GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 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, 2019 through December 31, 2019.
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: Patrick McCauley

Contact Title: Senior Financial Analyst

Phone: 706-721-8090

Fax: 706-721-9067

E-mail: pmccauley@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
N/A		

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
AU Medical Center, Inc.	Not for Profit	7/1/2000

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: AU Health System, Inc.
City: Augusta **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: MCG Health Inc. Insurance Company
City: Grand Cayman **State:** CI

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Georgia Alliance of Community Hospitals
City: Tifton **State:** GA

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: First Medical Network
City: Atlanta **State:** GA

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

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

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	30	1,534	4,699	1,538	4,735
Pediatrics (Non ICU)	62	1,604	9,078	1,601	9,091
Pediatric ICU	50	231	1,531	231	1,602
Gynecology (No OB)	0	149	456	150	459
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	246	13,693	83,927	13,710	86,232
Intensive Care	90	1,429	8,004	1,427	8,142
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
Epilepsy	6	226	545	226	545
	0	0	0	0	0
	0	0	0	0	0
Total	**484**	**18,866**	**108,240**	**18,883**	**110,806**

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	11	84
Asian	168	942
Black/African American	8,891	52,584
Hispanic/Latino	552	2,736
Pacific Islander/Hawaiian	0	0
White	9,078	51,105
Multi-Racial	166	789
Total	**18,866**	**108,240**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	9,242	57,929
Female	9,624	50,311
Total	**18,866**	**108,240**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,026	43,575
Medicaid	3,986	22,303
Peachare	2	2
Third-Party	4,187	22,126
Self-Pay	2,109	11,361
Other	1,556	8,873

5. Discharges to Death

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

677

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2019 (to the nearest whole dollar).

Service	Charge
Private Room Rate	990
Semi-Private Room Rate	990
Operating Room: Average Charge for the First Hour	4,446
Average Total Charge for an Inpatient Day	11,607

Part E : Emergency Department and Outpatient Services

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

84,967

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

11,933

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

61

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	2,549
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	11	4,248
General Beds	40	78,170
	0	0
	0	0
	0	0
	0	0

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

2,512

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

486,963

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

8,240

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

171.00

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.

3,630

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	2	1
ESWL	2	1
Billiary Lithotropter	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, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	1	1
Audiology Services	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	3,450
Number of ESWL Patients	38
Number of ESWL Procedures	38
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	81
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	6
Number of Diagnostic X-Ray Procedures	140,281
Number of CTS Units (machines)	3
Number of CTS Procedures	42,535
Number of Diagnostic Radioisotope Procedures	10,064
Number of PET Units (machines)	1
Number of PET Procedures	2,081
Number of Therapeautic Radioisotope Procedures	8,038
Number of Number of MRI Units	3
Number of Number of MRI Procedures	16,420
Number of Chemotherapy Treatments	29,207
Number of Respiratory Therapy Treatments	172,264
Number of Occupational Therapy Treatments	53,492
Number of Physical Therapy Treatments	93,447
Number of Speech Pathology Patients	14,880
Number of Gamma Ray Knife Procedures	115
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	1,303
Number of HIV/AIDS Diagnostic Procedures	4,370
Number of HIV/AIDS Patients	1,703
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	88
Number of Ultrasound/Medical Sonography Procedures	31,894
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).

109

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	746	daVinci Xi, daVinci Si

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2019. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2019.

Profession	Profession	Profession	Profession
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*)	1,270.27	340.93	218.60
Licensed Practical Nurses (LPNs)	73.38	12.10	0.00
Pharmacists	85.14	11.10	0.00
Other Health Services Professionals*	1,037.25	233.27	31.00
Administration and Support	175.93	44.00	0.00
All Other Hospital Personnel (not included above)	795.58	109.70	0.00

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	61-90 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 Days
Other Health Services Professionals	
All Other Hospital Personnel (not included above)	

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	97
Black/African American	38
Hispanic/Latino	26
Pacific Islander/Hawaiian	7
White	387
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	34	☐	34	34
General Internal Medicine	47	☐	47	47
Pediatricians	33	☐	33	33
Other Medical Specialties	89	☐	89	89

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	26	☐	26	26
Non-OB Physicians Providing OB Services	8	☐	8	8
Gynecology	26	☐	26	26
Ophthalmology Surgery	11	☐	11	11
Orthopedic Surgery	23	☐	23	23
Plastic Surgery	6	☐	6	6
General Surgery	5	☐	5	5
Thoracic Surgery	6	☐	6	6
Other Surgical Specialties	34	☐	34	34

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	34	☐	34	34
Dermatology	4	☐	4	4
Emergency Medicine	59	☐	59	59
Nuclear Medicine	1	☐	1	1
Pathology	14	☐	14	14
Psychiatry	22	☐	22	22
Radiology	35	☐	35	35
	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	15
Podiatrists	3
Certified Nurse Midwives with Clinical Privileges in the Hospital	3
All Other Staff Affiliates with Clinical Privileges in the Hospital	213

5b. Name of Other Professions

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

PhD, PSYD, CRNA, PA, NP

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	16	21	0	0	0	0	0	0	0	0	0	0	0
Appling	18	17	0	0	0	0	0	0	0	0	0	0	0
Atkinson	5	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	13	16	0	0	0	0	0	0	0	0	0	0	0
Baker	9	16	0	0	0	0	0	0	0	0	0	0	0
Baldwin	72	78	1	0	0	0	0	0	0	0	0	0	0
Banks	1	1	0	0	0	0	0	0	0	0	0	0	0
Barrow	5	9	0	0	0	0	0	0	0	0	0	0	0
Bartow	6	3	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	7	8	0	0	0	0	0	0	0	0	0	0	0
Berrien	7	13	1	0	0	0	0	0	0	0	0	0	0
Bibb	36	67	0	0	0	0	0	0	0	0	0	0	0
Bleckley	15	10	0	0	0	0	0	0	0	0	0	0	0
Brantley	8	7	0	0	0	0	0	0	0	0	0	0	0
Brooks	9	7	0	0	0	0	0	0	0	0	0	0	0
Bryan	25	23	0	0	0	0	0	0	0	0	0	0	0
Bulloch	206	178	8	0	0	0	0	0	0	0	0	0	0
Burke	630	441	84	0	0	0	0	0	0	0	0	0	0
Butts	7	14	0	0	0	0	0	0	0	0	0	0	0
Calhoun	9	1	1	0	0	0	0	0	0	0	0	0	0
Camden	0	5	0	0	0	0	0	0	0	0	0	0	0
Candler	38	32	1	0	0	0	0	0	0	0	0	0	0
Carroll	0	2	0	0	0	0	0	0	0	0	0	0	0
Charlton	2	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	99	67	1	0	0	0	0	0	0	0	0	0	0
Chattooga	1	5	0	0	0	0	0	0	0	0	0	0	0
Cherokee	7	4	0	0	0	0	0	0	0	0	0	0	0

Clarke	25	42	0	0	0	0	0	0	0	0	0	0	0
Clay	5	5	1	0	0	0	0	0	0	0	0	0	0
Clayton	10	3	1	0	0	0	0	0	0	0	0	0	0
Clinch	3	4	0	0	0	0	0	0	0	0	0	0	0
Cobb	15	29	2	0	0	0	0	0	0	0	0	0	0
Coffee	44	26	0	0	0	0	0	0	0	0	0	0	0
Colquitt	15	12	2	0	0	0	0	0	0	0	0	0	0
Columbia	1,856	2,136	188	0	0	0	0	0	0	0	0	0	0
Cook	9	9	1	0	0	0	0	0	0	0	0	0	0
Coweta	2	6	0	0	0	0	0	0	0	0	0	0	0
Crawford	4	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	10	14	0	0	0	0	0	0	0	0	0	0	0
Dawson	1	1	0	0	0	0	0	0	0	0	0	0	0
DeKalb	8	18	0	0	0	0	0	0	0	0	0	0	0
Dodge	19	24	0	0	0	0	0	0	0	0	0	0	0
Dooly	5	7	0	0	0	0	0	0	0	0	0	0	0
Dougherty	43	38	3	0	0	0	0	0	0	0	0	0	0
Douglas	1	6	0	0	0	0	0	0	0	0	0	0	0
Early	2	1	0	0	0	0	0	0	0	0	0	0	0
Echols	0	2	0	0	0	0	0	0	0	0	0	0	0
Effingham	25	29	0	0	0	0	0	0	0	0	0	0	0
Elbert	37	44	0	0	0	0	0	0	0	0	0	0	0
Emanuel	283	177	7	0	0	0	0	0	0	0	0	0	0
Evans	24	20	2	0	0	0	0	0	0	0	0	0	0
Fannin	2	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	3	5	0	0	0	0	0	0	0	0	0	0	0
Florida	44	39	1	0	0	0	0	0	0	0	0	0	0
Forsyth	2	10	0	0	0	0	0	0	0	0	0	0	0
Franklin	8	12	0	0	0	0	0	0	0	0	0	0	0
Fulton	15	26	2	0	0	0	0	0	0	0	0	0	0
Gilmer	1	1	0	0	0	0	0	0	0	0	0	0	0
Glascock	72	43	3	0	0	0	0	0	0	0	0	0	0
Glynn	39	29	1	0	0	0	0	0	0	0	0	0	0
Gordon	2	4	0	0	0	0	0	0	0	0	0	0	0
Grady	0	3	0	0	0	0	0	0	0	0	0	0	0
Greene	83	98	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	20	33	0	0	0	0	0	0	0	0	0	0	0
Habersham	3	3	0	0	0	0	0	0	0	0	0	0	0
Hall	8	8	0	0	0	0	0	0	0	0	0	0	0
Hancock	66	68	1	0	0	0	0	0	0	0	0	0	0
Haralson	1	1	0	0	0	0	0	0	0	0	0	0	0
Harris	1	0	1	0	0	0	0	0	0	0	0	0	0
Hart	7	12	1	0	0	0	0	0	0	0	0	0	0
Henry	10	4	1	0	0	0	0	0	0	0	0	0	0

Houston	43	46	0	0	0	0	0	0	0	0	0	0	0
Irwin	7	5	0	0	0	0	0	0	0	0	0	0	0
Jackson	17	12	0	0	0	0	0	0	0	0	0	0	0
Jasper	3	9	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	17	13	0	0	0	0	0	0	0	0	0	0	0
Jefferson	443	350	90	0	0	0	0	0	0	0	0	0	0
Jenkins	187	97	14	0	0	0	0	0	0	0	0	0	0
Johnson	87	43	3	0	0	0	0	0	0	0	0	0	0
Jones	6	13	1	0	0	0	0	0	0	0	0	0	0
Lamar	0	2	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	5	0	0	0	0	0	0	0	0	0	0	0
Laurens	137	128	1	0	0	0	0	0	0	0	0	0	0
Lee	13	10	0	0	0	0	0	0	0	0	0	0	0
Liberty	42	30	1	0	0	0	0	0	0	0	0	0	0
Lincoln	116	123	5	0	0	0	0	0	0	0	0	0	0
Long	7	9	0	0	0	0	0	0	0	0	0	0	0
Lowndes	71	60	1	0	0	0	0	0	0	0	0	0	0
Macon	6	3	0	0	0	0	0	0	0	0	0	0	0
Madison	20	19	0	0	0	0	0	0	0	0	0	0	0
Marion	7	0	0	0	0	0	0	0	0	0	0	0	0
McDuffie	399	352	24	0	0	0	0	0	0	0	0	0	0
McIntosh	1	2	0	0	0	0	0	0	0	0	0	0	0
Meriwether	0	2	0	0	0	0	0	0	0	0	0	0	0
Miller	1	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	14	11	0	0	0	0	0	0	0	0	0	0	0
Monroe	10	10	0	0	0	0	0	0	0	0	0	0	0
Montgomery	24	11	1	0	0	0	0	0	0	0	0	0	0
Morgan	16	33	0	0	0	0	0	0	0	0	0	0	0
Murray	1	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	6	15	0	0	0	0	0	0	0	0	0	0	0
Newton	13	17	0	0	0	0	0	0	0	0	0	0	0
North Carolina	25	21	0	0	0	0	0	0	0	0	0	0	0
Oconee	10	12	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	7	16	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	116	98	3	0	0	0	0	0	0	0	0	0	0
Paulding	0	4	0	0	0	0	0	0	0	0	0	0	0
Peach	16	13	0	0	0	0	0	0	0	0	0	0	0
Pickens	1	3	0	0	0	0	0	0	0	0	0	0	0
Pierce	10	10	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	0	1	0	0	0	0	0	0	0	0	0	0	0
Pulaski	6	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	45	58	0	0	0	0	0	0	0	0	0	0	0
Richmond	6,909	6,265	633	0	0	0	0	0	0	0	0	0	0

Rockdale	5	4	0	0	0	0	0	0	0	0	0	0	0
Schley	0	1	0	0	0	0	0	0	0	0	0	0	0
Screven	111	73	6	0	0	0	0	0	0	0	0	0	0
South Carolina	4,696	4,510	250	0	0	0	0	0	0	0	0	0	0
Spalding	3	5	0	0	0	0	0	0	0	0	0	0	0
Stephens	3	4	0	0	0	0	0	0	0	0	0	0	0
Sumter	8	10	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	32	12	0	0	0	0	0	0	0	0	0	0	0
Tattnall	37	32	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	3	0	0	0	0	0	0	0	0	0	0	0
Telfair	26	25	0	0	0	0	0	0	0	0	0	0	0
Tennessee	15	17	0	0	0	0	0	0	0	0	0	0	0
Terrell	2	3	0	0	0	0	0	0	0	0	0	0	0
Thomas	17	15	1	0	0	0	0	0	0	0	0	0	0
Tift	24	20	0	0	0	0	0	0	0	0	0	0	0
Toombs	57	63	0	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	6	13	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	4	10	0	0	0	0	0	0	0	0	0	0	0
Twiggs	8	3	0	0	0	0	0	0	0	0	0	0	0
Union	0	1	0	0	0	0	0	0	0	0	0	0	0
Upson	3	3	0	0	0	0	0	0	0	0	0	0	0
Walker	1	4	0	0	0	0	0	0	0	0	0	0	0
Walton	16	3	0	0	0	0	0	0	0	0	0	0	0
Ware	35	15	0	0	0	0	0	0	0	0	0	0	0
Warren	84	77	7	0	0	0	0	0	0	0	0	0	0
Washington	444	264	21	0	0	0	0	0	0	0	0	0	0
Wayne	28	5	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	16	6	0	0	0	0	0	0	0	0	0	0	0
White	2	1	0	0	0	0	0	0	0	0	0	0	0
Whitfield	2	2	0	0	0	0	0	0	0	0	0	0	0
Wilcox	4	6	0	0	0	0	0	0	0	0	0	0	0
Wilkes	198	150	7	0	0	0	0	0	0	0	0	0	0
Wilkinson	13	15	0	0	0	0	0	0	0	0	0	0	0
Worth	16	6	0	0	0	0	0	0	0	0	0	0	0
Total	**18,866**	**17,419**	**1,386**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	0	29
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	12
Other (Davinci and Hybrid)	0	0	3
Total	**0**	**0**	**45**

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	6,987	8,435
Cystoscopy	0	0	83	576
Endoscopy	0	0	1,481	5,804
Other (Davinci and Hybrid)	0	0	1,234	1,212
Total	**0**	**0**	**9,785**	**16,027**

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	4,966	6,384
Cystoscopy	0	0	71	496
Endoscopy	0	0	1,268	5,051
Other (Davinci and Hybrid)	0	0	843	874
Total	**0**	**0**	**7,148**	**12,805**

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	267
Black/African American	7,203
Hispanic/Latino	569
Pacific Islander/Hawaiian	0
White	9,126
Multi-Racial	239
Total	**17,419**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4,037
Ages 15-64	9,610
Ages 65-74	2,695
Ages 75-85	964
Ages 85 and Up	113
Total	**17,419**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	8,145
Female	9,274
Total	**17,419**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	4,735
Medicaid	4,100
Third-Party	7,590
Self-Pay	994

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: 12

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 446

6. Total Live Births: 1,465

7. Total Births (Live and Late Fetal Deaths): 1,500

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,824

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	1,035	3,301	0
Specialty Care (Intermediate Neonatal Care)	6	7	89	0
Subspecialty Care (Intensive Neonatal Care)	36	465	10,948	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	1	2
Asian	34	88
Black/African American	700	2,308
Hispanic/Latino	115	313
Pacific Islander/Hawaiian	0	0
White	511	1,450
Multi-Racial	25	70
Total	**1,386**	**4,231**

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	6
Ages 15-44	1,381	4,193
Ages 45 and Up	3	32
Total	**1,386**	**4,231**

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

$13,977.00

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

$20,336.00

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? 7.5 (FTE's)
What languages do they interpret?
Spanish

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

Bilingual Hospital Staff Member	☑	Bilingual Member of Patient's Family	☐
Community Volunteer Intrepreter	☐	Telephone Interpreter Service	☑
Refer Patient to Outside Agency	☐	Other (please describe):	☑

Video Remote Interpreters

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

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	1.29%	0	0	0
ASL	0.07%	0	0	0
Chinese	0.05%	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?

Training every two weeks at new employee orientation "Great Start". CLAS In-services to 80 plus

outpatient facilities/clinics, adult medical center and Children Hospital of Georgia staff/personnel. Web-based mandatory training to hospital and clinical staff through "Health Stream". Web-based mandatory training for students through "Healthy Perspective". In-person and video conferencing lectures/workshops to students and community outreach.

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

Need more trained medical interpreters on staff (increased of FTE's) to include a variety of languages (most commonly encounter). Continuous CLAS training to faculty, students, staff, patients and families.

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

1. English
2. Universal
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?

AU Health Indigent Care Trust Fund Program (706-721-2961)
AU College of Nursing, Nurse-Managed Health Center (706-721-1225)
Asociación Latina de Servicios del CSRA (ALAS), 706-940-ALAS (706-940-2527)
www.ALAS-CSRA.ORG
Christ Community Health Services, D'Antignac St., Augusta, GA 30901 (706-922-0600)
Faith Care Clinic, 625 Ronald Reagan Dr., Evans, GA (706-829-2584)
Margaret Weston Community Health Center, Clearwater, SC (803-593-9283)
Community Medical Clinic of Aiken, Aiken, SC (803-226-0630)
Harrisburg Family Healthcare Clinic, 423 Crawford Ave., Augusta, GA, 30904 (706-496-3885)
Druid Park Community Health Center, 1125 Druid Park Ave., Augusta, GA, 30904 (706-738-0455)
Medical Associates Plus, Belle Terrace Health and Wellness Center (706-790-4440)
Lamar Medical Center, 1448 Lee Beard Way, Augusta, GA, 30901-3414 (706-828-7468)

Comprehensive Inpatient Physical Rehabilitation Addendum

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

1. Admissions and Days of Care by Race

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

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

2. Admissions and Days of care by Gender

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

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

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

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

Part B : Referral Source

1. Referral Source

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

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

	0

1. Payers

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

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

2. Uncompensated Indigent and Charity Care

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

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

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

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

Electronic Signature

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

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

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

Authorized Signature: Katrina Keefer

Date: 3/17/2020

Title: CEO for Augusta University Health

Comments: