



2016 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP616

Facility Name: Phoebe Putney Memorial Hospital

County: Dougherty

Street Address: 417 West Third Avenue

City: Albany

Zip: 31706

Mailing Address: PO Box 3770

Mailing City: Albany

Mailing Zip: 31706-3770

Medicaid Provider Number: 000001482A

Medicare Provider Number: 110007

2. Report Period

Report Data for the full twelve month period- January 1, 2016 through December 31, 2016.
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: Lori Jenkins

Contact Title: Director, Strategy & Planning

Phone: 229-312-1432

Fax: 229-312-1495

E-mail: ljenkins@phoebehealth.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
Hospital Authority of Albany-Dougherty County	Hospital Authority	7/1/1941

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Memorial Hospital, Inc.	Not for Profit	9/1/1991

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Phoebe Putney Health System, Inc.	Not for Profit	9/1/1991

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable	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: Phoebe Putney Health System, Inc.

City: Albany **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company.

Name: Phoebe Putney Health System, Inc.

City: Albany **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: 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:

City: State:

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

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

10a. Managed Care Information: Formal Written Contract

Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO)

2. Preferred Provider Organization(PPO)

3. Physician Hospital Organization(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 type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input 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)

Not applicable

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)	42	2,572	7,772	2,561	7,679
Pediatrics (Non ICU)	26	500	1,862	505	1,965
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	14	323	988	307	898
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	305	11,101	54,484	13,456	70,711
Intensive Care	50	3,149	21,704	818	6,246
Psychiatry	38	1,074	4,955	1,081	5,064
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	25	357	4,869	356	4,832
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	500	19,076	96,634	19,084	97,395

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	8	29
Asian	52	184
Black/African American	10,165	52,440
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	6	19
White	8,519	42,248
Multi-Racial	326	1,714
Total	19,076	96,634

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,120	44,546
Female	10,956	52,088
Total	19,076	96,634

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	9,071	51,557
Medicaid	4,203	19,409
Peachare	0	0
Third-Party	3,824	16,562
Self-Pay	1,666	7,534
Other	312	1,572

5. Discharges to Death

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

497

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2016 (to the nearest whole dollar).

Service	Charge
Private Room Rate	655
Semi-Private Room Rate	655
Operating Room: Average Charge for the First Hour	3,630
Average Total Charge for an Inpatient Day	6,454

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

90,129

2. Inpatient Admissions from ER

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

10,746

3. Beds Available

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

52

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	4	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	0
General Beds	35	0
Fast Track	11	0
Resuscitation	1	0
	0	0
	0	0

5. Transfers

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

493

6. Non-Emergency Visits

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

1,042,584

7. Observation Visits/Cases

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

4,839

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.

5,796

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	1	1
ESWL	2	1
Biliary Lithotripter	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, 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	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	1	1
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	4,818
Number of ESWL Patients	161
Number of ESWL Procedures	161
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	83,191
Number of CTS Units (machines)	6
Number of CTS Procedures	43,993
Number of Diagnostic Radioisotope Procedures	2,278
Number of PET Units (machines)	1
Number of PET Procedures	962
Number of Therapeutic Radioisotope Procedures	37
Number of Number of MRI Units	4
Number of Number of MRI Procedures	10,688
Number of Chemotherapy Treatments	34,173
Number of Respiratory Therapy Treatments	209,079
Number of Occupational Therapy Treatments	64,696
Number of Physical Therapy Treatments	124,926
Number of Speech Pathology Patients	4,858
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,609
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	505
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	9
Number of Ultrasound/Medical Sonography Procedures	13,121
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).

47

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	376	IS200 da Vinci Surgical System

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2016. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2016.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	756.63000488281	173.66000366211	81
Licensed Practical Nurses (LPNs)	61.450000762939	11.050000190735	0
Pharmacists	42.689998626709	3.0899999141693	0
Other Health Services Professionals*	474.26998901367	88.169998168945	63
Administration and Support	164.75999450684	10.960000038147	28
All Other Hospital Personnel (not included above)	1223.9399414062	160.78999328613	207

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)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	61-90 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	38	<input checked="" type="checkbox"/>	38	38
General Internal Medicine	37	<input checked="" type="checkbox"/>	37	37
Pediatricians	24	<input type="checkbox"/>	24	24
Other Medical Specialties	34	<input checked="" type="checkbox"/>	34	34

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	14	<input type="checkbox"/>	14	14
Non-OB Physicians Providing OB Services	0	<input checked="" type="checkbox"/>	0	0
Gynecology	17	<input type="checkbox"/>	14	15
Ophthalmology Surgery	8	<input type="checkbox"/>	8	8
Orthopedic Surgery	15	<input checked="" type="checkbox"/>	15	15
Plastic Surgery	2	<input type="checkbox"/>	2	2
General Surgery	12	<input type="checkbox"/>	12	12
Thoracic Surgery	3	<input checked="" type="checkbox"/>	3	3
Other Surgical Specialties	22	<input checked="" type="checkbox"/>	21	21

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	11	<input checked="" type="checkbox"/>	11	11
Dermatology	1	<input type="checkbox"/>	1	1
Emergency Medicine	28	<input checked="" type="checkbox"/>	28	28
Nuclear Medicine	20	<input checked="" type="checkbox"/>	20	20
Pathology	5	<input checked="" type="checkbox"/>	5	5
Psychiatry	5	<input checked="" type="checkbox"/>	5	5
Radiology	20	<input checked="" type="checkbox"/>	20	20
Hamatology/Oncology	8	<input checked="" type="checkbox"/>	8	8
Neonatology	5	<input checked="" type="checkbox"/>	5	5
Radiation Oncology	3	<input checked="" type="checkbox"/>	3	3

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	7
Podiatrists	4
Certified Nurse Midwives with Clinical Privileges in the Hospital	10
All Other Staff Affiliates with Clinical Privileges in the Hospital	225

5b. Name of Other Professions

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

Physician assistants, surgical technologists, orthopedic technologists, dental assistants, ophthalmic technologists, nurse practitioners

Comments and Suggestions:

Data reported is for all beds/services/other categories for both Phoebe Main Campus and North Campus.

D.1.(a) Reported OB inpatient days include obstetric, labor and delivery, C-section, ante- and post-partum days.

D.2. Multiracial categories include patients whose race/ethnicity is unknown.

E.4. Phoebe Putney information systems are unable to capture Emergency Room visit by type of bed.

E.5. Transfer data includes transfers back to non-hospital institutions (e.g., nursing homes).

E.6. Visits reported here include visits provided under the auspices of Phoebe Physician Group.

E.10. Includes all patients (i) who registered but left against medical advice; or (ii) who left before being discharged. Some of these patients likely received some care before leaving.

F.1. Number of MRI units: Phoebe Putney operates 2 MRI units on its main campus, one on its north campus and 1 on its Meredyth Drive campus.

F.1. Number of CT units: Phoebe Putney operates 4 CT units on its main campus, 1 on its north campus and 1 on its Meredyth Drive campus.

F.1. Phoebe Putney has a critical care transport service that uses critical care ambulances for the transports. These ambulances are not part of the county's Emergency Medical System.

F.1.b. Respiratory treatments reflect all procedures with attached CPT code.

F.2. The breakdown of ventilators reported here is as follows: 34 adult, 12 neonatal and 1 transport.

G.3. Phoebe Putney does not capture the race/ethnicity of its medical staff.

G.4. Reported hospital-based physicians include both physicians with hospital-based practices and Phoebe Physician Group-employed physicians.

G.4. Some physicians are reported in both the Obstetrics and Gynecology categories.

G.4. The number of providers enrolled in Medicaid/PeachCare and/or Public Employee Health Benefits Plan was derived from hospital records. Any physician whose patient generated a charge where the financial class was Medicaid, State Health Benefit Plan or Board of Regents Health Plan is counted in the report.

Surgical Services Addendum B.2. Multiracial categories include patients whose race/ethnicity is unknown.

Perinatal Services Addendum C.1. Multiracial categories include patients whose race/ethnicity is

unknown.

Perinatal Services Addendum C.3. Average hospital charge for an uncomplicated delivery is based on charges for MS-DRG 775 (mothers' charges).

Perinatal Services Addendum C.4. Average charge for a premature delivery excludes outliers.

Psychiatric/Substance Abuse Addendum A.2: Phoebe Putney Memorial Hospital, including its inpatient psychiatric services, is accredited by DNV.

Psychiatric/Substance Abuse Addendum B.1: Multiracial categories include patients whose race/ethnicity is unknown.

Minority Health Addendum Part 3: Although Phoebe does have physicians, nurses, and employed staff who speak languages other than English, Phoebe does not have reliable data responsive to the survey request.

Comprehensive Inpatient Physical Rehabilitation Addendum A.1. Multiracial categories include patients whose race/ethnicity is unknown.

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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	31	3	2	5	0	0	0	0	0	0	0	0	0
Atkinson	7	4	2	2	0	0	0	0	0	0	0	0	0
Bacon	1	0	0	0	0	0	0	0	0	0	0	0	0
Baker	262	70	26	11	0	0	0	0	0	0	0	0	6
Baldwin	1	0	1	0	0	0	0	0	0	0	0	0	0
Banks	1	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	2	0	0	0	0	0	0	0	0	0	0	0	1
Bartow	4	0	0	4	0	0	0	0	0	0	0	0	0
Ben Hill	174	35	5	7	0	0	0	0	0	0	0	0	5
Berrien	49	16	20	7	0	0	0	0	0	0	0	0	0
Bibb	4	5	0	4	0	0	0	0	0	0	0	0	0
Bleckley	4	0	1	1	0	0	0	0	0	0	0	0	0
Brooks	9	2	4	1	0	0	0	0	0	0	0	0	0
Bulloch	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	2	1	0	0	0	0	0	0	0	0	0	0	0
Calhoun	413	197	38	20	0	0	0	0	0	0	0	0	10
Camden	8	0	0	0	0	0	0	0	0	0	0	0	0
Candler	2	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	8	1	0	8	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	6	0	2	0	0	0	0	0	0	0	0	0	0
Chattahoochee	0	1	0	0	0	0	0	0	0	0	0	0	0
Cherokee	1	0	0	0	0	0	0	0	0	0	0	0	0
Clay	83	32	24	3	0	0	0	0	0	0	0	0	2
Clayton	24	2	0	21	0	0	0	0	0	0	0	0	0
Clinch	1	0	1	0	0	0	0	0	0	0	0	0	0
Cobb	10	0	0	3	0	0	0	0	0	0	0	0	0

Coffee	22	16	3	9	0	0	0	0	0	0	0	0	0
Colquitt	341	151	39	25	0	0	0	0	0	0	0	0	2
Columbia	0	2	0	0	0	0	0	0	0	0	0	0	0
Cook	32	12	7	4	0	0	0	0	0	0	0	0	0
Coweta	8	0	0	8	0	0	0	0	0	0	0	0	0
Crisp	342	160	17	31	0	0	0	0	0	0	0	0	9
Decatur	87	59	32	8	0	0	0	0	0	0	0	0	1
DeKalb	12	4	0	5	0	0	0	0	0	0	0	0	0
Dodge	4	2	0	0	0	0	0	0	0	0	0	0	0
Dooly	107	35	2	16	0	0	0	0	0	0	0	0	1
Dougherty	9,409	3,711	1,337	383	0	0	0	0	0	0	0	0	160
Early	168	109	19	6	0	0	0	0	0	0	0	0	5
Echols	1	0	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	5	0	0	3	0	0	0	0	0	0	0	0	0
Florida	69	17	1	9	0	0	0	0	0	0	0	0	1
Floyd	2	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	29	5	3	20	0	0	0	0	0	0	0	0	0
Gilmer	1	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	17	0	1	2	0	0	0	0	0	0	0	0	0
Gordon	0	1	0	0	0	0	0	0	0	0	0	0	0
Grady	52	23	25	5	0	0	0	0	0	0	0	0	0
Gwinnett	2	2	0	0	0	0	0	0	0	0	0	0	0
Habersham	1	1	0	0	0	0	0	0	0	0	0	0	0
Hall	1	1	0	1	0	0	0	0	0	0	0	0	0
Haralson	4	0	0	4	0	0	0	0	0	0	0	0	0
Harris	2	0	0	1	0	0	0	0	0	0	0	0	0
Heard	1	0	0	1	0	0	0	0	0	0	0	0	0
Henry	12	2	0	8	0	0	0	0	0	0	0	0	1
Houston	38	3	6	22	0	0	0	0	0	0	0	0	1
Irwin	35	14	4	4	0	0	0	0	0	0	0	0	3
Jackson	1	0	1	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	1	1	0	0	0	0	0	0	0	0	0	0
Johnson	0	1	0	0	0	0	0	0	0	0	0	0	0
Jones	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	2	0	0	2	0	0	0	0	0	0	0	0	0
Lanier	4	1	2	0	0	0	0	0	0	0	0	0	0
Laurens	3	0	0	1	0	0	0	0	0	0	0	0	0
Lee	1,876	1,157	305	68	0	0	0	0	0	0	0	0	41
Lowndes	68	22	21	32	0	0	0	0	0	0	0	0	1
Macon	77	31	5	14	0	0	0	0	0	0	0	0	4
Marion	23	13	1	3	0	0	0	0	0	0	0	0	1
Meriwether	2	0	0	2	0	0	0	0	0	0	0	0	0
Miller	145	81	12	6	0	0	0	0	0	0	0	0	0

Mitchell	955	462	162	19	0	0	0	0	0	0	0	0	18
Muscogee	36	5	3	27	0	0	0	0	0	0	0	0	0
Newton	1	0	1	0	0	0	0	0	0	0	0	0	0
North Carolina	9	2	0	1	0	0	0	0	0	0	0	0	0
Oglethorpe	2	0	0	2	0	0	0	0	0	0	0	0	0
Other Out of State	51	14	1	7	0	0	0	0	0	0	0	0	2
Paulding	1	1	0	0	0	0	0	0	0	0	0	0	0
Peach	3	1	0	0	0	0	0	0	0	0	0	0	0
Pickens	5	0	0	4	0	0	0	0	0	0	0	0	0
Polk	1	0	0	1	0	0	0	0	0	0	0	0	0
Pulaski	6	9	0	4	0	0	0	0	0	0	0	0	0
Quitman	32	31	6	0	0	0	0	0	0	0	0	0	0
Randolph	473	210	64	14	0	0	0	0	0	0	0	0	8
Richmond	5	0	0	0	0	0	0	0	0	0	0	0	0
Rockdale	3	0	2	0	0	0	0	0	0	0	0	0	0
Schley	59	50	8	5	0	0	0	0	0	0	0	0	2
Seminole	22	17	3	1	0	0	0	0	0	0	0	0	0
Spalding	9	0	0	9	0	0	0	0	0	0	0	0	0
Stewart	50	22	4	3	0	0	0	0	0	0	0	0	2
Sumter	794	450	71	58	0	0	0	0	0	0	0	0	28
Talbot	1	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	6	5	0	2	0	0	0	0	0	0	0	0	0
Telfair	1	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	8	2	0	1	0	0	0	0	0	0	0	0	0
Terrell	877	371	98	27	0	0	0	0	0	0	0	0	17
Thomas	93	29	28	11	0	0	0	0	0	0	0	0	2
Tift	150	97	21	21	0	0	0	0	0	0	0	0	3
Toombs	3	1	0	0	0	0	0	0	0	0	0	0	0
Towns	1	0	1	0	0	0	0	0	0	0	0	0	0
Treutlen	1	0	0	0	0	0	0	0	0	0	0	0	0
Troup	15	3	0	10	0	0	0	0	0	0	0	0	0
Turner	105	57	10	5	0	0	0	0	0	0	0	0	3
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	1	0	0	0	0	0	0	0	0	0	0	0	0
Upson	5	0	0	5	0	0	0	0	0	0	0	0	0
Walton	1	0	0	1	0	0	0	0	0	0	0	0	0
Ware	5	1	2	0	0	0	0	0	0	0	0	0	0
Warren	0	1	0	0	0	0	0	0	0	0	0	0	0
Wayne	1	1	0	0	0	0	0	0	0	0	0	0	0
Webster	43	27	3	3	0	0	0	0	0	0	0	0	0
Wheeler	0	1	0	0	0	0	0	0	0	0	0	0	0
Whitfield	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilcox	44	23	5	6	0	0	0	0	0	0	0	0	1
Wilkes	1	0	0	0	0	0	0	0	0	0	0	0	0

Worth	1,080	530	109	27	0	0	0	0	0	0	0	0	16
Total	19,076	8,434	2,572	1,074	0	0	0	0	0	0	0	0	357

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	8	19
Cystoscopy (OR Suite)	0	0	3
Endoscopy (OR Suite)	0	0	0
Open Heart	1	0	0
Total	1	8	22

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	38	3,858	3,881	4,136
Cystoscopy	0	0	144	524
Endoscopy	0	0	30	34
Open Heart	262	0	0	0
Total	300	3,858	4,055	4,694

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	38	3,821	3,742	4,065
Cystoscopy	0	0	131	520
Endoscopy	0	0	26	28
Open Heart	254	0	0	0
Total	292	3,821	3,899	4,613

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	9
Asian	28
Black/African American	4,024
Hispanic/Latino	0
Pacific Islander/Hawaiian	10
White	4,154
Multi-Racial	209
Total	8,434

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,299
Ages 15-64	5,108
Ages 65-74	1,350
Ages 75-85	545
Ages 85 and Up	132
Total	8,434

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	3,545
Female	4,889
Total	8,434

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,558
Medicaid	1,983
Third-Party	3,494
Self-Pay	399

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: 2

2. Number of Birthing Rooms: 0
3. Number of LDR Rooms: 12
4. Number of LDRP Rooms: 0
5. Number of Cesarean Sections: 946
6. Total Live Births: 2,269
7. Total Births (Live and Late Fetal Deaths): 2,300
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,594

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)	44	1,990	3,570	61
Specialty Care (Intermediate Neonatal Care)	12	2	4,531	325
Subspecialty Care (Intensive Neonatal Care)	15	450	7,284	125

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	2
Asian	18	49
Black/African American	1,625	5,064
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	1	2
White	847	2,342
Multi-Racial	80	313
Total	2,572	7,772

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	6	20
Ages 15-44	2,560	7,737
Ages 45 and Up	6	15
Total	2,572	7,772

3. Average Charge for an Uncomplicated Delivery

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

\$9,000.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$17,284.00

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	38	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	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	1,074	4,955	1,081	5,064	2,219	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input 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	3	11
Asian	1	6
Black/African American	556	2,625
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	1	3
White	476	2,165
Multi-Racial	37	145
Total	1,074	4,955

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	500	2,423
Female	574	2,532
Total	1,074	4,955

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	256	2,215
Medicaid	371	1,588
Third Party	183	626
Self-Pay	164	526
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? (Check the box, if yes.)

If you checked yes, how many? 0 (FTE's)

What languages do they interpret?

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? (Check all that apply)

Bilingual Hospital Staff Member

Bilingual Member of Patient's Family

Community Volunteer Interpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

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

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	n/a	0	0	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?

Cultural diversity module included in the annual employee update and new employee orientation.

Nursing internship course includes diversity training.

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?

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

1. English

2. Spanish

3.

4.

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

If you checked yes, what is the name and location of that health care center or clinic?

Albany Area Primary Health Care. Locations in Dougherty, Lee, Baker, Calhoun and Terrell counties.

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	183	2,531
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	172	2,312
Multi-Racial	2	26

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	169	2,309
Female	188	2,560

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	147	1,939
65-84	176	2,490
85 Up	34	440

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	357
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	243
Third Party/Commercial	71
Self Pay	5
Other	38

2. Uncompensated Indigent and Charity Care

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

5

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	135
2. Brain Injury	16
3. Amputation	33
4. Spinal Cord	25
5. Fracture of the femur	0
6. Neurological disorders	17
7. Multiple Trauma	7
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	38
All Other	86

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: Joel Wernick

Date: 4/12/2017

Title: CEO

Comments: