GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 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, 2020 through December 31, 2020.
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)	32	2,039	5,744	2,040	5,834
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	314	7,503	55,388	7,429	56,063
Intensive Care	75	2,873	23,098	2,883	22,628
Psychiatry	80	1,933	9,338	1,921	10,799
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	31	283	5,127	286	5,405
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	**532**	**14,631**	**98,695**	**14,559**	**100,729**

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	93
Asian	86	569
Black/African American	10,557	70,208
Hispanic/Latino	606	3,346
Pacific Islander/Hawaiian	12	75
White	2,882	20,693
Multi-Racial	466	3,711
Total	**14,631**	**98,695**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	6,818	53,564
Female	7,813	45,131
Total	**14,631**	**98,695**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	4,884	42,286
Medicaid	4,051	24,801
Peachare	5	60
Third-Party	2,236	12,318
Self-Pay	2,391	10,936
Other	1,064	8,294

5. Discharges to Death

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

506

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2020 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,466
Semi-Private Room Rate	1,466
Operating Room: Average Charge for the First Hour	6,737
Average Total Charge for an Inpatient Day	13,094

Part E : Emergency Department and Outpatient Services

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

104,001

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

10,623

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	4,470
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	0	0
General Beds	56	99,531
	0	0
	0	0
	0	0
	0	0

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

861

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

38,932

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

2,610

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

6,248.00

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.

1,346

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	365
Number of Dialysis Treatments	4,688
Number of ESWL Patients	125
Number of ESWL Procedures	163
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	18
Number of Diagnostic X-Ray Procedures	111,575
Number of CTS Units (machines)	6
Number of CTS Procedures	49,289
Number of Diagnostic Radioisotope Procedures	2,544
Number of PET Units (machines)	1
Number of PET Procedures	10
Number of Therapeautic Radioisotope Procedures	1
Number of Number of MRI Units	1
Number of Number of MRI Procedures	6,227
Number of Chemotherapy Treatments	0
Number of Respiratory Therapy Treatments	314,822
Number of Occupational Therapy Treatments	50,014
Number of Physical Therapy Treatments	60,737
Number of Speech Pathology Patients	1,539
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	4,985
Number of HIV/AIDS Patients	296
Number of Ambulance Trips	0
Number of Hospice Patients	241
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	13
Number of Ultrasound/Medical Sonography Procedures	20,761
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	82	DaVinci

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2020. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2020.

Profession	Profession	Profession	Profession
Licensed Physicians	87.00	1.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	898.00	156.00	90.80
Licensed Practical Nurses (LPNs)	3.00	0.00	0.00
Pharmacists	55.00	1.00	0.00
Other Health Services Professionals*	791.00	85.00	11.80
Administration and Support	717.00	19.00	0.00
All Other Hospital Personnel (not included above)	118.00	78.00	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	1
Asian	105
Black/African American	249
Hispanic/Latino	17
Pacific Islander/Hawaiian	0
White	215
Multi-Racial	83

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	38	☐	38	38
General Internal Medicine	120	☑	120	120
Pediatricians	12	☐	12	12
Other Medical Specialties	126	☐	126	126

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	36	☐	0	19
Ophthalmology Surgery	11	☐	4	6
Orthopedic Surgery	25	☐	25	25
Plastic Surgery	4	☐	3	1
General Surgery	16	☐	16	16
Thoracic Surgery	1	☐	1	1
Other Surgical Specialties	60	☐	36	58

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	28	☑	28	28
Dermatology	0	☐	0	0
Emergency Medicine	60	☑	60	60
Nuclear Medicine	1	☐	0	0
Pathology	12	☑	12	12
Psychiatry	8	☐	6	8
Radiology	82	☑	82	82
Pediatric ER	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	6
Podiatrists	13
Certified Nurse Midwives with Clinical Privileges in the Hospital	25
All Other Staff Affiliates with Clinical Privileges in the Hospital	185

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. 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	78	10	3	8	0	0	0	0	0	0	0	0	2
Appling	1	0	0	1	0	0	0	0	0	0	0	0	0
Atkinson	1	0	0	0	0	0	0	0	0	0	0	0	0
Baldwin	5	6	1	0	0	0	0	0	0	0	0	0	0
Banks	5	0	1	1	0	0	0	0	0	0	0	0	1
Barrow	13	1	0	4	0	0	0	0	0	0	0	0	3
Bartow	23	3	1	5	0	0	0	0	0	0	0	0	0
Bibb	9	8	0	1	0	0	0	0	0	0	0	0	1
Bleckley	0	1	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	3	0	0	0	0	0	0	0	0	0	0	0	0
Butts	105	34	5	3	0	0	0	0	0	0	0	0	1
Calhoun	0	8	0	0	0	0	0	0	0	0	0	0	0
Carroll	123	20	12	3	0	0	0	0	0	0	0	0	4
Chatham	12	3	0	3	0	0	0	0	0	0	0	0	0
Chattooga	8	7	0	1	0	0	0	0	0	0	0	0	0
Cherokee	54	8	7	10	0	0	0	0	0	0	0	0	2
Clarke	11	0	4	5	0	0	0	0	0	0	0	0	0
Clayton	1,125	253	336	115	0	0	0	0	0	0	0	0	13
Cobb	371	123	123	61	0	0	0	0	0	0	0	0	9
Coffee	0	2	0	0	0	0	0	0	0	0	0	0	0
Columbia	1	1	0	1	0	0	0	0	0	0	0	0	0
Coweta	160	31	20	10	0	0	0	0	0	0	0	0	4
Crawford	1	0	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	1	0	0	0	0	0	0	0	0	0	0	0	0
DeKalb	1,888	326	286	232	0	0	0	0	0	0	0	0	45

Dodge	0	9	0	0	0	0	0	0	0	0	0	0	0
Dooly	3	4	0	0	0	0	0	0	0	0	0	0	0
Dougherty	12	0	1	1	0	0	0	0	0	0	0	0	0
Douglas	189	38	41	12	0	0	0	0	0	0	0	0	10
Effingham	2	0	0	0	0	0	0	0	0	0	0	0	0
Emanuel	0	4	0	0	0	0	0	0	0	0	0	0	0
Fannin	7	1	1	0	0	0	0	0	0	0	0	0	1
Fayette	118	24	30	11	0	0	0	0	0	0	0	0	7
Florida	74	3	6	19	0	0	0	0	0	0	0	0	2
Floyd	17	3	2	7	0	0	0	0	0	0	0	0	0
Forsyth	8	9	0	0	0	0	0	0	0	0	0	0	0
Franklin	1	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	7,993	1,095	860	1,159	0	0	0	0	0	0	0	0	103
Gilmer	8	0	0	1	0	0	0	0	0	0	0	0	1
Glynn	4	0	0	2	0	0	0	0	0	0	0	0	1
Gordon	5	0	2	1	0	0	0	0	0	0	0	0	0
Greene	3	0	0	1	0	0	0	0	0	0	0	0	0
Gwinnett	382	89	120	37	0	0	0	0	0	0	0	0	13
Habersham	18	6	1	0	0	0	0	0	0	0	0	0	0
Hall	18	5	3	3	0	0	0	0	0	0	0	0	0
Hancock	1	2	0	0	0	0	0	0	0	0	0	0	0
Haralson	14	4	1	0	0	0	0	0	0	0	0	0	0
Harris	3	0	0	1	0	0	0	0	0	0	0	0	0
Hart	1	1	0	0	0	0	0	0	0	0	0	0	0
Heard	10	0	0	1	0	0	0	0	0	0	0	0	0
Henry	336	108	76	20	0	0	0	0	0	0	0	0	4
Houston	7	1	1	0	0	0	0	0	0	0	0	0	1
Jackson	4	2	2	0	0	0	0	0	0	0	0	0	0
Jasper	8	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	1	0	0	0	0	0	0	0	0	0	0	0	0
Johnson	2	13	0	0	0	0	0	0	0	0	0	0	0
Lamar	29	1	0	4	0	0	0	0	0	0	0	0	1
Laurens	1	1	0	0	0	0	0	0	0	0	0	0	0
Lee	4	2	0	0	0	0	0	0	0	0	0	0	0
Liberty	2	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	4	7	1	1	0	0	0	0	0	0	0	0	0
Lumpkin	1	1	0	1	0	0	0	0	0	0	0	0	0
Macon	7	8	0	0	0	0	0	0	0	0	0	0	0
Madison	0	1	0	0	0	0	0	0	0	0	0	0	0
Meriwether	27	3	1	2	0	0	0	0	0	0	0	0	1
Mitchell	2	8	0	0	0	0	0	0	0	0	0	0	0
Monroe	7	5	0	0	0	0	0	0	0	0	0	0	0
Montgomery	2	2	0	0	0	0	0	0	0	0	0	0	0
Morgan	6	3	0	1	0	0	0	0	0	0	0	0	0

Murray	2	1	0	2	0	0	0	0	0	0	0	0	0
Muscogee	22	11	0	9	0	0	0	0	0	0	0	0	1
Newton	173	27	14	15	0	0	0	0	0	0	0	0	9
North Carolina	37	3	1	15	0	0	0	0	0	0	0	0	0
Oconee	4	0	0	1	0	0	0	0	0	0	0	0	1
Other Out of State	280	14	8	59	0	0	0	0	0	0	0	0	9
Paulding	102	26	23	8	0	0	0	0	0	0	0	0	6
Peach	1	0	0	1	0	0	0	0	0	0	0	0	0
Pickens	6	0	0	3	0	0	0	0	0	0	0	0	0
Pike	31	3	1	1	0	0	0	0	0	0	0	0	0
Polk	13	4	1	3	0	0	0	0	0	0	0	0	1
Pulaski	15	5	0	0	0	0	0	0	0	0	0	0	1
Putnam	6	0	1	1	0	0	0	0	0	0	0	0	0
Quitman	1	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	3	2	0	2	0	0	0	0	0	0	0	0	1
Richmond	14	0	2	5	0	0	0	0	0	0	0	0	0
Rockdale	113	26	15	12	0	0	0	0	0	0	0	0	2
Screven	1	0	0	1	0	0	0	0	0	0	0	0	0
South Carolina	31	2	2	7	0	0	0	0	0	0	0	0	0
Spalding	204	19	14	16	0	0	0	0	0	0	0	0	9
Stephens	4	0	0	0	0	0	0	0	0	0	0	0	1
Sumter	2	1	0	0	0	0	0	0	0	0	0	0	0
Talbot	1	0	0	1	0	0	0	0	0	0	0	0	0
Tattnall	1	16	0	0	0	0	0	0	0	0	0	0	0
Telfair	3	6	0	0	0	0	0	0	0	0	0	0	0
Tennessee	19	4	2	7	0	0	0	0	0	0	0	0	1
Thomas	1	1	0	0	0	0	0	0	0	0	0	0	0
Tift	4	0	1	0	0	0	0	0	0	0	0	0	1
Troup	128	10	1	6	0	0	0	0	0	0	0	0	6
Turner	1	0	0	1	0	0	0	0	0	0	0	0	0
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	0	2	0	0	0	0	0	0	0	0	0	0	0
Upson	13	0	0	0	0	0	0	0	0	0	0	0	1
Walker	0	1	0	0	0	0	0	0	0	0	0	0	0
Walton	30	7	3	5	0	0	0	0	0	0	0	0	3
Ware	1	3	0	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	3	8	1	0	0	0	0	0	0	0	0	0	0
Wheeler	1	0	0	0	0	0	0	0	0	0	0	0	0
White	4	1	1	1	0	0	0	0	0	0	0	0	0
Whitfield	7	0	0	2	0	0	0	0	0	0	0	0	0
Wilcox	5	2	0	0	0	0	0	0	0	0	0	0	0
Wilkes	1	0	0	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0

Total	**14,631**	**2,515**	**2,039**	**1,933**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**283**

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
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	3,888	2,759
Cystoscopy	0	0	4	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**3,892**	**2,759**

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	3,168	2,515
Cystoscopy	0	0	3	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**3,171**	**2,515**

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	1
Asian	28
Black/African American	1,770
Hispanic/Latino	102
Pacific Islander/Hawaiian	3
White	538
Multi-Racial	73
Total	**2,515**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	27
Ages 15-64	1,908
Ages 65-74	429
Ages 75-85	129
Ages 85 and Up	22
Total	**2,515**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,260
Female	1,255
Total	**2,515**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	498
Medicaid	1,193
Third-Party	635
Self-Pay	189

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: 661

6. Total Live Births: 2,015

7. Total Births (Live and Late Fetal Deaths): 2,039

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,055

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	1,832	3,574	3
Specialty Care (Intermediate Neonatal Care)	18	136	2,217	14
Subspecialty Care (Intensive Neonatal Care)	16	114	1,262	23

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	22
Asian	17	43
Black/African American	1,335	3,950
Hispanic/Latino	285	778
Pacific Islander/Hawaiian	0	0
White	334	793
Multi-Racial	60	158
Total	**2,039**	**5,744**

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	3	13
Ages 15-44	2,033	5,723
Ages 45 and Up	3	8
Total	**2,039**	**5,744**

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

$20,032.00

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

$35,653.00

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	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	1,933	9,338	1,921	10,799	4,944	☑
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	4	20
Asian	13	66
Black/African American	1,431	6,679
Hispanic/Latino	32	148
Pacific Islander/Hawaiian	1	4
White	344	1,849
Multi-Racial	108	572
Total	**1,933**	**9,338**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,069	5,112
Female	864	4,226
Total	**1,933**	**9,338**

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	461	2,763
Medicaid	713	3,487
Third Party	223	935
Self-Pay	535	2,151
PeachCare	1	2

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
SIgn	0.05%	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 their

preferred 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	0	0
Asian	5	121
Black/African American	162	2,941
Hispanic/Latino	7	112
Pacific Islander/Hawaiian	2	40
White	91	1,625
Multi-Racial	16	288

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	141	2,669
Female	142	2,458

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	150	2,585
65-84	120	2,273
85 Up	13	269

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	267
Long Term Care Hospital	15
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	162
Third Party/Commercial	55
Self Pay	9
Other	57

2. Uncompensated Indigent and Charity Care

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

21

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	43
2. Brain Injury	39
3. Amputation	13
4. Spinal Cord	35
5. Fracture of the femur	26
6. Neurological disorders	12
7. Multiple Trauma	57
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	58

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: 3/10/2021

Title: President and C.E.O.

Comments: