GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2022 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP605

Facility Name: Wellstar West Georgia Medical Center

County: Troup

Street Address: 1514 Vernon Road

City: LaGrange

Zip: 30240

Mailing Address: 1514 Vernon Road

Mailing City: LaGrange

Mailing Zip: 30240

Medicaid Provider Number: 000002065A

Medicare Provider Number: 110016

2. Report Period

Report Data for the full twelve month period- January 1, 2022 through December 31, 2022.
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: James Satcher

Contact Title: Regulatory Planning Consultant

Phone: 470-991-1834

Fax: 770-509-4217

E-mail: james.satcher@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
Lagrange-Troup County Hospital Authority	Hospital Authority	10/1/2006

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
West Georgia Medical Center, Inc.	Not for Profit	10/1/2009

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Wellstar Health System, Inc.	Not for Profit	4/1/2016

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: Georgia Alliance of Community Health (GACH)
City: Tifton   **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)	16	720	1,765	722	1,772
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	109	5,948	27,053	5,917	27,011
Intensive Care	24	1,089	2,698	1,100	2,789
Psychiatry	0	0	0	0	0
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**149**	**7,757**	**31,516**	**7,739**	**31,572**

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	12	45
Asian	26	110
Black/African American	2,746	11,896
Hispanic/Latino	277	575
Pacific Islander/Hawaiian	6	37
White	4,569	18,449
Multi-Racial	121	404
Total	7,757	31,516

3. Gender

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

Gender	Admissions	Inpatient Days
Male	3,327	14,997
Female	4,430	16,519
Total	7,757	31,516

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	3,976	18,545
Medicaid	1,297	4,909
Peachare	0	0
Third-Party	1,505	5,076
Self-Pay	815	2,377
Other	164	609

5. Discharges to Death

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

183

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2022 (to the nearest whole dollar).

Service	Charge
Private Room Rate	2,409
Semi-Private Room Rate	2,409
Operating Room: Average Charge for the First Hour	9,470
Average Total Charge for an Inpatient Day	16,540

Part E : Emergency Department and Outpatient Services

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

57,792

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

6,378

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

34

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	4	726
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	4	492
General Beds	26	56,574
	0	0
	0	0
	0	0
	0	0

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

435

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

64,480

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

2,582

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

7.00

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.

307

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	3	4
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	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	3	4
HIV/AIDS Diagnostic Treatment/Services	1	1
Ambulance Services	3	4
Hospice	3	4
Respite Care Services	3	4
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

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

Category	Total
Number of Podiatric Patients	100
Number of Dialysis Treatments	2,058
Number of ESWL Patients	53
Number of ESWL Procedures	56
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	23
Number of Diagnostic X-Ray Procedures	39,161
Number of CTS Units (machines)	4
Number of CTS Procedures	23,601
Number of Diagnostic Radioisotope Procedures	754
Number of PET Units (machines)	1
Number of PET Procedures	366
Number of Therapeautic Radioisotope Procedures	7
Number of Number of MRI Units	1
Number of Number of MRI Procedures	3,422
Number of Chemotherapy Treatments	3,986
Number of Respiratory Therapy Treatments	114,784
Number of Occupational Therapy Treatments	4,935
Number of Physical Therapy Treatments	34,845
Number of Speech Pathology Patients	893
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	1,411
Number of HIV/AIDS Patients	39
Number of Ambulance Trips	0
Number of Hospice Patients	0
Number of Respite care Patients	0
Number of Ultrasound/Medical Sonography Units	6
Number of Ultrasound/Medical Sonography Procedures	9,242
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).

18

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	737	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 12-31-2022. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2022.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	0.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	0.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	370.00	27.00	5.70
Licensed Practical Nurses (LPNs)	32.00	3.00	0.00
Pharmacists	18.00	0.00	0.00
Other Health Services Professionals*	370.00	53.00	0.00
Administration and Support	373.00	18.00	2.60
All Other Hospital Personnel (not included above)	211.00	34.00	0.00

2. Filling Vacancies
Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	Not Applicable
Registered Nurses (RNs-Advance Practice)	More than 90 Days
Licensed Practical Nurses (LPNs)	More than 90 Days
Pharmacists	30 Days or Less
Other Health Services Professionals	More than 90 Days
All Other Hospital Personnel (not included above)	61-90 Days

3. Race/Ethnicity of Physicians
Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	98
Black/African American	97
Hispanic/Latino	12
Pacific Islander/Hawaiian	0
White	155
Multi-Racial	33

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	3	☐	3	3
General Internal Medicine	125	☑	125	125
Pediatricians	10	☑	10	10
Other Medical Specialties	104	☐	104	104

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	13	☑	13	13
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	7	☐	3	3
Ophthalmology Surgery	2	☐	2	2
Orthopedic Surgery	6	☐	6	6
Plastic Surgery	1	☐	1	1
General Surgery	5	☐	5	5
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	12	☐	12	12

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	0	☐	0	0
Emergency Medicine	32	☑	32	32
Nuclear Medicine	1	☐	1	1
Pathology	21	☑	21	21
Psychiatry	1	☐	1	1
Radiology	42	☑	42	42
	0	☐	0	0
	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 surgeons) with Admitting Privleges	5
Podiatrists	3
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	123

5b. Name of Other Professions

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

Advanced Practice Registered Nurse, Certified Registered Nurse Anesthetist - CRNA, Physician Assistants - Certified, Ceritfied Nurse Midwifery

Comments and Suggestions:

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	609	298	45	0	0	0	0	0	0	0	0	0	0
BARTOW	2	1	0	0	0	0	0	0	0	0	0	0	0
BIBB	2	3	0	0	0	0	0	0	0	0	0	0	0
BLECKLEY	1	0	0	0	0	0	0	0	0	0	0	0	0
BUTTS	43	0	0	0	0	0	0	0	0	0	0	0	0
CAMDEN	1	0	1	0	0	0	0	0	0	0	0	0	0
CARROLL	13	15	2	0	0	0	0	0	0	0	0	0	0
CHATHAM	2	0	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
CHEROKEE	0	1	0	0	0	0	0	0	0	0	0	0	0
CLARKE	1	0	1	0	0	0	0	0	0	0	0	0	0
CLAYTON	15	2	1	0	0	0	0	0	0	0	0	0	0
COBB	16	1	0	0	0	0	0	0	0	0	0	0	0
COFFEE	1	0	0	0	0	0	0	0	0	0	0	0	0
COLUMBIA	0	1	0	0	0	0	0	0	0	0	0	0	0
COWETA	139	73	15	0	0	0	0	0	0	0	0	0	0
DAWSON	1	1	0	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	10	0	0	0	0	0	0	0	0	0	0	0	0
DOOLY	0	1	0	0	0	0	0	0	0	0	0	0	0
DOUGLAS	5	1	2	0	0	0	0	0	0	0	0	0	0
EARLY	0	1	0	0	0	0	0	0	0	0	0	0	0
EFFINGHAM	2	1	0	0	0	0	0	0	0	0	0	0	0
FAYETTE	5	3	0	0	0	0	0	0	0	0	0	0	0
Florida	16	1	2	0	0	0	0	0	0	0	0	0	0
FLOYD	0	1	0	0	0	0	0	0	0	0	0	0	0
FORSYTH	4	1	0	0	0	0	0	0	0	0	0	0	0

County													
FULTON	27	6	6	0	0	0	0	0	0	0	0	0	0
GWINNETT	9	2	0	0	0	0	0	0	0	0	0	0	0
HABERSHAM	1	0	0	0	0	0	0	0	0	0	0	0	0
HALL	2	0	0	0	0	0	0	0	0	0	0	0	0
HANCOCK	1	0	0	0	0	0	0	0	0	0	0	0	0
HARALSON	1	1	0	0	0	0	0	0	0	0	0	0	0
HARRIS	268	144	18	0	0	0	0	0	0	0	0	0	0
HEARD	281	105	16	0	0	0	0	0	0	0	0	0	0
HENRY	23	3	0	0	0	0	0	0	0	0	0	0	0
HOUSTON	1	0	0	0	0	0	0	0	0	0	0	0	0
JASPER	1	1	0	0	0	0	0	0	0	0	0	0	0
LAMAR	14	2	0	0	0	0	0	0	0	0	0	0	0
LOWNDES	1	0	0	0	0	0	0	0	0	0	0	0	0
MACON	0	1	0	0	0	0	0	0	0	0	0	0	0
MERIWETHER	660	251	48	0	0	0	0	0	0	0	0	0	0
MITCHELL	0	1	0	0	0	0	0	0	0	0	0	0	0
MONROE	1	0	0	0	0	0	0	0	0	0	0	0	0
MORGAN	2	0	0	0	0	0	0	0	0	0	0	0	0
MUSCOGEE	26	28	3	0	0	0	0	0	0	0	0	0	0
NEWTON	5	1	0	0	0	0	0	0	0	0	0	0	0
North Carolina	4	0	1	0	0	0	0	0	0	0	0	0	0
Other Out of State	27	3	0	0	0	0	0	0	0	0	0	0	0
PAULDING	5	0	0	0	0	0	0	0	0	0	0	0	0
PICKENS	3	0	0	0	0	0	0	0	0	0	0	0	0
PIKE	8	6	2	0	0	0	0	0	0	0	0	0	0
POLK	1	1	0	0	0	0	0	0	0	0	0	0	0
PULASKI	1	0	0	0	0	0	0	0	0	0	0	0	0
QUITMAN	0	1	0	0	0	0	0	0	0	0	0	0	0
RABUN	1	0	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	1	1	0	0	0	0	0	0	0	0	0	0	0
South Carolina	2	0	0	0	0	0	0	0	0	0	0	0	0
SPALDING	40	11	2	0	0	0	0	0	0	0	0	0	0
STEWART	0	1	0	0	0	0	0	0	0	0	0	0	0
TALBOT	21	10	1	0	0	0	0	0	0	0	0	0	0
TAYLOR	0	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	5	2	0	0	0	0	0	0	0	0	0	0	0
TERRELL	1	0	0	0	0	0	0	0	0	0	0	0	0
TROUP	5,408	2,207	551	0	0	0	0	0	0	0	0	0	0
UNION	0	1	0	0	0	0	0	0	0	0	0	0	0
UPSON	15	12	2	0	0	0	0	0	0	0	0	0	0
WALTON	1	0	0	0	0	0	0	0	0	0	0	0	0
Total	**7,757**	**3,212**	**720**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

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

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	2	6
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	0
	0	0	0
Total	0	2	6

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	1,646	1,567	3,370
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	1,646	1,567	3,370

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	1,077	1,096	2,135
Cystoscopy	0	0	0	0
Endoscopy	0	0	0	0
	0	0	0	0
Total	0	1,077	1,096	2,135

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	3
Asian	17
Black/African American	988
Hispanic/Latino	86
Pacific Islander/Hawaiian	0
White	1,990
Multi-Racial	128
Total	**3,212**

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	676
Ages 15-64	1,809
Ages 65-74	459
Ages 75-85	218
Ages 85 and Up	50
Total	**3,212**

3. Gender
Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,339
Female	1,873
Total	**3,212**

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

Primary Payment Source	Number of Patients
Medicare	852
Medicaid	828
Third-Party	1,419
Self-Pay	113

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: 2

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 10

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 233

6. Total Live Births: 707

7. Total Births (Live and Late Fetal Deaths): 724

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 734

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)	20	589	1,026	0
Specialty Care (Intermediate Neonatal Care)	6	120	725	91
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	0	0
Asian	7	16
Black/African American	325	837
Hispanic/Latino	48	110
Pacific Islander/Hawaiian	1	3
White	313	750
Multi-Racial	26	49
Total	**720**	**1,765**

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	2
Ages 15-44	719	1,763
Ages 45 and Up	0	0
Total	**720**	**1,765**

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

$26,917.00

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

$34,547.00

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? 21 (FTE's)
What languages do they interpret?
Spanish, American Sign Language (ASL) , Mandarin

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): ☑

Contracted On-Site Interpreters, Video Interpretation via contracted services and in house call center.

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	50.5%	0	0	0
Korean	3.2%	0	0	0
Esperanto	1.2%	0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

It is Wellstar's policy that all medical information is effectively communicated to our patients in their

preferred language to ensure both patient autonomy and the quality and safety of their care. Every new Wellstar team member is educated during their employee orientation on interpretation and Culturally Competent care. Cultural Competency education is also provided in new leadership orientation training. Wellstar created and offers to all staff computer-based learning modules that instruct them on how to determine a patient's preferred language, obtain a qualified medical interpreter, how to work with an interpreter, and how to chart medical interpretation usage according to the CLAS standards. Wellstar is developing a comprehensive tool and other resources for physicians and Wellstar staff and currently provides CBL cultural competence training as a resource.

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?

Resources for patients who are low vision/blind.
 The ability to respond to patients in MyChart in their preferred language.
 The external website available in multiple languages

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?

West Georgia Primary Care, LaGrange, GA
 LaGrange Personal Aid Association, LaGrange, GA
 Troup Cares, LaGrange, GA

Comprehensive Inpatient Physical Rehabilitation Addendum

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

1. Admissions and Days of Care by Race
Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

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

2. Admissions and Days of care by Gender
Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort
Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source
Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

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

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care
Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code
Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

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

Electronic Signature

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

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

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inccaccurate 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: 3/9/2023

Title: President and C.E.O.

Comments:

Part E.4 - Part E.4 - The hospital used Trauma Registry codes to determine Trauma cases. The hospital used ICD-10 codes to determine psych patients used 0-17 for peds patients and all other were general ED beds for survey reporting purposes. The visit data reflects the types of cases that relate to the described bed/room type, regardless of where in the emergency department the patient took place.

Part E.8 the hospital is not able to track diverted cases.

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 multiracial. All sections related to race: patients who do not identify a race are listed as multiracial.

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 not reflected in the survey count.

Perinatal Services Addendum:
Part C.1 and C.2: the mother's admission and inpatient days do not include antepartum admissions and days.

Minority Health Addendum: The Interpreters are shared across all Wellstar Health System hospitals.