GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 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, 2020 through December 31, 2020.
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:
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: 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	6,869	45,189	8,498	45,579
Pediatric ICU	46	1,733	9,363	916	9,845
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	693	8,033	54	8,593
	0	0	0	0	0
	0	0	0	0	0
Total	**280**	**9,295**	**62,585**	**9,468**	**64,017**

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	8	25
Asian	258	1,748
Black/African American	4,533	30,449
Hispanic/Latino	1,073	8,162
Pacific Islander/Hawaiian	13	90
White	3,134	20,217
Multi-Racial	276	1,894
Total	**9,295**	**62,585**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	4,790	32,938
Female	4,505	29,647
Total	**9,295**	**62,585**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	95	645
Medicaid	5,513	39,669
Peachare	338	1,382
Third-Party	3,116	19,690
Self-Pay	233	1,199
Other	0	0

5. Discharges to Death

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

171

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2020 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,428
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	10,341
Average Total Charge for an Inpatient Day	16,308

Part E : Emergency Department and Outpatient Services

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

51,477

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

5,506

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	1,648
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	41	49,829
	0	0
	0	0
	0	0
	0	0

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

983

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

176,419

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

5,349

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

2

9. Ambulance Diversion Hours
Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

7.00

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.

251

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	779
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	16
Number of Other-Organ/Tissues Treatments	103
Number of Diagnostic X-Ray Procedures	73,135
Number of CTS Units (machines)	2
Number of CTS Procedures	6,096
Number of Diagnostic Radioisotope Procedures	1,539
Number of PET Units (machines)	1
Number of PET Procedures	288
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	3
Number of Number of MRI Procedures	9,031
Number of Chemotherapy Treatments	7,196
Number of Respiratory Therapy Treatments	136,277
Number of Occupational Therapy Treatments	23,151
Number of Physical Therapy Treatments	30,143
Number of Speech Pathology Patients	994
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,007
Number of HIV/AIDS Diagnostic Procedures	1,108
Number of HIV/AIDS Patients	3
Number of Ambulance Trips	3,733
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	13,870
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).

242

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 12-31-2020. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2020.

Profession	Profession	Profession	Profession
Licensed Physicians	269.66	3.82	0.00
Physician Assistants Only (not including Licensed Physicians)	25.09	1.25	0.00
Registered Nurses (RNs-Advanced Practice*)	1,361.19	36.67	0.00
Licensed Practical Nurses (LPNs)	33.74	1.63	0.00
Pharmacists	39.37	1.00	0.00
Other Health Services Professionals*	1,165.70	40.49	0.00
Administration and Support	1,728.28	125.53	0.00
All Other Hospital Personnel (not included above)	42.23	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)	31-60 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	153	☑	124	0
Other Medical Specialties	265	☑	216	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	5	☐	3	0
Ophthalmology Surgery	38	☐	30	0
Orthopedic Surgery	17	☐	10	0
Plastic Surgery	5	☐	5	0
General Surgery	11	☐	7	0
Thoracic Surgery	6	☐	5	0
Other Surgical Specialties	91	☐	73	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	41	☑	37	0
Dermatology	18	☐	17	0
Emergency Medicine	46	☑	38	0
Nuclear Medicine	0	☐	0	0
Pathology	17	☑	14	0
Psychiatry	12	☐	10	0
Radiology	65	☑	49	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	17
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	330

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:

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	52	62	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	4	4	0	0	0	0	0	0	0	0	0	0	0
Bacon	2	2	0	0	0	0	0	0	0	0	0	0	0
Baker	2	3	0	0	0	0	0	0	0	0	0	0	0
Baldwin	23	20	0	0	0	0	0	0	0	0	0	0	0
Banks	26	51	0	0	0	0	0	0	0	0	0	0	0
Barrow	87	108	0	0	0	0	0	0	0	0	0	0	0
Bartow	65	93	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	4	6	0	0	0	0	0	0	0	0	0	0	0
Berrien	7	5	0	0	0	0	0	0	0	0	0	0	0
Bibb	85	66	0	0	0	0	0	0	0	0	0	0	0
Bleckley	12	3	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	9	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	13	8	0	0	0	0	0	0	0	0	0	0	0
Bulloch	16	5	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0	0
Butts	51	42	0	0	0	0	0	0	0	0	0	0	0
Calhoun	2	4	0	0	0	0	0	0	0	0	0	0	0
Camden	0	1	0	0	0	0	0	0	0	0	0	0	0
Candler	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	124	124	0	0	0	0	0	0	0	0	0	0	0
Catoosa	4	9	0	0	0	0	0	0	0	0	0	0	0
Chatham	32	39	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	1	0	0	0	0	0	0	0	0	0	0	0
Chattooga	3	9	0	0	0	0	0	0	0	0	0	0	0

Cherokee	148	121	0	0	0	0	0	0	0	0	0	0	0
Clarke	69	78	0	0	0	0	0	0	0	0	0	0	0
Clayton	510	386	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	395	487	0	0	0	0	0	0	0	0	0	0	0
Coffee	9	9	0	0	0	0	0	0	0	0	0	0	0
Colquitt	11	7	0	0	0	0	0	0	0	0	0	0	0
Columbia	10	3	0	0	0	0	0	0	0	0	0	0	0
Cook	7	5	0	0	0	0	0	0	0	0	0	0	0
Coweta	209	158	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	3	0	0	0	0	0	0	0	0	0	0	0
Crisp	10	8	0	0	0	0	0	0	0	0	0	0	0
Dade	2	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	16	29	0	0	0	0	0	0	0	0	0	0	0
Decatur	16	18	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,513	1,106	0	0	0	0	0	0	0	0	0	0	0
Dodge	6	4	0	0	0	0	0	0	0	0	0	0	0
Dooly	4	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	73	37	0	0	0	0	0	0	0	0	0	0	0
Douglas	155	130	0	0	0	0	0	0	0	0	0	0	0
Early	8	5	0	0	0	0	0	0	0	0	0	0	0
Effingham	8	9	0	0	0	0	0	0	0	0	0	0	0
Elbert	16	15	0	0	0	0	0	0	0	0	0	0	0
Emanuel	4	0	0	0	0	0	0	0	0	0	0	0	0
Evans	1	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	3	10	0	0	0	0	0	0	0	0	0	0	0
Fayette	135	113	0	0	0	0	0	0	0	0	0	0	0
Florida	33	13	0	0	0	0	0	0	0	0	0	0	0
Floyd	56	62	0	0	0	0	0	0	0	0	0	0	0
Forsyth	90	90	0	0	0	0	0	0	0	0	0	0	0
Franklin	21	27	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,258	1,135	0	0	0	0	0	0	0	0	0	0	0
Gilmer	7	13	0	0	0	0	0	0	0	0	0	0	0
Glynn	8	9	0	0	0	0	0	0	0	0	0	0	0
Gordon	45	28	0	0	0	0	0	0	0	0	0	0	0
Grady	5	2	0	0	0	0	0	0	0	0	0	0	0
Greene	7	8	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	779	793	0	0	0	0	0	0	0	0	0	0	0
Habersham	29	37	0	0	0	0	0	0	0	0	0	0	0
Hall	155	151	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	19	24	0	0	0	0	0	0	0	0	0	0	0
Harris	19	28	0	0	0	0	0	0	0	0	0	0	0
Hart	5	12	0	0	0	0	0	0	0	0	0	0	0

Heard	18	12	0	0	0	0	0	0	0	0	0	0	0
Henry	495	380	0	0	0	0	0	0	0	0	0	0	0
Houston	116	60	0	0	0	0	0	0	0	0	0	0	0
Irwin	0	2	0	0	0	0	0	0	0	0	0	0	0
Jackson	75	110	0	0	0	0	0	0	0	0	0	0	0
Jasper	16	12	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	2	5	0	0	0	0	0	0	0	0	0	0	0
Jefferson	2	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	7	2	0	0	0	0	0	0	0	0	0	0	0
Jones	7	4	0	0	0	0	0	0	0	0	0	0	0
Lamar	17	21	0	0	0	0	0	0	0	0	0	0	0
Lanier	1	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	19	13	0	0	0	0	0	0	0	0	0	0	0
Lee	13	31	0	0	0	0	0	0	0	0	0	0	0
Liberty	19	10	0	0	0	0	0	0	0	0	0	0	0
Long	4	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	39	21	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	20	11	0	0	0	0	0	0	0	0	0	0	0
Macon	2	4	0	0	0	0	0	0	0	0	0	0	0
Madison	17	26	0	0	0	0	0	0	0	0	0	0	0
Marion	5	7	0	0	0	0	0	0	0	0	0	0	0
McDuffie	3	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	19	22	0	0	0	0	0	0	0	0	0	0	0
Miller	2	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	11	20	0	0	0	0	0	0	0	0	0	0	0
Montgomery	1	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	27	30	0	0	0	0	0	0	0	0	0	0	0
Murray	12	14	0	0	0	0	0	0	0	0	0	0	0
Muscogee	189	195	0	0	0	0	0	0	0	0	0	0	0
Newton	257	188	0	0	0	0	0	0	0	0	0	0	0
North Carolina	20	10	0	0	0	0	0	0	0	0	0	0	0
Oconee	34	31	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	3	5	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	46	37	0	0	0	0	0	0	0	0	0	0	0
Paulding	110	105	0	0	0	0	0	0	0	0	0	0	0
Peach	30	16	0	0	0	0	0	0	0	0	0	0	0
Pickens	28	16	0	0	0	0	0	0	0	0	0	0	0
Pierce	12	15	0	0	0	0	0	0	0	0	0	0	0
Pike	25	18	0	0	0	0	0	0	0	0	0	0	0
Polk	34	38	0	0	0	0	0	0	0	0	0	0	0
Pulaski	7	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	26	14	0	0	0	0	0	0	0	0	0	0	0

Quitman	3	3	0	0	0	0	0	0	0	0	0	0	0
Rabun	17	18	0	0	0	0	0	0	0	0	0	0	0
Randolph	5	4	0	0	0	0	0	0	0	0	0	0	0
Richmond	25	30	0	0	0	0	0	0	0	0	0	0	0
Rockdale	193	127	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
Seminole	4	4	0	0	0	0	0	0	0	0	0	0	0
South Carolina	15	16	0	0	0	0	0	0	0	0	0	0	0
Spalding	142	87	0	0	0	0	0	0	0	0	0	0	0
Stephens	30	37	0	0	0	0	0	0	0	0	0	0	0
Stewart	2	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	13	7	0	0	0	0	0	0	0	0	0	0	0
Talbot	1	2	0	0	0	0	0	0	0	0	0	0	0
Tattnall	5	3	0	0	0	0	0	0	0	0	0	0	0
Taylor	6	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	2	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	25	11	0	0	0	0	0	0	0	0	0	0	0
Terrell	3	2	0	0	0	0	0	0	0	0	0	0	0
Thomas	19	24	0	0	0	0	0	0	0	0	0	0	0
Tift	22	13	0	0	0	0	0	0	0	0	0	0	0
Toombs	7	4	0	0	0	0	0	0	0	0	0	0	0
Towns	3	8	0	0	0	0	0	0	0	0	0	0	0
Treutlen	3	1	0	0	0	0	0	0	0	0	0	0	0
Troup	99	74	0	0	0	0	0	0	0	0	0	0	0
Turner	9	7	0	0	0	0	0	0	0	0	0	0	0
Twiggs	2	1	0	0	0	0	0	0	0	0	0	0	0
Union	13	20	0	0	0	0	0	0	0	0	0	0	0
Upson	16	34	0	0	0	0	0	0	0	0	0	0	0
Walker	21	23	0	0	0	0	0	0	0	0	0	0	0
Walton	194	162	0	0	0	0	0	0	0	0	0	0	0
Ware	5	6	0	0	0	0	0	0	0	0	0	0	0
Washington	5	3	0	0	0	0	0	0	0	0	0	0	0
Wayne	6	3	0	0	0	0	0	0	0	0	0	0	0
Webster	1	0	0	0	0	0	0	0	0	0	0	0	0
Wheeler	2	0	0	0	0	0	0	0	0	0	0	0	0
White	17	19	0	0	0	0	0	0	0	0	0	0	0
Whitfield	30	27	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
Wilkinson	7	5	0	0	0	0	0	0	0	0	0	0	0
Worth	14	10	0	0	0	0	0	0	0	0	0	0	0
Total	**9,295**	**8,181**	**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	14,638	18,446
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	4,658	0	0	0
Total	**4,658**	**0**	**14,638**	**18,446**

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	3,555	8,181
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	654	0	0	0
Total	**654**	**0**	**3,555**	**8,181**

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	222
Black/African American	3,174
Hispanic/Latino	1,019
Pacific Islander/Hawaiian	8
White	3,427
Multi-Racial	316
Total	**8,181**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	6,743
Ages 15-64	1,438
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**8,181**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,839
Female	3,342
Total	**8,181**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	22
Medicaid	4,452
Third-Party	3,575
Self-Pay	132

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	464	15,008	464

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? 8.5500001907349 (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 Interpreting Service and Contracted On-Site Interpreters

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	7.2%	0	0	0
Burmese	0.1%	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?

Interpreting/Translation Policy and Resources Presentation at New Hire Orientation and Patient

Care Provider Orientation, along with education in Annual Employee Assessment.

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?

Immediate access to additional bilingual personnel or technology via contractual relationships

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: 3/2/2021

Title: Chief Nursing and 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 stff 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

2020 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, 2020 through December 31, 2020.
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, Inc	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	7,919	38,359	9,475	38,399
Pediatric ICU	67	2,491	10,100	992	10,579
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	288	7,278	394	7,394
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**	**10,698**	**55,737**	**10,861**	**56,372**

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	15	88
Asian	407	2,177
Black/African American	3,121	18,189
Hispanic/Latino	2,040	10,638
Pacific Islander/Hawaiian	5	13
White	4,756	22,892
Multi-Racial	354	1,740
Total	**10,698**	**55,737**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,500	28,169
Female	5,198	27,568
Total	**10,698**	**55,737**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6	28
Medicaid	5,240	29,720
Peachare	428	1,920
Third-Party	4,764	23,138
Self-Pay	260	931
Other	0	0

5. Discharges to Death

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

73

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2020 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,428
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	8,388
Average Total Charge for an Inpatient Day	11,852

Part E : Emergency Department and Outpatient Services

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

67,775

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

7,058

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	2,143
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	57	65,632
	0	0
	0	0
	0	0
	0	0

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

893

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

221,119

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

7,229

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

21.00

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.

109

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	63,027
Number of CTS Units (machines)	4
Number of CTS Procedures	9,277
Number of Diagnostic Radioisotope Procedures	928
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	5
Number of Number of MRI Procedures	15,080
Number of Chemotherapy Treatments	6,590
Number of Respiratory Therapy Treatments	170,555
Number of Occupational Therapy Treatments	83,198
Number of Physical Therapy Treatments	249,954
Number of Speech Pathology Patients	3,010
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	3,778
Number of HIV/AIDS Diagnostic Procedures	712
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	10
Number of Ultrasound/Medical Sonography Procedures	19,670
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).

176

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	57	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 12-31-2020. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2020.

Profession	Profession	Profession	Profession
Licensed Physicians	161.02	2.38	0.00
Physician Assistants Only (not including Licensed Physicians)	12.55	0.75	0.00
Registered Nurses (RNs-Advanced Practice*)	1,091.61	22.53	0.00
Licensed Practical Nurses (LPNs)	19.83	0.37	0.00
Pharmacists	34.78	0.00	0.00
Other Health Services Professionals*	1,149.64	60.62	0.00
Administration and Support	1,589.92	117.97	0.00
All Other Hospital Personnel (not included above)	32.31	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)	31-60 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	129	☑	106	0
Other Medical Specialties	163	☑	143	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	3	☐	0	0
Ophthalmology Surgery	15	☐	12	0
Orthopedic Surgery	27	☐	20	0
Plastic Surgery	16	☐	8	0
General Surgery	14	☐	10	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	80	☐	65	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	24	☑	24	0
Dermatology	3	☐	1	0
Emergency Medicine	46	☑	42	0
Nuclear Medicine	0	☐	0	0
Pathology	7	☑	7	0
Psychiatry	6	☐	5	0
Radiology	9	☑	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 surgeions) with Admitting Privleges	41
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	259

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:

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	59	59	0	0	0	0	0	0	0	0	0	0	0
Appling	0	2	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	0	0	0	0	0	0	0	0	0	0	0	0
Baker	0	20	0	0	0	0	0	0	0	0	0	0	0
Baldwin	7	10	0	0	0	0	0	0	0	0	0	0	0
Banks	26	32	0	0	0	0	0	0	0	0	0	0	0
Barrow	139	184	0	0	0	0	0	0	0	0	0	0	0
Bartow	200	190	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	6	8	0	0	0	0	0	0	0	0	0	0	0
Berrien	4	3	0	0	0	0	0	0	0	0	0	0	0
Bibb	53	43	0	0	0	0	0	0	0	0	0	0	0
Bleckley	3	4	0	0	0	0	0	0	0	0	0	0	0
Brantley	1	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	6	3	0	0	0	0	0	0	0	0	0	0	0
Bryan	3	3	0	0	0	0	0	0	0	0	0	0	0
Bulloch	10	6	0	0	0	0	0	0	0	0	0	0	0
Burke	0	2	0	0	0	0	0	0	0	0	0	0	0
Butts	22	42	0	0	0	0	0	0	0	0	0	0	0
Calhoun	1	0	0	0	0	0	0	0	0	0	0	0	0
Camden	0	2	0	0	0	0	0	0	0	0	0	0	0
Carroll	214	192	0	0	0	0	0	0	0	0	0	0	0
Catoosa	3	12	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	22	14	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	4	0	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	595	631	0	0	0	0	0	0	0	0	0	0	0
Clarke	100	84	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	255	379	0	0	0	0	0	0	0	0	0	0	0
Clinch	0	1	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,439	1,329	0	0	0	0	0	0	0	0	0	0	0
Coffee	3	6	0	0	0	0	0	0	0	0	0	0	0
Colquitt	39	20	0	0	0	0	0	0	0	0	0	0	0
Columbia	16	22	0	0	0	0	0	0	0	0	0	0	0
Cook	20	8	0	0	0	0	0	0	0	0	0	0	0
Coweta	128	205	0	0	0	0	0	0	0	0	0	0	0
Crawford	0	2	0	0	0	0	0	0	0	0	0	0	0
Crisp	12	8	0	0	0	0	0	0	0	0	0	0	0
Dade	3	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	65	76	0	0	0	0	0	0	0	0	0	0	0
Decatur	9	9	0	0	0	0	0	0	0	0	0	0	0
DeKalb	774	1,148	0	0	0	0	0	0	0	0	0	0	0
Dodge	8	5	0	0	0	0	0	0	0	0	0	0	0
Dooly	2	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	33	19	0	0	0	0	0	0	0	0	0	0	0
Douglas	259	220	0	0	0	0	0	0	0	0	0	0	0
Early	4	3	0	0	0	0	0	0	0	0	0	0	0
Echols	0	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	7	5	0	0	0	0	0	0	0	0	0	0	0
Elbert	13	17	0	0	0	0	0	0	0	0	0	0	0
Emanuel	6	0	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	12	28	0	0	0	0	0	0	0	0	0	0	0
Fayette	125	192	0	0	0	0	0	0	0	0	0	0	0
Florida	41	38	0	0	0	0	0	0	0	0	0	0	0
Floyd	92	98	0	0	0	0	0	0	0	0	0	0	0
Forsyth	348	468	0	0	0	0	0	0	0	0	0	0	0
Franklin	17	39	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,488	1,737	0	0	0	0	0	0	0	0	0	0	0
Gilmer	41	57	0	0	0	0	0	0	0	0	0	0	0
Glynn	6	5	0	0	0	0	0	0	0	0	0	0	0
Gordon	48	34	0	0	0	0	0	0	0	0	0	0	0
Grady	2	3	0	0	0	0	0	0	0	0	0	0	0
Greene	10	7	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	1,465	1,650	0	0	0	0	0	0	0	0	0	0	0
Habersham	55	81	0	0	0	0	0	0	0	0	0	0	0
Hall	308	364	0	0	0	0	0	0	0	0	0	0	0
Haralson	44	33	0	0	0	0	0	0	0	0	0	0	0
Harris	12	19	0	0	0	0	0	0	0	0	0	0	0

Hart	22	18	0	0	0	0	0	0	0	0	0	0	0
Heard	6	17	0	0	0	0	0	0	0	0	0	0	0
Henry	222	413	0	0	0	0	0	0	0	0	0	0	0
Houston	52	43	0	0	0	0	0	0	0	0	0	0	0
Irwin	2	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	130	167	0	0	0	0	0	0	0	0	0	0	0
Jasper	5	8	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	3	0	0	0	0	0	0	0	0	0	0	0
Jefferson	3	1	0	0	0	0	0	0	0	0	0	0	0
Johnson	3	1	0	0	0	0	0	0	0	0	0	0	0
Jones	5	8	0	0	0	0	0	0	0	0	0	0	0
Lamar	6	8	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	11	5	0	0	0	0	0	0	0	0	0	0	0
Lee	6	9	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	0	3	0	0	0	0	0	0	0	0	0	0	0
Long	0	5	0	0	0	0	0	0	0	0	0	0	0
Lowndes	16	17	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	33	56	0	0	0	0	0	0	0	0	0	0	0
Macon	2	4	0	0	0	0	0	0	0	0	0	0	0
Madison	24	29	0	0	0	0	0	0	0	0	0	0	0
Marion	1	6	0	0	0	0	0	0	0	0	0	0	0
McDuffie	1	4	0	0	0	0	0	0	0	0	0	0	0
Meriwether	18	15	0	0	0	0	0	0	0	0	0	0	0
Miller	1	2	0	0	0	0	0	0	0	0	0	0	0
Mitchell	6	6	0	0	0	0	0	0	0	0	0	0	0
Monroe	16	9	0	0	0	0	0	0	0	0	0	0	0
Montgomery	1	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	10	23	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	126	123	0	0	0	0	0	0	0	0	0	0	0
Newton	101	166	0	0	0	0	0	0	0	0	0	0	0
North Carolina	21	11	0	0	0	0	0	0	0	0	0	0	0
Oconee	27	57	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	4	3	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	60	42	0	0	0	0	0	0	0	0	0	0	0
Paulding	222	222	0	0	0	0	0	0	0	0	0	0	0
Peach	17	13	0	0	0	0	0	0	0	0	0	0	0
Pickens	50	69	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	0	0	0	0	0	0	0	0	0	0	0	0
Pike	13	37	0	0	0	0	0	0	0	0	0	0	0
Polk	75	56	0	0	0	0	0	0	0	0	0	0	0
Pulaski	4	6	0	0	0	0	0	0	0	0	0	0	0

Putnam	11	13	0	0	0	0	0	0	0	0	0	0	0
Quitman	1	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	19	26	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	2	0	0	0	0	0	0	0	0	0	0	0
Richmond	6	16	0	0	0	0	0	0	0	0	0	0	0
Rockdale	71	104	0	0	0	0	0	0	0	0	0	0	0
Seminole	4	5	0	0	0	0	0	0	0	0	0	0	0
South Carolina	19	11	0	0	0	0	0	0	0	0	0	0	0
Spalding	50	92	0	0	0	0	0	0	0	0	0	0	0
Stephens	36	42	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	7	3	0	0	0	0	0	0	0	0	0	0	0
Talbot	2	0	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	0	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	3	2	0	0	0	0	0	0	0	0	0	0	0
Taylor	3	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	53	23	0	0	0	0	0	0	0	0	0	0	0
Terrell	4	5	0	0	0	0	0	0	0	0	0	0	0
Thomas	8	12	0	0	0	0	0	0	0	0	0	0	0
Tift	9	17	0	0	0	0	0	0	0	0	0	0	0
Toombs	2	3	0	0	0	0	0	0	0	0	0	0	0
Towns	0	11	0	0	0	0	0	0	0	0	0	0	0
Treutlen	0	4	0	0	0	0	0	0	0	0	0	0	0
Troup	62	69	0	0	0	0	0	0	0	0	0	0	0
Turner	3	0	0	0	0	0	0	0	0	0	0	0	0
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	27	35	0	0	0	0	0	0	0	0	0	0	0
Upson	11	16	0	0	0	0	0	0	0	0	0	0	0
Walker	9	7	0	0	0	0	0	0	0	0	0	0	0
Walton	162	228	0	0	0	0	0	0	0	0	0	0	0
Ware	3	4	0	0	0	0	0	0	0	0	0	0	0
Warren	1	0	0	0	0	0	0	0	0	0	0	0	0
Washington	4	0	0	0	0	0	0	0	0	0	0	0	0
Wheeler	1	2	0	0	0	0	0	0	0	0	0	0	0
White	30	45	0	0	0	0	0	0	0	0	0	0	0
Whitfield	23	31	0	0	0	0	0	0	0	0	0	0	0
Wilcox	4	2	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	2	6	0	0	0	0	0	0	0	0	0	0	0
Worth	5	10	0	0	0	0	0	0	0	0	0	0	0
Total	**10,698**	**12,450**	**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	5,891	13,578	22,328
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**5,891**	**13,578**	**22,328**

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	2,294	4,201	10,156
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**2,294**	**4,201**	**10,156**

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	496
Black/African American	3,290
Hispanic/Latino	2,027
Pacific Islander/Hawaiian	8
White	6,188
Multi-Racial	420
Total	**12,450**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	10,396
Ages 15-64	2,054
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**12,450**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	7,425
Female	5,025
Total	**12,450**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2
Medicaid	5,644
Third-Party	6,523
Self-Pay	281

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	394	12,978	394

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? 15.579999923706 (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): ☑

Also Video Remote interpreting service and contracted on-site qualified interpreters

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	10.8%	0	0	0
Vietnamese	0.1%	0	0	0
Portuguese	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?

Interpreting/Translation Policy and Resources Presentation at New Hire Orientation and Patient

Care Provider Orientation, along with education in Annual Employee Assessment.

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?

Immediate access to additional bilingual personnel or technology via contractual relationships

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	59
Black/African American	121	3,028
Hispanic/Latino	40	1,041
Pacific Islander/Hawaiian	0	0
White	116	3,078
Multi-Racial	4	72

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	158	3,574
Female	130	3,704

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	267	6,819
18-64	21	459
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	288
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	285
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: 3/2/2021

Title: Chief Nursing and 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 stff 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.