GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 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, 2021 through December 31, 2021.
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: James Satcher

Contact Title: Regulatory Planning Consultant

Phone: 470-991-1834

Fax: 770-509-4217

E-mail: james.satcher@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: Georgia Alliance of Community Hospitals (GACH)
City: Tifton **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(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)	51	5,761	16,159	5,746	16,944
Pediatrics (Non ICU)	12	580	1,169	580	1,158
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	28	668	3,134	672	3,160
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	437	23,902	140,306	25,166	140,304
Intensive Care	85	5,262	34,770	5,287	35,451
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	524	6,228	533	6,301
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**	**36,697**	**201,766**	**37,984**	**203,318**

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	86	479
Asian	662	3,493
Black/African American	8,359	50,573
Hispanic/Latino	3,135	15,115
Pacific Islander/Hawaiian	25	172
White	22,866	123,507
Multi-Racial	1,564	8,427
Total	**36,697**	**201,766**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	15,202	97,608
Female	21,495	104,158
Total	**36,697**	**201,766**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	16,495	101,688
Medicaid	4,591	23,092
Peachare	24	53
Third-Party	11,498	53,955
Self-Pay	2,916	15,432
Other	1,173	7,546

5. Discharges to Death

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

1,080

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2021 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,853
Semi-Private Room Rate	1,853
Operating Room: Average Charge for the First Hour	7,310
Average Total Charge for an Inpatient Day	17,375

Part E : Emergency Department and Outpatient Services

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

119,025

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

24,028

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

166

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	1,534
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	12	4,831
General Beds	126	96,933
Childrens Beds	16	15,727
	0	0
	0	0
	0	0

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

934

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

255,658

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

8,849

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

2,087.00

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.

4,160

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	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	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	962
Number of Dialysis Treatments	10,969
Number of ESWL Patients	63
Number of ESWL Procedures	69
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	18
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	123
Number of Diagnostic X-Ray Procedures	227,376
Number of CTS Units (machines)	17
Number of CTS Procedures	118,917
Number of Diagnostic Radioisotope Procedures	4,723
Number of PET Units (machines)	1
Number of PET Procedures	2,609
Number of Therapeautic Radioisotope Procedures	668
Number of Number of MRI Units	11
Number of Number of MRI Procedures	26,644
Number of Chemotherapy Treatments	32
Number of Respiratory Therapy Treatments	694,415
Number of Occupational Therapy Treatments	79,688
Number of Physical Therapy Treatments	288,358
Number of Speech Pathology Patients	5,267
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	36
Number of HIV/AIDS Diagnostic Procedures	9,272
Number of HIV/AIDS Patients	155
Number of Ambulance Trips	0
Number of Hospice Patients	2
Number of Respite care Patients	2
Number of Ultrasound/Medical Sonography Units	37
Number of Ultrasound/Medical Sonography Procedures	45,650
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

2. Medical Ventilators

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

<u>138</u>

3. Robotic Surgery System
Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
5	1,996	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 12-31-2021. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2021.

Profession	Profession	Profession	Profession
Licensed Physicians	146.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	1,736.00	309.00	165.00
Licensed Practical Nurses (LPNs)	11.00	1.00	0.00
Pharmacists	83.00	3.00	0.00
Other Health Services Professionals*	1,811.00	208.00	27.00
Administration and Support	1,531.00	40.00	0.00
All Other Hospital Personnel (not included above)	695.00	192.00	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	318
Black/African American	236
Hispanic/Latino	53
Pacific Islander/Hawaiian	1
White	655
Multi-Racial	96

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	24	☑	24	24
General Internal Medicine	235	☑	228	235
Pediatricians	49	☑	49	49
Other Medical Specialties	387	☐	386	387

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	74	☑	74	74
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	55	☐	8	16
Ophthalmology Surgery	14	☐	2	10
Orthopedic Surgery	36	☐	36	36
Plastic Surgery	17	☐	3	9
General Surgery	25	☐	25	25
Thoracic Surgery	4	☐	4	4
Other Surgical Specialties	150	☐	77	79

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	46	☑	46	46
Dermatology	13	☐	2	4
Emergency Medicine	108	☑	108	108
Nuclear Medicine	1	☐	0	1
Pathology	15	☑	15	15
Psychiatry	18	☐	3	1
Radiology	91	☑	91	91
Pediatric ER	66	☑	66	66
	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	9
Podiatrists	27
Certified Nurse Midwives with Clinical Privileges in the Hospital	24
All Other Staff Affiliates with Clinical Privileges in the Hospital	631

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 Anesthesist, Nurse Practitioner, Physician Anesthesia Assistant, Physician Assistant

Comments and Suggestions:

Part E.4 - Part E.4 - The hospital used Trauma Registry codes to determine Trauma cases. The hospital used ICD-10 codes to determine psych patients used 0-17 for peds patients and all other were general ED beds for survey reporting purposes. The visit data reflects the types of cases that relate to the described bed/room type, regardless of where in the emergency department the patient 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 G.3 physicians who do not identify a race are listed as multiracial. All sections related to race: patients who do not identify a race are listed as multiracial. Parts G.3 and G.4 colon the differences in the total number of physicians between these two categories are attributable to the physician's 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 not reflected in the survey count. Perinatal service is addendum Part C.1 and C.2: the mother's admission and inpatient days do not include antepartum admissions and days. Minority Health Addendum: The Interpreters are shared across all Wellstar Health System hospitals.

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	178	46	4	0	0	0	0	0	0	0	0	0	5
BALDWIN	3	1	1	0	0	0	0	0	0	0	0	0	0
BANKS	1	2	0	0	0	0	0	0	0	0	0	0	0
BARROW	13	2	3	0	0	0	0	0	0	0	0	0	0
BARTOW	1,086	545	252	0	0	0	0	0	0	0	0	0	10
BEN HILL	1	1	0	0	0	0	0	0	0	0	0	0	0
BIBB	15	2	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
BRYAN	2	0	0	0	0	0	0	0	0	0	0	0	0
BULLOCH	5	1	0	0	0	0	0	0	0	0	0	0	0
BUTTS	69	10	0	0	0	0	0	0	0	0	0	0	3
CALHOUN	2	0	0	0	0	0	0	0	0	0	0	0	0
CAMDEN	1	1	0	0	0	0	0	0	0	0	0	0	0
CANDLER	4	0	0	0	0	0	0	0	0	0	0	0	2
CARROLL	300	164	50	0	0	0	0	0	0	0	0	0	9
CATOOSA	3	1	0	0	0	0	0	0	0	0	0	0	0
CHATHAM	5	4	0	0	0	0	0	0	0	0	0	0	1
CHATTOOGA	11	8	0	0	0	0	0	0	0	0	0	0	0
CHEROKEE	4,259	2,258	691	0	0	0	0	0	0	0	0	0	62
CLARKE	7	2	0	0	0	0	0	0	0	0	0	0	1
CLAYTON	345	65	22	0	0	0	0	0	0	0	0	0	2
COBB	22,146	5,539	3,394	0	0	0	0	0	0	0	0	0	275
COFFEE	0	2	0	0	0	0	0	0	0	0	0	0	0
COLUMBIA	4	0	1	0	0	0	0	0	0	0	0	0	0
COOK	2	0	0	0	0	0	0	0	0	0	0	0	0
COWETA	51	22	6	0	0	0	0	0	0	0	0	0	1
CRISP	2	0	0	0	0	0	0	0	0	0	0	0	0

DAWSON	10	6	2	0	0	0	0	0	0	0	0	0	1
DEKALB	297	180	53	0	0	0	0	0	0	0	0	0	5
DOUGHERTY	5	0	0	0	0	0	0	0	0	0	0	0	0
DOUGLAS	905	507	123	0	0	0	0	0	0	0	0	0	28
EARLY	0	1	0	0	0	0	0	0	0	0	0	0	0
EFFINGHAM	2	0	1	0	0	0	0	0	0	0	0	0	0
ELBERT	0	1	0	0	0	0	0	0	0	0	0	0	0
EMANUEL	1	2	0	0	0	0	0	0	0	0	0	0	0
FANNIN	60	48	0	0	0	0	0	0	0	0	0	0	1
FAYETTE	38	27	2	0	0	0	0	0	0	0	0	0	1
Florida	142	31	6	0	0	0	0	0	0	0	0	0	0
FLOYD	62	54	9	0	0	0	0	0	0	0	0	0	1
FORSYTH	80	47	11	0	0	0	0	0	0	0	0	0	2
FRANKLIN	12	1	1	0	0	0	0	0	0	0	0	0	0
FULTON	1,240	654	168	0	0	0	0	0	0	0	0	0	16
GILMER	155	69	4	0	0	0	0	0	0	0	0	0	4
GLYNN	5	1	0	0	0	0	0	0	0	0	0	0	0
GORDON	67	44	7	0	0	0	0	0	0	0	0	0	0
GREENE	3	2	1	0	0	0	0	0	0	0	0	0	0
GWINNETT	233	110	27	0	0	0	0	0	0	0	0	0	8
HABERSHAM	5	1	0	0	0	0	0	0	0	0	0	0	0
HALL	23	15	1	0	0	0	0	0	0	0	0	0	0
HANCOCK	1	2	0	0	0	0	0	0	0	0	0	0	0
HARALSON	80	49	10	0	0	0	0	0	0	0	0	0	0
HARRIS	15	1	0	0	0	0	0	0	0	0	0	0	0
HART	4	0	0	0	0	0	0	0	0	0	0	0	0
HEARD	25	3	0	0	0	0	0	0	0	0	0	0	1
HENRY	101	45	7	0	0	0	0	0	0	0	0	0	3
HOUSTON	14	9	0	0	0	0	0	0	0	0	0	0	0
JACKSON	5	3	0	0	0	0	0	0	0	0	0	0	0
JASPER	8	3	0	0	0	0	0	0	0	0	0	0	0
JONES	1	0	0	0	0	0	0	0	0	0	0	0	0
LAMAR	26	4	0	0	0	0	0	0	0	0	0	0	1
LANIER	1	0	0	0	0	0	0	0	0	0	0	0	0
LAURENS	5	0	0	0	0	0	0	0	0	0	0	0	0
LEE	7	3	1	0	0	0	0	0	0	0	0	0	0
LIBERTY	1	4	0	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	2	1	1	0	0	0	0	0	0	0	0	0	0
LUMPKIN	2	0	0	0	0	0	0	0	0	0	0	0	0
MACON	1	0	0	0	0	0	0	0	0	0	0	0	0
MADISON	1	0	0	0	0	0	0	0	0	0	0	0	0
MARION	1	1	0	0	0	0	0	0	0	0	0	0	0
MCDUFFIE	1	0	0	0	0	0	0	0	0	0	0	0	0

County													
MERIWETHER	35	6	0	0	0	0	0	0	0	0	0	0	0
MITCHELL	2	0	0	0	0	0	0	0	0	0	0	0	0
MONROE	13	4	0	0	0	0	0	0	0	0	0	0	0
MONTGOMERY	1	0	0	0	0	0	0	0	0	0	0	0	0
MORGAN	3	0	0	0	0	0	0	0	0	0	0	0	0
MURRAY	22	6	0	0	0	0	0	0	0	0	0	0	2
MUSCOGEE	23	7	1	0	0	0	0	0	0	0	0	0	0
NEWTON	37	18	6	0	0	0	0	0	0	0	0	0	1
North Carolina	65	18	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	355	65	13	0	0	0	0	0	0	0	0	0	8
PAULDING	2,859	2,114	813	0	0	0	0	0	0	0	0	0	44
PEACH	2	1	0	0	0	0	0	0	0	0	0	0	0
PICKENS	257	142	16	0	0	0	0	0	0	0	0	0	11
PIKE	41	5	0	0	0	0	0	0	0	0	0	0	0
POLK	117	78	34	0	0	0	0	0	0	0	0	0	2
PULASKI	2	2	0	0	0	0	0	0	0	0	0	0	1
PUTNAM	4	1	0	0	0	0	0	0	0	0	0	0	0
RABUN	2	3	2	0	0	0	0	0	0	0	0	0	0
RANDOLPH	1	0	0	0	0	0	0	0	0	0	0	0	0
RICHMOND	8	3	1	0	0	0	0	0	0	0	0	0	0
ROCKDALE	29	14	2	0	0	0	0	0	0	0	0	0	0
SCHLEY	3	0	1	0	0	0	0	0	0	0	0	0	0
South Carolina	44	17	1	0	0	0	0	0	0	0	0	0	1
SPALDING	185	26	1	0	0	0	0	0	0	0	0	0	4
STEPHENS	3	0	0	0	0	0	0	0	0	0	0	0	0
SUMTER	3	0	0	0	0	0	0	0	0	0	0	0	0
TALBOT	6	0	0	0	0	0	0	0	0	0	0	0	0
TAYLOR	3	1	0	0	0	0	0	0	0	0	0	0	0
Tennessee	57	16	1	0	0	0	0	0	0	0	0	0	0
THOMAS	2	0	0	0	0	0	0	0	0	0	0	0	0
TIFT	2	0	0	0	0	0	0	0	0	0	0	0	0
TOOMBS	1	0	0	0	0	0	0	0	0	0	0	0	0
TOWNS	7	7	0	0	0	0	0	0	0	0	0	0	0
TROUP	243	23	2	0	0	0	0	0	0	0	0	0	3
UNION	24	18	1	0	0	0	0	0	0	0	0	0	1
UPSON	12	5	1	0	0	0	0	0	0	0	0	0	0
WALKER	7	7	1	0	0	0	0	0	0	0	0	0	0
WALTON	18	9	2	0	0	0	0	0	0	0	0	0	1
WAYNE	1	0	0	0	0	0	0	0	0	0	0	0	0
WHITE	5	1	1	0	0	0	0	0	0	0	0	0	0
WHITFIELD	29	9	0	0	0	0	0	0	0	0	0	0	2
WILCOX	0	1	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 | 36,697 | 13,234 | 5,761 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 524 |

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 Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	3,515	7,031	3,303	5,837
Cystoscopy	0	0	240	709
Endoscopy	0	0	0	0
CVOR/VIOR	1,499	0	544	398
Total	**5,014**	**7,031**	**4,087**	**6,944**

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	3,307	6,614	3,048	5,549
Cystoscopy	0	0	234	692
Endoscopy	0	0	0	0
CVOR/VIOR	1,459	0	529	379
Total	**4,766**	**6,614**	**3,811**	**6,620**

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	26
Asian	279
Black/African American	2,291
Hispanic/Latino	1,015
Pacific Islander/Hawaiian	6
White	9,056
Multi-Racial	561
Total	**13,234**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	495
Ages 15-64	8,962
Ages 65-74	2,399
Ages 75-85	1,166
Ages 85 and Up	212
Total	**13,234**

3. Gender
Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,423
Female	7,811
Total	**13,234**

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

Primary Payment Source	Number of Patients
Medicare	3,954
Medicaid	955
Third-Party	7,333
Self-Pay	992

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: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 21

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 2,093

6. Total Live Births: 5,781

7. Total Births (Live and Late Fetal Deaths): 5,838

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,872

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	5,296	12,206	85
Specialty Care (Intermediate Neonatal Care)	16	60	3,669	110
Subspecialty Care (Intensive Neonatal Care)	13	441	5,006	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	8	17
Asian	207	524
Black/African American	1,313	4,173
Hispanic/Latino	1,092	2,987
Pacific Islander/Hawaiian	7	33
White	2,798	7,499
Multi-Racial	336	926
Total	**5,761**	**16,159**

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	2
Ages 15-44	5,738	16,079
Ages 45 and Up	22	78
Total	**5,761**	**16,159**

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

$26,272.00

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

$50,192.00

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	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	0	0	0	0	0	☐
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	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? 17 (FTE's)
What languages do they interpret?
Spanish, Mandarin, American Sign Language, Mandarin

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): ☑

CulturaLink, Contracted Interpreter Services, Interpretek, Cloudbreak

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	3.64%	0	0	0
Portuguese	0.14%	0	0	0
Vietnamese	0.11%	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. Sign   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	0	0
Asian	7	105
Black/African American	112	1,412
Hispanic/Latino	16	185
Pacific Islander/Hawaiian	0	0
White	351	4,072
Multi-Racial	38	454

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	295	3,563
Female	229	2,665

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	262	3,035
65-84	231	2,802
85 Up	31	391

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	492
Long Term Care Hospital	31
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	279
Third Party/Commercial	170
Self Pay	22
Other	53

2. Uncompensated Indigent and Charity Care

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

53

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	231
2. Brain Injury	70
3. Amputation	12
4. Spinal Cord	46
5. Fracture of the femur	13
6. Neurological disorders	56
7. Multiple Trauma	55
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	41

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: 3/15/2022

Title: President and C.E.O.

Comments: