GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2024 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, 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: Patty Pharo

Contact Title: Senior Financial Analyst

Phone: 404-544-9702

Fax: 404-727-2606

E-mail: patty.pharo@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.

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

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

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

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

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	3,348	9,690	3,338	9,648
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	235	8,897	48,920	10,080	58,679
Intensive Care	32	2,150	15,004	987	6,350
Psychiatry	32	723	5,884	684	5,599
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	30	623	8,678	613	8,396
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	**391**	**15,741**	**88,176**	**15,702**	**88,672**

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	26	164
Asian	674	2,855
Black/African American	10,291	58,540
Hispanic/Latino	686	2,865
Pacific Islander/Hawaiian	11	54
White	3,463	20,307
Multi-Racial	590	3,391
Total	**15,741**	**88,176**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	5,962	38,230
Female	9,779	49,946
Total	**15,741**	**88,176**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	6,658	46,005
Medicaid	1,635	7,651
Peachare	0	0
Third-Party	6,235	28,255
Self-Pay	1,025	5,268
Other	188	997

5. Discharges to Death

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

405

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	1,973
Semi-Private Room Rate	1,973
Operating Room: Average Charge for the First Hour	9,283
Average Total Charge for an Inpatient Day	8,949

Part E : Emergency Department and Outpatient Services

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

68,548

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

8,834

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

53

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	2,367
General Beds	49	66,181
	0	0
	0	0
	0	0
	0	0

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

1,557

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

113,923

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

7,069

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

1,078.00

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.

2,935

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	3	4
Billiary Lithotropter	2	1
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	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	1	1
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	1,099
Number of Dialysis Treatments	4,283
Number of ESWL Patients	0
Number of ESWL Procedures	0
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	233
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	58,845
Number of CTS Units (machines)	3
Number of CTS Procedures	42,031
Number of Diagnostic Radioisotope Procedures	1,672
Number of PET Units (machines)	1
Number of PET Procedures	962
Number of Therapeautic Radioisotope Procedures	92
Number of Number of MRI Units	3
Number of Number of MRI Procedures	8,665
Number of Chemotherapy Treatments	3,873
Number of Respiratory Therapy Treatments	153,561
Number of Occupational Therapy Treatments	34,011
Number of Physical Therapy Treatments	44,804
Number of Speech Pathology Patients	3,579
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	3,483
Number of HIV/AIDS Diagnostic Procedures	4,256
Number of HIV/AIDS Patients	904
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	16,673
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).

34

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
4	1,297	DaVinci Single Console Xi (4)

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	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	780.50	162.50	23.40
Licensed Practical Nurses (LPNs)	4.70	0.00	0.00
Pharmacists	47.40	2.60	0.00
Other Health Services Professionals*	705.60	43.90	10.60
Administration and Support	66.70	2.50	0.00
All Other Hospital Personnel (not included above)	508.20	31.40	2.10

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)	More than 90 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	30 Days or Less
Other Health Services Professionals	61-90 Days
All Other Hospital Personnel (not included above)	31-60 Days

3. Race/Ethnicity of Physicians

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

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	7
Asian	536
Black/African American	276
Hispanic/Latino	98
Pacific Islander/Hawaiian	0
White	817
Multi-Racial	40

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	9	☐	0	0
General Internal Medicine	10	☐	0	0
Pediatricians	18	☐	0	0
Other Medical Specialties	473	☑	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	103	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	4	☐	0	0
Ophthalmology Surgery	29	☐	0	0
Orthopedic Surgery	27	☐	0	0
Plastic Surgery	6	☐	0	0
General Surgery	70	☐	0	0
Thoracic Surgery	1	☐	0	0
Other Surgical Specialties	94	☑	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	132	☑	0	0
Dermatology	16	☐	0	0
Emergency Medicine	55	☑	0	0
Nuclear Medicine	12	☐	0	0
Pathology	38	☑	0	0
Psychiatry	77	☐	0	0
Radiology	266	☑	0	0
Hospitalists	174	☑	0	0
Radiation Oncology	45	☑	0	0
Cardiovascular Disease	104	☐	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	2
Podiatrists	44
Certified Nurse Midwives with Clinical Privileges in the Hospital	67
All Other Staff Affiliates with Clinical Privileges in the Hospital	657

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

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. **(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	29	11	2	4	0	0	0	0	0	0	0	0	0
Baldwin	6	3	0	0	0	0	0	0	0	0	0	0	1
Barrow	32	51	11	3	0	0	0	0	0	0	0	0	1
Bartow	6	10	0	3	0	0	0	0	0	0	0	0	2
Ben Hill	2	1	0	1	0	0	0	0	0	0	0	0	0
Berrien	1	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	19	6	5	1	0	0	0	0	0	0	0	0	1
Bleckley	0	1	0	0	0	0	0	0	0	0	0	0	0
Brantley	1	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	0	0	1	0	0	0	0	0	0	0	0	0
Bulloch	2	0	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0	0
Butts	18	11	3	2	0	0	0	0	0	0	0	0	0
Camden	1	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	23	20	6	2	0	0	0	0	0	0	0	0	4
Catoosa	0	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	5	1	0	2	0	0	0	0	0	0	0	0	0
Chattooga	0	1	0	0	0	0	0	0	0	0	0	0	0
Cherokee	31	62	6	6	0	0	0	0	0	0	0	0	5
Clarke	9	16	1	4	0	0	0	0	0	0	0	0	0
Clay	0	1	0	0	0	0	0	0	0	0	0	0	0
Clayton	560	290	142	21	0	0	0	0	0	0	0	0	30
Cobb	173	222	39	25	0	0	0	0	0	0	0	0	22
Coffee	1	0	0	0	0	0	0	0	0	0	0	0	0
Colquitt	1	2	0	0	0	0	0	0	0	0	0	0	0
Columbia	3	0	0	1	0	0	0	0	0	0	0	0	0
Cook	4	0	0	0	0	0	0	0	0	0	0	0	0

Coweta	47	31	9	3	0	0	0	0	0	0	0	0	3
Crisp	0	4	0	0	0	0	0	0	0	0	0	0	0
Dawson	1	6	0	0	0	0	0	0	0	0	0	0	0
Decatur	1	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	10,519	3,117	1,971	402	0	0	0	0	0	0	0	0	312
Dooly	1	1	0	0	0	0	0	0	0	0	0	0	0
Dougherty	9	3	0	2	0	0	0	0	0	0	0	0	1
Douglas	96	52	19	0	0	0	0	0	0	0	0	0	5
Early	1	0	0	0	0	0	0	0	0	0	0	0	0
Elbert	2	1	0	0	0	0	0	0	0	0	0	0	1
Emanuel	1	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fayette	77	55	19	4	0	0	0	0	0	0	0	0	3
Florida	35	10	4	8	0	0	0	0	0	0	0	0	2
Floyd	4	2	0	0	0	0	0	0	0	0	0	0	0
Forsyth	25	39	2	4	0	0	0	0	0	0	0	0	5
Franklin	1	1	0	0	0	0	0	0	0	0	0	0	1
Fulton	1,463	734	313	143	0	0	0	0	0	0	0	0	99
Gilmer	1	3	1	0	0	0	0	0	0	0	0	0	0
Glynn	1	0	1	0	0	0	0	0	0	0	0	0	0
Gordon	0	2	0	0	0	0	0	0	0	0	0	0	0
Greene	4	2	1	2	0	0	0	0	0	0	0	0	0
Gwinnett	995	1,001	407	23	0	0	0	0	0	0	0	0	51
Habersham	5	4	1	0	0	0	0	0	0	0	0	0	1
Hall	26	82	5	6	0	0	0	0	0	0	0	0	0
Hancock	2	0	0	0	0	0	0	0	0	0	0	0	1
Haralson	4	3	0	0	0	0	0	0	0	0	0	0	1
Harris	1	1	0	0	0	0	0	0	0	0	0	0	0
Hart	3	2	0	0	0	0	0	0	0	0	0	0	1
Heard	1	1	1	0	0	0	0	0	0	0	0	0	0
Henry	500	283	165	13	0	0	0	0	0	0	0	0	10
Houston	9	1	0	2	0	0	0	0	0	0	0	0	1
Irwin	1	0	0	0	0	0	0	0	0	0	0	0	0
Jackson	13	32	8	1	0	0	0	0	0	0	0	0	1
Jasper	11	9	1	0	0	0	0	0	0	0	0	0	1
Jeff Davis	0	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Jones	2	0	0	0	0	0	0	0	0	0	0	0	0
Lamar	12	5	6	0	0	0	0	0	0	0	0	0	0
Laurens	3	7	0	1	0	0	0	0	0	0	0	0	0
Lee	0	1	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	2	0	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	2	3	0	2	0	0	0	0	0	0	0	0	0

Madison	3	2	0	0	0	0	0	0	0	0	0	0	1
Marion	2	0	0	0	0	0	0	0	0	0	0	0	1
McDuffie	2	0	0	1	0	0	0	0	0	0	0	0	0
Meriwether	5	0	1	0	0	0	0	0	0	0	0	0	0
Miller	1	0	0	0	0	0	0	0	0	0	0	0	1
Monroe	6	3	1	0	0	0	0	0	0	0	0	0	1
Montgomery	0	2	0	0	0	0	0	0	0	0	0	0	0
Morgan	1	4	0	0	0	0	0	0	0	0	0	0	0
Murray	2	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	10	4	3	0	0	0	0	0	0	0	0	0	1
Newton	188	167	45	3	0	0	0	0	0	0	0	0	11
North Carolina	13	7	2	1	0	0	0	0	0	0	0	0	0
Oconee	9	1	0	0	0	0	0	0	0	0	0	0	4
Oglethorpe	0	1	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	104	21	11	10	0	0	0	0	0	0	0	0	3
Paulding	15	26	3	1	0	0	0	0	0	0	0	0	1
Peach	2	2	0	1	0	0	0	0	0	0	0	0	0
Pickens	1	1	0	0	0	0	0	0	0	0	0	0	0
Pike	8	3	0	1	0	0	0	0	0	0	0	0	2
Polk	2	1	0	0	0	0	0	0	0	0	0	0	0
Putnam	1	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	7	0	0	0	0	0	0	0	0	0	0	0
Richmond	2	5	1	0	0	0	0	0	0	0	0	0	0
Rockdale	262	184	73	7	0	0	0	0	0	0	0	0	13
South Carolina	18	14	3	1	0	0	0	0	0	0	0	0	2
Spalding	45	28	6	2	0	0	0	0	0	0	0	0	1
Stephens	1	3	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0	1
Sumter	3	2	0	0	0	0	0	0	0	0	0	0	1
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	5	3	1	0	0	0	0	0	0	0	0	0	0
Thomas	2	1	0	1	0	0	0	0	0	0	0	0	0
Tift	7	2	1	0	0	0	0	0	0	0	0	0	0
Toombs	1	1	0	0	0	0	0	0	0	0	0	0	0
Towns	2	4	0	0	0	0	0	0	0	0	0	0	0
Treutlen	1	0	1	0	0	0	0	0	0	0	0	0	0
Troup	18	3	2	0	0	0	0	0	0	0	0	0	0
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	1	5	0	0	0	0	0	0	0	0	0	0	0
Upson	11	1	2	0	0	0	0	0	0	0	0	0	0
Walker	1	3	0	0	0	0	0	0	0	0	0	0	0
Walton	160	241	41	2	0	0	0	0	0	0	0	0	11
Ware	1	0	1	0	0	0	0	0	0	0	0	0	0
Warren	1	0	0	0	0	0	0	0	0	0	0	0	0

White	4	7	1	0	0	0	0	0	0	0	0	0	1
Whitfield	2	0	0	0	0	0	0	0	0	0	0	0	0
Wilkinson	0	2	0	0	0	0	0	0	0	0	0	0	0
Worth	2	0	0	0	0	0	0	0	0	0	0	0	1
Total	**15,741**	**6,973**	**3,348**	**723**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**623**

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	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	**0**	**0**	**18**

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	1,630	6,380
Cystoscopy	0	0	84	593
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**1,714**	**6,973**

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	1,630	6,380
Cystoscopy	0	0	84	593
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**1,714**	**6,973**

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	16
Asian	251
Black/African American	3,746
Hispanic/Latino	459
Pacific Islander/Hawaiian	7
White	2,270
Multi-Racial	224
Total	**6,973**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	5
Ages 15-64	4,603
Ages 65-74	1,500
Ages 75-85	741
Ages 85 and Up	124
Total	**6,973**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,518
Female	4,455
Total	**6,973**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	2,425
Medicaid	222
Third-Party	4,245
Self-Pay	81

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: 1,067

6. Total Live Births: 3,042

7. Total Births (Live and Late Fetal Deaths): 3,067

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,084

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)	52	2,669	6,045	206
Specialty Care (Intermediate Neonatal Care)	19	48	3,134	419
Subspecialty Care (Intensive Neonatal Care)	19	325	3,379	462

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	5	10
Asian	350	948
Black/African American	1,948	5,769
Hispanic/Latino	273	754
Pacific Islander/Hawaiian	6	16
White	644	1,866
Multi-Racial	122	327
Total	**3,348**	**9,690**

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	1	1
Ages 15-44	3,328	9,618
Ages 45 and Up	19	71
Total	**3,348**	**9,690**

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

$20,068.00

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

$24,631.00

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	31
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

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	723	5,884	684	5,599	3,102	☐
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	1	1
Asian	17	147
Black/African American	396	3,180
Hispanic/Latino	29	224
Pacific Islander/Hawaiian	0	0
White	244	2,084
Multi-Racial	36	248
Total	**723**	**5,884**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	368	3,072
Female	355	2,812
Total	**723**	**5,884**

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	186	2,142
Medicaid	139	1,025
Third Party	288	1,969
Self-Pay	110	748
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? 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): ☑

Video Remote Interpretation agency (iPad); We provide an Agency Interpreter coordinated by us; Over the phone interpretation. We work diligently on avoiding the use of family members or companions as medical interpreters. Only in emergency cases are they to be used.

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		0	0	0
Swahili		0	0	0
Amharic		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?

All staff interpreters must be qualified Medical Interpreters (minimum 40 hours training); New Employee orientation; Frequent In-services with Operating Units; Annual Regulatory requirement including cultural bias training

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?

Given ELP population growth, EHC is constantly evaluating need for expansion of services including the addition of interpreters

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
5582 Memorial Drive
Stone Mountain, GA 30083
(404) 298-8998
http://oakmed.org

Recovery Consultants of Atlanta
4229 Snapfinger Woods Drive
Decatur, GA 30035
(404) 286-9252
www.recoveryconsultants.org

Grady Primary Care
Asa G. Yancey Health Center
1247 Donald Lee Hollowell Pkwy. NW
Atlanta, GA 30318
(404) 616-2265

Grady Primary Care
Kirkwood Family Medicine
1863 Memorial Drive SE
Atlanta, GA 30317
(404) 616-9304

Grady Primary Care
East Point Health Center
1595 W. Cleveland Avenue
East Point, GA 30344
(404) 616-2886

Grady Primary Care
North DeKalb Health Center
3807 Clairmont Road NE
Chamblee, GA 30341
(404) 616-0700

HEALing Community Center
2600 Martin Luther King Jr. Drive SW
Atlanta, GA 30311
(404) 564-7749
www.healingourcommunities.org

Mercy Care Services
424 Decatur Street SE
Atlanta GA 30312
(678) 843-8500
http://mercycareservices.org

Oakhurst Medical Center
5582 Memorial Drive
Stone Mountain, GA 30083
(404) 298-8998
http://oakmed.org

AbsoluteCARE Medical Center
2140 Peachtree Road NW Suite 232
Atlanta, GA 30309
(404) 231-4431
www.absolutecarehealth.com/atlanta

Whitefoord Family Medical Center
30 Warren Street SE
Atlanta, GA 30317
(404) 373-6614
http://whitefoord.org

Grady Primary Care
80 Jesse Hill Jr. Drive SE
Atlanta, GA 30303
(404) 616-9355

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	12	130
Black/African American	369	5,267
Hispanic/Latino	21	324
Pacific Islander/Hawaiian	1	19
White	174	2,277
Multi-Racial	45	653

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	310	4,247
Female	313	4,431

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	263	3,831
65-84	307	4,114
85 Up	53	733

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	623
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	373
Third Party/Commercial	228
Self Pay	2
Other	20

2. Uncompensated Indigent and Charity Care

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

19

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	199
2. Brain Injury	51
3. Amputation	25
4. Spinal Cord	37
5. Fracture of the femur	34
6. Neurological disorders	99
7. Multiple Trauma	29
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	4
All Other	145

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: Jen Schuck

Date: 3/31/2025

Title: CEO

Comments:

32 inpatient psychiatric beds were renovated per CON2022-033