



Part A: General Information

UID: DTRC032

1. Identification

Facility Name:

Emory Hillandale Hospital

County:

DeKalb

Street Address:

2745 DeKalb Medical Parkway

City:

Lithonia

Zip:

30058

Mailing Address:

2745 DeKalb Medical Parkway

Mailing City:

Lithonia

Mailing Zip:

30058

Medicaid Provider Number:

000000536U

Medicare Provider Number:

110226

3. Report Period

Report Data for the full twelve month period, January 1, 2025 - December 31, 2025 (365 days). Do not use a different report period

Check the box to the right if your facility was not operational for the entire year ☐

If your facility was not operational for the entire year, provide the dates the facility was operational

Part B: Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey

Contact Name:

Aaron Brammer

Contact Title:

Administrator, Radiation Oncology

Phone:

404-778-3892

Fax:

404-778-3670

Email:

aaron.brammer@emory.edu

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)

DeKalb County Hospital Authority

Organization Type

Not For Profit

Effective Date

08/09/1991

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

C. Facility Operator

Full Legal Name (Or Not Applicable)

DeKalb Medical Center, Inc.

Organization Type

Not For Profit

Effective Date

03/23/1992

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)

Emory Healthcare, Inc.

Organization Type

Not For Profit

Effective Date

09/01/2018

E. Management Contractor

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)

Not Applicable

Organization Type

Not Applicable

Effective Date

mm/dd/yyyy

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the report period ☐

If you checked the box for yes, please explain in the box below and include effective dates

Part D: Services/Volume by Technology or Type

1. Conventional Radiation Therapy

Report conventional, non-special purpose megavoltage radiation therapy linear accelerators and cobalt therapy units, visits, and patients. All such units should be reported here including those units that were approved under the utilization exception to the MegaVoltage Radiation Therapy rules. Do not report units capable of providing stereotactic radiosurgery treatment visits in Question 1.

Type of Machine/Therapy	Number of Machines	Number of Visits	Number of Patients
Linear Accelerator/Radiation Therapy	0	0	0
Cobalt Therapy	0	0	0
Total	0	0	0

2a. Combined Radiation Therapy

For Part D, Question 2 (a & b) provide the number of machines with which both conventional, non-special purpose radiation therapy and stereotactic radiosurgery could be performed. Provide the number of visits and patients treated under each specific modality and for each type of treatment category for the report year and report any treatments performed on other machines that were capable of providing both conventional radiation therapy and stereotactic radiosurgery.

Equipment	Number of Machines	Conventional Visits	Conventional Patients
Trilogy	0	0	0
Synergy	0	0	0
Other Technology	1	8	2
Total	1	8	2

2b. Combined Radiation Therapy/Stereotactic Radiosurgery- Intracranial and Extracranial/Body Utilization

Equipment	Intracranial Stereotactic Radiosurgery Visits	Intracranial Stereotactic Patients	Stereotactic Body Radiosurgery Visits	Stereotactic Body Radiosurgery Patients
Trilogy	0	0	0	0
Synergy	0	0	0	0
Other Technology	0	0	0	0
Total	0	0	0	0

Grand Total Visits from Questions 1, 2a, and 2b

Total
8

3. Special Purpose MRT Units and Volume

Provide the number of SRS-only machines and the number of visits and patients treated on each by the treatment categories provided. For purposes of the survey, stereotactic radiosurgery consists of procedures utilizing accurately targeted doses of radiation in multiple treatments over a short period of time (usually 1 week).

Equipment	Number of Machines	Intracranial Stereotactic Radiosurgery Visits	Intracranial Stereotactic Radiosurgery Patients	Stereotactic Body Radiotherapy (SBRT) Visits	Stereotactic Body Radiotherapy (SBRT) Patients
Gamma Knife	0	0	0	0	0
Cyber Knife	0	0	0	0	0
Other Technology	0	0	0	0	0
Total	0	0	0	0	0

Total Visits from Question 3

Total
0

Grand Total of Special Purpose and Non-Special Purpose Visits

The grand total here should match the reported visit totals in Parts E and F

Special Purpose Visits	Non-Special Purpose Visits	Grand Total Visits
0	8	8

4. Non-Special MRT Treatment Visits by Type

Please report the following utilization numbers for non-special MRT treatments by type and the number of patients receiving those treatments. Volumes should reflect only those units reported in Part D, Questions 1 and 2 above. Patients can be duplicated across treatment categories.

Treatment Type	Non-Rule Exception Units Visits	Non-Rule Exception Units Patients
Simple Treatment	0	0
Intermediate Treatment	0	0
Complex Treatment	7	1
Intensity Modulated Radiation Therapy (IMRT)	1	1
Stereotactic Radiosurgery on Machines also performing radiation therapy	0	0
Total	8	2

5. Other Radiation Therapy

Report visits and patients receiving non-linear accelerator/penetrating ray radiation therapy.

Type of Therapy	Number of Visits	Number of Patients
Radium Therapy	0	0
Cesium Therapy	0	0
Superficial Radiation Therapy	0	0
Brachytherapy	0	0
Other Radiation Therapy	0	0
Total	0	0

6. Inventory of Radiation Therapy and Stereotactic Radiosurgery Technology

Provide the brand name, model number, date purchased, technology type (Conventional Radiation Therapy Only, Combined Radiation Therapy/Stereotactic Radiosurgery, or SRS-only), and number of treatment visits for all radiation therapy and stereotactic radiosurgery machines that were in operation during the report year. For linear accelerators also indicate if the unit is operating at greater than or equal to 1 million electron volts or less than 1 million electron volts. Report each unit on a separate line.

Brand Name	Model #	Type of Unit	Visits	Electron Volts	Date Purchased
Varian	Trilog	Combined Technology	8	Greater than or Equal to 1 million electron volts	12/01/2019

7. Inventory of Other Technology.

Provide the brand name, model number, date purchased and type for all other types of technology/machines that were in operation during the report year.

Brand Name	Model #	Date Purchased	Type of Machine
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Only use commas to separate values

Part E: Financial and Utilization Information for Radiation Therapy Services

1. Megavoltage Radiation Therapy Patients and Treatment Visits by Primary Payment Source

Please report the total megavoltage radiation therapy patients and treatment visits by primary payment source. Please unduplicate the number of patients by primary payment source. Please report Peachcare For Kids under Third-Party.

Primary Payment Source	Number of Radiation Therapy Patients (unduplicated)	Number of Treatment Visits
Medicare	2	8
Medicaid	0	0
Third-Party	0	0
Self-Pay	0	0

2a. Total Charges

Please report the total charges for megavoltage radiation therapy services provided during the report period.

Total Charges

17,390

2b. Reimbursement

Please report the actual reimbursement received for charges for megavoltage radiation therapy services provided during the report period.

Reimbursement

5,046

2c. Adjusted Gross Revenue

Please report the adjusted gross revenue for megavoltage radiation therapy services provided during the report period.

Adjusted Gross Revenue

5,046

3a. Total Uncompensated Charges

Please report the total uncompensated megavoltage radiation therapy indigent and charity care charges.

Total Uncompensated Charges

0

3b. Total Patients with Uncompensated Charges

Please report the total number of patients for megavoltage radiation therapy services for patients that are indigent or covered by charity care services.

Total Patients with Uncompensated Charges

0

4. Average Patient Charge

Report the average charge per patient for Non-Special Purpose MRT treatment visits and for Special Purpose MRT treatment visits.

Average Patient Charge Non Special Purpose MRT

2,174

Average Patient Charge Special Purpose MRT

0

5. Patients and Visits by Race/Ethnicity

Please report the number of megavoltage radiation therapy services patients (unduplicated) and treatment visits during the report period by the following race and ethnicity categories.

Race/Ethnicity	Number of Patients	Number of Treatment Visits
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	2	8
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	2	8

6. Patients and Visits by Gender

Please report the number of megavoltage radiation therapy services patients and treatment visits during the report period by gender.

Gender	Number of Patients	Number of Visits
Male	2	8
Female	0	0
Total	2	8

7. Patients and Visits by Age Group

Please report the number of megavoltage radiation therapy services patients and treatment visits during the report period by the following age groupings.

Age of Patient	Number of Patients	Number of Treatment Visits
Ages 0-14	0	0
Ages 15-29	0	0
Ages 30-64	0	0
Ages 65-84	2	8
Ages 85 and Up	0	0
Total	2	8

8. Participation in Reporting

9. Patients by Principle Diagnosis

Report the number of patients, total visits, and total gross charges during the report period by the patient's principle diagnosis as indicated below.

Principle Diagnosis	Number of Patients	Number of Treatment Visits	Gross Treatment Charge
Malignant Neoplasms of Female Breast (ICD10=C50; ICD9=174)	0	0	0
Colon and Rectum (ICD10=C18-C21; ICD9=153-154)	0	0	0
Prostate Cancer (ICD10=C61; ICD9=185)	0	0	0
Lung and Bronchus (ICD10=C33-C34; ICD9=162)	0	0	0
All Other	2	8	17,390
Total	2	8	17,390

10. Estimated Patients and Treatments in the Next Calendar Year

Please provide the number of patients and treatments estimated, expected, or scheduled in the next calendar year (CY2025) for conventional radiation therapy. If the number of patients and treatments that are scheduled is not known an estimate of what is expected is acceptable.

Number of Patients

2

Number of Treatments

8

Part F: Patient Origin For Non-Special Purpose and Special-Purpose MRT Services Patients

1. Patient Origin by County

Please complete the Patient Origin Table to reflect the county (or out-of-state) residence for each Non-Special Purpose and/or Special Purpose MegaVoltage radiation therapy patient treated at your facility during the reporting period. The county column has a pull-down menu listing all 159 Georgia counties in alphabetical order with out-of-state listings for AL, FL, NC, SC, TN, and all other out-of-state. Please select patient origin location from this menu and provide total number of patients and treatment visits for each location by category of treatment for the report period. To add a row press the button. To delete a row press the minus button at the end of the row.

County	Total Non-Duplicated Patients	Total Visits	Non-Special Purpose MRT Patients	Non-Special Purpose MRT Visits	Special Purpose MRT Patients	Special Purpose MRT Visits
DeKalb	2	8	2	8	0	0
Totals	2	8	2	8	0	0

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 inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act. **Do not sign until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could throw the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.**

Authorized Signature

Jennifer Schuck, MBA, MSW

Date

06/16/2026



Title

Chief Executive Officer

Comments