GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP327

Facility Name: North Fulton Regional Hospital

County: Fulton

Street Address: 3000 Hospital Boulevard

City: Roswell

Zip: 30076-9930

Mailing Address: 3000 Hospital Boulevard

Mailing City: Roswell

Mailing Zip: 30076-9930

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2008 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2008 To:12/31/2008

Please indicate your cost report year.
From: 01/01/2008 To:12/31/2008

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: Mike O'Hare

Contact Title: Assistant Controller

Phone: 770-751-2592

Fax: 770-751-2796

E-mail: Mike.OHare@Tenethealth.com

Part C : Financial Data and Indigent and Charity Care

1. Financial Table

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
Inpatient Gross Patient Revenue	462,908,783
Total Inpatient Admissions accounting for Inpatient Revenue	8,869
Outpatient Gross Patient Revenue	284,758,043
Total Outpatient Visits accounting for Outpatient Revenue	68,660
Medicare Contractual Adjustments	227,491,297
Medicaid Contractual Adjustments	57,294,159
Other Contractual Adjustments:	236,649,375
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	19,192,443
Uncompensated Indigent Care (net):	9,591,369
Uncompensated Charity Care (net):	9,228,832
Other Free Care:	44,836,350
Other Revenue/Gains:	182,215
Total Expenses:	126,356,082

2. Types of Other Free Care

Please enter the amount for each type of other free care. The amounts entered here must equal the total "Other Free Care" reported in Part C. Question 1. Use the blank line to indicate the type description and amount for other free care that is not included in the types listed.

Other Free Care Type	Other Free Care Amount
Self-Pay/Uninsured Discounts	0
Admin Discounts	0
Employee Discounts	0
	0
Total	**0**

Part D : Indigent/Charity Care Policies and Agreements

1. Formal Written Policy

Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during 2008? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2008?

06/01/2001

3. Person Responsible

Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.?

Director of Business Services

4. Charity Care Provisions

Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)? (Check box if yes.) ☑

5. Maximum Income Level

If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?

300

6. Agreements Concerning the Receipt of Government Funds

Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during 2008? (Check box if yes.) ☐

Part E : Indigent And Charity Care

1. Gross Indigent and Charity Care Charges

Please indicate the totals for indigent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	8,894,849	3,896,349	12,791,198
Outpatient	696,520	5,332,483	6,029,003
Total	**9,591,369**	**9,228,832**	**18,820,201**

2. Sources of Indigent and Charity Care Funding

Please indicate the source of funding for indigent and/or charity care in the table below.

Source of Funding	Amount
Home County	0
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	0
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**0**

3. Net Uncompensated Indigent and Charity Care Charges

Total net indigent care must balance to Part C net indigent care and total net charity care must balance to Part C net charity care.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**

Part F : Patient Origin

1. Total Gross Indigent/Charity Care By Charges County

Please report Indigent/Charity Care by County in the following categories. For non Georgia use Alabama, Florida, North Carolina, South Carolina, Tennessee, or Other-Out-of-State.
To add a row press the button. To delete a row press the minus button at the end of the row.
(You may enter the data on the web form or upload the data to the web form using the .csv file.)

Inp Ad-I = Inpatient Admissions (Indigent Care)
Inp Ch-I = Inpatient Charges (Indigent Care)
Out Vis-I = Outpatient Visits (Indigent Care)
Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)
Inp Ch-C = Inpatient Charges (Charity Care)
Out Vis-C = Outpatient Visits (Charity Care)
Out Ch-C = Outpatient Charges (Charity Care)

County	Inp Ad-I	Inp Ch-I	Out Vis-I	Out Ch-I	Inp Ad-C	Inp Ch-C	Out Vis-C	Out Ch-C
Alabama	0	0	2	668	3	35,743	11	5,001
Baldwin	0	0	0	0	1	7,676	0	0
Barrow	0	0	0	0	0	0	9	6,467
Bartow	0	0	0	0	0	0	15	10,530
Bibb	0	0	0	0	0	0	5	1,850
Bleckley	0	0	0	0	0	0	1	1,351
Butts	0	0	0	0	0	0	1	726
Camden	0	0	0	0	0	0	1	250
Carroll	0	0	0	0	0	0	7	2,701
Catoosa	0	0	0	0	0	0	2	800
Chatham	0	0	0	0	0	0	1	726
Cherokee	12	495,860	4	55,889	14	134,871	521	495,273
Clarke	0	0	0	0	0	0	2	1,901
Clayton	2	56,603	0	0	2	26,091	31	27,246
Cobb	5	674,856	3	23,857	8	65,632	280	279,743
Columbia	0	0	0	0	0	0	1	250
Coweta	0	0	1	9,954	0	0	2	2,125
Crisp	0	0	0	0	0	0	1	2,524
Dawson	4	158,949	4	10,716	1	7,800	52	46,805
DeKalb	16	919,357	14	92,735	21	550,524	668	568,985
Dooly	0	0	0	0	0	0	1	250
Dougherty	0	0	0	0	0	0	3	1,676
Douglas	0	0	0	0	0	0	12	14,344
Fannin	0	0	1	22,021	0	0	1	400
Fayette	0	0	0	0	0	0	2	650
Florida	1	120,702	1	7,748	1	8,734	27	23,190
Floyd	0	0	0	0	0	0	1	1,800
Forsyth	7	347,128	7	66,008	8	71,337	261	252,569
Franklin	0	0	0	0	0	0	2	2,125
Fulton	78	4,703,763	51	347,905	144	2,621,143	3,432	2,906,194
Gilmer	1	35,541	0	0	0	0	2	7,517
Glynn	1	53,936	0	0	0	0	2	1,126

Gordon	0	0	0	0	0	0	4	3,427
Gwinnett	5	545,468	2	12,826	10	187,539	418	357,620
Habersham	0	0	0	0	0	0	2	650
Hall	0	0	0	0	0	0	85	61,630
Haralson	0	0	0	0	0	0	2	1,276
Hart	0	0	0	0	0	0	2	800
Heard	0	0	0	0	0	0	1	550
Henry	0	0	0	0	0	0	9	9,051
Houston	0	0	0	0	0	0	2	950
Jackson	0	0	0	0	2	25,165	5	2,150
Jasper	0	0	0	0	1	38,971	1	400
Jefferson	0	0	0	0	0	0	1	1,976
Lamar	0	0	0	0	0	0	3	1,500
Lowndes	0	0	0	0	0	0	1	250
Lumpkin	1	52,145	1	13,815	1	2,725	21	24,038
Madison	0	0	0	0	0	0	1	1,976
Meriwether	1	64,671	0	0	0	0	2	1,573
Morgan	1	9,009	0	0	0	0	0	0
Murray	0	0	0	0	0	0	9	18,630
Muscogee	0	0	0	0	0	0	6	4,125
Newton	0	0	0	0	1	4,974	6	9,968
North Carolina	0	0	0	0	0	0	11	9,002
Other Out of State	4	132,822	3	30,674	5	67,621	106	83,951
Paulding	1	161,545	0	0	0	0	8	12,338
Peach	0	0	0	0	0	0	1	726
Pickens	0	0	0	0	1	10,723	21	21,314
Polk	0	0	0	0	0	0	1	400
Putnam	0	0	0	0	0	0	1	950
Rabun	1	362,494	0	0	0	0	0	0
Randolph	0	0	0	0	0	0	1	400
Richmond	0	0	0	0	0	0	4	1,776
Rockdale	0	0	0	0	0	0	6	7,260
South Carolina	0	0	0	0	0	0	9	7,677
Spalding	0	0	0	0	0	0	1	400
Stephens	0	0	0	0	1	5,439	1	250
Taylor	0	0	0	0	0	0	1	250
Tennessee	0	0	0	0	1	14,493	5	2,352
Troup	0	0	0	0	0	0	1	2,304
Union	0	0	0	0	0	0	2	500
Walker	0	0	0	0	0	0	2	2,702
Walton	0	0	0	0	0	0	3	2,261
Ware	0	0	0	0	1	9,148	0	0
Warren	0	0	0	0	0	0	4	3,626
Washington	0	0	1	1,704	0	0	0	0

White	0	0	0	0	0	0	2	2,159
Whitfield	0	0	0	0	0	0	1	250
Total	**141**	**8,894,849**	**95**	**696,520**	**227**	**3,896,349**	**6,130**	**5,332,483**

Indigent Care Trust Fund Addendum

1. Indigent Care Trust Fund

Did your hospital receive funds from the Indigent Care Trust Fund during its Fiscal Year 2008? (Check box if yes.) ☐

2. Amount Charged to ICTF

Indicate the amount charged to the ICTF by each State Fiscal Year (SFY) and for each of the patient categories indicated below during Hospital Fiscal Year 2008.

	Patient Category	SFY 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	0	0
B.	Medically Indigent Patients with incomes between 125% and 200% of the Federal Poverty Level Guidelines where adjustments were made to patient amounts due in accordance with an established sliding scale.	0	0	0
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
0	0	0

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

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.

Signature of Chief Executive: Debbie Keel

Date: 9/22/2011

Title: President and Chief Executive Officer

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. 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.

Signature of Financial Officer: Wes James

Date: 9/22/2011

Title: Chief Financial Officer

Comments: