



2018 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:hosp546

Facility Name: WellStar Cobb Hospital

County: Cobb

Street Address: 3950 Austell Road

City: Austell

Zip: 30106-1174

Mailing Address: 3950 Austell Road

Mailing City: Austell

Mailing Zip: 30106-1174

Medicaid Provider Number: 000000426A

Medicare Provider Number: 110143

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
Hospital Authority of Cobb County	Hospital Authority	1/1/1968

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
Cobb Hospital Inc.	Not for Profit	6/26/1984

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)	44	3,221	9,592	3,217	9,727
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	214	11,575	63,354	11,511	62,825
Intensive Care	24	2,185	6,775	2,172	6,635
Psychiatry	32	1,146	5,206	1,150	5,206
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	282	3,525	321	3,562
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	8	722	2,446	720	2,506
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	342	19,131	90,898	19,091	90,461

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	97
Asian	236	1,002
Black/African American	7,847	38,633
Hispanic/Latino	1,498	6,005
Pacific Islander/Hawaiian	5	10
White	8,901	42,568
Multi-Racial	623	2,583
Total	19,131	90,898

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,182	37,903
Female	11,949	52,995
Total	19,131	90,898

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,815	46,409
Medicaid	3,961	17,377
Peachare	8	17
Third-Party	4,860	17,387
Self-Pay	1,738	6,592
Other	749	3,116

5. Discharges to Death

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

273

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	10,889

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

87,541

2. Inpatient Admissions from ER

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

11,314

3. Beds Available

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

63

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	0	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	8	4,167
General Beds	42	76,891
Childrens General	13	16,483
	0	0
	0	0
	0	0

5. Transfers

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

1,189

6. Non-Emergency Visits

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

96,824

7. Observation Visits/Cases

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

4,464

8. Diverted Cases

Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

21

9. Ambulance Diversion Hours

Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

353.00

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.

956

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	2	1
Biliary Lithotripter	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, Diagnostic	1	1
Positron Emission Tomography (PET)	3	4
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	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	1	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	782
Number of Dialysis Treatments	6,509
Number of ESWL Patients	93
Number of ESWL Procedures	104
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	65
Number of Diagnostic X-Ray Procedures	97,659
Number of CTS Units (machines)	6
Number of CTS Procedures	39,944
Number of Diagnostic Radioisotope Procedures	2,321
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeutic Radioisotope Procedures	0
Number of Number of MRI Units	4
Number of Number of MRI Procedures	8,208
Number of Chemotherapy Treatments	9,715
Number of Respiratory Therapy Treatments	196,799
Number of Occupational Therapy Treatments	46,699
Number of Physical Therapy Treatments	103,008
Number of Speech Pathology Patients	2,425
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	7,967
Number of HIV/AIDS Patients	36
Number of Ambulance Trips	0
Number of Hospice Patients	1
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	8
Number of Ultrasound/Medical Sonography Procedures	30,177
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).

46

3. Robotic Surgery System

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

# Units	# Procedures	Type of Unit(s)
4	1,448	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	1.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	695.00	76.50	20.80
Licensed Practical Nurses (LPNs)	5.00	1.30	0.00
Pharmacists	42.00	0.20	0.00
Other Health Services Professionals*	804.00	61.40	19.10
Administration and Support	560.00	28.40	0.00
All Other Hospital Personnel (not included above)	267.00	49.70	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	More than 90 Days
Other Health Services Professionals	More than 90 Days
All Other Hospital Personnel (not included above)	61-90 Days

3. Race/Ethnicity of Physicians

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

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	69
Black/African American	51
Hispanic/Latino	11
Pacific Islander/Hawaiian	0
White	175
Multi-Racial	276

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 Plan 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	2	<input type="checkbox"/>	2	2
General Internal Medicine	50	<input checked="" type="checkbox"/>	50	50
Pediatricians	15	<input checked="" type="checkbox"/>	15	15
Other Medical Specialties	172	<input type="checkbox"/>	172	172

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	32	<input type="checkbox"/>	32	32
Non-OB Physicians Providing OB Services	0	<input type="checkbox"/>	0	0
Gynecology	13	<input type="checkbox"/>	3	13
Ophthalmology Surgery	6	<input type="checkbox"/>	3	6
Orthopedic Surgery	16	<input type="checkbox"/>	16	16
Plastic Surgery	4	<input type="checkbox"/>	3	4
General Surgery	7	<input type="checkbox"/>	7	7
Thoracic Surgery	4	<input type="checkbox"/>	4	4
Other Surgical Specialties	62	<input type="checkbox"/>	47	62

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	22	<input checked="" type="checkbox"/>	22	22
Dermatology	0	<input type="checkbox"/>	0	0
Emergency Medicine	60	<input checked="" type="checkbox"/>	60	60
Nuclear Medicine	0	<input type="checkbox"/>	0	0
Pathology	9	<input checked="" type="checkbox"/>	9	9
Psychiatry	19	<input type="checkbox"/>	19	16
Radiology	59	<input checked="" type="checkbox"/>	59	59
Pediatric ER	39	<input checked="" type="checkbox"/>	39	39
	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	2
Podiatrists	13
Certified Nurse Midwives with Clinical Privileges in the Hospital	19
All Other Staff Affiliates with Clinical Privileges in the Hospital	420

5b. Name of Other Professions

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

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

Comments and Suggestions:

Part E.4. – WellStar is reporting only ED beds dedicated for trauma and patients that qualify for the Trauma Registry. WellStar Cobb Hospital was not a designated trauma center in 2018 and thus had no dedicated ED trauma beds or trauma registry volume. WellStar previously reported trauma volumes based on ICD coding. Using ICD-10 codes, Cobb Hospital had 13,727 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 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	60	40	3	2	0	0	0	0	0	0	0	0	1
Baldwin	2	0	0	0	0	0	0	0	0	0	0	0	0
Banks	2	1	0	0	0	0	0	0	0	0	0	0	0
Barrow	7	6	0	0	0	0	0	0	0	0	0	0	0
Bartow	72	51	6	13	0	0	0	0	0	0	0	0	1
Ben Hill	2	0	0	0	0	0	0	0	0	0	0	0	0
Bibb	6	9	0	1	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	0	1	0	0	0	0	0	0	0	0	0	0	0
Bryan	1	0	0	0	0	0	0	0	0	0	0	0	0
Bulloch	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	21	11	2	0	0	0	0	0	0	0	0	0	1
Camden	1	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	505	220	185	16	0	0	0	0	0	0	0	0	15
Catoosa	3	4	0	0	0	0	0	0	0	0	0	0	0
Chatham	1	4	0	0	0	0	0	0	0	0	0	0	0
Chattahoochee	1	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	6	3	0	0	0	0	0	0	0	0	0	0	0
Cherokee	159	144	8	42	0	0	0	0	0	0	0	0	6
Clarke	3	2	1	0	0	0	0	0	0	0	0	0	0
Clayton	132	74	20	12	0	0	0	0	0	0	0	0	3
Cobb	11,493	3,454	1,447	573	0	0	0	0	0	0	0	0	122
Colquitt	2	0	0	0	0	0	0	0	0	0	0	0	0
Columbia	2	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	38	35	3	6	0	0	0	0	0	0	0	0	0
Crisp	2	0	0	0	0	0	0	0	0	0	0	0	0
Dade	2	0	0	0	0	0	0	0	0	0	0	0	1

Dawson	4	6	0	1	0	0	0	0	0	0	0	0	0
Decatur	2	2	0	0	0	0	0	0	0	0	0	0	0
DeKalb	134	86	13	15	0	0	0	0	0	0	0	0	1
Dougherty	9	0	1	0	0	0	0	0	0	0	0	0	0
Douglas	2,520	1,122	673	202	0	0	0	0	0	0	0	0	43
Elbert	1	0	0	0	0	0	0	0	0	0	0	0	0
Emanuel	1	0	0	0	0	0	0	0	0	0	0	0	0
Fannin	7	5	0	0	0	0	0	0	0	0	0	0	0
Fayette	22	25	5	1	0	0	0	0	0	0	0	0	1
Florida	70	14	1	2	0	0	0	0	0	0	0	0	1
Floyd	30	26	1	4	0	0	0	0	0	0	0	0	0
Forsyth	16	24	4	1	0	0	0	0	0	0	0	0	0
Franklin	2	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	951	449	147	63	0	0	0	0	0	0	0	0	23
Gilmer	19	22	0	2	0	0	0	0	0	0	0	0	1
Glynn	2	0	0	0	0	0	0	0	0	0	0	0	0
Gordon	19	14	1	0	0	0	0	0	0	0	0	0	1
Grady	1	3	0	0	0	0	0	0	0	0	0	0	0
Greene	1	0	0	0	0	0	0	0	0	0	0	0	0
Gwinnett	71	106	9	7	0	0	0	0	0	0	0	0	1
Habersham	8	5	1	0	0	0	0	0	0	0	0	0	0
Hall	15	13	0	0	0	0	0	0	0	0	0	0	0
Hancock	1	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	96	53	25	4	0	0	0	0	0	0	0	0	0
Harris	2	2	0	0	0	0	0	0	0	0	0	0	0
Hart	1	0	0	1	0	0	0	0	0	0	0	0	0
Heard	7	5	3	0	0	0	0	0	0	0	0	0	0
Henry	33	51	7	0	0	0	0	0	0	0	0	0	1
Houston	4	1	1	0	0	0	0	0	0	0	0	0	0
Irwin	0	2	0	0	0	0	0	0	0	0	0	0	0
Jackson	7	4	0	0	0	0	0	0	0	0	0	0	0
Jasper	0	1	0	0	0	0	0	0	0	0	0	0	0
Jeff Davis	0	1	0	0	0	0	0	0	0	0	0	0	0
Jefferson	0	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	3	5	0	0	0	0	0	0	0	0	0	0	0
Laurens	1	0	0	0	0	0	0	0	0	0	0	0	0
Lee	2	0	0	0	0	0	0	0	0	0	0	0	0
Liberty	2	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	0	1	0	0	0	0	0	0	0	0	0	0	0
Lumpkin	6	9	0	0	0	0	0	0	0	0	0	0	0
Macon	0	2	0	0	0	0	0	0	0	0	0	0	0
Meriwether	4	0	0	0	0	0	0	0	0	0	0	0	0
Mitchell	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	2	4	0	0	0	0	0	0	0	0	0	0	0

Morgan	0	1	0	0	0	0	0	0	0	0	0	0	0
Murray	6	8	0	0	0	0	0	0	0	0	0	0	0
Muscogee	34	44	0	0	0	0	0	0	0	0	0	0	1
Newton	17	18	0	1	0	0	0	0	0	0	0	0	1
North Carolina	33	7	2	0	0	0	0	0	0	0	0	0	0
Oconee	2	1	0	0	0	0	0	0	0	0	0	0	0
Oglethorpe	0	2	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	140	22	8	13	0	0	0	0	0	0	0	0	2
Paulding	1,979	1,011	621	143	0	0	0	0	0	0	0	0	46
Peach	3	3	0	0	0	0	0	0	0	0	0	0	0
Pickens	14	6	0	3	0	0	0	0	0	0	0	0	2
Pike	2	10	0	0	0	0	0	0	0	0	0	0	0
Polk	80	39	17	6	0	0	0	0	0	0	0	0	2
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0	0
Rabun	2	3	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	1	0	0	0	0	0	0	0	0	0	0	0
Richmond	2	0	1	0	0	0	0	0	0	0	0	0	0
Rockdale	15	10	1	0	0	0	0	0	0	0	0	0	0
Screven	2	2	1	0	0	0	0	0	0	0	0	0	0
South Carolina	16	2	1	1	0	0	0	0	0	0	0	0	1
Spalding	13	13	0	1	0	0	0	0	0	0	0	0	0
Stephens	2	3	0	0	0	0	0	0	0	0	0	0	0
Stewart	3	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	1	0	0	0	0	0	0	0	0	0	0	0	0
Talbot	2	0	0	0	0	0	0	0	0	0	0	0	0
Taliaferro	1	0	0	0	0	0	0	0	0	0	0	0	0
Taylor	1	2	0	0	0	0	0	0	0	0	0	0	0
Telfair	0	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	67	42	1	3	0	0	0	0	0	0	0	0	2
Thomas	1	0	0	0	0	0	0	0	0	0	0	0	0
Tift	3	1	0	0	0	0	0	0	0	0	0	0	0
Towns	0	2	0	0	0	0	0	0	0	0	0	0	0
Troup	21	8	0	4	0	0	0	0	0	0	0	0	2
Twiggs	1	0	0	0	0	0	0	0	0	0	0	0	0
Union	6	8	0	0	0	0	0	0	0	0	0	0	0
Upson	7	5	0	0	0	0	0	0	0	0	0	0	0
Walker	15	13	0	1	0	0	0	0	0	0	0	0	0
Walton	7	8	1	1	0	0	0	0	0	0	0	0	0
Ware	2	0	0	0	0	0	0	0	0	0	0	0	0
Warren	1	1	0	0	0	0	0	0	0	0	0	0	0
White	4	2	0	0	0	0	0	0	0	0	0	0	0
Whitfield	23	26	0	1	0	0	0	0	0	0	0	0	0
Worth	2	0	0	0	0	0	0	0	0	0	0	0	0
Total	19,131	7,453	3,221	1,146	0	0	0	0	0	0	0	0	282

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	7	8
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	7	9

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	5,461	4,683	1,558
Cystoscopy	0	0	109	704
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	5,461	4,792	2,262

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	5,282	4,563	1,485
Cystoscopy	0	0	108	686
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	5,282	4,671	2,171

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	10
Asian	123
Black/African American	2,748
Hispanic/Latino	619
Pacific Islander/Hawaiian	1
White	3,661
Multi-Racial	291
Total	7,453

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	747
Ages 15-64	5,153
Ages 65-74	1,017
Ages 75-85	446
Ages 85 and Up	90
Total	7,453

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,818
Female	4,635
Total	7,453

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,891
Medicaid	1,017
Third-Party	4,060
Self-Pay	485

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: 20
4. Number of LDRP Rooms: 6
5. Number of Cesarean Sections: 1,163
6. Total Live Births: 3,262
7. Total Births (Live and Late Fetal Deaths): 3,296
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,310

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)	38	2,827	5,248	4
Specialty Care (Intermediate Neonatal Care)	10	348	2,555	69
Subspecialty Care (Intensive Neonatal Care)	20	120	5,071	39

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	2	5
Asian	107	325
Black/African American	1,324	4,039
Hispanic/Latino	574	1,602
Pacific Islander/Hawaiian	2	5
White	1,043	3,153
Multi-Racial	169	463
Total	3,221	9,592

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	0	0
Ages 15-44	3,216	9,578
Ages 45 and Up	5	14
Total	3,221	9,592

3. Average Charge for an Uncomplicated Delivery

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

\$20,370.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$30,688.00

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	34	32
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
0	0	0

2. Admissions, Days, Discharges, Accreditation

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

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	1,146	5,206	1,150	5,206	3,435	<input checked="" 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	6	28
Black/African American	472	2,292
Hispanic/Latino	51	194
Pacific Islander/Hawaiian	0	0
White	568	2,488
Multi-Racial	49	204
Total	1,146	5,206

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	537	2,451
Female	609	2,755
Total	1,146	5,206

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	253	1,337
Medicaid	355	1,700
Third Party	532	2,150
Self-Pay	4	17
PeachCare	2	2

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? (Check the box, if yes.)

If you checked yes, how many? 3 (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):

Contacted 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	5	0	0	0
Vietnamese	>1	0	0	0
Creole	>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.

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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?

Kennestone Clinic

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Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	1	14
Asian	1	21
Black/African American	110	1,471
Hispanic/Latino	17	187
Pacific Islander/Hawaiian	0	0
White	146	1,733
Multi-Racial	7	99

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	147	1,883
Female	135	1,642

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	137	1,617
65-84	128	1,707
85 Up	17	201

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	275
Long Term Care Hospital	7
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0
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1. Payers

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

Primary Payment Source	Admissions
Medicare	173
Third Party/Commercial	66
Self Pay	6
Other	37

2. Uncompensated Indigent and Charity Care

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

14

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	110
2. Brain Injury	39
3. Amputation	29
4. Spinal Cord	12
5. Fracture of the femur	2
6. Neurological disorders	48
7. Multiple Trauma	7
8. Congenital deformity	0
9. Burns	9
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	4
All Other	22

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: 5/16/2019

Title: President and C.E.O.

Comments: