GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2024 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP416

Facility Name: Arthur M Blank Hospital

County: DeKalb

Street Address: 2220 North Druid Hills Road NE

City: Atlanta

Zip: 30329

Mailing Address: 2220 North Druid Hills Road NE

Mailing City: Atlanta

Mailing Zip: 30329

Medicaid Provider Number: 000000943A

Medicare Provider Number: 113300

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: Ariel Zhang

Contact Title: Senior Financial Analyst

Phone: 404-785-5721

Fax: 404-785-7027

E-mail: 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)	Organization Type	Effective Date
Arthur M. Blank Hospital, Inc.	Not for Profit	2/1/1998

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

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

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

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: The Children's Care Network, Inc.
City: **State:**

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

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☐

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	0	0	0	0	0
Pediatrics (Non ICU)	254	9,266	62,030	11,430	61,300
Pediatric ICU	72	2,169	11,695	671	11,272
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
CICU	40	744	9,850	87	9,839
	0	0	0	0	0
	0	0	0	0	0
Total	**366**	**12,179**	**83,575**	**12,188**	**82,411**

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	52	429
Asian	372	2,399
Black/African American	6,198	39,832
Hispanic/Latino	1,390	12,841
Pacific Islander/Hawaiian	8	29
White	3,814	25,232
Multi-Racial	345	2,813
Total	**12,179**	**83,575**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	6,633	46,154
Female	5,546	37,421
Total	**12,179**	**83,575**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	84	827
Medicaid	6,535	47,517
Peachare	421	2,337
Third-Party	4,719	31,030
Self-Pay	420	1,864
Other	0	0

5. Discharges to Death

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

199

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	3,120
Semi-Private Room Rate	0
Operating Room: Average Charge for the First Hour	11,361
Average Total Charge for an Inpatient Day	18,825

Part E : Emergency Department and Outpatient Services

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

80,474

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

8,535

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

75

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	6	1,790
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	69	78,684
	0	0
	0	0
	0	0
	0	0

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

1,133

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

266,770

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

8,547

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

16.00

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.

1,059

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

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

Service/Facilities	Site Code	Service Status
Podatric Services	3	4
Renal Dialysis	2	1
ESWL	3	4
Billiary Lithotropter	3	4
Kidney Transplants	1	1
Heart Transplants	1	1
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	3	4
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	1	1
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	1,337
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	20
Number of Heart Transplants	10
Number of Other-Organ/Tissues Treatments	76
Number of Diagnostic X-Ray Procedures	85,080
Number of CTS Units (machines)	2
Number of CTS Procedures	9,330
Number of Diagnostic Radioisotope Procedures	1,770
Number of PET Units (machines)	1
Number of PET Procedures	379
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	5
Number of Number of MRI Procedures	11,209
Number of Chemotherapy Treatments	8,286
Number of Respiratory Therapy Treatments	181,944
Number of Occupational Therapy Treatments	29,801
Number of Physical Therapy Treatments	42,212
Number of Speech Pathology Patients	1,354
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	1,225
Number of HIV/AIDS Diagnostic Procedures	2,253
Number of HIV/AIDS Patients	2
Number of Ambulance Trips	5,518
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	9
Number of Ultrasound/Medical Sonography Procedures	19,132
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).

304

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
0	0	

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2024. 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	384.80	4.00	0.00
Physician Assistants Only (not including Licensed Physicians)	36.30	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,694.70	63.40	0.00
Licensed Practical Nurses (LPNs)	27.40	1.50	0.00
Pharmacists	52.40	1.90	0.00
Other Health Services Professionals*	1,437.30	96.90	17.10
Administration and Support	2,690.00	112.80	0.00
All Other Hospital Personnel (not included above)	47.40	0.00	0.00

2. Filling Vacancies

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

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	31-60 Days
Licensed Practical Nurses (LPNs)	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	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	0	☐	0	0
General Internal Medicine	0	☐	0	0
Pediatricians	248	☑	185	0
Other Medical Specialties	478	☑	398	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	4	☐	4	0
Ophthalmology Surgery	28	☐	26	0
Orthopedic Surgery	28	☐	28	0
Plastic Surgery	7	☐	7	0
General Surgery	32	☐	29	0
Thoracic Surgery	6	☐	4	0
Other Surgical Specialties	114	☐	111	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	48	☑	45	0
Dermatology	17	☐	17	0
Emergency Medicine	139	☑	108	0
Nuclear Medicine	1	☑	1	0
Pathology	16	☑	14	0
Psychiatry	32	☐	23	0
Radiology	78	☑	78	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 Privleges	25
Podiatrists	0
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	532

5b. Name of Other Professions

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

PA, PAA, PNP, NNP, PhD, CRNA, CNS, CPNP, CNNP, DNP, FNP

Comments and Suggestions:

1. Budgeted FTE reported under Part G includes allocated FTEs from Corporate Support and Physician Practice.
2. Budgeted FTEs for Registered Nurses include Nurse Practitioners and APPs.
3. Vacant FTEs reflect actual open/vacant positions as of 12/31/2024.

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	81	67	0	0	0	0	0	0	0	0	0	0	0
Appling	5	0	0	0	0	0	0	0	0	0	0	0	0
Atkinson	5	3	0	0	0	0	0	0	0	0	0	0	0
Baker	1	2	0	0	0	0	0	0	0	0	0	0	0
Baldwin	36	11	0	0	0	0	0	0	0	0	0	0	0
Banks	23	19	0	0	0	0	0	0	0	0	0	0	0
Barrow	135	145	0	0	0	0	0	0	0	0	0	0	0
Bartow	121	101	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	11	7	0	0	0	0	0	0	0	0	0	0	0
Berrien	4	7	0	0	0	0	0	0	0	0	0	0	0
Bibb	115	79	0	0	0	0	0	0	0	0	0	0	0
Bleckley	9	6	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	1	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	7	7	0	0	0	0	0	0	0	0	0	0	0
Bulloch	22	11	0	0	0	0	0	0	0	0	0	0	0
Burke	2	1	0	0	0	0	0	0	0	0	0	0	0
Butts	41	43	0	0	0	0	0	0	0	0	0	0	0
Calhoun	0	1	0	0	0	0	0	0	0	0	0	0	0
Camden	7	1	0	0	0	0	0	0	0	0	0	0	0
Candler	2	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	187	140	0	0	0	0	0	0	0	0	0	0	0
Catoosa	7	11	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	2	0	0	0	0	0	0	0	0	0	0	0
Chatham	37	35	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	6	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	10	8	0	0	0	0	0	0	0	0	0	0	0

Cherokee	208	227	0	0	0	0	0	0	0	0	0	0	0
Clarke	76	73	0	0	0	0	0	0	0	0	0	0	0
Clayton	570	362	0	0	0	0	0	0	0	0	0	0	0
Clinch	2	2	0	0	0	0	0	0	0	0	0	0	0
Cobb	579	629	0	0	0	0	0	0	0	0	0	0	0
Coffee	11	17	0	0	0	0	0	0	0	0	0	0	0
Colquitt	20	27	0	0	0	0	0	0	0	0	0	0	0
Columbia	19	22	0	0	0	0	0	0	0	0	0	0	0
Cook	7	6	0	0	0	0	0	0	0	0	0	0	0
Coweta	239	191	0	0	0	0	0	0	0	0	0	0	0
Crawford	2	3	0	0	0	0	0	0	0	0	0	0	0
Crisp	13	11	0	0	0	0	0	0	0	0	0	0	0
Dade	2	2	0	0	0	0	0	0	0	0	0	0	0
Dawson	30	30	0	0	0	0	0	0	0	0	0	0	0
Decatur	14	15	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,878	1,149	0	0	0	0	0	0	0	0	0	0	0
Dodge	12	11	0	0	0	0	0	0	0	0	0	0	0
Dooly	18	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	65	43	0	0	0	0	0	0	0	0	0	0	0
Douglas	169	138	0	0	0	0	0	0	0	0	0	0	0
Early	1	6	0	0	0	0	0	0	0	0	0	0	0
Echols	3	1	0	0	0	0	0	0	0	0	0	0	0
Effingham	9	13	0	0	0	0	0	0	0	0	0	0	0
Elbert	25	14	0	0	0	0	0	0	0	0	0	0	0
Emanuel	2	0	0	0	0	0	0	0	0	0	0	0	0
Evans	3	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	18	18	0	0	0	0	0	0	0	0	0	0	0
Fayette	185	160	0	0	0	0	0	0	0	0	0	0	0
Florida	25	21	0	0	0	0	0	0	0	0	0	0	0
Floyd	73	60	0	0	0	0	0	0	0	0	0	0	0
Forsyth	166	127	0	0	0	0	0	0	0	0	0	0	0
Franklin	25	38	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,627	1,254	0	0	0	0	0	0	0	0	0	0	0
Gilmer	19	20	0	0	0	0	0	0	0	0	0	0	0
Glascock	1	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	8	14	0	0	0	0	0	0	0	0	0	0	0
Gordon	34	33	0	0	0	0	0	0	0	0	0	0	0
Grady	6	11	0	0	0	0	0	0	0	0	0	0	0
Greene	12	19	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	1,207	1,083	0	0	0	0	0	0	0	0	0	0	0
Habersham	58	55	0	0	0	0	0	0	0	0	0	0	0
Hall	208	193	0	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	28	33	0	0	0	0	0	0	0	0	0	0	0

Harris	24	27	0	0	0	0	0	0	0	0	0	0	0
Hart	12	13	0	0	0	0	0	0	0	0	0	0	0
Heard	12	12	0	0	0	0	0	0	0	0	0	0	0
Henry	715	416	0	0	0	0	0	0	0	0	0	0	0
Houston	97	130	0	0	0	0	0	0	0	0	0	0	0
Irwin	3	7	0	0	0	0	0	0	0	0	0	0	0
Jackson	155	145	0	0	0	0	0	0	0	0	0	0	0
Jasper	22	15	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	1	2	0	0	0	0	0	0	0	0	0	0	0
Jefferson	4	3	0	0	0	0	0	0	0	0	0	0	0
Jenkins	0	10	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	3	0	0	0	0	0	0	0	0	0	0	0
Jones	11	11	0	0	0	0	0	0	0	0	0	0	0
Lamar	28	29	0	0	0	0	0	0	0	0	0	0	0
Lanier	3	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	26	18	0	0	0	0	0	0	0	0	0	0	0
Lee	17	24	0	0	0	0	0	0	0	0	0	0	0
Liberty	14	6	0	0	0	0	0	0	0	0	0	0	0
Lincoln	1	2	0	0	0	0	0	0	0	0	0	0	0
Long	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	56	37	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	19	22	0	0	0	0	0	0	0	0	0	0	0
Macon	16	4	0	0	0	0	0	0	0	0	0	0	0
Madison	39	26	0	0	0	0	0	0	0	0	0	0	0
Marion	9	5	0	0	0	0	0	0	0	0	0	0	0
McDuffie	2	0	0	0	0	0	0	0	0	0	0	0	0
McIntosh	0	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	29	17	0	0	0	0	0	0	0	0	0	0	0
Miller	3	2	0	0	0	0	0	0	0	0	0	0	0
Mitchell	12	7	0	0	0	0	0	0	0	0	0	0	0
Monroe	15	28	0	0	0	0	0	0	0	0	0	0	0
Montgomery	2	2	0	0	0	0	0	0	0	0	0	0	0
Morgan	25	21	0	0	0	0	0	0	0	0	0	0	0
Murray	10	18	0	0	0	0	0	0	0	0	0	0	0
Muscogee	181	143	0	0	0	0	0	0	0	0	0	0	0
Newton	363	261	0	0	0	0	0	0	0	0	0	0	0
North Carolina	23	13	0	0	0	0	0	0	0	0	0	0	0
Oconee	26	42	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	9	9	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	82	70	0	0	0	0	0	0	0	0	0	0	0
Paulding	183	119	0	0	0	0	0	0	0	0	0	0	0
Peach	32	27	0	0	0	0	0	0	0	0	0	0	0
Pickens	26	19	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	2	0	0	0	0	0	0	0	0	0	0	0

Pike	22	31	0	0	0	0	0	0	0	0	0	0	0
Polk	40	35	0	0	0	0	0	0	0	0	0	0	0
Pulaski	13	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	15	8	0	0	0	0	0	0	0	0	0	0	0
Quitman	3	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	16	18	0	0	0	0	0	0	0	0	0	0	0
Randolph	4	3	0	0	0	0	0	0	0	0	0	0	0
Richmond	17	15	0	0	0	0	0	0	0	0	0	0	0
Rockdale	256	121	0	0	0	0	0	0	0	0	0	0	0
Schley	6	5	0	0	0	0	0	0	0	0	0	0	0
Screven	1	4	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	7	0	0	0	0	0	0	0	0	0	0	0
South Carolina	25	34	0	0	0	0	0	0	0	0	0	0	0
Spalding	136	86	0	0	0	0	0	0	0	0	0	0	0
Stephens	27	35	0	0	0	0	0	0	0	0	0	0	0
Stewart	2	2	0	0	0	0	0	0	0	0	0	0	0
Sumter	21	16	0	0	0	0	0	0	0	0	0	0	0
Talbot	5	2	0	0	0	0	0	0	0	0	0	0	0
Tattnall	5	2	0	0	0	0	0	0	0	0	0	0	0
Taylor	2	5	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	19	13	0	0	0	0	0	0	0	0	0	0	0
Terrell	3	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	30	23	0	0	0	0	0	0	0	0	0	0	0
Tift	22	27	0	0	0	0	0	0	0	0	0	0	0
Toombs	12	11	0	0	0	0	0	0	0	0	0	0	0
Towns	3	13	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	1	0	0	0	0	0	0	0	0	0	0	0
Troup	100	71	0	0	0	0	0	0	0	0	0	0	0
Turner	14	7	0	0	0	0	0	0	0	0	0	0	0
Twiggs	8	3	0	0	0	0	0	0	0	0	0	0	0
Union	22	13	0	0	0	0	0	0	0	0	0	0	0
Upson	24	27	0	0	0	0	0	0	0	0	0	0	0
Walker	25	13	0	0	0	0	0	0	0	0	0	0	0
Walton	293	240	0	0	0	0	0	0	0	0	0	0	0
Ware	6	6	0	0	0	0	0	0	0	0	0	0	0
Warren	1	2	0	0	0	0	0	0	0	0	0	0	0
Washington	20	2	0	0	0	0	0	0	0	0	0	0	0
Wayne	3	2	0	0	0	0	0	0	0	0	0	0	0
Webster	0	2	0	0	0	0	0	0	0	0	0	0	0
Wheeler	4	2	0	0	0	0	0	0	0	0	0	0	0
White	17	31	0	0	0	0	0	0	0	0	0	0	0
Whitfield	29	26	0	0	0	0	0	0	0	0	0	0	0
Wilcox	11	8	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	15	7	0	0	0	0	0	0	0	0	0	0	0
Worth	7	9	0	0	0	0	0	0	0	0	0	0	0
Total	**12,179**	**9,608**	**0**	**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	19
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
Cardiac	3	0	0
Total	**3**	**0**	**19**

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	16,892	14,849
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	5,379	0	0	0
Total	**5,379**	**0**	**16,892**	**14,849**

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	3,524	9,608
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
Cardiac	620	0	0	0
Total	**620**	**0**	**3,524**	**9,608**

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	27
Asian	312
Black/African American	3,625
Hispanic/Latino	1,497
Pacific Islander/Hawaiian	7
White	3,842
Multi-Racial	298
Total	**9,608**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	7,916
Ages 15-64	1,692
Ages 65-74	0
Ages 75-85	0
Ages 85 and Up	0
Total	**9,608**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,739
Female	3,869
Total	**9,608**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	14
Medicaid	4,661
Third-Party	4,711
Self-Pay	222

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	0	0	0	0
Specialty Care (Intermediate Neonatal Care)	0	0	0	0
Subspecialty Care (Intensive Neonatal Care)	60	504	17,986	504

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	0	0
Ages 15-44	0	0
Ages 45 and Up	0	0
Total	**0**	**0**

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

$0.00

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

$0.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, Gender and Payment Source

1. Race/Ethnicity
Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	0	0
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of 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? 13 (FTE's)
What languages do they interpret?
SPANISH

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☑
Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐
Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐
Other (please describe): ☑

VIDEO REMOTE INTERPRETER

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	7.8	0	0	0
AMHARIC	0.2	0	0	0
ARABIC	0.2	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?

EDUCATION AT NEW HIRE ORIENTATION

EDUCATION AT PATIENT CARE PROVIDER ORIENTATION
IN PERSON TRAINING WHEN IMPLEMENTED NEW VENDOR FOR TELEPHONIC AND VIDEO REMOTE INTERPRETATION
COMPUTER BASED TRAINING FOR NEW REMOTE INTERPRETING VENDOR

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?

INCREASED FTE
ADDITIONAL FTE AND COMPETETIVE PAY FOR ASL INTERPRETER OR OTHER LANGUAGES
BILINGUAL SIGNAGE

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

1. ENGLISH
2.
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?

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: Linda Cole

Date: 3/5/2025

Title: SVP AMB Hospital Operations and CNO

Comments:

1. Children's Healthcare of Atlanta does not track the race and ethnicity of physicians.
2. A complete list of nurses and other employed staff that speak the languages listed in Q3 of the minority health addendum is not available.
3. Children's provides emergency department services regardless of a patient's ability to pay in accordance with EMTALA. Children's has financial counselors available to assist uninsured patients in applying to Medicaid.