GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Part A: General Information

UID: HOSP731

1. Identifcication

Facility Name:
Atrium Health Navicent Rehabilitation Hospital

County:
Bibb

Street Address:
3351 Northside Drive

City:
Macon

Zip:
31210

Mailing Address:
3351 Northside Drive

Mailing City:
Macon

Mailing Zip:
31210

Medicaid Provider Number:
003213433A

Medicare Provider Number:
113029

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:
Stacy Wilson

Contact Title:
Budget Manager

Phone:
478-633-6970

Fax:
478-633-6970

Email:
stacy.f.wilson@advocatehealth.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)

Central Georgia Rehabilitation Hospital, LLC

Organization Type

Not For Profit

Effective Date

09/26/2006

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

Central Georgia Rehabilitation Hospital, LLC

Organization Type

Not For Profit

Effective Date

09/26/2006

C. Facility Operator

Full Legal Name (Or Not Applicable)

Central Georgia Rehabilitation Hospital, LLC

Organization Type

Not For Profit

Effective Date

09/26/2006

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)

Navicent Health, Inc.

Organization Type

Not For Profit

Effective Date

09/26/2006

E. Management Contractor

Full Legal Name (Or Not Applicable)

N/A

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

N/A

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

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

Advocate Health

City

Charlotte

State

North Carolina

4.

Check the box to the right if your hospital is a division or subsidiary of a holding company ☑

Name

Navicent Health, Inc.

City

Macon

State

Georgia

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

Premier, Inc.

City

Charlotte

State

North Carolina

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)	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	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)	58	1,271	17,829	1,271	17,034
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	58	1,271	17,829	1,271	17,034

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Intensive Care Totals	0	0	0	0	0
Rehab Totals	58	1,271	17,829	1,271	17,034

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	4	65
Asian	12	175
Black/African American	422	5,827
Hispanic/Latino	1	12
Pacific Islander/Hawaiian	2	37
White	817	11,455
Multi-Racial	13	258
Total	1,271	17,829

3. Gender

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

Gender	Admissions	Inpatient Days
Male	624	8,501
Female	647	9,328
Total	1,271	17,829

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	790	11,195
Medicaid	120	1,720
Peachare	0	0
Third-Party	289	3,870
Self-Pay	44	664
Other	28	380
Total	1,271	17,829

5. Discharges to Death

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

0

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	1,131
Semi-Private Room Rate	1,131
Operating Room: Average Charge for the First Hour	0
Average Total Charge for an Inpatient Day	3,254

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

0

2. Inpatient Admissions from ER

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

0

3. Beds Available

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

0

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	0	0
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

0

6. Non-Emergency Visits

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

7,597

7. Observation Visits/Cases

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

0

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

0

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

0

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
Podatric Services	3	4
Renal Dialysis	1	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	2	1
Computerized Tomography Scanner (CTS)	3	4
Radioisotope, Diagnositic	3	4
Positron Emission Tomography (PET)	3	4
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	3	4
Chemotherapy	3	4
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	3	4
HIV/AIDS Diagnostic Treatment/Services	3	4
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	2	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	233
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	42
Number of CTS Units (machines)	0
Number of CTS Procedures	0
Number of Diagnostic Radioisotope Procedures	0
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	0
Number of Number of MRI Procedures	0
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	10,847
Number of Occupational Therapy Treatments	91,397
Number of Physical Therapy Treatments	122,998
Number of Speech Pathology Patients	2,230
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	0
Number of Ultrasound/Medical Sonography Procedures	0
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)

0

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	1	0	1
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs Advanced Practice*)	38	0	0
Licensed Practical Nurses (LPNs)	11	0	0
Pharmacists	2	0	0
Other Health Services Professionals*	98	0	3
Administration and Support	58	0	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)	More than 90 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	31-60 Days
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

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	2
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0
Total	2

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	13	☑	13	13
General Internal Medicine	7	☑	7	7
Pediatricians	0	☑	0	0
Other Medical Specialties	11	☑	11	11

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	0	☐	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	0	☐	0	0
Dermatology	0	☐	0	0
Emergency Medicine	0	☐	0	0
Nuclear Medicine	0	☐	0	0
Pathology	0	☐	0	0
Psychiatry	0	☐	0	0
Radiology	2	☐	2	2
Nephrology	9	☐	9	9
Infectious Disease	1	☐	1	1
Neurology	1	☐	1	1

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	0
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	15

5b. Name of Other Professions

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

NPs

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. 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 two columns, with the full name and the left and the license number on the right. If you include column headings, they must match those provided in our template

Full Name	License Number
Kala Cunard	69106
Nicole Golding	99335
Todd Holmes	91485
Mendel Kupfer	81034
Trista Marshall	68927
Allison Scheetz	38356
Mayisha White-Dunham	90862
Diana Whiteman	37729

Only use commas to separate values

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.

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabam	3	0	0	0	0	0	0	0	0	0	0	0	0
Applin	0	0	0	0	0	0	0	0	0	0	0	0	0
Atkins	0	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	0	0	0	0	0	0	0	0	0	0	0	0	0
Baker	0	0	0	0	0	0	0	0	0	0	0	0	0
Baldwi	47	0	0	0	0	0	0	0	0	0	0	0	0
Banks	0	0	0	0	0	0	0	0	0	0	0	0	0
Barrow	0	0	0	0	0	0	0	0	0	0	0	0	0
Bartow	1	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hil	5	0	0	0	0	0	0	0	0	0	0	0	0
Berrien	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	486	0	0	0	0	0	0	0	0	0	0	0	0
Bleckle	6	0	0	0	0	0	0	0	0	0	0	0	0
Brantle	0	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	0	0	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0	0
Bulloch	2	0	0	0	0	0	0	0	0	0	0	0	0
Burke	0	0	0	0	0	0	0	0	0	0	0	0	0
Butts	7	0	0	0	0	0	0	0	0	0	0	0	0
Calhou	0	0	0	0	0	0	0	0	0	0	0	0	0
Camde	1	0	0	0	0	0	0	0	0	0	0	0	0
Candle	0	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	0	0	0	0	0	0	0	0	0	0	0	0	0
Catoos	0	0	0	0	0	0	0	0	0	0	0	0	0
Charlto	0	0	0	0	0	0	0	0	0	0	0	0	0
Chatha	2	0	0	0	0	0	0	0	0	0	0	0	0
Chattal	0	0	0	0	0	0	0	0	0	0	0	0	0
Chatto	0	0	0	0	0	0	0	0	0	0	0	0	0
Cherok	1	0	0	0	0	0	0	0	0	0	0	0	0
Clarke	1	0	0	0	0	0	0	0	0	0	0	0	0
Clay	0	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	4	0	0	0	0	0	0	0	0	0	0	0	0
Clinch	0	0	0	0	0	0	0	0	0	0	0	0	0
Cobb	0	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	0	0	0	0	0	0	0	0	0	0	0	0	0
Colquit	2	0	0	0	0	0	0	0	0	0	0	0	0
Columbi	0	0	0	0	0	0	0	0	0	0	0	0	0
Cook	1	0	0	0	0	0	0	0	0	0	0	0	0

Cowet	1	0	0	0	0	0	0	0	0	0	0	0	0
Crawfo	34	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	8	0	0	0	0	0	0	0	0	0	0	0	0
Dade	0	0	0	0	0	0	0	0	0	0	0	0	0
Dawso	0	0	0	0	0	0	0	0	0	0	0	0	0
Decatu	0	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	3	0	0	0	0	0	0	0	0	0	0	0	0
Dodge	5	0	0	0	0	0	0	0	0	0	0	0	0
Dooly	17	0	0	0	0	0	0	0	0	0	0	0	0
Dough	3	0	0	0	0	0	0	0	0	0	0	0	0
Dougla	1	0	0	0	0	0	0	0	0	0	0	0	0
Early	0	0	0	0	0	0	0	0	0	0	0	0	0
Echols	0	0	0	0	0	0	0	0	0	0	0	0	0
Effingh	0	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	0	0	0	0	0	0	0	0	0	0	0	0	0
Emanu	2	0	0	0	0	0	0	0	0	0	0	0	0
Evans	1	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	1	0	0	0	0	0	0	0	0	0	0	0	0
Florida	1	0	0	0	0	0	0	0	0	0	0	0	0
Floyd	0	0	0	0	0	0	0	0	0	0	0	0	0
Forsyth	0	0	0	0	0	0	0	0	0	0	0	0	0
Frankli	0	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	2	0	0	0	0	0	0	0	0	0	0	0	0
Gilmer	0	0	0	0	0	0	0	0	0	0	0	0	0
Glasco	0	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	1	0	0	0	0	0	0	0	0	0	0	0	0
Gordon	0	0	0	0	0	0	0	0	0	0	0	0	0
Grady	0	0	0	0	0	0	0	0	0	0	0	0	0
Greene	1	0	0	0	0	0	0	0	0	0	0	0	0
Gwinne	2	0	0	0	0	0	0	0	0	0	0	0	0
Habers	0	0	0	0	0	0	0	0	0	0	0	0	0
Hall	0	0	0	0	0	0	0	0	0	0	0	0	0
Hancoc	12	0	0	0	0	0	0	0	0	0	0	0	0
Haralso	0	0	0	0	0	0	0	0	0	0	0	0	0
Harris	0	0	0	0	0	0	0	0	0	0	0	0	0
Hart	0	0	0	0	0	0	0	0	0	0	0	0	0
Heard	0	0	0	0	0	0	0	0	0	0	0	0	0
Henry	6	0	0	0	0	0	0	0	0	0	0	0	0

Houst	204	0	0	0	0	0	0	0	0	0	0	0	0	0
Irwin	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Jackso	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Jasper	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Jeff Da	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Jeffers	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Jenkins	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Johnso	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Jones	39	0	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	14	0	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	21	0	0	0	0	0	0	0	0	0	0	0	0	0
Lee	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lincoln	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Long	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lownd	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Lumpk	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Macon	8	0	0	0	0	0	0	0	0	0	0	0	0	0
Madis	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Marion	1	0	0	0	0	0	0	0	0	0	0	0	0	0
McDuf	1	0	0	0	0	0	0	0	0	0	0	0	0	0
McInto	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Meriwe	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Miller	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mitche	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Monro	39	0	0	0	0	0	0	0	0	0	0	0	0	0
Monty	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Morga	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Murray	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Muscog	2	0	0	0	0	0	0	0	0	0	0	0	0	0
Newto	13	0	0	0	0	0	0	0	0	0	0	0	0	0
North	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Oconee	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Other	5	0	0	0	0	0	0	0	0	0	0	0	0	0
Ogleth	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Paulding	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Peach	83	0	0	0	0	0	0	0	0	0	0	0	0	0
Pickens	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pierce	0	0	0	0	0	0	0	0	0	0	0	0	0
Pike	4	0	0	0	0	0	0	0	0	0	0	0	0
Polk	0	0	0	0	0	0	0	0	0	0	0	0	0
Pulaski	12	0	0	0	0	0	0	0	0	0	0	0	0
Putnam	24	0	0	0	0	0	0	0	0	0	0	0	0
Quitman	0	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	0	0	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	2	0	0	0	0	0	0	0	0	0	0	0	0
Rockdale	1	0	0	0	0	0	0	0	0	0	0	0	0
Schley	0	0	0	0	0	0	0	0	0	0	0	0	0
Screven	0	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	0	0	0	0	0	0	0	0	0	0	0	0	0
Spalding	3	0	0	0	0	0	0	0	0	0	0	0	0
Southwest	0	0	0	0	0	0	0	0	0	0	0	0	0
Stephens	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	0	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	6	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	0	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	0	0	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	0	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	1	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	11	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	5	0	0	0	0	0	0	0	0	0	0	0	0
Terrell	0	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	0	0	0	0	0	0	0	0	0	0	0	0	0
Tift	2	0	0	0	0	0	0	0	0	0	0	0	0
Toombs	2	0	0	0	0	0	0	0	0	0	0	0	0
Towns	0	0	0	0	0	0	0	0	0	0	0	0	0
Treutlen	8	0	0	0	0	0	0	0	0	0	0	0	0
Troup	0	0	0	0	0	0	0	0	0	0	0	0	0
Turner	1	0	0	0	0	0	0	0	0	0	0	0	0
Twiggs	10	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	0	0	0	0	0	0	0	0	0	0	0	0
Upson	15	0	0	0	0	0	0	0	0	0	0	0	0
Walker	0	0	0	0	0	0	0	0	0	0	0	0	0
Walton	2	0	0	0	0	0	0	0	0	0	0	0	0
Ware	0	0	0	0	0	0	0	0	0	0	0	0	0
Warren	0	0	0	0	0	0	0	0	0	0	0	0	0

Warren	0	0	0	0	0	0	0	0	0	0	0	0	0
Washin	8	0	0	0	0	0	0	0	0	0	0	0	0
Wayne	0	0	0	0	0	0	0	0	0	0	0	0	0
Webste	0	0	0	0	0	0	0	0	0	0	0	0	0
Wheele	1	0	0	0	0	0	0	0	0	0	0	0	0
White	0	0	0	0	0	0	0	0	0	0	0	0	0
Whitfie	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilcox	7	0	0	0	0	0	0	0	0	0	0	0	0
Wilkes	0	0	0	0	0	0	0	0	0	0	0	0	0
Wilkins	24	0	0	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0
Totals	**1,271**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**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:

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

If you checked yes, how many? (FTEs)

What languages do they most often interpret?

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

We have Video Interpreting devices in every department with live Interpreters available 24/7

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	0
American Sign Language	0	0	0	0
Vietnamese	0	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?

Annual mandatory learning

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?

N/A

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

Language One:

English

Language Two:

Language Three:

Language Four:

If an unisured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? (Check the box, if yes) ☐

If you checked yes, what is the name and location of that health care center or clinic?

Comprehensive Inpatient Physical Rehabilitation Addendum

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	4	65
Asian	12	175
Black/African American	422	5,827
Hispanic/Latino	1	12
Pacific Islander/Hawaiian	2	37
White	817	11,455
Multi-Racial	13	258
Total	1,271	17,829

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	624	8,501
Female	647	9,328
Total	1,271	17,829

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	0	0
18-64	451	6,549
65-84	622	8,685
85 Up	198	2,595
Total	1,271	17,829

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	1,228
Long Term Care Hospital	0
Skilled Nursing Facility	4
Traumatic Brain Injury Facility	0
Home/Physician's Office/Other	39
Total	1,271

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	790
Third-Party/Commercial	289
Self-Pay	44
Other	148
Total	1,271

2. Uncompensated Indigent and Charity Care

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

0

Part D: Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1 Stroke	295
2 Brain Injury	186
3 Amputation	0
4 Spinal Cord	99
5 Fracture of the femur	0
6 Neurological disorders	71
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	620
Total	1,271

Nurse Employment Addendum

Did your facility employ one or more nurses holding a multistate license pursuant to O.C.G.A. § 43-26-60 et seq. for 30 days or more in 2025 (January 1, 2025 through December 31, 2025)? (Check the box, if yes.)

1.

If yes please list each nurse below: To add a row press the button. To delete a row press the minus button at the end of the row. (You may enter the data on the web form or upload the data to the web form using the .csv file. The csv file upload is recommended, especially if you have a large number of records to add to the form.)

Full Name	Work Address	Duration	Primary State of Residency	Employed by Agency? (Yes/No)	Primary Dates of Employment
ANDERSON, VON	Navicent Rehabilit	854	Georgia	No	10/30/2023-Current
BROWN, JORDAN	Navicent Rehabilit	784	Georgia	No	1/8/2024-Current
DAVIS, ALICIA LA	Navicent Rehabilit	2114	Georgia	No	5/18/2020-Current
FLETCHER, FREDE	Navicent Rehabilit	1487	Georgia	No	2/4/2022-Current
GREEN, KILEE CA	Navicent Rehabilit	812	Georgia	No	12/11/2023-Current
JOHNSON, DENI	Navicent Rehabilit	742	Georgia	No	2/19/2024-Current
LOFTON, LOUISA	Navicent Rehabilit	4760	Georgia	No	2/18/2013-Current
SASSAMAN, MAC	Navicent Rehabilit	938	Georgia	No	8/7/2023-Current
SNELGROVE, RUT	Navicent Rehabilit	826	Georgia	No	11/27/2023-Current
STRINGER, HUNT	Navicent Rehabilit	2996	Georgia	No	12/18/2017-Current
SUANO, NOVO G	Navicent Rehabilit	1036	Georgia	No	5/1/2023-Current
TAPIA-PERRY, DE	Navicent Rehabilit	441	Georgia	No	12/16/2024-Current
WILLIAMS, SHERI	Navicent Rehabilit	511	Georgia	No	10/7/2024-Current
WORTHY, ASSYR	Navicent Rehabilit	854	Georgia	No	10/30/2023-Current

Only use commas to separate values

Example Entry: Dean Venture, 1234 Street Name Atlanta GA 30033, 1 year 3 months 12 days, GA, Yes, January 2025 - Present
Note: This is an example and there is no unit requirement for Duration

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

Authorized Signature

Delvecchio Finley

Date

03/06/2026

Title

President, Atrium Health GA

Comments