HOSP420 2025 Annual Hospital Questionnaire

Part A: General Information

UID: HOSP420

1. Identifcication

Facility Name:

St. Mary's Good Samaritan Hospital

County:

Greene

Street Address:

5401 Lake Oconee Parkway

City:

Greensboro

Zip:

30642

Mailing Address:

5401 Lake Oconee Parkway

Mailing City:

Greensboro

Mailing Zip:

30642

Medicaid Provider Number:

000001328A

Medicare Provider Number:

11-1329

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:

Alan Kattelmann

Contact Title:

Director Financial Operations

Phone:

770-789-8593

Fax:

706-389-2610

Email:

Alan.Kattelmann@stmarysathens.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)

St. Mary's Good Samaritan Hospital

Organization Type

Not For Profit

Effective Date

01/01/2012

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

St. Mary's Health Care System, Inc

Organization Type

Not For Profit

Effective Date

01/01/2012

C. Facility Operator

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)

Trinity Health Inc.

Organization Type

Not For Profit

Effective Date

01/01/2012

E. Management Contractor

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

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

St. Mary's Health System

City

Athens

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	☐	☐	☐	☐
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)	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	1,312	5,125	1,312	5,125
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	27	138	27	138
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	25	1,339	5,263	1,339	5,263

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Intensive Care Totals	0	0	0	0	0
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	28
Asian	4	10
Black/African American	326	1,113
Hispanic/Latino	3	52
Pacific Islander/Hawaiian	1	9
White	974	4,014
Multi-Racial	30	37
Total	1,339	5,263

3. Gender

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

Gender	Admissions	Inpatient Days
Male	611	2,322
Female	728	2,941
Total	1,339	5,263

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	1,008	4,245
Medicaid	80	356
Peachare	0	0
Third-Party	198	528
Self-Pay	53	134
Other	0	0
Total	1,339	5,263

5. Discharges to Death

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

9

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	1,423
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	18,362
Average Total Charge for an Inpatient Day	3,287

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

17,522

2. Inpatient Admissions from ER

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

1,134

3. Beds Available

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

25

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	25	17,522
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

0

6. Non-Emergency Visits

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

26,883

7. Observation Visits/Cases

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

272

8. Diverted Cases

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

55

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

129

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	2	1
Renal Dialysis	3	4
ESWL	2	1
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	3	4
Magnetic Resonance Imaging (MRI)	2	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	2	1
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1

	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	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	9,992
Number of CTS Units (machines)	1
Number of CTS Procedures	9,863
Number of Diagnostic Radioisotope Procedures	1,582
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	2,934
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	5,897
Number of Occupational Therapy Treatments	6,264
Number of Physical Therapy Treatments	23,070
Number of Speech Pathology Patients	1,878
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	0
Number of Ultrasound/Medical Sonography Units	2
Number of Ultrasound/Medical Sonography Procedures	1,347
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)

3

3. Robotic Surgery System

Units

0

Procedures

0

Type of Unit(s)

0

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*)	37.7	5.4	47
Licensed Practical Nurses (LPNs)	1.9	0	32
Pharmacists	2	0	35
Other Health Services Professionals*	3.5	0	12
Administration and Support	21.7	0.9	292
All Other Hospital Personnel (not included in above)	88.6	2.25	58

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)	More than 90 Days
Pharmacists	30 Days or Less
Other Health Services Professionals	61-90 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	13
Black/African American	4
Hispanic/Latino	6
Pacific Islander/Hawaiian	0
White	52
Multi-Racial	3
Total	78

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	3	☑	3	3
General Internal Medicine	4	☑	4	4
Pediatricians	0	☐	0	0
Other Medical Specialties	26	☐	15	19

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	0	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	2	☐	2	2
Ophthalmology Surgery	2	☐	2	2
Orthopedic Surgery	11	☐	0	11
Plastic Surgery	2	☐	0	2
General Surgery	7	☐	7	8
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	1	☐	1	1

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	15	☑	15	15
Dermatology	0	☐	0	0
Emergency Medicine	19	☑	19	19
Nuclear Medicine	0	☐	0	0
Pathology	2	☑	2	2
Psychiatry	0	☐	0	0
Radiology	32	☑	32	32
	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	3
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	63

5b. Name of Other Professions

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

CRNA, Nurse Practitioner, Physician assistants

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
Emad Ahmed, MD	45157
Rebekah Anders, MD	103066
Erick Avelar, MD	70853
Bryan Barnes, MD	46038
Ranjana Bhargava, MD	68482
Sander Binderow, MD	36925
Jorge Chancay Rodriguez, MD	90245
Clay Chappell, MD	59693
Craig Colby, MD	64350
Ryan Corley, MD	66585
Roop Dutta, MD	103446
Itoro Edet Daniels, MD	80742
Centrael Evans, MD	76821
Logan Fields, MD	71733
Mason Florence, MD	69809
Kassandra Gadlin, MD	73896
Joseph Gaines, MD	28550
Benjamin Goodroe, MD	85292
Marcus Griffith, MD	35643
Parker Grow, MD	52943
Robert Ham, MD	33098
Brandon Harden, MD	63459
David Harkins, DO	55950
David Hatmaker, MD	26300
Ned Hembree, MD	71971

Christopher Hosfeld, MD	41836
Sean Javaheri, DO	63872
Kathleen Jeffery, MD	45508
Stephen Johnson, DO	59800
Susan Jones, MD	31268
Jeffrie Kamean, MD	40115
Ryan Katz, MD	62729
Andrew Ke, MD	80926
Sudha Lagudu, MD	95598
Joshua Lang, DO	73561
William Lawrence, MD	69888
John Layher, MD	46692
Robert Leffert, MD	51156
George Lingenfelser, MD	23381
Liana Lugo, MD	76474
Rene Mackay, MD	51680
Ormonde Mahoney, MD	30825
John Manfredi, MD	58899
Sergio Mejias, MD	40737
Raul Mendiola, MD	62258
Graham Mercier, MD	96717
Omar Mushfiq, MD	57399
Charles Neckman, MD	24471
Petros Nikolinakos, MD	63106
Matthew Olliff, MD	95513
Shaun O'Rear, MD	27233

Harvey Ouzts, MD	14976
Thomas Parent, MD	95058
James Parramore, MD	46898
Jack Paschal, MD	58808
Hiren Patel, MD	86105
Jaideep Patel, MD	51708
Julio Pena Polanco, MD	75119
Everett Perry, MD	56872
Philip Ploska, MD	36848
Asif Qadri, MD	60492
Mark Quinn, MD	50316
Joseph Rawlings, MD	65607
Srilakshmi Rebala, MD	51081
Dave Ringer, MD	30368
Marc Rosenberg, MD	47360
Priya Rudolph, MD, PhD	68852
Ali Sayed, MD	80173
Shahriar Sedghi, MD	37678
Amit Shah, MD	57839
Tirth Shah, MD	96206
Michael Shuler, MD	53723
Eric Silver, MD	63440
Brett Stanger, MD	68955
William Tally, MD	59776
Ashwin Thatti, MD	93549
Dat Vu, MD	92868

Zane Wade, MD	52236
Patrick Willis, MD	58835
Clayton Wing, MD	103683
Katherine Yancey, MD	100422
Everett Young, MD	99894
Marc Yune, MD	41395
Jeffrey Zweig, MD	45374

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
Baldv	42	0	0	0	0	0	0	0	0	0	0	0
Barrc	2	35	0	0	0	0	0	0	0	0	0	0
Bibb	2	0	0	0	0	0	0	0	0	0	0	0
Clark	12	3	0	0	0	0	0	0	0	0	0	0
Clay	7	0	0	0	0	0	0	0	0	0	0	0
DeKa	5	0	0	0	0	0	0	0	0	0	0	0
Fayet	2	0	0	0	0	0	0	0	0	0	0	0
Franl	2	0	0	0	0	0	0	0	0	0	0	0
Fultc	4	1	0	0	0	0	0	0	0	0	0	0
Gree	703	284	0	0	0	0	0	0	0	0	0	0
Gwin	1	0	0	0	0	0	0	0	0	0	0	0
Hanc	85	11	0	0	0	0	0	0	0	0	0	0
Henr	2	0	0	0	0	0	0	0	0	0	0	0
Hart	4	3	0	0	0	0	0	0	0	0	0	0
Jacks	24	11	0	0	0	0	0	0	0	0	0	0
Laure	0	1	0	0	0	0	0	0	0	0	0	0
Lincc	0	1	0	0	0	0	0	0	0	0	0	0
Mari	2	1	0	0	0	0	0	0	0	0	0	0
Morg	49	30	0	0	0	0	0	0	0	0	0	0
New	11	10	0	0	0	0	0	0	0	0	0	0
Ocor	11	4	0	0	0	0	0	0	0	0	0	0
Ogle	6	3	0	0	0	0	0	0	0	0	0	0
Paulc	2	0	0	0	0	0	0	0	0	0	0	0

Pike	2	0	0	0	0	0	0	0	0	0	0	0
Putn	325	164	0	0	0	0	0	0	0	0	0	0
Richr	1	1	0	0	0	0	0	0	0	0	0	0
Rock	2	2	0	0	0	0	0	0	0	0	0	0
Spalc	2	2	0	0	0	0	0	0	0	0	0	0
Taliaf	15	8	0	0	0	0	0	0	0	0	0	0
Thon	1	1	0	0	0	0	0	0	0	0	0	0
Walt	9	2	0	0	0	0	0	0	0	0	0	0
Wilk	4	2	0	0	0	0	0	0	0	0	0	0
Totals	**1,339**	**580**	**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	3	3
Cystoscopy (OR Suite)	0	0	0	0
Endoscopy (OR Suite)	0	0	1	1
	0	0	0	0
Total	0	0	4	4

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	0	580	580
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	580	580

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	0	580	580
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	580	580

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	6
Black/African American	85
Hispanic/Latino	9
Pacific Islander/Hawaiian	1
White	8
Multi-Racial	470
Total	580

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	1
Ages 15-64	211
Ages 65-74	214
Ages 75-85	137
Ages 85 and Up	17
Total	580

3. Gender

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

Gender	Number of Ambulatory Patients
Male	287
Female	293
Total	580

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	353
Medicaid	11
Third-Party	212
Self-Pay	4
Total	580

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)

N/A

What languages do they most often interpret?

N/A

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)

- [x] Bilingual hospital staff member
- [ ] Community Volunteer Interpreter
- [ ] Refer patient to outside agency
- [ ] Bilingual member of patient's family
- [x] Telephone interpreter service
- [x] Other

Please describe

Remote video Interpretation

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	2	0	0	2
Vietnamese	0	0	0	0
Besque/Hindi	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?

General orientation and annual education module

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?

On site, in person interpreter services

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

Language One:

English

Language Two:

Braille

Language Three:

N/A

Language Four:

N/A

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?

Oconee Valley Healthcare, Greene County Health Department

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	Address	Duration	Primary State of Residency	Employed by Agency? (Yes/No)	Primary Dates of Employment
Gina Armst	120 Kaitlyn C	0	GA	No	6/17/2024
Mary Beth A	403 Scuffleb	0	GA	No	8/18/2025
Tiffany Barr	1820 Northri	0	GA	No	5/22/2023
Caitlynn Bry	1259 Flat Ro	0	GA	No	5/8/2023
Kaylin Cole	169 Goodwi	0	GA	No	2/26/2024
Miranda Co	1030 Kent C	0	GA	No	9/29/2023
Donna Evar	758 South St	0	GA	No	1/17/2022
Katlyn Field	1202 Marsha	0	GA	No	12/22/2025
Susan Garci	1241 A P Ro	0	GA	No	12/9/2024
Pamela Gor	866 Pea Ridg	0	GA	No	6/22/2020
Cora Goss	134 Griswoo	0	GA	No	10/21/2019
Abby Greer	118 BASS RD	0	GA	No	1/15/2024
Sandra Hill	1020 Turners	0	GA	No	7/14/2025
Mikayla Ho	464 Ghettis S	0	GA	No	8/12/2024
Rebekah Hu	109 Old Tho	0	GA	No	12/29/2025
Alyssa Mille	250 Parks Mi	0	GA	No	9/15/2025
Tierra Myric	204A Sunnyl	0	GA	No	6/26/2023
Jennifer Ne	108 Newby L	0	GA	No	12/8/2025
Danielle Pay	3057 Heritag	0	GA	No	7/11/2022
Leigh Anne	657 Ingram I	0	GA	No	12/15/2025
Thurlon Reg	140 Lakesho	0	GA	No	5/22/2023
Hannah Sch	290 Long Sh	0	GA	No	11/17/2025
Nicole Scot	1631 Highwa	0	GA	No	9/11/2023
Lacey Thom	102 s rock is	0	GA	No	1/6/2025

Chaille Win	1390 N. Sho	0	GA	No	7/8/2024
Chirrikkia W	10 Aiken Wa	0	GA	No	10/30/2023
Leigh Jame	357 Ridgewo	0	GA	No	2/13/2023
BRANDI AL	1695 Post Ro	0	GA	No	11/17/2025
Ashley Whi	878 Crooked	0	GA	No	12/8/2025

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 incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act. **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.**

These fields will become unlocked after all other fields have been correctly filled out

Authorized Signature

Stonish Pierce

Date

03/06/2026

Title

Chief Executive Officer

Comments

Response Errors

TAB	QUESTION	ERROR
D	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.	

TAB	QUESTION	ERROR
Surgical	Please report the number of procedures by type of room.	