



Part A: General Information

UID: HOSP518

1. Identification

Facility Name:

Children's Healthcare of Atlanta at Hughes Spalding

County:

Fulton

Street Address:

35 Jesse Hill, Jr. Drive

City:

Atlanta

Zip:

30303

Mailing Address:

80 Jesse Hill, Jr. Drive

Mailing City:

Atlanta

Mailing Zip:

30303

Medicaid Provider Number:

000679808A

Medicare Provider Number:

110079

3. Report Period

Report Data for the full twelve month period, January 1, 2025 - December 31, 2025 (365 days). 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

Email:

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)

Fulton-DeKalb Hospital Authority

Organization Type

Hospital Authority

Effective Date

01/01/1946

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

C. Facility Operator

Full Legal Name (Or Not Applicable)

Grady Memorial Hospital Corporation

Organization Type

Not For Profit

Effective Date

05/19/2008

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

E. Management Contractor

Full Legal Name (Or Not Applicable)

HSOC, Inc.

Organization Type

Not For Profit

Effective Date

12/15/2005

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

Arthur M. Blank Hospital, Inc.

Organization Type

Not For Profit

Effective Date

02/01/1998

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 you checked the box for yes, 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

Grady Health System

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

University Health System Alliance

City

Oak Brook

State

IL

7.

Check the box to the right if your hospital is a participant in a health care network ☐

Name

City

State

8. Peer Review Process Related to Medical Errors

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

9. Primary Care Physician Group Practice

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)

Health Maintenance Organization(HMO) ☒

Preferred Provider Organization(PPO) ☒

Physician Hospital Organization(PHO) ☐

Provider Service Organization(PSO) ☐

Other Managed Care or Prepaid Plan ☐

10b. Manage 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. Do not include newborn and neonatal services. Do not include long-term care units, 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)	16	956	2,148	956	2,153
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	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
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	16	956	2,148	956	2,153

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Intensive Care Totals	0	0	0	0	0
Rehab Totals	0	0	0	0	0

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	0	0
Asian	2	4
Black/African American	829	1,933
Hispanic/Latino	72	118
Pacific Islander/Hawaiian	0	0
White	36	61
Multi-Racial	17	32
Total	956	2,148

3. Gender

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

Gender	Admissions	Inpatient Days
Male	504	1,200
Female	452	948
Total	956	2,148

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	0	0
Medicaid	749	1,691
Peachare	28	68
Third-Party	151	340
Self-Pay	28	49
Other	0	0
Total	956	2,148

5. Discharges to Death

Please report the total number of inpatient admissions discharges during the reporting period due to death

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2025 (to the nearest whole dollar)

Service	Charge
Private Room Rate	1,954
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	0
Average Total Charge for an Inpatient Day	12,203

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

2. Inpatient Admissions from ER

Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY

3. Beds Available

Please report the number of beds available in ER as of the last day of the report period

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	0	0
General Beds	37	57,377
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

6. Non-Emergency Visits

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

7. Observation Visits/Cases

Please provide the total number of Observation visits/cases for the entire report period

8. Diverted Cases

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

9. Ambulance Diversion Hours

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

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

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

Service Status Codes

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

Services/Facilities	Site Code	Service Status
Podiatric Services	3	4
Renal Dialysis	3	4
ESWL	3	4
Biliary Lithotripter	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, Diagnostic	3	4
Positron Emission Tomography (PET)	3	4
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	2	1
Chemotherapy	3	4
Respiratory Therapy	1	1
Occupational Therapy	2	1
Physical Therapy	2	1
Speech Pathology Therapy	2	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	12,572
Number of CTS Units (machines)	1
Number of CTS Procedures	764
Number of Diagnostic Radioisotope Procedures	0
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	0
Number of Number of MRI Procedures	1
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	13,605
Number of Occupational Therapy Treatments	0
Number of Physical Therapy Treatments	339
Number of Speech Pathology Patients	3
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,781
Number of HIV/AIDS Diagnostic Procedures	1,852
Number of HIV/AIDS Patients	1
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	1
Number of Ultrasound/Medical Sonography Procedures	2,499
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)

8

3. Robotic Surgery System

Units

0

Procedures

0

Type of Unit(s)

N/A

Part G: Facility Workforce Informaton

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2025. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2025

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	2	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs Advanced Practice*)	117	6	0
Licensed Practical Nurses (LPNs)	7	0	0
Pharmacists	6	0	0
Other Health Services Professionals*	129	15	1
Administration and Support	161	7	0
All Other Hospital Personnel (not included in above)	0	0	0

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 Need To Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	More than 90 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
Total	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 Plan 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	☒	80	0
Other Medical Specialties	119	☒	96	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	0	☐	0	0
Orthopedic Surgery	0	☐	0	0
Plastic Surgery	0	☐	0	0
General Surgery	0	☐	0	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	1	☐	1	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	0	☐	0	0
Dermatology	3	☐	3	0
Emergency Medicine	16	☒	12	0
Nuclear Medicine	0	☐	0	0
Pathology	1	☒	0	0
Psychiatry	35	☐	23	0
Radiology	12	☒	12	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 surgeons) with Admitting Privileges	0
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	102

5b. Name of Other Professions

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

CPNP, DNP, FNP-BC, PMHNP, PA-C, PNP-BC, PhD

Comments and Suggestions

- Budgeted FTEs for Registered Nurses include Nurse Practitioners, APPs and PAs
- Vacant FTEs reflect actual open/vacant positions as of 12/31/2025.
- Medical staff reported above only include physicians who have full privileges of admitting patients

Part I: Patient Origin Table

1. Patient Origin

- 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
- Rehab=Inpatient Physical Rehabilitation

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).You may enter the data on the web form or upload the data to the web form using a .csv file that matches our downloadable template.The .csv file must contain the same column headings as shown in our template, in exactly the same order. You do not need to include every county, but the county names, state names, and other out of state category must match those in our template.

[illegible]

[illegible]

[illegible]

Wilkes	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	0	0	0	0	0	0	0	0	0	0	0	0	0
Worth	0	0	0	0	0	0	0	0	0	0	0	0	0
Alabama	2	0	0	0	0	0	0	0	0	0	0	0	0
Totals													

Surgical Services Addendum

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	Total
General Operating	0	0	0	0
Cystoscopy (OR Suite)	0	0	0	0
Endoscopy (OR Suite)	0	0	0	0
	0	0	0	0
Total	0	0	0	0

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	Total
General Operating	0	0	0	0	0
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	0	0

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	Total
General Operating	0	0	0	0	0
Cystoscopy	0	0	0	0	0
Endoscopy	0	0	0	0	0
	0	0	0	0	0
Total	0	0	0	0	0

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	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0
Total	0

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	0
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	0

3. Gender

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

Gender	Number of Ambulatory Patients
Male	0
Female	0
Total	0

4. Payment Source

Please report the total number of ambulatory patients by payment source. Report Peachcare for Kids as Third-Party.

Primary Payment Source	Number of Ambulatory Patients
Medicare	0
Medicaid	0
Third-Party	0
Self-Pay	0
Total	0

Perinatal Services Addendum

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of the hospital or anywhere on its grounds.

Number of Delivery Rooms:

Number of Birthing Rooms:

Number of LDR Rooms:

Number of LDRP Rooms:

Number of Cesarean Sections:

Total Live Births:

Total Live Births (Live and Late Fetal Deaths):

Total Deliveries (Births + Early Fetal Deaths and Induced Terminations):

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)	60	583	20,258	583
Total	60	583	20,258	583

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	Admission 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)

4. Average Charge for an Premature Delivery.

Please report the average hospital charge for a premature delivery.

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:

Do you have paid medical interpreters on staff? (Check the box, if yes) ☒

If you checked yes, how many? (FTEs)

3.0

What languages do they most often interpret?

SPANISH

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 ☒

Community Volunteer Interpreter ☐

Refer patient to outside agency ☐

Bilingual member of patient's family ☐

Telephone interpreter service ☒

Other ☒

Please describe

VIDEO REMOTE INTERPRETATION SERVICE AND CONTRACTED ON-SITE INTERPRETERS

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	8	0	0	0
FRENCH	1	0	0	0
WOLOF	1	0	0	0

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?

EDUCATION ABOUT LAWS, REGULATORY STANDARDS AT NEW HIRE AND PATIENT CARE PROVIDER ORIENTATION
DEPARTMENT SPECIFIC IN-SERVICES
PART OF DEPARTMENT/ROLE-SPECIFIC ONBOARDING TRAININGS
STUDENT DIDACTICS FOR VARIOUS DEPARTMENTS, BOTH CLINICAL AND SUPPORT SERVICES

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 OF STAFF INTEPRETERS
ADDITIONAL FTE AND COMPETETIVE PAY FOR ASL INTERPRETER OR OTHER LANGUAGES OF NEED
BILINGUAL SIGNAGE

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

Language One:

ENGLISH

Language Two:

Language Three:

Language Four:

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?

1. Admissions and Days of Care by Race

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	121
Asian	9	323
Black/African American	95	3,592
Hispanic/Latino	36	1,160
Pacific Islander/Hawaiian	0	0
White	89	2,633
Multi-Racial	7	241
Total	236	8,070

2. Admissions and Days of Care by Gender

Please provide the number of admissions and inpatient days by gender

Gender of Patient	Number of Admissions	Inpatient Days
Male	137	4,773
Female	99	3,297
Total	236	8,070

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort

Age Cohort	Number of Admissions	Inpatient Days
0-17	222	7,398
18-64	14	672
65-84	0	0
85 Up	0	0
Total	236	8,070

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	236
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0
	0
Total	236

Part C: Payers

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	1
Third-Party/Commercial	103
Self-Pay	2
Other	130
Total	236

2. Uncompensated Indigent and Charity Care

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

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
Total	0

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 inaccurate 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. **Do not sign until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could throw the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.**

Authorized Signature

Lamarvia Stinson

Date

03/04/2026

Title

Vice President Operations Hughes Spalding

Comments