers**

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

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

**2. Uncompensated Indigent and Charity Care**

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

0

**Part D : Admissions by Diagnosis Code**

**1. Admissions by Diagnosis Code**

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

**Electronic Signature**

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

*I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and*

*completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.*

**Authorized Signature:** Peter F. Buckley, MD

**Date:** 8/11/2016

**Title:** CEO

**Comments:**