HOSP448 2025 Annual Hospital Questionnaire

Part A: General Information

UID: HOSP448

1. Identifcication

Facility Name:

Evans Memorial Hospital

County:

Evans

Street Address:

200 N River St

City:

Claxton

Zip:

30417

Mailing Address:

PO Box 518

Mailing City:

Claxton

Mailing Zip:

30417

Medicaid Provider Number:

000000734A

Medicare Provider Number:

110142

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:

John Wiggins

Contact Title:

CFO

Phone:

9127395139

Fax:

9127395101

Email:

jwiggins@evansmemorial.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)

Evans Memorial Hospital, Inc.

Organization Type

Not For Profit

Effective Date

08/12/1996

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)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

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)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

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

City

State

4.

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

Name

City

State

5.

Check the box to the right if the hospital itself operates subsidiary corporations ☐

Name

City

State

6.

Check the box to the right if your hospital is a member of an alliance ☐

Name

City

State

7.

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

Name

City

State

8. 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	20	425	1,544	429	1,560
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	20	425	1,544	429	1,560

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	0	0
Black/African American	128	449
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	280	1,036
Multi-Racial	17	59
Total	425	1,544

3. Gender

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

Gender	Admissions	Inpatient Days
Male	204	733
Female	221	811
Total	425	1,544

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	118	412
Medicaid	69	235
Peachare	0	0
Third-Party	186	771
Self-Pay	52	126
Other	0	0
Total	425	1,544

5. Discharges to Death

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

14

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	1,400
Semi-Private Room Rate	750
Operating Room: Average Charge for the First Hour	16,250
Average Total Charge for an Inpatient Day	12,860

Part E: Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only

9,479

2. Inpatient Admissions from ER

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

280

3. Beds Available

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

6

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	6	9,479
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

482

6. Non-Emergency Visits

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

21,915

7. Observation Visits/Cases

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

677

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

235

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	3	4
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	3	4
Positron Emission Tomography (PET)	3	4
Radioisotope, Therapeutic	3	4
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	3	4
Respiratory Therapy	1	1
Occupational Therapy	3	4
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	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	7,120
Number of CTS Units (machines)	2
Number of CTS Procedures	5,500
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	1
Number of Number of MRI Procedures	960
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	6,700
Number of Occupational Therapy Treatments	0
Number of Physical Therapy Treatments	19,050
Number of Speech Pathology Patients	12
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	1
Number of Ultrasound/Medical Sonography Procedures	1,773
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)

2

3. Robotic Surgery System

Units

0

Procedures

0

Type of Unit(s)

0

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*)	25	2	0
Licensed Practical Nurses (LPNs)	8	1	0
Pharmacists	1	0	0
Other Health Services Professionals*	4	0	0
Administration and Support	62	4	0
All Other Hospital Personnel (not included in above)	40	1	1

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	61-90 Days
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 Days
Other Health Services Professionals	31-60 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	4
Black/African American	4
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	37
Multi-Racial	1
Total	46

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	4	☐	4	4
General Internal Medicine	8	☐	8	8
Pediatricians	0	☐	0	0
Other Medical Specialties	7	☐	7	7

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	2	☐	2	2
Gynecology	0	☐	0	0
Ophthalmology Surgery	1	☐	1	1
Orthopedic Surgery	1	☐	1	1
Plastic Surgery	1	☐	0	0
General Surgery	2	☑	2	2
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	1	☐	1	1
Dermatology	0	☐	0	0
Emergency Medicine	7	☐	7	7
Nuclear Medicine	0	☐	0	0
Pathology	1	☐	1	1
Psychiatry	0	☐	0	0
Radiology	8	☐	8	8
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	0
Podiatrists	1
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	3

5b. Name of Other Professions

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

James Burnsed, FNP, Kathy Akins, NP, Elizabeth Herwig NP

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
Chadwick Gaddis	71233
Daniel Jung	74967
Olalekan Akinyokunbo	81386
Thomas Alexander	68094
Olatunji Awe	47570
Calvin Barnes	67518
Kwabena Boakye	76303
David Brantley	28506
Adam Brochert	52147
Glen Dasher	43354
Anurita Dass	65649
Matthew Day	84151
Chetan Deshpande	63314
Atul Devani	66590
Vinh Dong	99032
James Edwards	41784
Gary Elkin	52714
Thomas Ferrari	34829
Brian Gretta	62698
Mathew Griffith	77010
Joseph Gussler	38788
Karen Hannah	36538
Thomas Horn	52444
James Long	68237
Andrew Magnet	60215

Thomas Miller	67685
Jason Morris	49069
Adewumi Oguntunmibi	49393
Timothy Powell	47136
John Rathbun	23665
William Rice	88085
Adam Rudd	93861
Jesse Scott	43126
Inder Singh	40551
Chad Slaughter	62003
Erin Slaughter	72411
Douglas Sommers	37910
Rebecca Spahos	69188
Alan Stansfield	63893
Paul Thompson	54519
Kevin Timperman	96267
William Wallace	60513
Jessica Wilder	75407
Michael Wolverton	100792
Ryan Piche	OPT 003086

Only use commas to separate values

Part I: Patient Origin

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
Appl	0	12	0	0	0	0	0	0	0	0	0	0
Brya	18	34	0	0	0	0	0	0	0	0	0	0
Bullo	17	231	0	0	0	0	0	0	0	0	0	0
Canc	2	34	0	0	0	0	0	0	0	0	0	0
Chat	4	5	0	0	0	0	0	0	0	0	0	0
Coffe	0	1	0	0	0	0	0	0	0	0	0	0
Effin	1	2	0	0	0	0	0	0	0	0	0	0
Emar	2	16	0	0	0	0	0	0	0	0	0	0
Evan	220	433	0	0	0	0	0	0	0	0	0	0
Jenki	0	14	0	0	0	0	0	0	0	0	0	0
Liber	1	18	0	0	0	0	0	0	0	0	0	0
Long	4	20	0	0	0	0	0	0	0	0	0	0
Mon	0	3	0	0	0	0	0	0	0	0	0	0
Scre	0	18	0	0	0	0	0	0	0	0	0	0
Tattn	153	521	0	0	0	0	0	0	0	0	0	0
Toon	3	22	0	0	0	0	0	0	0	0	0	0
Wayı	0	5	0	0	0	0	0	0	0	0	0	0
Totals	**425**	**1,389**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

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	Total
General Operating	0	0	2	2
Cystoscopy (OR Suite)	0	0	0	0
Endoscopy (OR Suite)	0	1	0	1
	0	0	0	0
Total	0	1	2	3

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	3	322	325
Cystoscopy	0	0	0	0	0
Endoscopy	0	1,361	0	0	1,361
0	0	0	0	0	0
Total	0	1,361	3	322	1,686

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	3	300	303
Cystoscopy	0	0	0	0	0
Endoscopy	0	1,086	0	0	1,086
	0	0	0	0	0
Total	0	1,086	3	300	1,389

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	5
Black/African American	260
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	1,084
Multi-Racial	40
Total	1,389

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	2
Ages 15-64	840
Ages 65-74	365
Ages 75-85	165
Ages 85 and Up	17
Total	1,389

3. Gender

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

Gender	Number of Ambulatory Patients
Male	626
Female	763
Total	1,389

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	207
Medicaid	209
Third-Party	956
Self-Pay	17
Total	1,389

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

Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.):

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	10	1	2	3
Haitian Creole	5	0	0	0
	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 education on cultural diversity and competency

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?

We have resources in place for CLAS

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

Language One:

English

Language Two:

Spanish

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?

South East Health in Reidsville Georgia

Part A: Nurse 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.) ☐

If you've made an entry in the table, please check this box

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	Address	Duration	Primary State of Residency	Employed by Agency? (Yes/No)	Primary Dates of Employment

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.**

These fields will become unlocked after all other fields have been correctly filled out

Authorized Signature

John Wiggins

Date

02/12/2026

Title

CFO

Comments

Response Errors

TAB	QUESTION	ERROR
Nurse	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.)	If you've made an entry in the table, please check this box

TAB	QUESTION	ERROR
Nurse	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.)	This field is required