GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Annual Hospital Questionnaire

Part A : General Information

1. Identification   UID:HOSP720

Facility Name: DeKalb Medical Center

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: 00000536A

Medicare Provider Number: 110076

2. Report Period

Report Data for the full twelve month period- January 1, 2008 through December 31, 2008.
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: Donald Fears

Contact Title: Director of Regulatory & Facility Planning

Phone: 404-501-5790

Fax: 404-501-5969

E-mail: don.fears@dekalbmedical.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	Not for Profit	8/9/1991

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
DeKalb Regional Health System	Not for Profit	12/7/1992

C. Facility Operator

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

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
DeKalb Regional Health System	Not Applicable	12/7/1992

E. Management Contractor

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

F. Management's Parent Organization

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

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: DeKalb Regional Health System
City: Decatur   **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☑
Name: DeKalb Regional Health System
City: Decatur   **State:** GA

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: DeKalb Medical at Hillandale
City: Lithonia   **State:** GA

6. Check the box to the right if your hospital is a member of an alliance.   ☑
Name: Voluntary Hospitals of America
City: Dallas   **State:** TX

7. Check the box to the right if your hospital is a participant in a health care network   ☐
Name:
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)	62	5,891	17,288	5,872	17,157
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	253	13,135	72,698	13,106	72,448
Intensive Care	32	524	5,186	527	5,139
Psychiatry	18	970	4,094	974	4,085
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	24	286	4,140	284	4,043
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	**389**	**20,806**	**103,406**	**20,763**	**102,872**

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	28	128
Asian	460	1,814
Black/African American	12,428	63,731
Hispanic/Latino	1,392	4,087
Pacific Islander/Hawaiian	3	9
White	6,116	32,030
Multi-Racial	379	1,607
Total	**20,806**	**103,406**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	6,013	35,209
Female	14,793	68,197
Total	**20,806**	**103,406**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,616	48,668
Medicaid	5,111	20,723
Peachare	0	0
Third-Party	5,985	24,977
Self-Pay	1,372	5,659
Other	722	3,379

5. Discharges to Death

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

666

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2008 (to the nearest whole dollar).

Service	Charge
Private Room Rate	680
Semi-Private Room Rate	680
Operating Room: Average Charge for the First Hour	3,146
Average Total Charge for an Inpatient Day	3,738

Part E : Emergency Department and Outpatient Services

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

62,353

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

9,691

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

38

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	2	2,489
General Beds	36	59,864
	0	0
	0	0
	0	0
	0	0

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

776

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

127,182

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

2,831

8. Diverted Cases
Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

0

9. Ambulance Diversion Hours
Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

1,618

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	1	1
Billiary Lithotropter	3	3
Kidney Transplants	3	3
Heart Transplants	3	3
Other-Organ/Tissues Transplants	3	3
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	3
Audiology Services	1	1
HIV/AIDS Diagnostic Treatment/Services	3	3
Ambulance Services	3	3
Hospice	3	3
Respite Care Services	3	3
Ultrasound/Medical Sonography	1	11
	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	994
Number of Dialysis Treatments	4,675
Number of ESWL Patients	84
Number of ESWL Procedures	84
Number of ESWL Units	0
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	75,002
Number of CTS Units (machines)	3
Number of CTS Procedures	31,483
Number of Diagnostic Radioisotope Procedures	7,578
Number of PET Units (machines)	1
Number of PET Procedures	966
Number of Therapeautic Radioisotope Procedures	10,323
Number of Number of MRI Units	3
Number of Number of MRI Procedures	6,708
Number of Chemotherapy Treatments	1,497
Number of Respiratory Therapy Treatments	423,419
Number of Occupational Therapy Treatments	48,230
Number of Physical Therapy Treatments	89,931
Number of Speech Pathology Patients	15,969
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	8,004
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	34,661
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)
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 12-31-2008. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2008.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	31.450000762939	1	0
Physician Assistants Only (not including Licensed Physicians)	3.1500000953674	1	0
Registered Nurses (RNs-Advanced Practice*)	481.25	65.5	1
Licensed Practical Nurses (LPNs)	16.89999961853	1	0
Pharmacists	20.200000762939	0.40000000596046	0
Other Health Services Professionals*	255.46000671387	48.959999084473	2
Administration and Support	206.86999511719	57.150001525879	0
All Other Hospital Personnel (not included above)	671.16998291016	11.189999580383	0

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	30 Days or Less
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	31-60 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	16
Black/African American	110
Hispanic/Latino	9
Pacific Islander/Hawaiian	0
White	198
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	17	☐	5	1
General Internal Medicine	46	☑	13	5
Pediatricians	38	☐	33	7
Other Medical Specialties	0	☐	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	43	☐	29	20
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	4	☐	2	2
Ophthalmology Surgery	5	☐	4	4
Orthopedic Surgery	14	☐	7	7
Plastic Surgery	13	☐	1	1
General Surgery	21	☐	16	10
Thoracic Surgery	1	☐	0	0
Other Surgical Specialties	46	☐	22	15

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	15	☑	15	15
Dermatology	0	☐	0	0
Emergency Medicine	31	☑	31	31
Nuclear Medicine	0	☐	0	0
Pathology	6	☑	6	6
Psychiatry	5	☐	2	2
Radiology	15	☑	15	15
Oncology/Hematology	8	☐	8	8
Neonatology	5	☐	5	5
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	0
Podiatrists	32
Certified Nurse Midwives with Clinical Privileges in the Hospital	3
All Other Staff Affiliates with Clinical Privileges in the Hospital	0

5b. Name of Other Professions

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

0

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

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
Alabama	41	21	4	2	0	0	0	0	0	0	0	0
Atkinson	0	1	0	0	0	0	0	0	0	0	0	0
Baldwin	6	1	0	0	0	0	0	0	0	0	0	0
Banks	3	6	0	0	0	0	0	0	0	0	0	0
Barrow	52	42	0	1	0	0	0	0	0	0	0	0
Bartow	4	8	16	0	0	0	0	0	0	0	0	0
Berrien	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	8	10	1	0	0	0	0	0	0	0	0	0
Bleckley	3	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	1	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0
Burke	1	0	0	0	0	0	0	0	0	0	0	0
Butts	12	12	3	0	0	0	0	0	0	0	0	0
Carroll	23	14	13	1	0	0	0	0	0	0	0	0
Catoosa	2	1	1	0	0	0	0	0	0	0	0	0
Chatham	8	2	0	2	0	0	0	0	0	0	0	0
Chattooga	0	1	0	0	0	0	0	0	0	0	0	0
Cherokee	25	33	6	1	0	0	0	0	0	0	0	0
Clarke	18	19	2	1	0	0	0	0	0	0	0	0
Clayton	372	144	172	14	0	0	0	0	0	0	0	0
Cobb	171	148	73	15	0	0	0	0	0	0	0	0
Coffee	0	1	0	0	0	0	0	0	0	0	0	0
Colquitt	0	1	0	0	0	0	0	0	0	0	0	0
Columbia	2	1	0	0	0	0	0	0	0	0	0	0
Cook	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	24	20	4	2	0	0	0	0	0	0	0	0
Crisp	0	2	0	0	0	0	0	0	0	0	0	0
Dade	1	0	0	0	0	0	0	0	0	0	0	0

Dawson	5	7	0	0	0	0	0	0	0	0	0	0
Decatur	2	0	0	0	0	0	0	0	0	0	0	0
DeKalb	14,685	4,835	3,597	696	0	0	0	0	0	0	0	0
Dodge	3	0	0	0	0	0	0	0	0	0	0	0
Dougherty	4	7	0	0	0	0	0	0	0	0	0	0
Douglas	42	42	14	3	0	0	0	0	0	0	0	0
Early	1	0	0	0	0	0	0	0	0	0	0	0
Elbert	3	1	0	0	0	0	0	0	0	0	0	0
Evans	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	2	2	1	0	0	0	0	0	0	0	0	0
Fayette	27	27	7	1	0	0	0	0	0	0	0	0
Florida	47	17	3	5	0	0	0	0	0	0	0	0
Floyd	1	1	1	0	0	0	0	0	0	0	0	0
Forsyth	37	30	8	1	0	0	0	0	0	0	0	0
Franklin	1	3	0	0	0	0	0	0	0	0	0	0
Fulton	1,520	757	398	130	0	0	0	0	0	0	0	0
Gilmer	6	2	0	0	0	0	0	0	0	0	0	0
Glynn	1	0	0	0	0	0	0	0	0	0	0	0
Gordon	1	0	0	1	0	0	0	0	0	0	0	0
Grady	1	0	1	0	0	0	0	0	0	0	0	0
Greene	11	6	1	0	0	0	0	0	0	0	0	0
Gwinnett	2,109	1,402	1,100	32	0	0	0	0	0	0	0	0
Habersham	3	12	0	1	0	0	0	0	0	0	0	0
Hall	34	86	11	2	0	0	0	0	0	0	0	0
Hancock	1	3	0	0	0	0	0	0	0	0	0	0
Haralson	1	2	1	0	0	0	0	0	0	0	0	0
Harris	3	6	0	0	0	0	0	0	0	0	0	0
Hart	2	0	0	0	0	0	0	0	0	0	0	0
Heard	3	0	0	0	0	0	0	0	0	0	0	0
Henry	239	156	62	13	0	0	0	0	0	0	0	0
Houston	20	6	2	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0
Jackson	26	38	7	0	0	0	0	0	0	0	0	0
Jasper	16	15	1	1	0	0	0	0	0	0	0	0
Jeff Davis	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	2	0	0	0	0	0	0	0	0	0	0
Johnson	2	1	0	0	0	0	0	0	0	0	0	0
Jones	0	1	0	0	0	0	0	0	0	0	0	0
Lamar	5	4	0	0	0	0	0	0	0	0	0	0
Lanier	0	1	0	0	0	0	0	0	0	0	0	0
Laurens	1	2	0	0	0	0	0	0	0	0	0	0
Lee	2	2	0	0	0	0	0	0	0	0	0	0
Liberty	3	0	0	0	0	0	0	0	0	0	0	0
Lowndes	2	11	0	0	0	0	0	0	0	0	0	0

Lumpkin	4	5	0	0	0	0	0	0	0	0	0	0
Macon	0	2	0	0	0	0	0	0	0	0	0	0
Madison	3	8	0	0	0	0	0	0	0	0	0	0
McDuffie	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	2	3	0	0	0	0	0	0	0	0	0	0
Mitchell	1	0	1	0	0	0	0	0	0	0	0	0
Monroe	3	3	1	0	0	0	0	0	0	0	0	0
Morgan	10	11	1	0	0	0	0	0	0	0	0	0
Muscogee	25	8	0	0	0	0	0	0	0	0	0	0
Newton	234	176	41	10	0	0	0	0	0	0	0	0
North Carolina	28	8	2	3	0	0	0	0	0	0	0	0
Oconee	8	1	0	0	0	0	0	0	0	0	0	0
Oglethorpe	1	2	1	0	0	0	0	0	0	0	0	0
Other Out of State	150	36	16	11	0	0	0	0	0	0	0	0
Paulding	13	15	5	0	0	0	0	0	0	0	0	0
Peach	3	1	0	0	0	0	0	0	0	0	0	0
Pickens	8	5	0	1	0	0	0	0	0	0	0	0
Pike	2	5	0	0	0	0	0	0	0	0	0	0
Polk	7	0	1	0	0	0	0	0	0	0	0	0
Pulaski	4	0	0	0	0	0	0	0	0	0	0	0
Putnam	5	8	1	0	0	0	0	0	0	0	0	0
Rabun	1	4	0	0	0	0	0	0	0	0	0	0
Richmond	6	4	1	0	0	0	0	0	0	0	0	0
Rockdale	259	222	48	11	0	0	0	0	0	0	0	0
Schley	0	1	0	0	0	0	0	0	0	0	0	0
South Carolina	21	7	0	0	0	0	0	0	0	0	0	0
Spalding	18	13	1	2	0	0	0	0	0	0	0	0
Stephens	5	6	0	0	0	0	0	0	0	0	0	0
Sumter	2	0	0	1	0	0	0	0	0	0	0	0
Talbot	0	1	0	0	0	0	0	0	0	0	0	0
Tennessee	16	9	0	0	0	0	0	0	0	0	0	0
Thomas	4	0	1	0	0	0	0	0	0	0	0	0
Tift	2	1	1	0	0	0	0	0	0	0	0	0
Toombs	1	1	0	0	0	0	0	0	0	0	0	0
Towns	3	3	0	0	0	0	0	0	0	0	0	0
Troup	14	7	2	1	0	0	0	0	0	0	0	0
Twiggs	0	2	0	0	0	0	0	0	0	0	0	0
Union	4	4	0	0	0	0	0	0	0	0	0	0
Upson	6	3	0	0	0	0	0	0	0	0	0	0
Walker	1	0	0	0	0	0	0	0	0	0	0	0
Walton	255	282	58	4	0	0	0	0	0	0	0	0
Ware	1	2	0	0	0	0	0	0	0	0	0	0
Warren	1	0	0	0	0	0	0	0	0	0	0	0
Washington	1	2	0	0	0	0	0	0	0	0	0	0

White	14	18	5	1	0	0	0	0	0	0	0	0
Whitfield	1	3	0	0	0	0	0	0	0	0	0	0
Wilkes	2	0	0	0	0	0	0	0	0	0	0	0
Worth	1	1	0	0	0	0	0	0	0	0	0	0
Total	**20,806**	**8,869**	**5,697**	**970**	**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	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	0	8,869
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**0**	**8,869**

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	0	8,869
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**0**	**8,869**

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	8
Asian	211
Black/African American	4,203
Hispanic/Latino	226
Pacific Islander/Hawaiian	1
White	4,047
Multi-Racial	173
Total	**8,869**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	115
Ages 15-64	6,899
Ages 65-74	1,132
Ages 75-85	593
Ages 85 and Up	130
Total	**8,869**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,906
Female	5,963
Total	**8,869**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,702
Medicaid	256
Third-Party	6,760
Self-Pay	151

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: 1,873

6. Total Live Births: 5,147

7. Total Births (Live and Late Fetal Deaths): 5,260

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,301

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	4,572	10,097	50
Specialty Care (Intermediate Neonatal Care)	19	355	3,455	219
Subspecialty Care (Intensive Neonatal Care)	19	460	4,453	54

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	8	21
Asian	233	628
Black/African American	3,280	10,363
Hispanic/Latino	1,201	3,185
Pacific Islander/Hawaiian	2	7
White	773	2,105
Multi-Racial	200	594
Total	**5,697**	**16,903**

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	9	29
Ages 15-44	5,673	16,828
Ages 45 and Up	15	46
Total	5,697	16,903

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

$5,454.00

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

$20,677.00

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	36	18
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	970	4,094	974	4,085	7,029	☑
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	11	47
Black/African American	688	2,948
Hispanic/Latino	12	34
Pacific Islander/Hawaiian	0	0
White	248	1,024
Multi-Racial	11	41
Total	**970**	**4,094**

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

Gender of Patient	Admissions	Inpatient Days
Male	480	1,921
Female	490	2,173
Total	**970**	**4,094**

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	338	1,742
Medicaid	300	1,349
Third Party	229	721
Self-Pay	103	282
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? <u>0</u> (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): ☐

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	6.1	21	23	18
Burmese	0.7	0	0	0
Vietnamese	0.6	2	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?

<u>Every Employee receives diversity/cultural training as part of the system orientation process.</u>

Additionally, yearly all employees must complete an intranet-based course on diversity/cultural issues. Inservices have been provided to all nursing units and physician office staff on using the telephone language line.

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 translation 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 Clinics - Stone Mountain and Decatur

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: Eric P. Norwood

Date: 9/18/2009

Title: President & CEO

Comments: