GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2023 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

Mailing Address: 1405 Clifton Road NE

Mailing City: Atlanta

Mailing Zip: 30322

Medicaid Provider Number: 000000943A

Medicare Provider Number: 113300

2. Report Period

Report Data for the full twelve month period- January 1, 2023 through December 31, 2023.
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	8,372	56,049	10,369	55,273
Pediatric ICU	46	1,989	10,937	643	10,284
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	696	9,649	67	9,076
	0	0	0	0	0
	0	0	0	0	0
Total	**280**	**11,057**	**76,635**	**11,079**	**74,633**

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	32	275
Asian	305	1,934
Black/African American	5,482	36,904
Hispanic/Latino	1,495	10,393
Pacific Islander/Hawaiian	11	37
White	3,462	25,097
Multi-Racial	270	1,995
Total	**11,057**	**76,635**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,918	39,182
Female	5,139	37,453
Total	**11,057**	**76,635**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	121	841
Medicaid	6,304	45,054
Peachare	432	2,443
Third-Party	3,880	26,961
Self-Pay	320	1,336
Other	0	0

5. Discharges to Death

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

160

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2023 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,822
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	10,123
Average Total Charge for an Inpatient Day	17,463

Part E : Emergency Department and Outpatient Services

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

80,327

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

7,430

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	1,980
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	41	78,347
	0	0
	0	0
	0	0
	0	0

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

1,177

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

246,952

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

8,140

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

17.00

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.

2,155

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	1,298
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	22
Number of Heart Transplants	15
Number of Other-Organ/Tissues Treatments	84
Number of Diagnostic X-Ray Procedures	77,036
Number of CTS Units (machines)	2
Number of CTS Procedures	8,150
Number of Diagnostic Radioisotope Procedures	2,006
Number of PET Units (machines)	1
Number of PET Procedures	342
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	3
Number of Number of MRI Procedures	10,134
Number of Chemotherapy Treatments	6,274
Number of Respiratory Therapy Treatments	155,201
Number of Occupational Therapy Treatments	24,970
Number of Physical Therapy Treatments	36,953
Number of Speech Pathology Patients	1,294
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,162
Number of HIV/AIDS Diagnostic Procedures	1,639
Number of HIV/AIDS Patients	5
Number of Ambulance Trips	4,840
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	17,320
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 12-31-2023. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2023.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	311.00	3.70	0.00
Physician Assistants Only (not including Licensed Physicians)	28.40	3.20	0.00
Registered Nurses (RNs-Advanced Practice*)	1,501.20	41.20	17.20
Licensed Practical Nurses (LPNs)	33.50	1.50	0.00
Pharmacists	39.90	3.60	0.00
Other Health Services Professionals*	1,221.40	78.40	6.30
Administration and Support	2,191.40	129.20	0.00
All Other Hospital Personnel (not included above)	51.00	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	30 Days or Less
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	280	☑	220	0
Other Medical Specialties	557	☑	486	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	☐	4	0
Ophthalmology Surgery	34	☐	33	0
Orthopedic Surgery	31	☐	30	0
Plastic Surgery	9	☐	8	0
General Surgery	36	☐	33	0
Thoracic Surgery	6	☐	4	0
Other Surgical Specialties	85	☐	83	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	46	☑	46	0
Dermatology	18	☐	18	0
Emergency Medicine	147	☑	104	0
Nuclear Medicine	0	☐	0	0
Pathology	25	☑	23	0
Psychiatry	34	☐	22	0
Radiology	76	☑	75	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	5
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	556

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 Staff reported under Part G includes allocated FTEs from Corporate Support and Physician Practice.
2. Budgeted FTEs for Registered Nurses include Nurse Practitioners and APPs.
3. Vacant FTEs reflect actual open/vacant positions as of 12/31/2023.

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	92	72	0	0	0	0	0	0	0	0	0	0	0
Appling	1	3	0	0	0	0	0	0	0	0	0	0	0
Atkinson	7	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	0	2	0	0	0	0	0	0	0	0	0	0	0
Baker	3	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	27	17	0	0	0	0	0	0	0	0	0	0	0
Banks	14	27	0	0	0	0	0	0	0	0	0	0	0
Barrow	107	140	0	0	0	0	0	0	0	0	0	0	0
Bartow	98	89	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	13	9	0	0	0	0	0	0	0	0	0	0	0
Berrien	11	6	0	0	0	0	0	0	0	0	0	0	0
Bibb	98	111	0	0	0	0	0	0	0	0	0	0	0
Bleckley	9	8	0	0	0	0	0	0	0	0	0	0	0
Brantley	0	2	0	0	0	0	0	0	0	0	0	0	0
Brooks	3	5	0	0	0	0	0	0	0	0	0	0	0
Bryan	5	6	0	0	0	0	0	0	0	0	0	0	0
Bulloch	12	19	0	0	0	0	0	0	0	0	0	0	0
Burke	8	1	0	0	0	0	0	0	0	0	0	0	0
Butts	42	34	0	0	0	0	0	0	0	0	0	0	0
Calhoun	3	0	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	4	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	148	152	0	0	0	0	0	0	0	0	0	0	0
Catoosa	9	12	0	0	0	0	0	0	0	0	0	0	0
Chatham	36	27	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	3	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	14	11	0	0	0	0	0	0	0	0	0	0	0

Cherokee	159	189	0	0	0	0	0	0	0	0	0	0	0
Clarke	97	73	0	0	0	0	0	0	0	0	0	0	0
Clay	2	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	582	368	0	0	0	0	0	0	0	0	0	0	0
Clinch	0	3	0	0	0	0	0	0	0	0	0	0	0
Cobb	500	541	0	0	0	0	0	0	0	0	0	0	0
Coffee	20	19	0	0	0	0	0	0	0	0	0	0	0
Colquitt	20	23	0	0	0	0	0	0	0	0	0	0	0
Columbia	12	11	0	0	0	0	0	0	0	0	0	0	0
Cook	5	10	0	0	0	0	0	0	0	0	0	0	0
Coweta	260	213	0	0	0	0	0	0	0	0	0	0	0
Crawford	2	4	0	0	0	0	0	0	0	0	0	0	0
Crisp	15	11	0	0	0	0	0	0	0	0	0	0	0
Dade	2	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	21	33	0	0	0	0	0	0	0	0	0	0	0
Decatur	14	15	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,893	1,239	0	0	0	0	0	0	0	0	0	0	0
Dodge	12	8	0	0	0	0	0	0	0	0	0	0	0
Dooly	3	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	69	38	0	0	0	0	0	0	0	0	0	0	0
Douglas	164	151	0	0	0	0	0	0	0	0	0	0	0
Early	3	5	0	0	0	0	0	0	0	0	0	0	0
Effingham	7	8	0	0	0	0	0	0	0	0	0	0	0
Elbert	29	16	0	0	0	0	0	0	0	0	0	0	0
Emanuel	8	3	0	0	0	0	0	0	0	0	0	0	0
Evans	4	3	0	0	0	0	0	0	0	0	0	0	0
Fannin	4	9	0	0	0	0	0	0	0	0	0	0	0
Fayette	177	180	0	0	0	0	0	0	0	0	0	0	0
Florida	26	17	0	0	0	0	0	0	0	0	0	0	0
Floyd	92	63	0	0	0	0	0	0	0	0	0	0	0
Forsyth	88	155	0	0	0	0	0	0	0	0	0	0	0
Franklin	30	27	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,495	1,252	0	0	0	0	0	0	0	0	0	0	0
Gilmer	16	15	0	0	0	0	0	0	0	0	0	0	0
Glascock	0	1	0	0	0	0	0	0	0	0	0	0	0
Glynn	15	22	0	0	0	0	0	0	0	0	0	0	0
Gordon	34	35	0	0	0	0	0	0	0	0	0	0	0
Grady	11	9	0	0	0	0	0	0	0	0	0	0	0
Greene	25	13	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	894	1,094	0	0	0	0	0	0	0	0	0	0	0
Habersham	37	48	0	0	0	0	0	0	0	0	0	0	0
Hall	171	188	0	0	0	0	0	0	0	0	0	0	0
Hancock	4	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	36	26	0	0	0	0	0	0	0	0	0	0	0

Harris	43	20	0	0	0	0	0	0	0	0	0	0	0
Hart	8	9	0	0	0	0	0	0	0	0	0	0	0
Heard	13	9	0	0	0	0	0	0	0	0	0	0	0
Henry	594	425	0	0	0	0	0	0	0	0	0	0	0
Houston	153	107	0	0	0	0	0	0	0	0	0	0	0
Irwin	4	5	0	0	0	0	0	0	0	0	0	0	0
Jackson	85	132	0	0	0	0	0	0	0	0	0	0	0
Jasper	18	15	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	21	3	0	0	0	0	0	0	0	0	0	0	0
Jefferson	9	3	0	0	0	0	0	0	0	0	0	0	0
Jenkins	2	10	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	6	0	0	0	0	0	0	0	0	0	0	0
Jones	5	11	0	0	0	0	0	0	0	0	0	0	0
Lamar	29	18	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	3	0	0	0	0	0	0	0	0	0	0	0
Laurens	23	11	0	0	0	0	0	0	0	0	0	0	0
Lee	14	18	0	0	0	0	0	0	0	0	0	0	0
Liberty	4	8	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	1	0	0	0	0	0	0	0	0	0	0	0
Long	2	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	19	29	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	17	29	0	0	0	0	0	0	0	0	0	0	0
Macon	4	5	0	0	0	0	0	0	0	0	0	0	0
Madison	44	30	0	0	0	0	0	0	0	0	0	0	0
Marion	3	4	0	0	0	0	0	0	0	0	0	0	0
McDuffie	3	1	0	0	0	0	0	0	0	0	0	0	0
McIntosh	0	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	21	20	0	0	0	0	0	0	0	0	0	0	0
Mitchell	17	8	0	0	0	0	0	0	0	0	0	0	0
Monroe	14	16	0	0	0	0	0	0	0	0	0	0	0
Morgan	23	27	0	0	0	0	0	0	0	0	0	0	0
Murray	7	7	0	0	0	0	0	0	0	0	0	0	0
Muscogee	204	136	0	0	0	0	0	0	0	0	0	0	0
Newton	366	225	0	0	0	0	0	0	0	0	0	0	0
North Carolina	9	14	0	0	0	0	0	0	0	0	0	0	0
Oconee	33	36	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	7	7	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	68	37	0	0	0	0	0	0	0	0	0	0	0
Paulding	130	131	0	0	0	0	0	0	0	0	0	0	0
Peach	28	29	0	0	0	0	0	0	0	0	0	0	0
Pickens	22	19	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	6	0	0	0	0	0	0	0	0	0	0	0
Pike	27	35	0	0	0	0	0	0	0	0	0	0	0
Polk	32	33	0	0	0	0	0	0	0	0	0	0	0

Pulaski	8	8	0	0	0	0	0	0	0	0	0	0	0
Putnam	8	4	0	0	0	0	0	0	0	0	0	0	0
Quitman	1	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	17	16	0	0	0	0	0	0	0	0	0	0	0
Randolph	2	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	16	7	0	0	0	0	0	0	0	0	0	0	0
Rockdale	219	143	0	0	0	0	0	0	0	0	0	0	0
Schley	5	3	0	0	0	0	0	0	0	0	0	0	0
Screven	3	2	0	0	0	0	0	0	0	0	0	0	0
Seminole	0	5	0	0	0	0	0	0	0	0	0	0	0
South Carolina	26	14	0	0	0	0	0	0	0	0	0	0	0
Spalding	108	91	0	0	0	0	0	0	0	0	0	0	0
Stephens	31	32	0	0	0	0	0	0	0	0	0	0	0
Stewart	2	2	0	0	0	0	0	0	0	0	0	0	0
Sumter	12	9	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
Tattnall	2	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	2	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	2	5	0	0	0	0	0	0	0	0	0	0	0
Tennessee	18	19	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	18	12	0	0	0	0	0	0	0	0	0	0	0
Tift	25	25	0	0	0	0	0	0	0	0	0	0	0
Toombs	8	5	0	0	0	0	0	0	0	0	0	0	0
Towns	7	8	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	3	0	0	0	0	0	0	0	0	0	0	0
Troup	111	81	0	0	0	0	0	0	0	0	0	0	0
Turner	1	4	0	0	0	0	0	0	0	0	0	0	0
Twiggs	8	1	0	0	0	0	0	0	0	0	0	0	0
Union	10	16	0	0	0	0	0	0	0	0	0	0	0
Upson	27	26	0	0	0	0	0	0	0	0	0	0	0
Walker	23	18	0	0	0	0	0	0	0	0	0	0	0
Walton	285	246	0	0	0	0	0	0	0	0	0	0	0
Ware	11	4	0	0	0	0	0	0	0	0	0	0	0
Warren	0	1	0	0	0	0	0	0	0	0	0	0	0
Washington	5	10	0	0	0	0	0	0	0	0	0	0	0
Wayne	3	3	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	5	0	0	0	0	0	0	0	0	0	0	0	0
White	12	25	0	0	0	0	0	0	0	0	0	0	0
Whitfield	34	35	0	0	0	0	0	0	0	0	0	0	0
Wilcox	2	5	0	0	0	0	0	0	0	0	0	0	0
Wilkes	7	2	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	4	2	0	0	0	0	0	0	0	0	0	0	0

Worth	5	6	0	0	0	0	0	0	0	0	0	0	0
Total	**11,057**	**9,517**	**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	17,245	14,989
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	5,725	0	0	0
Total	**5,725**	**0**	**17,245**	**14,989**

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	3,557	9,517
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	591	0	0	0
Total	**591**	**0**	**3,557**	**9,517**

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	21
Asian	303
Black/African American	3,766
Hispanic/Latino	1,438
Pacific Islander/Hawaiian	11
White	3,654
Multi-Racial	324
Total	**9,517**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,791
Ages 15-64	1,726
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**9,517**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,794
Female	3,723
Total	**9,517**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	14
Medicaid	5,014
Third-Party	4,324
Self-Pay	165

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	488	17,909	488

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? 9.8000001907349 (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): ☑

Contract On-Site Interpreter and Video Remote Interpreting service

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	9.6%	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?

New hires receive training at new employee orientation regarding access to language services,

cultural humility and unbiased delivery of care.

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?

Increase interpreting FTE and funding for growing the bilingual employee qualification program.

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: 2/29/2024

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.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2023 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

Mailing Address: 1001 Johnson Ferry Road NE

Mailing City: Atlanta

Mailing Zip: 30342

Medicaid Provider Number: 000001636A

Medicare Provider Number: 13301

2. Report Period

Report Data for the full twelve month period- January 1, 2023 through December 31, 2023.
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: **State:**

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	11,231	54,041	13,910	53,826
Pediatric ICU	67	3,780	15,459	1,011	15,521
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	248	8,656	377	8,445
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**	**15,259**	**78,156**	**15,298**	**77,792**

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	42	214
Asian	666	3,235
Black/African American	4,719	26,375
Hispanic/Latino	3,005	15,602
Pacific Islander/Hawaiian	7	19
White	6,445	30,290
Multi-Racial	375	2,421
Total	**15,259**	**78,156**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	8,228	42,889
Female	7,031	35,267
Total	**15,259**	**78,156**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10	38
Medicaid	7,376	41,528
Peachare	588	2,849
Third-Party	6,803	31,924
Self-Pay	482	1,817
Other	0	0

5. Discharges to Death

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

106

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2023 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,822
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	8,910
Average Total Charge for an Inpatient Day	12,970

Part E : Emergency Department and Outpatient Services

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

107,533

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

11,211

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	2,025
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	57	105,508
	0	0
	0	0
	0	0
	0	0

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

1,073

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

262,117

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

9,409

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

45.00

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.

1,513

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	80,132
Number of CTS Units (machines)	4
Number of CTS Procedures	12,957
Number of Diagnostic Radioisotope Procedures	868
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	18,885
Number of Chemotherapy Treatments	5,908
Number of Respiratory Therapy Treatments	197,431
Number of Occupational Therapy Treatments	99,206
Number of Physical Therapy Treatments	294,400
Number of Speech Pathology Patients	3,612
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	5,623
Number of HIV/AIDS Diagnostic Procedures	864
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	25,794
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).

193

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	103	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 12-31-2023. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2023.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	214.80	3.80	0.00
Physician Assistants Only (not including Licensed Physicians)	14.20	0.80	0.00
Registered Nurses (RNs-Advanced Practice*)	1,211.60	41.40	2.80
Licensed Practical Nurses (LPNs)	22.90	0.40	0.00
Pharmacists	37.70	1.00	0.00
Other Health Services Professionals*	1,256.80	52.00	7.60
Administration and Support	1,817.70	86.80	0.00
All Other Hospital Personnel (not included above)	53.20	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	30 Days or Less
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	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	152	☑	119	0
Other Medical Specialties	536	☑	472	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	20	☐	19	0
Orthopedic Surgery	31	☐	30	0
Plastic Surgery	11	☐	9	0
General Surgery	30	☐	20	0
Thoracic Surgery	1	☐	0	0
Other Surgical Specialties	173	☐	163	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	39	☑	39	0
Dermatology	4	☐	4	0
Emergency Medicine	114	☑	96	0
Nuclear Medicine	0	☐	0	0
Pathology	24	☑	22	0
Psychiatry	34	☐	21	0
Radiology	68	☑	68	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	40
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	433

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 Staff reported under Part G includes allocated FTEs from Corporate Support and Physician Practice.
2. Budgeted FTEs for Registered Nurses include Nurse Practitioners and APPs.
3. Vacant FTEs reflect actual open/vacant positions as of 12/31/2023.

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	65	59	0	0	0	0	0	0	0	0	0	0	0
Appling	5	4	0	0	0	0	0	0	0	0	0	0	0
Atkinson	0	1	0	0	0	0	0	0	0	0	0	0	0
Bacon	3	2	0	0	0	0	0	0	0	0	0	0	0
Baker	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	12	18	0	0	0	0	0	0	0	0	0	0	0
Banks	28	45	0	0	0	0	0	0	0	0	0	0	0
Barrow	227	280	0	0	0	0	0	0	0	0	0	0	0
Bartow	256	194	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	7	6	0	0	0	0	0	0	0	0	0	0	0
Berrien	4	6	0	0	0	0	0	0	0	0	0	0	0
Bibb	66	73	0	0	0	0	0	0	0	0	0	0	0
Bleckley	2	4	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	6	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	5	4	0	0	0	0	0	0	0	0	0	0	0
Bulloch	8	2	0	0	0	0	0	0	0	0	0	0	0
Burke	1	6	0	0	0	0	0	0	0	0	0	0	0
Butts	37	56	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	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	246	239	0	0	0	0	0	0	0	0	0	0	0
Catoosa	2	4	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	19	24	0	0	0	0	0	0	0	0	0	0	0
Chattooga	14	19	0	0	0	0	0	0	0	0	0	0	0
Cherokee	764	733	0	0	0	0	0	0	0	0	0	0	0

Clarke	107	76	0	0	0	0	0	0	0	0	0	0	0
Clayton	317	401	0	0	0	0	0	0	0	0	0	0	0
Clinch	1	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,937	1,560	0	0	0	0	0	0	0	0	0	0	0
Coffee	8	18	0	0	0	0	0	0	0	0	0	0	0
Colquitt	12	22	0	0	0	0	0	0	0	0	0	0	0
Columbia	13	30	0	0	0	0	0	0	0	0	0	0	0
Cook	7	4	0	0	0	0	0	0	0	0	0	0	0
Coweta	222	242	0	0	0	0	0	0	0	0	0	0	0
Crawford	2	1	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	2	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	118	101	0	0	0	0	0	0	0	0	0	0	0
Decatur	6	4	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,304	1,435	0	0	0	0	0	0	0	0	0	0	0
Dodge	11	8	0	0	0	0	0	0	0	0	0	0	0
Dooly	7	6	0	0	0	0	0	0	0	0	0	0	0
Dougherty	39	23	0	0	0	0	0	0	0	0	0	0	0
Douglas	364	222	0	0	0	0	0	0	0	0	0	0	0
Early	2	5	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	1	5	0	0	0	0	0	0	0	0	0	0	0
Elbert	33	20	0	0	0	0	0	0	0	0	0	0	0
Emanuel	0	2	0	0	0	0	0	0	0	0	0	0	0
Evans	0	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	20	26	0	0	0	0	0	0	0	0	0	0	0
Fayette	167	201	0	0	0	0	0	0	0	0	0	0	0
Florida	41	27	0	0	0	0	0	0	0	0	0	0	0
Floyd	129	121	0	0	0	0	0	0	0	0	0	0	0
Forsyth	519	554	0	0	0	0	0	0	0	0	0	0	0
Franklin	20	42	0	0	0	0	0	0	0	0	0	0	0
Fulton	2,043	2,030	0	0	0	0	0	0	0	0	0	0	0
Gilmer	66	61	0	0	0	0	0	0	0	0	0	0	0
Glascock	0	3	0	0	0	0	0	0	0	0	0	0	0
Glynn	5	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	56	67	0	0	0	0	0	0	0	0	0	0	0
Grady	6	13	0	0	0	0	0	0	0	0	0	0	0
Greene	11	13	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	2,240	2,459	0	0	0	0	0	0	0	0	0	0	0
Habersham	86	91	0	0	0	0	0	0	0	0	0	0	0
Hall	384	457	0	0	0	0	0	0	0	0	0	0	0
Hancock	2	2	0	0	0	0	0	0	0	0	0	0	0
Haralson	93	67	0	0	0	0	0	0	0	0	0	0	0
Harris	15	18	0	0	0	0	0	0	0	0	0	0	0

Hart	15	21	0	0	0	0	0	0	0	0	0	0	0
Heard	13	22	0	0	0	0	0	0	0	0	0	0	0
Henry	375	485	0	0	0	0	0	0	0	0	0	0	0
Houston	72	79	0	0	0	0	0	0	0	0	0	0	0
Irwin	5	10	0	0	0	0	0	0	0	0	0	0	0
Jackson	204	272	0	0	0	0	0	0	0	0	0	0	0
Jasper	9	23	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	2	0	0	0	0	0	0	0	0	0	0	0	0
Jefferson	3	0	0	0	0	0	0	0	0	0	0	0	0
Jenkins	2	2	0	0	0	0	0	0	0	0	0	0	0
Johnson	2	2	0	0	0	0	0	0	0	0	0	0	0
Jones	2	3	0	0	0	0	0	0	0	0	0	0	0
Lamar	12	17	0	0	0	0	0	0	0	0	0	0	0
Lanier	1	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	16	18	0	0	0	0	0	0	0	0	0	0	0
Lee	18	19	0	0	0	0	0	0	0	0	0	0	0
Liberty	2	3	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	4	0	0	0	0	0	0	0	0	0	0	0
Long	1	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	23	32	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	51	60	0	0	0	0	0	0	0	0	0	0	0
Macon	3	5	0	0	0	0	0	0	0	0	0	0	0
Madison	35	36	0	0	0	0	0	0	0	0	0	0	0
Marion	1	5	0	0	0	0	0	0	0	0	0	0	0
McDuffie	1	15	0	0	0	0	0	0	0	0	0	0	0
Meriwether	19	28	0	0	0	0	0	0	0	0	0	0	0
Miller	0	2	0	0	0	0	0	0	0	0	0	0	0
Mitchell	5	3	0	0	0	0	0	0	0	0	0	0	0
Monroe	18	23	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	25	23	0	0	0	0	0	0	0	0	0	0	0
Murray	23	17	0	0	0	0	0	0	0	0	0	0	0
Muscogee	134	99	0	0	0	0	0	0	0	0	0	0	0
Newton	183	245	0	0	0	0	0	0	0	0	0	0	0
North Carolina	31	27	0	0	0	0	0	0	0	0	0	0	0
Oconee	50	51	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	6	6	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	110	64	0	0	0	0	0	0	0	0	0	0	0
Paulding	351	260	0	0	0	0	0	0	0	0	0	0	0
Peach	4	13	0	0	0	0	0	0	0	0	0	0	0
Pickens	69	84	0	0	0	0	0	0	0	0	0	0	0
Pierce	2	1	0	0	0	0	0	0	0	0	0	0	0
Pike	23	38	0	0	0	0	0	0	0	0	0	0	0
Polk	94	57	0	0	0	0	0	0	0	0	0	0	0

Pulaski	2	5	0	0	0	0	0	0	0	0	0	0	0
Putnam	13	21	0	0	0	0	0	0	0	0	0	0	0
Rabun	29	27	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	11	64	0	0	0	0	0	0	0	0	0	0	0
Rockdale	99	139	0	0	0	0	0	0	0	0	0	0	0
Schley	1	0	0	0	0	0	0	0	0	0	0	0	0
Screven	20	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	3	4	0	0	0	0	0	0	0	0	0	0	0
South Carolina	36	21	0	0	0	0	0	0	0	0	0	0	0
Spalding	102	102	0	0	0	0	0	0	0	0	0	0	0
Stephens	38	44	0	0	0	0	0	0	0	0	0	0	0
Stewart	10	4	0	0	0	0	0	0	0	0	0	0	0
Sumter	19	13	0	0	0	0	0	0	0	0	0	0	0
Talbot	3	5	0	0	0	0	0	0	0	0	0	0	0
Tattnall	2	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	0	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	50	25	0	0	0	0	0	0	0	0	0	0	0
Terrell	2	2	0	0	0	0	0	0	0	0	0	0	0
Thomas	29	15	0	0	0	0	0	0	0	0	0	0	0
Tift	13	14	0	0	0	0	0	0	0	0	0	0	0
Toombs	6	7	0	0	0	0	0	0	0	0	0	0	0
Towns	3	20	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	0	0	0	0	0	0	0	0	0	0	0	0
Troup	84	65	0	0	0	0	0	0	0	0	0	0	0
Turner	4	2	0	0	0	0	0	0	0	0	0	0	0
Twiggs	2	0	0	0	0	0	0	0	0	0	0	0	0
Union	31	37	0	0	0	0	0	0	0	0	0	0	0
Upson	20	25	0	0	0	0	0	0	0	0	0	0	0
Walker	9	9	0	0	0	0	0	0	0	0	0	0	0
Walton	291	365	0	0	0	0	0	0	0	0	0	0	0
Ware	2	5	0	0	0	0	0	0	0	0	0	0	0
Warren	0	4	0	0	0	0	0	0	0	0	0	0	0
Washington	1	1	0	0	0	0	0	0	0	0	0	0	0
Wayne	2	4	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	2	0	0	0	0	0	0	0	0	0	0	0
White	54	49	0	0	0	0	0	0	0	0	0	0	0
Whitfield	21	50	0	0	0	0	0	0	0	0	0	0	0
Wilcox	5	4	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	2	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	6	1	0	0	0	0	0	0	0	0	0	0	0
Worth	7	2	0	0	0	0	0	0	0	0	0	0	0

Total	**15,259**	**15,576**	**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	6,693	15,057	18,135
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**6,693**	**15,057**	**18,135**

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	3,644	4,194	11,932
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**3,644**	**4,194**	**11,932**

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	42
Asian	627
Black/African American	4,508
Hispanic/Latino	2,704
Pacific Islander/Hawaiian	12
White	7,291
Multi-Racial	392
Total	**15,576**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	13,460
Ages 15-64	2,116
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**15,576**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	9,120
Female	6,456
Total	**15,576**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	6
Medicaid	6,964
Third-Party	8,273
Self-Pay	333

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	437	13,733	437

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? 18.14999961853 (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): ☑

CONTRACT INTERPRETER ON-SITE, VIDEO REMOTE INTERPRETING SERVICE

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?

NEW HIRES RECEIVE TRAINING AT NEW EMPLOYEE ORIENTATION REGARDING ACCESS

TO LANGUAGE SERVICES, CULTURAL HUMILITY, AND UNBIASED DELIVERY OF CARE

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?

INCREASE INTERPRETING FTE AND FUNDING FOR GROWING THE BILINGUAL EMPLOYEE QUALIFICATION PROGRAM

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	3	277
Black/African American	122	3,859
Hispanic/Latino	27	996
Pacific Islander/Hawaiian	0	0
White	88	3,173
Multi-Racial	8	351

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	139	5,101
Female	109	3,555

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	236	8,176
18-64	12	480
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	248
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	245
Self Pay	3
Other	0

2. Uncompensated Indigent and Charity Care

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

7

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: 2/29/2024

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.