

2007 HOSPITAL FINANCIAL SURVEY FOR HOSPITAL FISCAL YEARS ENDING DURING 2007

- IMPORTANT NOTICE ABOUT SURVEY COMPLETION and ACCURACY -

The information and data collected through this survey are used for state regulatory, planning, and reimbursement purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important.

This survey is required under O.C.G.A. § 31-6-70 and DCH Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may adversely affect CON and ICTF determinations. Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

2007 HOSPITAL FINANCIAL SURVEY

The 2007 Hospital Financial Survey (HFS) and Indigent Care Trust Fund Addendum can be completed using an online interface. Microsoft Access databases will no longer be used to collect survey information. Providers of cardiac catheterizations may access the online survey by pointing their web browser to <http://www.georgiahealthdata.info/>. Notification letters were mailed to facility administrators regarding the 2007 HFS which included a unique facility identification number (UID) and a facility password. Both the UID and password will be needed to access and complete your survey. Instructions for accessing and completing the web-based survey are provided at the Health Planning Surveys web interface (<http://www.georgiahealthdata.info/>).

The deadline for filing the completed webform for your facility is March 27, 2009.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. Generally, the survey will be deemed complete on the day it is received by DCH. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date.

Copy of Completed Survey – The webform allows for printing (or saving) at completed copy of the survey. It is extremely important that you retain a copy of your completed survey. You must have your browser's pop-up blocker turned off for our website for the save and print feature to function properly.

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(d) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

Data Validation Requirements – The webform checks various totals as the survey is completed. Once the survey is complete and signed all edit and balance requirements will be checked before the survey is accepted.

PART A: GENERAL INFORMATION

Respond as requested. Please be sure to provide both the hospital's Medicaid and Medicare provider numbers. The hospital's name should appear as it was on the last day of the report period.

Report Period: The report period is the hospital's fiscal year that ended during calendar year 2007. Please make sure this section reflects beginning and ending dates of the hospital fiscal year. Generally, the fiscal year covered should agree with the report period covered in the hospital's cost report.

PART B: SURVEY CONTACT INFORMATION

Provide the name, title, and phone numbers of the person authorized to respond to inquiries about the responses to the survey. This person must retain a copy of the completed survey.

PARTS C - F: FINANCIAL DATA AND INDIGENT AND CHARITY CARE

These parts of the survey must be completed by all hospitals. The data is required for health planning and certificate of need purposes pursuant to Chapter 6 of Title 31 of the Official Code of Georgia Annotated. O.C.G.A. § 31-6-70 outlines the requirement for the collection of certain data elements:

§ 31-6-70 (b) The report required under subsection (a) of this Code section shall contain the following information:

- (1) Total gross revenues;*
- (2) Bad debts;*
- (3) Amounts of free care extended, excluding bad debts;*
- (4) Contractual adjustments;*
- (5) Amounts of care provided under a Hill-Burton commitment;*
- (6) Amounts of charity care provided to indigent persons;*
- (7) Amounts of outside sources of funding from governmental entities, philanthropic groups, or any other source, including the proportion of any such funding dedicated to the care of indigent persons; and*
- (8) For cases involving indigent persons:*
 - (A) The number of persons treated;*
 - (B) The number of inpatients and outpatients;*
 - (C) Total patient days;*
 - (D) The number of patients categorized by county of residence;**and*
 - (E) The indigent care costs incurred by the hospital by county of residence.*

What to Include in HFS Financials:

Parts C-F of the survey should include financial data for the hospital only. You should exclude financial data from all other healthcare facilities operated by the hospital or the system. As a general rule, you should include financial data for services or programs that are operated under the hospital's license. Revenues associated with swing beds should be included, regardless of whether service was charged at hospital or nursing home rates.

What to Exclude from HFS Financials:

Financial data for hospital-based and other nursing home facilities, hospice, home health agencies, freestanding ambulatory surgery programs and primary care/physician offices should not be included in these sections of the survey.

PART C: FINANCIAL DATA ELEMENTS

Definitions and descriptions for each of the financial data elements, and certain calculations that result from this data, are included in the Glossary, which follows these instructions. The definitions are listed in the order in which the data element appears in the survey. Following each definition, as appropriate, are potential sources for the data element and possible reconciling items. Each hospital should evaluate its own cost reports, audits, and other financial records to determine the most accurate source for completing this survey. The information submitted in this survey is subject to compliance review and potential audit by the Department.

Important Note: While the financial data requested in the Hospital Financial Survey is based in general on AICPA guidelines, there are specific differences in the presentation of the data and the reporting requirements. In the case of a conflict, please use the reporting instructions and definitions provided for the Hospital Financial Survey.

Reference Material: The Healthcare Financial Management Association (www.hfma.org) provides guidance and resource materials that may assist hospitals with various financial management practices and principles. The following statements, in particular, address issues of relevance to the Hospital Financial Survey:

P & P Board Statement 15: Valuation and Financial Statement Presentation of Charity Service and Bad Debts by Institutional Health Care Providers

P & P Board Statement 16: Classifying, Valuing, and Analyzing Accounts Receivable Related to Patient Services

PART D. INDIGENT/CHARITY CARE POLICIES

IMPORTANT NOTE: The basis for determining qualification for indigent and/or charity care are the Federal Poverty Guidelines (FPG), which are established annually by the U.S. Department of Health and Human Services. The guidelines are available at the department website (www.dch.ga.gov). Hospital indigent and charity care policies should incorporate the most recent guidelines and income levels, in force at the time the determination for indigent and charity care was made, to be used in determining eligibility for services.

Indigent and Charity Care Policy Filing Requirements:

If your hospital had a formal written policy(ies) concerning the provision of indigent and charity care during the 2007 reporting period (as reflected in the answers to the questions in Part D of the survey), **you are required to file a copy of your policy(ies) with the Department** for 2007. Further, the charity care policy of the hospital guides the provision of such services and such a policy is required in order to allow the hospital to attribute any charges to charity care. A hospital that indicates on the survey that it has an indigent and/or charity care policy or that documents the provision of charity care must file a copy of the policy(ies) with the Division of Health Planning. These policies are a matter of public record and a required component of the Hospital Financial Survey.

Please complete all items in Part D. Please note Part D, Question 5, which requires the hospital to detail the range of coverage provided under any established charity policy. In this section, the hospital should provide the upper level percentage of Federal Poverty Guidelines (FPG) for an individual or family that would be considered for charity care (e.g., 185%, 200%, 250%, etc.). The lowest threshold for charity care must always be above 125% of FPG. (For hospitals receiving ICTF funds, patients are considered medically indigent and eligible for charity services supported by ICTF funds if their income falls between 125% and 200% of FPG.) Responses in this section will be validated against the charity policy(ies) filed with the Department.

How to File Indigent and Charity Care Policies:

Please e-mail, fax, or send a copy of the following policies to the Division of Health Planning to the following:

Attn: Jacqueline Wayman
Georgia Department of Community Health
Division of Health Planning
#2 Peachtree Street NW; 5th Floor
Atlanta, GA 30303
EMAIL: jwayman@dch.ga.gov FAX: 404-656-0654

Please be sure that the transmittal reflects the name of your hospital, your formal written indigent/charity care policy or policies, and any agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during the 2007 reporting period.

PART E: INDIGENT AND CHARITY CARE REPORTING

For Part E, Question 1, please report Gross Charges associated with Inpatient and Outpatient Care for persons qualifying for Indigent Care (in accordance with state law) or Charity Care (in accordance with hospital policy).

For Part E, Question 2, please report by category all compensation received by the hospital to offset the cost of providing indigent or charity care. These amounts should include any direct compensation from local governments, hospital authority proceeds and private or charitable contributions. Further, hospitals should include funding provided by state programs (e.g., state cancer aid, vocational rehabilitation, etc.) if the patients receiving the state-funded service met the qualification for indigent or charity care. ***Indigent Care Trust Fund monies should not be included as state program funds and should not be included in this section or elsewhere in the Hospital Financial Survey. ICTF monies should be accounted for on the ICTF Addendum.***

PART F. TOTAL INDIGENT AND CHARITY CARE BY COUNTY

Please report, by patient's county of residence, the number of inpatient and outpatient admissions/visits and related charges that may be attributed to persons qualifying for indigent and charity care as reported in Part E.

VALIDATION OF BALANCES IN PARTS C – F:

Total uncompensated (net) Indigent Care plus uncompensated (net) Charity Care as reflected in Part C should equal the net of Gross Indigent and Charity Care (Part E, Question 1) less all compensation received for such services (Part E, Question 2).

Gross Inpatient and Outpatient Charges (Part E, Question 1) should equal Inpatient and Outpatient Charges by Indigent and Charity Care category reported in Part F.

SIGNATURE PAGE

The Signature Page is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. Additionally, the chief financial officer may sign the signature page. An electronic manually entered version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Page also will identify any out of balance edit checks and any validation rule criteria that are not correct. All edit and balance requirements and all required fields must be completed before the survey can be submitted.

Be sure to click the "Submit" button when the survey is complete and ready to be submitted to DCH. This will lock the survey as complete and no additional changes can be made unless DCH unlocks the survey.

HOSPITAL FINANCIAL SURVEY – GLOSSARY OF TERMS

DATA ELEMENTS IN PART C

GROSS PATIENT REVENUE (INPATIENT AND OUTPATIENT)

Inpatient Gross Patient Revenue - Room and board charges as well as ancillary charges for individuals registered as inpatients of the hospital.

Outpatient Gross Patient Revenue - Charges for individuals registered as outpatients of the hospital.

Gross patient service revenue should be reported on the basis of the gross charges to patients without consideration of contractual or other reductions. Patient service revenue should include only hospital services. Examples of exclusions from patient service revenues for the purposes of the Hospital Financial Survey are Nursing Facility Revenues and Home Health Agency Revenues.

Potential sources for patient service revenue are:

- i) Audited financial statements
- ii) Medicare Cost Report Worksheets
 - (1) Worksheet C
 - (2) Worksheet G-2
 - (3) Worksheet G-3
- iii) Internal financial statements or other internal records
- iv) Reported revenues from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.

Please do not include any UPL payments (gross or net) under patient revenue. Net UPL payments should be included as a reduction to Medicaid contractual adjustments.

CONTRACTUAL ADJUSTMENTS

Contractual adjustments represent any charges that are not paid by the third-party payers and cannot be billed to the patient pursuant to contractual agreements. Contractual adjustments for Medicare, Medicaid/PeachCare for Kids™ and other payers are reported separately in the Hospital Financial Survey.

Medicaid, Medicaid Care Management Organization (CMO), and PeachCare for Kids™ Contractual Adjustments should be reported without any reduction (positive offset) for net or gross monies received from the Indigent Care Trust Fund. Further, in the case of any other intergovernmental transfers related to Medicaid payments (frequently referred to as UPL payments), the net payments only should be considered a positive offset to Contractual Adjustments.

PeachCare for Kids™ and Medicaid CMOs/Medicaid managed care contractual adjustments can be counted with Medicaid Contractual Adjustments. Medicare Managed Care can be included with Medicare Contractual Adjustments.

Potential sources for contractual adjustments are:

- a) Supporting schedules for audited financial statements
- b) Internal financial statements or other internal records
- c) Contractual adjustments from the above sources may require adjustment for purposes of the Hospital Financial Survey.
 - i) Potential reconciling items:
 - (1) Noncovered charges eligible for treatment as indigent, charity or bad debt categories.
 - (2) Contractual adjustments for services to other than hospital patients.

DATA ELEMENTS IN PART C (CONTINUED):

HILL-BURTON OBLIGATIONS

Hill-Burton obligations reflect revenue forgone at full, established rates for uncompensated care provided under the hospital's Hill-Burton obligation, if any. Note that, for purposes of the HFS, Hill-Burton care is reported as a deduction from gross patient revenue, even though it may be disclosed only in the notes of the hospital's financial statement. Further note that care provided under a Hill-Burton obligation may not be considered indigent and charity care on the HFS and may not be counted in meeting an indigent or charity care commitment.

- 1) Amounts of care provided under a Hill-Burton commitment should be obtained from the Hill-Burton reports applicable to the hospital's fiscal year.
- 2) The amount of care provided to other than hospital patients should not be reported.
- 3) Potential sources for Hill-Burton obligations are:
 - a) Hill-Burton reports
 - b) Supporting schedules for audited financial statements
 - c) Internal financial statements or other internal records.

BAD DEBT

Bad debt is all hospital patient charges due from patients or other responsible parties which have not been or are not expected to be collected for patients identified as having income levels greater than 125% of Federal Poverty Guidelines (FPG) and which are not otherwise categorized as charity care, contractual adjustments, Hill-Burton, or other free care for the purposes of the HFS. Indigent and charity care are provided to patients with a demonstrated inability to pay as documented in accordance with state law and hospital policy. Charity care charges can only be reported as Bad Debt when the patient fails to pay an amount for which he/she was to be responsible such as part of a sliding fee scale charity care policy. Bad debt results from the unwillingness of a patient to pay the charges for which the patient is responsible;

Definitions

- a) An amount that some party has an obligation to pay but that is not collected. Bad debts represent the portion of a patient's account not collected from the patient or other responsible party (the patient's portion).
- b) The patient's portion of a bill should not be categorized or treated as a bad debt for patients whose income is less than or equal to 125% of the federal poverty guidelines unless the patient is paying for the service.
- c) Bad debts must be differentiated from charity services. Patients otherwise eligible for classification as charity care cases should be included in the bad debt category if all conditions of the charity care definition are not met.
- d) Charges for Medicare, Medicaid and other third-party payers not qualifying for treatment as contractual adjustments may be classified as bad debts if not categorized as indigent or charity.

Potential sources for bad debts are:

- a) Audited financial statements
- b) Internal financial statements or other internal records
- c) Reported bad debts from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.
- d) Potential reconciling items:
 - i) Bad debts eligible for treatment as charity or Hill-Burton write-offs which might otherwise qualify as bad debt had the individual not met the definition and received services in accordance with indigent, charity or Hill-Burton policies.

IMPORTANT NOTE: For the Hospital Financial Survey, bad debt is reported as a deduction from patient revenue. As such, when reporting Total Expenses, please DO NOT include Bad Debt as an expense.

DATA ELEMENTS IN PART C (CONTINUED):

INDIGENT CARE

Indigent care is defined as revenue forgone for services to income tested patients whose individual or family income is less than or equal to the 125% of the Federal Poverty Guidelines (FPG). Optimally, the patient's ability to pay should be evaluated at the time of hospital admission and the patient should be advised that he or she qualifies for indigent care. In certain instances, such notification and classification may be withheld pending additional information from the patient to the hospital accounts office. The accounts of patients classified as indigent will generally be kept in a separate log. Patient accounts generally should be classified as indigent care at the time of admission or shortly thereafter. Once classified as indigent due to the patient's inability to pay for services, these accounts should never be turned over to a collection agency.

- 1) Unpaid (and, generally, unbilled) charges for services to income tested patients whose family income is less than or equal to 125% of the Federal Poverty Guidelines are reported as indigent.
- 2) Potential sources for contractual adjustments are:
 - a) Supporting schedules for audited financial statements
 - b) Internal financial statements or other internal records
 - c) Indigent logs.
- 3) Potential reconciling items:
 - a) Write-offs of services to other than hospital patients.

Please note: The Indigent Care amount reported in Part C should reflect Uncompensated (net) Indigent Care. The uncompensated Indigent and Charity Care figures reported in Part C, when combined, should balance to the calculated net indigent and charity care balance in Part E (Gross Charges Less Compensation Received).

CHARITY CARE

Charity care is defined as revenue forgone for services to income tested patients whose individual or family income is greater than 125% of the Federal Poverty Guidelines (FPG) and whose charges for such services were written off to a valid charity account in the hospital's accounting records pursuant to a formal and official written charity policy. Frequently, charity policies provided for a sliding fee scale, which allows for a portion of the charges to be written off to charity care while the patient remains responsible for payment of the remainder of the charges. The charity policy should outline the financial and other qualifications of patients for waiver of some or all of the charges for services provided. Patients should be apprised of the provisions of any charity care policy prior to services being rendered and, optimally, the patient's ability to pay should be evaluated at the time of admission into service and the patient should be advised if he or she qualifies for charity care. In certain instances, such notification and classification may be withheld pending additional information from the patient to the hospital accounts office. The accounts of patients classified as charity care will generally be kept in a separate log. The portion of a patient's bill that is recognized for charity care due to the inability to pay for services should never be turned over to a collection agency.

Definitions:

- a) Charity care represents health care services that are provided but payment is not expected.
- b) Charity care is provided to a patient with demonstrated inability to pay.
- c) Only the portion of a patient's account that meets the organization's charity care criteria is recognized as charity.
- d) Charity care is defined as:
 - i) Unpaid charges for services to income tested patients whose family income is greater than 125% of the Federal Poverty Guidelines, and
 - ii) Have been provided in accordance with the hospital's formal written charity care policy, and
 - iii) Have been written off to a formal charity account in the hospital's accounting records.

Potential sources for charity care are:

- a) supporting schedules for audited financial statements
- b) Internal financial statements or other internal records
- c) Charity logs or other detail reports.

Potential reconciling items:

- a) Write-offs of services to other than hospital patients.

DATA ELEMENTS IN PART C (CONTINUED):

OTHER FREE CARE

- 1) Other free care includes uncompensated services as a result of employee discounts, administrative discounts, courtesy discounts, or other similar discounts not based on a patient's inability or unwillingness to pay or on contractual agreements with third-party payers.
- 2) Potential sources for free care are:
 - a) Supporting schedules for audited financial statements
 - b) Internal financial statements or other internal records.
- 3) Other free care from the above sources may require adjustment for purposes of the Hospital Financial Survey.

NOTE ON DATA CALCULATIONS: For purposes of the Hospital Financial Survey Contractual Adjustments, Hill Burton Obligations, Bad Debt, Uncompensated Indigent Care, Uncompensated Charity Care, and Other Free Care are considered reductions from (or offsets to) gross revenues.

OTHER REVENUES/GAINS

Definitions

- a) Other revenues/gains are derived from services other than providing services to patients.
- b) Other revenues/gains should include those revenues reported in the audited financial statements as other operating revenue, other revenue and non-operating revenue.

Examples of other revenues/gains are:

- a) Interest and dividends
- b) Rental of health care facility space.
- c) Sales of medical and pharmaceutical supplies to employees, physicians and others.
- d) Proceeds from sale of cafeteria meals and guest trays to employees, medical staff and visitors.
- e) Proceeds from the sale of scrap.
- f) Proceeds for sales at gift shops, parking lots and other service facilities operated by the hospital.

If other operating revenues, other revenue or non-operating revenues are shared with entities other than the hospital, the revenues should be allocated between the entities using an appropriate allocation method. **Indigent Care Trust Fund payments of any type should be excluded from this category.**

Potential sources for the above revenues are:

- a) Audited financial statements
- b) Medicare Cost Report Worksheets
 - i) Worksheet G-3
- c) Internal financial statements or other internal records
- d) Reported revenues from the above sources will likely require adjustment for purposes of the Hospital Financial Survey.

TOTAL EXPENSES

Definitions

- a) The sum of resources consumed in fulfillment of a hospital's ongoing major or central operations. Expenses may result from current expenditures, incurring obligations to make future expenditures, or consuming resources obtained from previous expenditures.
- b) Expenses associated with non-hospital services should be excluded from the Survey.
- c) Expenses related to activities shared with entities other than the hospital should be allocated between the entities. The expense component not allocated to the hospital should be eliminated from the Survey.
- d) Appropriate matching of the revenues and expenses excluded from the Survey should be made.

Potential sources for operating expenses are:

- e) Audited financial statements
- f) Medicare Cost Report Worksheets
 - i) Worksheet A
- g) Internal financial statements or other internal records.

Do not include Bad Debt as an expense. Bad Debt should be reported as a deduction from revenue.

HOSPITAL FINANCIAL SURVEY -- CALCULATIONS

ADJUSTED GROSS REVENUE: Adjusted Gross Revenue (AGR) is calculated by subtracting Medicaid and Medicare contractual adjustments *only* and bad debt from the hospital's total gross revenues. AGR is used as the basis for determining a hospital's level of uncompensated indigent and charity care services. Generally, these figures are presented as a percentage of the hospital's AGR. For those hospitals that have a CON commitment to provide indigent and charity care, the commitment (usually expressed as a percentage) is multiplied by the AGR to calculate the amount of uncompensated indigent and charity care that the hospital is required to provide.

COST TO CHARGE RATIO: Cost to Charge Ratio is calculated by dividing total operating expenses by gross patient revenue. The figure, generally expressed as a percentage, represents the relationship between the hospital's reported operating expenses to the patient charges for services during a common reporting period.

MARGIN: For purposes of the HFS, Margin is calculated by subtracting total expenses from total net revenues. The Margin is frequently used as one proxy for the financial health and stability of the facility. It is important to note that the HFS does not represent itself as an audited financial statement nor is the HFS designed to assess institutional or system stability or viability. However, hospitals should recognize that the data is used by associations, public officials and the media for these purposes.

MARGIN PERCENT: The margin percent represents margin as a percentage of total net revenues. It is calculated by dividing the margin by the total net revenues.

NET PATIENT REVENUE: This figure represents Gross Patient Revenue less reported deductions from revenues.

TOTAL GROSS REVENUE: Total Gross Revenue is the sum of Gross Patient Revenue plus any other revenues or gains.