GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP318

Facility Name: Piedmont Fayette Hospital

County: Fayette

Street Address: 1255 Highway 54 West

City: Fayetteville

Zip: 30214-4521

Mailing Address: 1255 Highway 54 West

Mailing City: Fayetteville

Mailing Zip: 30214-4521

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2012 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 7/1/2011 To:6/30/2012

Please indicate your cost report year.
From: 07/01/2011 To:06/30/2012

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: Sam Williamson

Contact Title: Director, Finance at Piedmont Fayette

Phone: 770-719-6006

Fax: 770-719-7092

E-mail: samuel.williamson@piedmont.org

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	360,738,160
Total Inpatient Admissions accounting for Inpatient Revenue	12,761
Outpatient Gross Patient Revenue	535,785,792
Total Outpatient Visits accounting for Outpatient Revenue	164,819
Medicare Contractual Adjustments	252,769,101
Medicaid Contractual Adjustments	59,950,179
Other Contractual Adjustments:	290,743,181
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	32,761,410
Uncompensated Indigent Care (net):	4,887,394
Uncompensated Charity Care (net):	16,276,361
Other Free Care:	342,993
Other Revenue/Gains:	5,489,593
Total Expenses:	207,869,796

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 2012? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2012?

02/01/2011

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.?

Chief Financial Officer

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 2012? (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	2,078,778	7,482,588	9,561,366
Outpatient	2,808,616	8,793,773	11,602,389
Total	**4,887,394**	**16,276,361**	**21,163,755**

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	2,078,778	7,482,588	9,561,366
Outpatient	2,808,616	8,793,773	11,602,389
Total	**4,887,394**	**16,276,361**	**21,163,755**

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	11	600	4	27,693	25	51,843
Appling	0	0	0	0	0	0	5	1,130
Baldwin	0	0	0	0	0	0	1	111
Barrow	0	0	0	0	0	0	2	8,184
Bartow	0	0	0	0	0	0	4	11,671
Bibb	0	0	0	0	0	0	1	2,187
Butts	0	0	4	7,269	4	19,655	10	21,018
Carroll	0	0	0	0	4	15,378	21	73,181
Chatham	0	0	4	23,387	0	0	0	0
Cherokee	1	21,650	1	1,334	0	0	0	0
Clarke	0	0	1	909	0	0	3	2,932
Clayton	32	344,478	364	351,957	105	1,126,812	946	1,885,834
Cobb	0	0	12	6,136	1	12,977	5	10,419
Colquitt	0	0	0	0	0	0	2	3,057
Coweta	40	278,177	330	494,480	110	1,209,112	572	1,312,868
Crisp	0	0	0	0	0	0	1	45
DeKalb	4	6,980	17	10,567	9	38,824	53	116,114
Dougherty	0	0	0	0	0	0	1	1,682
Douglas	2	2,572	3	350	1	354	12	21,972
Echols	0	0	0	0	0	0	1	2,481
Fannin	0	0	1	100	0	0	0	0
Fayette	59	882,481	1,359	1,180,886	53	1,346,453	297	801,792
Florida	1	35,638	0	0	7	185,683	26	69,940
Fulton	44	391,919	335	466,542	110	1,917,711	1,032	2,191,435
Gilmer	0	0	2	1,037	0	0	2	2,611
Gwinnett	0	0	16	2,096	0	0	3	3,210
Hall	0	0	2	1,608	0	0	1	1,651
Heard	1	1,098	2	2,097	4	3,202	10	46,054
Henry	14	93,178	154	140,143	48	479,316	374	830,396
Houston	0	0	0	0	0	0	1	1,306
Jasper	0	0	1	1,905	0	0	1	877
Lamar	0	0	2	1,049	5	55,775	13	32,938

Liberty	0	0	0	0	0	0	1	284
Long	0	0	0	0	0	0	1	6,637
Lowndes	0	0	1	986	0	0	0	0
Meriwether	1	1,132	14	4,970	16	543,943	85	351,201
Monroe	0	0	0	0	0	0	2	5,966
Newton	0	0	1	282	1	36,929	12	32,051
North Carolina	0	0	0	0	3	1,808	2	4,398
Other Out of State	10	6,399	18	13,295	7	87,775	79	151,302
Paulding	0	0	0	0	0	0	7	4,116
Pickens	0	0	0	0	0	0	2	7,093
Pike	2	550	20	21,758	13	118,830	42	65,460
Polk	0	0	0	0	0	0	1	8,138
Rockdale	0	0	0	0	0	0	4	41,547
South Carolina	0	0	1	811	2	859	7	12,336
Spalding	4	4,773	52	30,389	28	185,381	267	523,740
Stephens	0	0	0	0	0	0	1	2,974
Tennessee	0	0	3	3,224	0	0	5	11,309
Tift	0	0	0	0	0	0	1	2,225
Troup	2	5,465	4	5,845	7	47,773	32	42,052
Twiggs	0	0	0	0	0	0	1	144
Upson	2	2,288	5	32,604	2	19,324	5	5,782
Walton	0	0	0	0	1	1,021	1	1,133
White	0	0	0	0	0	0	1	2,627
Whitfield	0	0	0	0	0	0	1	1,399
Worth	0	0	0	0	0	0	1	920
Total	**219**	**2,078,778**	**2,740**	**2,808,616**	**545**	**7,482,588**	**3,986**	**8,793,773**

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 2012? (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 2012.

	Patient Category	SFY 2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	4,611,524	4,887,393	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.	15,067,680	16,276,361	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 2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13
10,211	7,490	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: J. Michael Burnett

Date: 1/6/2014

Title: President/Chief Administrative 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: Sheryl Klink

Date: 1/6/2014

Title: Vice President/Chief Financial Officer

Comments: