GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2017 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP901

Facility Name: Emory Johns Creek Hospital

County: Fulton

Street Address: 6325 Hospital Parkway

City: Johns Creek

Zip: 30097

Mailing Address: 6325 Hospital Parkway

Mailing City: Johns Creek

Mailing Zip: 30097

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2017 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 9/1/2016 To:8/31/2017

Please indicate your cost report year.
From: 09/01/2016 To:08/31/2017

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period. ☐
If your facility's trauma center designation changed, provide the date and type of change.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Patty Pharo
Contact Title: Senior Financial Analyst
Phone: 678-474-7045
Fax: 678-474-7053
E-mail: patty.pharo@emoryhealthcare.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	232,427,532
Total Inpatient Admissions accounting for Inpatient Revenue	7,311
Outpatient Gross Patient Revenue	225,707,337
Total Outpatient Visits accounting for Outpatient Revenue	74,881
Medicare Contractual Adjustments	139,893,153
Medicaid Contractual Adjustments	18,550,117
Other Contractual Adjustments:	119,479,122
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	12,971,598
Gross Indigent Care:	3,470,399
Gross Charity Care:	6,628,188
Uncompensated Indigent Care (net):	3,470,399
Uncompensated Charity Care (net):	6,628,188
Other Free Care:	5,871,080
Other Revenue/Gains:	13,637,216
Total Expenses:	137,098,933

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	5,488,273
Admin Discounts	382,807
Employee Discounts	0
	0
Total	**5,871,080**

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 2017? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2017?

07/01/2017

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 Patient Financial 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.)?

400%

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 2017? (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	1,624,885	3,214,944	4,839,829
Outpatient	1,845,514	3,413,244	5,258,758
Total	**3,470,399**	**6,628,188**	**10,098,587**

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	1,624,885	3,214,944	4,839,829
Outpatient	1,845,514	3,413,244	5,258,758
Total	**3,470,399**	**6,628,188**	**10,098,587**

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	5	16,926	0	0	3	7,296
Baldwin	0	0	0	0	0	0	1	716
Barrow	0	0	15	10,145	2	810	11	14,292
Bartow	0	0	2	8,490	0	0	0	0
Bibb	0	0	1	903	0	0	0	0
Calhoun	0	0	0	0	0	0	1	236
Carroll	0	0	0	0	0	0	3	4,989
Cherokee	0	0	27	47,293	4	55,779	32	33,395
Clarke	1	9,264	0	0	0	0	0	0
Clayton	0	0	4	13,252	0	0	4	7,171
Cobb	4	84,105	14	24,729	4	167,693	24	46,140
Coweta	2	58,312	2	8,684	0	0	1	505
Dawson	2	17,404	11	57,409	2	12,421	15	98,989
DeKalb	2	19,338	34	71,173	12	117,872	76	162,987
Douglas	1	5,000	1	921	1	2,476	2	5,066
Elbert	0	0	0	0	0	0	1	787
Fannin	0	0	0	0	0	0	2	701
Fayette	0	0	0	0	0	0	1	225
Florida	1	20,052	10	25,705	2	20,594	25	49,176
Floyd	2	42,055	1	7,328	0	0	0	0
Forsyth	13	232,787	96	197,291	22	489,485	167	308,077
Fulton	22	256,756	228	437,615	91	822,016	568	1,093,769
Glynn	0	0	0	0	0	0	2	5,190
Gordon	0	0	3	3,426	0	0	1	221
Greene	0	0	0	0	0	0	1	2,358
Gwinnett	59	441,345	347	671,560	118	1,307,586	696	1,328,039
Habersham	0	0	0	0	0	0	1	353
Hall	0	0	20	42,807	1	898	25	42,424
Haralson	0	0	1	2,005	0	0	3	38,594
Henry	2	16,231	7	4,958	1	1,528	12	5,323
Houston	0	0	2	1,960	0	0	2	2,022
Jackson	1	58,161	6	14,709	0	0	4	1,110

Lamar	0	0	1	199	0	0	0	0
Lanier	0	0	0	0	0	0	3	288
Laurens	0	0	0	0	0	0	1	1,099
Lumpkin	0	0	5	11,290	1	395	8	7,025
Madison	0	0	0	0	0	0	1	98
McDuffie	0	0	1	5,625	0	0	0	0
Muscogee	0	0	0	0	0	0	1	253
Newton	0	0	0	0	1	5,341	4	8,823
North Carolina	0	0	3	2,972	2	30,597	0	0
Oconee	0	0	0	0	0	0	1	442
Oglethorpe	0	0	0	0	1	377	0	0
Other Out of State	6	150,250	32	55,403	4	141,999	30	96,001
Paulding	2	23,959	2	1,067	0	0	0	0
Polk	0	0	0	0	0	0	1	317
Randolph	0	0	1	288	0	0	0	0
Richmond	0	0	1	695	0	0	0	0
Rockdale	0	0	4	7,732	2	30,998	3	2,562
South Carolina	1	139	3	5,754	0	0	3	2,571
Spalding	0	0	2	3,872	0	0	0	0
Stephens	0	0	0	0	0	0	3	3,039
Tennessee	2	55,523	2	7,986	0	0	6	2,724
Towns	0	0	0	0	0	0	1	16,340
Troup	0	0	0	0	1	3,339	0	0
Union	2	70,560	0	0	0	0	0	0
Walton	4	0	19	72,406	2	2,740	11	7,088
White	1	63,644	1	742	0	0	1	4,423
Worth	0	0	1	194	0	0	0	0
Total	**130**	**1,624,885**	**915**	**1,845,514**	**274**	**3,214,944**	**1,762**	**3,413,244**

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 2017? (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 2017.

	Patient Category	SFY 2016 7/1/15-6/30/16	SFY2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	2,634,167	836,232
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	5,508,106	1,009,641
C.	Other Patients in accordance with the department approved policy.	0	33,179	8,977

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2016 7/1/15-6/30/16	SFY2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18
0	2,405	653

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: Marilyn Margolis

Date: 7/27/2018

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: JoAnn Manning

Date: 7/27/2018

Title: Chief Financial Officer

Comments: