GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HOSP539 2025 Annual Hospital Questionnaire

Part A: General Information

UID: HOSP539

1. Identification

Facility Name:

Memorial Hospital of Bainbridge

County:

Decatur

Street Address:

1500 East Shotwell

City:

Bainbridge

Zip:

39819

Mailing Address:

1500 East Shotwell

Mailing City:

Bainbridge

Mailing Zip:

39819

Medicaid Provider Number:

000001262A

Medicare Provider Number:

110132

3. Report Period

Report Data for the full twelve month period, January 1, 2025 - December 31, 2025 (365 days). 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:

Jessica Williamson

Contact Title:

Chief Financial Officer

Phone:

2297265589

Fax:

NA

Email:

jessicamw@mh-m.org

Part C: Ownership, Operation, and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

C. Facility Operator

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

E. Management Contractor

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

The Hospital Authority of the City of Bainbridge and Decatur County Georgia

Organization Type

Hospital Authority

Effective Date

04/01/1960

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 you checked the box for yes, 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

Memorial Hospital and Manor

City

Bainbridge

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

City

Atlanta

State

Ga

7.

Check the box to the right if your hospital is a participant in a health care network ☑

Name

Hometown Health

City

Bainbridge

State

GA

8. Peer Review Process Related to Medical Errors

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

9. Primary Care Physician Group Practice

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)

Health Maintenance Organization(HMO) ☑

Preferred Provider Organization(PPO) ☑

Physician Hospital Organization(PHO) ☑

Provider Service Organization(PSO) ☐

Other Managed Care or Prepaid Plan ☐

10b. Manage 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. Do not include newborn and neonatal services. Do not include long-term care units, 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)	8	367	701	366	696
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	6	13	35	13	35
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	51	701	2,772	687	2,850
Intensive Care	10	154	613	150	619
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)	5	86	939	83	962
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	80	1,321	5,060	1,299	5,162

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Intensive Care Totals	10	154	613	150	619
Rehab Totals	0	0	0	0	0

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	1	1
Asian	4	9
Black/African American	610	2,240
Hispanic/Latino	38	80
Pacific Islander/Hawaiian	2	4
White	659	2,712
Multi-Racial	7	14
Total	1,321	5,060

3. Gender

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

Gender	Admissions	Inpatient Days
Male	389	1,701
Female	932	3,359
Total	1,321	5,060

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	519	2,923
Medicaid	327	869
Peachare	0	0
Third-Party	0	0
Self-Pay	76	219
Other	399	1,049
Total	1,321	5,060

5. Discharges to Death

Please report the total number of inpatient admissions discharges during the reporting period due to death

15

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2025 (to the nearest whole dollar)

Service	Charge
Private Room Rate	1,071
Semi-Private Room Rate	720
Operating Room: Average Charge for the First Hour	7,150
Average Total Charge for an Inpatient Day	6,345

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

17,484

2. Inpatient Admissions from ER

Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY

531

3. Beds Available

Please report the number of beds available in ER as of the last day of the report period

14

4. Utilization by Specific type of ER bed or room for the report period

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	4	3,497
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	240
General Beds	9	13,747
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

739

6. Non-Emergency Visits

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

32,166

7. Observation Visits/Cases

Please provide the total number of Observation visits/cases for the entire report period

640

8. Diverted Cases

Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period

0

9. Ambulance Diversion Hours

Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted

522

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

Service Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Services/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	3	4
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	0	0
Radioisotope, Therapeutic	0	0
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	3	4
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	1	1
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	0
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	11,112
Number of CTS Units (machines)	1
Number of CTS Procedures	7,520
Number of Diagnostic Radioisotope Procedures	0
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	897
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	374
Number of Occupational Therapy Treatments	391
Number of Physical Therapy Treatments	9,305
Number of Speech Pathology Patients	112
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	1
Number of Ultrasound/Medical Sonography Units	1
Number of Ultrasound/Medical Sonography Procedures	2,313
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)

5

3. Robotic Surgery System

Units

0

Procedures

0

Type of Unit(s)

N/A

Part G: Facility Workforce Informaton

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2025. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2025

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	13	3	10
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs Advanced Practice*)	64	11	4
Licensed Practical Nurses (LPNs)	31	3	1
Pharmacists	3	0	1
Other Health Services Professionals*	92	19	0
Administration and Support	112	12	9
All Other Hospital Personnel (not included in above)	61	3	14

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 Need To Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	31-60 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

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	2
Asian	0
Black/African American	2
Hispanic/Latino	1
Pacific Islander/Hawaiian	1
White	29
Multi-Racial	0
Total	35

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	5	☐	0	0
General Internal Medicine	5	☐	0	0
Pediatricians	3	☐	0	0
Other Medical Specialties	0	☐	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	3	☑	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	3	☑	0	0
Ophthalmology Surgery	0	☑	0	0
Orthopedic Surgery	0	☐	0	0
Plastic Surgery	0	☐	0	0
General Surgery	4	☑	0	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	0	☐	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	1	☑	0	0
Dermatology	0	☐	0	0
Emergency Medicine	1	☑	0	0
Nuclear Medicine	1	☑	0	0
Pathology	1	☑	0	0
Psychiatry	0	☐	0	0
Radiology	1	☑	0	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	0
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	1
All Other Staff Affiliates with Clinical Privileges in the Hospital	12

5b. Name of Other Professions

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

Nurse Practioners, Physician Assistant, CRNA

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. You may enter the data on the web form or upload the data to the web form using a .csv file that matches our downloadable template. The .csv file must contain two columns, with the full name and the left and the license number on the right. If you include column headings, they must match those provided in our template

Full Name	License Number
Prashant Baliga	64756
Charles Miller Brown	77094
Gloria Yvonne Browne	60050
Matthew David Buck	68704
James Sydney Cochran	18631
Elving Colon	67205
Shaun Howard Hoenstine	82417
Brett Michael Howard	71258
Muhammad Ali Niaz Khan	63080
Troy Franklin Kimsey	46876
Craig Jerome Lenz	78067
Jason Belmont Moye	64420
George Joseph Myers	77649
Kristopher Michael Palmer	75974
Thomas Hubert Parker	21779
Winston St. Clair Price	58915
John Barber Reynolds	40207
Robert Evan Smallwood	86379
Mary Claire Smallwood	89729
Mary Beth Smith	70431
Macy Phillips Tabb	95579
Whitney Brooke Vance	76515
Charles Andrew Walker	29816
Charles Alday	11666
Cynthia Bates	235732
Willie Booker	6331
Sabrina Caban	13203
Karen Carver	107350
Alicia Cook	257506
Janett Davis	195675
Samuel Fletcher	178608
Kaila Galpin	8073
William Hooks	4545
Alto Johnson	121767
Vince Kelley	141881
Wesley Kelley	230209
Katherine Kelley Trice	213485
David Kelly	201485

Full Name	License Number
Robert Lancaster	281899
Stephanie McLain	230610
Brian McLaughlin	162160
Ivy Merriman	248506
Melanie Mock	83558
Lauren Musgrove	4879
Gena Peterson	126548
Zacharey Powell	222419
Erica Powell	213685
John Rowe	3941
Shalonda Sanders	193546
Daniel Smith	113417
Sharon Traylor	286002
William Tyus	3760
Angela Tyus	143534
David Vickers	164513
Jenni Wade	197857
Dorraine Webb	91563

Only use commas to separate values

Part I: Patient Origin Table

1. Patient Origin

- 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
- 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
- Rehab=Inpatient Physical Rehabilitation

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).You may enter the data on the web form or upload the data to the web form using a .csv file that matches our downloadable template.The .csv file must contain the same column headings as shown in our template, in exactly the same order. You do not need to include every county, but the county names, state names, and other out of state category must match those in our template.

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	3	2	0	0	0	0	0	0	0	0	0	0	0
Appling	0	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	0	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	0	0	0	0	0	0	0	0	0	0	0	0	0
Baker	0	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	0	0	0	0	0	0	0	0	0	0	0	0	0
Banks	0	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	0	0	0	0	0	0	0	0	0	0	0	0	0
Bartow	0	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	0	9	0	0	0	0	0	0	0	0	0	0	0
Berrien	0	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	0	0	0	0	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0	0
Brantley	0	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	0	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	0	0	0	0	0	0	0	0	0	0	0	0	0
Bulloch	0	0	0	0	0	0	0	0	0	0	0	0	0
Burke	0	0	0	0	0	0	0	0	0	0	0	0	0
Butts	0	0	0	0	0	0	0	0	0	0	0	0	0
Calhoun	7	88	5	0	0	0	0	0	0	0	0	0	0
Camden	0	0	0	0	0	0	0	0	0	0	0	0	0
Candler	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	0	0	0	0	0	0	0	0	0	0	0
Catoosa	0	0	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	0	0	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	0	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	0	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	0	0	0	0	0	0	0	0	0	0	0	0	0
Clarke	0	0	0	0	0	0	0	0	0	0	0	0	0
Clay	17	8	9	0	0	0	0	0	0	0	0	0	0
Clayton	0	0	0	0	0	0	0	0	0	0	0	0	0
Clinch	0	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	0	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	0	0	0	0	0	0	0	0	0	0	0	0	0
Colquitt	2	0	2	0	0	0	0	0	0	0	0	0	0
Columbia	0	0	0	0	0	0	0	0	0	0	0	0	0
Cook	1	0	1	0	0	0	0	0	0	0	0	0	0
Coweta	0	0	0	0	0	0	0	0	0	0	0	0	0
Crawford	0	0	0	0	0	0	0	0	0	0	0	0	0

Crisp	0	0	0	0	0	0	0	0	0	0	0	0	0
Dade	0	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	0	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	979	366	210	0	0	0	0	0	0	0	0	0	0
DeKalb	0	0	0	0	0	0	0	0	0	0	0	0	0
Dodge	0	0	0	0	0	0	0	0	0	0	0	0	0
Dooly	0	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	4	6	4	0	0	0	0	0	0	0	0	0	0
Douglas	0	0	0	0	0	0	0	0	0	0	0	0	0
Early	87	303	53	0	0	0	0	0	0	0	0	0	0
Echols	0	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	0	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	0	0	0	0	0	0	0	0	0	0	0	0	0
Emanuel	0	0	0	0	0	0	0	0	0	0	0	0	0
Evans	0	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	0	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	0	0	0	0	0	0	0	0	0	0	0	0	0
Florida	19	10	3	0	0	0	0	0	0	0	0	0	0
Floyd	0	0	0	0	0	0	0	0	0	0	0	0	0
Forsyth	0	0	0	0	0	0	0	0	0	0	0	0	0
Franklin	0	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	0	0	0	0	0	0	0	0	0	0	0	0	0
Gilmer	0	0	0	0	0	0	0	0	0	0	0	0	0
Glascock	0	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	0	0	0	0	0	0	0	0	0	0	0	0	0
Gordon	0	0	0	0	0	0	0	0	0	0	0	0	0
Grady	67	83	33	0	0	0	0	0	0	0	0	0	0
Greene	0	0	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	0	0	0	0	0	0	0	0	0	0	0	0	0
Habersham	0	0	0	0	0	0	0	0	0	0	0	0	0
Hall	0	0	0	0	0	0	0	0	0	0	0	0	0
Hancock	0	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	0	0	0	0	0	0	0	0	0	0	0	0	0
Harris	0	0	0	0	0	0	0	0	0	0	0	0	0
Hart	0	0	0	0	0	0	0	0	0	0	0	0	0
Heard	0	0	0	0	0	0	0	0	0	0	0	0	0
Henry	0	0	0	0	0	0	0	0	0	0	0	0	0
Houston	0	0	0	0	0	0	0	0	0	0	0	0	0
Irwin	0	0	0	0	0	0	0	0	0	0	0	0	0
Jackson	0	0	0	0	0	0	0	0	0	0	0	0	0
Jasper	0	0	0	0	0	0	0	0	0	0	0	0	0

Jeff Davis	0	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	0	0	0	0	0	0	0	0	0	0	0	0
Jenkins	0	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	0	0	0	0	0	0	0	0	0	0	0	0	0
Jones	0	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	0	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	0	0	0	0	0	0	0	0	0	0	0	0	0
Lee	0	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	0	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0	0
Long	0	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	1	2	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	0	0	0	0	0	0	0	0	0	0	0	0	0
Macon	0	0	0	0	0	0	0	0	0	0	0	0	0
Madison	0	0	0	0	0	0	0	0	0	0	0	0	0
Marion	0	0	0	0	0	0	0	0	0	0	0	0	0
McDuffie	0	0	0	0	0	0	0	0	0	0	0	0	0
McIntosh	0	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	0	0	0	0	0	0	0	0	0	0	0	0	0
Miller	6	13	4	0	0	0	0	0	0	0	0	0	0
Mitchell	7	3	4	0	0	0	0	0	0	0	0	0	0
Monroe	0	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	0	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	0	0	0	0	0	0	0	0	0	0	0	0	0
Murray	0	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	0	1	0	0	0	0	0	0	0	0	0	0	0
Newton	0	0	0	0	0	0	0	0	0	0	0	0	0
North Carolina	0	0	0	0	0	0	0	0	0	0	0	0	0
Oconee	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	3	0	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	0	0	0	0	0	0	0	0	0	0	0	0	0
Paulding	0	0	0	0	0	0	0	0	0	0	0	0	0
Peach	0	0	0	0	0	0	0	0	0	0	0	0	0
Pickens	0	0	0	0	0	0	0	0	0	0	0	0	0
Pierce	0	0	0	0	0	0	0	0	0	0	0	0	0
Pike	0	0	0	0	0	0	0	0	0	0	0	0	0
Polk	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	0	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	0	0	0	0	0	0	0	0	0	0	0	0	0
Quitman	0	0	0	0	0	0	0	0	0	0	0	0	0

Quitman	0	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	0	0	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	0	0	0	0	0	0	0	0	0	0	0	0	0
Rockdale	0	0	0	0	0	0	0	0	0	0	0	0	0
Schley	0	0	0	0	0	0	0	0	0	0	0	0	0
Screven	0	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	113	19	58	0	0	0	0	0	0	0	0	0	0
Spalding	0	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephens	0	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	0	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	0	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	0	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	0	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	0	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	0	0	0	0	0	0	0	0	0	0	0	0	0
Terrell	0	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	4	0	3	0	0	0	0	0	0	0	0	0	0
Tift	0	0	0	0	0	0	0	0	0	0	0	0	0
Toombs	0	0	0	0	0	0	0	0	0	0	0	0	0
Towns	0	0	0	0	0	0	0	0	0	0	0	0	0
Treutlen	0	0	0	0	0	0	0	0	0	0	0	0	0
Troup	0	1	0	0	0	0	0	0	0	0	0	0	0
Turner	0	0	0	0	0	0	0	0	0	0	0	0	0
Twiggs	0	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	0	0	0	0	0	0	0	0	0	0	0	0
Upson	0	0	0	0	0	0	0	0	0	0	0	0	0
Walker	0	0	0	0	0	0	0	0	0	0	0	0	0
Walton	0	0	0	0	0	0	0	0	0	0	0	0	0
Ware	0	0	0	0	0	0	0	0	0	0	0	0	0
Warren	0	0	0	0	0	0	0	0	0	0	0	0	0
Washington	0	0	0	0	0	0	0	0	0	0	0	0	0
Wayne	0	0	0	0	0	0	0	0	0	0	0	0	0
Webster	0	0	0	0	0	0	0	0	0	0	0	0	0
Wheeler	0	0	0	0	0	0	0	0	0	0	0	0	0
White	0	0	0	0	0	0	0	0	0	0	0	0	0
Whitfield	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilcox	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	0	0	0	0	0	0	0	0	0	0	0	0	0

Wilkes	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	0	0	0	0	0	0	0	0	0	0	0	0	0
Worth	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,321**	**914**	**389**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

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	Total
General Operating	0	0	2	2
Cystoscopy (OR Suite)	0	0	1	1
Endoscopy (OR Suite)	0	0	1	1
C-SECTION	1	0	0	1
Total	1	0	4	5

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	Total
General Operating	0	0	243	664	907
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	722	722
C-SECTION	83	0	0	0	83
Total	83	0	243	1,386	1,712

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	Total
General Operating	0	0	243	664	907
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	722	722
C-SECTION	83	0	0	0	83
Total	83	0	243	1,386	1,712

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	1
Asian	2
Black/African American	308
Hispanic/Latino	19
Pacific Islander/Hawaiian	0
White	580
Multi-Racial	4
Total	914

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	12
Ages 15-64	622
Ages 65-74	194
Ages 75-85	75
Ages 85 and Up	11
Total	914

3. Gender

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

Gender	Number of Ambulatory Patients
Male	300
Female	614
Total	914

4. Payment Source

Please report the total number of ambulatory patients by payment source. Report Peachcare for Kids as Third-Party.

Primary Payment Source	Number of Ambulatory Patients
Medicare	309
Medicaid	124
Third-Party	457
Self-Pay	24
Total	914

Perinatal Services Addendum

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

Number of Delivery Rooms:

0

Number of Birthing Rooms:

0

Number of LDR Rooms:

0

Number of LDRP Rooms:

8

Number of Cesarean Sections:

83

Total Live Births:

423

Total Live Births (Live and Late Fetal Deaths):

423

Total Deliveries (Births + Early Fetal Deaths and Induced Terminations):

423

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)	10	417	753	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0
Total	10	417	753	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	Admission by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	3	6
Black/African American	200	372
Hispanic/Latino	19	35
Pacific Islander/Hawaiian	2	4
White	160	305
Multi-Racial	5	11
Total	389	733

2. Age Grouping

Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	2	5
Ages 15-44	385	722
Ages 45 and Up	2	6
Total	389	733

3. Average Charge for an Uncomplicated Delivery

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

16,467

4. Average Charge for an Premature Delivery

Please report the average hospital charge for a premature delivery.

21,757

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:

Do you have paid medical interpreters on staff? (Check the box, if yes) ☑

If you checked yes, how many? (FTEs)

2

What languages do they most often interpret?

Spanish

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
- ☐ Community Volunteer Interpreter
- ☐ Refer patient to outside agency
- ☐ Bilingual member of patient's family
- ☑ Telephone interpreter service
- ☑ Other

Please describe

We have a contract with Vizient-A Language Service Provider for all Physician offices and our ED. We use the telephone serv

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	5	0	0	3
Vietnamese	2	0	0	0
Haitian Creole	2	0	0	0

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?

Annual Training

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?

Additional Hands-On Training and Materials

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

Language One:

English

Language Two:

Spanish

Language Three:

Language Four:

If an unisured 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?

Decatur County Health Department-920 West Street Bainbridge, Ga 39819Georgia Farm Worker Health Program-920 West S

Nurse Employment Addendum

Did your facility employ one or more nurses holding a multistate license pursuant to O.C.G.A. § 43-26-60 et seq. for 30 days or more in 2025 (January 1, 2025 through December 31, 2025)? (Check the box, if yes.) ☐

1.

If yes please list each nurse below: To add a row press the button. To delete a row press the minus button at the end of the row. (You may enter the data on the web form or upload the data to the web form using the .csv file. The csv file upload is recommended, especially if you have a large number of records to add to the form.)

Full Name	Work Address	Duration	Primary State of Residency	Employed by Agency? (Yes/No)	Primary Dates of Employment

Only use commas to separate values

Example Entry: Dean Venture, 1234 Street Name Atlanta GA 30033, 1 year 3 months 12 days, GA, Yes, January 2025 - Present

Note: This is an example and there is no unit requirement for Duration

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 inaccurate 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. **Do not sign until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could throw the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.**

Authorized Signature

Landon Chavis

Date

09/14/2026

Title

Acting CEO

Comments

Response Errors

TAB	QUESTION	ERROR
A-B	Phone:	Enter the number in 000-000-0000 format
A-B	Fax:	Enter the number in 000-000-0000 format