GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	30	1,288	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
Total	**409**	**17,812**	**99,942**	**17,902**	**101,734**

2. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	15	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
Total	**17,812**	**99,942**

3. Gender

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

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

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,915	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).

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

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	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 Therapeautic 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	☐	22	22
General Internal Medicine	44	☐	44	44
Pediatricians	86	☐	86	86
Other Medical Specialties	121	☐	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	☐	45	45
Non-OB Physicians Providing OB Services	11	☐	11	11
Gynecology	47	☐	47	47
Ophthalmology Surgery	13	☐	13	13
Orthopedic Surgery	20	☐	20	20
Plastic Surgery	9	☐	9	9
General Surgery	12	☐	12	12
Thoracic Surgery	7	☐	7	7
Other Surgical Specialties	63	☐	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	☐	63	63
Dermatology	7	☐	7	7
Emergency Medicine	54	☐	54	54
Nuclear Medicine	1	☐	1	1
Pathology	18	☐	18	18
Psychiatry	30	☐	30	30
Radiology	38	☐	38	38
	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	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
Glascock	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
Total	**17,812**	**11,726**	**1,295**	**909**	**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	29
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	12
daVinci Robot	0	0	1
Total	**0**	**0**	**43**

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
Total	**0**	**0**	**10,624**	**20,694**

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
Total	**0**	**0**	**7,371**	**15,592**

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
Total	**11,726**

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
Total	**11,726**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,422
Female	6,304
Total	**11,726**

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 th 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
Total	**1,295**	**3,790**

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
Total	**1,295**	**3,790**

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
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

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

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	27	27
B- General Acute Psychiatric Adolescents 13-17	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	☑
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	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
Total	**909**	**4,171**

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
Total	**909**	**4,171**

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 Intrepreter ☑	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

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

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

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

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

1. English
2. Universal Symbols
3.
4.

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

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

Comprehensive Inpatient Physical Rehabilitation Addendum

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

1. Admissions and Days of Care by Race

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

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

2. Admissions and Days of care by Gender

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

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

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

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

Part B : Referral Source

1. Referral Source

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

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

	0

1. Payers

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

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

2. Uncompensated Indigent and Charity Care

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

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

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

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

Electronic Signature

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

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

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

Authorized Signature: Peter F. Buckley, MD

Date: 8/11/2016

Title: CEO

Comments: