Georgia Department of Community Health

2018 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: 00000943A

Medicare Provider Number: 113300

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
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: Holly Walton

Contact Title: Senior Planning Analyst

Phone: 404-785-7906

Fax: 404-785-7801

E-mail: holly.walton@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	NA	

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: 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)	177	8,258	48,061	10,034	47,794
Pediatric ICU	46	2,082	10,722	961	10,405
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
Cardiac	27	662	7,777	54	7,985
	0	0	0	0	0
	0	0	0	0	0
Total	**250**	**11,002**	**66,560**	**11,049**	**66,184**

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	10	46
Asian	293	1,975
Black/African American	5,372	31,089
Hispanic/Latino	1,203	8,547
Pacific Islander/Hawaiian	7	26
White	3,756	22,267
Multi-Racial	361	2,610
Total	**11,002**	**66,560**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,959	35,486
Female	5,043	31,074
Total	**11,002**	**66,560**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	85	385
Medicaid	6,641	44,246
Peachare	360	1,717
Third-Party	3,577	19,176
Self-Pay	339	1,036
Other	0	0

5. Discharges to Death

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

142

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,591
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	4,240
Average Total Charge for an Inpatient Day	13,722

Part E : Emergency Department and Outpatient Services

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

79,870

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

6,966

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	2,023
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	41	77,847
	0	0
	0	0
	0	0
	0	0

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

972

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

253,288

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

7,704

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.

382

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	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	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	20
Number of Heart Transplants	14
Number of Other-Organ/Tissues Treatments	123
Number of Diagnostic X-Ray Procedures	77,536
Number of CTS Units (machines)	2
Number of CTS Procedures	5,457
Number of Diagnostic Radioisotope Procedures	1,598
Number of PET Units (machines)	1
Number of PET Procedures	283
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	3
Number of Number of MRI Procedures	9,114
Number of Chemotherapy Treatments	6,009
Number of Respiratory Therapy Treatments	249,970
Number of Occupational Therapy Treatments	21,949
Number of Physical Therapy Treatments	33,340
Number of Speech Pathology Patients	1,016
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	811
Number of HIV/AIDS Diagnostic Procedures	319
Number of HIV/AIDS Patients	5
Number of Ambulance Trips	5,189
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	14,075
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).

234

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 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	263	3.1	
Physician Assistants Only (not including Licensed Physicians)	22	0	
Registered Nurses (RNs-Advanced Practice*)	1311	26.5	
Licensed Practical Nurses (LPNs)	37	4.1	
Pharmacists	38	1	
Other Health Services Professionals*	1070	22.7	
Administration and Support	1706	79.2	0
All Other Hospital Personnel (not included above)	38		

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)	30 Days or Less
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	157	☑	129	0
Other Medical Specialties	239	☑	212	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	40	☐	29	0
Orthopedic Surgery	28	☐	19	0
Plastic Surgery	6	☐	6	0
General Surgery	15	☐	14	0
Thoracic Surgery	5	☐	3	0
Other Surgical Specialties	80	☐	70	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	45	☑	38	0
Dermatology	3	☐	3	0
Emergency Medicine	37	☑	36	0
Nuclear Medicine	0	☐	0	0
Pathology	18	☑	14	0
Psychiatry	10	☐	9	0
Radiology	64	☑	51	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	18
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	294

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	63	74	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	8	4	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	20	15	0	0	0	0	0	0	0	0	0	0	0
Banks	18	13	0	0	0	0	0	0	0	0	0	0	0
Barrow	87	81	0	0	0	0	0	0	0	0	0	0	0
Bartow	67	81	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	2	1	0	0	0	0	0	0	0	0	0	0	0
Berrien	9	10	0	0	0	0	0	0	0	0	0	0	0
Bibb	78	60	0	0	0	0	0	0	0	0	0	0	0
Bleckley	7	3	0	0	0	0	0	0	0	0	0	0	0
Brantley	1	2	0	0	0	0	0	0	0	0	0	0	0
Brooks	2	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	14	13	0	0	0	0	0	0	0	0	0	0	0
Bulloch	13	4	0	0	0	0	0	0	0	0	0	0	0
Burke	1	1	0	0	0	0	0	0	0	0	0	0	0
Butts	70	34	0	0	0	0	0	0	0	0	0	0	0
Calhoun	8	4	0	0	0	0	0	0	0	0	0	0	0
Camden	3	1	0	0	0	0	0	0	0	0	0	0	0
Candler	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	148	90	0	0	0	0	0	0	0	0	0	0	0
Catoosa	9	11	0	0	0	0	0	0	0	0	0	0	0
Chatham	41	36	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	22	18	0	0	0	0	0	0	0	0	0	0	0
Cherokee	166	165	0	0	0	0	0	0	0	0	0	0	0

Clarke	70	70	0	0	0	0	0	0	0	0	0	0	0
Clay	0	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	733	455	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	474	500	0	0	0	0	0	0	0	0	0	0	0
Coffee	12	8	0	0	0	0	0	0	0	0	0	0	0
Colquitt	20	19	0	0	0	0	0	0	0	0	0	0	0
Columbia	11	16	0	0	0	0	0	0	0	0	0	0	0
Cook	15	9	0	0	0	0	0	0	0	0	0	0	0
Coweta	240	159	0	0	0	0	0	0	0	0	0	0	0
Crawford	0	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	10	6	0	0	0	0	0	0	0	0	0	0	0
Dade	0	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	11	17	0	0	0	0	0	0	0	0	0	0	0
Decatur	8	20	0	0	0	0	0	0	0	0	0	0	0
DeKalb	2,040	1,238	0	0	0	0	0	0	0	0	0	0	0
Dodge	5	13	0	0	0	0	0	0	0	0	0	0	0
Dooly	11	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	45	42	0	0	0	0	0	0	0	0	0	0	0
Douglas	153	145	0	0	0	0	0	0	0	0	0	0	0
Early	13	3	0	0	0	0	0	0	0	0	0	0	0
Effingham	18	5	0	0	0	0	0	0	0	0	0	0	0
Elbert	10	12	0	0	0	0	0	0	0	0	0	0	0
Emanuel	10	2	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	20	6	0	0	0	0	0	0	0	0	0	0	0
Fayette	153	127	0	0	0	0	0	0	0	0	0	0	0
Florida	41	15	0	0	0	0	0	0	0	0	0	0	0
Floyd	62	51	0	0	0	0	0	0	0	0	0	0	0
Forsyth	70	100	0	0	0	0	0	0	0	0	0	0	0
Franklin	21	30	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,404	1,217	0	0	0	0	0	0	0	0	0	0	0
Gilmer	7	12	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	5	4	0	0	0	0	0	0	0	0	0	0	0
Gordon	49	36	0	0	0	0	0	0	0	0	0	0	0
Grady	11	7	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	835	905	0	0	0	0	0	0	0	0	0	0	0
Habersham	32	37	0	0	0	0	0	0	0	0	0	0	0
Hall	230	188	0	0	0	0	0	0	0	0	0	0	0
Hancock	2	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	27	26	0	0	0	0	0	0	0	0	0	0	0
Harris	22	29	0	0	0	0	0	0	0	0	0	0	0

Hart	10	5	0	0	0	0	0	0	0	0	0	0	0
Heard	12	8	0	0	0	0	0	0	0	0	0	0	0
Henry	602	373	0	0	0	0	0	0	0	0	0	0	0
Houston	126	88	0	0	0	0	0	0	0	0	0	0	0
Irwin	4	4	0	0	0	0	0	0	0	0	0	0	0
Jackson	81	99	0	0	0	0	0	0	0	0	0	0	0
Jasper	15	18	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	2	2	0	0	0	0	0	0	0	0	0	0	0
Jefferson	7	8	0	0	0	0	0	0	0	0	0	0	0
Jenkins	0	1	0	0	0	0	0	0	0	0	0	0	0
Johnson	4	2	0	0	0	0	0	0	0	0	0	0	0
Jones	4	5	0	0	0	0	0	0	0	0	0	0	0
Lamar	13	14	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	2	0	0	0	0	0	0	0	0	0	0	0
Laurens	12	10	0	0	0	0	0	0	0	0	0	0	0
Lee	21	23	0	0	0	0	0	0	0	0	0	0	0
Liberty	12	3	0	0	0	0	0	0	0	0	0	0	0
Long	3	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	25	23	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	18	10	0	0	0	0	0	0	0	0	0	0	0
Macon	9	6	0	0	0	0	0	0	0	0	0	0	0
Madison	66	34	0	0	0	0	0	0	0	0	0	0	0
Marion	1	3	0	0	0	0	0	0	0	0	0	0	0
McDuffie	0	5	0	0	0	0	0	0	0	0	0	0	0
McIntosh	2	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	32	22	0	0	0	0	0	0	0	0	0	0	0
Miller	0	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	10	17	0	0	0	0	0	0	0	0	0	0	0
Monroe	24	26	0	0	0	0	0	0	0	0	0	0	0
Montgomery	7	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	25	18	0	0	0	0	0	0	0	0	0	0	0
Murray	12	7	0	0	0	0	0	0	0	0	0	0	0
Muscogee	145	176	0	0	0	0	0	0	0	0	0	0	0
Newton	324	209	0	0	0	0	0	0	0	0	0	0	0
North Carolina	16	8	0	0	0	0	0	0	0	0	0	0	0
Oconee	22	28	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	6	4	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	81	54	0	0	0	0	0	0	0	0	0	0	0
Paulding	114	112	0	0	0	0	0	0	0	0	0	0	0
Peach	23	12	0	0	0	0	0	0	0	0	0	0	0
Pickens	25	20	0	0	0	0	0	0	0	0	0	0	0
Pierce	6	4	0	0	0	0	0	0	0	0	0	0	0
Pike	35	24	0	0	0	0	0	0	0	0	0	0	0
Polk	31	29	0	0	0	0	0	0	0	0	0	0	0

Pulaski	9	4	0	0	0	0	0	0	0	0	0	0	0
Putnam	10	7	0	0	0	0	0	0	0	0	0	0	0
Quitman	8	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	14	13	0	0	0	0	0	0	0	0	0	0	0
Randolph	2	2	0	0	0	0	0	0	0	0	0	0	0
Richmond	21	26	0	0	0	0	0	0	0	0	0	0	0
Rockdale	271	170	0	0	0	0	0	0	0	0	0	0	0
Schley	2	0	0	0	0	0	0	0	0	0	0	0	0
Screven	4	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	1	2	0	0	0	0	0	0	0	0	0	0	0
South Carolina	34	17	0	0	0	0	0	0	0	0	0	0	0
Spalding	141	82	0	0	0	0	0	0	0	0	0	0	0
Stephens	36	25	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	3	0	0	0	0	0	0	0	0	0	0	0
Sumter	33	14	0	0	0	0	0	0	0	0	0	0	0
Talbot	1	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	9	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	3	0	0	0	0	0	0	0	0	0	0	0
Tennessee	22	14	0	0	0	0	0	0	0	0	0	0	0
Terrell	5	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	13	9	0	0	0	0	0	0	0	0	0	0	0
Tift	35	14	0	0	0	0	0	0	0	0	0	0	0
Toombs	4	7	0	0	0	0	0	0	0	0	0	0	0
Towns	6	4	0	0	0	0	0	0	0	0	0	0	0
Treutlen	3	0	0	0	0	0	0	0	0	0	0	0	0
Troup	116	71	0	0	0	0	0	0	0	0	0	0	0
Turner	7	6	0	0	0	0	0	0	0	0	0	0	0
Twiggs	4	1	0	0	0	0	0	0	0	0	0	0	0
Union	8	13	0	0	0	0	0	0	0	0	0	0	0
Upson	19	28	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	274	185	0	0	0	0	0	0	0	0	0	0	0
Ware	7	7	0	0	0	0	0	0	0	0	0	0	0
Washington	4	3	0	0	0	0	0	0	0	0	0	0	0
Wayne	6	8	0	0	0	0	0	0	0	0	0	0	0
Wheeler	3	2	0	0	0	0	0	0	0	0	0	0	0
White	25	20	0	0	0	0	0	0	0	0	0	0	0
Whitfield	41	23	0	0	0	0	0	0	0	0	0	0	0
Wilcox	4	4	0	0	0	0	0	0	0	0	0	0	0
Wilkes	7	1	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	4	3	0	0	0	0	0	0	0	0	0	0	0
Worth	6	6	0	0	0	0	0	0	0	0	0	0	0
Total	**11,002**	**8,622**	**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	13
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
Cardiac	2	0	0
Total	**2**	**0**	**13**

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	14,197	20,578
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	4,011	0	0	0
Total	**4,011**	**0**	**14,197**	**20,578**

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	3,561	8,622
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	628	0	0	0
Total	**628**	**0**	**3,561**	**8,622**

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	25
Asian	319
Black/African American	3,487
Hispanic/Latino	1,042
Pacific Islander/Hawaiian	5
White	3,391
Multi-Racial	353
Total	**8,622**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,229
Ages 15-64	1,393
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**8,622**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,131
Female	3,491
Total	**8,622**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	34
Medicaid	5,049
Third-Party	3,402
Self-Pay	137

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)	45	493	15,257	493

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? 6.1 (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

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	9.9%	0	0	0
Burmese	0.1	0	0	0
Amharic	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?

1.5 hours of training at Patient Care Provided Orientation at the time of new hire.

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

Added interpreting FTE to match organization growth.

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

1. Spanish
2. English
3. Braille
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 inpatient 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: 2/27/2019

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 all 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 for Medicaid.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 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, 2018 through December 31, 2018.
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: Holly Walton

Contact Title: Senior Planning Analyst

Phone: 404-785-7906

Fax: 404-785-7801

E-mail: holly.walton@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	Not Applicable	

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

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	10,277	46,131	12,549	46,797
Pediatric ICU	67	3,275	14,270	883	14,221
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	311	8,005	436	8,330
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**	**13,863**	**68,406**	**13,868**	**69,348**

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	42
Asian	553	2,346
Black/African American	4,213	22,689
Hispanic/Latino	2,446	12,845
Pacific Islander/Hawaiian	14	40
White	6,086	27,464
Multi-Racial	536	2,980
Total	**13,863**	**68,406**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,548	31,573
Female	6,315	36,833
Total	**13,863**	**68,406**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7	28
Medicaid	6,900	38,600
Peachare	461	2,129
Third-Party	6,086	25,979
Self-Pay	409	1,670
Other	0	0

5. Discharges to Death

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

92

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,591
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	4,019
Average Total Charge for an Inpatient Day	9,963

Part E : Emergency Department and Outpatient Services

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

99,620

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

9,829

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

54

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	2,412
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	50	97,208
	0	0
	0	0
	0	0
	0	0

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

775

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

272,929

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

11,140

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

48.00

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.

421

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	74,628
Number of CTS Units (machines)	4
Number of CTS Procedures	10,064
Number of Diagnostic Radioisotope Procedures	1,253
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	15,770
Number of Chemotherapy Treatments	4,637
Number of Respiratory Therapy Treatments	377,703
Number of Occupational Therapy Treatments	132,440
Number of Physical Therapy Treatments	355,051
Number of Speech Pathology Patients	4,118
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	5,817
Number of HIV/AIDS Diagnostic Procedures	203
Number of HIV/AIDS Patients	7
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	19,020
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).

160

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	60	daVinci Si

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	158	3.7	
Physician Assistants Only (not including Licensed Physicians)	11	2	
Registered Nurses (RNs-Advanced Practice*)	1061	28.3	
Licensed Practical Nurses (LPNs)	21	2.5	
Pharmacists	35	1	
Other Health Services Professionals*	1173	44.6	
Administration and Support	1619	64.4	0
All Other Hospital Personnel (not included above)	27		

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	117	☑	108	0
Other Medical Specialties	165	☑	156	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	16	☐	14	0
Orthopedic Surgery	27	☐	23	0
Plastic Surgery	14	☐	9	0
General Surgery	7	☐	7	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	89	☐	74	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	7	☐	3	0
Emergency Medicine	41	☑	41	0
Nuclear Medicine	0	☐	0	0
Pathology	8	☑	8	0
Psychiatry	9	☐	8	0
Radiology	11	☑	10	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	42
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	256

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	82	68	0	0	0	0	0	0	0	0	0	0	0
Appling	1	2	0	0	0	0	0	0	0	0	0	0	0
Atkinson	2	3	0	0	0	0	0	0	0	0	0	0	0
Bacon	1	1	0	0	0	0	0	0	0	0	0	0	0
Baker	1	5	0	0	0	0	0	0	0	0	0	0	0
Baldwin	13	8	0	0	0	0	0	0	0	0	0	0	0
Banks	24	34	0	0	0	0	0	0	0	0	0	0	0
Barrow	175	174	0	0	0	0	0	0	0	0	0	0	0
Bartow	207	190	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	11	9	0	0	0	0	0	0	0	0	0	0	0
Berrien	2	7	0	0	0	0	0	0	0	0	0	0	0
Bibb	51	38	0	0	0	0	0	0	0	0	0	0	0
Bleckley	3	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	4	9	0	0	0	0	0	0	0	0	0	0	0
Bryan	5	2	0	0	0	0	0	0	0	0	0	0	0
Bulloch	1	5	0	0	0	0	0	0	0	0	0	0	0
Burke	0	3	0	0	0	0	0	0	0	0	0	0	0
Butts	38	42	0	0	0	0	0	0	0	0	0	0	0
Calhoun	0	2	0	0	0	0	0	0	0	0	0	0	0
Camden	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	255	198	0	0	0	0	0	0	0	0	0	0	0
Catoosa	5	10	0	0	0	0	0	0	0	0	0	0	0
Chatham	17	16	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	5	0	0	0	0	0	0	0	0	0	0	0
Chattooga	23	13	0	0	0	0	0	0	0	0	0	0	0
Cherokee	717	690	0	0	0	0	0	0	0	0	0	0	0

Clarke	111	89	0	0	0	0	0	0	0	0	0	0	0
Clay	1	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	382	379	0	0	0	0	0	0	0	0	0	0	0
Clinch	2	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,904	1,487	0	0	0	0	0	0	0	0	0	0	0
Coffee	6	12	0	0	0	0	0	0	0	0	0	0	0
Colquitt	19	13	0	0	0	0	0	0	0	0	0	0	0
Columbia	13	9	0	0	0	0	0	0	0	0	0	0	0
Cook	6	4	0	0	0	0	0	0	0	0	0	0	0
Coweta	184	255	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	9	3	0	0	0	0	0	0	0	0	0	0	0
Dade	1	1	0	0	0	0	0	0	0	0	0	0	0
Dawson	113	104	0	0	0	0	0	0	0	0	0	0	0
Decatur	5	9	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,085	1,173	0	0	0	0	0	0	0	0	0	0	0
Dodge	2	6	0	0	0	0	0	0	0	0	0	0	0
Dooly	12	13	0	0	0	0	0	0	0	0	0	0	0
Dougherty	33	23	0	0	0	0	0	0	0	0	0	0	0
Douglas	338	254	0	0	0	0	0	0	0	0	0	0	0
Early	1	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	3	8	0	0	0	0	0	0	0	0	0	0	0
Elbert	43	12	0	0	0	0	0	0	0	0	0	0	0
Emanuel	10	2	0	0	0	0	0	0	0	0	0	0	0
Evans	1	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	23	43	0	0	0	0	0	0	0	0	0	0	0
Fayette	202	197	0	0	0	0	0	0	0	0	0	0	0
Florida	29	30	0	0	0	0	0	0	0	0	0	0	0
Floyd	115	94	0	0	0	0	0	0	0	0	0	0	0
Forsyth	429	540	0	0	0	0	0	0	0	0	0	0	0
Franklin	19	38	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,983	1,975	0	0	0	0	0	0	0	0	0	0	0
Gilmer	67	59	0	0	0	0	0	0	0	0	0	0	0
Glynn	3	5	0	0	0	0	0	0	0	0	0	0	0
Gordon	55	53	0	0	0	0	0	0	0	0	0	0	0
Grady	6	6	0	0	0	0	0	0	0	0	0	0	0
Greene	1	8	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	1,933	1,891	0	0	0	0	0	0	0	0	0	0	0
Habersham	50	83	0	0	0	0	0	0	0	0	0	0	0
Hall	354	367	0	0	0	0	0	0	0	0	0	0	0
Hancock	1	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	66	40	0	0	0	0	0	0	0	0	0	0	0
Harris	16	25	0	0	0	0	0	0	0	0	0	0	0
Hart	11	22	0	0	0	0	0	0	0	0	0	0	0

Heard	15	17	0	0	0	0	0	0	0	0	0	0	0
Henry	321	441	0	0	0	0	0	0	0	0	0	0	0
Houston	65	57	0	0	0	0	0	0	0	0	0	0	0
Irwin	5	4	0	0	0	0	0	0	0	0	0	0	0
Jackson	128	211	0	0	0	0	0	0	0	0	0	0	0
Jasper	8	12	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	4	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	2	1	0	0	0	0	0	0	0	0	0	0	0
Jones	5	3	0	0	0	0	0	0	0	0	0	0	0
Lamar	11	15	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	2	0	0	0	0	0	0	0	0	0	0	0
Laurens	5	7	0	0	0	0	0	0	0	0	0	0	0
Lee	9	18	0	0	0	0	0	0	0	0	0	0	0
Liberty	0	2	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	1	0	0	0	0	0	0	0	0	0	0	0
Long	2	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	22	28	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	42	59	0	0	0	0	0	0	0	0	0	0	0
Macon	3	2	0	0	0	0	0	0	0	0	0	0	0
Madison	35	48	0	0	0	0	0	0	0	0	0	0	0
Marion	5	5	0	0	0	0	0	0	0	0	0	0	0
McDuffie	1	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	24	14	0	0	0	0	0	0	0	0	0	0	0
Miller	1	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	6	13	0	0	0	0	0	0	0	0	0	0	0
Monroe	6	12	0	0	0	0	0	0	0	0	0	0	0
Montgomery	2	0	0	0	0	0	0	0	0	0	0	0	0
Morgan	22	18	0	0	0	0	0	0	0	0	0	0	0
Murray	24	10	0	0	0	0	0	0	0	0	0	0	0
Muscogee	117	97	0	0	0	0	0	0	0	0	0	0	0
Newton	121	159	0	0	0	0	0	0	0	0	0	0	0
North Carolina	27	25	0	0	0	0	0	0	0	0	0	0	0
Oconee	44	33	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	11	5	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	100	88	0	0	0	0	0	0	0	0	0	0	0
Paulding	318	241	0	0	0	0	0	0	0	0	0	0	0
Peach	12	9	0	0	0	0	0	0	0	0	0	0	0
Pickens	79	62	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	18	34	0	0	0	0	0	0	0	0	0	0	0
Polk	78	71	0	0	0	0	0	0	0	0	0	0	0
Pulaski	0	6	0	0	0	0	0	0	0	0	0	0	0
Putnam	5	6	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	27	31	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	24	2	0	0	0	0	0	0	0	0	0	0	0
Rockdale	80	124	0	0	0	0	0	0	0	0	0	0	0
Schley	0	2	0	0	0	0	0	0	0	0	0	0	0
Screven	3	1	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	30	26	0	0	0	0	0	0	0	0	0	0	0
Spalding	63	115	0	0	0	0	0	0	0	0	0	0	0
Stephens	52	46	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	19	7	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	4	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	2	0	0	0	0	0	0	0	0	0	0	0
Tattnall	3	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	5	0	0	0	0	0	0	0	0	0	0	0
Tennessee	60	29	0	0	0	0	0	0	0	0	0	0	0
Terrell	3	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	23	16	0	0	0	0	0	0	0	0	0	0	0
Tift	19	21	0	0	0	0	0	0	0	0	0	0	0
Toombs	5	2	0	0	0	0	0	0	0	0	0	0	0
Towns	13	17	0	0	0	0	0	0	0	0	0	0	0
Troup	73	106	0	0	0	0	0	0	0	0	0	0	0
Turner	1	1	0	0	0	0	0	0	0	0	0	0	0
Twiggs	3	0	0	0	0	0	0	0	0	0	0	0	0
Union	29	25	0	0	0	0	0	0	0	0	0	0	0
Upson	26	21	0	0	0	0	0	0	0	0	0	0	0
Walker	4	18	0	0	0	0	0	0	0	0	0	0	0
Walton	196	264	0	0	0	0	0	0	0	0	0	0	0
Ware	1	2	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	2	2	0	0	0	0	0	0	0	0	0	0	0
Wheeler	4	2	0	0	0	0	0	0	0	0	0	0	0
White	33	49	0	0	0	0	0	0	0	0	0	0	0
Whitfield	31	30	0	0	0	0	0	0	0	0	0	0	0
Wilcox	11	6	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	5	3	0	0	0	0	0	0	0	0	0	0	0
Worth	11	6	0	0	0	0	0	0	0	0	0	0	0
Total	**13,863**	**13,702**	**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	13
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**3**	**13**

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	4,897	13,747	28,999
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**4,897**	**13,747**	**28,999**

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	1,815	4,470	11,887
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**1,815**	**4,470**	**11,887**

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	18
Asian	536
Black/African American	3,306
Hispanic/Latino	2,040
Pacific Islander/Hawaiian	12
White	7,226
Multi-Racial	564
Total	**13,702**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	11,671
Ages 15-64	2,031
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**13,702**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	7,938
Female	5,764
Total	**13,702**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2
Medicaid	6,466
Third-Party	6,952
Self-Pay	282

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	375	12,876	375

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? 11.4 (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

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	9.9%	0	0	0
Portuguese	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?

1.5 hours of training at Patient Care Provider Orientation at the time of hire.

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

Increased needs for staff interpreters based on hospital growth.

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

1. Spanish
2. English
3. Braille
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	143
Black/African American	137	3,702
Hispanic/Latino	47	1,046
Pacific Islander/Hawaiian	0	0
White	108	2,799
Multi-Racial	12	315

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	173	4,645
Female	138	3,360

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	291	7,558
18-64	20	447
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	311
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	303
Self Pay	8
Other	0

2. Uncompensated Indigent and Charity Care

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

4

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: 2/27/2019

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 all 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 for Medicaid.