Georgia Department of Community Health

2015 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: 00000426

Medicare Provider Number: 110143

2. Report Period

Report Data for the full twelve month period- January 1, 2015 through December 31, 2015.
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: 770-509-4270

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:** 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)	46	3,500	9,457	3,494	9,428
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	239	11,918	58,028	11,957	58,374
Intensive Care	24	2,324	6,238	2,334	6,405
Psychiatry	33	1,675	7,505	1,669	7,492
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	308	3,467	312	3,470
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	5	587	2,357	587	2,290
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	**367**	**20,312**	**87,052**	**20,353**	**87,459**

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	29	119
Asian	255	1,056
Black/African American	7,643	33,858
Hispanic/Latino	1,353	4,621
Pacific Islander/Hawaiian	10	38
White	10,232	43,966
Multi-Racial	790	3,394
Total	**20,312**	**87,052**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	7,486	34,689
Female	12,826	52,363
Total	**20,312**	**87,052**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	7,981	41,726
Medicaid	4,269	17,526
Peachare	5	13
Third-Party	5,376	17,951
Self-Pay	1,767	6,109
Other	914	3,727

5. Discharges to Death

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

304

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2015 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,230
Semi-Private Room Rate	1,230
Operating Room: Average Charge for the First Hour	6,053
Average Total Charge for an Inpatient Day	9,141

Part E : Emergency Department and Outpatient Services

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

101,499

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

11,325

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

64

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	14,688
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	8	4,039
General Beds	41	64,216
Children	14	18,556
	0	0
	0	0
	0	0

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

2,122

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

80,606

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

5,078

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.

673

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	2	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	1	1
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	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	728
Number of Dialysis Treatments	5,322
Number of ESWL Patients	98
Number of ESWL Procedures	115
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	34
Number of Diagnostic X-Ray Procedures	89,957
Number of CTS Units (machines)	4
Number of CTS Procedures	32,974
Number of Diagnostic Radioisotope Procedures	25,233
Number of PET Units (machines)	0
Number of PET Procedures	0
Number of Therapeautic Radioisotope Procedures	54
Number of Number of MRI Units	3
Number of Number of MRI Procedures	7,200
Number of Chemotherapy Treatments	3,125
Number of Respiratory Therapy Treatments	299,991
Number of Occupational Therapy Treatments	20,781
Number of Physical Therapy Treatments	81,637
Number of Speech Pathology Patients	1,919
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	6,633
Number of HIV/AIDS Patients	30
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	8
Number of Ultrasound/Medical Sonography Procedures	51,828
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).

95

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	1,012	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 12-31-2015. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2015.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	1	0	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	660	69.900001525879	0
Licensed Practical Nurses (LPNs)	7	0.20000000298023	0
Pharmacists	31	2	0
Other Health Services Professionals*	692	42.200000762939	0
Administration and Support	549	25.299999237061	0
All Other Hospital Personnel (not included above)	251	59.099998474121	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
Pharmacists	61-90 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	56
Black/African American	37
Hispanic/Latino	14
Pacific Islander/Hawaiian	0
White	177
Multi-Racial	204

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	5	☐	5	5
General Internal Medicine	40	☑	34	34
Pediatricians	5	☑	5	5
Other Medical Specialties	150	☑	150	150

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	24	☑	24	24
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	23	☐	3	14
Ophthalmology Surgery	6	☐	1	3
Orthopedic Surgery	18	☐	18	18
Plastic Surgery	6	☐	3	3
General Surgery	6	☐	6	6
Thoracic Surgery	3	☐	3	3
Other Surgical Specialties	52	☐	52	25

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	14	☑	14	14
Dermatology	2	☐	1	0
Emergency Medicine	60	☑	60	60
Nuclear Medicine	0	☐	0	0
Pathology	8	☑	8	8
Psychiatry	11	☐	11	10
Radiology	44	☑	44	44
Pediactric Emergency	31	☑	31	31
Medicine	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	3
Podiatrists	10
Certified Nurse Midwives with Clinical Privileges in the Hospital	15
All Other Staff Affiliates with Clinical Privileges in the Hospital	348

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 Anestheist, Nurse Practioner, Physician Anesthesia Assistant, Physician Assistant

Comments and Suggestions:

Part E.4: The hospital used ICD9 and 10 codes to determine Trauma and 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. For example, the “Beds dedicated for Trauma” line item includes all trauma visits, including less severe trauma cases that were seen in general ED beds.

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.

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.

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	19	2	6	0	0	0	0	0	0	0	0	3
Appling	1	0	1	0	0	0	0	0	0	0	0	0	0
Baker	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	4	6	0	0	0	0	0	0	0	0	0	0	0
Bartow	80	44	8	13	0	0	0	0	0	0	0	0	2
Bibb	16	1	0	4	0	0	0	0	0	0	0	0	2
Brooks	1	0	0	0	0	0	0	0	0	0	0	0	0
Burke	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	5	2	0	3	0	0	0	0	0	0	0	0	0
Candler	1	1	0	0	0	0	0	0	0	0	0	0	0
Carroll	433	307	164	20	0	0	0	0	0	0	0	0	7
Catoosa	2	0	0	1	0	0	0	0	0	0	0	0	0
Chatham	6	0	0	1	0	0	0	0	0	0	0	0	0
Chattahoochee	4	0	0	0	0	0	0	0	0	0	0	0	0
Chattooga	9	4	0	1	0	0	0	0	0	0	0	0	1
Cherokee	199	114	11	70	0	0	0	0	0	0	0	0	2
Clarke	3	0	0	1	0	0	0	0	0	0	0	0	0
Clay	1	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	106	66	13	11	0	0	0	0	0	0	0	0	3
Cobb	12,218	3,615	1,692	813	0	0	0	0	0	0	0	0	146
Columbia	2	1	0	0	0	0	0	0	0	0	0	0	0
Coweta	25	32	1	5	0	0	0	0	0	0	0	0	0
Crawford	3	2	0	0	0	0	0	0	0	0	0	0	0
Dade	2	0	0	0	0	0	0	0	0	0	0	0	0
Dawson	6	1	0	2	0	0	0	0	0	0	0	0	0
DeKalb	132	63	17	25	0	0	0	0	0	0	0	0	3

Dodge	1	0	0	1	0	0	0	0	0	0	0	0	0
Dougherty	1	0	1	0	0	0	0	0	0	0	0	0	0
Douglas	2,709	1,386	805	231	0	0	0	0	0	0	0	0	63
Early	4	3	0	0	0	0	0	0	0	0	0	0	0
Elbert	1	1	0	0	0	0	0	0	0	0	0	0	0
Emanuel	1	0	0	1	0	0	0	0	0	0	0	0	0
Fannin	16	4	0	3	0	0	0	0	0	0	0	0	0
Fayette	21	19	4	4	0	0	0	0	0	0	0	0	1
Florida	76	6	2	6	0	0	0	0	0	0	0	0	1
Floyd	35	8	2	22	0	0	0	0	0	0	0	0	0
Forsyth	22	12	3	3	0	0	0	0	0	0	0	0	1
Franklin	1	0	0	1	0	0	0	0	0	0	0	0	0
Fulton	892	268	137	80	0	0	0	0	0	0	0	0	16
Gilmer	19	5	0	5	0	0	0	0	0	0	0	0	2
Gordon	26	12	0	7	0	0	0	0	0	0	0	0	0
Gwinnett	83	59	11	10	0	0	0	0	0	0	0	0	2
Habersham	10	1	0	3	0	0	0	0	0	0	0	0	0
Hall	18	12	0	6	0	0	0	0	0	0	0	0	0
Hancock	1	0	0	0	0	0	0	0	0	0	0	0	0
Haralson	90	53	30	14	0	0	0	0	0	0	0	0	1
Harris	1	2	0	0	0	0	0	0	0	0	0	0	0
Hart	2	0	1	0	0	0	0	0	0	0	0	0	0
Heard	3	11	0	0	0	0	0	0	0	0	0	0	0
Henry	46	34	5	5	0	0	0	0	0	0	0	0	1
Houston	3	5	1	2	0	0	0	0	0	0	0	0	0
Irwin	1	0	0	0	0	0	0	0	0	0	0	0	1
Jackson	5	3	0	1	0	0	0	0	0	0	0	0	0
Jones	2	1	0	0	0	0	0	0	0	0	0	0	0
Lamar	2	3	0	0	0	0	0	0	0	0	0	0	0
Liberty	1	1	1	0	0	0	0	0	0	0	0	0	0
Lowndes	2	2	0	1	0	0	0	0	0	0	0	0	0
Lumpkin	5	1	0	0	0	0	0	0	0	0	0	0	1
Macon	1	3	0	1	0	0	0	0	0	0	0	0	0
Madison	2	0	0	2	0	0	0	0	0	0	0	0	0
Meriwether	3	2	0	0	0	0	0	0	0	0	0	0	0
Miller	1	0	0	0	0	0	0	0	0	0	0	0	0
Monroe	3	3	1	0	0	0	0	0	0	0	0	0	1
Morgan	1	0	0	0	0	0	0	0	0	0	0	0	0
Murray	18	8	0	5	0	0	0	0	0	0	0	0	0
Muscogee	19	23	1	1	0	0	0	0	0	0	0	0	0
Newton	16	13	0	3	0	0	0	0	0	0	0	0	0
North Carolina	27	7	3	1	0	0	0	0	0	0	0	0	1
Other Out of State	125	14	8	13	0	0	0	0	0	0	0	0	4
Paulding	2,274	1,172	551	189	0	0	0	0	0	0	0	0	33

Peach	4	2	0	1	0	0	0	0	0	0	0	0	0
Pickens	17	12	0	8	0	0	0	0	0	0	0	0	0
Pierce	1	0	0	0	0	0	0	0	0	0	0	0	0
Pike	6	5	0	0	0	0	0	0	0	0	0	0	0
Polk	82	57	22	13	0	0	0	0	0	0	0	0	0
Putnam	1	1	0	0	0	0	0	0	0	0	0	0	0
Quitman	2	2	0	0	0	0	0	0	0	0	0	0	0
Rabun	6	0	0	5	0	0	0	0	0	0	0	0	0
Richmond	1	0	0	0	0	0	0	0	0	0	0	0	0
Rockdale	10	5	1	3	0	0	0	0	0	0	0	0	1
Schley	1	0	0	0	0	0	0	0	0	0	0	0	0
Screven	2	0	0	2	0	0	0	0	0	0	0	0	0
South Carolina	26	1	0	3	0	0	0	0	0	0	0	0	0
Spalding	14	12	0	7	0	0	0	0	0	0	0	0	2
Stephens	4	2	0	1	0	0	0	0	0	0	0	0	0
Tattnall	0	2	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
Tennessee	116	38	0	5	0	0	0	0	0	0	0	0	4
Thomas	3	0	0	1	0	0	0	0	0	0	0	0	0
Toombs	1	0	0	0	0	0	0	0	0	0	0	0	0
Towns	2	2	0	0	0	0	0	0	0	0	0	0	0
Troup	15	5	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	8	1	0	1	0	0	0	0	0	0	0	0	0
Upson	4	6	0	3	0	0	0	0	0	0	0	0	0
Walker	21	3	0	7	0	0	0	0	0	0	0	0	0
Walton	13	9	0	4	0	0	0	0	0	0	0	0	0
Ware	1	0	0	0	0	0	0	0	0	0	0	0	0
Washington	2	0	0	0	0	0	0	0	0	0	0	0	1
White	5	3	1	2	0	0	0	0	0	0	0	0	0
Whitfield	28	20	0	8	0	0	0	0	0	0	0	0	0
Wilkinson	1	0	0	0	0	0	0	0	0	0	0	0	0
Worth	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**20,312**	**7,626**	**3,500**	**1,675**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**308**

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	5,311	4,208	1,861
Cystoscopy	0	0	148	756
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**5,311**	**4,356**	**2,617**

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	5,110	4,074	1,766
Cystoscopy	0	0	146	750
Endoscopy	0	0	0	0
	0	0	0	0
Total	**0**	**5,110**	**4,220**	**2,516**

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	96
Black/African American	2,497
Hispanic/Latino	531
Pacific Islander/Hawaiian	3
White	4,226
Multi-Racial	263
Total	**7,626**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	911
Ages 15-64	5,166
Ages 65-74	998
Ages 75-85	466
Ages 85 and Up	85
Total	**7,626**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	2,869
Female	4,757
Total	**7,626**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,941
Medicaid	1,320
Third-Party	4,011
Self-Pay	354

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: 1,171

6. Total Live Births: 3,590

7. Total Births (Live and Late Fetal Deaths): 3,633

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 3,682

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)	46	3,239	5,989	12
Specialty Care (Intermediate Neonatal Care)	10	217	3,667	54
Subspecialty Care (Intensive Neonatal Care)	10	177	3,984	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	3	7
Asian	117	316
Black/African American	1,423	4,091
Hispanic/Latino	554	1,272
Pacific Islander/Hawaiian	1	2
White	1,235	3,334
Multi-Racial	167	435
Total	**3,500**	**9,457**

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

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	2	5
Ages 15-44	3,496	9,446
Ages 45 and Up	2	6
Total	**3,500**	**9,457**

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

$17,079.00

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

$27,289.00

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	33
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	1,675	7,505	1,669	7,492	3,003	☑
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

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

1. Race/Ethnicity

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

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	1	3
Asian	6	17
Black/African American	631	3,134
Hispanic/Latino	56	317
Pacific Islander/Hawaiian	0	0
White	929	3,795
Multi-Racial	52	239
Total	**1,675**	**7,505**

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	794	3,603
Female	881	3,902
Total	**1,675**	**7,505**

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	326	1,666
Medicaid	584	2,780
Third Party	752	3,014
Self-Pay	13	45
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? 1 (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):

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	4.78	85	0	0
Vietnamese	0.13	5	0	0
Creole	0.06	1	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?

Cultural competency education is provided to new leader orientation trainings.

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?

Reimbursement/assistance to fund these services.

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

1. English
2. Spanish
3. Braille
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?

Bethesda Community Clinic Inc., 107 Mountain Brook Drive, Suite #100, Canton, GA 30115
Clinica De La Salud Hispana, 969 Windy Hill Road, Suite #E, Smyrna, GA 30080
Family Health Centers of Georgia (Cobb), 805 Campbell Hill Street, Marietta, GA 30060
Family Health Centers of Georgia, *Main Office, 868 York Ave SW, Atlanta, GA 30310
Good Samaritan Health Center- Cobb , 1605 Roberta Drive SW, Marietta, GA 30008
Good Samaritan Health Center, 1015 Donald Lee Hollowell Parkway, Atlanta, GA 30318
Grassroots Dental, 4485 North Town Square, Suite #108, Powder Springs, GA 30127
Grassroots Medical, 5000 Austell Powder Springs Road, Suite #273, Austell, GA 30160
HEALing Community Center, 2600 Martin Luther King Jr. Drive SW, Atlanta, GA 30311
Horizon Medical Associates, 1680 Mulkey Road, Suite #E, Austell, GA 30106
Kool Smiles, P.C., 2900 South Cobb Drive, Suite #B-2, Smyrna, GA 30080
Life University Community Outreach Clinic, 1323 Roswell Road, Marietta, GA 30062
MedCare of Adairsville (Bartow County), 321-A North Main Street, Adairsville, GA 30103
Planned Parenthood Southeast - Cobb, 220 North Cobb Parkway, Suite # 500, Marietta, GA 30062
Senior Wellness Center , 1150 Powder Springs Street, Suite 100B, Marietta, GA 30064
Southside Medical Center, *Main Office, 1046 Ridge Avenue SW , Atlanta, GA 30315
WellStar Community Clinic at Kennestone, 52 Tower Road, Marietta, GA 30060
WellStar Community Clinic at Cobb, 1790 Mulkey Road, Suite 10, Austell, GA 30106
Cobb County Board of Health,1650 County Services Pkwy, Marietta, GA. 30008

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	3	24
Black/African American	105	1,177
Hispanic/Latino	17	215
Pacific Islander/Hawaiian	0	0
White	171	1,931
Multi-Racial	12	120

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	137	1,582
Female	171	1,885

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	1	9
18-64	149	1,604
65-84	139	1,654
85 Up	19	200

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	291
Long Term Care Hospital	15
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

IRF and Home	2

1. Payers

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

Primary Payment Source	Admissions
Medicare	181
Third Party/Commercial	64
Self Pay	10
Other	53

2. Uncompensated Indigent and Charity Care

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

18

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	118
2. Brain Injury	28
3. Amputation	22
4. Spinal Cord	17
5. Fracture of the femur	21
6. Neurological disorders	37
7. Multiple Trauma	17
8. Congenital deformity	0
9. Burns	12
10. Osteoarthritis	0
11. Rheumatoid arthritis	1
12. Systemic vasculidities	0
13. Joint replacement	7
All Other	28

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Candice Saunders

Date: 5/16/2016

Title: President and C.E.O.

Comments: