GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 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: 1600 Tullie Circle

Mailing City: Atlanta

Mailing Zip: 30329

Medicaid Provider Number: 00000943A

Medicare Provider Number: 113300

2. Report Period

Report Data for the full twelve month period- January 1, 2008 through December 31, 2008.
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: Nicole Mansfield

Contact Title: Strategic Planning Project Manager

Phone: 404-785-7560

Fax: 404-785-7027

E-mail: nicole.mansfield@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	Not for Profit	2/1/1998

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

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

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

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

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

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

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

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)	149	7,414	40,441	8,589	40,472
Pediatric ICU	66	2,155	15,533	791	15,932
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
Cystic Fibrosis	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**215**	**9,569**	**55,974**	**9,380**	**56,404**

2. Race/Ethnicity

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	8	131
Asian	150	957
Black/African American	4,462	25,940
Hispanic/Latino	889	5,646
Pacific Islander/Hawaiian	1	1
White	3,940	22,620
Multi-Racial	119	679
Total	**9,569**	**55,974**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,250	30,268
Female	4,319	25,706
Total	**9,569**	**55,974**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	104	693
Medicaid	4,834	32,953
Peachare	473	1,896
Third-Party	3,622	18,357
Self-Pay	301	854
Other	235	1,221

5. Discharges to Death

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

184

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2008 (to the nearest whole dollar).

Service	Charge
Private Room Rate	720
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	1,988
Average Total Charge for an Inpatient Day	7,047

Part E : Emergency Department and Outpatient Services

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

46,318

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

5,318

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

34

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	1,163
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	30	45,155
	0	0
	0	0
	0	0
	0	0

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

62

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

180,204

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

2,452

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

348.00

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.

361

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	1	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	2,609
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	24
Number of Heart Transplants	11
Number of Other-Organ/Tissues Treatments	79
Number of Diagnostic X-Ray Procedures	61,775
Number of CTS Units (machines)	1
Number of CTS Procedures	7,290
Number of Diagnostic Radioisotope Procedures	867
Number of PET Units (machines)	1
Number of PET Procedures	110
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	2
Number of Number of MRI Procedures	5,621
Number of Chemotherapy Treatments	3,418
Number of Respiratory Therapy Treatments	147,647
Number of Occupational Therapy Treatments	22,540
Number of Physical Therapy Treatments	62,458
Number of Speech Pathology Patients	1,182
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	2,665
Number of HIV/AIDS Diagnostic Procedures	659
Number of HIV/AIDS Patients	16
Number of Ambulance Trips	5,542
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	3
Number of Ultrasound/Medical Sonography Procedures	6,243
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).

132

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 12-31-2008. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	79.900001525879	1	0
Physician Assistants Only (not including Licensed Physicians)	3.5999999046326	0	0
Registered Nurses (RNs-Advanced Practice*)	795.59997558594	14.050000190735	18.89999961853
Licensed Practical Nurses (LPNs)	14.5	0	0
Pharmacists	35	1	0
Other Health Services Professionals*	602.40002441406	8	2.4000000953674
Administration and Support	1134.6999511719	4	30.10000038147
All Other Hospital Personnel (not included above)		4.0999999046326	

2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	Not Applicable
Pharmacists	61-90 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	61-90 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	197	☑	0	0
Other Medical Specialties	125	☑	0	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	2	☐	0	0
Ophthalmology Surgery	23	☐	0	0
Orthopedic Surgery	16	☐	0	0
Plastic Surgery	9	☐	0	0
General Surgery	20	☐	0	0
Thoracic Surgery	5	☐	0	0
Other Surgical Specialties	62	☐	0	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	20	☑	0	0
Dermatology	4	☐	0	0
Emergency Medicine	28	☑	0	0
Nuclear Medicine	0	☐	0	0
Pathology	21	☑	0	0
Psychiatry	14	☑	0	0
Radiology	37	☐	0	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	5
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	116

5b. Name of Other Professions

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

PA, NP, PhD, CRNA, CNS

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
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
Alabama	64	39	0	0	0	0	0	0	0	0	0	0
Appling	6	6	0	0	0	0	0	0	0	0	0	0
Atkinson	0	3	0	0	0	0	0	0	0	0	0	0
Bacon	1	0	0	0	0	0	0	0	0	0	0	0
Baker	0	10	0	0	0	0	0	0	0	0	0	0
Baldwin	23	4	0	0	0	0	0	0	0	0	0	0
Banks	15	16	0	0	0	0	0	0	0	0	0	0
Barrow	79	89	0	0	0	0	0	0	0	0	0	0
Bartow	77	59	0	0	0	0	0	0	0	0	0	0
Ben Hill	3	4	0	0	0	0	0	0	0	0	0	0
Berrien	2	11	0	0	0	0	0	0	0	0	0	0
Bibb	79	80	0	0	0	0	0	0	0	0	0	0
Bleckley	11	9	0	0	0	0	0	0	0	0	0	0
Brantley	3	1	0	0	0	0	0	0	0	0	0	0
Brooks	2	2	0	0	0	0	0	0	0	0	0	0
Bryan	3	2	0	0	0	0	0	0	0	0	0	0
Bulloch	3	5	0	0	0	0	0	0	0	0	0	0
Burke	1	5	0	0	0	0	0	0	0	0	0	0
Butts	40	32	0	0	0	0	0	0	0	0	0	0
Calhoun	3	11	0	0	0	0	0	0	0	0	0	0
Camden	2	1	0	0	0	0	0	0	0	0	0	0
Carroll	112	72	0	0	0	0	0	0	0	0	0	0
Catoosa	7	3	0	0	0	0	0	0	0	0	0	0
Chatham	37	18	0	0	0	0	0	0	0	0	0	0
Chattahoochee	5	0	0	0	0	0	0	0	0	0	0	0
Chattooga	4	14	0	0	0	0	0	0	0	0	0	0
Cherokee	113	132	0	0	0	0	0	0	0	0	0	0
Clarke	79	41	0	0	0	0	0	0	0	0	0	0

Clayton	527	294	0	0	0	0	0	0	0	0	0	0
Clinch	2	0	0	0	0	0	0	0	0	0	0	0
Cobb	423	430	0	0	0	0	0	0	0	0	0	0
Coffee	4	6	0	0	0	0	0	0	0	0	0	0
Colquitt	30	15	0	0	0	0	0	0	0	0	0	0
Columbia	19	9	0	0	0	0	0	0	0	0	0	0
Cook	4	6	0	0	0	0	0	0	0	0	0	0
Coweta	238	159	0	0	0	0	0	0	0	0	0	0
Crawford	5	5	0	0	0	0	0	0	0	0	0	0
Crisp	18	6	0	0	0	0	0	0	0	0	0	0
Dade	6	0	0	0	0	0	0	0	0	0	0	0
Dawson	15	21	0	0	0	0	0	0	0	0	0	0
Decatur	0	6	0	0	0	0	0	0	0	0	0	0
DeKalb	1,762	1,368	0	0	0	0	0	0	0	0	0	0
Dodge	13	5	0	0	0	0	0	0	0	0	0	0
Dooly	1	2	0	0	0	0	0	0	0	0	0	0
Dougherty	69	40	0	0	0	0	0	0	0	0	0	0
Douglas	111	117	0	0	0	0	0	0	0	0	0	0
Early	3	3	0	0	0	0	0	0	0	0	0	0
Effingham	14	10	0	0	0	0	0	0	0	0	0	0
Elbert	11	5	0	0	0	0	0	0	0	0	0	0
Emanuel	3	5	0	0	0	0	0	0	0	0	0	0
Evans	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	17	12	0	0	0	0	0	0	0	0	0	0
Fayette	106	104	0	0	0	0	0	0	0	0	0	0
Florida	39	26	0	0	0	0	0	0	0	0	0	0
Floyd	49	46	0	0	0	0	0	0	0	0	0	0
Forsyth	61	92	0	0	0	0	0	0	0	0	0	0
Franklin	31	33	0	0	0	0	0	0	0	0	0	0
Fulton	1,223	1,216	0	0	0	0	0	0	0	0	0	0
Gilmer	9	8	0	0	0	0	0	0	0	0	0	0
Glynn	7	2	0	0	0	0	0	0	0	0	0	0
Gordon	26	33	0	0	0	0	0	0	0	0	0	0
Grady	10	4	0	0	0	0	0	0	0	0	0	0
Greene	8	3	0	0	0	0	0	0	0	0	0	0
Gwinnett	810	769	0	0	0	0	0	0	0	0	0	0
Habersham	51	35	0	0	0	0	0	0	0	0	0	0
Hall	221	205	0	0	0	0	0	0	0	0	0	0
Haralson	30	13	0	0	0	0	0	0	0	0	0	0
Harris	24	19	0	0	0	0	0	0	0	0	0	0
Hart	2	14	0	0	0	0	0	0	0	0	0	0
Heard	8	10	0	0	0	0	0	0	0	0	0	0
Henry	455	290	0	0	0	0	0	0	0	0	0	0
Houston	110	84	0	0	0	0	0	0	0	0	0	0

Irwin	3	3	0	0	0	0	0	0	0	0	0	0
Jackson	97	67	0	0	0	0	0	0	0	0	0	0
Jasper	15	16	0	0	0	0	0	0	0	0	0	0
Jeff Davis	5	2	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0
Johnson	2	0	0	0	0	0	0	0	0	0	0	0
Jones	14	8	0	0	0	0	0	0	0	0	0	0
Lamar	20	19	0	0	0	0	0	0	0	0	0	0
Lanier	4	1	0	0	0	0	0	0	0	0	0	0
Laurens	15	12	0	0	0	0	0	0	0	0	0	0
Lee	10	16	0	0	0	0	0	0	0	0	0	0
Liberty	7	5	0	0	0	0	0	0	0	0	0	0
Lincoln	2	0	0	0	0	0	0	0	0	0	0	0
Lowndes	34	22	0	0	0	0	0	0	0	0	0	0
Lumpkin	16	23	0	0	0	0	0	0	0	0	0	0
Macon	5	4	0	0	0	0	0	0	0	0	0	0
Madison	25	18	0	0	0	0	0	0	0	0	0	0
Marion	1	4	0	0	0	0	0	0	0	0	0	0
McDuffie	4	2	0	0	0	0	0	0	0	0	0	0
McIntosh	4	2	0	0	0	0	0	0	0	0	0	0
Meriwether	20	14	0	0	0	0	0	0	0	0	0	0
Miller	3	0	0	0	0	0	0	0	0	0	0	0
Mitchell	6	8	0	0	0	0	0	0	0	0	0	0
Monroe	20	14	0	0	0	0	0	0	0	0	0	0
Montgomery	1	2	0	0	0	0	0	0	0	0	0	0
Morgan	35	17	0	0	0	0	0	0	0	0	0	0
Murray	9	9	0	0	0	0	0	0	0	0	0	0
Muscogee	158	133	0	0	0	0	0	0	0	0	0	0
Newton	312	149	0	0	0	0	0	0	0	0	0	0
North Carolina	26	5	0	0	0	0	0	0	0	0	0	0
Oconee	19	23	0	0	0	0	0	0	0	0	0	0
Oglethorpe	1	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	47	27	0	0	0	0	0	0	0	0	0	0
Paulding	52	57	0	0	0	0	0	0	0	0	0	0
Peach	25	9	0	0	0	0	0	0	0	0	0	0
Pickens	12	14	0	0	0	0	0	0	0	0	0	0
Pierce	2	0	0	0	0	0	0	0	0	0	0	0
Pike	17	29	0	0	0	0	0	0	0	0	0	0
Polk	29	14	0	0	0	0	0	0	0	0	0	0
Pulaski	7	4	0	0	0	0	0	0	0	0	0	0
Putnam	7	11	0	0	0	0	0	0	0	0	0	0
Rabun	6	14	0	0	0	0	0	0	0	0	0	0
Randolph	15	6	0	0	0	0	0	0	0	0	0	0
Richmond	22	2	0	0	0	0	0	0	0	0	0	0

Rockdale	270	135	0	0	0	0	0	0	0	0	0	0
Schley	3	1	0	0	0	0	0	0	0	0	0	0
Seminole	6	4	0	0	0	0	0	0	0	0	0	0
South Carolina	36	32	0	0	0	0	0	0	0	0	0	0
Spalding	121	91	0	0	0	0	0	0	0	0	0	0
Stephens	24	44	0	0	0	0	0	0	0	0	0	0
Stewart	2	5	0	0	0	0	0	0	0	0	0	0
Sumter	11	15	0	0	0	0	0	0	0	0	0	0
Talbot	24	4	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	2	0	0	0	0	0	0	0	0	0	0
Taylor	7	1	0	0	0	0	0	0	0	0	0	0
Telfair	21	2	0	0	0	0	0	0	0	0	0	0
Tennessee	22	8	0	0	0	0	0	0	0	0	0	0
Terrell	8	2	0	0	0	0	0	0	0	0	0	0
Thomas	20	18	0	0	0	0	0	0	0	0	0	0
Tift	23	17	0	0	0	0	0	0	0	0	0	0
Toombs	7	6	0	0	0	0	0	0	0	0	0	0
Towns	5	17	0	0	0	0	0	0	0	0	0	0
Treutlen	3	2	0	0	0	0	0	0	0	0	0	0
Troup	103	81	0	0	0	0	0	0	0	0	0	0
Turner	1	10	0	0	0	0	0	0	0	0	0	0
Twiggs	4	2	0	0	0	0	0	0	0	0	0	0
Union	18	15	0	0	0	0	0	0	0	0	0	0
Upson	23	24	0	0	0	0	0	0	0	0	0	0
Walker	13	6	0	0	0	0	0	0	0	0	0	0
Walton	205	171	0	0	0	0	0	0	0	0	0	0
Ware	5	2	0	0	0	0	0	0	0	0	0	0
Washington	6	4	0	0	0	0	0	0	0	0	0	0
Wayne	8	11	0	0	0	0	0	0	0	0	0	0
Wheeler	1	1	0	0	0	0	0	0	0	0	0	0
White	30	25	0	0	0	0	0	0	0	0	0	0
Whitfield	27	14	0	0	0	0	0	0	0	0	0	0
Wilcox	3	3	0	0	0	0	0	0	0	0	0	0
Wilkes	3	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	11	4	0	0	0	0	0	0	0	0	0	0
Worth	7	8	0	0	0	0	0	0	0	0	0	0
Total	**9,569**	**7,772**	**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	2	0	0
Total	**2**	**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	9,778	12,590
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	3,833	0	0	0
Total	**3,833**	**0**	**9,778**	**12,590**

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	3,611	7,772
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	1,106	0	0	0
Total	**1,106**	**0**	**3,611**	**7,772**

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	5
Asian	117
Black/African American	3,001
Hispanic/Latino	724
Pacific Islander/Hawaiian	3
White	3,714
Multi-Racial	208
Total	**7,772**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,015
Ages 15-64	757
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**7,772**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	4,701
Female	3,071
Total	**7,772**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	27
Medicaid	4,138
Third-Party	3,529
Self-Pay	78

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)	37	558	11,547	558

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? 5.25 (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):

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	4.36	46	3	5
Vietnamese	0.10	2	0	0
Korean	0.02	4	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-Staff Development Training class on Cultural Care

2-Training on cultural competency during new employee orientation
3-On line resources

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?

1-Interpreting/Translating Services
2-Kleinman questions

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?

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: Csrolyn Kenny

Date: 10/23/2012

Title: Chief Operating Officer

Comments:

1. Children's Healthcare of Atlanta does not track the race and ethnicity of physicians (Part G3 Facility Workforce Information). 2. A complete list of enrolled providers in Medicaid/Peachcare and PEHB Plan was unavailable for year 2008. (Part G4 Facility Workforce Information). 3. Perinatal addendum - Question 4. Children's does not provide Obstetrical services; therefore, part C was not completed. 4. Children's does not operate Psychiatric or LTCH beds; therefore, no data was provided for these sections. 5. The number of nurses and other employed staff that speak Spanish are estimates based on shift differential data available through the Payroll department (Minority Health Section - question #3) 6. Children's provides emergency department services to patients regardless of their ability to pay in accordance with EMTALA. (Minority Health Section - question #7)