GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2016 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, 2016 through December 31, 2016.
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
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:** Ga

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

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

6. Check the box to the right if your hospital is a member of an alliance. ☑
Name: Voluntary Hospitals of America
City: Atlanta **State:** Ga

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

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

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

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(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)	68	5,472	17,339	5,477	17,249
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	21	720	1,727	719	1,724
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	436	22,685	118,567	22,657	119,206
Intensive Care	88	8,897	38,524	8,890	38,526
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	20	511	6,557	526	6,647
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	**633**	**38,285**	**182,714**	**38,269**	**183,352**

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	58	224
Asian	562	2,552
Black/African American	6,992	36,165
Hispanic/Latino	2,407	9,772
Pacific Islander/Hawaiian	14	31
White	26,801	126,611
Multi-Racial	1,451	7,359
Total	**38,285**	**182,714**

3. Gender

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

Gender	Admissions	Inpatient Days
Male	15,527	80,899
Female	22,758	101,815
Total	**38,285**	**182,714**

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	17,471	95,170
Medicaid	4,608	23,062
Peachare	33	51
Third-Party	12,378	47,112
Self-Pay	2,856	12,618
Other	939	4,701

5. Discharges to Death

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

865

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2016 (to the nearest whole dollar).

Service	Charge
Private Room Rate	1,292
Semi-Private Room Rate	1,292
Operating Room: Average Charge for the First Hour	6,454
Average Total Charge for an Inpatient Day	11,512

Part E : Emergency Department and Outpatient Services

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

142,428

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

22,708

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

84

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	25,372
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	10	5,722
General Beds	62	94,069
Childrens Beds	9	17,265
	0	0
	0	0
	0	0

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

3,391

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

213,603

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

12,383

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

1

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

1.00

10. Untreated Cases

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

1,185

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podatric Services	1	1
Renal Dialysis	2	1
ESWL	1	1
Billiary Lithotropter	3	4
Kidney Transplants	3	4
Heart Transplants	3	4
Other-Organ/Tissues Transplants	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	2	1
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	720
Number of Dialysis Treatments	5,646
Number of ESWL Patients	109
Number of ESWL Procedures	186
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	1
Number of Biliary Lithotripter Units	1
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	76
Number of Diagnostic X-Ray Procedures	220,548
Number of CTS Units (machines)	13
Number of CTS Procedures	99,188
Number of Diagnostic Radioisotope Procedures	9,624
Number of PET Units (machines)	1
Number of PET Procedures	2,616
Number of Therapeautic Radioisotope Procedures	932
Number of Number of MRI Units	8
Number of Number of MRI Procedures	23,699
Number of Chemotherapy Treatments	3,182
Number of Respiratory Therapy Treatments	598,316
Number of Occupational Therapy Treatments	73,053
Number of Physical Therapy Treatments	264,060
Number of Speech Pathology Patients	4,694
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	16
Number of HIV/AIDS Diagnostic Procedures	8,249
Number of HIV/AIDS Patients	31
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	62
Number of Ultrasound/Medical Sonography Procedures	56,608
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).

145

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	1,058	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 12-31-2016. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2016.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	2	0.5	0
Physician Assistants Only (not including Licensed Physicians)	0	0	0
Registered Nurses (RNs-Advanced Practice*)	1375	189.60000610352	5.5799999237061
Licensed Practical Nurses (LPNs)	13	1.3999999761581	0
Pharmacists	64	1.6000000238419	0
Other Health Services Professionals*	1545	89.5	2.460000038147
Administration and Support	1003	62.299999237061	0
All Other Hospital Personnel (not included above)	584	93.400001525879	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	Not Applicable
Registered Nurses (RNs-Advance Practice)	61-90 Days
Licensed Practical Nurses (LPNs)	31-60 Days
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	65
Black/African American	34
Hispanic/Latino	19
Pacific Islander/Hawaiian	0
White	296
Multi-Racial	323

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	7	☐	7	7
General Internal Medicine	63	☑	63	63
Pediatricians	49	☑	49	49
Other Medical Specialties	210	☑	210	210

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	37	☐	37	37
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	39	☐	3	39
Ophthalmology Surgery	6	☐	4	6
Orthopedic Surgery	30	☐	30	30
Plastic Surgery	12	☐	4	12
General Surgery	10	☑	10	10
Thoracic Surgery	2	☐	2	2
Other Surgical Specialties	102	☑	102	102

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	38	☑	38	38
Dermatology	1	☐	1	1
Emergency Medicine	50	☑	50	50
Nuclear Medicine	0	☐	0	0
Pathology	8	☑	8	8
Psychiatry	10	☐	4	0
Radiology	54	☑	54	54
Childrens Emergency Med	45	☑	45	45
	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	11
Certified Nurse Midwives with Clinical Privileges in the Hospital	18
All Other Staff Affiliates with Clinical Privileges in the Hospital	511

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 Psychologist, Nurse Anesthetist,Nurse Practitioner, Physician Anesthesia Assistant and Physician Assistant Nurse

Comments and Suggestions:

Part E.4: The hospital used ICD 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 do not show activities of Wellstar owned hospice facilities.In the 2015 AHQ,Diagnostic Radioisotope Procedures and Ultrasound/Medical Sonography Procedures were incorrectly reported by work load units.

G.3 Physicians who do not identify a race are listed as multi-racial.

All sections related to race: Patients who do not identify a race are listed as multi-racial.

Parts G.3 and G.4: The differences in the total number of physicians between these two categories are attributable to the physicians accounted for in G.4 who do not have admitting privileges; consistent with the survey instructions, those non-admitting physicians are not counted in G.3.

Part G.4: The reported number of physician providers enrolled in Medicaid/PeachCare and/or Public Employee Health Benefits Plan was derived from hospital billing records. The hospital expects that there are additional physicians on its medical staff who are enrolled in these programs but whom are not reflected in the survey count.

Perinatal Services Addendum Part C.1 and C.2: The mothers' admissions and inpatient days do not include ante-partum admissions and days.

‘Other’ Payor group is now being used, previously other was included with Third-Party.

In sections of the survey where MEDICAID is not listed as a payor choice, Medicaid is combined with OTHER.

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	119	26	3	0	0	0	0	0	0	0	0	0	2
BALDWIN	7	5	1	0	0	0	0	0	0	0	0	0	0
BANKS	3	0	0	0	0	0	0	0	0	0	0	0	0
BARROW	18	8	3	0	0	0	0	0	0	0	0	0	2
BARTOW	1,207	540	202	0	0	0	0	0	0	0	0	0	24
BEN HILL	1	0	0	0	0	0	0	0	0	0	0	0	0
BIBB	12	7	2	0	0	0	0	0	0	0	0	0	0
BRYAN	4	0	0	0	0	0	0	0	0	0	0	0	2
BULLOCH	7	1	0	0	0	0	0	0	0	0	0	0	0
BURKE	2	0	0	0	0	0	0	0	0	0	0	0	0
BUTTS	6	4	1	0	0	0	0	0	0	0	0	0	0
CALHOUN	0	1	0	0	0	0	0	0	0	0	0	0	0
CAMDEN	2	0	0	0	0	0	0	0	0	0	0	0	0
CANDLER	1	0	0	0	0	0	0	0	0	0	0	0	0
CARROLL	228	134	24	0	0	0	0	0	0	0	0	0	5
CATOOSA	6	4	1	0	0	0	0	0	0	0	0	0	0
CHATHAM	18	2	1	0	0	0	0	0	0	0	0	0	0
CHATTOOGA	8	3	0	0	0	0	0	0	0	0	0	0	0
CHEROKEE	5,654	2,693	828	0	0	0	0	0	0	0	0	0	63
CLARKE	10	5	0	0	0	0	0	0	0	0	0	0	0
CLAY	1	0	0	0	0	0	0	0	0	0	0	0	0
CLAYTON	92	52	6	0	0	0	0	0	0	0	0	0	0
COBB	23,007	7,591	3,343	0	0	0	0	0	0	0	0	0	267
COFFEE	3	2	0	0	0	0	0	0	0	0	0	0	0
COLQUITT	1	0	0	0	0	0	0	0	0	0	0	0	0
COLUMBIA	4	3	0	0	0	0	0	0	0	0	0	0	0
COOK	1	0	0	0	0	0	0	0	0	0	0	0	0

COWETA	64	26	3	0	0	0	0	0	0	0	0	0	4
CRAWFORD	2	0	0	0	0	0	0	0	0	0	0	0	0
CRISP	3	2	0	0	0	0	0	0	0	0	0	0	0
DADE	4	1	0	0	0	0	0	0	0	0	0	0	0
DAWSON	16	13	1	0	0	0	0	0	0	0	0	0	1
DECATUR	3	0	0	0	0	0	0	0	0	0	0	0	0
DEKALB	233	135	30	0	0	0	0	0	0	0	0	0	3
DODGE	2	1	0	0	0	0	0	0	0	0	0	0	0
DOUGHERTY	5	5	0	0	0	0	0	0	0	0	0	0	0
DOUGLAS	926	383	81	0	0	0	0	0	0	0	0	0	25
EFFINGHAM	2	0	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
FANNIN	83	33	3	0	0	0	0	0	0	0	0	0	0
FAYETTE	36	23	2	0	0	0	0	0	0	0	0	0	1
Florida	144	30	2	0	0	0	0	0	0	0	0	0	3
FLOYD	54	23	4	0	0	0	0	0	0	0	0	0	1
FORSYTH	60	45	12	0	0	0	0	0	0	0	0	0	1
FRANKLIN	5	0	0	0	0	0	0	0	0	0	0	0	0
FULTON	881	416	99	0	0	0	0	0	0	0	0	0	19
GILMER	275	87	12	0	0	0	0	0	0	0	0	0	7
GLASCOCK	0	1	0	0	0	0	0	0	0	0	0	0	0
GLYNN	4	1	0	0	0	0	0	0	0	0	0	0	0
GORDON	97	31	6	0	0	0	0	0	0	0	0	0	4
GRADY	1	0	0	0	0	0	0	0	0	0	0	0	0
GREENE	0	1	0	0	0	0	0	0	0	0	0	0	0
GWINNETT	174	88	28	0	0	0	0	0	0	0	0	0	3
HABERSHAM	3	3	0	0	0	0	0	0	0	0	0	0	0
HALL	20	12	3	0	0	0	0	0	0	0	0	0	0
HARALSON	53	21	6	0	0	0	0	0	0	0	0	0	0
HARRIS	10	1	0	0	0	0	0	0	0	0	0	0	1
HART	3	1	0	0	0	0	0	0	0	0	0	0	0
HEARD	21	2	0	0	0	0	0	0	0	0	0	0	2
HENRY	44	50	4	0	0	0	0	0	0	0	0	0	1
HOUSTON	15	4	1	0	0	0	0	0	0	0	0	0	0
IRWIN	1	0	0	0	0	0	0	0	0	0	0	0	0
JACKSON	3	4	0	0	0	0	0	0	0	0	0	0	0
JASPER	5	1	0	0	0	0	0	0	0	0	0	0	0
JEFF DAVIS	0	1	0	0	0	0	0	0	0	0	0	0	0
JEFFERSON	1	0	0	0	0	0	0	0	0	0	0	0	0
JENKINS	1	0	0	0	0	0	0	0	0	0	0	0	0
JOHNSON	1	0	0	0	0	0	0	0	0	0	0	0	0
JONES	2	2	0	0	0	0	0	0	0	0	0	0	0
LAMAR	8	2	0	0	0	0	0	0	0	0	0	0	0
LAURENS	2	0	0	0	0	0	0	0	0	0	0	0	0

LEE	0	3	0	0	0	0	0	0	0	0	0	0	0
LIBERTY	1	1	0	0	0	0	0	0	0	0	0	0	0
LOWNDES	4	1	0	0	0	0	0	0	0	0	0	0	0
LUMPKIN	4	1	0	0	0	0	0	0	0	0	0	0	0
MADISON	3	1	0	0	0	0	0	0	0	0	0	0	0
MARION	2	0	0	0	0	0	0	0	0	0	0	0	0
MCINTOSH	1	0	0	0	0	0	0	0	0	0	0	0	0
MERIWETHER	19	1	0	0	0	0	0	0	0	0	0	0	1
MILLER	4	0	0	0	0	0	0	0	0	0	0	0	1
MITCHELL	3	0	0	0	0	0	0	0	0	0	0	0	0
MONROE	4	2	0	0	0	0	0	0	0	0	0	0	0
MONTGOMERY	1	0	0	0	0	0	0	0	0	0	0	0	0
MORGAN	4	2	0	0	0	0	0	0	0	0	0	0	0
MURRAY	4	5	0	0	0	0	0	0	0	0	0	0	0
MUSCOGEE	22	3	0	0	0	0	0	0	0	0	0	0	0
NEWTON	30	12	2	0	0	0	0	0	0	0	0	0	0
North Carolina	61	28	0	0	0	0	0	0	0	0	0	0	2
OCONEE	1	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	426	77	15	0	0	0	0	0	0	0	0	0	9
PAULDING	3,031	1,589	666	0	0	0	0	0	0	0	0	0	39
PEACH	4	0	0	0	0	0	0	0	0	0	0	0	1
PICKENS	353	161	39	0	0	0	0	0	0	0	0	0	6
PIKE	10	1	0	0	0	0	0	0	0	0	0	0	0
POLK	116	54	26	0	0	0	0	0	0	0	0	0	0
PUTNAM	4	3	0	0	0	0	0	0	0	0	0	0	0
RABUN	6	2	0	0	0	0	0	0	0	0	0	0	0
RICHMOND	5	1	1	0	0	0	0	0	0	0	0	0	0
ROCKDALE	17	13	2	0	0	0	0	0	0	0	0	0	0
SEMINOLE	1	0	0	0	0	0	0	0	0	0	0	0	0
South Carolina	76	13	1	0	0	0	0	0	0	0	0	0	1
SPALDING	38	7	1	0	0	0	0	0	0	0	0	0	0
STEPHENS	3	1	0	0	0	0	0	0	0	0	0	0	0
SUMTER	3	0	0	0	0	0	0	0	0	0	0	0	1
TALBOT	2	0	0	0	0	0	0	0	0	0	0	0	0
TAYLOR	1	0	0	0	0	0	0	0	0	0	0	0	0
TELFAIR	0	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	86	29	3	0	0	0	0	0	0	0	0	0	0
TERRELL	0	1	0	0	0	0	0	0	0	0	0	0	0
TIFT	2	1	0	0	0	0	0	0	0	0	0	0	0
TOWNS	18	2	0	0	0	0	0	0	0	0	0	0	1
TREUTLEN	2	0	0	0	0	0	0	0	0	0	0	0	1
TROUP	118	9	1	0	0	0	0	0	0	0	0	0	5
TWIGGS	1	0	1	0	0	0	0	0	0	0	0	0	0
UNION	37	29	0	0	0	0	0	0	0	0	0	0	1

UPSON	2	0	0	0	0	0	0	0	0	0	0	0	0
WALKER	8	4	0	0	0	0	0	0	0	0	0	0	0
WALTON	19	11	1	0	0	0	0	0	0	0	0	0	0
WARE	1	0	0	0	0	0	0	0	0	0	0	0	0
WARREN	2	0	0	0	0	0	0	0	0	0	0	0	0
WASHINGTON	3	0	0	0	0	0	0	0	0	0	0	0	0
WHITE	8	4	0	0	0	0	0	0	0	0	0	0	1
WHITFIELD	22	13	0	0	0	0	0	0	0	0	0	0	0
WILCOX	1	0	1	0	0	0	0	0	0	0	0	0	0
WILKES	0	1	0	0	0	0	0	0	0	0	0	0	0
WILKINSON	1	0	0	0	0	0	0	0	0	0	0	0	0
WORTH	0	1	0	0	0	0	0	0	0	0	0	0	0
Total	**38,285**	**14,620**	**5,472**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**511**

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 OR/ 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	4,615	6,461	4,570	7,429
Cystoscopy	0	0	237	987
Endoscopy	0	0	0	0
Cardio-Vascular OR/ Vascular	1,326	0	753	496
Total	**5,941**	**6,461**	**5,560**	**8,912**

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	4,396	6,155	4,418	7,013
Cystoscopy	0	0	237	984
Endoscopy	0	0	0	0
Cardio-Vascular OR/ Vascular	1,279	0	731	480
Total	**5,675**	**6,155**	**5,386**	**8,477**

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	16
Asian	259
Black/African American	2,008
Hispanic/Latino	802
Pacific Islander/Hawaiian	8
White	11,011
Multi-Racial	516
Total	**14,620**

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	572
Ages 15-64	10,353
Ages 65-74	2,442
Ages 75-85	1,024
Ages 85 and Up	229
Total	**14,620**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	5,612
Female	9,008
Total	**14,620**

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	3,945
Medicaid	824
Third-Party	8,858
Self-Pay	993

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: 1,958

6. Total Live Births: 5,530

7. Total Births (Live and Late Fetal Deaths): 5,584

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 5,593

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	5,133	11,966	21
Specialty Care (Intermediate Neonatal Care)	16	158	3,704	126
Subspecialty Care (Intensive Neonatal Care)	8	293	4,134	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	9	21
Asian	160	431
Black/African American	1,085	3,625
Hispanic/Latino	906	2,473
Pacific Islander/Hawaiian	2	5
White	3,072	8,680
Multi-Racial	238	691
Total	**5,472**	**15,926**

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	4
Ages 15-44	5,465	15,900
Ages 45 and Up	6	22
Total	**5,472**	**15,926**

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

$17,724.00

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

$26,502.00

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? 5.1999998092651 (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): ☐

We only use Bilingual Hospital Staff whose language proficiency has been tested and who have received a certificate from a 40-hour medical interpretation training program

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	4.37	100	7	41
PORTUGUESE	0.14	5	0	3
Vietnamese	0.06	5	0	1

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?

a. There is a section on Interpretation and Culturally Competent care that is included in every new team members' employee orientation.
b. Cultural Competency education is also specifically provided to new leadership orientation trainings
c. WellStar created and offers to all staff, computer-based learning modules that instruct them on how to determine a patient's preferred language, obtain a qualified medical interpreter, how to work with an interpreter, and how to chart medical interpretation usage according to the CLAS standards.

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?

a. Video Remote Interpretation as an additional interpretation resource for our patient's
b. Additional educational tools such as webinars or computer tools that address and go beyond just the language needs of our patients, but also the Cultural Competency needs of our patients.

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

1. English
2. Spanish
3. 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	1	10
Asian	6	80
Black/African American	122	1,560
Hispanic/Latino	16	187
Pacific Islander/Hawaiian	0	0
White	350	4,447
Multi-Racial	16	236

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	266	3,404
Female	245	3,116

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	263	3,215
65-84	227	2,992
85 Up	21	313

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	491
Long Term Care Hospital	20
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	262
Third Party/Commercial	156
Self Pay	19
Other	74

2. Uncompensated Indigent and Charity Care

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

27

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	259
2. Brain Injury	77
3. Amputation	23
4. Spinal Cord	46
5. Fracture of the femur	11
6. Neurological disorders	49
7. Multiple Trauma	30
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	5
All Other	11

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: 3/7/2017

Title: President and C.E.O.

Comments: