



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2010 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP366

Facility Name: Gwinnett Medical Center

County: Gwinnett

Street Address: 1000 Medical Center Boulevard

City: Lawrenceville

Zip: 30045-7694

Mailing Address: PO Box 1190

Mailing City: Lawrenceville

Mailing Zip: 30046

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2010 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 7/1/2009 To:6/30/2010

Please indicate your cost report year.

From: 07/01/2009 To:06/30/2010

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: Hans Schermerhorn

Contact Title: Senior Governmental Reimbursement Advisor

Phone: 678-312-5622

Fax: 770-339-3459

E-mail: hschermerhorn@gwinnettmmedicalcenter.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	439,277,851
Total Inpatient Admissions accounting for Inpatient Revenue	18,484
Outpatient Gross Patient Revenue	581,586,137
Total Outpatient Visits accounting for Outpatient Revenue	285,609
Medicare Contractual Adjustments	162,071,050
Medicaid Contractual Adjustments	100,910,048
Other Contractual Adjustments:	284,296,618
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	66,057,465
Uncompensated Indigent Care (net):	37,451,164
Uncompensated Charity Care (net):	22,686,874
Other Free Care:	2,803,627
Other Revenue/Gains:	22,046,605
Total Expenses:	328,083,774

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 2010? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2010?

03/01/2007

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.?

Assistant Vice President, Revenue Management

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.)?

200%

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 2010? (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	17,869,256	10,214,486	28,083,742
Outpatient	20,246,394	12,472,388	32,718,782
Total	38,115,650	22,686,874	60,802,524

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	391,500
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	272,986
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	664,486

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	17,537,013	10,214,486	27,751,499
Outpatient	19,914,151	12,472,388	32,386,539
Total	37,451,164	22,686,874	60,138,038

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	22,023	0	0	0	0	2	2,713
Banks	1	1,033	0	0	0	0	2	16,967
Barrow	59	1,028,387	463	1,098,397	92	1,018,372	551	722,496
Bartow	0	0	0	0	1	35,757	0	0
Bibb	0	0	0	0	1	74,350	1	333
Bleckley	0	0	1	40	0	0	0	0
Cherokee	2	16,534	1	1,298	1	40,465	0	0
Clarke	5	249,371	19	76,014	0	0	1	531
Clayton	2	55,823	9	103,671	0	0	9	12,045
Cobb	3	91,746	13	60,526	6	245,208	31	65,013
Cook	0	0	1	213	0	0	0	0
Coweta	0	0	0	0	0	0	4	3,825
Dawson	1	22,714	2	17,020	1	456	1	4,019
DeKalb	34	751,103	214	626,409	48	652,655	238	403,344
Dodge	0	0	2	4,659	0	0	0	0
Dougherty	0	0	0	0	0	0	2	1,512
Douglas	0	0	7	6,081	1	33,755	3	1,752
Elbert	0	0	0	0	1	495	0	0
Fayette	0	0	0	0	0	0	2	1,078
Florida	2	41,272	2	2,284	4	56,927	7	9,975
Floyd	0	0	1	8,144	0	0	0	0
Forsyth	3	206,456	7	42,479	2	103,343	17	26,521
Franklin	2	57,423	16	28,876	0	0	1	145
Fulton	4	61,836	41	149,504	9	228,784	79	70,816
Gilmer	0	0	1	2,785	0	0	0	0
Gordon	0	0	2	684	0	0	0	0
Greene	0	0	0	0	2	22,294	2	1,502
Gwinnett	729	14,173,553	6,532	16,563,711	709	6,784,660	6,897	10,354,899
Habersham	0	0	0	0	1	1,070	4	2,992
Hall	18	3,015	98	517,820	16	143,601	72	168,011
Hart	0	0	6	1,050	0	0	2	8,327
Henry	1	1,070	0	0	1	20,981	4	4,286

Jackson	19	268,161	94	154,888	22	170,166	103	177,737
Lowndes	0	0	1	1,854	0	0	0	0
Lumpkin	0	0	4	7,270	0	0	2	2,483
Madison	0	0	6	44,417	2	1,658	16	97,388
Miller	0	0	0	0	1	500	0	0
Morgan	1	32,265	3	4,126	0	0	0	0
Muscogee	0	0	1	1,985	0	0	0	0
Newton	4	114,008	20	78,605	3	36,506	13	22,114
North Carolina	0	0	0	0	0	0	1	100
Oconee	1	1,050	3	9,901	3	189,601	1	11,036
Oglethorpe	0	0	0	0	0	0	1	126
Other Out of State	12	365,753	39	111,882	10	283,202	65	148,555
Peach	0	0	13	140,904	1	550	0	0
Pickens	1	32,215	2	5,703	0	0	0	0
Putnam	0	0	2	977	1	1,073	1	31
Richmond	0	0	0	0	0	0	1	2,098
Rockdale	1	31,415	20	21,167	0	0	9	6,445
South Carolina	0	0	0	0	3	15,421	2	1,881
Spalding	0	0	1	7,002	0	0	1	873
Stephens	0	0	3	4,142	0	0	0	0
Stewart	0	0	0	0	0	0	1	142
Tennessee	0	0	0	0	1	33,126	0	0
Thomas	0	0	1	1,231	1	1,113	1	395
Tift	1	1,654	0	0	0	0	0	0
Troup	0	0	0	0	0	0	3	10,784
Union	1	789	0	0	0	0	0	0
Upson	0	0	0	0	0	0	1	197
Walker	0	0	0	0	0	0	2	1,611
Walton	6	110,207	76	322,638	6	12,620	38	102,153
Washington	0	0	0	0	0	0	1	418
White	2	128,380	14	16,037	2	5,777	0	0
Wilkes	0	0	0	0	0	0	2	2,719
Total	916	17,869,256	7,741	20,246,394	952	10,214,486	8,197	12,472,388

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 2010?
(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 2010.

Patient Category		SFY 2010 7/1/09-6/30/10	SFY2010 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	38,115,650	0
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	8,482,046	0
C.	Other Patients in accordance with the department approved policy.	0	14,204,827	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2010 7/1/09-6/30/10	SFY2010 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
0	8,971	0

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: Philip R. Wolfe

Date: 7/6/2011

Title: President and 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: Thomas Y. McBride III

Date: 7/6/2011

Title: Executive Vice President and CFO

Comments:

Deductions were estimated for professional fees due to lack of transaction code to specifically identify professional fee contractals and adjustments for accounts that had both hospital and professional fee charges. Indigent and Charity Care charges reported in E.1. of the survey represent charges written off to indigent or charity and are net of payments from any payor including state programs. Payments reported in E.2. of the survey are payments for indigent or charity care that were not posted at the account level.