GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 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, 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: 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	Not Applicable	

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	Not Applicable	

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: 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)	26	1,630	4,948	1,623	4,967
Pediatrics (Non ICU)	67	1,714	8,683	1,714	8,244
Pediatric ICU	50	261	1,746	264	2,051
Gynecology (No OB)	0	128	353	127	352
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	242	13,324	95,347	13,353	96,051
Intensive Care	101	1,192	10,673	1,205	11,127
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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**486**	**18,249**	**121,750**	**18,286**	**122,792**

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	16	50
Asian	209	1,377
Black/African American	8,590	58,865
Hispanic/Latino	283	1,665
Pacific Islander/Hawaiian	0	0
White	8,841	57,972
Multi-Racial	310	1,821
Total	**18,249**	**121,750**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,836	65,224
Female	9,413	56,526
Total	**18,249**	**121,750**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,636	49,873
Medicaid	3,944	24,350
Peachare	0	0
Third-Party	4,076	25,712
Self-Pay	2,079	13,189
Other	1,514	8,626

5. Discharges to Death

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

1,083

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	993
Semi-Private Room Rate	1,357
Operating Room: Average Charge for the First Hour	5,141
Average Total Charge for an Inpatient Day	12,662

Part E : Emergency Department and Outpatient Services

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

79,595

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

13,345

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

87

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	3,350
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	11	3,275
General Beds	66	72,970
	0	0
	0	0
	0	0
	0	0

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

2,239

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

609,092

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

5,999

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

3,927.00

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.

1,629

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	4,258
Number of ESWL Patients	52
Number of ESWL Procedures	53
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	59
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	145,030
Number of CTS Units (machines)	3
Number of CTS Procedures	48,144
Number of Diagnostic Radioisotope Procedures	16,506
Number of PET Units (machines)	1
Number of PET Procedures	2,077
Number of Therapeautic Radioisotope Procedures	3,864
Number of Number of MRI Units	3
Number of Number of MRI Procedures	14,843
Number of Chemotherapy Treatments	27,176
Number of Respiratory Therapy Treatments	96,617
Number of Occupational Therapy Treatments	61,189
Number of Physical Therapy Treatments	99,412
Number of Speech Pathology Patients	17,921
Number of Gamma Ray Knife Procedures	124
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	531
Number of HIV/AIDS Diagnostic Procedures	937
Number of HIV/AIDS Patients	696
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	99
Number of Ultrasound/Medical Sonography Procedures	37,250
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).

144

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	781	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 12-31-2021. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2021.

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*)	1,455.09	793.55	130.43
Licensed Practical Nurses (LPNs)	64.75	78.20	8.98
Pharmacists	85.84	14.05	0.00
Other Health Services Professionals*	1,165.58	456.72	26.86
Administration and Support	198.94	46.25	0.00
All Other Hospital Personnel (not included above)	805.26	272.40	140.02

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	More than 90 Days
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	61-90 Days
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	61-90 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	33
Asian	16
Black/African American	44
Hispanic/Latino	32
Pacific Islander/Hawaiian	9
White	462
Multi-Racial	3

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	53	☐	53	53
Pediatricians	42	☐	42	42
Other Medical Specialties	99	☐	99	99

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	28	☐	28	28
Non-OB Physicians Providing OB Services	7	☐	7	7
Gynecology	25	☐	25	25
Ophthalmology Surgery	11	☐	11	11
Orthopedic Surgery	20	☐	20	20
Plastic Surgery	4	☐	4	4
General Surgery	10	☐	10	10
Thoracic Surgery	10	☐	10	10
Other Surgical Specialties	121	☐	121	121

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	41	☐	41	41
Dermatology	7	☐	7	7
Emergency Medicine	65	☐	65	65
Nuclear Medicine	1	☐	1	1
Pathology	17	☐	17	17
Psychiatry	19	☐	19	19
Radiology	47	☐	47	47
	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	26
Podiatrists	4
Certified Nurse Midwives with Clinical Privileges in the Hospital	3
All Other Staff Affiliates with Clinical Privileges in the Hospital	265

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	25	9	1	0	0	0	0	0	0	0	0	0	0
Appling	22	13	1	0	0	0	0	0	0	0	0	0	0
Atkinson	3	3	0	0	0	0	0	0	0	0	0	0	0
Bacon	7	2	0	0	0	0	0	0	0	0	0	0	0
Baker	2	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	73	51	3	0	0	0	0	0	0	0	0	0	0
Banks	4	3	0	0	0	0	0	0	0	0	0	0	0
Barrow	10	6	0	0	0	0	0	0	0	0	0	0	0
Bartow	3	4	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	12	3	1	0	0	0	0	0	0	0	0	0	0
Berrien	7	3	2	0	0	0	0	0	0	0	0	0	0
Bibb	61	64	0	0	0	0	0	0	0	0	0	0	0
Bleckley	6	7	0	0	0	0	0	0	0	0	0	0	0
Brantley	8	2	0	0	0	0	0	0	0	0	0	0	0
Brooks	3	4	0	0	0	0	0	0	0	0	0	0	0
Bryan	25	17	1	0	0	0	0	0	0	0	0	0	0
Bulloch	111	140	6	0	0	0	0	0	0	0	0	0	0
Burke	511	363	81	0	0	0	0	0	0	0	0	0	0
Butts	4	7	0	0	0	0	0	0	0	0	0	0	0
Calhoun	6	7	0	0	0	0	0	0	0	0	0	0	0
Camden	7	6	0	0	0	0	0	0	0	0	0	0	0
Candler	64	17	1	0	0	0	0	0	0	0	0	0	0
Carroll	1	4	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	6	0	0	0	0	0	0	0	0	0	0	0
Chatham	66	62	6	0	0	0	0	0	0	0	0	0	0
Chattahoochee	0	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	4	7	0	0	0	0	0	0	0	0	0	0	0

Cherokee	6	1	0	0	0	0	0	0	0	0	0	0	0
Clarke	21	34	2	0	0	0	0	0	0	0	0	0	0
Clayton	5	5	0	0	0	0	0	0	0	0	0	0	0
Clinch	1	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	8	17	0	0	0	0	0	0	0	0	0	0	0
Coffee	34	20	1	0	0	0	0	0	0	0	0	0	0
Colquitt	16	7	0	0	0	0	0	0	0	0	0	0	0
Columbia	2,802	2,769	344	0	0	0	0	0	0	0	0	0	0
Cook	8	12	0	0	0	0	0	0	0	0	0	0	0
Coweta	1	9	0	0	0	0	0	0	0	0	0	0	0
Crawford	0	5	0	0	0	0	0	0	0	0	0	0	0
Crisp	6	7	0	0	0	0	0	0	0	0	0	0	0
Dawson	1	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	5	5	0	0	0	0	0	0	0	0	0	0	0
DeKalb	12	10	1	0	0	0	0	0	0	0	0	0	0
Dodge	23	7	0	0	0	0	0	0	0	0	0	0	0
Dooly	3	5	0	0	0	0	0	0	0	0	0	0	0
Dougherty	36	43	1	0	0	0	0	0	0	0	0	0	0
Douglas	3	4	0	0	0	0	0	0	0	0	0	0	0
Early	6	1	0	0	0	0	0	0	0	0	0	0	0
Echols	1	2	0	0	0	0	0	0	0	0	0	0	0
Effingham	56	28	0	0	0	0	0	0	0	0	0	0	0
Elbert	56	26	0	0	0	0	0	0	0	0	0	0	0
Emanuel	342	153	19	0	0	0	0	0	0	0	0	0	0
Evans	42	19	0	0	0	0	0	0	0	0	0	0	0
Fayette	2	5	0	0	0	0	0	0	0	0	0	0	0
Florida	32	33	0	0	0	0	0	0	0	0	0	0	0
Floyd	1	0	0	0	0	0	0	0	0	0	0	0	0
Forsyth	0	2	0	0	0	0	0	0	0	0	0	0	0
Franklin	16	14	2	0	0	0	0	0	0	0	0	0	0
Fulton	23	18	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	62	43	3	0	0	0	0	0	0	0	0	0	0
Glynn	21	26	0	0	0	0	0	0	0	0	0	0	0
Gordon	0	2	0	0	0	0	0	0	0	0	0	0	0
Grady	6	3	1	0	0	0	0	0	0	0	0	0	0
Greene	46	69	2	0	0	0	0	0	0	0	0	0	0
Gwinnett	6	15	0	0	0	0	0	0	0	0	0	0	0
Habersham	1	1	0	0	0	0	0	0	0	0	0	0	0
Hall	2	6	0	0	0	0	0	0	0	0	0	0	0
Hancock	60	48	2	0	0	0	0	0	0	0	0	0	0
Haralson	3	0	0	0	0	0	0	0	0	0	0	0	0
Harris	0	4	0	0	0	0	0	0	0	0	0	0	0
Hart	13	7	1	0	0	0	0	0	0	0	0	0	0

Henry	5	7	1	0	0	0	0	0	0	0	0	0	0
Houston	36	46	1	0	0	0	0	0	0	0	0	0	0
Irwin	2	2	0	0	0	0	0	0	0	0	0	0	0
Jackson	12	13	2	0	0	0	0	0	0	0	0	0	0
Jasper	6	10	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	15	16	0	0	0	0	0	0	0	0	0	0	0
Jefferson	436	253	75	0	0	0	0	0	0	0	0	0	0
Jenkins	147	71	10	0	0	0	0	0	0	0	0	0	0
Johnson	65	33	2	0	0	0	0	0	0	0	0	0	0
Jones	12	12	0	0	0	0	0	0	0	0	0	0	0
Lamar	0	1	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	2	1	0	0	0	0	0	0	0	0	0	0
Laurens	98	115	2	0	0	0	0	0	0	0	0	0	0
Lee	12	13	0	0	0	0	0	0	0	0	0	0	0
Liberty	19	9	1	0	0	0	0	0	0	0	0	0	0
Lincoln	147	99	11	0	0	0	0	0	0	0	0	0	0
Long	5	4	0	0	0	0	0	0	0	0	0	0	0
Lowndes	55	50	3	0	0	0	0	0	0	0	0	0	0
Lumpkin	0	1	0	0	0	0	0	0	0	0	0	0	0
Macon	7	8	0	0	0	0	0	0	0	0	0	0	0
Madison	19	19	1	0	0	0	0	0	0	0	0	0	0
Marion	2	0	0	0	0	0	0	0	0	0	0	0	0
McDuffie	351	317	32	0	0	0	0	0	0	0	0	0	0
McIntosh	2	3	0	0	0	0	0	0	0	0	0	0	0
Meriwether	1	0	0	0	0	0	0	0	0	0	0	0	0
Miller	1	0	1	0	0	0	0	0	0	0	0	0	0
Mitchell	19	10	0	0	0	0	0	0	0	0	0	0	0
Monroe	10	6	0	0	0	0	0	0	0	0	0	0	0
Montgomery	18	11	0	0	0	0	0	0	0	0	0	0	0
Morgan	33	28	0	0	0	0	0	0	0	0	0	0	0
Murray	2	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	2	6	1	0	0	0	0	0	0	0	0	0	0
Newton	15	10	0	0	0	0	0	0	0	0	0	0	0
North Carolina	22	31	1	0	0	0	0	0	0	0	0	0	0
Oconee	12	18	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	6	10	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	90	57	4	0	0	0	0	0	0	0	0	0	0
Paulding	0	3	0	0	0	0	0	0	0	0	0	0	0
Peach	18	19	0	0	0	0	0	0	0	0	0	0	0
Pierce	11	11	0	0	0	0	0	0	0	0	0	0	0
Polk	0	2	0	0	0	0	0	0	0	0	0	0	0
Pulaski	9	6	0	0	0	0	0	0	0	0	0	0	0
Putnam	35	54	1	0	0	0	0	0	0	0	0	0	0
Randolph	0	4	0	0	0	0	0	0	0	0	0	0	0

Richmond	6,255	4,210	546	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	1	0	0	0	0	0	0	0	0	0	0	0	0
Screven	101	76	6	0	0	0	0	0	0	0	0	0	0
Seminole	1	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4,365	3,828	261	0	0	0	0	0	0	0	0	0	0
Spalding	6	6	0	0	0	0	0	0	0	0	0	0	0
Stephens	8	4	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	5	9	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	27	26	2	0	0	0	0	0	0	0	0	0	0
Tattnall	73	32	2	0	0	0	0	0	0	0	0	0	0
Taylor	1	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	12	25	0	0	0	0	0	0	0	0	0	0	0
Tennessee	7	8	1	0	0	0	0	0	0	0	0	0	0
Terrell	6	2	1	0	0	0	0	0	0	0	0	0	0
Thomas	6	7	0	0	0	0	0	0	0	0	0	0	0
Tift	19	13	1	0	0	0	0	0	0	0	0	0	0
Toombs	37	39	1	0	0	0	0	0	0	0	0	0	0
Treutlen	17	10	0	0	0	0	0	0	0	0	0	0	0
Troup	2	0	1	0	0	0	0	0	0	0	0	0	0
Turner	3	7	0	0	0	0	0	0	0	0	0	0	0
Twiggs	0	7	0	0	0	0	0	0	0	0	0	0	0
Union	2	0	1	0	0	0	0	0	0	0	0	0	0
Upson	1	1	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	12	16	0	0	0	0	0	0	0	0	0	0	0
Ware	13	12	0	0	0	0	0	0	0	0	0	0	0
Warren	62	55	4	0	0	0	0	0	0	0	0	0	0
Washington	337	235	12	0	0	0	0	0	0	0	0	0	0
Wayne	28	7	0	0	0	0	0	0	0	0	0	0	0
Wheeler	11	14	0	0	0	0	0	0	0	0	0	0	0
White	1	4	0	0	0	0	0	0	0	0	0	0	0
Whitfield	3	1	0	0	0	0	0	0	0	0	0	0	0
Wilcox	3	5	0	0	0	0	0	0	0	0	0	0	0
Wilkes	198	108	8	0	0	0	0	0	0	0	0	0	0
Wilkinson	18	19	1	0	0	0	0	0	0	0	0	0	0
Worth	8	3	0	0	0	0	0	0	0	0	0	0	0
Total	**18,249**	**14,489**	**1,482**	**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	6,753	6,790
Cystoscopy	0	0	45	388
Endoscopy	0	0	1,237	5,091
Other (Davinci and Hybrid)	0	0	951	712
Total	**0**	**0**	**8,986**	**12,981**

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	4,845	5,405
Cystoscopy	0	0	41	316
Endoscopy	0	0	924	3,923
Other (Davinci and Hybrid)	0	0	702	530
Total	**0**	**0**	**6,512**	**10,174**

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	16
Asian	221
Black/African American	5,983
Hispanic/Latino	340
Pacific Islander/Hawaiian	0
White	7,615
Multi-Racial	314
Total	**14,489**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	3,544
Ages 15-64	7,664
Ages 65-74	2,290
Ages 75-85	847
Ages 85 and Up	144
Total	**14,489**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	7,135
Female	7,354
Total	**14,489**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,678
Medicaid	3,252
Third-Party	6,769
Self-Pay	790

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: 438

6. Total Live Births: 1,606

7. Total Births (Live and Late Fetal Deaths): 1,642

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,895

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	1,165	2,785	0
Specialty Care (Intermediate Neonatal Care)	9	239	2,326	0
Subspecialty Care (Intensive Neonatal Care)	36	500	11,010	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	2	4
Asian	56	218
Black/African American	705	2,263
Hispanic/Latino	63	145
Pacific Islander/Hawaiian	0	0
White	590	1,658
Multi-Racial	66	169
Total	**1,482**	**4,457**

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	7
Ages 15-44	1,478	4,437
Ages 45 and Up	2	13
Total	**1,482**	**4,457**

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

$15,292.00

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

$25,031.00

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? 8 (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	1.27	0	0	0
Chinese	0.05	0	0	0
ASL	0.04	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 "JagStart Orientation".

CLAS In-services to 80 plus outpatient facilities/clinics, AU Health 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 staff, 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 Augusta University students, hospital employees, patients and families.
The need to collect language proficiency data of staff/healthcare personnel.

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

1. English
2. Spanish
3. Universal symbols
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:

Date: 3/3/2022

Title:

Comments: