GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2018 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP618

Facility Name: South Georgia Medical Center

County: Lowndes

Street Address: 2501 North Patterson Street, PO Box 1727

City: Valdosta

Zip: 31603-1727

Mailing Address: 2501 North Patterson Street, PO Box 1727

Mailing City: Valdosta

Mailing Zip: 31603-1727

Medicaid Provider Number: 000001724

Medicare Provider Number: 110122

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
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: Bryan McRee

Contact Title: Manager Business Intelligence

Phone: 229-333-1145

Fax: 000-000-0000

E-mail: bryan.mcree@sgmc.org

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 Valdosta and Lowndes Co.,GA	Hospital Authority	7/1/1955

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hospital Authority of Valdosta and Lowndes Co.,GA	Hospital Authority	7/1/1955

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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:
City: State:

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: State:

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)	28	2,339	6,136	2,321	6,082
Pediatrics (Non ICU)	22	352	875	378	944
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	34	3,056	17,586	3,141	18,015
General Surgery	58	3,287	16,098	3,279	16,352
Medical/Surgical	106	4,095	21,056	3,924	21,981
Intensive Care	52	1,428	6,563	1,084	5,832
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	24	260	3,460	257	3,392
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	**324**	**14,817**	**71,774**	**14,384**	**72,598**

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	17	120
Asian	70	293
Black/African American	5,136	27,153
Hispanic/Latino	395	2,106
Pacific Islander/Hawaiian	4	10
White	8,537	43,418
Multi-Racial	1,447	4,214
Total	**15,606**	**77,314**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	6,549	34,936
Female	9,057	42,378
Total	**15,606**	**77,314**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	2,485	10,537
Medicaid	5,678	32,653
Peachare	0	0
Third-Party	36	148
Self-Pay	7,408	33,977
Other	0	0

5. Discharges to Death

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

302

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	919
Semi-Private Room Rate	867
Operating Room: Average Charge for the First Hour	6,096
Average Total Charge for an Inpatient Day	6,755

Part E : Emergency Department and Outpatient Services

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

65,995

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

9,487

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

44

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	9,487
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	40	65,995
	0	0
	0	0
	0	0
	0	0

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

513

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

337,652

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

9,079

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.

2,824

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	1	1
Renal Dialysis	1	1
ESWL	1	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	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	1	1
Hospice	1	1
Respite Care Services	1	1
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	584
Number of Dialysis Treatments	3,678
Number of ESWL Patients	118
Number of ESWL Procedures	184
Number of ESWL Units	2
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	5,083
Number of CTS Units (machines)	5
Number of CTS Procedures	29,700
Number of Diagnostic Radioisotope Procedures	4,424
Number of PET Units (machines)	1
Number of PET Procedures	1,132
Number of Therapeautic Radioisotope Procedures	25
Number of Number of MRI Units	3
Number of Number of MRI Procedures	6,205
Number of Chemotherapy Treatments	8,046
Number of Respiratory Therapy Treatments	112,787
Number of Occupational Therapy Treatments	29,005
Number of Physical Therapy Treatments	49,889
Number of Speech Pathology Patients	7,576
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	19,480
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	6
Number of Ultrasound/Medical Sonography Procedures	14,608
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).

23

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	181	daVinci Surgical System. IS3000 $am. HD

Part G : Facility Workforce Information

1. Budgeted Staff
Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	15.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	6.00	1.00	0.00
Registered Nurses (RNs-Advanced Practice*)	638.00	64.50	90.00
Licensed Practical Nurses (LPNs)	68.00	4.00	0.00
Pharmacists	32.00	0.00	0.00
Other Health Services Professionals*	573.00	22.30	14.00
Administration and Support	256.00	1.00	0.00
All Other Hospital Personnel (not included above)	670.00	100.70	51.00

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)	More than 90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 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	51
Black/African American	39
Hispanic/Latino	13
Pacific Islander/Hawaiian	5
White	334
Multi-Racial	19

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	12	☑	0	0
General Internal Medicine	49	☐	0	0
Pediatricians	7	☐	0	0
Other Medical Specialties	155	☐	0	0

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	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	14	☐	0	0
Ophthalmology Surgery	7	☐	0	0
Orthopedic Surgery	14	☐	0	0
Plastic Surgery	4	☐	0	0
General Surgery	14	☐	0	0
Thoracic Surgery	2	☐	0	0
Other Surgical Specialties	66	☐	0	0

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	9	☐	0	0
Dermatology	1	☐	0	0
Emergency Medicine	34	☐	0	0
Nuclear Medicine	8	☐	0	0
Pathology	3	☐	0	0
Psychiatry	5	☐	0	0
Radiology	39	☐	0	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	10
Podiatrists	7
Certified Nurse Midwives with Clinical Privileges in the Hospital	4
All Other Staff Affiliates with Clinical Privileges in the Hospital	0

5b. Name of Other Professions

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

NA

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	10	0	0	0	0	0	0	0	0	0	0	0	0
Appling	3	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	67	121	1	0	0	0	0	0	0	0	0	0	1
Bacon	3	10	0	0	0	0	0	0	0	0	0	0	0
Baldwin	3	0	0	0	0	0	0	0	0	0	0	0	1
Banks	1	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	5	1	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	33	86	0	0	0	0	0	0	0	0	0	0	0
Berrien	797	752	75	0	0	0	0	0	0	0	0	0	12
Bibb	5	2	0	0	0	0	0	0	0	0	0	0	0
Bleckley	2	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	9	1	0	0	0	0	0	0	0	0	0	0
Brooks	762	703	71	0	0	0	0	0	0	0	0	0	17
Bryan	1	2	0	0	0	0	0	0	0	0	0	0	0
Bulloch	3	0	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0	0
Calhoun	0	6	0	0	0	0	0	0	0	0	0	0	0
Camden	7	4	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	13	0	0	0	0	0	0	0	0	0	0	0
Chatham	1	2	0	0	0	0	0	0	0	0	0	0	0
Cherokee	0	3	0	0	0	0	0	0	0	0	0	0	0
Clarke	0	1	1	0	0	0	0	0	0	0	0	0	0
Clayton	0	1	0	0	0	0	0	0	0	0	0	0	0
Clinch	318	441	35	0	0	0	0	0	0	0	0	0	9
Cobb	4	6	1	0	0	0	0	0	0	0	0	0	0
Coffee	413	399	5	0	0	0	0	0	0	0	0	0	6

County													
Colquitt	298	404	11	0	0	0	0	0	0	0	0	0	4
Columbia	4	0	0	0	0	0	0	0	0	0	0	0	0
Cook	555	713	59	0	0	0	0	0	0	0	0	0	9
Coweta	1	1	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	2	5	0	0	0	0	0	0	0	0	0	0	0
Decatur	9	39	0	0	0	0	0	0	0	0	0	0	0
DeKalb	5	2	1	0	0	0	0	0	0	0	0	0	0
Dodge	7	1	0	0	0	0	0	0	0	0	0	0	0
Dooly	7	9	0	0	0	0	0	0	0	0	0	0	0
Dougherty	15	35	1	0	0	0	0	0	0	0	0	0	0
Douglas	1	2	0	0	0	0	0	0	0	0	0	0	0
Early	1	4	0	0	0	0	0	0	0	0	0	0	0
Echols	326	243	26	0	0	0	0	0	0	0	0	0	0
Effingham	3	2	0	0	0	0	0	0	0	0	0	0	0
Emanuel	12	6	0	0	0	0	0	0	0	0	0	0	0
Fannin	2	0	0	0	0	0	0	0	0	0	0	0	0
Florida	1,021	108	30	0	0	0	0	0	0	0	0	0	17
Forsyth	2	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	6	2	0	0	0	0	0	0	0	0	0	0	0
Glynn	7	5	0	0	0	0	0	0	0	0	0	0	0
Grady	18	73	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	4	4	0	0	0	0	0	0	0	0	0	0	0
Hall	1	0	0	0	0	0	0	0	0	0	0	0	0
Harris	0	2	0	0	0	0	0	0	0	0	0	0	0
Henry	7	2	0	0	0	0	0	0	0	0	0	0	0
Houston	8	8	0	0	0	0	0	0	0	0	0	0	0
Irwin	19	43	0	0	0	0	0	0	0	0	0	0	0
Jackson	1	0	0	0	0	0	0	0	0	0	0	0	0
Jasper	1	0	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	15	23	0	0	0	0	0	0	0	0	0	0	0
Jefferson	11	1	1	0	0	0	0	0	0	0	0	0	0
Johnson	3	1	0	0	0	0	0	0	0	0	0	0	0
Jones	1	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	12	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	594	705	75	0	0	0	0	0	0	0	0	0	16
Laurens	2	0	1	0	0	0	0	0	0	0	0	0	0
Lee	12	6	0	0	0	0	0	0	0	0	0	0	0
Liberty	2	3	0	0	0	0	0	0	0	0	0	0	0
Long	0	3	0	0	0	0	0	0	0	0	0	0	0
Lowndes	8,995	12,078	1,576	0	0	0	0	0	0	0	0	0	160
Macon	0	4	0	0	0	0	0	0	0	0	0	0	0
Madison	341	1	0	0	0	0	0	0	0	0	0	0	9
Marion	5	0	1	0	0	0	0	0	0	0	0	0	0

McDuffie	1	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	0	12	0	0	0	0	0	0	0	0	0	0	0
Mitchell	8	29	0	0	0	0	0	0	0	0	0	0	0
Monroe	3	2	0	0	0	0	0	0	0	0	0	0	0
Montgomery	1	2	0	0	0	0	0	0	0	0	0	0	0
Murray	3	2	0	0	0	0	0	0	0	0	0	0	0
Muscogee	1	1	0	0	0	0	0	0	0	0	0	0	0
North Carolina	11	2	0	0	0	0	0	0	0	0	0	0	0
Oconee	0	0	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	471	14	8	0	0	0	0	0	0	0	0	0	1
Paulding	0	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
Pierce	9	29	0	0	0	0	0	0	0	0	0	0	0
Pike	1	0	0	0	0	0	0	0	0	0	0	0	0
Polk	3	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	2	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	3	3	0	0	0	0	0	0	0	0	0	0	0
Rabun	3	0	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	2	0	0	0	0	0	0	0	0	0	0	0
Richmond	1	3	0	0	0	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	1	8	0	0	0	0	0	0	0	0	0	0	0
South Carolina	8	1	2	0	0	0	0	0	0	0	0	0	0
Spalding	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	0	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	3	5	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	7	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	0	3	0	0	0	0	0	0	0	0	0	0	0
Tennessee	7	1	1	0	0	0	0	0	0	0	0	0	0
Terrell	0	4	0	0	0	0	0	0	0	0	0	0	0
Thomas	139	226	3	0	0	0	0	0	0	0	0	0	3
Tift	59	187	0	0	0	0	0	0	0	0	0	0	1
Toombs	4	1	0	0	0	0	0	0	0	0	0	0	0
Treutlen	3	0	0	0	0	0	0	0	0	0	0	0	0
Troup	1	0	0	0	0	0	0	0	0	0	0	0	0
Turner	9	30	1	0	0	0	0	0	0	0	0	0	0
Twiggs	2	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	5	0	0	0	0	0	0	0	0	0	0	0
Walker	1	0	0	0	0	0	0	0	0	0	0	0	0
Walton	3	0	0	0	0	0	0	0	0	0	0	0	0
Ware	36	103	4	0	0	0	0	0	0	0	0	0	0
Warren	0	1	1	0	0	0	0	0	0	0	0	0	0

Washington	1	0	0	0	0	0	0	0	0	0	0	0
Wayne	4	7	0	0	0	0	0	0	0	0	0	0
Wilcox	4	11	0	0	0	0	0	0	0	0	0	0
Worth	7	39	1	0	0	0	0	0	0	0	0	2
Total	**15,606**	**17,841**	**1,994**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**268**

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	21
Cystoscopy (OR Suite)	0	0	3
Endoscopy (OR Suite)	0	0	2
	0	0	0
Total	**0**	**0**	**26**

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	6,834	15,089
Cystoscopy	0	0	159	1,108
Endoscopy	0	0	1,325	1,866
	0	0	0	0
Total	**0**	**0**	**8,318**	**18,063**

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	6,560	14,540
Cystoscopy	0	0	152	1,043
Endoscopy	0	0	1,282	1,799
	0	0	0	0
Total	**0**	**0**	**7,994**	**17,382**

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	74
Black/African American	5,080
Hispanic/Latino	422
Pacific Islander/Hawaiian	2
White	12,188
Multi-Racial	60
Total	**17,841**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1,129
Ages 15-64	10,652
Ages 65-74	3,929
Ages 75-85	1,833
Ages 85 and Up	298
Total	**17,841**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	8,008
Female	9,833
Total	**17,841**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	7,418
Medicaid	803
Third-Party	8,825
Self-Pay	795

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 8

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 898

6. Total Live Births: 2,041

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,156

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)	30	2,087	6,417	0
Specialty Care (Intermediate Neonatal Care)	10	262	2,501	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	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	3	7
Asian	21	51
Black/African American	797	2,292
Hispanic/Latino	133	364
Pacific Islander/Hawaiian	1	2
White	1,013	2,670
Multi-Racial	26	60
Total	**1,994**	**5,446**

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	3	8
Ages 15-44	1,989	5,434
Ages 45 and Up	2	4
Total	**1,994**	**5,446**

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

$9,252.00

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

$10,815.00

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	0	0
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	0	0	0	0	0	☐
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	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. 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**

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	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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 Intrepreter ☐   Telephone Interpreter Service ☑

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

We will pay for ASL 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	45	0	0	0
Vietnamese	05	0	0	0
Romanian	05	0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

New hire orientation, new management orientation, and in practice alert. Patient Rights 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?

We are currently in compliance.

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

1. Spanish   2. Arabic   3. Chinese   4. French

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?

Health Care South - Valdosta Georgia

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	2	18
Black/African American	70	993
Hispanic/Latino	1	15
Pacific Islander/Hawaiian	0	0
White	182	2,324
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	141	1,862
Female	114	1,488

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	54	745
65-84	162	2,101
85 Up	39	504

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	254
Long Term Care Hospital	1
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	223
Third Party/Commercial	26
Self Pay	2
Other	4

2. Uncompensated Indigent and Charity Care

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

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

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

Diagnosis	Admissions
1. Stroke	108
2. Brain Injury	14
3. Amputation	19
4. Spinal Cord	10
5. Fracture of the femur	14
6. Neurological disorders	19
7. Multiple Trauma	5
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	33
13. Joint replacement	3
All Other	30

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: Grant Byers

Date: 4/21/2019

Title: Chief Financial Officer

Comments: