



2011 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP151

Facility Name: WellStar Paulding Hospital

County: Paulding

Street Address: 600 West Memorial Drive

City: Dallas

Zip: 30132-4118

Mailing Address: 600 West Memorial Drive

Mailing City: Dallas

Mailing Zip: 30132-4118

Medicaid Provider Number: 00001438

Medicare Provider Number: 110042

2. Report Period

Report Data for the full twelve month period- January 1, 2011 through December 31, 2011.

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: Caroline Aultman

Contact Title: Director, Strategic Planning

Phone: 678-331-6885

Fax: 678-331-6894

E-mail: Caroline.Aultman@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 |
|-------------------------------------|--------------------|----------------|
| Paulding County Hospital Authority | Hospital Authority | 1/6/1954 |

B. Owner's Parent Organization

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

C. Facility Operator

| Full Legal Name (Or Not Applicable) | Organization Type | Effective Date |
|-------------------------------------|-------------------|----------------|
| Paulding Medical Center, Inc. | Not for Profit | 1/1/1958 |

D. Operator's Parent Organization

| Full Legal Name (Or Not Applicable) | Organization Type | Effective Date |
|-------------------------------------|-------------------|----------------|
| Wellstar Health System, Inc. | Not for Profit | 12/30/1993 |

E. Management Contractor

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

F. Management's Parent Organization

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

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:** Georgia

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: Georgia

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) | 0 | 0 | 0 | 0 | 0 |
| 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 | 30 | 1,802 | 5,647 | 1,800 | 5,629 |
| Intensive Care | 4 | 260 | 501 | 264 | 515 |
| Psychiatry | 0 | 0 | 0 | 0 | 0 |
| Substance Abuse | 0 | 0 | 0 | 0 | 0 |
| Adult Physical Rehabilitation (18 & Up) | 0 | 0 | 0 | 0 | 0 |
| 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 | 34 | 2,062 | 6,148 | 2,064 | 6,144 |

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 | 0 | 0 |
| Asian | 2 | 2 |
| Black/African American | 233 | 625 |
| Hispanic/Latino | 17 | 44 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 1,802 | 5,454 |
| Multi-Racial | 8 | 23 |
| Total | 2,062 | 6,148 |

3. Gender

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

| Gender | Admissions | Inpatient Days |
|---------------|-------------------|-----------------------|
| Male | 888 | 2,584 |
| Female | 1,174 | 3,564 |
| Total | 2,062 | 6,148 |

4. Payment Source

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

| Primary Payment Source | Admissions | Inpatient Days |
|-------------------------------|-------------------|-----------------------|
| Medicare | 1,037 | 3,474 |
| Medicaid | 169 | 545 |
| Peachare | 0 | 0 |
| Third-Party | 516 | 1,288 |
| Self-Pay | 340 | 841 |
| Other | 0 | 0 |

5. Discharges to Death

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

17

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2011 (to the nearest whole dollar).

| Service | Charge |
|---------------------------------------------------|---------------|
| Private Room Rate | 1,014 |
| Semi-Private Room Rate | 1,014 |
| Operating Room: Average Charge for the First Hour | 4,295 |
| Average Total Charge for an Inpatient Day | 7,344 |

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

39,938

2. Inpatient Admissions from ER

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

1,902

3. Beds Available

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

16

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 | 1 | 2,496 |
| Beds or Rooms dedicated for Psychiatric /Substance Abuse cases | 1 | 2,496 |
| General Beds | 14 | 34,946 |
| | 0 | 0 |
| | 0 | 0 |
| | 0 | 0 |
| | 0 | 0 |

5. Transfers

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

1,623

6. Non-Emergency Visits

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

32,794

7. Observation Visits/Cases

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

627

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

0

10. Untreated Cases

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

1,241

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 | 3 | 4 |
| ESWL | 3 | 4 |
| Biliary Lithotripter | 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, Diagnostic | 1 | 1 |
| Positron Emission Tomography (PET) | 3 | 4 |
| Radioisotope, Therapeutic | 3 | 4 |
| Magnetic Resonance Imaging (MRI) | 1 | 1 |
| Chemotherapy | 1 | 2 |
| 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 | 3 | 4 |
| 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 | 60 |
| Number of Dialysis Treatments | 0 |
| Number of ESWL Patients | 0 |
| Number of ESWL Procedures | 0 |
| Number of ESWL Units | 0 |
| 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 | 0 |
| Number of Diagnostic X-Ray Procedures | 24,391 |
| Number of CTS Units (machines) | 2 |
| Number of CTS Procedures | 18,440 |
| Number of Diagnostic Radioisotope Procedures | 470 |
| Number of PET Units (machines) | 0 |
| Number of PET Procedures | 0 |
| Number of Therapeutic Radioisotope Procedures | 0 |
| Number of Number of MRI Units | 1 |
| Number of Number of MRI Procedures | 3,121 |
| Number of Chemotherapy Treatments | 73 |
| Number of Respiratory Therapy Treatments | 24,863 |
| Number of Occupational Therapy Treatments | 1,982 |
| Number of Physical Therapy Treatments | 5,832 |
| Number of Speech Pathology Patients | 289 |
| 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 | 10 |
| Number of HIV/AIDS Patients | 1 |
| Number of Ambulance Trips | 0 |
| Number of Hospice Patients | 0 |
| Number of Respite care Patients | 0 |
| Number of Ultrasound/Medical Sonography Units | 3 |
| Number of Ultrasound/Medical Sonography Procedures | 7,972 |
| 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).

7

3. Robotic Surgery System

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

| # Units | # Procedures | Type of Unit(s) |
|---------|--------------|-----------------|
| 0 | 0 | |

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2011. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2011.

| Profession | Budgeted FTEs | Vacant Budgeted FTEs | Contract/Temporary Staff FTEs |
|---------------------------------------------------------------|-----------------|----------------------|-------------------------------|
| Licensed Physicians | 0 | 0 | 0 |
| Physician Assistants Only (not including Licensed Physicians) | 0 | 0 | 0 |
| Registered Nurses (RNs-Advanced Practice*) | 69 | 2.7999999523163 | 0 |
| Licensed Practical Nurses (LPNs) | 7.9000000953674 | 0.20000000298023 | 0 |
| Pharmacists | 5.1999998092651 | 0.89999997615814 | 0 |
| Other Health Services Professionals* | 102.19999694824 | 1.8999999761581 | 0 |
| Administration and Support | 134 | 2 | 0 |
| All Other Hospital Personnel (not included above) | 70.199996948242 | 5.3000001907349 | 0 |

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 | 30 Days or Less |
| Registered Nurses (RNs-Advance Practice) | 31-60 Days |
| Licensed Practical Nurses (LPNs) | 30 Days or Less |
| Pharmacists | 31-60 Days |
| Other Health Services Professionals | 31-60 Days |
| All Other Hospital Personnel (not included above) | 31-60 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 | 10 |
| Black/African American | 10 |
| Hispanic/Latino | 2 |
| Pacific Islander/Hawaiian | 0 |
| White | 67 |
| Multi-Racial | 61 |

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 | 4 | <input type="checkbox"/> | 4 | 1 |
| General Internal Medicine | 14 | <input checked="" type="checkbox"/> | 14 | 5 |
| Pediatricians | 0 | <input type="checkbox"/> | 0 | 0 |
| Other Medical Specialties | 29 | <input type="checkbox"/> | 29 | 3 |

| 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 | 0 | <input type="checkbox"/> | 0 | 0 |
| Non-OB Physicians Providing OB Services | 0 | <input type="checkbox"/> | 0 | 0 |
| Gynecology | 1 | <input type="checkbox"/> | 1 | 0 |
| Ophthalmology Surgery | 0 | <input type="checkbox"/> | 0 | 0 |
| Orthopedic Surgery | 2 | <input type="checkbox"/> | 2 | 1 |
| Plastic Surgery | 0 | <input type="checkbox"/> | 0 | 0 |
| General Surgery | 4 | <input type="checkbox"/> | 4 | 0 |
| Thoracic Surgery | 0 | <input type="checkbox"/> | 0 | 0 |
| Other Surgical Specialties | 6 | <input type="checkbox"/> | 6 | 0 |

| 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 | 10 | <input checked="" type="checkbox"/> | 10 | 10 |
| Dermatology | 0 | <input type="checkbox"/> | 0 | 0 |
| Emergency Medicine | 34 | <input checked="" type="checkbox"/> | 34 | 34 |
| Nuclear Medicine | 0 | <input type="checkbox"/> | 0 | 0 |
| Pathology | 3 | <input checked="" type="checkbox"/> | 3 | 3 |
| Psychiatry | 1 | <input type="checkbox"/> | 1 | 0 |
| Radiology | 41 | <input checked="" type="checkbox"/> | 41 | 41 |
| | 0 | <input type="checkbox"/> | 0 | 0 |
| | 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 | 0 |
| Podiatrists | 1 |
| Certified Nurse Midwives with Clinical Privileges in the Hospital | 0 |
| All Other Staff Affiliates with Clinical Privileges in the Hospital | 83 |

5b. Name of Other Professions

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

Clinical Psychology, Nurse Anesthetist, Nurse Practitioner, Physician Anesthesia Assistant, Physician Assistant

Comments and Suggestions:

Part E.4: The hospital does not track ED visits by ED bed. Accordingly, ED visits are allocated proportionately among the ED beds for survey reporting purposes. Obviously, the hospital cannot verify that such an allocation accurately reflects the actual number of ED visits per ED bed category.

Part G.3: Physicians 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 2 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.

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 | 10 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| BARROW | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| BARTOW | 17 | 18 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CARROLL | 68 | 52 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CHATTOOGA | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CHEROKEE | 10 | 33 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| CLAYTON | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| COBB | 154 | 358 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| COFFEE | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| COWETA | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DOUGLAS | 74 | 82 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FANNIN | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FLORIDA | 4 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FLOYD | 2 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FORSYTH | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| FULTON | 7 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GILMER | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GORDON | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| GWINNETT | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| HARALSON | 16 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| IRWIN | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MORGAN | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| MUSCOGEE | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| NORTH CAROLINA | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Other Out of STATE | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PAULDING | 1,528 | 841 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PICKENS | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| | | | | | | | | | | | | | |
|----------------|--------------|--------------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|
| POLK | 147 | 57 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| PUTNAM | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| ROCKDALE | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SOUTH CAROLINA | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TENNESSEE | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 2,062 | 1,468 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

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 | 2 |
| Cystoscopy (OR Suite) | 0 | 0 | 0 |
| Endoscopy (OR Suite) | 0 | 0 | 0 |
| | 0 | 0 | 0 |
| Total | 0 | 0 | 2 |

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 | 429 | 1,534 |
| Cystoscopy | 0 | 0 | 0 | 0 |
| Endoscopy | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 429 | 1,534 |

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 | 425 | 1,468 |
| Cystoscopy | 0 | 0 | 0 | 0 |
| Endoscopy | 0 | 0 | 0 | 0 |
| | 0 | 0 | 0 | 0 |
| Total | 0 | 0 | 425 | 1,468 |

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 | 0 |
| Asian | 13 |
| Black/African American | 139 |
| Hispanic/Latino | 37 |
| Pacific Islander/Hawaiian | 2 |
| White | 1,259 |
| Multi-Racial | 18 |
| Total | 1,468 |

2. Age Grouping

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

| Age of Patient | Number of Ambulatory Patients |
|----------------|-------------------------------|
| Ages 0-14 | 465 |
| Ages 15-64 | 811 |
| Ages 65-74 | 130 |
| Ages 75-85 | 51 |
| Ages 85 and Up | 11 |
| Total | 1,468 |

3. Gender

Please report the total number of ambulatory patients by gender.

| Gender | Number of Ambulatory Patients |
|--------------|-------------------------------|
| Male | 767 |
| Female | 701 |
| Total | 1,468 |

4. Payment Source

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

| Primary Payment Source | Number of Patients |
|------------------------|--------------------|
| Medicare | 228 |
| Medicaid | 165 |
| Third-Party | 1,031 |
| Self-Pay | 44 |

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of the hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 0

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 0

6. Total Live Births: 0

7. Total Births (Live and Late Fetal Deaths): 0

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 0

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) | 0 | 0 | 0 | 0 |
| Specialty Care (Intermediate Neonatal Care) | 0 | 0 | 0 | 0 |
| Subspecialty Care (Intensive Neonatal Care) | 0 | 0 | 0 | 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 | 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 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 | 0 | 0 |
| Ages 45 and Up | 0 | 0 |
| Total | 0 | 0 |

3. Average Charge for an Uncomplicated Delivery

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

\$0.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$0.00

LTCH Addendum

Part A : General Information

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

1b. Level/Status of Accreditation

Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

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

1. Race/Ethnicity

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

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

2. Age of LTCH Patient

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

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

3. Gender

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

| Gender of Patient | Admissions | Inpatient Days |
|-------------------|------------|----------------|
| Male | 0 | 0 |
| Female | 0 | 0 |
| Total | 0 | 0 |

4. Payment Source

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

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

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

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

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

2. Admissions, Days, Discharges, Accreditation

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

| Program Type | Admissions | Inpatient 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 | <input type="checkbox"/> |
| General Acute Psychiatric Adolescents 13-17 | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| General Acute Psychiatric Children 12 and Under | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| Acute Substance Abuse Adults 18 and over | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| Acute Substance Abuse Adolescents 13-17 | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| Extended Care Adults 18 and over | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| Extended Care Adolescents 13-17 | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |
| Extended Care Adolescents 0-12 | 0 | 0 | 0 | 0 | 0 | <input type="checkbox"/> |

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

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

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

2. Gender

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

| Gender of Patient | Admissions | Inpatient Days |
|-------------------|------------|----------------|
| Male | 0 | 0 |
| Female | 0 | 0 |
| Total | 0 | 0 |

3. Payment Source

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

| Primary Payment Source | Number of Patients | Inpatient Days |
|------------------------|--------------------|----------------|
| Medicare | 0 | 0 |
| Medicaid | 0 | 0 |
| Third Party | 0 | 0 |
| Self-Pay | 0 | 0 |
| PeachCare | 0 | 0 |

Georgia Minority Health Advisory Council Addendum

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

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

If you checked yes, how many? 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 Interpreter

Telephone Interpreter Service

Refer Patient to Outside Agency

Other (please describe):

When a patient has a pre-planned appointment at a WellStar facility and a trained in-house medical interpreter is not available to assist with communication, providers can schedule a medical interpreter to be present during the medical appointment. WellStar maintains a contractual relationship with three (3) agencies to supplement our in-house medical interpretation services capability.

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 | 0.5 | 34 | 0 | 0 |
| Vietnamese | 0.02 | 1 | 0 | 0 |
| | | 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?

Over the last few years, WellStar has enhanced interpretation services at all of our facilities in order to ensure effective communication and to provide culturally competent care. In-person medical interpretation services for patients who speak Spanish is now available at our two largest hospitals, Kennestone Hospital on a 24-hour basis daily and at Cobb Hospital, 8 hours/daily however all facilities have access to telephonic interpretation services which are available, twenty-four (24) hours daily with access to over 150 languages.

- Effective January 2012, Emergency Rooms were equipped with over 200 dual handset phones. Dual handset phones allow enhanced communication with patients with limited English proficiency (LEP). In addition to the emergency rooms, over 200 dual handset phones were already available in patient care units.

- Departments were trained on the use of these resources and how to document the use of interpretation services in patients' medical records. Additionally, an interpretation services toolkit was distributed to all departments. Information about CLAS Standards and detailed instructions on how to quickly access interpretation services are included in the toolkit and have been provided during department staff meetings and trainings.

- WellStar has also implemented programs to engage team members and train providers on how to provide culturally competent care. The Cultural Diplomat Program consists of WellStar team members of culturally and ethnically diverse backgrounds who offer insights, knowledge and cultural awareness to providers when they are confronted with cultural issues that may be impacting understanding during a patient's hospitalization or other patient care encounters. Review of the CLAS standards is an intricate part of this program. WellStar also has a monthly newsletter, Cultural Connections, which highlights a different culture dimension of diversity. In addition, WellStar offers additional online tools to support culturally competent care including the following:

- Culture Vision, a robust database that is geared to healthcare professionals. It provides cultural, religious and other information about several ethnic groups.
- DiversityToolkit , a resource designed for managers, leaders and front-line workers to help to successfully build and manage diverse workgroups.
- CareNotes provides inpatient/discharge information and drug-related information to patients. Information can be customized in multiple languages.
- Annual Diversity Forum – annual educational conference which focuses on diversity and cultural competency in health care. This conference is geared to all WellStar providers and system leaders.

- A key component of the boarding process at WellStar is training of all nurses who have recently graduated from nursing school and are entering the workforce at WellStar.

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?

At WellStar, we are pleased to be able to provide care that is culturally and linguistically appropriate for our patients.

6. In what languages are the signs written that direct patients within your facility?

1. English 2. Braille 3. Spanish (not all signs) 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) Good Samaritan Health Center of Cobb
1605 Roberta Drive SW
Marietta, GA 30008

- 2) Kennesaw State University Community Health Clinic at MUST
1407 Cobb Parkway NW
Marietta, GA 30062

- 3) Sweetwater Community Health Center
6289 Veterans Memorial Highway
Austell, GA 30168

- 4) Luke's Place
948 Front Street
Mableton, GA 30126

- 5) The Family Health Center at Cobb
An affiliate of West End Medical Centers, Inc. (This is a Federally Qualified Health Center in Fulton County)
805 Campbell Hill Street
Marietta, GA 30060

- 6) WellStar Community Clinic at Kennestone
52 Tower Road
Marietta, GA 30060

- 7) WellStar Community Clinic at Cobb
1790 Mulkey Road
Suite 10
Austell, GA 30106

- 8) Georgia Highlands Medical Services
(This is also a Federally Qualified Health Center out of Cumming, Georgia)
220 Oakside Lane Building
Canton, Georgia 30114

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 | 0 | 0 |
| Black/African American | 0 | 0 |
| Hispanic/Latino | 0 | 0 |
| Pacific Islander/Hawaiian | 0 | 0 |
| White | 0 | 0 |
| Multi-Racial | 0 | 0 |

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 | 0 | 0 |
| Female | 0 | 0 |

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 | 0 | 0 |
| 65-84 | 0 | 0 |
| 85 Up | 0 | 0 |

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 | 0 |
| 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 | 0 |
| Third Party/Commercial | 0 |
| Self Pay | 0 |
| Other | 0 |

2. Uncompensated Indigent and Charity Care

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

0

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

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: Reynold J. Jennings

Date: 3/26/2012

Title: President and C.E.O.

Comments:

Georgia Minority Health Council Addendum Part 3: Although the hospital does employ nurses and staff who speak languages in addition to English, the hospital does not have reliable data responsive to the request