GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:hosp709

Facility Name: WellStar Atlanta Medical Center

County: Fulton

Street Address: 303 Parkway Drive

City: Atlanta

Zip: 30312-1212

Mailing Address: 303 Parkway Drive

Mailing City: Atlanta

Mailing Zip: 30312-1212

Medicaid Provider Number: 000000789A

Medicare Provider Number: 110115

2. Report Period

Report Data for the full twelve month period- January 1, 2019 through December 31, 2019.
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: April Austin

Contact Title: Manager, Strategic Planning

Phone: 470-644-0057

Fax: 770-509-4217

E-mail: april.austin@wellstar.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
WellStar Atlanta Medical Center, Inc	Not for Profit	4/1/2016

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
WellStar Health System, Inc.	Not for Profit	4/1/2016

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
WellStar Atlanta Medical Center, Inc.	Not for Profit	4/1/2016

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
WellStar Health System, Inc.	Not for Profit	4/1/2016

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	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: WELLSTAR HEALTH SYSTEM
City: MARIETTA **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:
City: **State:**

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)	30	2,313	6,854	2,306	6,699
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	267	7,895	55,210	7,884	55,421
Intensive Care	75	4,001	21,893	3,996	21,671
Psychiatry	62	2,286	11,765	2,288	11,323
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	18	271	5,615	280	5,323
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	**452**	**16,766**	**101,337**	**16,754**	**100,437**

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	22	131
Asian	107	555
Black/African American	11,594	68,980
Hispanic/Latino	748	3,446
Pacific Islander/Hawaiian	14	49
White	3,814	25,399
Multi-Racial	467	2,777
Total	**16,766**	**101,337**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,438	52,451
Female	9,328	48,886
Total	**16,766**	**101,337**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,810	42,851
Medicaid	4,612	26,503
Peachare	4	13
Third-Party	2,688	13,172
Self-Pay	2,433	10,258
Other	1,219	8,540

5. Discharges to Death

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

425

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2019 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,370
Semi-Private Room Rate	1,370
Operating Room: Average Charge for the First Hour	6,296
Average Total Charge for an Inpatient Day	12,482

Part E : Emergency Department and Outpatient Services

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

124,494

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

11,384

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

60

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	4	4,231
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	56	120,263
	0	0
	0	0
	0	0
	0	0

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

671

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

45,855

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

2,746

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

2,016.00

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.

3,755

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	2	1
ESWL	1	1
Billiary Lithotropter	3	4
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)	2	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	2	1
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	456
Number of Dialysis Treatments	5,089
Number of ESWL Patients	189
Number of ESWL Procedures	299
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	23
Number of Diagnostic X-Ray Procedures	119,147
Number of CTS Units (machines)	6
Number of CTS Procedures	49,905
Number of Diagnostic Radioisotope Procedures	3,521
Number of PET Units (machines)	1
Number of PET Procedures	81
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	7,840
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	259,115
Number of Occupational Therapy Treatments	47,021
Number of Physical Therapy Treatments	56,466
Number of Speech Pathology Patients	1,675
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	3,446
Number of HIV/AIDS Patients	457
Number of Ambulance Trips	0
Number of Hospice Patients	29
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	22,973
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).

73

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
2	131	DaVinci and MAKO

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2019. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2019.

Profession	Profession	Profession	Profession
Licensed Physicians	85.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	784.00	73.00	77.90
Licensed Practical Nurses (LPNs)	10.00	0.00	0.00
Pharmacists	42.00	1.00	0.00
Other Health Services Professionals*	673.00	52.00	7.40
Administration and Support	619.00	18.00	0.00
All Other Hospital Personnel (not included above)	104.00	18.00	0.00

2. Filling Vacancies

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

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	Not Applicable
Pharmacists	More than 90 Days
Other Health Services Professionals	More than 90 Days
All Other Hospital Personnel (not included above)	61-90 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	63
Black/African American	175
Hispanic/Latino	11
Pacific Islander/Hawaiian	0
White	181
Multi-Racial	243

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	42	☐	42	42
General Internal Medicine	85	☑	85	85
Pediatricians	11	☐	11	11
Other Medical Specialties	141	☐	141	141

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	45	☑	45	45
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	35	☐	3	10
Ophthalmology Surgery	10	☐	7	10
Orthopedic Surgery	26	☐	26	26
Plastic Surgery	4	☐	3	2
General Surgery	18	☐	18	18
Thoracic Surgery	1	☐	1	1
Other Surgical Specialties	67	☐	32	63

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	25	☑	25	25
Dermatology	0	☐	0	0
Emergency Medicine	61	☑	61	61
Nuclear Medicine	1	☐	0	0
Pathology	12	☑	12	12
Psychiatry	7	☐	7	7
Radiology	99	☑	99	99
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeions) with Admitting Privleges	7
Podiatrists	14
Certified Nurse Midwives with Clinical Privileges in the Hospital	29
All Other Staff Affiliates with Clinical Privileges in the Hospital	186

5b. Name of Other Professions

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

Advanced Practice Registered Nurse, Certified Perioperative Blood Management Tech, Dental Assistant, Certified Registered Nurse Anesthetist, Intraoperative Monitoring, Lic Marriage/Family Therapist, Licensed Prof Counselor, Medical Physicist, Nurse Anesthetist, Nurse Midwife, Nurse Practitioner, Physician Anesthesia Asst, Physician Assistant, Registered Nurse, Surgical Assistant, Surgical First Assistant, Surgical Technician

Comments and Suggestions:

Part E.4. – The hospital used ICD10 codes to determine Trauma and Psych patients, used 0-17 for Peds patients, and all other were General ED beds for survey reporting purposes. The visit data reflect the types of cases that relate to the described bed/room type, regardless of where in the emergency department the patient visit took place. Part E.8 The Hospital is not able to track diverted cases. Part F.1.b Hospice counts show Hospice patients in a hospital bed, and do not show activities of WellStar owned hospice facilities. Part Part E.8 Unable to track diverted cases
G.3: Physicians who do not identify a race are listed as multi-racial. All sections related to race: Patients who do not identify a race are listed as multi-racial. Parts G.3 and G.4: The differences in the total number of physicians between these two categories are attributable to the physicians accounted for in G.4 who do not have admitting privileges; consistent with the survey instructions, those non-admitting physicians are not counted in G.3. Part G.4: The reported number of physician providers enrolled in Medicaid/PeachCare and/or Public Employee Health Benefits Plan was derived from hospital billing records. The hospital expects that there are additional physicians on its medical staff who are enrolled in these programs but whom are not reflected in the survey count. Perinatal Services Addendum Part C.1 and C.2: The mothers' admissions and inpatient days do not include ante-partum admissions and days. Part F.1.b HIV Diagnostics and HIV patients. Not all HIV+ patients are re-tested on each visit. As the survey requires the count of tests to be higher than the number of patients, the numbers are added together. Budgeted Physicians may include Hospital residents. Patients not designating a gender are assigned randomly for this survey.

–

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	94	17	5	10	0	0	0	0	0	0	0	0	2
Appling	0	1	0	0	0	0	0	0	0	0	0	0	0
Baker	2	0	0	0	0	0	0	0	0	0	0	0	1
Baldwin	12	6	2	2	0	0	0	0	0	0	0	0	0
Banks	2	1	0	0	0	0	0	0	0	0	0	0	0
Barrow	22	2	5	1	0	0	0	0	0	0	0	0	0
Bartow	41	11	4	9	0	0	0	0	0	0	0	0	4
Ben Hill	1	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	35	20	2	3	0	0	0	0	0	0	0	0	3
Bleckley	1	2	0	0	0	0	0	0	0	0	0	0	0
Bryan	0	1	0	0	0	0	0	0	0	0	0	0	0
Bulloch	2	0	0	0	0	0	0	0	0	0	0	0	0
Butts	160	84	3	6	0	0	0	0	0	0	0	0	6
Calhoun	4	14	0	0	0	0	0	0	0	0	0	0	0
Camden	1	1	1	0	0	0	0	0	0	0	0	0	0
Candler	1	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	186	38	14	7	0	0	0	0	0	0	0	0	9
Catoosa	2	0	0	1	0	0	0	0	0	0	0	0	0
Chatham	13	3	0	1	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	1	0	0	0	0	0	0	0	0	0	0
Chattooga	11	20	0	0	0	0	0	0	0	0	0	0	0
Cherokee	75	22	17	7	0	0	0	0	0	0	0	0	1
Clarke	19	3	1	10	0	0	0	0	0	0	0	0	0
Clayton	1,419	398	350	213	0	0	0	0	0	0	0	0	20
Cobb	521	201	140	99	0	0	0	0	0	0	0	0	11
Coffee	5	0	0	0	0	0	0	0	0	0	0	0	0
Colquitt	3	0	0	1	0	0	0	0	0	0	0	0	0

Columbia	13	4	3	4	0	0	0	0	0	0	0	0	0
Cook	1	0	0	0	0	0	0	0	0	0	0	0	0
Coweta	211	41	23	19	0	0	0	0	0	0	0	0	7
Crawford	1	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	1	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	7	5	0	0	0	0	0	0	0	0	0	0	3
Decatur	2	1	0	2	0	0	0	0	0	0	0	0	0
DeKalb	2,155	559	340	299	0	0	0	0	0	0	0	0	55
Dodge	6	13	0	0	0	0	0	0	0	0	0	0	0
Dooly	0	11	0	0	0	0	0	0	0	0	0	0	0
Dougherty	7	3	1	0	0	0	0	0	0	0	0	0	1
Douglas	263	71	46	40	0	0	0	0	0	0	0	0	10
Effingham	2	0	0	0	0	0	0	0	0	0	0	0	0
Emanuel	3	10	0	0	0	0	0	0	0	0	0	0	0
Evans	0	1	0	0	0	0	0	0	0	0	0	0	0
Fannin	5	3	0	2	0	0	0	0	0	0	0	0	0
Fayette	155	67	49	6	0	0	0	0	0	0	0	0	4
Florida	95	12	5	21	0	0	0	0	0	0	0	0	1
Floyd	19	9	2	4	0	0	0	0	0	0	0	0	0
Forsyth	23	12	6	6	0	0	0	0	0	0	0	0	0
Franklin	5	0	0	3	0	0	0	0	0	0	0	0	0
Fulton	8,695	1,847	982	1,275	0	0	0	0	0	0	0	0	77
Gilmer	16	6	1	1	0	0	0	0	0	0	0	0	1
Glascock	2	0	0	0	0	0	0	0	0	0	0	0	0
Glynn	6	0	0	0	0	0	0	0	0	0	0	0	0
Gordon	4	0	1	1	0	0	0	0	0	0	0	0	0
Greene	5	1	0	0	0	0	0	0	0	0	0	0	1
Gwinnett	409	132	130	40	0	0	0	0	0	0	0	0	9
Habersham	31	20	0	3	0	0	0	0	0	0	0	0	0
Hall	18	8	4	6	0	0	0	0	0	0	0	0	0
Hancock	2	2	0	0	0	0	0	0	0	0	0	0	0
Haralson	54	5	3	1	0	0	0	0	0	0	0	0	4
Harris	15	0	1	0	0	0	0	0	0	0	0	0	0
Hart	5	3	0	3	0	0	0	0	0	0	0	0	0
Heard	23	1	0	0	0	0	0	0	0	0	0	0	0
Henry	400	154	73	37	0	0	0	0	0	0	0	0	11
Houston	21	2	1	0	0	0	0	0	0	0	0	0	1
Jackson	8	1	3	3	0	0	0	0	0	0	0	0	0
Jasper	18	3	0	2	0	0	0	0	0	0	0	0	2
Jefferson	2	4	0	0	0	0	0	0	0	0	0	0	0
Johnson	1	22	0	0	0	0	0	0	0	0	0	0	0
Jones	1	0	1	0	0	0	0	0	0	0	0	0	0
Lamar	40	10	1	4	0	0	0	0	0	0	0	0	1
Lanier	1	2	0	1	0	0	0	0	0	0	0	0	0

Laurens	7	2	1	2	0	0	0	0	0	0	0	0	0
Lee	3	2	0	0	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	0	0	0	0	0	0	0	0	0
Long	1	4	0	0	0	0	0	0	0	0	0	0	0
Lowndes	8	4	1	0	0	0	0	0	0	0	0	0	0
Lumpkin	1	3	0	0	0	0	0	0	0	0	0	0	0
Macon	9	3	0	1	0	0	0	0	0	0	0	0	0
Madison	2	0	1	1	0	0	0	0	0	0	0	0	0
Marion	1	0	0	0	0	0	0	0	0	0	0	0	0
McDuffie	2	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	46	9	1	7	0	0	0	0	0	0	0	0	1
Mitchell	1	5	0	0	0	0	0	0	0	0	0	0	0
Monroe	14	4	1	0	0	0	0	0	0	0	0	0	0
Morgan	6	3	0	2	0	0	0	0	0	0	0	0	0
Murray	5	1	0	1	0	0	0	0	0	0	0	0	0
Muscogee	25	14	2	5	0	0	0	0	0	0	0	0	0
Newton	156	41	16	6	0	0	0	0	0	0	0	0	3
North Carolina	40	5	0	6	0	0	0	0	0	0	0	0	3
Oconee	5	0	1	2	0	0	0	0	0	0	0	0	0
Oglethorpe	1	0	0	1	0	0	0	0	0	0	0	0	0
Paulding	124	36	15	17	0	0	0	0	0	0	0	0	2
Peach	7	0	0	1	0	0	0	0	0	0	0	0	0
Pickens	11	2	0	2	0	0	0	0	0	0	0	0	0
Pierce	0	1	0	0	0	0	0	0	0	0	0	0	0
Pike	29	6	1	1	0	0	0	0	0	0	0	0	0
Polk	13	8	1	2	0	0	0	0	0	0	0	0	0
Pulaski	20	22	0	0	0	0	0	0	0	0	0	0	0
Putnam	7	1	0	2	0	0	0	0	0	0	0	0	0
Rabun	3	0	0	0	0	0	0	0	0	0	0	0	0
Richmond	21	2	1	2	0	0	0	0	0	0	0	0	0
Rockdale	194	58	22	16	0	0	0	0	0	0	0	0	9
South Carolina	36	3	2	5	0	0	0	0	0	0	0	0	0
Spalding	226	43	6	15	0	0	0	0	0	0	0	0	3
Stephens	7	5	0	3	0	0	0	0	0	0	0	0	0
Stewart	1	1	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
Talbot	2	0	0	0	0	0	0	0	0	0	0	0	0
Tattnall	9	22	0	1	0	0	0	0	0	0	0	0	0
Taylor	1	0	0	0	0	0	0	0	0	0	0	0	0
Telfair	8	6	0	2	0	0	0	0	0	0	0	0	0
Tennessee	42	0	1	7	0	0	0	0	0	0	0	0	0
Thomas	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	4	0	0	1	0	0	0	0	0	0	0	0	1
Toombs	6	0	2	0	0	0	0	0	0	0	0	0	0

Towns	2	0	0	1	0	0	0	0	0	0	0	0	0
Treutlen	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	169	22	5	8	0	0	0	0	0	0	0	0	4
Turner	1	0	1	0	0	0	0	0	0	0	0	0	0
Union	5	4	0	0	0	0	0	0	0	0	0	0	0
Upson	22	6	2	0	0	0	0	0	0	0	0	0	0
Walker	5	1	1	1	0	0	0	0	0	0	0	0	0
Walton	35	15	5	5	0	0	0	0	0	0	0	0	0
Ware	5	8	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
Washington	1	5	0	0	0	0	0	0	0	0	0	0	0
White	7	2	0	1	0	0	0	0	0	0	0	0	0
Whitfield	14	1	1	6	0	0	0	0	0	0	0	0	0
Wilcox	4	8	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	1	0	0	0	0	0	0	0	0	0	0
Worth	2	0	0	0	0	0	0	0	0	0	0	0	0
Total	**16,766**	**4,281**	**2,313**	**2,286**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**271**

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	24
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
0	0	0	0
Total	**0**	**0**	**25**

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	4,191	4,358
Cystoscopy	0	0	38	54
Endoscopy	0	0	0	0
0	0	0	0	0
Total	**0**	**0**	**4,229**	**4,412**

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	3,862	4,228
Cystoscopy	0	0	38	53
Endoscopy	0	0	0	0
0	0	0	0	0
Total	**0**	**0**	**3,900**	**4,281**

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	2
Asian	34
Black/African American	2,885
Hispanic/Latino	207
Pacific Islander/Hawaiian	5
White	971
Multi-Racial	177
Total	**4,281**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	296
Ages 15-64	2,877
Ages 65-74	764
Ages 75-85	290
Ages 85 and Up	54
Total	**4,281**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,089
Female	2,192
Total	**4,281**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,225
Medicaid	980
Third-Party	1,897
Self-Pay	179

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: 20

2. Number of Birthing Rooms: 30

3. Number of LDR Rooms: 13

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 722

6. Total Live Births: 2,288

7. Total Births (Live and Late Fetal Deaths): 2,314

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,328

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)	30	2,009	4,371	0
Specialty Care (Intermediate Neonatal Care)	18	161	2,660	0
Subspecialty Care (Intensive Neonatal Care)	16	144	1,548	0

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	7	21
Asian	29	100
Black/African American	1,448	4,537
Hispanic/Latino	372	1,050
Pacific Islander/Hawaiian	4	12
White	369	928
Multi-Racial	84	206
Total	**2,313**	**6,854**

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	5
Ages 15-44	2,309	6,839
Ages 45 and Up	3	10
Total	**2,313**	**6,854**

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

$18,699.00

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

$33,128.00

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	66	62
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	2,286	11,765	2,288	11,323	4,137	☑
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	15	87
Black/African American	1,629	8,128
Hispanic/Latino	52	264
Pacific Islander/Hawaiian	1	3
White	479	2,723
Multi-Racial	110	560
Total	**2,286**	**11,765**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,221	6,275
Female	1,065	5,490
Total	**2,286**	**11,765**

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	658	4,514
Medicaid	841	4,015
Third Party	211	971
Self-Pay	576	2,265
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): ☑

Contracted Interpreter 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	1.04%	0	0	0
Vietnamese	0.07%	0	0	0
Esperanto	0.03%	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?

It is WellStar's policy that all medical information is effectively communicated to our patients in

theirpreferred language to ensure both patient autonomy and the quality and safety of their care. Every new WellStar team member is educated during their employee orientation on interpretation and Culturally Competent care. Cultural Competency education is also provided in new leadership orientation training. WellStar created and offers to all staff computer-based learning modules that instruct them on how to determine a patient's preferred language, obtain a qualified medical interpreter, how to work with an interpreter, and how to chart medical interpretation usage according to the CLAS standards. WellStar is developing a comprehensive tool and other resources for physicians and WellStar staff and currently provides CBL cultural competence training as a resource.

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?

Video Remote Interpretation as an additional interpretation resource for our patients as well as additional educational tools (e.g. webinars, computer tools) that go beyond simply the language needs of our patients and address cultural competency needs of our patients.

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?

1 - Sheffield Clinic 265 Boulevard NE, Atlanta, GA 30312
2 - Southside Clinic 1100 Cleveland Avenue

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	16
Asian	3	58
Black/African American	158	3,307
Hispanic/Latino	14	215
Pacific Islander/Hawaiian	0	0
White	81	1,759
Multi-Racial	14	260

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	171	3,588
Female	100	2,027

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	165	3,233
65-84	95	2,155
85 Up	11	227

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	259
Long Term Care Hospital	11
Skilled Nursing Facility	1
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	136
Third Party/Commercial	41
Self Pay	12
Other	82

2. Uncompensated Indigent and Charity Care

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

39

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	66
2. Brain Injury	50
3. Amputation	15
4. Spinal Cord	25
5. Fracture of the femur	10
6. Neurological disorders	9
7. Multiple Trauma	52
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	44

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: Candice Saunders

Date: 4/3/2020

Title: President and C.E.O.

Comments: