



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2020 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP615

Facility Name: Wellstar Kennestone Hospital

County: Cobb

Street Address: 677 Church Street NE

City: Marietta

Zip: 30060-1148

Mailing Address: 677 Church Street NE

Mailing City: Marietta

Mailing Zip: 30060-1148

Medicaid Provider Number: 000001119A

Medicare Provider Number: 110035

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
Cobb County Kennestone Hospital Authority	Hospital Authority	1/1/1948

B. Owner's Parent Organization

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

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Kennestone Hospital, Inc.	Not for Profit	2/16/1993

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Wellstar Health System, Inc.	Not for Profit	2/16/1993

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, Inc.

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: Voluntary Hospitals of America

City: Atlanta **State:** GA

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(PHO)

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preferred Provider Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indemnity Fee-for-Service Plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Another Insurance Product Not Listed Above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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. Do not include newborn and neonatal services. Do not include long-term care units, 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)	46	5,404	14,773	5,410	14,389
Pediatrics (Non ICU)	12	452	831	456	784
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	28	839	2,205	839	2,172
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	438	23,437	138,370	23,445	137,226
Intensive Care	89	5,813	35,843	5,813	35,249
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	480	6,048	489	5,975
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	633	36,425	198,070	36,452	195,795

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	90	575
Asian	636	3,290
Black/African American	8,024	48,319
Hispanic/Latino	2,933	14,746
Pacific Islander/Hawaiian	26	112
White	23,296	122,264
Multi-Racial	1,420	8,764
Total	36,425	198,070

3. Gender

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

Gender	Admissions	Inpatient Days
Male	15,310	95,607
Female	21,115	102,463
Total	36,425	198,070

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	16,496	101,292
Medicaid	4,345	24,118
Peachare	19	47
Third-Party	11,254	50,580
Self-Pay	3,183	15,729
Other	1,128	6,304

5. Discharges to Death

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

1,025

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	16,164

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

103,158

2. Inpatient Admissions from ER

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

23,841

3. Beds Available

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

118

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	12	16,570
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	12	4,794
General Beds	77	74,317
Childrens	17	7,477
	0	0
	0	0
	0	0

5. Transfers

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

793

6. Non-Emergency Visits

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

231,516

7. Observation Visits/Cases

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

9,024

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

628.00

10. Untreated Cases

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

2,021

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
Podiatric 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	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	2	1
Radioisotope, Diagnostic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	2	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	831
Number of Dialysis Treatments	10,649
Number of ESWL Patients	54
Number of ESWL Procedures	60
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	25
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	45
Number of Diagnostic X-Ray Procedures	211,432
Number of CTS Units (machines)	13
Number of CTS Procedures	107,688
Number of Diagnostic Radioisotope Procedures	4,740
Number of PET Units (machines)	1
Number of PET Procedures	2,539
Number of Therapeutic Radioisotope Procedures	608
Number of Number of MRI Units	10
Number of Number of MRI Procedures	23,547
Number of Chemotherapy Treatments	17
Number of Respiratory Therapy Treatments	594,415
Number of Occupational Therapy Treatments	73,823
Number of Physical Therapy Treatments	257,716
Number of Speech Pathology Patients	4,743
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	11,049
Number of HIV/AIDS Patients	192
Number of Ambulance Trips	0
Number of Hospice Patients	30
Number of Respite care Patients	1
Number of Ultrasound/Medical Sonography Units	13
Number of Ultrasound/Medical Sonography Procedures	40,235
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).

118

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
5	1,501	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	135.00	1.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,785.00	234.00	137.80
Licensed Practical Nurses (LPNs)	11.00	0.00	0.00
Pharmacists	85.00	1.00	0.00
Other Health Services Professionals*	1,862.00	130.00	21.60
Administration and Support	1,523.00	39.00	0.00
All Other Hospital Personnel (not included above)	709.00	116.00	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	61-90 Days
Other Health Services Professionals	61-90 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	244
Black/African American	187
Hispanic/Latino	33
Pacific Islander/Hawaiian	1
White	573
Multi-Racial	173

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	Number Enrolled as
			Medicaid/PeachCare	Providers in PEHB Plan
General and Family Practice	16	<input type="checkbox"/>	16	16
General Internal Medicine	173	<input checked="" type="checkbox"/>	173	173
Pediatricians	46	<input checked="" type="checkbox"/>	46	46
Other Medical Specialties	338	<input type="checkbox"/>	338	338

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in	Number Enrolled as
			Medicaid/PeachCare	Providers in PEHB Plan
Obstetrics	64	<input checked="" type="checkbox"/>	64	64
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	21	<input type="checkbox"/>	4	21
Ophthalmology Surgery	15	<input type="checkbox"/>	2	11
Orthopedic Surgery	35	<input type="checkbox"/>	35	35
Plastic Surgery	17	<input type="checkbox"/>	8	17
General Surgery	22	<input type="checkbox"/>	22	22
Thoracic Surgery	3	<input type="checkbox"/>	3	3
Other Surgical Specialties	109	<input type="checkbox"/>	70	109

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in	Number Enrolled as
			Medicaid/PeachCare	Providers in PEHB Plan
Anesthesiology	46	<input checked="" type="checkbox"/>	46	46
Dermatology	12	<input type="checkbox"/>	0	5
Emergency Medicine	96	<input checked="" type="checkbox"/>	96	96
Nuclear Medicine	1	<input type="checkbox"/>	0	0
Pathology	16	<input checked="" type="checkbox"/>	16	16
Psychiatry	13	<input type="checkbox"/>	9	4
Radiology	84	<input checked="" type="checkbox"/>	84	84
Pediatric ER	54	<input checked="" type="checkbox"/>	54	54
	0	<input type="checkbox"/>	0	0
	0	<input type="checkbox"/>	0	0

5a. Non-Physicians

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

Profession	Number
Dentists (include oral surgeons) with Admitting Privileges	13
Podiatrists	27
Certified Nurse Midwives with Clinical Privileges in the Hospital	22
All Other Staff Affiliates with Clinical Privileges in the Hospital	616

5b. Name of Other Professions

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

Audiology, Behavioral Health Clinical Nurse Specialist, Clinical Psychology, Nurse Anesthetist, Nurse Practitioner, Physician Anesthesia Assistant, Physician Assistant.

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 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. In sections of the survey where MEDICAID is not listed as a payor choice, Medicaid is combined with OTHER. Some of the employed physicians are residents.

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	119	33	6	0	0	0	0	0	0	0	0	0	5
Appling	1	0	0	0	0	0	0	0	0	0	0	0	0
Bacon	0	1	0	0	0	0	0	0	0	0	0	0	0
Baldwin	2	1	0	0	0	0	0	0	0	0	0	0	0
Banks	3	2	0	0	0	0	0	0	0	0	0	0	0
Barrow	19	3	1	0	0	0	0	0	0	0	0	0	0
Bartow	1,224	426	237	0	0	0	0	0	0	0	0	0	15
Ben Hill	0	1	0	0	0	0	0	0	0	0	0	0	0
Bibb	27	5	1	0	0	0	0	0	0	0	0	0	0
Bleckley	0	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	1	0	0	0	0	0	0	0	0	0	0	0	0
Bullock	6	0	0	0	0	0	0	0	0	0	0	0	0
Butts	50	4	2	0	0	0	0	0	0	0	0	0	1
Calhoun	1	0	0	0	0	0	0	0	0	0	0	0	0
Camden	0	1	0	0	0	0	0	0	0	0	0	0	0
Candler	2	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	260	131	35	0	0	0	0	0	0	0	0	0	9
Catoosa	4	6	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	0	0	0	0	0	0	0	0	0	0	0	0
Chatham	11	2	1	0	0	0	0	0	0	0	0	0	0
Chattooga	15	1	0	0	0	0	0	0	0	0	0	0	0
Cherokee	4,321	1,740	643	0	0	0	0	0	0	0	0	0	60
Clarke	8	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	152	58	19	0	0	0	0	0	0	0	0	0	1
Cobb	22,180	6,834	3,148	0	0	0	0	0	0	0	0	0	220
Colquitt	2	1	0	0	0	0	0	0	0	0	0	0	0
Columbia	7	0	0	0	0	0	0	0	0	0	0	0	0

Cook	1	0	0	0	0	0	0	0	0	0	0	0	0
Coweta	42	23	4	0	0	0	0	0	0	0	0	0	2
Crawford	1	0	0	0	0	0	0	0	0	0	0	0	0
Crisp	2	0	0	0	0	0	0	0	0	0	0	0	0
Dade	0	1	0	0	0	0	0	0	0	0	0	0	0
Dawson	23	5	4	0	0	0	0	0	0	0	0	0	2
Decatur	0	1	0	0	0	0	0	0	0	0	0	0	0
DeKalb	264	128	39	0	0	0	0	0	0	0	0	0	4
Dodge	1	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	11	4	0	0	0	0	0	0	0	0	0	0	2
Douglas	867	360	128	0	0	0	0	0	0	0	0	0	22
Elbert	2	1	0	0	0	0	0	0	0	0	0	0	0
Emanuel	0	2	0	0	0	0	0	0	0	0	0	0	0
Fannin	60	35	6	0	0	0	0	0	0	0	0	0	4
Fayette	30	29	1	0	0	0	0	0	0	0	0	0	0
Florida	122	24	5	0	0	0	0	0	0	0	0	0	0
Floyd	60	40	12	0	0	0	0	0	0	0	0	0	2
Forsyth	81	47	11	0	0	0	0	0	0	0	0	0	2
Franklin	2	1	0	0	0	0	0	0	0	0	0	0	0
Fulton	1,261	421	150	0	0	0	0	0	0	0	0	0	19
Gilmer	180	57	3	0	0	0	0	0	0	0	0	0	4
Glynn	1	2	0	0	0	0	0	0	0	0	0	0	0
Gordon	66	35	8	0	0	0	0	0	0	0	0	0	2
Greene	5	4	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	210	133	31	0	0	0	0	0	0	0	0	0	3
Habersham	5	1	0	0	0	0	0	0	0	0	0	0	1
Hall	41	9	5	0	0	0	0	0	0	0	0	0	3
Haralson	65	33	13	0	0	0	0	0	0	0	0	0	1
Harris	21	1	0	0	0	0	0	0	0	0	0	0	0
Hart	3	0	0	0	0	0	0	0	0	0	0	0	0
Heard	17	4	0	0	0	0	0	0	0	0	0	0	1
Henry	84	39	8	0	0	0	0	0	0	0	0	0	2
Houston	17	3	0	0	0	0	0	0	0	0	0	0	0
Jackson	14	0	1	0	0	0	0	0	0	0	0	0	0
Jasper	9	3	0	0	0	0	0	0	0	0	0	0	0
Jenkins	0	1	0	0	0	0	0	0	0	0	0	0	0
Jones	3	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	33	3	0	0	0	0	0	0	0	0	0	0	2
Lanier	1	0	0	0	0	0	0	0	0	0	0	0	0
Laurens	3	1	0	0	0	0	0	0	0	0	0	0	0
Lee	8	2	0	0	0	0	0	0	0	0	0	0	1
Liberty	2	1	1	0	0	0	0	0	0	0	0	0	0
Lincoln	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	1	1	0	0	0	0	0	0	0	0	0	0	0

Lumpkin	6	3	0	0	0	0	0	0	0	0	0	0	0
Macon	7	0	0	0	0	0	0	0	0	0	0	0	1
Marion	2	0	0	0	0	0	0	0	0	0	0	0	0
McIntosh	1	0	0	0	0	0	0	0	0	0	0	0	0
Meriwether	27	3	1	0	0	0	0	0	0	0	0	0	0
Miller	3	0	0	0	0	0	0	0	0	0	0	0	1
Mitchell	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	8	3	1	0	0	0	0	0	0	0	0	0	0
Morgan	7	1	0	0	0	0	0	0	0	0	0	0	0
Murray	18	3	1	0	0	0	0	0	0	0	0	0	0
Muscogee	37	8	0	0	0	0	0	0	0	0	0	0	0
Newton	37	18	2	0	0	0	0	0	0	0	0	0	2
North Carolina	83	15	6	0	0	0	0	0	0	0	0	0	3
Oconee	4	0	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	2	1	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	325	56	13	0	0	0	0	0	0	0	0	0	8
Paulding	2,775	1,469	798	0	0	0	0	0	0	0	0	0	43
Peach	1	1	0	0	0	0	0	0	0	0	0	0	0
Pickens	215	118	21	0	0	0	0	0	0	0	0	0	4
Pike	24	3	0	0	0	0	0	0	0	0	0	0	2
Polk	103	80	20	0	0	0	0	0	0	0	0	0	3
Pulaski	0	2	0	0	0	0	0	0	0	0	0	0	0
Putnam	5	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	3	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	6	1	0	0	0	0	0	0	0	0	0	0	0
Rockdale	29	15	4	0	0	0	0	0	0	0	0	0	1
Schley	2	3	0	0	0	0	0	0	0	0	0	0	0
South Carolina	41	12	1	0	0	0	0	0	0	0	0	0	1
Spalding	166	19	2	0	0	0	0	0	0	0	0	0	8
Stephens	5	1	0	0	0	0	0	0	0	0	0	0	0
Stewart	1	0	0	0	0	0	0	0	0	0	0	0	0
Sumter	5	1	1	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	1	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	1	0	0	0	0	0	0	0	0	0	0	0
Telfair	1	0	0	0	0	0	0	0	0	0	0	0	0
Tennessee	58	9	3	0	0	0	0	0	0	0	0	0	0
Terrell	1	1	0	0	0	0	0	0	0	0	0	0	0
Thomas	7	0	0	0	0	0	0	0	0	0	0	0	1
Tift	0	1	0	0	0	0	0	0	0	0	0	0	0
Toombs	2	4	0	0	0	0	0	0	0	0	0	0	0
Towns	30	9	0	0	0	0	0	0	0	0	0	0	4
Treutlen	2	0	0	0	0	0	0	0	0	0	0	0	0
Troup	193	33	1	0	0	0	0	0	0	0	0	0	3

Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	43	21	0	0	0	0	0	0	0	0	0	0	1
Upson	19	1	0	0	0	0	0	0	0	0	0	0	1
Walker	4	4	0	0	0	0	0	0	0	0	0	0	0
Walton	20	6	5	0	0	0	0	0	0	0	0	0	0
Ware	1	0	0	0	0	0	0	0	0	0	0	0	0
Washington	3	0	0	0	0	0	0	0	0	0	0	0	0
Wayne	1	0	0	0	0	0	0	0	0	0	0	0	0
Webster	3	0	0	0	0	0	0	0	0	0	0	0	0
White	9	4	0	0	0	0	0	0	0	0	0	0	0
Whitfield	35	10	1	0	0	0	0	0	0	0	0	0	3
Wilcox	2	0	0	0	0	0	0	0	0	0	0	0	0
Worth	2	1	0	0	0	0	0	0	0	0	0	0	0
Total	36,425	12,652	5,404	0	480								

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	5	10	13
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
CVOR/VIOR	3	0	2
Total	8	10	16

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated	Dedicated	Shared	Shared
	Inpatient Rooms	Outpatient Rooms	Inpatient Rooms	Outpatient Rooms
General Operating	3,470	6,940	3,890	5,131
Cystoscopy	0	0	218	867
Endoscopy	0	0	0	0
CVOR/VIOR	1,499	0	548	316
Total	4,969	6,940	4,656	6,314

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated	Dedicated	Shared	Shared
	Inpatient Rooms	Outpatient Rooms	Inpatient Rooms	Outpatient Rooms
General Operating	3,272	6,545	3,564	4,944
Cystoscopy	0	0	215	857
Endoscopy	0	0	0	0
CVOR/VIOR	1,469	0	544	306
Total	4,741	6,545	4,323	6,107

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	35
Asian	204
Black/African American	2,021
Hispanic/Latino	856
Pacific Islander/Hawaiian	8
White	9,023
Multi-Racial	505
Total	12,652

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	399
Ages 15-64	8,453
Ages 65-74	2,467
Ages 75-85	1,151
Ages 85 and Up	182
Total	12,652

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,263
Female	7,389
Total	12,652

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,941
Medicaid	867
Third-Party	6,999
Self-Pay	845

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 the hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

- 2. Number of Birthing Rooms: 0**
- 3. Number of LDR Rooms: 21**
- 4. Number of LDRP Rooms: 0**
- 5. Number of Cesarean Sections: 1,961**
- 6. Total Live Births: 5,361**
- 7. Total Births (Live and Late Fetal Deaths): 5,404**
- 8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,447**

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)	67	4,895	10,783	0
Specialty Care (Intermediate Neonatal Care)	16	148	3,663	118
Subspecialty Care (Intensive Neonatal Care)	8	398	4,199	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	6	17
Asian	183	466
Black/African American	1,222	3,739
Hispanic/Latino	939	2,419
Pacific Islander/Hawaiian	4	15
White	2,788	7,404
Multi-Racial	262	713
Total	5,404	14,773

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	9
Ages 15-44	5,385	14,711
Ages 45 and Up	16	53
Total	5,404	14,773

3. Average Charge for an Uncomplicated Delivery

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

\$22,655.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$36,457.00

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	0	0
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	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program
						is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adults 18 and over	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 13-17	0	0	0	0	0	<input type="checkbox"/>
Extended Care Adolescents 0-12	0	0	0	0	0	<input type="checkbox"/>

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	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. 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

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	0	0
Medicaid	0	0
Third Party	0	0
Self-Pay	0	0
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? 6 (FTE's)

What languages do they interpret?

Spanish

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 Interpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

Contracted Interpreter Service

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	3.76%	0	0	0
Portuguese	0.15%	0	0	0
Vietnamese	0.10%	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- GME Internal Medicine Clinic and GME GYN Clinic at 833 Campbell Hill St in Marietta GA 30060
2- GME Family Medicine Clinic at 582 Concord Rd in Smyrna GA 30082

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	2	26
Asian	10	120
Black/African American	108	1,351
Hispanic/Latino	25	288
Pacific Islander/Hawaiian	0	0
White	309	3,952
Multi-Racial	26	311

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	264	3,298
Female	216	2,750

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	206	2,437
65-84	246	3,259
85 Up	28	352

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	449
Long Term Care Hospital	29
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	282
Third Party/Commercial	141
Self Pay	16
Other	41

2. Uncompensated Indigent and Charity Care

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

52

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	253
2. Brain Injury	59
3. Amputation	17
4. Spinal Cord	34
5. Fracture of the femur	7
6. Neurological disorders	69
7. Multiple Trauma	27
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	1
All Other	13

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 inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Candice Saunders

Date: 3/10/2021

Title: President and C.E.O.

Comments: