



2016 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP719

Facility Name: AU 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, 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: Stacie Pankow

Contact Title: IR Analyst

Phone: 706-721-2553

Fax: 706-434-6181

E-mail: spankow@augusta.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)	24	1,294	4,113	1,388	4,673
Pediatrics (Non ICU)	48	1,089	4,699	2,490	10,526
Pediatric ICU	60	334	1,333	266	1,301
Gynecology (No OB)	6	488	2,307	483	2,516
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	225	10,249	66,091	11,905	70,128
Intensive Care	90	4,850	22,471	1,503	11,424
Psychiatry	23	738	3,770	807	4,273
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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	476	19,042	104,784	18,842	104,841

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	19	78
Asian	215	1,086
Black/African American	8,564	48,147
Hispanic/Latino	448	2,149
Pacific Islander/Hawaiian	0	0
White	9,607	52,515
Multi-Racial	189	809
Total	19,042	104,784

3. Gender

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

Gender	Admissions	Inpatient Days
Male	9,027	52,739
Female	10,015	52,045
Total	19,042	104,784

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,504	40,186
Medicaid	4,946	25,584
Peachare	5	12
Third-Party	5,694	28,702
Self-Pay	1,892	10,299
Other	1	1

5. Discharges to Death

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

466

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	792
Semi-Private Room Rate	792
Operating Room: Average Charge for the First Hour	3,995
Average Total Charge for an Inpatient Day	10,083

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

87,936

2. Inpatient Admissions from ER

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

11,078

3. Beds Available

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

75

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	2,712
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	10	3,042
General Beds	55	82,182
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

1,266

6. Non-Emergency Visits

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

425,569

7. Observation Visits/Cases

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

6,853

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

383.00

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.

3,571

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	3	4
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	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	2	1
Hospice	2	1
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	4,799
Number of ESWL Patients	39
Number of ESWL Procedures	39
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	0
Number of Diagnostic X-Ray Procedures	112,060
Number of CTS Units (machines)	3
Number of CTS Procedures	40,903
Number of Diagnostic Radioisotope Procedures	3,895
Number of PET Units (machines)	1
Number of PET Procedures	1,658
Number of Therapeutic Radioisotope Procedures	2,884
Number of Number of MRI Units	3
Number of Number of MRI Procedures	16,883
Number of Chemotherapy Treatments	11,901
Number of Respiratory Therapy Treatments	178,990
Number of Occupational Therapy Treatments	48,195
Number of Physical Therapy Treatments	84,615
Number of Speech Pathology Patients	13,831
Number of Gamma Ray Knife Procedures	137
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	1,875
Number of HIV/AIDS Diagnostic Procedures	1,637
Number of HIV/AIDS Patients	1,637
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	22,490
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	502	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 12-31-2016. 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	1	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	0
All Other Hospital Personnel (not included above)		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 Plan 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	30	<input type="checkbox"/>	30	30
General Internal Medicine	41	<input type="checkbox"/>	41	41
Pediatricians	104	<input type="checkbox"/>	104	104
Other Medical Specialties	87	<input type="checkbox"/>	87	87

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	41	<input type="checkbox"/>	41	41
Non-OB Physicians Providing OB Services	11	<input type="checkbox"/>	11	11
Gynecology	35	<input type="checkbox"/>	35	35
Ophthalmology Surgery	13	<input type="checkbox"/>	13	13
Orthopedic Surgery	19	<input type="checkbox"/>	19	19
Plastic Surgery	8	<input type="checkbox"/>	8	8
General Surgery	10	<input type="checkbox"/>	10	10
Thoracic Surgery	9	<input type="checkbox"/>	9	9
Other Surgical Specialties	74	<input type="checkbox"/>	74	74

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	69	<input type="checkbox"/>	69	69
Dermatology	7	<input type="checkbox"/>	7	7
Emergency Medicine	55	<input type="checkbox"/>	55	55
Nuclear Medicine	1	<input type="checkbox"/>	1	1
Pathology	21	<input type="checkbox"/>	21	21
Psychiatry	30	<input type="checkbox"/>	30	30
Radiology	42	<input type="checkbox"/>	42	42
	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	28
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	3
All Other Staff Affiliates with Clinical Privileges in the Hospital	204

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	22	5	0	0	0	0	0	0	0	0	0	0	0
Appling	17	3	0	0	0	0	0	0	0	0	0	0	0
Atkinson	4	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	14	3	1	0	0	0	0	0	0	0	0	0	0
Baker	1	4	0	0	0	0	0	0	0	0	0	0	0
Baldwin	89	83	2	0	0	0	0	0	0	0	0	0	0
Banks	3	6	0	0	0	0	0	0	0	0	0	0	0
Barrow	17	9	1	0	0	0	0	0	0	0	0	0	0
Bartow	4	4	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	11	14	0	0	0	0	0	0	0	0	0	0	0
Berrien	8	10	0	0	0	0	0	0	0	0	0	0	0
Bibb	26	27	0	0	0	0	0	0	0	0	0	0	0
Bleckley	7	3	0	0	0	0	0	0	0	0	0	0	0
Brantley	7	25	0	0	0	0	0	0	0	0	0	0	0
Brooks	15	10	0	0	0	0	0	0	0	0	0	0	0
Bryan	28	11	0	0	0	0	0	0	0	0	0	0	0
Bulloch	160	87	10	0	0	0	0	0	0	0	0	0	0
Burke	640	269	82	16	0	0	0	0	0	0	0	0	0
Butts	11	9	0	0	0	0	0	0	0	0	0	0	0
Calhoun	8	7	0	0	0	0	0	0	0	0	0	0	0
Camden	7	1	0	0	0	0	0	0	0	0	0	0	0
Candler	36	18	1	1	0	0	0	0	0	0	0	0	0
Carroll	1	1	0	0	0	0	0	0	0	0	0	0	0
Catoosa	1	0	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	81	48	1	0	0	0	0	0	0	0	0	0	0
Chattooga	1	2	0	0	0	0	0	0	0	0	0	0	0

Cherokee	9	5	0	1	0	0	0	0	0	0	0	0	0
Clarke	53	64	4	0	0	0	0	0	0	0	0	0	0
Clayton	4	3	0	0	0	0	0	0	0	0	0	0	0
Clinch	6	1	0	0	0	0	0	0	0	0	0	0	0
Cobb	13	15	1	0	0	0	0	0	0	0	0	0	0
Coffee	27	18	0	0	0	0	0	0	0	0	0	0	0
Colquitt	21	8	2	0	0	0	0	0	0	0	0	0	0
Columbia	2,722	2,068	245	169	0	0	0	0	0	0	0	0	0
Cook	8	6	1	0	0	0	0	0	0	0	0	0	0
Coweta	2	0	1	0	0	0	0	0	0	0	0	0	0
Crawford	0	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	15	9	1	0	0	0	0	0	0	0	0	0	0
Dawson	1	1	0	0	0	0	0	0	0	0	0	0	0
Decatur	6	5	0	0	0	0	0	0	0	0	0	0	0
DeKalb	14	12	0	1	0	0	0	0	0	0	0	0	0
Dodge	22	22	1	0	0	0	0	0	0	0	0	0	0
Dooly	9	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	48	75	1	0	0	0	0	0	0	0	0	0	0
Douglas	1	1	0	0	0	0	0	0	0	0	0	0	0
Early	1	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	30	14	0	0	0	0	0	0	0	0	0	0	0
Elbert	18	42	0	0	0	0	0	0	0	0	0	0	0
Emanuel	303	104	7	0	0	0	0	0	0	0	0	0	0
Evans	19	13	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	1	0	0	0	0	0	0	0	0	0	0	0
Florida	35	35	1	1	0	0	0	0	0	0	0	0	0
Floyd	5	7	0	0	0	0	0	0	0	0	0	0	0
Forsyth	7	3	0	0	0	0	0	0	0	0	0	0	0
Franklin	9	10	0	0	0	0	0	0	0	0	0	0	0
Fulton	18	17	0	1	0	0	0	0	0	0	0	0	0
Glascocock	58	34	4	0	0	0	0	0	0	0	0	0	0
Glynn	26	18	0	0	0	0	0	0	0	0	0	0	0
Grady	11	11	0	0	0	0	0	0	0	0	0	0	0
Greene	35	57	2	0	0	0	0	0	0	0	0	0	0
Gwinnett	12	17	0	0	0	0	0	0	0	0	0	0	0
Habersham	3	7	0	0	0	0	0	0	0	0	0	0	0
Hall	20	7	1	0	0	0	0	0	0	0	0	0	0
Hancock	60	53	1	0	0	0	0	0	0	0	0	0	0
Haralson	1	0	0	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	13	16	0	0	0	0	0	0	0	0	0	0	0
Heard	1	0	0	0	0	0	0	0	0	0	0	0	0
Henry	11	3	1	1	0	0	0	0	0	0	0	0	0

Houston	31	35	2	0	0	0	0	0	0	0	0	0	0
Irwin	4	3	0	0	0	0	0	0	0	0	0	0	0
Jackson	8	18	1	0	0	0	0	0	0	0	0	0	0
Jasper	9	6	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	13	10	0	0	0	0	0	0	0	0	0	0	0
Jefferson	576	233	105	21	0	0	0	0	0	0	0	0	0
Jenkins	151	64	8	0	0	0	0	0	0	0	0	0	0
Johnson	62	33	0	0	0	0	0	0	0	0	0	0	0
Jones	11	13	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	7	5	0	0	0	0	0	0	0	0	0	0	0
Laurens	148	86	5	1	0	0	0	0	0	0	0	0	0
Lee	22	10	1	0	0	0	0	0	0	0	0	0	0
Liberty	33	15	3	0	0	0	0	0	0	0	0	0	0
Lincoln	144	103	5	1	0	0	0	0	0	0	0	0	0
Long	8	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	51	74	1	0	0	0	0	0	0	0	0	0	0
Macon	9	1	1	0	0	0	0	0	0	0	0	0	0
Madison	22	15	1	0	0	0	0	0	0	0	0	0	0
McDuffie	396	267	10	5	0	0	0	0	0	0	0	0	0
McIntosh	11	3	0	0	0	0	0	0	0	0	0	0	0
Meriwether	0	1	0	0	0	0	0	0	0	0	0	0	0
Miller	0	7	0	0	0	0	0	0	0	0	0	0	0
Mitchell	9	11	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	5	0	0	0	0	0	0	0	0	0	0	0
Montgomery	17	13	0	0	0	0	0	0	0	0	0	0	0
Morgan	25	20	0	0	0	0	0	0	0	0	0	0	0
Murray	0	3	0	0	0	0	0	0	0	0	0	0	0
Muscogee	7	4	0	0	0	0	0	0	0	0	0	0	0
Newton	12	9	0	0	0	0	0	0	0	0	0	0	0
North Carolina	34	23	0	0	0	0	0	0	0	0	0	0	0
Oconee	8	21	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	7	18	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	81	29	1	11	0	0	0	0	0	0	0	0	0
Paulding	2	1	0	0	0	0	0	0	0	0	0	0	0
Peach	8	5	1	0	0	0	0	0	0	0	0	0	0
Pickens	2	1	0	0	0	0	0	0	0	0	0	0	0
Pierce	5	6	0	0	0	0	0	0	0	0	0	0	0
Pike	2	1	0	0	0	0	0	0	0	0	0	0	0
Polk	4	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	9	3	0	0	0	0	0	0	0	0	0	0	0
Putnam	33	37	2	5	0	0	0	0	0	0	0	0	0
Randolph	7	7	0	0	0	0	0	0	0	0	0	0	0
Richmond	6,288	3,271	451	424	1	0	0	0	0	0	0	0	0

Rockdale	10	8	2	0	0	0	0	0	0	0	0	0	0
Schley	4	1	0	0	0	0	0	0	0	0	0	0	0
Screven	106	46	5	0	0	0	0	0	0	0	0	0	0
Seminole	4	4	1	0	0	0	0	0	0	0	0	0	0
South Carolina	4,614	3,263	271	72	0	0	0	0	0	0	0	0	0
Spalding	4	1	0	0	0	0	0	0	0	0	0	0	0
Stephens	4	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	8	7	2	0	0	0	0	0	0	0	0	0	0
Taliaferro	48	18	3	0	0	0	0	0	0	0	0	0	0
Tattnall	53	22	1	0	0	0	0	0	0	0	0	0	0
Taylor	3	2	0	0	0	0	0	0	0	0	0	0	0
Telfair	18	14	0	0	0	0	0	0	0	0	0	0	0
Tennessee	18	12	0	0	0	0	0	0	0	0	0	0	0
Terrell	5	6	0	0	0	0	0	0	0	0	0	0	0
Thomas	13	2	2	1	0	0	0	0	0	0	0	0	0
Tift	21	26	2	0	0	0	0	0	0	0	0	0	0
Toombs	64	32	1	0	0	0	0	0	0	0	0	0	0
Towns	0	1	0	0	0	0	0	0	0	0	0	0	0
Treutlen	14	14	0	0	0	0	0	0	0	0	0	0	0
Troup	3	1	0	0	0	0	0	0	0	0	0	0	0
Turner	4	2	1	0	0	0	0	0	0	0	0	0	0
Twiggs	3	1	0	0	0	0	0	0	0	0	0	0	0
Union	2	0	0	0	0	0	0	0	0	0	0	0	0
Upson	3	4	0	0	0	0	0	0	0	0	0	0	0
Walker	1	1	0	0	0	0	0	0	0	0	0	0	0
Walton	19	12	0	0	0	0	0	0	0	0	0	0	0
Ware	23	27	0	0	0	0	0	0	0	0	0	0	0
Warren	101	43	5	0	0	0	0	0	0	0	0	0	0
Washington	403	185	21	0	0	0	0	0	0	0	0	0	0
Wayne	17	15	1	0	0	0	0	0	0	0	0	0	0
Webster	2	1	0	0	0	0	0	0	0	0	0	0	0
Wheeler	15	1	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	4	1	0	0	0	0	0	0	0	0	0	0	0
Wilcox	9	5	0	0	0	0	0	0	0	0	0	0	0
Wilkes	224	141	5	5	0	0	0	0	0	0	0	0	0
Wilkinson	13	20	1	0	0	0	0	0	0	0	0	0	0
Worth	8	9	0	0	0	0	0	0	0	0	0	0	0
Total	19,042	11,895	1,294	737	1	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
Other (daVinci)	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	9,711	16,104
Cystoscopy	0	0	91	432
Endoscopy	0	0	812	4,163
Other (daVinci)	0	0	171	331
Total	0	0	10,785	21,030

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	6,635	11,910
Cystoscopy	0	0	86	400
Endoscopy	0	0	679	3,476
	0	0	149	197
Total	0	0	7,549	15,983

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	15
Asian	150
Black/African American	4,558
Hispanic/Latino	408
Pacific Islander/Hawaiian	0
White	6,551
Multi-Racial	213
Total	11,895

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4,536
Ages 15-64	5,584
Ages 65-74	1,199
Ages 75-85	502
Ages 85 and Up	74
Total	11,895

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,708
Female	6,187
Total	11,895

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,354
Medicaid	3,713
Third-Party	5,309
Self-Pay	519

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: 470
6. Total Live Births: 1,388
7. Total Births (Live and Late Fetal Deaths): 1,430
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,782

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)	0	962	2,996	0
Specialty Care (Intermediate Neonatal Care)	6	2	40	0
Subspecialty Care (Intensive Neonatal Care)	36	496	11,948	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	5	14
Asian	41	103
Black/African American	642	2,210
Hispanic/Latino	78	204
Pacific Islander/Hawaiian	0	0
White	505	1,516
Multi-Racial	23	66
Total	1,294	4,113

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	1,290	4,104
Ages 45 and Up	2	5
Total	1,294	4,113

3. Average Charge for an Uncomplicated Delivery

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

\$13,797.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$23,729.00

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	22	22
B- General Acute Psychiatric Adolescents 13-17	1	1
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	737	3,758	806	4,261	2,854	<input checked="" type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	1	12	1	12	1,999	<input checked="" 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	0	0
Asian	4	17
Black/African American	304	1,621
Hispanic/Latino	10	47
Pacific Islander/Hawaiian	0	0
White	413	2,052
Multi-Racial	7	33
Total	738	3,770

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	357	1,801
Female	381	1,969
Total	738	3,770

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	190	1,176
Medicaid	242	1,298
Third Party	251	1,084
Self-Pay	55	212
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 Interpreter

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	1.17	0	0	0
Chinese	0.06	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?

Training is provided at new employee orientations "Great Start", Patient and Family Centered-Care

Comprehensive Inpatient Physical Rehabilitation Addendum

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

1. Admissions and Days of Care by Race

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

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

2. Admissions and Days of care by Gender

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

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

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

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

Part B : Referral Source

1. Referral Source

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

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

	0
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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: Lee Ann Liska

Date: 5/10/2017

Title: Chief Executive Officer

Comments: