

# HOSP602 2025 Annual Hospital Questionnaire

## Part A: General Information

UID: HOSP602

### 1. Identification

Facility Name:

Phoebe Sumter Medical Center

County:

Sumter

Street Address:

126 Highway 280 W

City:

Americus

Zip:

31709

Mailing Address:

126 Highway 280 W

Mailing City:

Americus

Mailing Zip:

31709 - 8645

Medicaid Provider Number:

000000019A

Medicare Provider Number:

110044

### 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:

Christopher M. Kane

Contact Title:

Senior Vice President & Chief Strategy Officer

Phone:

239-312-4100

Fax:

229-312-4105

Email:

ckane@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)

Americus & Sumter County Hospital Authority

Organization Type

Hospital Authority

Effective Date

01/01/1948

#### B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

N/A

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

#### C. Facility Operator

Full Legal Name (Or Not Applicable)

Phoebe Sumter Medical Center, Inc.

Organization Type

Not For Profit

Effective Date

07/01/2009

**D. Operator's Parent Organization**

Full Legal Name (Or Not Applicable)

Phoebe Putney Health System, Inc.

Organization Type

Not Applicable

Effective Date

07/01/2009

**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 For Profit

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 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. 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	<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)	10	436	893	432	882
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	58	2,602	13,662	3,001	16,444
Intensive Care	10	627	4,070	221	1,034
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
<b>Total</b>	<b>78</b>	<b>3,665</b>	<b>18,625</b>	<b>3,654</b>	<b>18,360</b>

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
<b>Intensive Care Totals</b>	10	627	4,070	221	1,034
<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	7
Asian	5	13
Black/African American	1,836	9,684
Hispanic/Latino	176	631
Pacific Islander/Hawaiian	0	0
White	1,597	8,083
Multi-Racial	49	207
<b>Total</b>	<b>3,665</b>	<b>18,625</b>

### **3. Gender**

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

Gender	Admissions	Inpatient Days
Male	1,378	7,659
Female	2,287	10,966
<b>Total</b>	<b>3,665</b>	<b>18,625</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	1,924	11,777
Medicaid	598	2,373
Peachare	0	0
Third-Party	811	3,096
Self-Pay	200	758
Other	132	621
<b>Total</b>	<b>3,665</b>	<b>18,625</b>

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

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

112

### **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	8,002
Average Total Charge for an Inpatient Day	8,800

## Part E: Emergency Department and Outpatient Services

### 1. Emergency Visits

Please report the number of emergency visits only

22,007

### 2. Inpatient Admissions from ER

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

2,915

### 3. Beds Available

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

17

### 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	2	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	0
General Beds	14	0
	0	0
	0	0
	0	0
	0	0

### 5. Transfers

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

1,143

### **6. Non-Emergency Visits**

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

56,070

### **7. Observation Visits/Cases**

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

1,294

### **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

1,189

## **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	1	1
Renal Dialysis	2	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)	3	4
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	2	1
Gamma Ray Knife	3	4
Audiology Services	2	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	2	1
Hospice	1	1
Respite Care Services	1	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	4
Number of Dialysis Treatments	877
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	21,752
Number of CTS Units (machines)	2
Number of CTS Procedures	14,867
Number of Diagnostic Radioisotope Procedures	531
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	1,718
Number of Chemotherapy Treatments	12,581
Number of Respiratory Therapy Treatments	41,538
Number of Occupational Therapy Treatments	8,932
Number of Physical Therapy Treatments	50,006
Number of Speech Pathology Patients	576
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	8
Number of HIV/AIDS Patients	8
Number of Ambulance Trips	0
Number of Hospice Patients	171
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	4

Number of Ultrasound/Medical Sonography Procedures	4,219
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)

23

**3. Robotic Surgery System**

# Units

1

# Procedures

487

Type of Unit(s)

daVinci Systems

**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	0	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs Advanced Practice*)	138	9	29
Licensed Practical Nurses (LPNs)	37	10	0
Pharmacists	5	0	0
Other Health Services Professionals*	127	1	49
Administration and Support	42	2	6
All Other Hospital Personnel (not included in above)	113	5	46

## 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)	61-90 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	31-60 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	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	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0
<b>Total</b>	<b>0</b>

## 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	12	<input checked="" type="checkbox"/>	12	12
General Internal Medicine	18	<input checked="" type="checkbox"/>	18	18
Pediatricians	3	<input checked="" type="checkbox"/>	3	3
Other Medical Specialties	8	<input type="checkbox"/>	8	8

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	7	<input type="checkbox"/>	7	7
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	7	<input type="checkbox"/>	7	7
Ophthalmology Surgery	0	<input type="checkbox"/>	0	0
Orthopedic Surgery	2	<input checked="" type="checkbox"/>	2	2
Plastic Surgery	0	<input type="checkbox"/>	0	0
General Surgery	4	<input checked="" type="checkbox"/>	4	4
Thoracic Surgery	0	<input type="checkbox"/>	0	0
Other Surgical Specialties	0	<input type="checkbox"/>	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	3	<input type="checkbox"/>	3	3
Dermatology	0	<input type="checkbox"/>	0	0
Emergency Medicine	7	<input checked="" type="checkbox"/>	7	7
Nuclear Medicine	14	<input type="checkbox"/>	14	14
Pathology	2	<input type="checkbox"/>	2	2
Psychiatry	3	<input type="checkbox"/>	3	3
Radiology	14	<input type="checkbox"/>	14	14
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	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 Privileges	0
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	6
All Other Staff Affiliates with Clinical Privileges in the Hospital	66

**5b. Name of Other Professions**

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

Nurse Anesthetist, Optometrist, Physician Assistant, 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
Perry Thomas	48732
John Stevens	36881
Kristin Tott	69786
Clarence Paine	22171
Kenneth Healey	24689
Bernadette Blount	59603
Barry Iguobadia	71240
Abdul-Faisal Akesode	61548
James Sirleaf	67036
Mohan Papudesu	29063
Richard Lee	27216
Lawrence Crimmins	33062
Jose Rebeil De La Rosa	78647
Ryan Breland	82519
Sreelatha Diviti	82586
Jontu Solomon	85028
Tracy Chason	74036
Francis Ogbobe	86796
Jeffrey Nasworthy	89337
Dominiq Okoduwa	84498
Jacqueline McLatchy	90768
Olamide Oladipo	89596
Henry LeBoyd	78692
Sejalben Patel	90784
Temidayo Abe	91023
Temidayo Abe	91023
Carey Linker	92161
Ekei Tanifum	78358
Nathaniel Spencer	97049
Jordan Simmons	95985

Full Name	License Number
Jordan Simmons	95985
Joseph Watson	98196
Joseph Watson	98196
Garrett Collins	83025
Rotimi Samuel	44082
Mark Branch	81934
Bryan Lucenta	102717
Ivana Okor	103852
Marsha Glover	34750
Charles Springer	105108
Jacob Rice	103978
Blessing Aroh	96955
Robert Brown	61706
Estrellita Redmon	101960
Chinyelu Ofodile	67859
Oluwatomiwa Babade	98615
Dan Phillips	40843
Benjamin Andrews	31867
Michael Busman	40628
Michael Busman	40628
Sandra Zornes	28340
Kenneth DiNella	36716
Linda Hudson	47771
Linda Hudson	47771
Leonard LaRussa	POD000775
B. Law	46879
Nelson Madrazo	49862
Michael Raines	35979
Michael Raines	35979
Michael Raines	35979
Neil Seeley	53947
Pradeep Nalla	50318

Full Name	License Number
Brian Jordan	53561
Syed Alam	51013
Syed Alam	51013
Jeremy Joyner	61272
Tibor Gyorfi	51585
James Bise	54062
Lorenzo Carson	46057
Shailaja Sappati	58819
Ebenezer Frans	62844
Patrick Crimmins	39314
Rakesh Patel	62589
John Fennessy	58957
Malcolm Floyd	64930
Jill Olek	64646
Sean Sheff	65888
Brent Deem	37523
Ashley Harris	92900
Jesse Sundar	102261
Moemen Eltelbany	102695
Moemen Eltelbany	102695
Queendaleen Chukwurah	99576
Robert Abernathy	49132

Only use commas to separate values

## Part I: Patient Origin Table

### 1. Patient Origin

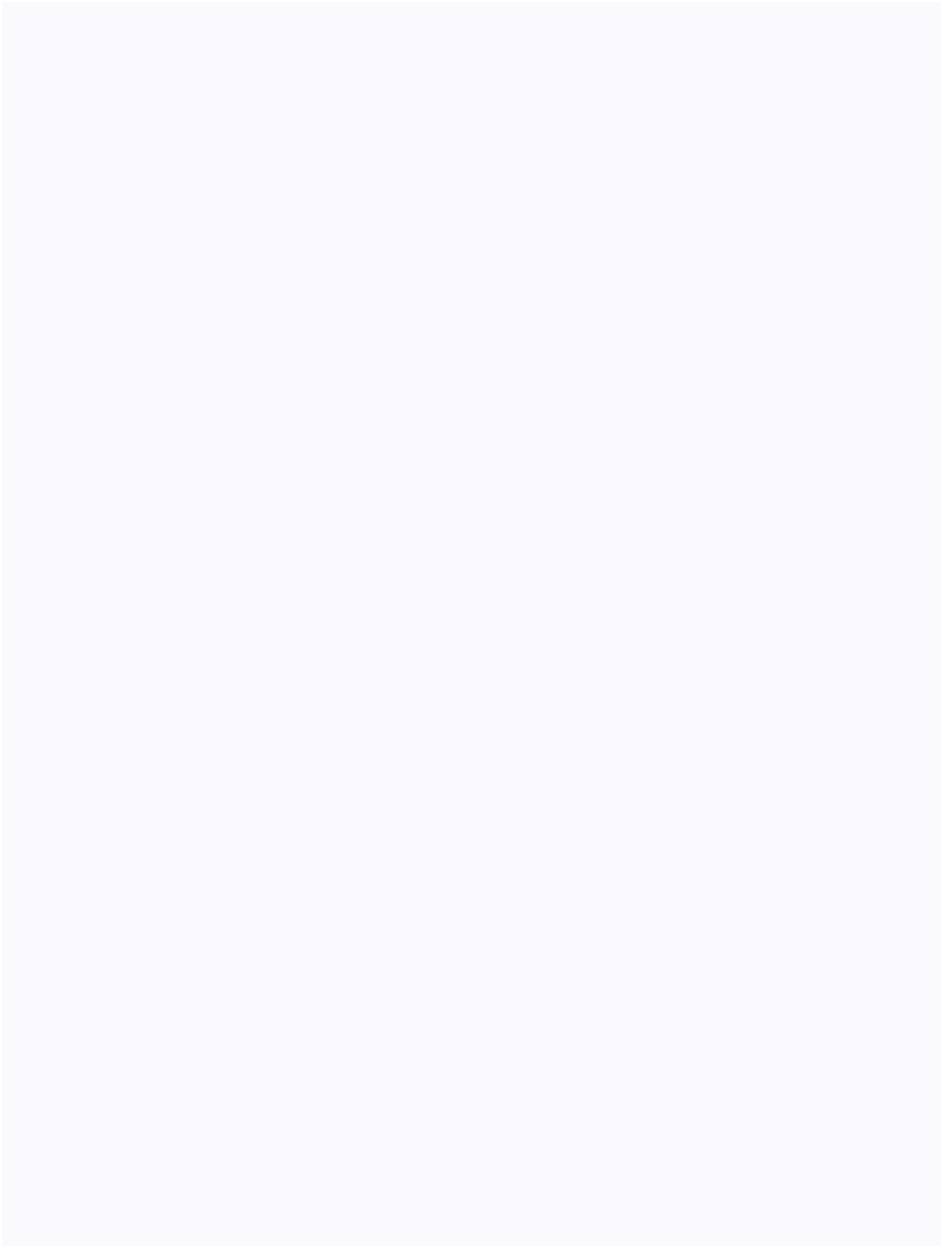
- Inpat=Inpatient Services
- Surg=Outpatient Surgical
- OB=Obstetric
- P18+=Acute psychiatric adult 18 and over
- P13-17=Acute psychiatric adolescent 13-17
- P0-12=Acute psychiatric children 12 and under
- S18+=Substance abuse adult 18 and over
- S13-17=Substance abuse adolescent 13-17
- E18+=Extended 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
Alabar	2	5	0	0	0	0	0	0	0	0	0	0	0
Bartow	1	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hil	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	2	2	1	0	0	0	0	0	0	0	0	0	0
Calhou	7	12	2	0	0	0	0	0	0	0	0	0	0
Camde	4	1	0	0	0	0	0	0	0	0	0	0	0
Chattal	1	3	1	0	0	0	0	0	0	0	0	0	0
Cherok	1	1	0	0	0	0	0	0	0	0	0	0	0
Clay	1	7	0	0	0	0	0	0	0	0	0	0	0
Colquit	1	3	0	0	0	0	0	0	0	0	0	0	0
Coweta	2	0	0	0	0	0	0	0	0	0	0	0	0
Crawfo	1	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	26	115	9	0	0	0	0	0	0	0	0	0	0
Decatu	1	2	0	0	0	0	0	0	0	0	0	0	0
DeKalb	2	1	1	0	0	0	0	0	0	0	0	0	0
Dodge	3	4	0	0	0	0	0	0	0	0	0	0	0
Dooly	31	84	9	0	0	0	0	0	0	0	0	0	0
Dough	102	248	21	0	0	0	0	0	0	0	0	0	0
Early	3	2	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	9	4	0	0	0	0	0	0	0	0	0	0	0
Gwinne	1	0	1	0	0	0	0	0	0	0	0	0	0
Harris	1	2	0	0	0	0	0	0	0	0	0	0	0
Housto	3	10	0	0	0	0	0	0	0	0	0	0	0
Lee	164	217	29	0	0	0	0	0	0	0	0	0	0
Macon	307	290	33	0	0	0	0	0	0	0	0	0	0
Marion	139	149	17	0	0	0	0	0	0	0	0	0	0
Miller	2	1	0	0	0	0	0	0	0	0	0	0	0
Mitchel	5	8	0	0	0	0	0	0	0	0	0	0	0
Monro	1	2	1	0	0	0	0	0	0	0	0	0	0

Muscoç	3	9	0	0	0	0	0	0	0	0	0	0	0
North	1	1	0	0	0	0	0	0	0	0	0	0	0
Other	15	3	1	0	0	0	0	0	0	0	0	0	0
Peach	6	3	3	0	0	0	0	0	0	0	0	0	0
Pierce	3	0	0	0	0	0	0	0	0	0	0	0	0
Quitma	3	1	1	0	0	0	0	0	0	0	0	0	0
Randol	26	54	5	0	0	0	0	0	0	0	0	0	0
Schley	220	289	23	0	0	0	0	0	0	0	0	0	0
South	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	111	85	3	0	0	0	0	0	0	0	0	0	0
Sumter	2,213	1,860	237	0	0	0	0	0	0	0	0	0	0
Talbot	12	19	2	0	0	0	0	0	0	0	0	0	0
Taylor	19	30	5	0	0	0	0	0	0	0	0	0	0
Terrell	107	85	16	0	0	0	0	0	0	0	0	0	0
Thoma:	1	6	0	0	0	0	0	0	0	0	0	0	0
Tift	2	4	0	0	0	0	0	0	0	0	0	0	0
Troup	1	0	0	0	0	0	0	0	0	0	0	0	0
Turner	3	7	0	0	0	0	0	0	0	0	0	0	0
Upton	4	0	0	0	0	0	0	0	0	0	0	0	0
Wayne	1	1	0	0	0	0	0	0	0	0	0	0	0
Webste	79	97	12	0	0	0	0	0	0	0	0	0	0
Wilcox	4	8	1	0	0	0	0	0	0	0	0	0	0
Worth	5	23	2	0	0	0	0	0	0	0	0	0	0
Baker	0	4	0	0	0	0	0	0	0	0	0	0	0
Baldwir	0	1	0	0	0	0	0	0	0	0	0	0	0
Barrow	0	1	0	0	0	0	0	0	0	0	0	0	0
Blecker	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	0	1	0	0	0	0	0	0	0	0	0	0	0
Cook	0	1	0	0	0	0	0	0	0	0	0	0	0
Fulton	0	1	0	0	0	0	0	0	0	0	0	0	0
Grady	0	1	0	0	0	0	0	0	0	0	0	0	0
L...	5	1	5	5	5	5	5	5	5	5	5	5	5

Laurens	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	0	2	0	0	0	0	0	0	0	0	0	0	0
Meriw	0	1	0	0	0	0	0	0	0	0	0	0	0
Pauldin	0	1	0	0	0	0	0	0	0	0	0	0	0
Pike	0	2	0	0	0	0	0	0	0	0	0	0	0
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0	0
Rockda	0	1	0	0	0	0	0	0	0	0	0	0	0
Semin	0	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	0	1	0	0	0	0	0	0	0	0	0	0	0
Wilkins	0	1	0	0	0	0	0	0	0	0	0	0	0
<b>Totals</b>	<b>3,665</b>	<b>3,781</b>	<b>436</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="5"/>	5
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="1"/>	1
<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>6</b>	<b>6</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="762"/>	<input type="text" value="2,264"/>	3,026
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="152"/>	<input type="text" value="1,526"/>	1,678
<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>914</b>	<b>3,790</b>	<b>4,704</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="698"/>	<input type="text" value="2,258"/>	2,956
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="143"/>	<input type="text" value="1,523"/>	1,666
<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>841</b>	<b>3,781</b>	<b>4,622</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	6
Asian	26
Black/African American	1,713
Hispanic/Latino	124
Pacific Islander/Hawaiian	1
White	1,846
Multi-Racial	65
<b>Total</b>	<b>3,781</b>

## **2. Age Grouping**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	60
Ages 15-64	2,359
Ages 65-74	907
Ages 75-85	422
Ages 85 and Up	33
<b>Total</b>	<b>3,781</b>

## **3. Gender**

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

Gender	Number of Ambulatory Patients
Male	1,505
Female	2,276
<b>Total</b>	<b>3,781</b>

## **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	1,512
Medicaid	368
Third-Party	1,780
Self-Pay	121
<b>Total</b>	<b>3,781</b>

## 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:

Number of Birthing Rooms:

Number of LDR Rooms:

Number of LDRP Rooms:

Number of Cesarean Sections:

Total Live Births:

Total Live Births (Live and Late Fetal Deaths):

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

## 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)	17	386	784	0
Specialty Care (Intermediate Neonatal Care)	3	31	86	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0
<b>Total</b>	<b>20</b>	<b>417</b>	<b>870</b>	<b>0</b>

**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	208	450
Hispanic/Latino	87	167
Pacific Islander/Hawaiian	0	0
White	120	235
Multi-Racial	18	35
<b>Total</b>	<b>436</b>	<b>893</b>

**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	1	2
Ages 15-44	435	891
Ages 45 and Up	0	0
<b>Total</b>	<b>436</b>	<b>893</b>

**3. Average Charge for an Uncomplicated Delivery**

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

19,883

**4. Average Charge for an Premature Delivery**

Please report the average hospital charge for a premature delivery.

22,339

## 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
Spanish	0	0	0	0
	0	0	0	0
	0	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?

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:

Spanish

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?

Americus Urgent Care 618 E. Lamar Street Americus, GA. 31709-3738 Sumter Faith Clinic 127 S. Jackson St. Americus, GA. 31709 After Hours Care 208 E. Li

## 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

Carlyle Walton

Date

03/06/2026

Title

CEO

Comments

Part E.4: Phoebe information systems are unable to capture emergency room visits by type of bed.  
 Part E.10: Includes all patients (i) who registered but left without being seen; (ii) who left before being discharged. Some of these patients likely received some care before leaving.  
 Part G.3: Phoebe does not capture race/ethnicity of its medical staff.

## Response Errors

TAB	QUESTION	ERROR
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