GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP615

Facility Name: WellStar Kennestone Hospital

County: Cobb

Street Address: 677 Church Street NE

City: Marietta

Zip: 30060-1148

Mailing Address: 677 Church Street NE

Mailing City: Marietta

Mailing Zip: 30060-1148

Medicaid Provider Number: 0000119

Medicare Provider Number: 110035

2. Report Period

Report Data for the full twelve month period- January 1, 2012 through December 31, 2012.
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: Stephen Vault

Contact Title: Director, Strategic Planning

Phone: 678-331-6887

Fax: 678-331-6887

E-mail: Stephen.Vault@Wellstar.org

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

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

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Cobb County Kennestone Hospital Authority	Hospital Authority	1/1/1948

B. Owner's Parent Organization

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

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

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

2. Changes in Ownership, Operation or Management

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

3. Check the box to the right if your facility is part of a health care system ☑
Name: Wellstar Health System, Inc.
City: Marietta **State:** 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(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)	66	5,526	15,849	5,575	16,177
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	20	721	1,787	719	1,772
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	400	22,049	113,007	22,042	114,756
Intensive Care	78	6,693	26,715	6,730	27,217
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	454	5,567	464	5,745
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	**584**	**35,443**	**162,925**	**35,530**	**165,667**

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	75	342
Asian	599	2,718
Black/African American	5,681	27,072
Hispanic/Latino	1,750	6,430
Pacific Islander/Hawaiian	35	121
White	27,016	124,861
Multi-Racial	287	1,381
Total	**35,443**	**162,925**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	14,062	70,579
Female	21,381	92,346
Total	**35,443**	**162,925**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	15,648	83,214
Medicaid	3,876	16,352
Peachare	5	22
Third-Party	12,542	47,905
Self-Pay	3,372	15,432
Other	0	0

5. Discharges to Death

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

681

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2012 (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	5,154
Average Total Charge for an Inpatient Day	8,697

Part E : Emergency Department and Outpatient Services

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

127,088

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

20,965

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

86

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	4,433
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	2,956
General Beds	72	106,399
Children Bed	9	13,300
	0	0
	0	0
	0	0

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

3,067

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

188,398

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

8,730

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.

4,558

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	3	4
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	1	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	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	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	354
Number of Dialysis Treatments	4,394
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	43
Number of Diagnostic X-Ray Procedures	159,608
Number of CTS Units (machines)	12
Number of CTS Procedures	94,687
Number of Diagnostic Radioisotope Procedures	7,009
Number of PET Units (machines)	1
Number of PET Procedures	2,847
Number of Therapeautic Radioisotope Procedures	1,138
Number of Number of MRI Units	10
Number of Number of MRI Procedures	20,459
Number of Chemotherapy Treatments	2,588
Number of Respiratory Therapy Treatments	694,818
Number of Occupational Therapy Treatments	44,007
Number of Physical Therapy Treatments	131,746
Number of Speech Pathology Patients	14,331
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	7
Number of HIV/AIDS Diagnostic Procedures	11,562
Number of HIV/AIDS Patients	57
Number of Ambulance Trips	0
Number of Hospice Patients	20
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	13
Number of Ultrasound/Medical Sonography Procedures	39,669
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).

115

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	823	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 12-31-2012. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2012.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0.80000001192093	0	0
Physician Assistants Only (not including Licensed Physicians)	1.2000000476837	0	0
Registered Nurses (RNs-Advanced Practice*)	1286.1999511719	101.80000305176	18.39999961853
Licensed Practical Nurses (LPNs)	30.200000762939	0	0
Pharmacists	48.700000762939	3.5	0
Other Health Services Professionals*	1245.6999511719	71.599998474121	0
Administration and Support	1130.8000488281	32.299999237061	0
All Other Hospital Personnel (not included above)	639.59997558594	66.400001525879	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)	61-90 Days
Pharmacists	31-60 Days
Other Health Services Professionals	61-90 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	48
Black/African American	28
Hispanic/Latino	13
Pacific Islander/Hawaiian	0
White	288
Multi-Racial	205

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	15	☐	15	15
General Internal Medicine	63	☑	63	63
Pediatricians	35	☐	35	35
Other Medical Specialties	167	☑	128	135

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	35	☐	35	35
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	41	☐	1	4
Ophthalmology Surgery	5	☐	5	3
Orthopedic Surgery	20	☐	18	20
Plastic Surgery	10	☐	4	9
General Surgery	11	☐	11	11
Thoracic Surgery	3	☐	3	3
Other Surgical Specialties	85	☑	70	70

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	28	☑	28	28
Dermatology	1	☐	0	1
Emergency Medicine	26	☑	26	26
Nuclear Medicine	0	☐	0	0
Pathology	9	☑	9	9
Psychiatry	6	☐	1	0
Radiology	41	☑	41	41
Pediactric Emergency Medicine	16	☑	16	16
	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	8
Certified Nurse Midwives with Clinical Privileges in the Hospital	16
All Other Staff Affiliates with Clinical Privileges in the Hospital	326

5b. Name of Other Professions

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

Clinical Nurse Specialist, 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 F.1.b Hospice counts show Hospice patients in a hospital bed, and do not show activities of a Wellstar owned hospice.
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.
Perinatal Services Addendum Part C.1 and C.2: The mothers' admissions and inpatient days do not include antepartum admissions and days.
Minority Health 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.

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	65	26	3	0	0	0	0	0	0	0	0	0	2
APPLING	4	1	0	0	0	0	0	0	0	0	0	0	0
BALDWIN	3	1	0	0	0	0	0	0	0	0	0	0	0
BANKS	2	2	0	0	0	0	0	0	0	0	0	0	0
BARROW	14	5	1	0	0	0	0	0	0	0	0	0	0
BARTOW	924	400	181	0	0	0	0	0	0	0	0	0	18
BEN HILL	1	0	0	0	0	0	0	0	0	0	0	0	0
BERRIEN	1	0	0	0	0	0	0	0	0	0	0	0	0
BIBB	16	9	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	1	0	0	0	0	0	0	0	0	0	0	0	0
BURKE	1	0	0	0	0	0	0	0	0	0	0	0	0
BUTTS	2	2	0	0	0	0	0	0	0	0	0	0	0
CARROLL	189	130	23	0	0	0	0	0	0	0	0	0	5
CATOOSA	4	4	1	0	0	0	0	0	0	0	0	0	0
CHATHAM	5	4	1	0	0	0	0	0	0	0	0	0	0
CHATTAHOOCHEE	0	1	0	0	0	0	0	0	0	0	0	0	0
CHATTOOGA	16	4	0	0	0	0	0	0	0	0	0	0	0
CHEROKEE	6,847	2,754	885	0	0	0	0	0	0	0	0	0	92
CLARKE	7	8	0	0	0	0	0	0	0	0	0	0	0
CLAYTON	66	26	5	0	0	0	0	0	0	0	0	0	0
COBB	21,213	7,355	3,259	0	0	0	0	0	0	0	0	0	238
COFFEE	3	0	0	0	0	0	0	0	0	0	0	0	1
COLQUITT	0	3	0	0	0	0	0	0	0	0	0	0	0
COLUMBIA	11	1	0	0	0	0	0	0	0	0	0	0	1
COOK	1	1	0	0	0	0	0	0	0	0	0	0	0

COWETA	39	11	1	0	0	0	0	0	0	0	0	0	0
CRAWFORD	0	1	0	0	0	0	0	0	0	0	0	0	0
CRISP	0	1	0	0	0	0	0	0	0	0	0	0	0
DADE	3	1	0	0	0	0	0	0	0	0	0	0	0
DAWSON	14	5	3	0	0	0	0	0	0	0	0	0	0
DECATUR	0	1	0	0	0	0	0	0	0	0	0	0	0
DEKALB	178	84	31	0	0	0	0	0	0	0	0	0	4
DODGE	0	1	0	0	0	0	0	0	0	0	0	0	0
DOUGHERTY	5	1	0	0	0	0	0	0	0	0	0	0	0
DOUGLAS	676	355	63	0	0	0	0	0	0	0	0	0	17
EMANUEL	0	1	0	0	0	0	0	0	0	0	0	0	0
FANNIN	83	52	6	0	0	0	0	0	0	0	0	0	1
FAYETTE	13	9	1	0	0	0	0	0	0	0	0	0	0
FLORIDA	115	21	0	0	0	0	0	0	0	0	0	0	0
FLOYD	52	18	4	0	0	0	0	0	0	0	0	0	0
FORSYTH	39	39	5	0	0	0	0	0	0	0	0	0	2
FRANKLIN	3	1	0	0	0	0	0	0	0	0	0	0	0
FULTON	655	375	87	0	0	0	0	0	0	0	0	0	11
GILMER	157	68	8	0	0	0	0	0	0	0	0	0	4
GLYNN	2	1	0	0	0	0	0	0	0	0	0	0	0
GORDON	68	31	11	0	0	0	0	0	0	0	0	0	0
GREENE	6	2	0	0	0	0	0	0	0	0	0	0	0
GWINNETT	157	88	18	0	0	0	0	0	0	0	0	0	3
HABERSHAM	9	4	0	0	0	0	0	0	0	0	0	0	1
HALL	30	14	1	0	0	0	0	0	0	0	0	0	0
HANCOCK	8	3	0	0	0	0	0	0	0	0	0	0	1
HARALSON	38	38	3	0	0	0	0	0	0	0	0	0	0
HARRIS	4	0	0	0	0	0	0	0	0	0	0	0	0
HART	6	0	0	0	0	0	0	0	0	0	0	0	0
HEARD	1	2	0	0	0	0	0	0	0	0	0	0	0
HENRY	56	26	3	0	0	0	0	0	0	0	0	0	0
HOUSTON	13	7	0	0	0	0	0	0	0	0	0	0	0
JACKSON	3	2	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
JONES	1	3	0	0	0	0	0	0	0	0	0	0	0
LAMAR	3	1	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	0	1	0	0	0	0	0	0	0	0	0	0	0
LIBERTY	2	0	1	0	0	0	0	0	0	0	0	0	0
LOWNDES	5	1	0	0	0	0	0	0	0	0	0	0	0
LUMPKIN	3	6	0	0	0	0	0	0	0	0	0	0	1
MACON	2	0	0	0	0	0	0	0	0	0	0	0	0
MADISON	4	0	0	0	0	0	0	0	0	0	0	0	0
MARION	3	0	0	0	0	0	0	0	0	0	0	0	1

MCDUFFIE	2	0	0	0	0	0	0	0	0	0	0	0	0
MCINTOSH	2	0	0	0	0	0	0	0	0	0	0	0	0
MERIWETHER	1	0	0	0	0	0	0	0	0	0	0	0	0
MORGAN	3	2	0	0	0	0	0	0	0	0	0	0	0
MURRAY	17	3	0	0	0	0	0	0	0	0	0	0	2
MUSCOGEE	15	5	2	0	0	0	0	0	0	0	0	0	0
NEWTON	15	6	1	0	0	0	0	0	0	0	0	0	0
NORTH CAROLINA	68	22	1	0	0	0	0	0	0	0	0	0	0
OCONEE	3	4	0	0	0	0	0	0	0	0	0	0	0
OGLETHORPE	1	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	424	44	6	0	0	0	0	0	0	0	0	0	4
PAULDING	2,294	1,166	523	0	0	0	0	0	0	0	0	0	29
PEACH	6	0	0	0	0	0	0	0	0	0	0	0	0
PICKENS	307	167	27	0	0	0	0	0	0	0	0	0	10
PIKE	8	1	0	0	0	0	0	0	0	0	0	0	0
POLK	160	86	23	0	0	0	0	0	0	0	0	0	3
PUTNAM	4	2	0	0	0	0	0	0	0	0	0	0	0
RABUN	2	1	0	0	0	0	0	0	0	0	0	0	0
RANDOLPH	1	0	0	0	0	0	0	0	0	0	0	0	0
RICHMOND	5	1	0	0	0	0	0	0	0	0	0	0	0
ROCKDALE	10	6	0	0	0	0	0	0	0	0	0	0	0
SCHLEY	2	0	0	0	0	0	0	0	0	0	0	0	0
SCREVEN	1	0	0	0	0	0	0	0	0	0	0	0	0
SOUTH CAROLINA	37	16	1	0	0	0	0	0	0	0	0	0	0
SPALDING	12	7	0	0	0	0	0	0	0	0	0	0	3
STEPHENS	2	1	0	0	0	0	0	0	0	0	0	0	0
SUMTER	4	1	1	0	0	0	0	0	0	0	0	0	0
TALBOT	1	0	0	0	0	0	0	0	0	0	0	0	0
TAYLOR	0	1	0	0	0	0	0	0	0	0	0	0	0
TELFAIR	3	0	0	0	0	0	0	0	0	0	0	0	0
TENNESSEE	42	15	3	0	0	0	0	0	0	0	0	0	0
THOMAS	7	0	1	0	0	0	0	0	0	0	0	0	0
TIFT	1	1	0	0	0	0	0	0	0	0	0	0	0
TOOMBS	2	0	0	0	0	0	0	0	0	0	0	0	0
TOWNS	3	9	0	0	0	0	0	0	0	0	0	0	0
TROUP	19	4	1	0	0	0	0	0	0	0	0	0	0
UNION	33	17	2	0	0	0	0	0	0	0	0	0	0
UPSON	3	3	0	0	0	0	0	0	0	0	0	0	1
WALKER	7	7	0	0	0	0	0	0	0	0	0	0	0
WALTON	21	9	2	0	0	0	0	0	0	0	0	0	0
WARE	2	0	0	0	0	0	0	0	0	0	0	0	0
WASHINGTON	4	0	0	0	0	0	0	0	0	0	0	0	0
WAYNE	1	0	0	0	0	0	0	0	0	0	0	0	0
WHITE	3	3	0	0	0	0	0	0	0	0	0	0	0

WHITFIELD	28	4	1	0	0	0	0	0	0	0	0	0	1
WILKES	0	1	0	0	0	0	0	0	0	0	0	0	0
WILKINSON	2	1	0	0	0	0	0	0	0	0	0	0	0
WORTH	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**35,443**	**13,630**	**5,200**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**456**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	5	7	13
Cystoscopy (OR Suite)	0	0	1
Endoscopy (OR Suite)	0	0	0
Cardio-Vascular and Vascular	3	0	2
Total	**8**	**7**	**16**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	4,184	5,858	4,068	6,811
Cystoscopy	0	0	150	889
Endoscopy	0	0	0	0
Cardio-Vascular and Vascular	597	0	1,079	523
Total	**4,781**	**5,858**	**5,297**	**8,223**

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	4,041	5,658	3,934	6,574
Cystoscopy	0	0	150	888
Endoscopy	0	0	0	0
Cardio-Vascular and Vascular	589	0	1,053	510
Total	**4,630**	**5,658**	**5,137**	**7,972**

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	32
Asian	231
Black/African American	1,742
Hispanic/Latino	541
Pacific Islander/Hawaiian	3
White	10,949
Multi-Racial	132
Total	**13,630**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	640
Ages 15-64	9,924
Ages 65-74	1,958
Ages 75-85	915
Ages 85 and Up	193
Total	**13,630**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,155
Female	8,475
Total	**13,630**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,284
Medicaid	759
Third-Party	8,501
Self-Pay	1,086

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

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

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 21

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 1,878

6. Total Live Births: 5,294

7. Total Births (Live and Late Fetal Deaths): 5,321

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,379

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)	60	4,744	10,984	34
Specialty Care (Intermediate Neonatal Care)	16	177	3,784	250
Subspecialty Care (Intensive Neonatal Care)	8	373	2,470	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	21	74
Asian	157	414
Black/African American	1,058	3,410
Hispanic/Latino	718	1,872
Pacific Islander/Hawaiian	9	26
White	3,140	8,756
Multi-Racial	97	254
Total	**5,200**	**14,806**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	1	3
Ages 15-44	5,192	14,779
Ages 45 and Up	7	24
Total	**5,200**	**14,806**

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

$14,784.00

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

$24,362.00

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	☐
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

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

1. Race/Ethnicity

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

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

2. Gender

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

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

3. Payment Source

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

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

Georgia Minority Health Advisory Council Addendum

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

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 4.1999998092651 (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 Intrepreter	☐	Telephone Interpreter Service	☑
Refer Patient to Outside Agency	☐	Other (please describe):	☑

Team members are trained to access interpretation services for patients who are deaf or hearing impaired.

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	2.97	114	0	0
Portuguese	0.09	3	0	0
Vietnamese	0.05	3	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?

Multiple classes, meetings, newsletters and online training for physicians, staff care givers and

leaders discuss different dimensions of diversity, including culture and language scenarios, and the need to access interpretation services or resources. Cultural competency is woven throughout the curriculum of each leadership development program.

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?

WellStar provides care that is culturally and linguistically appropriate for our patients and we continue to provide ongoing education and training to team members on the importance of providing patient-centered, culturally competent care.

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) 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	12	137
Black/African American	71	940
Hispanic/Latino	4	61
Pacific Islander/Hawaiian	0	0
White	358	4,587
Multi-Racial	11	98

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	245	3,197
Female	211	2,626

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	240	2,838
65-84	193	2,687
85 Up	23	298

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	424
Long Term Care Hospital	32
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	231
Third Party/Commercial	173
Self Pay	26
Other	26

2. Uncompensated Indigent and Charity Care

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

20

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	142
2. Brain Injury	44
3. Amputation	18
4. Spinal Cord	38
5. Fracture of the femur	26
6. Neurological disorders	55
7. Multiple Trauma	35
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	2
12. Systemic vasculidities	0
13. Joint replacement	8
All Other	88

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: Reynold J. Jennings

Date: 3/15/2013

Title: President & CEO

Comments: