GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 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 2010 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2009 To:9/30/2010

Please indicate your cost report year.
From: 10/01/2009 To:09/30/2010

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: 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	915,047,729
Total Inpatient Admissions accounting for Inpatient Revenue	28,170
Outpatient Gross Patient Revenue	667,262,230
Total Outpatient Visits accounting for Outpatient Revenue	309,112
Medicare Contractual Adjustments	504,495,463
Medicaid Contractual Adjustments	144,971,373
Other Contractual Adjustments:	285,934,144
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	47,652,371
Uncompensated Indigent Care (net):	47,382,541
Uncompensated Charity Care (net):	36,766,187
Other Free Care:	19,440,426
Other Revenue/Gains:	20,096,770
Total Expenses:	447,340,902

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?

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 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	20,659,518	16,026,070	36,685,588
Outpatient	26,723,023	20,740,117	47,463,140
Total	**47,382,541**	**36,766,187**	**84,148,728**

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	20,659,518	16,026,070	36,685,588
Outpatient	26,723,023	20,740,117	47,463,140
Total	**47,382,541**	**36,766,187**	**84,148,728**

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	1	786	0	0	0	0
Banks	19	194,522	175	459,843	22	489,602	253	554,056
Barrow	3	98,922	38	113,231	7	240,533	102	179,394
Bibb	0	0	0	0	0	0	2	1,149
Carroll	0	0	0	0	0	0	1	4,201
Chatham	0	0	1	37	0	0	1	1,425
Cherokee	0	0	3	46	0	0	20	20,011
Clarke	2	9,597	2	2,705	2	40,038	24	17,385
Clinch	2	5	0	0	1	2	3	3,265
Cobb	1	14,277	2	12,258	0	0	13	52,673
Dawson	27	654,736	149	233,157	19	408,984	217	392,236
DeKalb	1	2	0	0	1	29,775	17	24,701
Douglas	0	0	1	1,185	0	0	1	1,478
Elbert	0	0	0	0	0	0	4	3,412
Fannin	0	0	0	0	2	54,858	11	10,205
Fayette	1	24,279	0	0	0	0	0	0
Florida	0	0	0	0	0	0	2	1,044
Forsyth	4	246,817	75	245,891	10	135,960	164	253,330
Franklin	5	288,627	11	83,118	6	65,460	35	109,679
Fulton	2	101,992	16	54,924	0	0	40	79,694
Gilmer	0	0	0	0	0	0	11	14,501
Greene	0	0	0	0	0	0	1	623
Gwinnett	25	488,634	237	632,116	22	175,682	304	425,150
Habersham	61	1,184,274	442	1,253,857	58	931,250	543	937,426
Hall	629	11,923,307	8,698	19,029,267	544	9,122,414	8,556	13,133,293
Hart	3	125,651	9	1,780	1	11,268	5	56,136
Henry	0	0	0	0	0	0	2	1,705
Jackson	55	763,791	473	1,045,910	52	880,908	688	1,113,740
Lumpkin	36	540,568	274	512,065	39	599,863	408	845,599
Madison	0	0	0	0	0	0	5	3,713
McIntosh	0	0	0	0	0	0	1	1,399
Monroe	0	0	0	0	0	0	1	1,300

Murray	0	0	0	0	0	0	8	9,924
Newton	0	0	0	0	0	0	1	250
North Carolina	0	0	0	0	3	99,984	9	14,512
Oconee	0	0	1	2,950	1	4,278	1	290
Other Out of State	13	361,360	8	4,168	11	292,723	132	180,294
Paulding	0	0	0	0	0	0	2	2,459
Pickens	0	0	0	0	1	4,875	8	20,091
Rabun	16	454,350	132	448,498	28	324,549	93	242,392
Richmond	0	0	0	0	0	0	4	2,831
Rockdale	0	0	0	0	0	0	2	865
Screven	0	0	0	0	0	0	1	2,449
South Carolina	1	16,840	0	0	2	25,433	11	20,124
Stephens	22	228,759	128	300,045	23	829,389	107	274,855
Sumter	0	0	0	0	0	0	2	2,041
Tennessee	0	0	0	0	0	0	1	616
Towns	5	96,147	82	183,129	9	327,803	26	19,681
Union	12	423,718	29	132,837	3	67,969	41	77,379
Walton	1	12,656	3	6,955	0	0	16	22,164
White	98	2,405,687	744	1,962,265	76	862,470	783	1,602,137
Wilkinson	0	0	0	0	0	0	1	840
Total	**1,044**	**20,659,518**	**11,734**	**26,723,023**	**943**	**16,026,070**	**12,684**	**20,740,117**

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	34,195,993	13,186,548
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	9,234,186	3,691,695
C.	Other Patients in accordance with the department approved policy.	0	16,284,467	7,555,839

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	12,403	4,093

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: Carol H. Burrell

Date: 7/8/2011

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: 7/8/2011

Title: Vice President Finance & Systems / CFO

Comments: