GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 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 2009 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2008 To:9/30/2009

Please indicate your cost report year.
From: 10/01/2008 To:09/30/2009

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	807,891,773
Total Inpatient Admissions accounting for Inpatient Revenue	27,462
Outpatient Gross Patient Revenue	582,992,736
Total Outpatient Visits accounting for Outpatient Revenue	254,942
Medicare Contractual Adjustments	438,393,161
Medicaid Contractual Adjustments	116,515,926
Other Contractual Adjustments:	245,903,044
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	45,238,022
Uncompensated Indigent Care (net):	35,104,395
Uncompensated Charity Care (net):	27,793,687
Other Free Care:	23,569,983
Other Revenue/Gains:	-32,116,106
Total Expenses:	400,878,899

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 2009? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2009?

09/01/2009

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.?

Dir. of Patient Access or Mgr. of Financial Counseling

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 2009? (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	13,603,398	10,365,844	23,969,242
Outpatient	21,500,997	17,427,843	38,928,840
Total	**35,104,395**	**27,793,687**	**62,898,082**

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	13,603,398	10,365,844	23,969,242
Outpatient	21,500,997	17,427,843	38,928,840
Total	**35,104,395**	**27,793,687**	**62,898,082**

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	1	5,359	3	13,085
Appling	0	0	0	0	0	0	1	2,501
Baldwin	0	0	0	0	0	0	1	579
Banks	33	389,825	232	343,525	27	230,601	313	457,603
Barrow	7	242,087	28	18,432	7	156,904	105	343,040
Bartow	1	34,068	0	0	0	0	3	3,421
Bibb	0	0	0	0	0	0	2	500
Brooks	0	0	0	0	0	0	0	0
Carroll	0	0	2	5,467	0	0	5	3,079
Chatham	0	0	2	86	0	0	1	551
Cherokee	0	0	0	0	1	25,326	1	1,817
Clarke	2	36,863	12	25,389	1	3,185	16	18,952
Clinch	4	10,947	0	0	2	25,111	1	127
Cobb	0	0	6	4,907	0	0	17	14,578
Coweta	0	0	0	0	0	0	2	1,366
Dade	0	0	0	0	0	0	1	1,819
Dawson	23	284,727	196	272,572	21	490,121	211	331,711
DeKalb	0	0	0	0	1	10,925	14	11,041
Dougherty	0	0	0	0	0	0	1	1,501
Douglas	1	93,250	2	3,889	0	0	1	565
Elbert	0	0	0	0	0	0	6	10,898
Evans	0	0	0	0	0	0	1	1,096
Fannin	1	14,132	1	211	0	0	3	4,445
Forsyth	9	72,663	51	118,749	12	220,254	107	192,908
Franklin	6	1,332	12	28,646	3	613	19	21,121
Fulton	1	70,842	0	0	1	23,788	24	32,839
Gilmer	0	0	0	0	1	6,005	5	5,563
Gordon	0	0	0	0	0	0	1	951
Greene	0	0	0	0	0	0	5	5,606
Gwinnett	34	695,229	252	517,080	29	304,214	323	403,871
Habersham	73	483,026	557	973,212	79	664,623	746	862,538
Hall	823	8,021,935	9,488	15,686,660	654	5,707,933	9,603	10,816,564

Hart	1	520	0	0	0	0	5	5,284
Henry	0	0	0	0	0	0	1	579
Jackson	52	508,712	657	931,597	80	406,879	748	985,668
Jasper	0	0	0	0	0	0	1	1,259
Lowndes	0	0	0	0	0	0	1	778
Lumpkin	47	601,526	239	399,798	44	361,932	448	697,677
Madison	0	0	0	0	5	38,151	2	1,514
Marion	0	0	0	0	0	0	1	1,273
Montgomery	1	10,211	0	0	0	0	0	0
Morgan	0	0	0	0	1	133	0	0
Muscogee	0	0	0	0	0	0	5	6
North Carolina	2	38,989	0	0	2	57,329	8	5,522
Oconee	1	300	0	0	0	0	2	9,673
Other Out of State	6	21,519	17	11,381	13	281,101	103	148,898
Paulding	0	0	0	0	0	0	1	1,024
Pickens	0	0	8	34,903	1	24,973	4	3,306
Pike	0	0	1	6,962	0	0	0	0
Putnam	0	0	0	0	0	0	1	1,511
Rabun	42	436,513	114	288,468	33	410,660	153	312,819
Rockdale	0	0	0	0	0	0	1	709
South Carolina	0	0	0	0	0	0	2	3,027
Stephens	27	453,527	162	293,831	34	386,381	167	274,016
Tift	0	0	0	0	0	0	1	1,642
Towns	14	76,853	50	65,263	7	3,630	23	24,455
Union	27	111,433	67	105,808	19	148,392	45	86,034
Walton	0	0	12	25,548	0	0	10	24,383
White	93	892,369	853	1,338,613	89	371,321	950	1,270,550
Total	**1,331**	**13,603,398**	**13,021**	**21,500,997**	**1,168**	**10,365,844**	**14,225**	**17,427,843**

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 2009? (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 2009.

	Patient Category	SFY 2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09	SFY2010 7/1/09-6/30/10
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	22,447,891	12,656,504
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	4,184,967	2,533,801
C.	Other Patients in accordance with the department approved policy.	0	16,656,575	4,418,344

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09	SFY2010 7/1/09-6/30/10
0	11,511	5,489

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: 8/4/2010

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: 8/4/2010

Title: Vice President Finance & Systems / CFO

Comments: