GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP720

Facility Name: Emory Decatur Hospital

County: DeKalb

Street Address: 2701 North Decatur Road

City: Decatur

Zip: 30033-5995

Mailing Address: 2701 North Decatur Road

Mailing City: Decatur

Mailing Zip: 30033-5995

Medicaid Provider Number: 0000536A

Medicare Provider Number: 110076

2. Report Period

Report Data for the full twelve month period- January 1, 2018 through December 31, 2018.
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: Dawn Stone

Contact Title: Controller

Phone: 404-501-5686

Fax: 404-501-2891

E-mail: dawn.stone@emoryhealthcare.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management
As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Dekalb Medical Center, Inc.	Not for Profit	8/9/1991

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Healthcare, Inc.	Not for Profit	9/1/2018

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory Healthcare, Inc.	Not for Profit	9/1/2018

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Emory University	Not for Profit	9/1/2018

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.
DeKalb Medical Center was acquired by Emory Healthcare. This was effective on 9/1/2018.

3. Check the box to the right if your facility is part of a health care system ☑
Name: Emory Healthcare
City: Atlanta   **State:** Georgia

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: State:

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Vizient
City: Irving   **State:** Texas

7. Check the box to the right if your hospital is a participant in a health care network ☑
Name: Emory Healthcare
City: Atlanta   **State:** GA

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

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

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

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☑

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☑

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

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

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

Part D : Inpatient Services

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

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

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	62	3,612	13,378	3,631	16,363
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	280	11,081	53,037	11,738	53,528
Intensive Care	32	1,784	9,275	694	9,002
Psychiatry	18	1,351	4,059	1,374	4,071
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	30	629	7,552	627	7,527
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	**422**	**18,457**	**87,301**	**18,064**	**90,491**

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	19	64
Asian	785	3,217
Black/African American	12,810	60,592
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	3	14
White	4,083	20,064
Multi-Racial	757	3,350
Total	**18,457**	**87,301**

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

Gender	Admissions	Inpatient Days
Male	6,713	35,722
Female	11,744	51,579
Total	**18,457**	**87,301**

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,667	43,278
Medicaid	3,869	15,832
Peachare	0	0
Third-Party	4,564	18,064
Self-Pay	1,997	8,282
Other	360	1,845

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

367

6. Charges for Selected Services
Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,213
Semi-Private Room Rate	1,213
Operating Room: Average Charge for the First Hour	5,750
Average Total Charge for an Inpatient Day	6,361

Part E : Emergency Department and Outpatient Services

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

67,082

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

11,079

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

54

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	4	264
General Beds	50	66,818
	0	0
	0	0
	0	0
	0	0

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

831

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

94,663

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

5,256

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

167.00

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.

2,344

Part F : Services and Facilities

1a. Services and Facilities

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

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

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

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	1	1
ESWL	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	3	4
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	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	1,007
Number of Dialysis Treatments	4,009
Number of ESWL Patients	1
Number of ESWL Procedures	7
Number of ESWL Units	1
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	61,469
Number of CTS Units (machines)	3
Number of CTS Procedures	31,633
Number of Diagnostic Radioisotope Procedures	6,543
Number of PET Units (machines)	1
Number of PET Procedures	1,156
Number of Therapeautic Radioisotope Procedures	5,613
Number of Number of MRI Units	3
Number of Number of MRI Procedures	7,927
Number of Chemotherapy Treatments	5,275
Number of Respiratory Therapy Treatments	174,632
Number of Occupational Therapy Treatments	55,062
Number of Physical Therapy Treatments	97,839
Number of Speech Pathology Patients	22,595
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	4,896
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	2
Number of Ultrasound/Medical Sonography Procedures	18,178
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).

<u>31</u>

3. Robotic Surgery System
Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
1	652	DaVinci Si HD Model SM3000 V8.1

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	604.78	82.70	14.66
Licensed Practical Nurses (LPNs)	8.30	1.00	0.00
Pharmacists	32.36	0.00	0.00
Other Health Services Professionals*	596.91	35.20	0.58
Administration and Support	48.27	5.90	0.00
All Other Hospital Personnel (not included above)	509.13	42.50	64.44

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)	61-90 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	Not Applicable
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

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

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	☐	0	0
General Internal Medicine	51	☐	0	0
Pediatricians	23	☐	0	0
Other Medical Specialties	165	☑	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	52	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	6	☐	0	0
Ophthalmology Surgery	32	☐	0	0
Orthopedic Surgery	19	☐	0	0
Plastic Surgery	7	☐	0	0
General Surgery	24	☐	0	0
Thoracic Surgery	2	☐	0	0
Other Surgical Specialties	23	☐	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	17	☑	0	0
Dermatology	7	☐	0	0
Emergency Medicine	37	☑	0	0
Nuclear Medicine	0	☐	0	0
Pathology	17	☑	0	0
Psychiatry	4	☐	0	0
Radiology	13	☑	0	0
Hospitalists	0	☐	0	0
Radiation Oncology	16	☐	0	0
Cardiovascular Disease	30	☐	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	1
Podiatrists	38
Certified Nurse Midwives with Clinical Privileges in the Hospital	15
All Other Staff Affiliates with Clinical Privileges in the Hospital	163

5b. Name of Other Professions

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

Physician Assistants, Nurse Practitioners, Certified Registered Nurse Anesthetist, Surgical Assistants

Comments and Suggestions:

We do not track the race/ethnicity of the physicians.

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	39	36	3	0	0	0	0	0	0	0	0	0	2
Baldwin	4	2	0	0	0	0	0	0	0	0	0	0	0
Banks	4	9	0	1	0	0	0	0	0	0	0	0	0
Barrow	34	28	7	3	0	0	0	0	0	0	0	0	3
Bartow	8	7	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	2	0	0	0	0	0	0	0	0	0	0	0	1
Berrien	0	2	0	0	0	0	0	0	0	0	0	0	0
Bibb	11	10	0	2	0	0	0	0	0	0	0	0	0
Bulloch	1	1	0	0	0	0	0	0	0	0	0	0	0
Butts	3	9	2	0	0	0	0	0	0	0	0	0	0
Calhoun	4	0	0	0	0	0	0	0	0	0	0	0	1
Camden	0	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	20	3	4	3	0	0	0	0	0	0	0	0	3
Catoosa	0	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	3	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	29	22	2	1	0	0	0	0	0	0	0	0	1
Clarke	18	12	1	1	0	0	0	0	0	0	0	0	1
Clayton	330	151	77	17	0	0	0	0	0	0	0	0	19
Cobb	135	107	14	15	0	0	0	0	0	0	0	0	9
Coffee	1	1	0	0	0	0	0	0	0	0	0	0	0
Colquitt	1	4	0	0	0	0	0	0	0	0	0	0	0
Columbia	5	1	0	0	0	0	0	0	0	0	0	0	2
Cook	0	3	1	0	0	0	0	0	0	0	0	0	0
Coweta	19	14	0	1	0	0	0	0	0	0	0	0	1
Crisp	1	0	2	0	0	0	0	0	0	0	0	0	0
Dawson	7	3	0	0	0	0	0	0	0	0	0	0	0
Decatur	31	16	9	2	0	0	0	0	0	0	0	0	1

DeKalb	13,875	4,287	2,766	1,022	9	0	0	0	0	0	0	0	340
Dodge	5	1	0	0	0	0	0	0	0	0	0	0	0
Dooly	2	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	7	7	0	2	0	0	0	0	0	0	0	0	0
Douglas	27	31	5	4	0	0	0	0	0	0	0	0	2
Effingham	0	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	3	2	0	0	0	0	0	0	0	0	0	0	1
Fayette	28	23	3	3	0	0	0	0	0	0	0	0	4
Florida	47	9	4	0	0	0	0	0	0	0	0	0	5
Floyd	6	1	0	0	0	0	0	0	0	0	0	0	0
Forsyth	25	33	0	5	0	0	0	0	0	0	0	0	3
Franklin	3	8	0	0	0	0	0	0	0	0	0	0	1
Fulton	1,195	568	185	150	0	0	0	0	0	0	0	0	106
Gilmer	2	5	0	0	0	0	0	0	0	0	0	0	0
Glascock	0	0	0	1	0	0	0	0	0	0	0	0	0
Glynn	2	0	1	0	0	0	0	0	0	0	0	0	1
Gordon	1	2	0	0	0	0	0	0	0	0	0	0	0
Greene	4	8	0	0	0	0	0	0	0	0	0	0	1
Gwinnett	1,240	1,475	313	44	0	0	0	0	0	0	0	0	42
Habersham	8	9	0	1	0	0	0	0	0	0	0	0	1
Hall	24	80	2	3	0	0	0	0	0	0	0	0	1
Hancock	0	1	0	0	0	0	0	0	0	0	0	0	0
Haralson	5	1	0	0	0	0	0	0	0	0	0	0	1
Harris	0	3	0	0	0	0	0	0	0	0	0	0	0
Hart	0	4	0	0	0	0	0	0	0	0	0	0	0
Heard	1	0	0	0	0	0	0	0	0	0	0	0	0
Henry	207	154	47	7	0	0	0	0	0	0	0	0	21
Houston	15	11	0	0	0	0	0	0	0	0	0	0	2
Irwin	1	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	16	25	0	1	0	0	0	0	0	0	0	0	3
Jasper	6	9	0	0	0	0	0	0	0	0	0	0	0
Lamar	1	1	0	0	0	0	0	0	0	0	0	0	0
Laurens	4	1	1	1	0	0	0	0	0	0	0	0	0
Lee	3	0	1	0	0	0	0	0	0	0	0	0	0
Liberty	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	2	10	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	4	10	0	0	0	0	0	0	0	0	0	0	0
Macon	1	0	0	0	0	0	0	0	0	0	0	0	0
Madison	7	3	0	2	0	0	0	0	0	0	0	0	0
McDuffie	0	0	0	1	0	0	0	0	0	0	0	0	0
Meriwether	3	1	0	0	0	0	0	0	0	0	0	0	0
Mitchell	2	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	1	1	1	0	0	0	0	0	0	0	0	0	0
Morgan	4	10	0	0	0	0	0	0	0	0	0	0	0

Muscogee	6	6	0	1	0	0	0	0	0	0	0	0	0
Newton	205	209	48	9	0	0	0	0	0	0	0	0	16
North Carolina	26	11	2	0	0	0	0	0	0	0	0	0	1
Oconee	1	2	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	0	1	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	145	33	6	4	0	0	0	0	0	0	0	0	3
Paulding	15	12	2	2	0	0	0	0	0	0	0	0	2
Peach	0	2	0	0	0	0	0	0	0	0	0	0	0
Pickens	2	2	0	0	0	0	0	0	0	0	0	0	0
Pike	5	2	0	0	0	0	0	0	0	0	0	0	0
Polk	0	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	9	9	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	4	0	0	0	0	0	0	0	0	0	0	1
Randolph	0	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	5	2	0	3	0	0	0	0	0	0	0	0	1
Rockdale	273	249	66	20	0	0	0	0	0	0	0	0	14
Schley	4	0	1	0	0	0	0	0	0	0	0	0	1
South Carolina	27	13	0	0	0	0	0	0	0	0	0	0	0
Spalding	14	9	1	2	0	0	0	0	0	0	0	0	1
Stephens	2	3	0	0	0	0	0	0	0	0	0	0	0
Sumter	2	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	6	0	0	0	0	0	0	0	0	0	0	0	2
Tennessee	14	9	1	0	0	0	0	0	0	0	0	0	2
Thomas	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	4	2	0	1	0	0	0	0	0	0	0	0	0
Towns	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	12	7	3	0	0	0	0	0	0	0	0	0	0
Turner	0	1	0	0	0	0	0	0	0	0	0	0	0
Union	0	3	0	0	0	0	0	0	0	0	0	0	0
Upson	2	2	1	0	0	0	0	0	0	0	0	0	0
Walker	2	2	0	1	0	0	0	0	0	0	0	0	0
Walton	172	221	30	6	0	0	0	0	0	0	0	0	6
Washington	3	2	0	0	0	0	0	0	0	0	0	0	0
White	0	5	0	0	0	0	0	0	0	0	0	0	0
Whitfield	0	2	0	0	0	0	0	0	0	0	0	0	0
Worth	1	2	0	0	0	0	0	0	0	0	0	0	0
Total	**18,457**	**8,072**	**3,612**	**1,342**	**9**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**629**

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	17
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	0	17

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	3,444	8,146
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	3,444	8,146

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	3,171	8,072
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	0	3,171	8,072

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	5
Asian	178
Black/African American	4,337
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	3,029
Multi-Racial	523
Total	**8,072**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	268
Ages 15-64	5,194
Ages 65-74	1,749
Ages 75-85	743
Ages 85 and Up	118
Total	**8,072**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,482
Female	5,590
Total	**8,072**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,003
Medicaid	476
Third-Party	4,285
Self-Pay	308

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: 3

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 18

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,192

6. Total Live Births: 3,594

7. Total Births (Live and Late Fetal Deaths): 3,612

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,623

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

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

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	36	2,490	5,568	21
Specialty Care (Intermediate Neonatal Care)	19	804	4,340	4
Subspecialty Care (Intensive Neonatal Care)	19	318	5,540	3

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	4	8
Asian	419	1,537
Black/African American	2,454	11,307
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	3	8
White	441	1,457
Multi-Racial	291	1,131
Total	**3,612**	**15,448**

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	8	37
Ages 15-44	3,597	15,380
Ages 45 and Up	7	31
Total	**3,612**	**15,448**

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

$12,723.00

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

$31,332.00

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	35	17
B- General Acute Psychiatric Adolescents 13-17	1	1
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	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	1,342	4,041	1,260	3,785	2,988	☐
General Acute Psychiatric Adolescents 13-17	9	18	5	14	2,162	☐
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	16	48
Black/African American	1,025	3,076
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	266	817
Multi-Racial	44	118
Total	**1,351**	**4,059**

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

Gender of Patient	Admissions	Inpatient Days
Male	730	2,128
Female	621	1,931
Total	**1,351**	**4,059**

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	313	1,111
Medicaid	354	1,167
Third Party	235	658
Self-Pay	449	1,123
PeachCare	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:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? 0 (FTE's)
What languages do they interpret?

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): ☑

Interpretek (telephone services) SpectraCorp (sign language services)

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	12.5	10	30	0
Nepali	8.2	2	1	0
Burmese	7.9	0	3	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?

Every employee receives diversity/cultural training as part of the system orientation process. Also,

all employees must complete and intranet based course on diversity/cultural issues and sensitivity yearly. Inservices have also been provided to all nursing units along with other patient care departments on using the telephone interpreter service.

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?

Funding for interpretive services

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

1. English	2. Spanish	3.	4.

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

Oakhurst Medical center and Physicians care Clinic
 1760 Candler Road
 Decatur, GA 30032

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	1	8
Asian	9	115
Black/African American	407	4,829
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	1	9
White	177	2,134
Multi-Racial	34	457

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	353	4,209
Female	276	3,343

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	6	80
18-64	338	3,992
65-84	251	3,030
85 Up	34	450

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	628
Long Term Care Hospital	1
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	332
Third Party/Commercial	215
Self Pay	36
Other	46

2. Uncompensated Indigent and Charity Care

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

16

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	249
2. Brain Injury	63
3. Amputation	49
4. Spinal Cord	54
5. Fracture of the femur	31
6. Neurological disorders	83
7. Multiple Trauma	14
8. Congenital deformity	0
9. Burns	1
10. Osteoarthritis	1
11. Rheumatoid arthritis	2
12. Systemic vasculidities	1
13. Joint replacement	7
All Other	74

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: Jim Forstner

Date: 4/8/2019

Title: Chief Executive Officer

Comments: