GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP611

Facility Name: Northeast Georgia Medical Center

County: Hall

Street Address: 743 Spring Street NE

City: Gainesville

Zip: 30501-3899

Mailing Address: 743 Spring Street NE

Mailing City: Gainesville

Mailing Zip: 30501-3899

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: 10/1/2007 To:9/30/2008

Please indicate your cost report year.
From: 10/01/2007 To:09/30/2008

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: Linda Nicholson

Contact Title: Controller

Phone: 770-219-6622

Fax: 770-219-6644

E-mail: Linda.Nicholson@nghs.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	752,220,598
Total Inpatient Admissions accounting for Inpatient Revenue	23,623
Outpatient Gross Patient Revenue	524,997,152
Total Outpatient Visits accounting for Outpatient Revenue	213,083
Medicare Contractual Adjustments	412,432,037
Medicaid Contractual Adjustments	96,289,971
Other Contractual Adjustments:	222,975,040
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	39,880,332
Uncompensated Indigent Care (net):	38,709,545
Uncompensated Charity Care (net):	23,195,939
Other Free Care:	22,382,621
Other Revenue/Gains:	-19,683,073
Total Expenses:	381,564,276

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?

01/01/2008

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 Accounts

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 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	19,618,748	7,177,520	26,796,268
Outpatient	19,090,797	16,018,419	35,109,216
Total	**38,709,545**	**23,195,939**	**61,905,484**

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	0	0	0	0	3	2,295
Baldwin	0	0	0	0	0	0	1	219
Banks	56	461,406	257	354,586	23	170,511	266	337,716
Barrow	9	98,135	64	135,106	6	41,053	90	225,412
Bartow	0	0	0	0	0	0	1	396
Bibb	1	146,373	0	0	1	6,248	1	665
Bulloch	0	0	1	2	0	0	0	0
Butts	0	0	1	8,910	0	0	0	0
Carroll	0	0	0	0	0	0	5	5,274
Cherokee	0	0	4	18,388	2	37,474	11	16,513
Clarke	0	0	2	3,436	3	34,019	19	36,158
Clay	2	550	0	0	0	0	0	0
Clayton	0	0	0	0	0	0	1	4,826
Clinch	2	1,953	2	2,276	1	21,019	1	3,347
Cobb	4	10,405	9	27,982	1	31,277	33	32,163
Dawson	34	488,005	226	297,125	14	187,010	166	279,903
DeKalb	0	0	5	13,625	1	38,365	11	17,799
Elbert	3	1,959	4	6,904	0	0	3	598
Evans	0	0	0	0	0	0	2	7,216
Fannin	6	77,803	1	78,679	0	0	14	22,436
Fayette	0	0	1	3,567	0	0	0	0
Forsyth	17	194,374	70	123,799	5	99,577	166	267,185
Franklin	3	26,108	32	15,017	5	47,198	36	48,074
Fulton	1	17,580	11	39,153	3	97,340	32	51,414
Gilmer	0	0	2	9,005	0	0	12	18,663
Greene	0	0	0	0	1	8,367	0	0
Gwinnett	35	420,035	251	481,540	16	127,973	298	450,340
Habersham	145	1,124,960	543	832,264	79	594,019	592	792,755
Hall	1,136	10,731,349	9,188	12,850,676	494	3,890,305	8,806	10,210,531
Hart	0	0	0	0	0	0	16	28,253
Henry	0	0	0	0	0	0	1	872
Jackson	107	1,854,480	581	932,181	50	259,935	602	735,960

Lowndes	0	0	0	0	0	0	1	580
Lumpkin	70	653,626	333	389,631	24	156,230	356	540,322
Madison	0	0	9	4,628	0	0	5	7,390
Morgan	0	0	0	0	1	22,573	0	0
Murray	0	0	0	0	0	0	6	6,340
North Carolina	7	51,161	15	31,823	0	0	15	17,820
Other Out of State	25	640,359	28	37,604	5	90,934	143	161,972
Pickens	0	0	16	40,867	2	203	3	2,646
Polk	0	0	0	0	0	0	1	630
Rabun	39	581,281	205	496,037	17	289,878	96	193,299
Richmond	0	0	0	0	0	0	2	1,044
Rockdale	0	0	0	0	0	0	1	566
South Carolina	0	0	6	3,881	3	5,014	8	13,220
Spalding	0	0	0	0	0	0	2	1,119
Stephens	51	436,235	152	304,169	21	269,829	144	126,244
Sumter	0	0	0	0	0	0	2	7,606
Tennessee	0	0	0	0	0	0	1	2,791
Thomas	0	0	0	0	0	0	1	342
Towns	16	194,027	9	36,104	2	9,244	15	12,134
Union	14	505,623	47	92,156	14	1,720	60	91,474
Walker	0	0	1	1,448	0	0	0	0
Walton	1	4,257	2	846	0	0	27	27,299
Washington	0	0	0	0	0	0	1	2,206
White	153	896,704	1,014	1,417,382	55	640,205	893	1,201,133
Whitfield	0	0	0	0	0	0	1	3,259
Total	**1,937**	**19,618,748**	**13,092**	**19,090,797**	**849**	**7,177,520**	**12,973**	**16,018,419**

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	30,470,787	8,238,758
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	2,434,816	2,010,783
C.	Other Patients in accordance with the department approved policy.	0	13,837,505	4,912,438

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	12,376	3,537

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: James Gardner Jr

Date: 9/30/2009

Title: President & CEO

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: Anthony M. Herdener

Date: 9/30/2009

Title: Vice President Finance & Systems / CFO

Comments: