



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2013 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: Roswell

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 calendar year 2013 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 1/1/2013 To:12/31/2013

Please indicate your cost report year.

From: 01/01/2013 To:12/31/2013

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: Felix Soto

Contact Title: Controller

Phone: 770-751-2787

Fax: 770-751-2796

E-mail: FELIX.Sotolzaguirre@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	470,191,405
Total Inpatient Admissions accounting for Inpatient Revenue	6,946
Outpatient Gross Patient Revenue	373,276,023
Total Outpatient Visits accounting for Outpatient Revenue	68,967
Medicare Contractual Adjustments	293,732,416
Medicaid Contractual Adjustments	66,787,453
Other Contractual Adjustments:	293,424,116
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	16,287,062
Uncompensated Indigent Care (net):	21,496,050
Uncompensated Charity Care (net):	8,264,264
Other Free Care:	3,055,449
Other Revenue/Gains:	3,006,557
Total Expenses:	120,697,562

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	3,055,449
Employee Discounts	0
	0
Total	3,055,449

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 2013? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2013?

02/11/2005

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.?

Corporate Director of PFS

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 2013? (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	18,343,038	1,471,075	19,814,113
Outpatient	3,153,012	6,793,189	9,946,201
Total	21,496,050	8,264,264	29,760,314

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	18,343,038	1,471,075	19,814,113
Outpatient	3,153,012	6,793,189	9,946,201
Total	21,496,050	8,264,264	29,760,314

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	1	38,530	0	0	0	0	16	22,952
Baldwin	0	0	1	22,400	0	0	0	0
Barrow	0	0	1	720	0	0	10	5,431
Bartow	0	0	0	0	1	16,826	12	26,230
Bibb	0	0	0	0	0	0	1	550
Bulloch	0	0	0	0	0	0	2	5,088
Carroll	0	0	0	0	1	15,630	10	8,038
Chatham	0	0	0	0	0	0	8	5,228
Chattooga	0	0	0	0	0	0	1	550
Cherokee	12	1,238,198	35	337,780	9	76,693	544	477,913
Clarke	1	307,164	0	0	0	0	3	3,328
Clayton	1	45,257	0	0	1	8,825	41	33,075
Cobb	6	525,492	12	100,083	6	90,733	420	394,999
Coffee	0	0	0	0	0	0	2	950
Colquitt	0	0	0	0	0	0	2	1,276
Columbia	0	0	0	0	0	0	1	1,226
Coweta	0	0	0	0	0	0	6	5,619
Dawson	0	0	2	58,113	0	0	39	40,726
DeKalb	18	1,344,718	50	359,037	9	32,186	762	689,603
Douglas	0	0	0	0	0	0	25	18,189
Emanuel	0	0	0	0	0	0	1	2,296
Fannin	0	0	0	0	0	0	2	1,126
Fayette	0	0	0	0	0	0	4	2,952
Florida	2	132,462	3	9,338	2	35,991	52	40,260
Floyd	0	0	0	0	0	0	4	7,213
Forsyth	5	520,735	10	76,867	2	30,071	292	286,320
Franklin	0	0	0	0	0	0	1	550
Fulton	121	10,179,958	216	1,939,437	68	1,078,892	4,686	3,961,580
Gilmer	0	0	0	0	1	3,700	2	14,862
Glynn	0	0	0	0	0	0	2	2,276
Gordon	1	77,998	1	3,204	0	0	1	7,211
Greene	0	0	0	0	0	0	1	876

Gwinnett	8	2,014,068	15	93,658	6	27,510	459	384,560
Hall	1	25,544	3	28,241	0	0	48	44,030
Haralson	0	0	0	0	0	0	4	3,800
Hart	0	0	0	0	0	0	2	1,500
Heard	0	0	0	0	0	0	1	29
Henry	0	0	0	0	1	0	19	30,559
Houston	0	0	0	0	0	0	2	1,100
Jackson	0	0	1	720	0	0	7	14,612
Jasper	0	0	0	0	0	0	1	550
Lincoln	0	0	0	0	0	0	2	550
Lowndes	0	0	0	0	0	0	2	550
Lumpkin	1	187,126	0	0	0	0	10	9,127
Madison	0	0	0	0	0	0	2	2,676
Meriwether	0	0	0	0	0	0	1	250
Murray	0	0	0	0	0	0	3	2,526
Muscogee	1	95,012	0	0	1	3,391	6	4,152
Newton	0	0	0	0	0	0	7	8,437
North Carolina	0	0	0	0	1	8,177	26	24,652
Oconee	0	0	0	0	0	0	1	2,226
Other Out of State	5	488,947	4	51,215	1	7,849	124	106,866
Paulding	0	0	1	14,719	0	0	13	11,720
Pickens	4	1,121,828	0	0	3	10,942	14	26,532
Polk	0	0	1	10,094	0	0	2	1,276
Putnam	0	0	0	0	0	0	1	2,362
Richmond	0	0	1	19,779	0	0	0	0
Rockdale	0	0	0	0	0	0	7	4,689
South Carolina	0	0	1	2,613	0	0	14	11,798
Spalding	0	0	0	0	0	0	1	550
Stephens	0	0	0	0	0	0	2	950
Tennessee	0	0	0	0	1	9,794	11	9,678
Thomas	0	0	0	0	0	0	2	4,502
Troup	0	0	1	24,997	0	0	1	400
Union	0	0	0	0	1	13,866	1	550
Walton	0	0	0	0	0	0	4	5,258
Whitfield	0	0	0	0	0	0	3	1,676
Wilkes	0	0	0	0	0	0	1	0
Total	188	18,343,037	359	3,153,015	115	1,471,076	7,757	6,793,186

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 2013?
(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 2013.

Patient Category		SFY 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	9,582,675	11,913,375
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	3,855,813	4,408,451
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 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
0	3,172	2,877

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 inaccurate 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: Deborah Keel

Date: 7/31/2014

Title: 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: Lyra Howalt

Date: 7/31/2014

Title: Chief Financial Officer

Comments: