

# HOSP343 2025 Annual Hospital Questionnaire

## Part A: General Information

UID: HOSP343

### 1. Identification

Facility Name:

Phoebe Worth Medical Center

County:

Worth

Street Address:

P O Box 545

City:

Sylvester

Zip:

31791

Mailing Address:

P O Box 545

Mailing City:

Sylvester

Mailing Zip:

31791-0545

Medicaid Provider Number:

00002109A

Medicare Provider Number:

111328

### 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:

Candace Guarneri

Contact Title:

CFO

Phone:

229-777-4506

Fax:

229-776-0057

Email:

cguarnieri@phoebehealth.com

## 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)

Phoebe Worth Medical Center

Organization Type

Not For Profit

Effective Date

05/01/2002

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

Phoebe Putney Health System, Inc.

Organization Type

Not For Profit

Effective Date

05/01/2002

#### C. Facility Operator

Full Legal Name (Or Not Applicable)

Phoebe Worth Medical Center

Organization Type

Not For Profit

Effective Date

05/01/2002

**D. Operator's Parent Organization**

Full Legal Name (Or Not Applicable)

Phoebe Putney Health System, Inc.

Organization Type

Not For Profit

Effective Date

05/01/2002

**E. Management Contractor**

Full Legal Name (Or Not Applicable)

N/A

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

**F. Management's Parent Organization**

Full Legal Name (Or Not Applicable)

N/A

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

**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

Phoebe Putney Health System, Inc.

City

Albany

State

Georgia

**4.**

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

Name

City

State

**5.**

Check the box to the right if the hospital itself operates subsidiary corporations

Name

City

State

**6.**

Check the box to the right if your hospital is a member of an alliance

Name

City

State

**7.**

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

Name

City

State

**8. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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)	0	0	0	0	0
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	25	62	186	62	187
Intensive Care	0	0	0	0	0
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	414	5,527	411	5,495
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
<b>Total</b>	<b>25</b>	<b>476</b>	<b>5,713</b>	<b>473</b>	<b>5,682</b>

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
<b>Intensive Care Totals</b>	0	0	0	0	0
<b>Rehab Totals</b>	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	2	26
Asian	2	28
Black/African American	171	2,061
Hispanic/Latino	11	137
Pacific Islander/Hawaiian	285	3,357
White	5	104
Multi-Racial	0	0
<b>Total</b>	<b>476</b>	<b>5,713</b>

### **3. Gender**

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

Gender	Admissions	Inpatient Days
Male	207	2,551
Female	269	3,162
<b>Total</b>	<b>476</b>	<b>5,713</b>

### **4. Payment Source**

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	381	4,710
Medicaid	2	5
Peachare	0	0
Third-Party	61	659
Self-Pay	8	25
Other	24	314
<b>Total</b>	<b>476</b>	<b>5,713</b>

### **5. Discharges to Death**

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

1

### **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	1,248
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	0
Average Total Charge for an Inpatient Day	2,687

## Part E: Emergency Department and Outpatient Services

### 1. Emergency Visits

Please report the number of emergency visits only

12,532

### 2. Inpatient Admissions from ER

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

60

### 3. Beds Available

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

6

### 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	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	6	12,288
	0	0
	0	0
	0	0
	0	0

### 5. Transfers

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

620

**6. Non-Emergency Visits**

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

**7. Observation Visits/Cases**

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

**8. Diverted Cases**

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

**9. Ambulance Diversion Hours**

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

**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

**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
Podiatric Services	3	4
Renal Dialysis	3	4
ESWL	3	4
Biliary Lithotripter	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, Diagnostic	3	4
Positron Emission Tomography (PET)	3	4
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	3	4
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	2	1
Ultrasound/Medical Sonography	2	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	6,435
Number of CTS Units (machines)	1
Number of CTS Procedures	3,840
Number of Diagnostic Radioisotope Procedures	0
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	0
Number of Number of MRI Procedures	0
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	5,661
Number of Occupational Therapy Treatments	9,009
Number of Physical Therapy Treatments	11,691
Number of Speech Pathology Patients	22
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	51

Number of Ultrasound/Medical Sonography Units	1
Number of Ultrasound/Medical Sonography Procedures	633
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)

1

## **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	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Physician Assistants Only (not including Licensed Physicians)	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Registered Nurses (RNs Advanced Practice*)	<input type="text" value="26"/>	<input type="text" value="5"/>	<input type="text" value="1"/>
Licensed Practical Nurses (LPNs)	<input type="text" value="7"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Pharmacists	<input type="text" value="1"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Other Health Services Professionals*	<input type="text" value="36"/>	<input type="text" value="5"/>	<input type="text" value="1"/>
Administration and Support	<input type="text" value="26"/>	<input type="text" value="3"/>	<input type="text" value="0"/>
All Other Hospital Personnel (not included in above)	<input type="text" value="29"/>	<input type="text" value="1"/>	<input type="text" value="8"/>

### 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	<input type="text" value="Not Applicable"/>
Registered Nurses (RNs-Advance Practice)	<input type="text" value="61-90 Days"/>
Licensed Practical Nurses (LPNs)	<input type="text" value="61-90 Days"/>
Pharmacists	<input type="text" value="31-60 Days"/>
Other Health Services Professionals	<input type="text" value="31-60 Days"/>
All Other Hospital Personnel (not included above)	<input type="text" value="31-60 Days"/>

### 3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	<input type="text" value="0"/>
Asian	<input type="text" value="0"/>
Black/African American	<input type="text" value="0"/>
Hispanic/Latino	<input type="text" value="0"/>
Pacific Islander/Hawaiian	<input type="text" value="0"/>
White	<input type="text" value="0"/>
Multi-Racial	<input type="text" value="0"/>
Total	0

### 4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan)

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	<input type="text" value="2"/>	<input checked="" type="checkbox"/>	<input type="text" value="2"/>	<input type="text" value="2"/>
General Internal Medicine	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Pediatricians	<input type="text" value="2"/>	<input type="checkbox"/>	<input type="text" value="2"/>	<input type="text" value="2"/>
Other Medical Specialties	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="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	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Non-OB Physicians Providing OB Services	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Gynecology	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Ophthalmology Surgery	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Orthopedic Surgery	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Plastic Surgery	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
General Surgery	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Thoracic Surgery	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Other Surgical Specialties	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="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	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Dermatology	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Emergency Medicine	<input type="text" value="16"/>	<input checked="" type="checkbox"/>	<input type="text" value="16"/>	<input type="text" value="16"/>
Nuclear Medicine	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Pathology	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Psychiatry	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
Radiology	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="text"/>	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="text"/>	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="text"/>	<input type="text" value="0"/>	<input type="checkbox"/>	<input type="text" value="0"/>	<input type="text" value="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 Privileges	<input type="text" value="0"/>
Podiatrists	<input type="text" value="0"/>
Certified Nurse Midwives with Clinical Privileges in the Hospital	<input type="text" value="0"/>
All Other Staff Affiliates with Clinical Privileges in the Hospital	<input type="text" value="5"/>

**5b. Name of Other Professions**

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

Nurse Practitioners

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
Wael Azer	73935
James Black	57777
Johnathan Gaskins	56836
Mana Kasongo	57753
Larry Medley	73584
James Sirleaf	67036
Nilam Vaughan	72841
Daren Wooten	62177
Edward Bass	49270
Shivan Patel	99755
Grace Davis	39770
Sucheta Garg	38492
Nevine Mahmoud	65557
Samuel Ojewale	101013
Maneesha Sabharwal	74346
Todd Smith	40794
Alfred Woodard	40592
Syeda Fatima	65963
Nancy Echefu	78562
Donald Okeakpu	76425

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
Baker	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	1	0	0	0	0	0	0	0	0	0	0	0	0
Calhour	3	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	1	0	0	0	0	0	0	0	0	0	0	0	0
Colquit	8	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	12	0	0	0	0	0	0	0	0	0	0	0	0
Dough	224	0	0	0	0	0	0	0	0	0	0	0	0
Early	1	0	0	0	0	0	0	0	0	0	0	0	0
Other C	1	0	0	0	0	0	0	0	0	0	0	0	0
Grady	1	0	0	0	0	0	0	0	0	0	0	0	0
Housto	1	0	0	0	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0	0
Lee	46	0	0	0	0	0	0	0	0	0	0	0	0
Alabam	1	0	0	0	0	0	0	0	0	0	0	0	0
Macon	2	0	0	0	0	0	0	0	0	0	0	0	0
Marion	1	0	0	0	0	0	0	0	0	0	0	0	0
Mitchel	8	0	0	0	0	0	0	0	0	0	0	0	0
Quitma	1	0	0	0	0	0	0	0	0	0	0	0	0
Randol	7	0	0	0	0	0	0	0	0	0	0	0	0
Schley	3	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	8	0	0	0	0	0	0	0	0	0	0	0	0
Terrell	13	0	0	0	0	0	0	0	0	0	0	0	0
Tift	19	0	0	0	0	0	0	0	0	0	0	0	0
Turner	9	0	0	0	0	0	0	0	0	0	0	0	0
Worth	102	0	0	0	0	0	0	0	0	0	0	0	0
<b>Totals</b>	<b>476</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

# 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	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Cystoscopy (OR Suite)	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Endoscopy (OR Suite)	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Cystoscopy	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Endoscopy	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Cystoscopy	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
Endoscopy	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	<input type="text" value="0"/>
Asian	<input type="text" value="0"/>
Black/African American	<input type="text" value="0"/>
Hispanic/Latino	<input type="text" value="0"/>
Pacific Islander/Hawaiian	<input type="text" value="0"/>
White	<input type="text" value="0"/>
Multi-Racial	<input type="text" value="0"/>
Total	0

## **2. Age Grouping**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	<input type="text" value="0"/>
Ages 15-64	<input type="text" value="0"/>
Ages 65-74	<input type="text" value="0"/>
Ages 75-85	<input type="text" value="0"/>
Ages 85 and Up	<input type="text" value="0"/>
Total	0

## **3. Gender**

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

Gender	Number of Ambulatory Patients
Male	<input type="text" value="0"/>
Female	<input type="text" value="0"/>
Total	0

## **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	<input type="text" value="0"/>
Medicaid	<input type="text" value="0"/>
Third-Party	<input type="text" value="0"/>
Self-Pay	<input type="text" value="0"/>
<b>Total</b>	<b>0</b>

## 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)

What languages do they most often interpret?

**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

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
<input type="text" value="Spanish"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>
<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="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?

New Employee Orientation and Annual Employee Updates

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?

N/A

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

Language One:

English

Language Two:

Language Three:

Language Four:

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?

Phoebe Worth Medical Family Medicine 1014 W. Franklin St Sylvester, GA. 31791

## 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
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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 through the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.**

Authorized Signature

Kim Gilman

Date

03/06/2026

Title

CEO

Comments

G.3. Phoebe Worth Medical Center does not capture the race/ethnicity of its medical staff.

## Response Errors

TAB

QUESTION

ERROR