GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 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, 2018 through December 31, 2018.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: April Austin

Contact Title: Manager, Strategic Planning

Phone: 470-644-0057

Fax: 770-509-4217

E-mail: april.austin@wellstar.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

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

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☑
Name: WELLSTAR HEALTH SYSTEM
City: MARIETTA **State:** GA

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☐
Name:
City: **State:**

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☑

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☐

10a. Managed Care Information: Formal Written Contract

Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☑

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products

Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State

If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	30	2,338	6,497	2,316	6,442
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	267	8,194	61,713	8,409	58,729
Intensive Care	75	4,016	19,628	3,572	20,482
Psychiatry	62	2,379	11,054	2,345	10,737
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	18	281	3,924	285	3,800
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**452**	**17,208**	**102,816**	**16,927**	**100,190**

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	21	88
Asian	104	644
Black/African American	11,998	71,794
Hispanic/Latino	717	3,097
Pacific Islander/Hawaiian	13	68
White	3,796	23,724
Multi-Racial	559	3,401
Total	**17,208**	**102,816**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,552	52,206
Female	9,656	50,610
Total	**17,208**	**102,816**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	5,835	42,823
Medicaid	4,704	27,494
Peachare	6	20
Third-Party	2,852	12,891
Self-Pay	2,561	10,792
Other	1,250	8,796

5. Discharges to Death

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

452

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2018 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,483
Semi-Private Room Rate	1,483
Operating Room: Average Charge for the First Hour	5,940
Average Total Charge for an Inpatient Day	9,471

Part E : Emergency Department and Outpatient Services

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

126,042

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

11,557

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	3	3,331
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	8	7,858
General Beds	49	114,853
	0	0
	0	0
	0	0
	0	0

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

980

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

47,227

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

2,557

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

813.00

10. Untreated Cases

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

3,683

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	496
Number of Dialysis Treatments	4,063
Number of ESWL Patients	222
Number of ESWL Procedures	324
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	22
Number of Diagnostic X-Ray Procedures	115,537
Number of CTS Units (machines)	6
Number of CTS Procedures	44,678
Number of Diagnostic Radioisotope Procedures	3,780
Number of PET Units (machines)	1
Number of PET Procedures	92
Number of Therapeautic Radioisotope Procedures	0
Number of Number of MRI Units	1
Number of Number of MRI Procedures	7,285
Number of Chemotherapy Treatments	38
Number of Respiratory Therapy Treatments	207,814
Number of Occupational Therapy Treatments	46,694
Number of Physical Therapy Treatments	43,969
Number of Speech Pathology Patients	1,882
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	996
Number of HIV/AIDS Diagnostic Procedures	1,009
Number of HIV/AIDS Patients	417
Number of Ambulance Trips	0
Number of Hospice Patients	3
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	10
Number of Ultrasound/Medical Sonography Procedures	24,296
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).

53

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	106	MAKO, 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 12-31-2018. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2018.

Profession	Profession	Profession	Profession
Licensed Physicians	85.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	714.00	78.60	37.70
Licensed Practical Nurses (LPNs)	7.00	0.10	0.00
Pharmacists	42.00	0.00	0.00
Other Health Services Professionals*	604.00	58.40	40.50
Administration and Support	338.00	19.50	0.00
All Other Hospital Personnel (not included above)	88.00	14.30	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)	More than 90 Days
Pharmacists	Not Applicable
Other Health Services Professionals	More than 90 Days
All Other Hospital Personnel (not included above)	More than 90 Days

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	33
Black/African American	143
Hispanic/Latino	8
Pacific Islander/Hawaiian	0
White	109
Multi-Racial	262

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	44	☑	44	44
General Internal Medicine	72	☑	72	72
Pediatricians	13	☐	13	13
Other Medical Specialties	126	☐	113	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	46	☑	46	46
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	2	☐	2	2
Ophthalmology Surgery	11	☐	7	11
Orthopedic Surgery	27	☐	25	27
Plastic Surgery	4	☐	4	2
General Surgery	18	☐	18	18
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	69	☐	25	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	15	☑	15	15
Dermatology	0	☐	0	0
Emergency Medicine	52	☑	52	52
Nuclear Medicine	1	☐	0	0
Pathology	3	☑	3	3
Psychiatry	7	☐	7	7
Radiology	20	☑	20	20
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	9
Podiatrists	16
Certified Nurse Midwives with Clinical Privileges in the Hospital	24
All Other Staff Affiliates with Clinical Privileges in the Hospital	171

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. – WellStar is reporting only ED beds dedicated for trauma and patients that qualify for the Trauma Registry. WellStar Atlanta Medical Center was a Level I designated Trauma Center in 2018 with 3 dedicated trauma beds and 3,331 trauma visits as reported on the Trauma Registry and above in Part E.4. WellStar previously reported trauma volumes based on ICD coding. Using ICD-10 codes, Atlanta Medical Center had 54,821 trauma visits in 2018. The hospital used ICD10 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 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 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 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.

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	75	15	1	7	0	0	0	0	0	0	0	0	1
Appling	1	5	0	0	0	0	0	0	0	0	0	0	0
Baldwin	10	13	0	1	0	0	0	0	0	0	0	0	0
Barrow	12	7	1	0	0	0	0	0	0	0	0	0	0
Bartow	31	10	4	3	0	0	0	0	0	0	0	0	1
Bibb	25	18	0	5	0	0	0	0	0	0	0	0	0
Bleckley	3	1	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	2	0	0	0	0	0	0	0	0	0	0	0
Bulloch	2	1	0	1	0	0	0	0	0	0	0	0	0
Butts	126	58	0	9	0	0	0	0	0	0	0	0	0
Calhoun	1	14	0	0	0	0	0	0	0	0	0	0	0
Camden	1	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	175	36	19	7	0	0	0	0	0	0	0	0	3
Catoosa	0	1	0	0	0	0	0	0	0	0	0	0	0
Chatham	14	10	1	0	0	0	0	0	0	0	0	0	0
Chattahoochee	2	0	1	0	0	0	0	0	0	0	0	0	0
Chattooga	6	18	0	0	0	0	0	0	0	0	0	0	0
Cherokee	58	18	11	18	0	0	0	0	0	0	0	0	2
Clarke	9	4	1	4	0	0	0	0	0	0	0	0	0
Clayton	1,416	299	279	171	0	0	0	0	0	0	0	0	27
Cobb	555	111	172	146	0	0	0	0	0	0	0	0	6
Coffee	1	0	0	0	0	0	0	0	0	0	0	0	0
Colquitt	2	0	0	1	0	0	0	0	0	0	0	0	0
Columbia	7	8	0	0	0	0	0	0	0	0	0	0	0
Cook	1	0	1	0	0	0	0	0	0	0	0	0	0
Coweta	192	43	27	13	0	0	0	0	0	0	0	0	1
Crawford	9	5	1	1	0	0	0	0	0	0	0	0	0

Crisp	2	0	0	0	0	0	0	0	0	0	0	0	0
Dade	1	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	1	3	0	1	0	0	0	0	0	0	0	0	0
Decatur	4	6	0	1	0	0	0	0	0	0	0	0	0
DeKalb	1,822	405	360	337	0	0	0	0	0	0	0	0	46
Dodge	3	9	0	0	0	0	0	0	0	0	0	0	0
Dooly	3	12	0	0	0	0	0	0	0	0	0	0	0
Dougherty	9	3	2	2	0	0	0	0	0	0	0	0	0
Douglas	241	60	41	58	0	0	0	0	0	0	0	0	5
Early	1	0	0	0	0	0	0	0	0	0	0	0	0
Effingham	2	1	1	0	0	0	0	0	0	0	0	0	0
Elbert	3	0	1	1	0	0	0	0	0	0	0	0	0
Emanuel	0	3	0	0	0	0	0	0	0	0	0	0	0
Fannin	3	2	1	1	0	0	0	0	0	0	0	0	0
Fayette	147	39	34	4	0	0	0	0	0	0	0	0	5
Florida	102	15	4	25	0	0	0	0	0	0	0	0	2
Floyd	11	8	1	4	0	0	0	0	0	0	0	0	0
Forsyth	17	15	4	3	0	0	0	0	0	0	0	0	0
Franklin	2	1	2	0	0	0	0	0	0	0	0	0	0
Fulton	9,610	1,237	1,079	1,272	0	0	0	0	0	0	0	0	123
Gilmer	6	8	0	4	0	0	0	0	0	0	0	0	0
Glynn	7	2	1	2	0	0	0	0	0	0	0	0	0
Gordon	5	1	1	0	0	0	0	0	0	0	0	0	1
Grady	0	1	0	0	0	0	0	0	0	0	0	0	0
Greene	3	2	0	1	0	0	0	0	0	0	0	0	0
Gwinnett	443	98	138	45	0	0	0	0	0	0	0	0	8
Habersham	19	20	2	1	0	0	0	0	0	0	0	0	0
Hall	29	15	3	5	0	0	0	0	0	0	0	0	0
Hancock	2	3	0	0	0	0	0	0	0	0	0	0	0
Haralson	34	24	0	1	0	0	0	0	0	0	0	0	1
Harris	5	2	0	1	0	0	0	0	0	0	0	0	0
Hart	6	4	0	0	0	0	0	0	0	0	0	0	0
Heard	17	7	0	0	0	0	0	0	0	0	0	0	1
Henry	364	122	50	29	0	0	0	0	0	0	0	0	7
Houston	17	5	1	3	0	0	0	0	0	0	0	0	2
Jackson	4	6	0	0	0	0	0	0	0	0	0	0	0
Jasper	6	5	0	0	0	0	0	0	0	0	0	0	1
Jefferson	3	5	0	1	0	0	0	0	0	0	0	0	0
Johnson	18	15	0	0	0	0	0	0	0	0	0	0	0
Jones	2	1	0	1	0	0	0	0	0	0	0	0	0
Lamar	28	10	0	1	0	0	0	0	0	0	0	0	1
Laurens	2	0	0	2	0	0	0	0	0	0	0	0	0
Lee	1	2	0	0	0	0	0	0	0	0	0	0	0
Liberty	4	0	0	2	0	0	0	0	0	0	0	0	0

Long	0	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	7	9	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	3	8	0	2	0	0	0	0	0	0	0	0	0
Macon	5	7	1	0	0	0	0	0	0	0	0	0	0
Madison	2	2	0	0	0	0	0	0	0	0	0	0	0
Marion	2	1	0	1	0	0	0	0	0	0	0	0	0
Meriwether	20	9	0	1	0	0	0	0	0	0	0	0	1
Mitchell	6	9	0	0	0	0	0	0	0	0	0	0	0
Monroe	7	4	1	1	0	0	0	0	0	0	0	0	0
Montgomery	1	2	0	0	0	0	0	0	0	0	0	0	0
Morgan	4	3	0	0	0	0	0	0	0	0	0	0	0
Murray	0	1	0	0	0	0	0	0	0	0	0	0	0
Muscogee	23	21	1	6	0	0	0	0	0	0	0	0	1
Newton	184	47	13	20	0	0	0	0	0	0	0	0	6
North Carolina	26	10	3	1	0	0	0	0	0	0	0	0	0
Oconee	1	1	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	5	1	1	1	0	0	0	0	0	0	0	0	0
Other Out of State	351	26	7	67	0	0	0	0	0	0	0	0	3
Paulding	102	29	27	22	0	0	0	0	0	0	0	0	1
Peach	2	0	1	0	0	0	0	0	0	0	0	0	0
Pickens	4	8	0	3	0	0	0	0	0	0	0	0	0
Pierce	1	0	0	0	0	0	0	0	0	0	0	0	0
Pike	29	18	2	0	0	0	0	0	0	0	0	0	0
Polk	3	5	0	0	0	0	0	0	0	0	0	0	0
Pulaski	16	25	0	0	0	0	0	0	0	0	0	0	0
Putnam	1	0	0	0	0	0	0	0	0	0	0	0	0
Rabun	0	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	13	1	2	5	0	0	0	0	0	0	0	0	0
Rockdale	149	46	11	16	0	0	0	0	0	0	0	0	9
Screven	6	0	2	1	0	0	0	0	0	0	0	0	0
South Carolina	24	5	0	2	0	0	0	0	0	0	0	0	1
Spalding	223	58	6	18	0	0	0	0	0	0	0	0	12
Stephens	4	3	0	0	0	0	0	0	0	0	0	0	0
Tattnall	7	26	0	0	0	0	0	0	0	0	0	0	0
Telfair	3	6	1	0	0	0	0	0	0	0	0	0	0
Tennessee	28	5	1	3	0	0	0	0	0	0	0	0	1
Thomas	1	0	0	1	0	0	0	0	0	0	0	0	0
Tift	1	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	0	1	0	0	0	0	0	0	0	0	0	0	0
Troup	91	14	6	4	0	0	0	0	0	0	0	0	1
Turner	2	1	0	0	0	0	0	0	0	0	0	0	0
Twiggs	1	1	0	0	0	0	0	0	0	0	0	0	0
Union	4	5	1	0	0	0	0	0	0	0	0	0	0

Upson	10	6	0	1	0	0	0	0	0	0	0	0	0
Walker	3	2	1	0	0	0	0	0	0	0	0	0	0
Walton	58	18	4	7	0	0	0	0	0	0	0	0	1
Ware	6	3	0	0	0	0	0	0	0	0	0	0	0
Washington	6	20	0	0	0	0	0	0	0	0	0	0	0
Wheeler	1	1	0	0	0	0	0	0	0	0	0	0	0
White	2	6	0	0	0	0	0	0	0	0	0	0	0
Whitfield	5	1	1	1	0	0	0	0	0	0	0	0	0
Wilcox	9	15	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
Total	**17,208**	**3,366**	**2,338**	**2,379**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**281**

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	3,738	3,893
Cystoscopy	0	0	12	46
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**3,750**	**3,939**

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	3,086	3,321
Cystoscopy	0	0	12	45
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**0**	**3,098**	**3,366**

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	36
Black/African American	2,161
Hispanic/Latino	185
Pacific Islander/Hawaiian	0
White	729
Multi-Racial	254
Total	**3,366**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	407
Ages 15-64	2,107
Ages 65-74	590
Ages 75-85	224
Ages 85 and Up	38
Total	**3,366**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,647
Female	1,719
Total	**3,366**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	938
Medicaid	891
Third-Party	1,394
Self-Pay	143

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: 704

6. Total Live Births: 2,348

7. Total Births (Live and Late Fetal Deaths): 2,378

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 2,389

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	1,985	4,486	0
Specialty Care (Intermediate Neonatal Care)	18	247	2,803	0
Subspecialty Care (Intensive Neonatal Care)	16	146	1,575	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	4	13
Asian	17	44
Black/African American	1,445	4,187
Hispanic/Latino	287	773
Pacific Islander/Hawaiian	1	1
White	481	1,181
Multi-Racial	103	298
Total	**2,338**	**6,497**

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	2	4
Ages 15-44	2,334	6,490
Ages 45 and Up	2	3
Total	**2,338**	**6,497**

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

$17,862.00

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

$29,375.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, Gender and Payment Source

1. Race/Ethnicity
Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	66	62
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	2,379	11,054	2,345	10,737	3,881	☑
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	1	3
Asian	15	62
Black/African American	1,712	7,809
Hispanic/Latino	53	268
Pacific Islander/Hawaiian	1	2
White	517	2,513
Multi-Racial	80	397
Total	**2,379**	**11,054**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	1,149	5,710
Female	1,230	5,344
Total	**2,379**	**11,054**

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	717	4,254
Medicaid	915	4,017
Third Party	204	756
Self-Pay	543	2,027
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☐
If you checked yes, how many? 0 (FTE's)
What languages do they interpret?

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☐	Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☑

contracted interpreter services

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish	1.0%	0	0	0
Vietnamese	>0.1%	0	0	0
Esperanto	>0.1%	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	1	25
Black/African American	191	2,728
Hispanic/Latino	6	79
Pacific Islander/Hawaiian	0	0
White	60	760
Multi-Racial	23	332

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	150	2,086
Female	131	1,838

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	179	2,396
65-84	97	1,440
85 Up	5	88

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	281
Long Term Care Hospital	0
Skilled Nursing Facility	0
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	132
Third Party/Commercial	70
Self Pay	12
Other	67

2. Uncompensated Indigent and Charity Care

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

22

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	79
2. Brain Injury	36
3. Amputation	14
4. Spinal Cord	16
5. Fracture of the femur	20
6. Neurological disorders	26
7. Multiple Trauma	51
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	1
12. Systemic vasculidities	0
13. Joint replacement	1
All Other	37

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: 5/16/2019

Title: President and C.E.O.

Comments: