GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2021 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: 31701

Mailing Address: PO Box 3770

Mailing City: Albany

Mailing Zip: 31706

Medicaid Provider Number: 000001482A

Medicare Provider Number: 110007

2. Report Period

Report Data for the full twelve month period- January 1, 2021 through December 31, 2021.
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-Dought County	Hospital Authority	7/1/1941

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	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 Applicable	9/1/1991

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	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:
City: State:

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(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)	29	2,252	6,975	2,274	7,139
Pediatrics (Non ICU)	12	300	693	297	687
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	14	182	662	181	639
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	325	12,177	74,136	13,534	86,721
Intensive Care	54	2,224	21,985	903	10,458
Psychiatry	18	396	2,339	396	2,255
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	25	232	3,509	240	3,740
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	**477**	**17,763**	**110,299**	**17,825**	**111,639**

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	7	31
Asian	53	334
Black/African American	9,926	62,613
Hispanic/Latino	290	1,541
Pacific Islander/Hawaiian	10	146
White	7,261	44,102
Multi-Racial	216	1,532
Total	**17,763**	**110,299**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,649	52,593
Female	10,114	57,706
Total	**17,763**	**110,299**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	8,583	61,278
Medicaid	3,641	18,589
Peachare	0	0
Third-Party	3,516	17,979
Self-Pay	1,866	11,499
Other	157	954

5. Discharges to Death

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

718

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2021 (to the nearest whole dollar).

Service	Charge
Private Room Rate	995
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	5,800
Average Total Charge for an Inpatient Day	8,538

Part E : Emergency Department and Outpatient Services

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

57,379

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

13,107

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	3	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	4	0
General Beds	24	0
Provider First Beds	6	0
Provider First Chairs	15	0
	0	0
	0	0

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

1,081

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

1,148,748

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

3,371

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.

3,644

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	1	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	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	5,163
Number of ESWL Patients	54
Number of ESWL Procedures	54
Number of ESWL Units	0
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	81,814
Number of CTS Units (machines)	6
Number of CTS Procedures	39,306
Number of Diagnostic Radioisotope Procedures	4,916
Number of PET Units (machines)	1
Number of PET Procedures	870
Number of Therapeautic Radioisotope Procedures	29
Number of Number of MRI Units	4
Number of Number of MRI Procedures	10,138
Number of Chemotherapy Treatments	77,252
Number of Respiratory Therapy Treatments	133,949
Number of Occupational Therapy Treatments	47,600
Number of Physical Therapy Treatments	104,792
Number of Speech Pathology Patients	2,927
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,119
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	524
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	9
Number of Ultrasound/Medical Sonography Procedures	14,682
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

2. Medical Ventilators

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

<u>127</u>

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

# Units	# Procedures	Type of Unit(s)
2	466	da Vinci Surgical Systems

Part G : Facility Workforce Information

1. Budgeted Staff
Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2021. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2021.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	921.20	420.91	454.00
Licensed Practical Nurses (LPNs)	38.89	4.64	4.00
Pharmacists	37.26	0.56	4.00
Other Health Services Professionals*	312.82	96.52	99.00
Administration and Support	119.97	15.97	7.00
All Other Hospital Personnel (not included above)	1,369.72	213.35	225.92

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)	61-90 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	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	40	☑	40	40
General Internal Medicine	39	☑	39	39
Pediatricians	21	☐	21	21
Other Medical Specialties	43	☑	43	43

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	20	☐	20	20
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	22	☐	22	22
Ophthalmology Surgery	10	☐	10	10
Orthopedic Surgery	12	☑	12	12
Plastic Surgery	1	☐	1	1
General Surgery	11	☑	11	11
Thoracic Surgery	3	☑	3	3
Other Surgical Specialties	14	☑	14	14

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	12	☑	12	12
Dermatology	2	☐	2	2
Emergency Medicine	26	☑	26	26
Nuclear Medicine	24	☑	24	24
Pathology	6	☑	6	6
Psychiatry	4	☑	4	4
Radiology	24	☑	24	24
Hematology/Oncology	8	☑	8	8
Radiation Oncology	2	☑	2	2
Neonatoloty	4	☑	4	4

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 Privleges	6
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	14
All Other Staff Affiliates with Clinical Privileges in the Hospital	242

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. PPMH's total CON-authorized inpatient bed complements remains 691 beds.
 D.1. PPMH's CON-authorized complement of OB beds remains 42. In 2021, PPMH had 29 of the 42 beds SUS. Reported OB inpatient days include obstetric, labor and delivery, ante- and post-partum days.
 D. 1/Psych/Substance Abuse Addendum A.1: PPMH's CON-authorized complement of adult inpatient psychiatric/substance abuse beds remains 38 beds. In 2021, PPMH had 18 of the 38 beds SUS.
 D.2. Multiracial categories include patients whose race/ethnicity is unknown.
 D.6: Based on Level 2 surgical case charges
 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.2. Data do not include neonatal vents.
 G.1. The large number of contract RN FTEs reflects the extraordinary circumstances associated with the COVID public health emergency.
 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 Benefit Plan is estimated. PPMH does not have access to Medicaid/PeachCare and Public Employee Health Benefit Plan enrollment.

Perinatal Services Addendum B. 1. PPMH's model of care for normal newborns is that they primarily room-in with their mothers. Accordingly, the normal newborn nursery has been significantly downsized and now typically operates with 4 bassinets.

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	S18+=Substance abuse adult 18 and over
Surg=Outpatient Surgical	S13-17=Substance abuse adolescent 13-17
OB=Obstetric	E18+=Extended care adult 18 and over
P18+=Acute psychiatric adult 18 and over	E13-17=Extended care adolescent 13-17
P13-17=Acute psychiatric adolescent 13-17	E0-12=Extended care children 0-12
P0-12=Acute psychiatric children 12 and under	LTCH=Long Term Care Hospital
Rehab=Inpatient Rehabilitation	

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	57	7	5	1	0	0	0	0	0	0	0	0	1
Appling	1	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	4	3	1	0	0	0	0	0	0	0	0	0	0
Bacon	1	0	1	0	0	0	0	0	0	0	0	0	0
Baker	216	67	19	6	0	0	0	0	0	0	0	0	2
Baldwin	2	9	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	100	25	7	0	0	0	0	0	0	0	0	0	4
Berrien	26	12	10	0	0	0	0	0	0	0	0	0	0
Bibb	10	4	0	2	0	0	0	0	0	0	0	0	0
Bleckley	2	2	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	0	0	1	0	0	0	0	0	0	0	0	0
Brooks	16	5	9	0	0	0	0	0	0	0	0	0	0
Bulloch	1	1	0	0	0	0	0	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0	0
Calhoun	401	174	38	14	0	0	0	0	0	0	0	0	7
Camden	1	0	0	1	0	0	0	0	0	0	0	0	0
Carroll	1	2	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	3	2	0	1	0	0	0	0	0	0	0	0	0
Chattahoochee	0	2	0	0	0	0	0	0	0	0	0	0	0
Cherokee	5	0	0	1	0	0	0	0	0	0	0	0	0
Clarke	2	1	0	1	0	0	0	0	0	0	0	0	0
Clay	44	38	11	0	0	0	0	0	0	0	0	0	0
Clayton	2	1	0	1	0	0	0	0	0	0	0	0	0
Clinch	2	1	2	0	0	0	0	0	0	0	0	0	0
Cobb	7	1	1	3	0	0	0	0	0	0	0	0	0
Coffee	21	6	14	0	0	0	0	0	0	0	0	0	0

County													
Colquitt	139	111	24	4	0	0	0	0	0	0	0	0	0
Cook	33	9	10	0	0	0	0	0	0	0	0	0	0
Coweta	1	3	0	0	0	0	0	0	0	0	0	0	0
Crawford	2	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	194	128	29	2	0	0	0	0	0	0	0	0	6
Decatur	70	83	28	4	0	0	0	0	0	0	0	0	0
DeKalb	12	2	1	2	0	0	0	0	0	0	0	0	0
Dodge	7	3	0	0	0	0	0	0	0	0	0	0	1
Dooly	43	27	5	2	0	0	0	0	0	0	0	0	0
Dougherty	9,311	3,299	1,167	203	0	0	0	0	0	0	0	0	112
Douglas	2	0	0	0	0	0	0	0	0	0	0	0	0
Early	110	85	17	2	0	0	0	0	0	0	0	0	0
Effingham	1	1	0	0	0	0	0	0	0	0	0	0	0
Emanuel	1	0	0	0	0	0	0	0	0	0	0	0	0
Evans	2	0	0	1	0	0	0	0	0	0	0	0	0
Fannin	0	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	71	17	8	2	0	0	0	0	0	0	0	0	0
Forsyth	3	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	10	1	1	1	0	0	0	0	0	0	0	0	0
Gilmer	2	0	0	2	0	0	0	0	0	0	0	0	0
Glynn	1	0	1	0	0	0	0	0	0	0	0	0	0
Gordon	2	0	0	0	0	0	0	0	0	0	0	0	0
Grady	38	25	24	0	0	0	0	0	0	0	0	0	0
Greene	0	1	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	5	2	2	0	0	0	0	0	0	0	0	0	0
Hall	0	2	0	0	0	0	0	0	0	0	0	0	0
Henry	6	3	2	0	0	0	0	0	0	0	0	0	0
Houston	21	15	3	1	0	0	0	0	0	0	0	0	0
Irwin	17	9	1	0	0	0	0	0	0	0	0	0	0
Jasper	2	4	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	1	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	0	0	0	0	0	0	0	0	0	0	0	0
Jones	2	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	2	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	3	2	0	0	0	0	0	0	0	0	0	0
Laurens	3	1	0	0	0	0	0	0	0	0	0	0	0
Lee	1,884	1,015	268	31	0	0	0	0	0	0	0	0	24
Liberty	1	1	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	46	38	33	2	0	0	0	0	0	0	0	0	0
Macon	110	33	1	6	0	0	0	0	0	0	0	0	1
Marion	46	25	2	0	0	0	0	0	0	0	0	0	0

McIntosh	0	1	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	91	55	6	3	0	0	0	0	0	0	0	0	1
Mitchell	814	390	103	9	0	0	0	0	0	0	0	0	11
Monroe	2	2	0	0	0	0	0	0	0	0	0	0	0
Montgomery	2	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	2	0	0	0	0	0	0	0	0	0	0	0	0
Murray	5	0	0	1	0	0	0	0	0	0	0	0	0
Muscogee	17	7	3	1	0	0	0	0	0	0	0	0	0
Newton	2	0	1	1	0	0	0	0	0	0	0	0	0
North Carolina	5	1	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	62	23	4	5	0	0	0	0	0	0	0	0	2
Paulding	1	1	0	0	0	0	0	0	0	0	0	0	0
Peach	11	7	0	0	0	0	0	0	0	0	0	0	0
Polk	1	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	4	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	2	0	0	0	0	0	0	0	0	0	0	0	0
Quitman	14	6	4	0	0	0	0	0	0	0	0	0	1
Rabun	0	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	422	183	54	4	0	0	0	0	0	0	0	0	6
Richmond	3	1	0	1	0	0	0	0	0	0	0	0	0
Rockdale	0	1	0	0	0	0	0	0	0	0	0	0	0
Schley	78	62	6	1	0	0	0	0	0	0	0	0	2
Seminole	30	47	9	0	0	0	0	0	0	0	0	0	0
South Carolina	6	0	0	0	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	37	16	1	2	0	0	0	0	0	0	0	0	0
Sumter	771	499	60	38	0	0	0	0	0	0	0	0	15
Talbot	1	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	4	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	7	2	0	0	0	0	0	0	0	0	0	0	0
Telfair	2	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	8	1	0	0	0	0	0	0	0	0	0	0	1
Terrell	869	343	73	12	0	0	0	0	0	0	0	0	12
Thomas	84	40	53	2	0	0	0	0	0	0	0	0	1
Tift	122	64	31	2	0	0	0	0	0	0	0	0	5
Toombs	5	0	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	1	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	63	50	8	0	0	0	0	0	0	0	0	0	1
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Upson	1	0	0	0	0	0	0	0	0	0	0	0	0
Walton	2	0	0	0	0	0	0	0	0	0	0	0	0
Ware	3	0	0	0	0	0	0	0	0	0	0	0	0

Wayne	2	0	0	0	0	0	0	0	0	0	0	0	0
Webster	36	20	4	0	0	0	0	0	0	0	0	0	2
Wilcox	34	15	3	0	0	0	0	0	0	0	0	0	0
Worth	995	517	82	17	0	0	0	0	0	0	0	0	14
Total	**17,763**	**7,675**	**2,252**	**396**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**232**

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	0	0	2,667	7,072
Cystoscopy	0	0	169	578
Endoscopy	0	0	67	32
Open Heart	183	0	0	0
Total	**183**	**0**	**2,903**	**7,682**

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	2,652	7,067
Cystoscopy	0	0	168	576
Endoscopy	0	0	66	32
Open Heart	180	0	0	0
Total	**180**	**0**	**2,886**	**7,675**

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	34
Black/African American	3,751
Hispanic/Latino	23
Pacific Islander/Hawaiian	3
White	3,655
Multi-Racial	201
Total	**7,675**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	899
Ages 15-64	4,686
Ages 65-74	1,475
Ages 75-85	511
Ages 85 and Up	104
Total	**7,675**

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

Gender	Number of Ambulatory Patients
Male	3,287
Female	4,388
Total	**7,675**

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

Primary Payment Source	Number of Patients
Medicare	2,486
Medicaid	1,564
Third-Party	3,141
Self-Pay	484

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 12

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 846

6. Total Live Births: 2,019

7. Total Births (Live and Late Fetal Deaths): 2,045

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,039

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)	4	1,617	3,208	441
Specialty Care (Intermediate Neonatal Care)	12	0	8,062	46
Subspecialty Care (Intensive Neonatal Care)	15	548	4,870	575

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	0	0
Asian	19	47
Black/African American	1,336	4,260
Hispanic/Latino	112	303
Pacific Islander/Hawaiian	1	3
White	745	2,219
Multi-Racial	39	143
Total	**2,252**	**6,975**

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	5
Ages 15-44	2,247	6,962
Ages 45 and Up	3	8
Total	**2,252**	**6,975**

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

$14,574.00

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

$27,616.00

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	18
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	396	2,339	396	2,255	2,993	☑
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	0	0
Black/African American	237	1,374
Hispanic/Latino	4	100
Pacific Islander/Hawaiian	0	0
White	146	788
Multi-Racial	9	77
Total	**396**	**2,339**

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

Gender of Patient	Admissions	Inpatient Days
Male	196	1,157
Female	200	1,182
Total	**396**	**2,339**

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	68	575
Medicaid	138	782
Third Party	93	419
Self-Pay	97	563
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? <u>0</u> (FTE's)
What languages do they interpret?

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

Bilingual Hospital Staff Member ☑   Bilingual Member of Patient's Family ☑

Community Volunteer Intrepreter ☑   Telephone Interpreter Service ☑

Refer Patient to Outside Agency ☐   Other (please describe): ☐

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

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

<u>Cultural diversity module included in annual employee update and new employee orientation.</u>

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

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?

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

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	98	1,540
Hispanic/Latino	1	21
Pacific Islander/Hawaiian	0	0
White	133	1,948
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	116	1,790
Female	116	1,719

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	90	1,246
65-84	116	1,855
85 Up	26	408

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	232
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	146
Third Party/Commercial	51
Self Pay	16
Other	19

2. Uncompensated Indigent and Charity Care

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

16

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	98
2. Brain Injury	10
3. Amputation	14
4. Spinal Cord	18
5. Fracture of the femur	2
6. Neurological disorders	5
7. Multiple Trauma	6
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	3
All Other	76

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: Joe Austin

Date: 3/4/2022

Title: CEO

Comments: