GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 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, 2021 through December 31, 2021.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Ariel Zhang

Contact Title: Senior Financial Analyst

Phone: 404-785-5721

Fax: 404-785-7027

E-mail: ariel.zhang@choa.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Egleston Children's Hospital at Emory University	Not for Profit	2/1/1998

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Children's Healthcare of Atlanta
City: Atlanta **State:** GA

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

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

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

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: The Children's Care Network, Inc.
City: Atlanta **State:** GA

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

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☐

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	0	0	0	0	0
Pediatrics (Non ICU)	202	7,865	48,459	9,937	49,249
Pediatric ICU	46	2,293	11,044	865	11,186
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	695	8,266	54	8,075
	0	0	0	0	0
	0	0	0	0	0
Total	**280**	**10,853**	**67,769**	**10,856**	**68,510**

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	6	15
Asian	307	2,480
Black/African American	5,365	32,373
Hispanic/Latino	1,244	8,420
Pacific Islander/Hawaiian	10	40
White	3,612	22,238
Multi-Racial	309	2,203
Total	**10,853**	**67,769**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,704	37,188
Female	5,149	30,581
Total	**10,853**	**67,769**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	96	643
Medicaid	6,420	39,937
Peachare	467	2,204
Third-Party	3,579	23,855
Self-Pay	291	1,130
Other	0	0

5. Discharges to Death

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

194

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2021 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,615
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	10,428
Average Total Charge for an Inpatient Day	17,093

Part E : Emergency Department and Outpatient Services

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

70,007

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

6,871

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	1,889
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	41	68,118
	0	0
	0	0
	0	0
	0	0

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

1,281

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

221,548

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

6,968

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

13

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

30.00

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

2,260

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	2	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	1	1
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	1,232
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	23
Number of Heart Transplants	16
Number of Other-Organ/Tissues Treatments	103
Number of Diagnostic X-Ray Procedures	79,456
Number of CTS Units (machines)	2
Number of CTS Procedures	6,966
Number of Diagnostic Radioisotope Procedures	1,677
Number of PET Units (machines)	1
Number of PET Procedures	297
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	3
Number of Number of MRI Procedures	9,857
Number of Chemotherapy Treatments	6,326
Number of Respiratory Therapy Treatments	120,266
Number of Occupational Therapy Treatments	22,311
Number of Physical Therapy Treatments	32,389
Number of Speech Pathology Patients	1,134
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,211
Number of HIV/AIDS Diagnostic Procedures	1,238
Number of HIV/AIDS Patients	9
Number of Ambulance Trips	4,333
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	5
Number of Ultrasound/Medical Sonography Procedures	15,517
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).

245

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 12-31-2021. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2021.

Profession	Profession	Profession	Profession
Licensed Physicians	275.01	1.60	0.00
Physician Assistants Only (not including Licensed Physicians)	26.09	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,306.99	132.90	79.60
Licensed Practical Nurses (LPNs)	32.14	0.00	0.90
Pharmacists	39.11	1.00	0.00
Other Health Services Professionals*	1,097.87	37.15	19.70
Administration and Support	1,884.10	200.07	0.00
All Other Hospital Personnel (not included above)	42.76	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	30 Days or Less
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

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

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

4. Medical Staff

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

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

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	0	☐	0	0
General Internal Medicine	0	☐	0	0
Pediatricians	169	☑	118	0
Other Medical Specialties	277	☑	217	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	☐	3	0
Ophthalmology Surgery	41	☐	30	0
Orthopedic Surgery	11	☐	11	0
Plastic Surgery	5	☐	4	0
General Surgery	9	☐	7	0
Thoracic Surgery	6	☐	3	0
Other Surgical Specialties	82	☐	69	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	39	☑	35	0
Dermatology	18	☐	18	0
Emergency Medicine	44	☑	39	0
Nuclear Medicine	0	☐	0	0
Pathology	19	☑	17	0
Psychiatry	18	☐	13	0
Radiology	62	☑	41	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	13
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	351

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	86	56	0	0	0	0	0	0	0	0	0	0	0
Appling	1	0	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	3	0	0	0	0	0	0	0	0	0	0	0
Baker	0	4	0	0	0	0	0	0	0	0	0	0	0
Baldwin	17	21	0	0	0	0	0	0	0	0	0	0	0
Banks	22	38	0	0	0	0	0	0	0	0	0	0	0
Barrow	107	106	0	0	0	0	0	0	0	0	0	0	0
Bartow	106	79	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	5	7	0	0	0	0	0	0	0	0	0	0	0
Berrien	4	7	0	0	0	0	0	0	0	0	0	0	0
Bibb	99	82	0	0	0	0	0	0	0	0	0	0	0
Bleckley	6	5	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	10	14	0	0	0	0	0	0	0	0	0	0	0
Bulloch	9	9	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	47	48	0	0	0	0	0	0	0	0	0	0	0
Calhoun	1	3	0	0	0	0	0	0	0	0	0	0	0
Camden	2	1	0	0	0	0	0	0	0	0	0	0	0
Candler	2	3	0	0	0	0	0	0	0	0	0	0	0
Carroll	148	158	0	0	0	0	0	0	0	0	0	0	0
Catoosa	2	6	0	0	0	0	0	0	0	0	0	0	0
Chatham	42	21	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	4	3	0	0	0	0	0	0	0	0	0	0	0
Chattooga	9	10	0	0	0	0	0	0	0	0	0	0	0

Cherokee	180	187	0	0	0	0	0	0	0	0	0	0	0
Clarke	83	93	0	0	0	0	0	0	0	0	0	0	0
Clay	2	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	576	415	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	471	568	0	0	0	0	0	0	0	0	0	0	0
Coffee	16	13	0	0	0	0	0	0	0	0	0	0	0
Colquitt	25	15	0	0	0	0	0	0	0	0	0	0	0
Columbia	8	14	0	0	0	0	0	0	0	0	0	0	0
Cook	3	6	0	0	0	0	0	0	0	0	0	0	0
Coweta	244	180	0	0	0	0	0	0	0	0	0	0	0
Crawford	7	4	0	0	0	0	0	0	0	0	0	0	0
Crisp	8	6	0	0	0	0	0	0	0	0	0	0	0
Dade	0	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	35	31	0	0	0	0	0	0	0	0	0	0	0
Decatur	13	23	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,790	1,271	0	0	0	0	0	0	0	0	0	0	0
Dodge	7	8	0	0	0	0	0	0	0	0	0	0	0
Dooly	1	2	0	0	0	0	0	0	0	0	0	0	0
Dougherty	72	45	0	0	0	0	0	0	0	0	0	0	0
Douglas	185	158	0	0	0	0	0	0	0	0	0	0	0
Early	12	5	0	0	0	0	0	0	0	0	0	0	0
Echols	1	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	16	15	0	0	0	0	0	0	0	0	0	0	0
Elbert	23	13	0	0	0	0	0	0	0	0	0	0	0
Emanuel	1	7	0	0	0	0	0	0	0	0	0	0	0
Evans	1	4	0	0	0	0	0	0	0	0	0	0	0
Fannin	7	7	0	0	0	0	0	0	0	0	0	0	0
Fayette	172	149	0	0	0	0	0	0	0	0	0	0	0
Florida	40	24	0	0	0	0	0	0	0	0	0	0	0
Floyd	63	48	0	0	0	0	0	0	0	0	0	0	0
Forsyth	89	130	0	0	0	0	0	0	0	0	0	0	0
Franklin	22	33	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,448	1,270	0	0	0	0	0	0	0	0	0	0	0
Gilmer	15	10	0	0	0	0	0	0	0	0	0	0	0
Glascock	1	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	6	9	0	0	0	0	0	0	0	0	0	0	0
Gordon	41	42	0	0	0	0	0	0	0	0	0	0	0
Grady	7	13	0	0	0	0	0	0	0	0	0	0	0
Greene	14	18	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	903	947	0	0	0	0	0	0	0	0	0	0	0
Habersham	61	46	0	0	0	0	0	0	0	0	0	0	0
Hall	159	154	0	0	0	0	0	0	0	0	0	0	0
Hancock	4	4	0	0	0	0	0	0	0	0	0	0	0

Haralson	42	37	0	0	0	0	0	0	0	0	0	0	0
Harris	24	25	0	0	0	0	0	0	0	0	0	0	0
Hart	15	22	0	0	0	0	0	0	0	0	0	0	0
Heard	21	7	0	0	0	0	0	0	0	0	0	0	0
Henry	627	438	0	0	0	0	0	0	0	0	0	0	0
Houston	117	98	0	0	0	0	0	0	0	0	0	0	0
Irwin	1	4	0	0	0	0	0	0	0	0	0	0	0
Jackson	89	112	0	0	0	0	0	0	0	0	0	0	0
Jasper	28	28	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	3	4	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
Jenkins	3	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	7	6	0	0	0	0	0	0	0	0	0	0	0
Jones	9	14	0	0	0	0	0	0	0	0	0	0	0
Lamar	19	22	0	0	0	0	0	0	0	0	0	0	0
Lanier	3	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	20	17	0	0	0	0	0	0	0	0	0	0	0
Lee	19	34	0	0	0	0	0	0	0	0	0	0	0
Liberty	10	11	0	0	0	0	0	0	0	0	0	0	0
Long	1	5	0	0	0	0	0	0	0	0	0	0	0
Lowndes	28	33	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	26	20	0	0	0	0	0	0	0	0	0	0	0
Macon	6	0	0	0	0	0	0	0	0	0	0	0	0
Madison	35	31	0	0	0	0	0	0	0	0	0	0	0
Marion	4	9	0	0	0	0	0	0	0	0	0	0	0
McDuffie	4	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	37	25	0	0	0	0	0	0	0	0	0	0	0
Miller	3	6	0	0	0	0	0	0	0	0	0	0	0
Mitchell	10	11	0	0	0	0	0	0	0	0	0	0	0
Monroe	21	16	0	0	0	0	0	0	0	0	0	0	0
Montgomery	2	3	0	0	0	0	0	0	0	0	0	0	0
Morgan	32	28	0	0	0	0	0	0	0	0	0	0	0
Murray	9	12	0	0	0	0	0	0	0	0	0	0	0
Muscogee	192	202	0	0	0	0	0	0	0	0	0	0	0
Newton	286	204	0	0	0	0	0	0	0	0	0	0	0
North Carolina	15	15	0	0	0	0	0	0	0	0	0	0	0
Oconee	37	40	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	5	13	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	68	47	0	0	0	0	0	0	0	0	0	0	0
Paulding	118	128	0	0	0	0	0	0	0	0	0	0	0
Peach	18	22	0	0	0	0	0	0	0	0	0	0	0
Pickens	27	20	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	9	0	0	0	0	0	0	0	0	0	0	0
Pike	38	34	0	0	0	0	0	0	0	0	0	0	0

Polk	50	36	0	0	0	0	0	0	0	0	0	0	0
Pulaski	17	11	0	0	0	0	0	0	0	0	0	0	0
Putnam	15	11	0	0	0	0	0	0	0	0	0	0	0
Quitman	2	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	23	11	0	0	0	0	0	0	0	0	0	0	0
Randolph	5	3	0	0	0	0	0	0	0	0	0	0	0
Richmond	16	21	0	0	0	0	0	0	0	0	0	0	0
Rockdale	214	145	0	0	0	0	0	0	0	0	0	0	0
Schley	2	3	0	0	0	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	2	0	0	0	0	0	0	0	0	0	0	0
South Carolina	37	18	0	0	0	0	0	0	0	0	0	0	0
Spalding	134	104	0	0	0	0	0	0	0	0	0	0	0
Stephens	37	35	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	12	10	0	0	0	0	0	0	0	0	0	0	0
Talbot	2	2	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	11	1	0	0	0	0	0	0	0	0	0	0	0
Taylor	3	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	5	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	17	11	0	0	0	0	0	0	0	0	0	0	0
Terrell	2	7	0	0	0	0	0	0	0	0	0	0	0
Thomas	31	22	0	0	0	0	0	0	0	0	0	0	0
Tift	19	23	0	0	0	0	0	0	0	0	0	0	0
Toombs	8	5	0	0	0	0	0	0	0	0	0	0	0
Towns	5	5	0	0	0	0	0	0	0	0	0	0	0
Treutlen	4	0	0	0	0	0	0	0	0	0	0	0	0
Troup	120	72	0	0	0	0	0	0	0	0	0	0	0
Turner	4	11	0	0	0	0	0	0	0	0	0	0	0
Twiggs	2	2	0	0	0	0	0	0	0	0	0	0	0
Union	15	16	0	0	0	0	0	0	0	0	0	0	0
Upson	30	33	0	0	0	0	0	0	0	0	0	0	0
Walker	14	14	0	0	0	0	0	0	0	0	0	0	0
Walton	234	189	0	0	0	0	0	0	0	0	0	0	0
Ware	1	4	0	0	0	0	0	0	0	0	0	0	0
Warren	0	1	0	0	0	0	0	0	0	0	0	0	0
Washington	5	9	0	0	0	0	0	0	0	0	0	0	0
Wayne	8	2	0	0	0	0	0	0	0	0	0	0	0
White	23	27	0	0	0	0	0	0	0	0	0	0	0
Whitfield	34	41	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
Wilkes	12	2	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	5	6	0	0	0	0	0	0	0	0	0	0	0

Worth	14	9	0	0	0	0	0	0	0	0	0	0	0
Total	**10,853**	**9,429**	**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	15,744	22,390
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	4,134	0	0	0
Total	**4,134**	**0**	**15,744**	**22,390**

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	3,577	9,429
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	545	0	0	0
Total	**545**	**0**	**3,577**	**9,429**

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	16
Asian	291
Black/African American	3,788
Hispanic/Latino	1,233
Pacific Islander/Hawaiian	9
White	3,773
Multi-Racial	319
Total	**9,429**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,690
Ages 15-64	1,739
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**9,429**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,527
Female	3,902
Total	**9,429**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	21
Medicaid	5,681
Third-Party	3,598
Self-Pay	129

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	513	16,695	513

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? 8.5799999237061 (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	9.4%	0	0	0
VIETNAMESE	0.2%	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?

New Hire Orientation and Patient Care Provider Orientation

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

Increased FTE for more in-person interpreting.

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: 3/4/2022

Title: Chief Nursing and Hospital Operations Office

Comments:

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 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, 2021 through December 31, 2021.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Ariel Zhang

Contact Title: Senior Financial Analyst

Phone: 404-785-5721

Fax: 404-785-7027

E-mail: ariel.zhang@choa.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Scottish Rite Children's Medical Center, Inc.	Not for Profit	2/1/1998

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Children's Healthcare of Atlanta, Inc.
City: Atlanta **State:** GA

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

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

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

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: The Children's Care Network, Inc.
City: Atlanta **State:** GA

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

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☐

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	0	0	0	0	0
Pediatrics (Non ICU)	185	9,561	46,304	11,800	46,021
Pediatric ICU	67	3,397	14,788	989	14,595
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	324	8,755	424	8,666
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**	**13,282**	**69,847**	**13,213**	**69,282**

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	26	85
Asian	500	2,451
Black/African American	4,010	22,989
Hispanic/Latino	2,490	12,586
Pacific Islander/Hawaiian	8	34
White	5,801	28,666
Multi-Racial	447	3,036
Total	**13,282**	**69,847**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,086	36,864
Female	6,196	32,983
Total	**13,282**	**69,847**

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	27
Medicaid	6,470	37,254
Peachare	574	2,522
Third-Party	5,893	28,579
Self-Pay	339	1,465
Other	0	0

5. Discharges to Death

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

94

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2021 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,615
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	8,674
Average Total Charge for an Inpatient Day	12,318

Part E : Emergency Department and Outpatient Services

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

95,763

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

9,399

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	2,099
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	57	93,664
	0	0
	0	0
	0	0
	0	0

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

1,186

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

249,242

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

8,761

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

8

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

14.00

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

1,078

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	74,793
Number of CTS Units (machines)	4
Number of CTS Procedures	11,012
Number of Diagnostic Radioisotope Procedures	1,021
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	6
Number of Number of MRI Procedures	17,753
Number of Chemotherapy Treatments	6,151
Number of Respiratory Therapy Treatments	167,138
Number of Occupational Therapy Treatments	95,669
Number of Physical Therapy Treatments	269,543
Number of Speech Pathology Patients	3,397
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	4,935
Number of HIV/AIDS Diagnostic Procedures	734
Number of HIV/AIDS Patients	6
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	11
Number of Ultrasound/Medical Sonography Procedures	23,640
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).

181

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	52	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 12-31-2021. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2021.

Profession	Profession	Profession	Profession
Licensed Physicians	179.62	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	13.01	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,029.73	78.71	68.00
Licensed Practical Nurses (LPNs)	20.72	0.80	0.00
Pharmacists	36.22	0.00	0.00
Other Health Services Professionals*	1,122.00	74.45	21.10
Administration and Support	1,559.42	172.36	0.00
All Other Hospital Personnel (not included above)	30.60	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	30 Days or Less
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

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

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

4. Medical Staff

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

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

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	0	☐	0	0
General Internal Medicine	0	☐	0	0
Pediatricians	115	☑	104	0
Other Medical Specialties	159	☑	140	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	0	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	0	☐	0	0
Ophthalmology Surgery	13	☐	13	0
Orthopedic Surgery	23	☐	19	0
Plastic Surgery	12	☐	7	0
General Surgery	15	☐	14	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	79	☐	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	28	☑	27	0
Dermatology	2	☐	1	0
Emergency Medicine	47	☑	42	0
Nuclear Medicine	0	☐	0	0
Pathology	7	☑	7	0
Psychiatry	5	☐	3	0
Radiology	6	☑	6	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	38
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	255

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	70	75	0	0	0	0	0	0	0	0	0	0	0
Appling	2	1	0	0	0	0	0	0	0	0	0	0	0
Atkinson	2	2	0	0	0	0	0	0	0	0	0	0	0
Bacon	1	0	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	30	37	0	0	0	0	0	0	0	0	0	0	0
Barrow	153	240	0	0	0	0	0	0	0	0	0	0	0
Bartow	227	187	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	5	10	0	0	0	0	0	0	0	0	0	0	0
Berrien	3	6	0	0	0	0	0	0	0	0	0	0	0
Bibb	42	62	0	0	0	0	0	0	0	0	0	0	0
Bleckley	3	10	0	0	0	0	0	0	0	0	0	0	0
Brantley	3	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	2	5	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	3	2	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	38	52	0	0	0	0	0	0	0	0	0	0	0
Calhoun	4	2	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
Carroll	272	221	0	0	0	0	0	0	0	0	0	0	0
Catoosa	9	7	0	0	0	0	0	0	0	0	0	0	0
Chatham	23	12	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	4	2	0	0	0	0	0	0	0	0	0	0	0
Chattooga	12	13	0	0	0	0	0	0	0	0	0	0	0
Cherokee	672	669	0	0	0	0	0	0	0	0	0	0	0
Clarke	106	84	0	0	0	0	0	0	0	0	0	0	0

Clayton	293	369	0	0	0	0	0	0	0	0	0	0	0
Cobb	1,838	1,378	0	0	0	0	0	0	0	0	0	0	0
Coffee	3	8	0	0	0	0	0	0	0	0	0	0	0
Colquitt	21	17	0	0	0	0	0	0	0	0	0	0	0
Columbia	16	29	0	0	0	0	0	0	0	0	0	0	0
Cook	12	9	0	0	0	0	0	0	0	0	0	0	0
Coweta	177	237	0	0	0	0	0	0	0	0	0	0	0
Crawford	1	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	11	3	0	0	0	0	0	0	0	0	0	0	0
Dade	3	5	0	0	0	0	0	0	0	0	0	0	0
Dawson	86	99	0	0	0	0	0	0	0	0	0	0	0
Decatur	3	12	0	0	0	0	0	0	0	0	0	0	0
DeKalb	991	1,193	0	0	0	0	0	0	0	0	0	0	0
Dodge	5	5	0	0	0	0	0	0	0	0	0	0	0
Dooly	8	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	29	30	0	0	0	0	0	0	0	0	0	0	0
Douglas	303	240	0	0	0	0	0	0	0	0	0	0	0
Early	15	7	0	0	0	0	0	0	0	0	0	0	0
Echols	1	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	3	3	0	0	0	0	0	0	0	0	0	0	0
Elbert	31	13	0	0	0	0	0	0	0	0	0	0	0
Emanuel	2	0	0	0	0	0	0	0	0	0	0	0	0
Evans	0	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	38	38	0	0	0	0	0	0	0	0	0	0	0
Fayette	147	176	0	0	0	0	0	0	0	0	0	0	0
Florida	28	28	0	0	0	0	0	0	0	0	0	0	0
Floyd	128	100	0	0	0	0	0	0	0	0	0	0	0
Forsyth	468	521	0	0	0	0	0	0	0	0	0	0	0
Franklin	25	41	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,791	1,834	0	0	0	0	0	0	0	0	0	0	0
Gilmer	64	50	0	0	0	0	0	0	0	0	0	0	0
Glynn	2	3	0	0	0	0	0	0	0	0	0	0	0
Gordon	71	55	0	0	0	0	0	0	0	0	0	0	0
Grady	3	2	0	0	0	0	0	0	0	0	0	0	0
Greene	17	10	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	1,879	1,716	0	0	0	0	0	0	0	0	0	0	0
Habersham	66	91	0	0	0	0	0	0	0	0	0	0	0
Hall	402	394	0	0	0	0	0	0	0	0	0	0	0
Hancock	1	2	0	0	0	0	0	0	0	0	0	0	0
Haralson	59	71	0	0	0	0	0	0	0	0	0	0	0
Harris	6	17	0	0	0	0	0	0	0	0	0	0	0
Hart	7	27	0	0	0	0	0	0	0	0	0	0	0
Heard	15	6	0	0	0	0	0	0	0	0	0	0	0
Henry	290	465	0	0	0	0	0	0	0	0	0	0	0

Houston	60	66	0	0	0	0	0	0	0	0	0	0	0
Irwin	2	4	0	0	0	0	0	0	0	0	0	0	0
Jackson	159	212	0	0	0	0	0	0	0	0	0	0	0
Jasper	14	18	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	0	2	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	1	0	0	0	0	0	0	0	0	0	0	0	0
Jones	7	7	0	0	0	0	0	0	0	0	0	0	0
Lamar	16	17	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	13	5	0	0	0	0	0	0	0	0	0	0	0
Lee	9	12	0	0	0	0	0	0	0	0	0	0	0
Liberty	3	0	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	1	3	0	0	0	0	0	0	0	0	0	0	0
Lowndes	26	25	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	50	75	0	0	0	0	0	0	0	0	0	0	0
Macon	0	5	0	0	0	0	0	0	0	0	0	0	0
Madison	31	27	0	0	0	0	0	0	0	0	0	0	0
Marion	0	1	0	0	0	0	0	0	0	0	0	0	0
McDuffie	2	11	0	0	0	0	0	0	0	0	0	0	0
Meriwether	9	12	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	15	0	0	0	0	0	0	0	0	0	0	0
Morgan	20	25	0	0	0	0	0	0	0	0	0	0	0
Murray	20	12	0	0	0	0	0	0	0	0	0	0	0
Muscogee	146	122	0	0	0	0	0	0	0	0	0	0	0
Newton	120	185	0	0	0	0	0	0	0	0	0	0	0
North Carolina	26	13	0	0	0	0	0	0	0	0	0	0	0
Oconee	27	49	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	7	15	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	115	41	0	0	0	0	0	0	0	0	0	0	0
Paulding	332	267	0	0	0	0	0	0	0	0	0	0	0
Peach	27	12	0	0	0	0	0	0	0	0	0	0	0
Pickens	72	68	0	0	0	0	0	0	0	0	0	0	0
Pierce	3	2	0	0	0	0	0	0	0	0	0	0	0
Pike	25	28	0	0	0	0	0	0	0	0	0	0	0
Polk	74	63	0	0	0	0	0	0	0	0	0	0	0
Pulaski	3	7	0	0	0	0	0	0	0	0	0	0	0
Putnam	8	16	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	12	22	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	6	36	0	0	0	0	0	0	0	0	0	0	0

Rockdale	72	127	0	0	0	0	0	0	0	0	0	0	0
Schley	2	3	0	0	0	0	0	0	0	0	0	0	0
Screven	0	1	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	3	0	0	0	0	0	0	0	0	0	0	0
South Carolina	22	28	0	0	0	0	0	0	0	0	0	0	0
Spalding	78	104	0	0	0	0	0	0	0	0	0	0	0
Stephens	29	66	0	0	0	0	0	0	0	0	0	0	0
Stewart	0	2	0	0	0	0	0	0	0	0	0	0	0
Sumter	8	10	0	0	0	0	0	0	0	0	0	0	0
Talbot	4	6	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	1	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	0	5	0	0	0	0	0	0	0	0	0	0	0
Telfair	3	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	62	19	0	0	0	0	0	0	0	0	0	0	0
Terrell	0	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	16	15	0	0	0	0	0	0	0	0	0	0	0
Tift	19	25	0	0	0	0	0	0	0	0	0	0	0
Toombs	1	7	0	0	0	0	0	0	0	0	0	0	0
Towns	12	17	0	0	0	0	0	0	0	0	0	0	0
Treutlen	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	74	88	0	0	0	0	0	0	0	0	0	0	0
Turner	1	2	0	0	0	0	0	0	0	0	0	0	0
Twiggs	1	2	0	0	0	0	0	0	0	0	0	0	0
Union	15	45	0	0	0	0	0	0	0	0	0	0	0
Upson	18	21	0	0	0	0	0	0	0	0	0	0	0
Walker	11	9	0	0	0	0	0	0	0	0	0	0	0
Walton	207	269	0	0	0	0	0	0	0	0	0	0	0
Ware	8	1	0	0	0	0	0	0	0	0	0	0	0
Warren	1	3	0	0	0	0	0	0	0	0	0	0	0
Washington	2	5	0	0	0	0	0	0	0	0	0	0	0
Wayne	1	0	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	1	0	0	0	0	0	0	0	0	0	0	0
White	34	64	0	0	0	0	0	0	0	0	0	0	0
Whitfield	31	39	0	0	0	0	0	0	0	0	0	0	0
Wilcox	6	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	2	1	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	4	5	0	0	0	0	0	0	0	0	0	0	0
Worth	4	5	0	0	0	0	0	0	0	0	0	0	0
Total	**13,282**	**13,541**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

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

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	3	14
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**3**	**14**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	6,874	13,338	23,394
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**6,874**	**13,338**	**23,394**

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	2,583	4,037	10,958
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**2,583**	**4,037**	**10,958**

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	14
Asian	550
Black/African American	3,615
Hispanic/Latino	2,210
Pacific Islander/Hawaiian	7
White	6,700
Multi-Racial	445
Total	**13,541**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	11,128
Ages 15-64	2,413
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**13,541**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	7,945
Female	5,596
Total	**13,541**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	7
Medicaid	7,007
Third-Party	6,286
Self-Pay	241

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	401	13,112	401

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? 19.139999389648 (FTE's)
What languages do they interpret?
Spanish

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

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

Video remote 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	10%	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?

New Hire Orientation and Patient Care Provider Orientation

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

Increased FTE for more in-person interpreting.

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	8	156
Black/African American	167	4,343
Hispanic/Latino	30	814
Pacific Islander/Hawaiian	0	0
White	114	3,177
Multi-Racial	5	265

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	190	4,790
Female	134	3,965

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	190	8,016
18-64	134	739
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	324
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	311
Self Pay	13
Other	0

2. Uncompensated Indigent and Charity Care

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

10

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: 3/4/2022

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