**Part I  Financial Assistance and Certain Other Community Benefits at Cost**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>1b</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3a</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3b</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5a</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5b</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>5c</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6a</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>6b</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Assistance and Certain Other Community Benefits at Cost</th>
<th>(a) Number of activities or programs (optional)</th>
<th>(b) Persons served (optional)</th>
<th>(c) Total community benefit expense</th>
<th>(d) Direct offsetting revenue</th>
<th>(e) Not community benefit expense</th>
<th>(f) Percent of total expense</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Financial Assistance at cost</strong> (from Worksheet 1)</td>
<td></td>
<td>5,392,872.</td>
<td>5,392,872.</td>
<td>5.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicaid</strong> (from Worksheet 3, column a)</td>
<td></td>
<td>4,244,417.</td>
<td>4,414,773.</td>
<td>-170,356.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Costs of other means-tested government programs (from Worksheet 3, column b)</strong></td>
<td></td>
<td>1,302,894.</td>
<td>1,302,894.</td>
<td></td>
<td></td>
<td>1.33</td>
</tr>
<tr>
<td><strong>Total Financial Assistance and Means-Tested Government Programs</strong></td>
<td></td>
<td>10,940,183.</td>
<td>4,414,773.</td>
<td>6,525,410.</td>
<td></td>
<td>6.82</td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community health improvement services and community benefit operations</strong> (from Worksheet 4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health professions education</strong> (from Worksheet 5)</td>
<td></td>
<td>524,394.</td>
<td>524,394.</td>
<td></td>
<td></td>
<td>.53</td>
</tr>
<tr>
<td><strong>Subsidized health services</strong> (from Worksheet 6)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Research</strong> (from Worksheet 7)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cash and in-kind contributions for community benefit</strong> (from Worksheet 8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total, Other Benefits</strong></td>
<td></td>
<td>524,394.</td>
<td>524,394.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total, Add lines 7d and 7e</strong></td>
<td></td>
<td>11,464,577.</td>
<td>4,414,773.</td>
<td>7,049,804.</td>
<td></td>
<td>7.35</td>
</tr>
</tbody>
</table>
## Part II  Community Building Activities

Complete this table if the organization conducted any community building activities during the tax year, and describe in Part VI how its community building activities promoted the health of the communities it serves.

<table>
<thead>
<tr>
<th></th>
<th>(a) Number of activities or programs (optional)</th>
<th>(b) Persons served (optional)</th>
<th>(c) Total community building expense</th>
<th>(d) Direct offsetting revenue</th>
<th>(e) Net community building expense</th>
<th>(f) Percent of total expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical improvements and housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Economic development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Community support</td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td>Environmental improvements</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Leadership development and training for community members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Coalition building</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>7</td>
<td>Community health improvement advocacy</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>8</td>
<td>Workforce development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Other</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td><strong>Total</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

## Part III  Bad Debt, Medicare, & Collection Practices

### Section A. Bad Debt Expense

1. Did the organization report bad debt expense in accordance with Healthcare Financial Management Association Statement No. 15?  
   - Yes  
   - No  

2. Enter the amount of the organization's bad debt expense. Explain in Part VI the methodology used by the organization to estimate this amount.  
   - 10,185,827.

3. Enter the estimated amount of the organization's bad debt expense attributable to patients eligible under the organization's financial assistance policy. Explain in Part VI the methodology used by the organization to estimate this amount and the rationale, if any, for including this portion of bad debt as community benefit.  
   - 626,530.

4. Provide in Part VI the text of the footnote to the organization's financial statements that describes bad debt expense or the page number on which this footnote is contained in the attached financial statements.

### Section B. Medicare

5. Enter total revenue received from Medicare (including DSH and IME).  
   - 21,046,852.

6. Enter Medicare allowable costs of care relating to payments on line 5.  
   - 20,006,085.

7. Subtract line 6 from line 5. This is the surplus (or shortfall)  
   - 1,040,767.

8. Describe in Part VI the extent to which any shortfall reported in line 7 should be treated as community benefit. Also describe in Part VI the costing methodology or source used to determine the amount reported on line 6. Check the box that describes the method used:
   - Cost accounting system  
   - Cost to charge ratio  
   - Other

### Section C. Collection Practices

9a. Did the organization have a written debt collection policy during the tax year?  
   - No

9b. If "Yes," did the organization's collection policy that applied to the largest number of its patients during the tax year contain provisions on the collection practices to be followed for patients who are known to qualify for financial assistance? Describe in Part VI.  
   - Yes

## Part IV  Management Companies and Joint Ventures

(owned 10% or more by officers, directors, trustees, key employees, and physicians - see instructions)

<table>
<thead>
<tr>
<th></th>
<th>(a) Name of entity</th>
<th>(b) Description of primary activity of entity</th>
<th>(c) Organization's profit % or stock ownership %</th>
<th>(d) Officers, directors, trustees, or key employees' profit % or stock ownership %</th>
<th>(e) Physicians' profit % or stock ownership %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>12</td>
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<tr>
<td>13</td>
<td></td>
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</tr>
</tbody>
</table>
### Section A. Hospital Facilities

(list in order of size, from largest to smallest - see instructions)

How many hospital facilities did the organization operate during the tax year? __________ 1

Name, address, primary website address, and state license number (and if a group return, the name and EIN of the subordinate hospital organization that operates the hospital facility)

<table>
<thead>
<tr>
<th>Facility reporting group</th>
<th>Other (describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PIEDMONT ROCKDALE HOSPITAL, INC.</td>
<td>122-726</td>
</tr>
<tr>
<td>1412 MILSTEAD AVENUE</td>
<td>X X X</td>
</tr>
<tr>
<td>CONYERS GA 30012</td>
<td>1</td>
</tr>
<tr>
<td><a href="http://WWW.PIEDMONT.ORG">WWW.PIEDMONT.ORG</a></td>
<td>1</td>
</tr>
</tbody>
</table>

2

3

4

5

6

7

8

9

10
Part V  Facility Information (continued)

Section B. Facility Policies and Practices
(complete a separate Section B for each of the hospital facilities or facility reporting groups listed in Part V, Section A)

Name of hospital facility or letter of facility reporting group: PIEDMONT ROCKDALE HOSPITAL, INC.

Line number of hospital facility, or line numbers of hospital facilities in a facility reporting group (from Part V, Section A): 1

Community Health Needs Assessment

1. Was the hospital facility first licensed, registered, or similarly recognized by a state as a hospital facility in the current tax year or the immediately preceding tax year?  X

2. Was the hospital facility acquired or placed into service as a tax-exempt hospital in the current tax year or the immediately preceding tax year?  X

3. During the tax year or either of the two immediately preceding tax years, did the hospital facility conduct a community health needs assessment (CHNA)?  X

If "Yes," indicate what the CHNA report describes (check all that apply):

a. A definition of the community served by the hospital facility
b. Demographics of the community
c. Existing health care facilities and resources within the community that are available to respond to the health needs of the community
d. How data was obtained
e. The significant health needs of the community
f. Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups
g. The process for identifying and prioritizing community health needs and services to meet the community health needs
h. The process for consulting with persons representing the community's interests
i. The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)
j. Other (describe in Section C)

4. Indicate the tax year the hospital facility last conducted a CHNA: 2017

5. In conducting its most recent CHNA, did the hospital facility take into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health?  Yes

6a. Was the hospital facility's CHNA conducted with one or more other hospital facilities?  Yes

b. Was the hospital facility's CHNA conducted with one or more organizations other than hospital facilities?  Yes

7. Did the hospital facility make its CHNA report widely available to the public?  Yes

If "Yes," indicate how the CHNA report was made widely available (check all that apply):

a. Hospital facility's website (list url):

b. Other website (list url):

c. Made a paper copy available for public inspection without charge at the hospital facility

d. Other (describe in Section C)

8. Did the hospital facility adopt an implementation strategy to meet the significant community health needs identified through its most recently conducted CHNA?  Yes

9. Indicate the tax year the hospital facility last adopted an implementation strategy: 2017

10. Is the hospital facility's most recently adopted implementation strategy posted on a website?  Yes

a. If "Yes," (list url):

b. If "No," is the hospital facility's most recently adopted implementation strategy attached to this return?  Yes

11. Describe in Section C how the hospital facility is addressing the significant needs identified in its most recently conducted CHNA and any such needs that are not being addressed together with the reasons why such needs are not being addressed.

12a. Did the organization incur an excise tax under section 4959 for the hospital facility's failure to conduct a CHNA as required by section 501(r)(3)?  Yes

b. If "Yes" to line 12a, did the organization file Form 4720 to report the section 4959 excise tax?  No

c. If "Yes" to line 12b, what is the total amount of section 4959 excise tax the organization reported on Form 4720 for all of its hospital facilities?  $
### Financial Assistance Policy (FAP)

**Name of hospital facility or letter of facility reporting group:** PIEDMONT ROCKDALE HOSPITAL, INC.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Did the hospital facility have in place during the tax year a written financial assistance policy that:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Federal poverty guidelines (FPG), with FPG family income limit for eligibility for free care of 200.0000% and FPG family income limit for eligibility for discounted care of 300.0000%</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Income level other than FPG (describe in Section C)</td>
<td></td>
</tr>
<tr>
<td>c</td>
<td>Other (describe in Section C)</td>
<td></td>
</tr>
<tr>
<td>d</td>
<td>Medical indigency</td>
<td></td>
</tr>
<tr>
<td>e</td>
<td>Insurance status</td>
<td></td>
</tr>
<tr>
<td>f</td>
<td>Underinsurance status</td>
<td></td>
</tr>
<tr>
<td>g</td>
<td>Residency</td>
<td></td>
</tr>
<tr>
<td>h</td>
<td>Medical status</td>
<td></td>
</tr>
<tr>
<td>i</td>
<td>Other (describe in Section C)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Explained the basis for calculating amounts charged to patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Explained the method for applying for financial assistance?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Was widely publicized within the community served by the hospital facility?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Schedule H (Form 990) 2017**

**PIEDMONT ROCKDALE HOSPITAL, INC.**

**JSA**

**7E1323 1.000**

**6/7/2019 2:52:53 PM PAGE 30**

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### Billing and Collections

**Part V  Facility Information (continued)**

**Name of hospital facility or letter of facility reporting group**  
PIEDMONT ROCKDALE HOSPITAL, INC.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Did the hospital facility have in place during the tax year a separate billing and collections policy, or a written financial assistance policy (FAP) that explained all of the actions the hospital facility or other authorized party may take upon nonpayment?**

**Check all of the following actions against an individual that were permitted under the hospital facility's policies during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP:**

- Reporting to credit agency(ies)
- Selling an individual's debt to another party
- Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- Actions that require a legal or judicial process
- Other similar actions (describe in Section C)
- None of these actions or other similar actions were permitted

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Did the hospital facility or other authorized party perform any of the following actions during the tax year before making reasonable efforts to determine the individual's eligibility under the facility's FAP?**

- Reporting to credit agency(ies)
- Selling an individual's debt to another party
- Deferring, denying, or requiring a payment before providing medically necessary care due to nonpayment of a previous bill for care covered under the hospital facility's FAP
- Actions that require a legal or judicial process
- Other similar actions (describe in Section C)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>19</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

**Policy Relating to Emergency Medical Care**

**Did the hospital facility have in place during the tax year a written policy relating to emergency medical care that required the hospital facility to provide, without discrimination, care for emergency medical conditions to individuals regardless of their eligibility under the hospital facility's financial assistance policy?**

If "No," indicate why:

- The hospital facility did not provide care for any emergency medical conditions
- The hospital facility's policy was not in writing
- The hospital facility limited who was eligible to receive care for emergency medical conditions (describe in Section C)
- Other (describe in Section C)

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td></td>
<td>X</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
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<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
### Part V Facility Information (continued)

**Charges to Individuals Eligible for Assistance Under the FAP (FAP-Eligible Individuals)**

**Name of hospital facility or letter of facility reporting group**  
Piedmont Rockdale Hospital, Inc.

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>d</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Indicate how the hospital facility determined, during the tax year, the maximum amounts that can be charged to FAP-eligible individuals for emergency or other medically necessary care.

**a** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service during a prior 12-month period

**b** The hospital facility used a look-back method based on claims allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period

**c** The hospital facility used a look-back method based on claims allowed by Medicaid, either alone or in combination with Medicare fee-for-service and all private health insurers that pay claims to the hospital facility during a prior 12-month period

**d** The hospital facility used a prospective Medicare or Medicaid method

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

During the tax year, did the hospital facility charge any FAP-eligible individual to whom the hospital facility provided emergency or other medically necessary services more than the amounts generally billed to individuals who had insurance covering such care?  

If "Yes," explain in Section C.

During the tax year, did the hospital facility charge any FAP-eligible individual an amount equal to the gross charge for any service provided to that individual?  

If "Yes," explain in Section C.
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

SCHEDULE H, PART V, LINES 1 AND 2: NEW HOSPITAL ENTITY

PIEDMONT ROCKDALE HOSPITAL, INC. ("PRH") was created as a new entity on August 1, 2017 following the purchase of the assets of ROCKDALE MEDICAL CENTER, INC. from LIFEPOINT HEALTH, LLC, a for-profit company. During FY18, the internal revenue service granted PRH's tax-exempt status, retroactive to its date of organization.

SCHEDULE H, PART V, LINE 3: COMMUNITY HEALTH NEEDS ASSESSMENT

PIEDMONT ROCKDALE HOSPITAL, INC. ("PRH") was created as a new entity on August 1, 2017 following the purchase of the assets of ROCKDALE MEDICAL CENTER, INC. from LIFEPOINT HEALTH, LLC, a for-profit company. As PRH was created as a new entity and did not exist as a not-for-profit hospital prior to PIEDMONT HEALTHCARE's acquisition of these assets, no community health needs assessment was conducted. Pursuant to the requirements of internal revenue code section 501(r), PIEDMONT HEALTHCARE will complete a community health needs assessment for PRH and its surrounding community within the first three years of PRH's existence.

SCHEDULE H, PART V, LINE 16: FINANCIAL ASSISTANCE POLICY WEBSITES

FINANCIAL ASSISTANCE POLICY -
HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-POLICY.PDF

FINANCIAL ASSISTANCE APPLICATION -
HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-APPLICATION.PDF
Section C. Supplemental Information for Part V, Section B. Provide descriptions required for Part V, Section B, lines 2, 3j, 5, 6a, 6b, 7d, 11, 13b, 13h, 15e, 16j, 18e, 19e, 20e, 21c, 21d, 23, and 24. If applicable, provide separate descriptions for each hospital facility in a facility reporting group, designated by facility reporting group letter and hospital facility line number from Part V, Section A ("A, 1," "A, 4," "B, 2," "B, 3," etc.) and name of hospital facility.

FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY –

HTTPS://WWW.PIEDMONT.ORG/MEDIA/FILE/FINANCIAL-ASSISTANCE-PLAIN-LANGUAGE-SUMMARY-ENGLISH.PDF
Part V  Facility Information (continued)

Section D. Other Health Care Facilities That Are Not Licensed, Registered, or Similarly Recognized as a Hospital Facility
(list in order of size, from largest to smallest)

How many non-hospital health care facilities did the organization operate during the tax year? ____________________________

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<tr>
<th>Name and address</th>
<th>Type of Facility (describe)</th>
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Schedule H (Form 990) 2017
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHINAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

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**SCHEDULE H, PART VI, LINE 1: REQUIRED DISCLOSURES**

**PUBLIC AVAILABILITY OF COMMUNITY BENEFIT REPORT**

**SCHEDULE H, PART I, LINE 6A**

PIEDMONT ROCKDALE HOSPITAL, INC. ("PRH") WAS CREATED AS A NEW ENTITY ON AUGUST 1, 2017 FOLLOWING THE PURCHASE OF THE ASSETS OF ROCKDALE MEDICAL CENTER, INC. FROM LIFEPOINT HEALTH, LLC, A FOR-PROFIT COMPANY. AS PRH WAS CREATED AS A NEW ENTITY AND DID NOT EXIST AS A NOT-FOR-PROFIT HOSPITAL PRIOR TO PIEDMONT HEALTHCARE'S ACQUISITION OF THESE ASSETS, NO COMMUNITY HEALTH NEEDS ASSESSMENT WAS CONDUCTED. PURSUANT TO THE REQUIREMENTS OF INTERNAL REVENUE CODE SECTION 501(R), PIEDMONT HEALTHCARE WILL COMPLETE A COMMUNITY HEALTH NEEDS ASSESSMENT FOR PRH AND ITS SURROUNDING COMMUNITY WITHIN THE FIRST THREE YEARS OF PRH'S EXISTENCE.

**PERCENT OF TOTAL EXPENSE**

**SCHEDULE H, PART I, LINE 7(F)**

THE DENOMINATOR USED FOR THE CALCULATION OF COLUMN (F), PERCENT OF TOTAL EXPENSE, WAS THE AMOUNT OF TOTAL FUNCTIONAL EXPENSES ON FORM 990, PART IX, LINE 25, COLUMN (A) OF $153,624,463, LESS BAD DEBT EXPENSE OF
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHINAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

$55,404,143 FROM FORM 990, PART IX, LINE 24(A).

**FINANCIAL ASSISTANCE AND CERTAIN OTHER COMMUNITY BENEFITS AT COST**

**SCHEDULE H, PART I, LINE 7**

A RATIO OF PATIENT CARE COST TO CHARGES, CONSISTENT WITH WORKSHEET 2, WAS USED TO REPORT THE AMOUNTS IN PART I, LINES 7A-7D. FOR AMOUNTS ON LINES 7E-7K, ACTUAL EXPENSES FOR EACH COMMUNITY BENEFIT ACTIVITY ARE TRACED AND REPORTED USING THE ORGANIZATION'S COST ACCOUNTING SYSTEM.

**BAD DEBT EXPENSE CALCULATION AND FOOTNOTE**

**SCHEDULE H, PART III, LINES 2-4**

THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE AND OTHER COLLECTION INDICATORS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBLE ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYER CATEGORY. THE RESULTS OF THE REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBTS TO ESTABLISH AN APPROPRIATE
Part VI Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHINAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES.

THE AMOUNT REPORTED ON PART III, LINE 3, WAS DETERMINED BY TAKING THE AVERAGE ACCEPTANCE RATE FOR ALL CHARITY CARE APPLICATIONS RECEIVED DURING THE YEAR MULTIPLIED BY THE NUMBER OF DENIALS THAT WERE ATTRIBUTABLE TO INSUFFICIENT INFORMATION. THAT TOTAL WAS THEN ADJUSTED DOWNWARD FOR THE ORGANIZATION'S USE OF PRESumptive ELigibility WHEN DETERMINING ITS COMMUNITY BENEFITS.

BAD DEBT EXPENSE FOOTNOTE FROM CONSOLIDATED, AUDITED FINANCIAL STATEMENTS:

THE PROVISION FOR BAD DEBTS IS BASED UPON MANAGEMENT'S ASSESSMENT OF HISTORICAL AND EXPECTED NET COLLECTIONS CONSIDERING BUSINESS AND ECONOMIC CONDITIONS, TRENDS IN HEALTH CARE COVERAGE, AND OTHER COLLECTION INDICATORS. PERIODICALLY, MANAGEMENT ASSESSES THE ADEQUACY OF THE ALLOWANCE FOR DOUBTFUL ACCOUNTS BASED UPON HISTORICAL WRITE-OFF EXPERIENCE BY PAYOR CATEGORY. THE RESULTS OF THIS REVIEW ARE THEN USED TO MAKE ANY MODIFICATIONS TO THE PROVISION FOR BAD DEBT TO ESTABLISH AN
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**APPROPRIATE ALLOWANCE FOR UNCOLLECTIBLE RECEIVABLES.**

**PRH PROVIDES CARE TO PATIENTS WHO MEET CERTAIN CRITERIA UNDER ITS CHARITY CARE POLICY WITHOUT CHARGE OR AT AMOUNTS LESS THAN ITS ESTABLISHED RATES. AMOUNTS DETERMINED TO QUALIFY AS CHARITY CARE ARE NOT REPORTED AS REVENUE.**

**MEDICARE SHORTFALLS AS COMMUNITY BENEFIT**

**SCHEDULE H, PART III, LINE 8**

THE AMOUNT REPORTED ON PART III, LINE 6, WAS CALCULATED IN ACCORDANCE WITH SCHEDULE H INSTRUCTIONS AND UTILIZING THE ORGANIZATION'S ALLOWABLE MEDICARE COST AS REPORTED IN THE MEDICARE COST REPORT, WHICH IS BASED ON A COST TO CHARGE RATIO. HOWEVER, THE ALLOWABLE COSTS IN THE MEDICARE COST REPORT DO NOT REFLECT THE ACTUAL COST OF PROVIDING CARE TO PATIENTS, SINCE THE MEDICARE COST REPORT EXCLUDES MANY DIRECT PATIENT CARE COSTS THAT ARE ESSENTIAL TO PROVIDE QUALITY HEALTHCARE FOR MEDICARE PATIENTS. FOR EXAMPLE, CERTAIN COVERAGE FEES TO PHYSICIANS, COST OF MEDICARE C AND D, AND OTHER SIMILAR DIRECT PATIENT CARE EXPENSES ARE SPECIFICALLY
Part VI  Supplemental Information

Provide the following information.

1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHINAs reported in Part V, Section B.

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6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

EXCLUDE FROM ALLOWABLE COST IN THE MEDICARE COST REPORT.

THE ORGANIZATION BELIEVES THAT THE HOSPITAL'S MEDICARE SHORTFALL REPORTED ON PART III, LINE 7 OF SCHEDULE H, SHOULD BE CONSIDERED A COMMUNITY BENEFIT AS THE IRS COMMUNITY BENEFIT STANDARD INCLUDES THE PROVISION OF CARE TO ELDERLY AND MEDICARE PATIENTS. IRS REVENUE RULING 69-545 PROVIDES, IN PART, THAT HOSPITALS SERVING PATIENTS WITH GOVERNMENTAL HEALTH INSURANCE, SUCH AS MEDICARE, IS AN INDICATION THE HOSPITAL OPERATES TO PROMOTE HEALTH IN THE COMMUNITY. ADDITIONALLY, MEDICARE ACCOUNTED FOR 45.53% OF THE HOSPITAL'S PATIENT SERVICE REVENUE. THE HOSPITAL'S POLICY IS TO TREAT MEDICARE PATIENTS, REGARDLESS OF THE EXTENT TO WHICH MEDICARE ACTUALLY PAYS FOR THE TREATMENT. FOR MANY SERVICES, MEDICARE'S REIMBURSEMENT IS LESS THAN THE COST OF THE CARE PROVIDED, RESULTING IN SHORTFALLS THAT ARE TO BE ABSORBED BY THE HOSPITAL IN HONOR OF THE HOSPITAL'S COMMITMENT TO TREAT ELDERLY PATIENTS.

COLLECTION PRACTICES

SCHEDULE H, PART III, LINE 9(B)
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**INITIAL SCREENINGS OF ALL INPATIENT, EMERGENCY, AND SURGERY ENCOUNTERS,**

AS WELL AS MOST OUTPATIENT VISITS, ARE CONDUCTED BY FINANCIAL COUNSELORS IN ORDER TO IDENTIFY ANY AVAILABLE INSURANCE OR OTHER COVERAGE FOR EACH PATIENT. COUNSELORS CONTACT PATIENTS AND THEIR FAMILIES DIRECTLY, EITHER IN PERSON OR BY LETTER, TO ASSIST THE FAMILY IN IDENTIFYING ANY PROGRAMS FOR WHICH THE PATIENT/SERVICE MAY QUALIFY (INCLUDING MEDICAID, STATE CHILDREN'S HEALTH INSURANCE PROGRAM ("SCHIP"), PRIVATE OR GOVERNMENT INSURANCE COVERAGE, AND CHARITY ASSISTANCE). IF THE FAMILY CANNOT BE TIMELY LOCATED OR IS UNCOOPERATIVE, RELATED ACCOUNTS ARE TRANSFERRED TO AN INTERNAL COLLECTION DEPARTMENT FOR FURTHER ATTEMPTS TO OBTAIN PAYMENT OR, IF THE PATIENT MAY QUALIFY FOR ASSISTANCE, TO SECURE A FINANCIAL ASSISTANCE APPLICATION. THE ORGANIZATION'S DEBT COLLECTION POLICY AND PROCEDURES PROHIBIT ANY COLLECTION EFFORTS FOR THE PORTION OF A PATIENT ACCOUNT BALANCE THAT QUALIFIES FOR FINANCIAL ASSISTANCE UNDER THE ORGANIZATION'S CHARITY CARE POLICY.
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**SCHEDULE H, PART VI, LINE 2: NEEDS ASSESSMENT**

In 2017, PIEDMONT HEALTHCARE PURCHASED PIEDMONT ROCKDALE, THEN KNOWN AS ROCKDALE MEDICAL CENTER, A FOR-PROFIT HOSPITAL OWNED BY LIFEPPOINT HEALTH, A FOR-PROFIT COMPANY BASED IN TENNESSEE. BECAUSE OF THAT, THE HOSPITAL WAS NOT REQUIRED TO FILE A COMMUNITY HEALTH NEEDS ASSESSMENT WITH THE IRS. THAT SAID, THE HOSPITAL HAS ALWAYS MAINTAINED TIES TO ITS COMMUNITY, AND IN THE PROCESS OF PURCHASING THE HOSPITAL, PIEDMONT HEALTHCARE TOOK THE OPPORTUNITY TO FULLY UNDERSTAND POTENTIAL COMMUNITY UNMET HEALTH NEEDS. THIS INCLUDED REGULAR COMMUNICATION WITH COMMUNITY STAKEHOLDERS, ENGAGEMENT WITH LAWMAKERS AND THE GATHERING OF HOSPITAL- AND COMMUNITY-BASED DATA. ADDITIONALLY, THE HOSPITAL IS A PART OF PIEDMONT HEALTHCARE'S FY19 CHNA.

**SCHEDULE H, PART VI, LINE 3: PATIENT EDUCATION OF ASSISTANCE ELIGIBILITY**

PATIENT EDUCATION OF AVAILABILITY OF ASSISTANCE: PIEDMONT HEALTHCARE UNDERSTANDS THAT NOT EVERYONE WILL HAVE THE ABILITY TO PAY THEIR HOSPITAL BILL DUE TO THEIR INSURANCE STATUS OR A LIMITED INCOME, AND BECAUSE OF THIS, WE OFFER FINANCIAL ASSISTANCE TO QUALIFYING PATIENTS. NOTIFICATION
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**ABOUT FINANCIAL ASSISTANCE AVAILABLE AT PIEDMONT ROCKDALE HOSPITAL**

INCLUDES PROVIDING A DEDICATED CONTACT NUMBER, WHICH IS DISSEMINATED BY

THE HOSPITAL TO PATIENTS BY VARIOUS MEANS. THESE INCLUDE, BUT ARE NOT

LIMITED TO: THE PUBLICATION OF NOTICES IN PATIENT BILLS AND BY POSTING

NOTICES IN EMERGENCY ROOMS, IN THE CONDITIONS OF ADMISSION FORM, AT

ADMITTING AND REGISTRATION DEPARTMENTS, HOSPITAL BUSINESS OFFICES, AND

PATIENT FINANCIAL SERVICES OFFICES THAT ARE LOCATED ON FACILITY CAMPUSES,

AND AT OTHER PUBLIC PLACES THE HOSPITAL MAY ELECT, INCLUDING AVAILABILITY

AT LOCAL LOW-COST CLINICS PRIMARILY TREATING UNINSURED POPULATIONS.

PIEDMONT ROCKDALE HOSPITAL ALSO PUBLISHES AND WIDELY PUBLICIZES A PLAIN

LANGUAGE SUMMARY OF THIS FINANCIAL ASSISTANCE CARE POLICY ON ITS FACILITY

WEBSITE, WHICH WILL INCLUDE A LINK TO FULL POLICY. REFERRAL OF PATIENTS

FOR FINANCIAL ASSISTANCE MAY BE MADE BY ANY STAFF OR MEDICAL STAFF MEMBER

AT THE HOSPITAL, INCLUDING PHYSICIANS, NURSES, FINANCIAL COUNSELORS,

SOCIAL WORKERS, CASE MANAGERS, CHAPLAINS AND RELIGIOUS SPONSORS. A

REQUEST FOR FINANCIAL ASSISTANCE MAY BE MADE BY THE PATIENT OR A FAMILY

MEMBER, CLOSE FRIEND, OR ASSOCIATE OF THE PATIENT, SUBJECT TO APPLICABLE

PRIVACY LAWS.
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**ADDITIONALLY, PIEDMONT HEALTHCARE ANNUALLY PUBLISHES A DIRECTORY OF SERVICES AND PROGRAMS FOR LOW-INCOME COMMUNITY MEMBERS, AND WITHIN THIS RESOURCE GUIDE ARE EXTENSIVE DIRECTIONS AND ADVICE ON HOW TO APPLY FOR PATIENT FINANCIAL ASSISTANCE. THIS GUIDE IS WIDELY DISTRIBUTED TO THE COMMUNITY VIA HARDCOPY, IS AVAILABLE WITHIN OUR HOSPITALS AND IS DIGITALLY AVAILABLE ONLINE. COPIES ARE PROVIDED IN BOTH ENGLISH AND SPANISH.**

**SCHEDULE H, PART VI, LINE 4: COMMUNITY INFORMATION**

Part VI  Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

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FIFTEEN PERCENT OF ROCKDALE COUNTY IS UNINSURED, AND NON-ELDERLY ADULT UNINSURED RATES ARE PARTICULARLY HIGH AT 22 PERCENT. NINE PERCENT OF CHILDREN ARE UNINSURED. SEVENTY PERCENT OF CHILDREN QUALIFIED FOR FREE OR REDUCED COST FOR FREE LUNCH IN THE 2015-2016 SCHOOL YEAR, AS COMPARED TO A STATE AVERAGE OF 62 PERCENT AND A NATIONAL AVERAGE OF 52 PERCENT. THAT SAME SCHOOL YEAR, 82 PERCENT OF THE COUNTY'S HIGH SCHOOL STUDENTS GRADUATED WITHIN FOUR YEARS (NATIONAL CENTER FOR EDUCATION STATISTICS). UNEMPLOYMENT WAS AT 4.2 PERCENT IN 2018, WHICH IS HIGHER THAN BOTH STATE AND NATIONAL AVERAGES (US DEPARTMENT OF LABOR, BUREAU OF LABOR STATISTICS).

IN ROCKDALE COUNTY, IN 2017, THERE WAS ONE PRIMARY CARE PHYSICIAN FOR EVERY 2,330 RESIDENTS OF THE COUNTY, COMPARED TO THE STATE AVERAGE OF ONE FOR 1,030 RESIDENTS. APPROXIMATELY 15 PERCENT OF ADULTS REPORTED THEY WERE IN POOR OR FAIR HEALTH, A FIGURE BETTER THAN THE GEORGIA BENCHMARK OF 19 PERCENT. EIGHTEEN PERCENT OF ADULTS SMOKED, NEARLY A THIRD WERE OBESE AND A FIFTH WERE PHYSICALLY INACTIVE. (UNIVERSITY OF WISCONSIN POPULATION HEALTH INSTITUTE, COUNTY HEALTH RANKINGS, 2018, WITH DATA
Part VI  Supplemental Information

Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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YEARS RANGING FROM 2014 TO 2017). TWELVE PERCENT OF ADULT RESIDENTS LIVED WITH DIABETES IN 2015 (CENTER FOR DISEASE CONTROL AND PREVENTION, NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION).

SCHEDULE H, PART VI, LINE 5: PROMOTION OF COMMUNITY HEALTH

PIEDMONT ROCKDALE HOSPITAL ACTIVELY PROMOTES THE HEALTH OF ITS COMMUNITY THROUGH COMMUNITY-BASED HEALTH SCREENINGS, EDUCATIONAL ACTIVITIES, THE OPERATION OF A 24-HOUR EMERGENCY DEPARTMENT AVAILABLE TO THE ENTIRE COMMUNITY, THE OPERATION OF AN EMERGENCY ROOM OPEN TO ALL MEMBERS OF THE COMMUNITY WITHOUT REGARD TO ABILITY TO PAY, A GOVERNANCE BOARD COMPOSED OF COMMUNITY MEMBERS, USE OF SURPLUS REVENUE FOR FACILITIES IMPROVEMENT, PATIENT CARE, AND MEDICAL TRAINING, EDUCATION, AND RESEARCH, THE PROVISION OF INPATIENT HOSPITAL CARE FOR ALL PERSONS IN THE COMMUNITY ABLE TO PAY, INCLUDING THOSE COVERED BY MEDICARE AND MEDICAID, AND AN OPEN MEDICAL STAFF WITH PRIVILEGES AVAILABLE TO ALL QUALIFYING PHYSICIANS.

IN FY18, PIEDMONT ROCKDALE PROVIDED HEALTH PROFESSIONS EDUCATION TO
Provide the following information.

1 Required descriptions. Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 Needs assessment. Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

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4 Community information. Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 Promotion of community health. Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 Affiliated health care system. If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 State filing of community benefit report. If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

STUDENTS AND RESIDENTS TRAINING TO BE HEALTH PROFESSIONALS. THAT YEAR,

THE HOSPITAL OVERSAW TRAINING AT A COST OF $524,397.

SCHEDULE H, PART VI, LINE 6: AFFILIATED HEALTH CARE SYSTEM


CONDUCTING THE TRIENNIAL CHNA AND SUBSEQUENT IMPLEMENTATION STRATEGY,

ENSURING THE FINANCIAL ASSISTANCE POLICY IS COMMUNICATED TO THE COMMUNITY, MAINTAINING THE COMMUNITY BENEFIT WEBPAGE, AUTHORING THE COMMUNITY BENEFIT ANNUAL REPORT, PREPARING BOARD MATERIALS, DEVELOPING AND EXECUTING THE COMMUNITY BENEFIT GRANTS PROGRAM AND COMPILING ALL COMMUNITY BENEFIT FIGURES. EACH HOSPITAL AND CERTAIN DEPARTMENTS OF PIEDMONT HEALTHCARE PROVIDE KEY INPUT AND EXECUTE PROGRAMMING. THIS INCLUDES OUR REVENUE DEPARTMENT, WHICH OVERSEES AND EXECUTES THE
Provide the following information.

1 **Required descriptions.** Provide the descriptions required for Part I, lines 3c, 6a, and 7; Part II and Part III, lines 2, 3, 4, 8 and 9b.

2 **Needs assessment.** Describe how the organization assesses the health care needs of the communities it serves, in addition to any CHNAs reported in Part V, Section B.

3 **Patient education of eligibility for assistance.** Describe how the organization informs and educates patients and persons who may be billed for patient care about their eligibility for assistance under federal, state, or local government programs or under the organization's financial assistance policy.

4 **Community information.** Describe the community the organization serves, taking into account the geographic area and demographic constituents it serves.

5 **Promotion of community health.** Provide any other information important to describing how the organization's hospital facilities or other health care facilities further its exempt purpose by promoting the health of the community (e.g., open medical staff, community board, use of surplus funds, etc.).

6 **Affiliated health care system.** If the organization is part of an affiliated health care system, describe the respective roles of the organization and its affiliates in promoting the health of the communities served.

7 **State filing of community benefit report.** If applicable, identify all states with which the organization, or a related organization, files a community benefit report.

**FINANCIAL ASSISTANCE POLICY AND PROGRAM.**

SCHEDULE H, PART VI, LINE 7: STATE OF FILING OF COMMUNITY BENEFIT REPORT

PIEDMONT ROCKDALE HOSPITAL IS NOT REQUIRED TO FILE A COMMUNITY BENEFIT REPORT; HOWEVER, THE HOSPITAL IS REQUIRED TO FILE WITH THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH INFORMATION ON ITS INDIGENT AND CHARITY CARE, AS WELL AS ITS MEDICAID AND MEDICARE SHORTFALLS.