GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2023 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP719

Facility Name: Wellstar MCG Health

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, 2023 through December 31, 2023.
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
Wellstar Health System, Inc.	Not for Profit	8/29/2023

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.

Wellstar Health System, Inc. became AU Medical Center, Inc.â€™s parent organization effective 8/29/2023.

3. Check the box to the right if your facility is part of a health care system ☑

Name: Wellstar Health System, Inc

City: Marietta **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐

Name:

City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

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

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☑

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	22	1,757	5,596	1,765	5,844
Pediatrics (Non ICU)	52	2,254	10,578	2,255	11,452
Pediatric ICU	59	175	1,287	174	1,300
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	267	14,280	97,141	14,287	101,320
Intensive Care	101	1,685	10,405	1,687	10,536
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	**501**	**20,151**	**125,007**	**20,168**	**130,452**

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	29	187
Asian	169	997
Black/African American	9,326	60,551
Hispanic/Latino	286	1,389
Pacific Islander/Hawaiian	0	0
White	9,942	60,009
Multi-Racial	399	1,874
Total	**20,151**	**125,007**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	9,748	65,779
Female	10,403	59,228
Total	**20,151**	**125,007**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,642	52,956
Medicaid	4,199	22,405
Peachare	0	0
Third-Party	4,579	27,068
Self-Pay	1,951	11,917
Other	1,780	10,661

5. Discharges to Death

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

868

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2023 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,688
Semi-Private Room Rate	1,688
Operating Room: Average Charge for the First Hour	6,201
Average Total Charge for an Inpatient Day	14,863

Part E : Emergency Department and Outpatient Services

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

79,915

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

14,125

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	3,505
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	10	3,570
General Beds	67	72,840
	0	0
	0	0
	0	0
	0	0

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

1,183

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

463,276

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

7,437

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

1,598.00

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.

3,357

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	536
Number of Dialysis Treatments	5,787
Number of ESWL Patients	569
Number of ESWL Procedures	585
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	59
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	90
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	125,655
Number of CTS Units (machines)	3
Number of CTS Procedures	57,041
Number of Diagnostic Radioisotope Procedures	17,110
Number of PET Units (machines)	1
Number of PET Procedures	2,505
Number of Therapeautic Radioisotope Procedures	8,688
Number of Number of MRI Units	3
Number of Number of MRI Procedures	14,819
Number of Chemotherapy Treatments	28,440
Number of Respiratory Therapy Treatments	112,350
Number of Occupational Therapy Treatments	48,878
Number of Physical Therapy Treatments	91,350
Number of Speech Pathology Patients	12,461
Number of Gamma Ray Knife Procedures	101
Number of Gamma Ray Knife Units	1
Number of Audiology Patients	1,123
Number of HIV/AIDS Diagnostic Procedures	806
Number of HIV/AIDS Patients	644
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	104
Number of Ultrasound/Medical Sonography Procedures	40,208
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).

138

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	1,063	daVinci XI

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2023. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2023.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,334.63	321.00	181.52
Licensed Practical Nurses (LPNs)	65.98	21.70	8.76
Pharmacists	103.28	12.20	0.00
Other Health Services Professionals*	1,180.77	325.30	34.06
Administration and Support	213.92	33.10	0.00
All Other Hospital Personnel (not included above)	859.69	195.40	41.86

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	0
Asian	125
Black/African American	45
Hispanic/Latino	32
Pacific Islander/Hawaiian	2
White	783
Multi-Racial	11

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	33	☐	33	33
General Internal Medicine	19	☐	19	19
Pediatricians	32	☐	32	32
Other Medical Specialties	143	☐	143	143

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	6	☐	6	6
Gynecology	24	☐	24	24
Ophthalmology Surgery	10	☐	10	10
Orthopedic Surgery	21	☐	21	21
Plastic Surgery	3	☐	3	3
General Surgery	7	☐	7	7
Thoracic Surgery	11	☐	11	11
Other Surgical Specialties	104	☐	104	104

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	6	☐	6	6
Emergency Medicine	66	☐	66	66
Nuclear Medicine	2	☐	2	2
Pathology	16	☐	16	16
Psychiatry	25	☐	25	25
Radiology	57	☐	57	57
	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 surgeons) with Admitting Privleges	23
Podiatrists	3
Certified Nurse Midwives with Clinical Privileges in the Hospital	4
All Other Staff Affiliates with Clinical Privileges in the Hospital	368

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	13	5	0	0	0	0	0	0	0	0	0	0	0
Appling	13	15	0	0	0	0	0	0	0	0	0	0	0
Atkinson	9	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	5	7	1	0	0	0	0	0	0	0	0	0	0
Baldwin	130	62	6	0	0	0	0	0	0	0	0	0	0
Banks	3	3	0	0	0	0	0	0	0	0	0	0	0
Barrow	7	9	2	0	0	0	0	0	0	0	0	0	0
Bartow	7	2	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	11	6	0	0	0	0	0	0	0	0	0	0	0
Berrien	10	6	1	0	0	0	0	0	0	0	0	0	0
Bibb	94	70	0	0	0	0	0	0	0	0	0	0	0
Bleckley	15	13	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	6	0	0	0	0	0	0	0	0	0	0	0
Brooks	5	5	0	0	0	0	0	0	0	0	0	0	0
Bryan	30	22	1	0	0	0	0	0	0	0	0	0	0
Bulloch	151	157	3	0	0	0	0	0	0	0	0	0	0
Burke	594	248	94	0	0	0	0	0	0	0	0	0	0
Butts	8	5	0	0	0	0	0	0	0	0	0	0	0
Calhoun	2	5	0	0	0	0	0	0	0	0	0	0	0
Camden	2	7	0	0	0	0	0	0	0	0	0	0	0
Candler	67	31	0	0	0	0	0	0	0	0	0	0	0
Carroll	3	2	0	0	0	0	0	0	0	0	0	0	0
Charlton	4	3	0	0	0	0	0	0	0	0	0	0	0
Chatham	60	45	2	0	0	0	0	0	0	0	0	0	0
Chattooga	2	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	5	1	0	0	0	0	0	0	0	0	0	0	0
Clarke	65	45	7	0	0	0	0	0	0	0	0	0	0

Clayton	7	6	0	0	0	0	0	0	0	0	0	0	0
Clinch	1	5	0	0	0	0	0	0	0	0	0	0	0
Cobb	7	8	0	0	0	0	0	0	0	0	0	0	0
Coffee	57	23	0	0	0	0	0	0	0	0	0	0	0
Colquitt	16	8	1	0	0	0	0	0	0	0	0	0	0
Columbia	3,212	2,390	374	0	0	0	0	0	0	0	0	0	0
Cook	9	11	1	0	0	0	0	0	0	0	0	0	0
Coweta	8	2	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	15	14	0	0	0	0	0	0	0	0	0	0	0
Decatur	10	4	0	0	0	0	0	0	0	0	0	0	0
DeKalb	13	10	2	0	0	0	0	0	0	0	0	0	0
Dodge	59	33	2	0	0	0	0	0	0	0	0	0	0
Dooly	11	8	0	0	0	0	0	0	0	0	0	0	0
Dougherty	52	55	3	0	0	0	0	0	0	0	0	0	0
Douglas	11	3	0	0	0	0	0	0	0	0	0	0	0
Early	4	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	31	34	2	0	0	0	0	0	0	0	0	0	0
Elbert	53	25	1	0	0	0	0	0	0	0	0	0	0
Emanuel	289	153	15	0	0	0	0	0	0	0	0	0	0
Evans	40	19	1	0	0	0	0	0	0	0	0	0	0
Fannin	0	1	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	55	11	1	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	2	2	0	0	0	0	0	0	0	0	0	0	0
Franklin	12	14	1	0	0	0	0	0	0	0	0	0	0
Fulton	22	7	2	0	0	0	0	0	0	0	0	0	0
Gilmer	0	1	0	0	0	0	0	0	0	0	0	0	0
Glascock	53	28	6	0	0	0	0	0	0	0	0	0	0
Glynn	20	15	2	0	0	0	0	0	0	0	0	0	0
Gordon	1	1	0	0	0	0	0	0	0	0	0	0	0
Grady	10	6	2	0	0	0	0	0	0	0	0	0	0
Greene	65	64	2	0	0	0	0	0	0	0	0	0	0
Gwinnett	24	13	1	0	0	0	0	0	0	0	0	0	0
Habersham	1	2	0	0	0	0	0	0	0	0	0	0	0
Hall	10	7	0	0	0	0	0	0	0	0	0	0	0
Hancock	71	42	1	0	0	0	0	0	0	0	0	0	0
Harris	1	1	0	0	0	0	0	0	0	0	0	0	0
Hart	12	10	1	0	0	0	0	0	0	0	0	0	0
Henry	11	4	0	0	0	0	0	0	0	0	0	0	0
Houston	58	50	1	0	0	0	0	0	0	0	0	0	0
Irwin	2	4	0	0	0	0	0	0	0	0	0	0	0
Jackson	21	7	2	0	0	0	0	0	0	0	0	0	0

Jasper	7	9	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	9	9	0	0	0	0	0	0	0	0	0	0	0
Jefferson	508	184	79	0	0	0	0	0	0	0	0	0	0
Jenkins	207	85	13	0	0	0	0	0	0	0	0	0	0
Johnson	95	33	11	0	0	0	0	0	0	0	0	0	0
Jones	7	7	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	3	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	9	0	0	0	0	0	0	0	0	0	0	0
Laurens	114	99	10	0	0	0	0	0	0	0	0	0	0
Lee	19	18	0	0	0	0	0	0	0	0	0	0	0
Liberty	33	20	2	0	0	0	0	0	0	0	0	0	0
Lincoln	139	79	10	0	0	0	0	0	0	0	0	0	0
Long	4	3	0	0	0	0	0	0	0	0	0	0	0
Lowndes	56	67	2	0	0	0	0	0	0	0	0	0	0
Macon	10	7	0	0	0	0	0	0	0	0	0	0	0
Madison	30	10	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	393	227	41	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	2	1	1	0	0	0	0	0	0	0	0	0	0
Mitchell	7	9	0	0	0	0	0	0	0	0	0	0	0
Monroe	9	6	0	0	0	0	0	0	0	0	0	0	0
Montgomery	11	12	0	0	0	0	0	0	0	0	0	0	0
Morgan	43	28	0	0	0	0	0	0	0	0	0	0	0
Murray	0	2	0	0	0	0	0	0	0	0	0	0	0
Muscogee	12	5	2	0	0	0	0	0	0	0	0	0	0
Newton	14	13	0	0	0	0	0	0	0	0	0	0	0
North Carolina	33	22	1	0	0	0	0	0	0	0	0	0	0
Oconee	13	14	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	6	12	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	116	23	4	0	0	0	0	0	0	0	0	0	0
Paulding	4	0	0	0	0	0	0	0	0	0	0	0	0
Peach	22	20	0	0	0	0	0	0	0	0	0	0	0
Pickens	1	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	18	10	0	0	0	0	0	0	0	0	0	0	0
Pike	1	1	0	0	0	0	0	0	0	0	0	0	0
Polk	1	2	0	0	0	0	0	0	0	0	0	0	0
Pulaski	10	11	0	0	0	0	0	0	0	0	0	0	0
Putnam	46	53	3	0	0	0	0	0	0	0	0	0	0
Rabun	3	2	1	0	0	0	0	0	0	0	0	0	0
Randolph	0	3	0	0	0	0	0	0	0	0	0	0	0
Richmond	6,566	3,030	639	0	0	0	0	0	0	0	0	0	0
Rockdale	6	7	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	99	73	4	0	0	0	0	0	0	0	0	0	0
Seminole	0	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	4,711	3,269	344	0	0	0	0	0	0	0	0	0	0
Spalding	2	1	0	0	0	0	0	0	0	0	0	0	0
Stephens	2	3	0	0	0	0	0	0	0	0	0	0	0
Sumter	20	6	1	0	0	0	0	0	0	0	0	0	0
Taliaferro	25	19	0	0	0	0	0	0	0	0	0	0	0
Tattnall	41	34	3	0	0	0	0	0	0	0	0	0	0
Taylor	3	3	0	0	0	0	0	0	0	0	0	0	0
Telfair	37	15	1	0	0	0	0	0	0	0	0	0	0
Tennessee	8	3	0	0	0	0	0	0	0	0	0	0	0
Terrell	7	6	0	0	0	0	0	0	0	0	0	0	0
Thomas	8	5	1	0	0	0	0	0	0	0	0	0	0
Tift	23	14	0	0	0	0	0	0	0	0	0	0	0
Toombs	84	57	3	0	0	0	0	0	0	0	0	0	0
Towns	1	0	0	0	0	0	0	0	0	0	0	0	0
Treutlen	16	19	0	0	0	0	0	0	0	0	0	0	0
Troup	5	2	0	0	0	0	0	0	0	0	0	0	0
Turner	5	4	1	0	0	0	0	0	0	0	0	0	0
Twiggs	8	1	0	0	0	0	0	0	0	0	0	0	0
Upson	2	3	0	0	0	0	0	0	0	0	0	0	0
Walker	0	3	0	0	0	0	0	0	0	0	0	0	0
Walton	34	15	3	0	0	0	0	0	0	0	0	0	0
Ware	23	18	0	0	0	0	0	0	0	0	0	0	0
Warren	89	41	7	0	0	0	0	0	0	0	0	0	0
Washington	389	163	17	0	0	0	0	0	0	0	0	0	0
Wayne	16	16	1	0	0	0	0	0	0	0	0	0	0
Wheeler	13	12	1	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	7	0	0	0	0	0	0	0	0	0	0	0
Wilkes	180	89	9	0	0	0	0	0	0	0	0	0	0
Wilkinson	27	11	0	0	0	0	0	0	0	0	0	0	0
Worth	7	5	0	0	0	0	0	0	0	0	0	0	0
Total	**20,151**	**11,965**	**1,757**	**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	28
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
Other (Davinci and Hybrid)	0	0	4
Total	**0**	**0**	**33**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	9,828	16,765
Cystoscopy	0	0	101	651
Endoscopy	0	0	0	0
Other (Davinci and Hybrid)	0	0	1,203	816
Total	**0**	**0**	**11,132**	**18,232**

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	6,465	11,174
Cystoscopy	0	0	60	433
Endoscopy	0	0	0	0
Other (Davinci and Hybrid)	0	0	786	574
Total	**0**	**0**	**7,311**	**12,181**

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	9
Asian	120
Black/African American	4,538
Hispanic/Latino	241
Pacific Islander/Hawaiian	0
White	6,665
Multi-Racial	392
Total	**11,965**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	4,186
Ages 15-64	5,230
Ages 65-74	1,624
Ages 75-85	801
Ages 85 and Up	124
Total	**11,965**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,912
Female	6,053
Total	**11,965**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,825
Medicaid	3,255
Third-Party	5,491
Self-Pay	394

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: 517

6. Total Live Births: 1,616

7. Total Births (Live and Late Fetal Deaths): 1,638

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 1,897

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	779	1,521	0
Specialty Care (Intermediate Neonatal Care)	9	161	1,662	0
Subspecialty Care (Intensive Neonatal Care)	36	976	12,850	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	2
Asian	37	103
Black/African American	867	2,799
Hispanic/Latino	67	194
Pacific Islander/Hawaiian	0	0
White	726	2,352
Multi-Racial	58	149
Total	**1,757**	**5,599**

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	4	11
Ages 15-44	1,751	5,583
Ages 45 and Up	2	5
Total	**1,757**	**5,599**

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

$18,723.00

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

$42,088.00

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? 10.5 (FTE's)
What languages do they interpret?
Spanish, ASL interpreters via contracted agency

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 (including Telehealth)

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	1.71	0	0	0
ASL	.09	0	0	0
Chinese	.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.

Ongoing CLAS In-services to outpatient clinics, Wellstar MCG 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?

The need for 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, Wellstar AU Health employees, patients and families.
More effective way to collect language proficiency data on 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)
Centro Medico William Salazar -Asociación Latina de Servicios del CSRA (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: Candice Saunders

Date: 3/7/2024

Title: President and C.E.O.

Comments: