GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Part A: General Information

UID: HOSP310

1. Identifcication

Facility Name:

Donalsonville Hospital, Inc.

County:

Seminole

Street Address:

102 Hospital Circle

City:

Donalsonville

Zip:

39845

Mailing Address:

102 Hospital Circle

Mailing City:

Donalsonville

Mailing Zip:

39845

Medicaid Provider Number:

000206181A

Medicare Provider Number:

110194

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:

Kay Livingston

Contact Title:

CFO

Phone:

229-524-5217

Fax:

229-524-6034

Email:

cfo.admin@donalsonvillehospital.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)

Donalsonville Hospital, Inc.

Organization Type

Not For Profit

Effective Date

12/15/1977

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

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)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

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

City

State

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	41	484	2,312	476	2,257
Intensive Care	0	0	0	0	0
Psychiatry	24	995	6,715	982	6,578
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	65	1,479	9,027	1,458	8,835

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	0	0
Asian	0	0
Black/African American	573	3,536
Hispanic/Latino	2	13
Pacific Islander/Hawaiian	0	0
White	904	5,478
Multi-Racial	0	0
Total	1,479	9,027

3. Gender

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

Gender	Admissions	Inpatient Days
Male	742	4,597
Female	737	4,430
Total	1,479	9,027

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	607	4,048
Medicaid	620	3,756
Peachare	0	0
Third-Party	205	1,047
Self-Pay	47	176
Other	0	0
Total	1,479	9,027

5. Discharges to Death

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

8

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	0
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	0
Average Total Charge for an Inpatient Day	0

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

6,493

2. Inpatient Admissions from ER

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

602

3. Beds Available

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

13

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	519
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	130
General Beds	10	5,844
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

288

6. Non-Emergency Visits

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

17,117

7. Observation Visits/Cases

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

415

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

191

Part F: Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. (Use the blank lines to specify other services.)

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

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

Services/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	3	4
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	3	4
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	2	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	1	1
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	0
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	7,289
Number of CTS Units (machines)	1
Number of CTS Procedures	3,387
Number of Diagnostic Radioisotope Procedures	0
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	170
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	31,076
Number of Occupational Therapy Treatments	506
Number of Physical Therapy Treatments	8,881
Number of Speech Pathology Patients	46
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	15

Number of Ultrasound/Medical Sonography Units	1
Number of Ultrasound/Medical Sonography Procedures	1,306
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)

0

3. Robotic Surgery System

Units

0

Procedures

0

Type of Unit(s)

Not Applicable

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	2	0	0
Physician Assistants Only (not including Licensed Physicians)	1	0	0
Registered Nurses (RNs Advanced Practice*)	55	0	0
Licensed Practical Nurses (LPNs)	24	0	0
Pharmacists	1	0	0
Other Health Services Professionals*	91	0	0
Administration and Support	52	0	0
All Other Hospital Personnel (not included in above)	76	0	0

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)	31-60 Days
Pharmacists	Not Applicable
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	1
Black/African American	1
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	10
Multi-Racial	0
Total	12

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	0
General Internal Medicine	1	☐	1	0
Pediatricians	2	☐	2	0
Other Medical Specialties	0	☐	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	0	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	0	☐	0	0
Ophthalmology Surgery	0	☐	0	0
Orthopedic Surgery	0	☐	0	0
Plastic Surgery	0	☐	0	0
General Surgery	2	☑	2	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	0	☐	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	0	☐	0	0
Dermatology	1	☐	1	0
Emergency Medicine	2	☐	2	0
Nuclear Medicine	0	☐	0	0
Pathology	0	☐	0	0
Psychiatry	1	☐	1	0
Radiology	0	☐	0	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

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

5b. Name of Other Professions

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

Nurse Practitioner and Physician Assistant

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
Andrea Alexander	060626
Greg Hall	051586
Homer Breckenridge III	019644
Jeffery Holley	009837
Joseph Walker	060890
Sarah Hampton	033591
John Strunk	077238
Jacob Holley	081053
Romana Bairan	048971
Dion Martin	063095
Linda Jones	030111
David Swearingain	047995

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
Alabam	25	3	0	16	3	2	0	0	0	0	0	0	0
Calhoui	7	7	0	2	3	1	0	0	0	0	0	0	0
Catoosa	8	0	0	2	0	3	0	0	0	0	0	0	0
Clay	2	2	0	0	0	0	0	0	0	0	0	0	0
Decatu	104	68	0	13	14	8	0	0	0	0	0	0	0
Early	60	100	0	11	6	1	0	0	0	0	0	0	0
Florida	28	16	0	11	0	1	0	0	0	0	0	0	0
Fulton	65	0	0	26	26	12	0	0	0	0	0	0	0
Lee	2	0	0	0	1	0	0	0	0	0	0	0	0
Miller	68	33	0	7	6	2	0	0	0	0	0	0	0
Semino	329	218	0	30	4	3	0	0	0	0	0	0	0
Bacon	1	0	0	1	0	0	0	0	0	0	0	0	0
Baldwir	2	0	0	2	0	0	0	0	0	0	0	0	0
Banks	1	0	0	1	0	0	0	0	0	0	0	0	0
Bartow	7	0	0	3	1	3	0	0	0	0	0	0	0
Ben Hil	2	0	0	2	0	0	0	0	0	0	0	0	0
Berrien	3	0	0	2	0	1	0	0	0	0	0	0	0
Bibb	28	0	0	7	19	2	0	0	0	0	0	0	0
Brooks	4	0	0	2	2	0	0	0	0	0	0	0	0
Bryan	2	0	0	1	0	1	0	0	0	0	0	0	0
Bulloch	7	0	0	1	3	3	0	0	0	0	0	0	0
Camde	9	0	0	4	5	0	0	0	0	0	0	0	0
Carroll	19	0	0	14	5	0	0	0	0	0	0	0	0
Charlto	3	0	0	2	1	0	0	0	0	0	0	0	0
Chatha	8	0	0	8	0	0	0	0	0	0	0	0	0
Chattoo	2	0	0	1	0	1	0	0	0	0	0	0	0
Cherok	27	0	0	21	2	4	0	0	0	0	0	0	0
Clarke	10	0	0	5	1	4	0	0	0	0	0	0	0
Clayton	18	0	0	3	6	9	0	0	0	0	0	0	0
Cobb	17	0	0	6	7	4	0	0	0	0	0	0	0

Coffee	7	0	0	2	4	1	0	0	0	0	0	0	0
Colquit	14	0	0	4	8	2	0	0	0	0	0	0	0
Columb	7	0	0	3	1	3	0	0	0	0	0	0	0
Cook	3	0	0	1	0	2	0	0	0	0	0	0	0
Coweta	6	0	0	1	3	2	0	0	0	0	0	0	0
Crisp	2	0	0	1	1	0	0	0	0	0	0	0	0
Dade	2	0	0	2	0	0	0	0	0	0	0	0	0
DeKalb	30	0	0	21	9	0	0	0	0	0	0	0	0
Dodge	8	0	0	1	0	7	0	0	0	0	0	0	0
Dooly	1	0	0	1	0	0	0	0	0	0	0	0	0
Dough	6	1	0	1	4	1	0	0	0	0	0	0	0
Dougla	11	0	0	3	6	2	0	0	0	0	0	0	0
Effingh	1	0	0	1	0	0	0	0	0	0	0	0	0
Elbert	3	0	0	1	1	1	0	0	0	0	0	0	0
Fayette	2	0	0	1	0	1	0	0	0	0	0	0	0
Floyd	21	0	0	14	7	0	0	0	0	0	0	0	0
Gilmer	1	0	0	1	0	0	0	0	0	0	0	0	0
Glynn	14	0	0	9	3	2	0	0	0	0	0	0	0
Gordon	8	0	0	5	2	1	0	0	0	0	0	0	0
Grady	12	2	0	2	8	2	0	0	0	0	0	0	0
Greene	2	0	0	1	1	0	0	0	0	0	0	0	0
Gwinne	42	0	0	23	10	9	0	0	0	0	0	0	0
Habersl	4	0	0	4	0	0	0	0	0	0	0	0	0
Hall	3	0	0	3	0	0	0	0	0	0	0	0	0
Haralso	4	0	0	2	0	2	0	0	0	0	0	0	0
Harris	4	0	0	2	0	2	0	0	0	0	0	0	0
Heard	2	0	0	2	0	0	0	0	0	0	0	0	0
Housto	22	0	0	10	8	4	0	0	0	0	0	0	0
Jackso	3	0	0	1	2	0	0	0	0	0	0	0	0
Laurens	8	0	0	4	3	1	0	0	0	0	0	0	0
Liberty	1	0	0	1	0	0	0	0	0	0	0	0	0

Long	1	0	0	1	0	0	0	0	0	0	0	0	0
Lownde	33	0	0	11	13	9	0	0	0	0	0	0	0
Lumpki	2	0	0	1	0	1	0	0	0	0	0	0	0
McDuff	1	0	0	1	0	0	0	0	0	0	0	0	0
McInto:	1	0	0	1	0	0	0	0	0	0	0	0	0
Mitchel	4	0	0	1	3	0	0	0	0	0	0	0	0
Monroe	2	0	0	2	0	0	0	0	0	0	0	0	0
Murray	2	0	0	1	1	0	0	0	0	0	0	0	0
Muscog	40	0	0	15	11	14	0	0	0	0	0	0	0
Newtor	8	0	0	2	5	1	0	0	0	0	0	0	0
Peach	4	0	0	2	0	2	0	0	0	0	0	0	0
Pierce	4	0	0	2	0	2	0	0	0	0	0	0	0
Polk	25	0	0	16	5	4	0	0	0	0	0	0	0
Richmo	39	0	0	12	21	6	0	0	0	0	0	0	0
Rockda	5	0	0	2	1	2	0	0	0	0	0	0	0
Schley	1	0	0	1	0	0	0	0	0	0	0	0	0
Screver	5	0	0	3	2	0	0	0	0	0	0	0	0
South C	2	0	0	2	0	0	0	0	0	0	0	0	0
Spaldin	13	0	0	6	3	4	0	0	0	0	0	0	0
Stephe	2	0	0	2	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	1	0	0	0	0	0	0	0	0	0
Sumter	3	0	0	1	1	1	0	0	0	0	0	0	0
Tattnall	1	0	0	1	0	0	0	0	0	0	0	0	0
Thomas	19	1	0	1	15	3	0	0	0	0	0	0	0
Tift	8	0	0	7	0	1	0	0	0	0	0	0	0
Toombs	3	0	0	2	0	1	0	0	0	0	0	0	0
Troup	10	0	0	5	4	1	0	0	0	0	0	0	0
Twiggs	1	0	0	1	0	0	0	0	0	0	0	0	0
Upson	3	0	0	3	0	0	0	0	0	0	0	0	0
Other C	1	0	0	1	0	0	0	0	0	0	0	0	0
Walker	7	0	0	1	5	1	0	0	0	0	0	0	0

Walton	3	0	0	2	1	0	0	0	0	0	0	0	0
Ware	7	0	0	5	1	1	0	0	0	0	0	0	0
Washin	1	0	0	1	0	0	0	0	0	0	0	0	0
Wayne	4	0	0	3	1	0	0	0	0	0	0	0	0
Wheele	1	0	0	1	0	0	0	0	0	0	0	0	0
White	4	0	0	1	0	3	0	0	0	0	0	0	0
Whitfie	25	0	0	15	7	3	0	0	0	0	0	0	0
Wilcox	2	0	0	2	0	0	0	0	0	0	0	0	0
Wilkes	2	0	0	2	0	0	0	0	0	0	0	0	0
Wilkins	1	0	0	1	0	0	0	0	0	0	0	0	0
Applinç	2	0	0	0	1	1	0	0	0	0	0	0	0
Atkinso	1	0	0	0	1	0	0	0	0	0	0	0	0
Barrow	2	0	0	0	2	0	0	0	0	0	0	0	0
Burke	1	0	0	0	1	0	0	0	0	0	0	0	0
Butts	2	0	0	0	2	0	0	0	0	0	0	0	0
Emanue	1	0	0	0	1	0	0	0	0	0	0	0	0
Henry	9	0	0	0	5	4	0	0	0	0	0	0	0
Jasper	1	0	0	0	1	0	0	0	0	0	0	0	0
Jeff Da	1	0	0	0	1	0	0	0	0	0	0	0	0
Lanier	1	0	0	0	0	1	0	0	0	0	0	0	0
Madiso	2	0	0	0	1	1	0	0	0	0	0	0	0
Marion	1	0	0	0	1	0	0	0	0	0	0	0	0
Oconee	1	0	0	0	1	0	0	0	0	0	0	0	0
Pauldin	10	0	0	0	6	4	0	0	0	0	0	0	0
Pike	1	0	0	0	1	0	0	0	0	0	0	0	0
Quitma	3	0	0	0	1	2	0	0	0	0	0	0	0
Randol	1	0	0	0	1	0	0	0	0	0	0	0	0
Talbot	2	0	0	0	1	1	0	0	0	0	0	0	0
Telfair	2	0	0	0	1	1	0	0	0	0	0	0	0
Tennes	2	0	0	0	2	0	0	0	0	0	0	0	0
Terrell	1	0	0	0	1	0	0	0	0	0	0	0	0

Turner	3	0	0	0	2	1	0	0	0	0	0	0	0
Warren	2	0	0	0	1	1	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	1	0	0	0	0	0	0	0
Forsyth	1	0	0	0	0	1	0	0	0	0	0	0	0
Hart	1	0	0	0	0	1	0	0	0	0	0	0	0
Oglethc	1	0	0	0	0	1	0	0	0	0	0	0	0
Baker	0	2	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,479**	**453**	**0**	**473**	**331**	**191**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms	Total
General Operating	0	0	2	2
Cystoscopy (OR Suite)	0	0	0	0
Endoscopy (OR Suite)	0	0	0	0
	0	0	0	0
Total	0	0	2	2

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	548	548
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	548	548

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	453	453
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	453	453

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	0
Asian	0
Black/African American	143
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	310
Multi-Racial	0
Total	453

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	19
Ages 15-64	266
Ages 65-74	114
Ages 75-85	45
Ages 85 and Up	9
Total	453

3. Gender

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

Gender	Number of Ambulatory Patients
Male	205
Female	248
Total	453

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	182
Medicaid	38
Third-Party	215
Self-Pay	18
Total	453

Psychiatric/Substance Abuse Services Addendum

Part A: Psychiatric and Substance Abuse Data by Program

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	12	12
B- General Acute Psychiatric Adolescents 13-17	6	6
C- General Acute Psychiatric Children 12 and under	6	6
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F- Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	473	3,574	460	3,467	2,464	☐
General Acute Psychiatric Adolescents 13-17	331	1,986	332	1,980	4,427	☐
General Acute Psychiatric Children 12 and Under	191	1,155	190	1,131	2,025	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

Part B: Psychiatric and Substance Abuse Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	1	10
Black/African American	436	2,847
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	558	3,858
White	0	0
Multi-Racial	0	0
Total	995	6,715

2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications

Gender of Patient	Number of Admissions	Inpatient Days
Male	538	3,577
Female	457	3,138
Total	995	6,715

Total Psych Admissions from Patient Origin Table
995

3. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	287	2,431
Medicaid	588	3,610
Third-Party	97	591
Self-Pay	23	83
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

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	1	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?

Employee Orientation, pamphlets, online training

What is the most urgent tool or resource you need in order to increase your ability to provide Culturally and Linguistically Appropriate Services (CLAS) to your patients?

Interpreters

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

Language One:

English

Language Two:

Spanish

Language Three:

Language Four:

If an unisured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? (Check the box, if yes) ☑

If you checked yes, what is the name and location of that health care center or clinic?

Southwest Georgia Healthcare Clinic, Inc. Donalsonville, GA

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
Shana Butler	207 Phillips St., Colc	5 years	GA	No	January 2013-Present
Taylor Johnson	830 SW St, Apt C, Ba	2 years	GA	No	January 2023-Present

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.**

Authorized Signature

Kay Livingston

Date

02/26/2026

Title

CFO

Comments