Georgia Department of Community Health

2022 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP416

Facility Name: Children's Healthcare of Atlanta at Egleston

County: DeKalb

Street Address: 1405 Clifton Road NE

City: Atlanta

Zip: 30322-1101

Mailing Address: 1405 Clifton Road NE

Mailing City: Atlanta

Mailing Zip: 30322-1101

Medicaid Provider Number: 000000943A

Medicare Provider Number: 113300

2. Report Period

Report Data for the full twelve month period- January 1, 2022 through December 31, 2022.
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: Ariel Zhang

Contact Title: Senior Financial Analyst

Phone: 404-785-5721

Fax: 404-785-7027

E-mail: ariel.zhang@choa.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)	Organization Type	Effective Date
Egleston Children's Hospital at Emory University	Not for Profit	2/1/1998

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Children's Healthcare of Atlanta	Not for Profit	2/1/1998

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

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 checked, 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: Children's Healthcare of Atlanta
City: Atlanta **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: HSOC Inc
City: Atlanta **State:** GA

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: The Children's Care Network, Inc.
City: Atlanta **State:** GA

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

9. 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)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. 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	☐	☐	☐	☐
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. Dod not include newborn and neonatal services. Do not include long-term care untits, 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)	202	8,526	51,258	10,456	50,896
Pediatric ICU	46	1,985	10,710	685	10,657
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	0	0	0	0	0
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	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
CICU	32	663	8,865	62	8,937
	0	0	0	0	0
	0	0	0	0	0
Total	**280**	**11,174**	**70,833**	**11,203**	**70,490**

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	27	77
Asian	303	1,440
Black/African American	5,578	34,148
Hispanic/Latino	1,416	11,166
Pacific Islander/Hawaiian	12	44
White	3,538	21,697
Multi-Racial	300	2,261
Total	**11,174**	**70,833**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,928	36,188
Female	5,246	34,645
Total	**11,174**	**70,833**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	103	648
Medicaid	6,557	43,181
Peachare	426	2,103
Third-Party	3,888	23,747
Self-Pay	200	1,154
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

169

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2022 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,694
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	10,343
Average Total Charge for an Inpatient Day	17,385

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

81,987

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

6,883

3. Beds Available
Please report the number of beds available in ER as of the last day of the report period.

45

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	4	1,954
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	41	80,033
	0	0
	0	0
	0	0
	0	0

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

1,259

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

243,844

7. Observation Visits/Cases
Please provide the total number of Observation visits/cases for the entire report period.

7,806

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

159.00

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.

4,785

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	2	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	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	1,454
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	15
Number of Heart Transplants	11
Number of Other-Organ/Tissues Treatments	96
Number of Diagnostic X-Ray Procedures	83,907
Number of CTS Units (machines)	2
Number of CTS Procedures	7,597
Number of Diagnostic Radioisotope Procedures	1,527
Number of PET Units (machines)	1
Number of PET Procedures	363
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	3
Number of Number of MRI Procedures	9,825
Number of Chemotherapy Treatments	6,772
Number of Respiratory Therapy Treatments	135,898
Number of Occupational Therapy Treatments	21,106
Number of Physical Therapy Treatments	31,358
Number of Speech Pathology Patients	1,134
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	996
Number of HIV/AIDS Diagnostic Procedures	1,133
Number of HIV/AIDS Patients	6
Number of Ambulance Trips	3,898
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	16,067
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).

246

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
0	0	

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2022. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2022.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	274.57	4.48	0.00
Physician Assistants Only (not including Licensed Physicians)	24.68	0.58	0.00
Registered Nurses (RNs-Advanced Practice*)	1,413.64	69.30	95.80
Licensed Practical Nurses (LPNs)	30.32	7.95	0.00
Pharmacists	39.76	2.00	0.00
Other Health Services Professionals*	1,135.51	62.09	40.40
Administration and Support	2,084.67	126.79	0.00
All Other Hospital Personnel (not included above)	49.24	0.00	0.00

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 Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	More than 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

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	0	☐	0	0
General Internal Medicine	0	☐	0	0
Pediatricians	206	☑	111	0
Other Medical Specialties	302	☑	206	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	4	☐	2	0
Ophthalmology Surgery	37	☐	18	0
Orthopedic Surgery	12	☐	10	0
Plastic Surgery	6	☐	3	0
General Surgery	17	☐	8	0
Thoracic Surgery	6	☐	3	0
Other Surgical Specialties	77	☐	54	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	42	☑	31	0
Dermatology	18	☐	14	0
Emergency Medicine	50	☑	39	0
Nuclear Medicine	0	☐	0	0
Pathology	20	☑	12	0
Psychiatry	19	☐	13	0
Radiology	49	☑	36	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 surgeons) with Admitting Privleges	8
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	367

5b. Name of Other Professions

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

PA, PAA, NP, PhD, CRNA, CNS, RNFA, and PsyD.

Comments and Suggestions:

1. Budgeted FTEs for Registered Nurses include Nurse Practitioners and APPs
2. Vacant FTEs reflect actual open/vacant positions as of 12/31/2022

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

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
Rehab=Inpatient Rehabilitation
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

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	50	83	0	0	0	0	0	0	0	0	0	0	0
Appling	3	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	2	5	0	0	0	0	0	0	0	0	0	0	0
Bacon	2	0	0	0	0	0	0	0	0	0	0	0	0
Baker	0	2	0	0	0	0	0	0	0	0	0	0	0
Baldwin	35	13	0	0	0	0	0	0	0	0	0	0	0
Banks	26	21	0	0	0	0	0	0	0	0	0	0	0
Barrow	113	114	0	0	0	0	0	0	0	0	0	0	0
Bartow	99	83	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	2	5	0	0	0	0	0	0	0	0	0	0	0
Berrien	9	8	0	0	0	0	0	0	0	0	0	0	0
Bibb	98	87	0	0	0	0	0	0	0	0	0	0	0
Bleckley	10	7	0	0	0	0	0	0	0	0	0	0	0
Brantley	0	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	5	6	0	0	0	0	0	0	0	0	0	0	0
Bryan	5	2	0	0	0	0	0	0	0	0	0	0	0
Bulloch	9	22	0	0	0	0	0	0	0	0	0	0	0
Burke	1	1	0	0	0	0	0	0	0	0	0	0	0
Butts	54	45	0	0	0	0	0	0	0	0	0	0	0
Calhoun	2	2	0	0	0	0	0	0	0	0	0	0	0
Camden	3	3	0	0	0	0	0	0	0	0	0	0	0
Candler	6	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	159	159	0	0	0	0	0	0	0	0	0	0	0
Catoosa	2	10	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	40	29	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	2	0	0	0	0	0	0	0	0	0	0	0

Chattooga	12	13	0	0	0	0	0	0	0	0	0	0	0
Cherokee	142	169	0	0	0	0	0	0	0	0	0	0	0
Clarke	101	95	0	0	0	0	0	0	0	0	0	0	0
Clay	1	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	633	383	0	0	0	0	0	0	0	0	0	0	0
Clinch	9	5	0	0	0	0	0	0	0	0	0	0	0
Cobb	457	556	0	0	0	0	0	0	0	0	0	0	0
Coffee	12	9	0	0	0	0	0	0	0	0	0	0	0
Colquitt	20	15	0	0	0	0	0	0	0	0	0	0	0
Columbia	18	7	0	0	0	0	0	0	0	0	0	0	0
Cook	6	6	0	0	0	0	0	0	0	0	0	0	0
Coweta	236	215	0	0	0	0	0	0	0	0	0	0	0
Crawford	0	4	0	0	0	0	0	0	0	0	0	0	0
Crisp	20	8	0	0	0	0	0	0	0	0	0	0	0
Dade	1	3	0	0	0	0	0	0	0	0	0	0	0
Dawson	22	31	0	0	0	0	0	0	0	0	0	0	0
Decatur	12	11	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,876	1,228	0	0	0	0	0	0	0	0	0	0	0
Dodge	17	3	0	0	0	0	0	0	0	0	0	0	0
Dooly	4	3	0	0	0	0	0	0	0	0	0	0	0
Dougherty	43	50	0	0	0	0	0	0	0	0	0	0	0
Douglas	184	152	0	0	0	0	0	0	0	0	0	0	0
Early	10	2	0	0	0	0	0	0	0	0	0	0	0
Echols	1	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	8	8	0	0	0	0	0	0	0	0	0	0	0
Elbert	22	8	0	0	0	0	0	0	0	0	0	0	0
Emanuel	3	3	0	0	0	0	0	0	0	0	0	0	0
Evans	3	4	0	0	0	0	0	0	0	0	0	0	0
Fannin	4	11	0	0	0	0	0	0	0	0	0	0	0
Fayette	154	158	0	0	0	0	0	0	0	0	0	0	0
Florida	43	16	0	0	0	0	0	0	0	0	0	0	0
Floyd	63	59	0	0	0	0	0	0	0	0	0	0	0
Forsyth	97	120	0	0	0	0	0	0	0	0	0	0	0
Franklin	21	33	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,523	1,270	0	0	0	0	0	0	0	0	0	0	0
Gilmer	9	16	0	0	0	0	0	0	0	0	0	0	0
Glascock	2	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	11	8	0	0	0	0	0	0	0	0	0	0	0
Gordon	34	31	0	0	0	0	0	0	0	0	0	0	0
Grady	4	16	0	0	0	0	0	0	0	0	0	0	0
Greene	12	10	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	1,049	984	0	0	0	0	0	0	0	0	0	0	0
Habersham	57	65	0	0	0	0	0	0	0	0	0	0	0
Hall	218	181	0	0	0	0	0	0	0	0	0	0	0

Hancock	1	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	34	39	0	0	0	0	0	0	0	0	0	0	0
Harris	16	30	0	0	0	0	0	0	0	0	0	0	0
Hart	19	13	0	0	0	0	0	0	0	0	0	0	0
Heard	14	11	0	0	0	0	0	0	0	0	0	0	0
Henry	669	443	0	0	0	0	0	0	0	0	0	0	0
Houston	138	101	0	0	0	0	0	0	0	0	0	0	0
Irwin	1	5	0	0	0	0	0	0	0	0	0	0	0
Jackson	94	111	0	0	0	0	0	0	0	0	0	0	0
Jasper	24	17	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	10	2	0	0	0	0	0	0	0	0	0	0	0
Jefferson	3	2	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	14	4	0	0	0	0	0	0	0	0	0	0	0
Jones	8	8	0	0	0	0	0	0	0	0	0	0	0
Lamar	24	35	0	0	0	0	0	0	0	0	0	0	0
Laurens	15	20	0	0	0	0	0	0	0	0	0	0	0
Lee	13	27	0	0	0	0	0	0	0	0	0	0	0
Liberty	13	7	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	0	0	0	0	0	0	0	0	0	0	0	0
Long	4	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	28	30	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	17	21	0	0	0	0	0	0	0	0	0	0	0
Macon	6	1	0	0	0	0	0	0	0	0	0	0	0
Madison	29	17	0	0	0	0	0	0	0	0	0	0	0
Marion	3	3	0	0	0	0	0	0	0	0	0	0	0
Meriwether	23	14	0	0	0	0	0	0	0	0	0	0	0
Miller	0	6	0	0	0	0	0	0	0	0	0	0	0
Mitchell	12	11	0	0	0	0	0	0	0	0	0	0	0
Monroe	13	16	0	0	0	0	0	0	0	0	0	0	0
Montgomery	3	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	27	23	0	0	0	0	0	0	0	0	0	0	0
Murray	7	12	0	0	0	0	0	0	0	0	0	0	0
Muscogee	175	194	0	0	0	0	0	0	0	0	0	0	0
Newton	326	244	0	0	0	0	0	0	0	0	0	0	0
North Carolina	12	5	0	0	0	0	0	0	0	0	0	0	0
Oconee	26	34	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	7	5	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	67	43	0	0	0	0	0	0	0	0	0	0	0
Paulding	136	133	0	0	0	0	0	0	0	0	0	0	0
Peach	17	40	0	0	0	0	0	0	0	0	0	0	0
Pickens	23	17	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	5	0	0	0	0	0	0	0	0	0	0	0
Pike	27	27	0	0	0	0	0	0	0	0	0	0	0

Polk	25	37	0	0	0	0	0	0	0	0	0	0	0
Pulaski	12	10	0	0	0	0	0	0	0	0	0	0	0
Putnam	15	17	0	0	0	0	0	0	0	0	0	0	0
Quitman	2	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	13	21	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	18	9	0	0	0	0	0	0	0	0	0	0	0
Rockdale	208	135	0	0	0	0	0	0	0	0	0	0	0
Schley	4	4	0	0	0	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	4	0	0	0	0	0	0	0	0	0	0	0
South Carolina	27	17	0	0	0	0	0	0	0	0	0	0	0
Spalding	145	102	0	0	0	0	0	0	0	0	0	0	0
Stephens	33	39	0	0	0	0	0	0	0	0	0	0	0
Sumter	14	15	0	0	0	0	0	0	0	0	0	0	0
Talbot	1	6	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	2	0	0	0	0	0	0	0	0	0	0	0
Tattnall	5	4	0	0	0	0	0	0	0	0	0	0	0
Taylor	6	2	0	0	0	0	0	0	0	0	0	0	0
Telfair	8	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	15	12	0	0	0	0	0	0	0	0	0	0	0
Terrell	6	3	0	0	0	0	0	0	0	0	0	0	0
Thomas	20	24	0	0	0	0	0	0	0	0	0	0	0
Tift	18	25	0	0	0	0	0	0	0	0	0	0	0
Toombs	7	17	0	0	0	0	0	0	0	0	0	0	0
Towns	5	4	0	0	0	0	0	0	0	0	0	0	0
Treutlen	2	2	0	0	0	0	0	0	0	0	0	0	0
Troup	125	83	0	0	0	0	0	0	0	0	0	0	0
Turner	3	5	0	0	0	0	0	0	0	0	0	0	0
Twiggs	4	0	0	0	0	0	0	0	0	0	0	0	0
Union	10	19	0	0	0	0	0	0	0	0	0	0	0
Upson	21	15	0	0	0	0	0	0	0	0	0	0	0
Walker	9	14	0	0	0	0	0	0	0	0	0	0	0
Walton	287	208	0	0	0	0	0	0	0	0	0	0	0
Ware	4	3	0	0	0	0	0	0	0	0	0	0	0
Washington	5	7	0	0	0	0	0	0	0	0	0	0	0
Wayne	8	2	0	0	0	0	0	0	0	0	0	0	0
Webster	0	1	0	0	0	0	0	0	0	0	0	0	0
Wheeler	0	1	0	0	0	0	0	0	0	0	0	0	0
White	26	32	0	0	0	0	0	0	0	0	0	0	0
Whitfield	27	35	0	0	0	0	0	0	0	0	0	0	0
Wilcox	1	4	0	0	0	0	0	0	0	0	0	0	0
Wilkes	3	1	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	8	7	0	0	0	0	0	0	0	0	0	0	0

Worth	8	7	0	0	0	0	0	0	0	0	0	0	0
Total	**11,174**	**9,418**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

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
General Operating	0	0	12
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
Cardiac	3	0	0
Total	**3**	**0**	**12**

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
General Operating	0	0	16,158	20,172
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	4,307	0	0	0
Total	**4,307**	**0**	**16,158**	**20,172**

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
General Operating	0	0	3,373	9,418
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	529	0	0	0
Total	**529**	**0**	**3,373**	**9,418**

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	15
Asian	292
Black/African American	3,805
Hispanic/Latino	1,311
Pacific Islander/Hawaiian	12
White	3,682
Multi-Racial	301
Total	**9,418**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,707
Ages 15-64	1,711
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**9,418**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,708
Female	3,710
Total	**9,418**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	7
Medicaid	5,186
Third-Party	4,126
Self-Pay	99

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

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)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	50	502	16,546	502

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	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

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	0	0
Ages 15-44	0	0
Ages 45 and Up	0	0
Total	**0**	**0**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$0.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$0.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, 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	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. 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	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

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	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
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	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
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 : Psych/SA 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	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

3. Payment Source

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

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 7.7300000190735 (FTE's)
What languages do they interpret?
SPANISH

2. 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	☑	Bilingual Member of Patient's Family	☐
Community Volunteer Intrepreter	☐	Telephone Interpreter Service	☑
Refer Patient to Outside Agency	☐	Other (please describe):	☑

VIDEO REMOTE INTERPRETER SERVICE, CONTRACT INTERPRETER ON-SITE

3. 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	9.7%	0	0	0
PORTUGUESE	0.2%	0	0	0
BURMESE	0.1%	0	0	0

4. 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?

CULTURAL SENSITIVITY AND WORKING EFFECTIVELY WITH AN INTERPRETER TRAININGS

AT NEW HIRE PATIENT CARE PROVIDER ORIENTATION

5. 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?

Increased FTE for on-site interpreters for Spanish

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

1. ENGLISH
2. SPANISH
3.
4.

7. 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?

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care

Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

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.

Authorized Signature: Linda Cole

Date: 3/3/2023

Title: Chief Nursing & Hospital Operations Officer

Comments:

1. Children's Healthcare of Atlanta does not track the race and ethnicity of physicians.
2. A complete list of nurses and other employed staff that speak the languages listed in Q3 of the minority health addendum is not available.
3. Children's provides emergency department services regardless of a patient's ability to pay in accordance with EMTALA. Children's has financial counselors available to assist uninsured patients in applying to Medicaid.
4.Budgeted Staff reported under Part G includes allocated FTEs from Corporate Support and Physician Practice.

Georgia Department of Community Health

2022 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP518

Facility Name: Children's Healthcare of Atlanta at Scottish Rite

County: Fulton

Street Address: 1001 Johnson Ferry Road NE

City: Atlanta

Zip: 30342-1605

Mailing Address: 1001 Johnson Ferry Road NE

Mailing City: Atlanta

Mailing Zip: 30342-1605

Medicaid Provider Number: 000001636A

Medicare Provider Number: 13301

2. Report Period

Report Data for the full twelve month period- January 1, 2022 through December 31, 2022.
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: Ariel Zhang

Contact Title: Senior Financial Analyst

Phone: 404-785-5721

Fax: 404-785-7027

E-mail: ariel.zhang@choa.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)	Organization Type	Effective Date
Scottish Rite Children's Medical Center, Inc.	Not for Profit	2/1/1998

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Children's Healthcare of Atlanta	Not for Profit	2/1/1998

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A		

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 checked, 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: : Children's Healthcare of Atlanta, Inc.

City: Atlanta **State:** GA

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

Name:

City: Atlanta **State:** GA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: CHOA Surgery Center at Meridian Mark Plaza, LLC
City: Atlanta **State:** GA

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: The Children's Care Network, Inc.
City: Atlanta **State:** GA

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

9. 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)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. 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	☐	☐	☐	☐
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. Dod not include newborn and neonatal services. Do not include long-term care untits, 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)	185	10,469	50,569	13,271	50,468
Pediatric ICU	67	3,791	16,534	908	16,419
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	0	0	0	0	0
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)	28	296	8,263	432	8,294
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	**280**	**14,556**	**75,366**	**14,611**	**75,181**

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	49	132
Asian	586	2,829
Black/African American	4,549	27,388
Hispanic/Latino	2,848	15,267
Pacific Islander/Hawaiian	21	154
White	6,119	27,702
Multi-Racial	384	1,894
Total	**14,556**	**75,366**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,861	38,504
Female	6,695	36,862
Total	**14,556**	**75,366**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	4	30
Medicaid	7,072	40,150
Peachare	557	3,031
Third-Party	6,589	30,725
Self-Pay	334	1,430
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

103

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2022 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,694
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	10,343
Average Total Charge for an Inpatient Day	12,547

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

111,227

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

9,408

3. Beds Available
Please report the number of beds available in ER as of the last day of the report period.

61

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

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	4	2,141
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	57	109,086
	0	0
	0	0
	0	0
	0	0

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

1,178

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

246,771

7. Observation Visits/Cases
Please provide the total number of Observation visits/cases for the entire report period.

9,718

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

50.00

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.

2,260

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	3	4
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	3	4
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
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	77,014
Number of CTS Units (machines)	4
Number of CTS Procedures	11,880
Number of Diagnostic Radioisotope Procedures	871
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	6
Number of Number of MRI Procedures	17,774
Number of Chemotherapy Treatments	5,959
Number of Respiratory Therapy Treatments	183,153
Number of Occupational Therapy Treatments	91,073
Number of Physical Therapy Treatments	273,630
Number of Speech Pathology Patients	3,311
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	4,854
Number of HIV/AIDS Diagnostic Procedures	752
Number of HIV/AIDS Patients	3
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	11
Number of Ultrasound/Medical Sonography Procedures	23,952
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).

192

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
1	59	DaVinci

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2022. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2022.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	200.72	3.52	0.00
Physician Assistants Only (not including Licensed Physicians)	14.26	0.62	0.00
Registered Nurses (RNs-Advanced Practice*)	1,117.43	54.05	52.40
Licensed Practical Nurses (LPNs)	23.17	3.15	0.00
Pharmacists	36.59	1.00	0.00
Other Health Services Professionals*	1,205.18	93.74	36.90
Administration and Support	1,744.11	114.71	0.00
All Other Hospital Personnel (not included above)	37.05	0.00	0.00

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 Needed to Fill Vacancies
Physician's Assistants	31-60 Days
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	31-60 Days
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	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	0	☐	0	0
General Internal Medicine	0	☐	0	0
Pediatricians	127	☑	102	0
Other Medical Specialties	162	☑	135	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	13	☐	12	0
Orthopedic Surgery	25	☐	18	0
Plastic Surgery	12	☐	3	0
General Surgery	16	☐	9	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	74	☐	61	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	27	☑	25	0
Dermatology	1	☐	1	0
Emergency Medicine	51	☑	41	0
Nuclear Medicine	0	☐	0	0
Pathology	7	☑	7	0
Psychiatry	5	☐	3	0
Radiology	6	☑	5	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 surgeons) with Admitting Privleges	28
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	278

5b. Name of Other Professions

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

PA, PAA, NP, PhD, CRNA, CNS, RNFA, and PsyD.

Comments and Suggestions:

1. Budgeted FTEs for Registered Nurses include Nurse Practitioners and APPs
2. Vacant FTEs reflect actual open/vacant positions as of 12/31/2022

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

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
Rehab=Inpatient Rehabilitation
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

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	67	65	0	0	0	0	0	0	0	0	0	0	0
Appling	3	2	0	0	0	0	0	0	0	0	0	0	0
Atkinson	1	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	1	2	0	0	0	0	0	0	0	0	0	0	0
Baker	2	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	13	10	0	0	0	0	0	0	0	0	0	0	0
Banks	36	46	0	0	0	0	0	0	0	0	0	0	0
Barrow	203	268	0	0	0	0	0	0	0	0	0	0	0
Bartow	233	199	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	5	4	0	0	0	0	0	0	0	0	0	0	0
Berrien	3	6	0	0	0	0	0	0	0	0	0	0	0
Bibb	58	55	0	0	0	0	0	0	0	0	0	0	0
Bleckley	3	5	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	2	0	0	0	0	0	0	0	0	0	0	0
Brooks	2	4	0	0	0	0	0	0	0	0	0	0	0
Bryan	4	3	0	0	0	0	0	0	0	0	0	0	0
Bulloch	8	1	0	0	0	0	0	0	0	0	0	0	0
Burke	4	9	0	0	0	0	0	0	0	0	0	0	0
Butts	28	53	0	0	0	0	0	0	0	0	0	0	0
Calhoun	2	0	0	0	0	0	0	0	0	0	0	0	0
Camden	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	279	260	0	0	0	0	0	0	0	0	0	0	0
Catoosa	3	6	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	16	21	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	2	0	0	0	0	0	0	0	0	0	0	0
Chattooga	9	23	0	0	0	0	0	0	0	0	0	0	0

Cherokee	714	703	0	0	0	0	0	0	0	0	0	0	0
Clarke	107	93	0	0	0	0	0	0	0	0	0	0	0
Clayton	324	368	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,813	1,442	0	0	0	0	0	0	0	0	0	0	0
Coffee	6	10	0	0	0	0	0	0	0	0	0	0	0
Colquitt	14	16	0	0	0	0	0	0	0	0	0	0	0
Columbia	13	49	0	0	0	0	0	0	0	0	0	0	0
Cook	11	14	0	0	0	0	0	0	0	0	0	0	0
Coweta	225	243	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	2	0	0	0	0	0	0	0	0	0	0	0
Crisp	8	6	0	0	0	0	0	0	0	0	0	0	0
Dade	1	3	0	0	0	0	0	0	0	0	0	0	0
Dawson	93	133	0	0	0	0	0	0	0	0	0	0	0
Decatur	13	7	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,269	1,345	0	0	0	0	0	0	0	0	0	0	0
Dodge	13	6	0	0	0	0	0	0	0	0	0	0	0
Dooly	2	5	0	0	0	0	0	0	0	0	0	0	0
Dougherty	43	33	0	0	0	0	0	0	0	0	0	0	0
Douglas	338	219	0	0	0	0	0	0	0	0	0	0	0
Early	5	5	0	0	0	0	0	0	0	0	0	0	0
Effingham	1	1	0	0	0	0	0	0	0	0	0	0	0
Elbert	22	20	0	0	0	0	0	0	0	0	0	0	0
Emanuel	3	0	0	0	0	0	0	0	0	0	0	0	0
Evans	1	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	21	40	0	0	0	0	0	0	0	0	0	0	0
Fayette	218	256	0	0	0	0	0	0	0	0	0	0	0
Florida	34	48	0	0	0	0	0	0	0	0	0	0	0
Floyd	109	116	0	0	0	0	0	0	0	0	0	0	0
Forsyth	509	595	0	0	0	0	0	0	0	0	0	0	0
Franklin	11	28	0	0	0	0	0	0	0	0	0	0	0
Fulton	2,076	1,988	0	0	0	0	0	0	0	0	0	0	0
Gilmer	71	45	0	0	0	0	0	0	0	0	0	0	0
Glynn	3	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	58	41	0	0	0	0	0	0	0	0	0	0	0
Grady	9	6	0	0	0	0	0	0	0	0	0	0	0
Greene	15	11	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	2,103	2,122	0	0	0	0	0	0	0	0	0	0	0
Habersham	75	88	0	0	0	0	0	0	0	0	0	0	0
Hall	348	458	0	0	0	0	0	0	0	0	0	0	0
Hancock	2	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	64	75	0	0	0	0	0	0	0	0	0	0	0
Harris	24	33	0	0	0	0	0	0	0	0	0	0	0
Hart	12	20	0	0	0	0	0	0	0	0	0	0	0
Heard	9	8	0	0	0	0	0	0	0	0	0	0	0

Henry	342	502	0	0	0	0	0	0	0	0	0	0	0
Houston	84	61	0	0	0	0	0	0	0	0	0	0	0
Irwin	7	5	0	0	0	0	0	0	0	0	0	0	0
Jackson	176	231	0	0	0	0	0	0	0	0	0	0	0
Jasper	14	14	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	2	0	0	0	0	0	0	0	0	0	0	0
Jefferson	1	4	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	3	0	0	0	0	0	0	0	0	0	0	0	0
Jones	8	11	0	0	0	0	0	0	0	0	0	0	0
Lamar	16	24	0	0	0	0	0	0	0	0	0	0	0
Lanier	2	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	13	13	0	0	0	0	0	0	0	0	0	0	0
Lee	12	14	0	0	0	0	0	0	0	0	0	0	0
Liberty	5	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	7	0	0	0	0	0	0	0	0	0	0	0
Lowndes	29	36	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	48	76	0	0	0	0	0	0	0	0	0	0	0
Macon	2	2	0	0	0	0	0	0	0	0	0	0	0
Madison	28	35	0	0	0	0	0	0	0	0	0	0	0
Marion	5	4	0	0	0	0	0	0	0	0	0	0	0
McDuffie	0	12	0	0	0	0	0	0	0	0	0	0	0
Meriwether	25	19	0	0	0	0	0	0	0	0	0	0	0
Miller	0	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	9	6	0	0	0	0	0	0	0	0	0	0	0
Monroe	12	20	0	0	0	0	0	0	0	0	0	0	0
Montgomery	0	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	28	25	0	0	0	0	0	0	0	0	0	0	0
Murray	29	19	0	0	0	0	0	0	0	0	0	0	0
Muscogee	103	110	0	0	0	0	0	0	0	0	0	0	0
Newton	179	209	0	0	0	0	0	0	0	0	0	0	0
North Carolina	26	23	0	0	0	0	0	0	0	0	0	0	0
Oconee	29	44	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	8	7	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	107	43	0	0	0	0	0	0	0	0	0	0	0
Paulding	375	283	0	0	0	0	0	0	0	0	0	0	0
Peach	14	17	0	0	0	0	0	0	0	0	0	0	0
Pickens	82	68	0	0	0	0	0	0	0	0	0	0	0
Pierce	3	4	0	0	0	0	0	0	0	0	0	0	0
Pike	25	48	0	0	0	0	0	0	0	0	0	0	0
Polk	68	71	0	0	0	0	0	0	0	0	0	0	0
Pulaski	4	3	0	0	0	0	0	0	0	0	0	0	0
Putnam	13	16	0	0	0	0	0	0	0	0	0	0	0
Quitman	0	1	0	0	0	0	0	0	0	0	0	0	0

Rabun	19	38	0	0	0	0	0	0	0	0	0	0	0
Randolph	15	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	5	48	0	0	0	0	0	0	0	0	0	0	0
Rockdale	91	119	0	0	0	0	0	0	0	0	0	0	0
Schley	1	2	0	0	0	0	0	0	0	0	0	0	0
Screven	0	1	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	3	0	0	0	0	0	0	0	0	0	0	0
South Carolina	31	18	0	0	0	0	0	0	0	0	0	0	0
Spalding	93	113	0	0	0	0	0	0	0	0	0	0	0
Stephens	40	59	0	0	0	0	0	0	0	0	0	0	0
Stewart	2	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	14	18	0	0	0	0	0	0	0	0	0	0	0
Talbot	4	3	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	0	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	5	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	53	16	0	0	0	0	0	0	0	0	0	0	0
Terrell	0	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	23	18	0	0	0	0	0	0	0	0	0	0	0
Tift	20	19	0	0	0	0	0	0	0	0	0	0	0
Toombs	1	4	0	0	0	0	0	0	0	0	0	0	0
Towns	13	18	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	1	0	0	0	0	0	0	0	0	0	0	0
Troup	68	96	0	0	0	0	0	0	0	0	0	0	0
Turner	1	5	0	0	0	0	0	0	0	0	0	0	0
Twiggs	1	3	0	0	0	0	0	0	0	0	0	0	0
Union	19	30	0	0	0	0	0	0	0	0	0	0	0
Upson	13	24	0	0	0	0	0	0	0	0	0	0	0
Walker	7	16	0	0	0	0	0	0	0	0	0	0	0
Walton	209	264	0	0	0	0	0	0	0	0	0	0	0
Ware	2	3	0	0	0	0	0	0	0	0	0	0	0
Washington	4	2	0	0	0	0	0	0	0	0	0	0	0
Wheeler	1	1	0	0	0	0	0	0	0	0	0	0	0
White	31	51	0	0	0	0	0	0	0	0	0	0	0
Whitfield	21	37	0	0	0	0	0	0	0	0	0	0	0
Wilcox	3	1	0	0	0	0	0	0	0	0	0	0	0
Wilkes	0	2	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	4	3	0	0	0	0	0	0	0	0	0	0	0
Worth	1	2	0	0	0	0	0	0	0	0	0	0	0
Total	**14,556**	**14,888**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

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
General Operating	0	3	14
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**3**	**14**

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
General Operating	0	7,882	13,537	22,414
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**7,882**	**13,537**	**22,414**

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
General Operating	0	3,063	4,011	11,825
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**3,063**	**4,011**	**11,825**

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	10
Asian	584
Black/African American	4,166
Hispanic/Latino	2,621
Pacific Islander/Hawaiian	8
White	7,085
Multi-Racial	414
Total	**14,888**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	12,589
Ages 15-64	2,299
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**14,888**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	8,717
Female	6,171
Total	**14,888**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	3
Medicaid	6,968
Third-Party	7,673
Self-Pay	244

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

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)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	39	515	12,796	515

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	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

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	0	0
Ages 15-44	0	0
Ages 45 and Up	0	0
Total	**0**	**0**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$0.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$0.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, 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	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. 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	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

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	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
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	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
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 : Psych/SA 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	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

3. Payment Source

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

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 16.139999389648 (FTE's)
What languages do they interpret?
SPANISH

2. 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 ☑	Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☑

VIDEO REMOTE INTERPRETER SERVICE, CONTRACTOR ON-SITE

3. 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	11.5%	0	0	0
Portuguese	0.2%	0	0	0
Vietnamese	0.1%	0	0	0

4. 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?

CULTURAL SENSITIVITY TRAINING AND WORKING EFFECTIVELY WITH AN INTERPRETER

TRAININGS AT PATIENT CARE PROVIDER ORIENTATION AT TIME OF HIRE

5. 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?

INCREASED FTE FOR WRITTEN TRANSLATION POSITIONS

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

1. ENGLISH
2. SPANISH
3.
4.

7. 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?

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	7	233
Black/African American	141	4,245
Hispanic/Latino	40	1,189
Pacific Islander/Hawaiian	0	0
White	99	2,444
Multi-Racial	9	152

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	176	4,824
Female	120	3,439

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	281	7,970
18-64	15	293
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	296
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	289
Self Pay	7
Other	0

2. Uncompensated Indigent and Charity Care

Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

9

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

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.

Authorized Signature: Linda Cole

Date: 3/3/2023

Title: Chief Nursing & Hospital Operations Officer

Comments:

1. Children's Healthcare of Atlanta does not track the race and ethnicity of physicians.
2. A complete list of nurses and other employed staff that speak the languages listed in Q3 of the minority health addendum is not available.
3. Children's provides emergency department services regardless of a patient's ability to pay in accordance with EMTALA. Children's has financial counselors available to assist uninsured patients in applying to Medicaid.
4. The number of MRI units reported under F1b (6) includes 1 iMRI unit which is used for both intra-operative procedures and diagnostic scans. The number of MRI procedures only include the diagnostic component.
5. Budgeted Staff reported under Part G includes allocated FTEs from Corporate Support and Physician Practice.