GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2024 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP705

Facility Name: Emory University Hospital Midtown

County: Fulton

Street Address: 550 Peachtree Street NE

City: Atlanta

Zip: 30308

Mailing Address: 550 Peachtree Street NE

Mailing City: Atlanta

Mailing Zip: 30308

Medicaid Provider Number: 00000503

Medicare Provider Number: 110078

2. Report Period

Report Data for the full twelve month period- January 1, 2024 through December 31, 2024.
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: Patty Pharo

Contact Title: Senior Financial Analyst

Phone: 404-544-9702

Fax: 404-727-2606

E-mail: patty.pharo@emoryhealthcare.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
Emory University	Not for Profit	1/1/1944

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Healthcare, Inc.	Not for Profit	1/1/1997

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory University	Not for Profit	1/1/1944

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: Emory Healthcare

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: Vizient
City: Irving **State:** TX

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Emory Healthcare
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)	62	5,138	16,087	5,127	16,173
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	405	15,511	106,007	18,940	132,560
Intensive Care	70	4,501	34,990	1,041	11,011
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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**537**	**25,150**	**157,084**	**25,108**	**159,744**

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	39	212
Asian	430	2,376
Black/African American	17,004	108,456
Hispanic/Latino	1,102	6,195
Pacific Islander/Hawaiian	47	279
White	5,420	31,968
Multi-Racial	1,108	7,598
Total	**25,150**	**157,084**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	9,969	70,892
Female	15,181	86,192
Total	**25,150**	**157,084**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	10,185	79,376
Medicaid	4,532	22,196
Peachare	0	0
Third-Party	8,359	43,238
Self-Pay	1,523	8,378
Other	551	3,896

5. Discharges to Death

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

483

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2024 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,973
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	9,383
Average Total Charge for an Inpatient Day	12,107

Part E : Emergency Department and Outpatient Services

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

88,598

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

14,051

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

59

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	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	1	6,156
General Beds	58	82,442
	0	0
	0	0
	0	0
	0	0

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

1,388

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

549,386

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

11,278

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

242.00

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.

7,775

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	1	1
Renal Dialysis	1	1
ESWL	2	1
Billiary Lithotropter	2	1
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)	1	1
Radioisotope, Therapeutic	1	1
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	2	1
Respite Care Services	1	1
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	2,375
Number of Dialysis Treatments	8,772
Number of ESWL Patients	14
Number of ESWL Procedures	14
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	183
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	91,932
Number of CTS Units (machines)	9
Number of CTS Procedures	59,820
Number of Diagnostic Radioisotope Procedures	3,283
Number of PET Units (machines)	2
Number of PET Procedures	3,786
Number of Therapeautic Radioisotope Procedures	148
Number of Number of MRI Units	7
Number of Number of MRI Procedures	18,525
Number of Chemotherapy Treatments	95,575
Number of Respiratory Therapy Treatments	309,638
Number of Occupational Therapy Treatments	40,903
Number of Physical Therapy Treatments	73,492
Number of Speech Pathology Patients	5,169
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	4,820
Number of HIV/AIDS Diagnostic Procedures	20,630
Number of HIV/AIDS Patients	4,191
Number of Ambulance Trips	0
Number of Hospice Patients	204
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	58
Number of Ultrasound/Medical Sonography Procedures	16,750
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).

66

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
5	1,045	DaVinci Dual Console Xi (3), DaVinci Dual Console X (1), DaVinci Single Console SP (1)

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2024. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2024.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,823.30	232.40	51.00
Licensed Practical Nurses (LPNs)	31.20	4.00	0.00
Pharmacists	145.80	11.20	0.00
Other Health Services Professionals*	1,398.90	103.90	49.60
Administration and Support	202.30	9.30	0.00
All Other Hospital Personnel (not included above)	814.40	51.90	71.93

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)	More than 90 Days
Licensed Practical Nurses (LPNs)	61-90 Days
Pharmacists	61-90 Days
Other Health Services Professionals	61-90 Days
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	5
Asian	652
Black/African American	269
Hispanic/Latino	146
Pacific Islander/Hawaiian	0
White	1,176
Multi-Racial	63

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	15	☐	0	0
General Internal Medicine	55	☐	0	0
Pediatricians	9	☐	0	0
Other Medical Specialties	767	☑	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	108	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	5	☐	0	0
Ophthalmology Surgery	53	☐	0	0
Orthopedic Surgery	43	☐	0	0
Plastic Surgery	17	☐	0	0
General Surgery	87	☐	0	0
Thoracic Surgery	30	☐	0	0
Other Surgical Specialties	111	☑	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	159	☑	0	0
Dermatology	15	☐	0	0
Emergency Medicine	192	☑	0	0
Nuclear Medicine	14	☑	0	0
Pathology	73	☑	0	0
Psychiatry	31	☐	0	0
Radiology	233	☑	0	0
Hospitalists	150	☑	0	0
Radiation Oncology	44	☑	0	0
Cardiovascular Disease	85	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeons) with Admitting Privleges	15
Podiatrists	11
Certified Nurse Midwives with Clinical Privileges in the Hospital	25
All Other Staff Affiliates with Clinical Privileges in the Hospital	1,114

5b. Name of Other Professions

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

Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetist

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	219	85	2	0	0	0	0	0	0	0	0	0	0
Appling	5	1	0	0	0	0	0	0	0	0	0	0	0
Atkinson	2	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	1	0	1	0	0	0	0	0	0	0	0	0	0
Baker	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	35	14	0	0	0	0	0	0	0	0	0	0	0
Banks	5	4	1	0	0	0	0	0	0	0	0	0	0
Barrow	73	35	5	0	0	0	0	0	0	0	0	0	0
Bartow	78	51	2	0	0	0	0	0	0	0	0	0	0
Ben Hill	4	4	0	0	0	0	0	0	0	0	0	0	0
Berrien	7	2	0	0	0	0	0	0	0	0	0	0	0
Bibb	108	51	6	0	0	0	0	0	0	0	0	0	0
Bleckley	8	3	0	0	0	0	0	0	0	0	0	0	0
Brantley	2	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	4	0	1	0	0	0	0	0	0	0	0	0	0
Bryan	3	5	0	0	0	0	0	0	0	0	0	0	0
Bulloch	10	0	0	0	0	0	0	0	0	0	0	0	0
Burke	2	0	0	0	0	0	0	0	0	0	0	0	0
Butts	62	21	4	0	0	0	0	0	0	0	0	0	0
Calhoun	3	1	0	0	0	0	0	0	0	0	0	0	0
Camden	3	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	317	100	13	0	0	0	0	0	0	0	0	0	0
Catoosa	2	2	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	29	8	1	0	0	0	0	0	0	0	0	0	0
Chattahoochee	4	2	1	0	0	0	0	0	0	0	0	0	0
Chattooga	9	3	0	0	0	0	0	0	0	0	0	0	0

Cherokee	167	140	19	0	0	0	0	0	0	0	0	0	0
Clarke	24	27	1	0	0	0	0	0	0	0	0	0	0
Clay	1	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	1,552	450	557	0	0	0	0	0	0	0	0	0	0
Clinch	4	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	922	546	255	0	0	0	0	0	0	0	0	0	0
Coffee	26	7	0	0	0	0	0	0	0	0	0	0	0
Colquitt	32	2	0	0	0	0	0	0	0	0	0	0	0
Columbia	22	12	2	0	0	0	0	0	0	0	0	0	0
Cook	10	8	1	0	0	0	0	0	0	0	0	0	0
Coweta	153	106	29	0	0	0	0	0	0	0	0	0	0
Crawford	4	2	0	0	0	0	0	0	0	0	0	0	0
Crisp	17	7	2	0	0	0	0	0	0	0	0	0	0
Dade	1	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	20	8	2	0	0	0	0	0	0	0	0	0	0
Decatur	9	4	1	0	0	0	0	0	0	0	0	0	0
DeKalb	4,301	1,601	1,205	0	0	0	0	0	0	0	0	0	0
Dodge	7	2	0	0	0	0	0	0	0	0	0	0	0
Dooly	3	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	60	33	2	0	0	0	0	0	0	0	0	0	0
Douglas	347	148	104	0	0	0	0	0	0	0	0	0	0
Early	0	2	0	0	0	0	0	0	0	0	0	0	0
Effingham	10	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	9	2	0	0	0	0	0	0	0	0	0	0	0
Emanuel	4	1	1	0	0	0	0	0	0	0	0	0	0
Evans	1	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	14	15	3	0	0	0	0	0	0	0	0	0	0
Fayette	245	119	72	0	0	0	0	0	0	0	0	0	0
Florida	148	35	8	0	0	0	0	0	0	0	0	0	0
Floyd	52	21	2	0	0	0	0	0	0	0	0	0	0
Forsyth	107	52	12	0	0	0	0	0	0	0	0	0	0
Franklin	15	9	1	0	0	0	0	0	0	0	0	0	0
Fulton	11,494	2,349	2,115	0	0	0	0	0	0	0	0	0	0
Gilmer	19	14	0	0	0	0	0	0	0	0	0	0	0
Glynn	7	11	0	0	0	0	0	0	0	0	0	0	0
Gordon	38	13	3	0	0	0	0	0	0	0	0	0	0
Grady	8	2	1	0	0	0	0	0	0	0	0	0	0
Greene	14	6	1	0	0	0	0	0	0	0	0	0	0
Gwinnett	839	517	235	0	0	0	0	0	0	0	0	0	0
Habersham	18	20	1	0	0	0	0	0	0	0	0	0	0
Hall	88	72	7	0	0	0	0	0	0	0	0	0	0
Hancock	3	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	61	22	3	0	0	0	0	0	0	0	0	0	0
Harris	42	29	0	0	0	0	0	0	0	0	0	0	0

Hart	6	3	0	0	0	0	0	0	0	0	0	0	0
Heard	13	4	0	0	0	0	0	0	0	0	0	0	0
Henry	784	397	258	0	0	0	0	0	0	0	0	0	0
Houston	123	56	3	0	0	0	0	0	0	0	0	0	0
Irwin	8	3	0	0	0	0	0	0	0	0	0	0	0
Jackson	53	36	9	0	0	0	0	0	0	0	0	0	0
Jasper	10	14	1	0	0	0	0	0	0	0	0	0	0
Jeff Davis	7	3	0	0	0	0	0	0	0	0	0	0	0
Jefferson	2	1	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	1	0	0	0	0	0	0	0	0	0	0	0
Jones	6	4	0	0	0	0	0	0	0	0	0	0	0
Lamar	24	7	3	0	0	0	0	0	0	0	0	0	0
Lanier	4	2	0	0	0	0	0	0	0	0	0	0	0
Laurens	28	9	2	0	0	0	0	0	0	0	0	0	0
Lee	16	11	1	0	0	0	0	0	0	0	0	0	0
Liberty	3	2	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	0	0	0	0	0	0	0	0	0	0	0	0
Long	1	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	35	12	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	5	13	0	0	0	0	0	0	0	0	0	0	0
Macon	6	6	0	0	0	0	0	0	0	0	0	0	0
Madison	5	7	0	0	0	0	0	0	0	0	0	0	0
Marion	8	2	1	0	0	0	0	0	0	0	0	0	0
McDuffie	0	1	0	0	0	0	0	0	0	0	0	0	0
McIntosh	3	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	14	6	0	0	0	0	0	0	0	0	0	0	0
Miller	3	1	2	0	0	0	0	0	0	0	0	0	0
Mitchell	17	3	0	0	0	0	0	0	0	0	0	0	0
Monroe	15	12	1	0	0	0	0	0	0	0	0	0	0
Montgomery	8	1	0	0	0	0	0	0	0	0	0	0	0
Morgan	14	11	0	0	0	0	0	0	0	0	0	0	0
Murray	13	6	0	0	0	0	0	0	0	0	0	0	0
Muscogee	128	76	10	0	0	0	0	0	0	0	0	0	0
Newton	161	100	32	0	0	0	0	0	0	0	0	0	0
North Carolina	71	34	3	0	0	0	0	0	0	0	0	0	0
Oconee	15	9	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	5	2	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	263	66	10	0	0	0	0	0	0	0	0	0	0
Paulding	104	53	24	0	0	0	0	0	0	0	0	0	0
Peach	40	16	2	0	0	0	0	0	0	0	0	0	0
Pickens	17	11	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	0	0	0	0	0	0	0	0	0	0	0	0
Pike	26	9	1	0	0	0	0	0	0	0	0	0	0

Polk	41	15	4	0	0	0	0	0	0	0	0	0	0
Pulaski	16	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	16	11	2	0	0	0	0	0	0	0	0	0	0
Quitman	2	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	6	9	1	0	0	0	0	0	0	0	0	0	0
Randolph	5	3	1	0	0	0	0	0	0	0	0	0	0
Richmond	23	10	4	0	0	0	0	0	0	0	0	0	0
Rockdale	174	125	24	0	0	0	0	0	0	0	0	0	0
Schley	2	2	0	0	0	0	0	0	0	0	0	0	0
Screven	2	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	1	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	96	27	1	0	0	0	0	0	0	0	0	0	0
Spalding	114	58	17	0	0	0	0	0	0	0	0	0	0
Stephens	14	6	2	0	0	0	0	0	0	0	0	0	0
Stewart	8	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	22	12	2	0	0	0	0	0	0	0	0	0	0
Talbot	3	1	0	0	0	0	0	0	0	0	0	0	0
Tattnall	8	2	0	0	0	0	0	0	0	0	0	0	0
Taylor	5	4	0	0	0	0	0	0	0	0	0	0	0
Telfair	5	4	0	0	0	0	0	0	0	0	0	0	0
Tennessee	74	34	2	0	0	0	0	0	0	0	0	0	0
Terrell	9	3	0	0	0	0	0	0	0	0	0	0	0
Thomas	19	8	2	0	0	0	0	0	0	0	0	0	0
Tift	31	15	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	6	1	0	0	0	0	0	0	0	0	0	0
Treutlen	2	0	0	0	0	0	0	0	0	0	0	0	0
Troup	126	40	3	0	0	0	0	0	0	0	0	0	0
Turner	4	1	0	0	0	0	0	0	0	0	0	0	0
Twiggs	5	2	0	0	0	0	0	0	0	0	0	0	0
Union	14	13	0	0	0	0	0	0	0	0	0	0	0
Upson	47	17	1	0	0	0	0	0	0	0	0	0	0
Walker	11	7	0	0	0	0	0	0	0	0	0	0	0
Walton	174	106	19	0	0	0	0	0	0	0	0	0	0
Ware	3	3	1	0	0	0	0	0	0	0	0	0	0
Warren	1	0	1	0	0	0	0	0	0	0	0	0	0
Washington	4	2	0	0	0	0	0	0	0	0	0	0	0
Wayne	3	0	0	0	0	0	0	0	0	0	0	0	0
Webster	2	4	0	0	0	0	0	0	0	0	0	0	0
White	9	10	0	0	0	0	0	0	0	0	0	0	0
Whitfield	35	16	3	0	0	0	0	0	0	0	0	0	0
Wilcox	1	4	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	3	4	0	0	0	0	0	0	0	0	0	0	0

Worth	13	5	2	0	0	0	0	0	0	0	0	0	0
Total	**25,150**	**8,420**	**5,138**	**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	34
Cystoscopy (OR Suite)	0	0	2
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**36**

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	6,540	7,684
Cystoscopy	0	0	160	736
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**6,700**	**8,420**

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	6,540	7,684
Cystoscopy	0	0	160	736
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**6,700**	**8,420**

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	227
Black/African American	4,319
Hispanic/Latino	408
Pacific Islander/Hawaiian	11
White	3,084
Multi-Racial	355
Total	**8,420**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	0
Ages 15-64	5,654
Ages 65-74	1,804
Ages 75-85	847
Ages 85 and Up	115
Total	**8,420**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	3,343
Female	5,077
Total	**8,420**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,099
Medicaid	580
Third-Party	4,641
Self-Pay	100

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: 5

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 18

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,907

6. Total Live Births: 4,975

7. Total Births (Live and Late Fetal Deaths): 4,989

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,010

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)	36	4,177	11,444	921
Specialty Care (Intermediate Neonatal Care)	24	44	6,351	1,626
Subspecialty Care (Intensive Neonatal Care)	15	754	10,832	1,839

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	6	13
Asian	149	425
Black/African American	3,810	12,087
Hispanic/Latino	465	1,399
Pacific Islander/Hawaiian	9	26
White	519	1,486
Multi-Racial	180	651
Total	**5,138**	**16,087**

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	5	17
Ages 15-44	5,109	15,932
Ages 45 and Up	24	138
Total	**5,138**	**16,087**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$20,531.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$29,925.00

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 Georgiaï¿½s 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 systemsï¿½ 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? 3 (FTE's)
What languages do they interpret?
Spanish, Korean and Vietnamese

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 Interpretation agency (iPad); We provide an Agency Interpreter coordinated by us; Over the phone interpretation. We work diligently on avoiding the use of family members or companions as medical interpreters. Only in emergency cases are they to be used.

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		0	0	0
Korean		0	0	0
Vietnamese		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?

All staff interpreters must be qualified Medical Interpreters (minimum 40 hours training); New Employee orientation; Frequent In-services with Operating Units; Annual Regulatory requirement including cultural bias training

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?

Given ELP population growth, EHC is constantly evaluating need for expansion of services including the addition of interpreters

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

1. English
2. Some in 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?

Grady Primary Care
Asa G. Yancey Health Center
1247 Donald Lee Hollowell Pkwy. NW
Atlanta, GA 30318 -404 616-2265

Grady Primary Care
Kirkwood Family Medicine
1863 Memorial Drive SE
Atlanta, GA 30317 -404 616-9304

Grady Primary Care
East Point Health Center
1595 W. Cleveland Avenue
East Point, GA 30344 -404 616-2886

Grady Primary Care
2695 Buford Highway NE Suite 200
Atlanta, GA 30324 -404 616-6999

Center for Black Women's Wellness
477 Windsor Street SW Suite #309
Atlanta, GA 30312 -404 688-9202 ext. 110
http://cbww.org

Good Samaritan Clinic
1015 Donald Lee Hollowell Pkwy. NW
Atlanta, GA 30318 -404 523-6571
www.goodsamatlanta.org

HEALing Community Center

2600 Martin Luther King Jr. Drive SW
Atlanta, GA 30311 -404 564-7749
www.healingourcommunities.org

Mercy Care Services
424 Decatur Street SE
Atlanta GA 30312 -678 843-8500
http://mercycareservices.org

Family Health Centers of Georgia
868 York Avenue SW
Atlanta, GA 30310
http://fhcga.org
-404 752-1400

Southside Medical Center
1046 Ridge Avenue SW
Atlanta GA 30315 -404 688-1350
www.southsidemedical.net

AbsoluteCARE Medical Center
2140 Peachtree Road NW Suite 232
Atlanta, GA 30309 -404 231-4431
www.absolutecarehealth.com/atlanta

Whitefoord Family Medical Center
30 Warren Street SE
Atlanta, GA 30317 -404 373-6614
http://whitefoord.org

Grady Primary Care
80 Jesse Hill Jr. Drive SE
Atlanta, GA 30303 -404 616-9355

Recovery Consultants of Atlanta
4229 Snapfinger Woods Drive
Decatur, GA 30035 -404 286-9252
www.recoveryconsultants.org

Physicians' Care Clinic
440 Winn Way
Decatur, GA 30030 -404 501-7960
www.physicianscareclinic.org

Comprehensive Family Healthcare Center
1513 E. Cleveland Avenue, Building 500
East Point, GA 30344 -404 752- 1000
www.morehousehealthcare.om

Grant Park Family Health Center
1340 Boulevard SE
Atlanta, GA 30315 -404 627-4259
www.grantparkclinic.org

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: Adam Webb, MD

Date: 3/31/2025

Title: Chief Operating Officer

Comments: