GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2011 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

Mailing Address: 743 Spring Street NE

Mailing City: Gainesville

Mailing Zip: 30501

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2011 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2010 To:9/30/2011

Please indicate your cost report year.
From: 10/01/2010 To:09/30/2011

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	973,181,781
Total Inpatient Admissions accounting for Inpatient Revenue	27,891
Outpatient Gross Patient Revenue	756,844,328
Total Outpatient Visits accounting for Outpatient Revenue	347,701
Medicare Contractual Adjustments	583,533,668
Medicaid Contractual Adjustments	152,851,545
Other Contractual Adjustments:	314,336,129
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	55,925,868
Uncompensated Indigent Care (net):	49,201,286
Uncompensated Charity Care (net):	50,931,971
Other Free Care:	20,156,511
Other Revenue/Gains:	38,831,433
Total Expenses:	465,817,580

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 2011? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2011?

10/01/2010

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 2011? (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	19,542,915	20,168,314	39,711,229
Outpatient	29,658,371	30,763,657	60,422,028
Total	**49,201,286**	**50,931,971**	**100,133,257**

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	19,542,915	20,168,314	39,711,229
Outpatient	29,658,371	30,763,657	60,422,028
Total	**49,201,286**	**50,931,971**	**100,133,257**

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	53,426	0	0	2	61,738	2	8,553
Baldwin	0	0	0	0	0	0	1	5,219
Banks	19	440,865	140	986,109	26	209,335	294	689,622
Barrow	2	36,495	49	181,484	6	108,576	101	167,444
Bartow	0	0	0	0	0	0	3	2,299
Carroll	0	0	0	0	0	0	3	4,071
Chatham	0	0	0	0	0	0	1	342
Cherokee	1	13,095	2	3,633	0	0	10	17,991
Clarke	0	0	2	5,324	4	6,160	24	41,485
Clay	2	64,870	0	0	0	0	2	2,749
Clinch	0	0	0	0	2	314,720	0	0
Cobb	2	54,849	0	0	3	75,615	15	37,370
Colquitt	0	0	0	0	0	0	1	938
Coweta	0	0	0	0	0	0	1	4,530
Dawson	27	896,100	174	587,923	26	774,966	225	594,853
DeKalb	0	0	11	3,233	2	15,845	14	26,443
Douglas	0	0	0	0	1	5,280	5	3,606
Elbert	1	2	0	0	0	0	2	5,576
Emanuel	0	0	0	0	0	0	1	2,768
Fannin	0	0	1	708	1	14,537	5	8,818
Florida	2	113,163	0	0	1	46,123	19	57,549
Forsyth	11	155,804	78	220,636	13	162,739	168	367,590
Franklin	3	114,440	10	118,120	6	62,548	33	132,233
Fulton	2	277,037	2	8,492	2	27,607	42	86,307
Gilmer	2	63,483	1	3,267	1	8,630	9	7,413
Glynn	0	0	0	0	0	0	1	1,038
Greene	0	0	0	0	0	0	4	12,419
Gwinnett	32	990,599	226	754,744	17	256,765	330	604,389
Habersham	75	876,652	471	1,314,822	75	1,631,052	551	1,537,822
Hall	480	10,315,051	8,125	20,432,857	645	10,563,449	10,012	19,711,322
Hart	0	0	0	0	5	91,941	18	77,692
Henry	0	0	0	0	0	0	3	1,616

Jackson	38	653,876	481	1,011,207	83	1,249,386	868	1,371,154
Jefferson	0	0	0	0	0	0	2	5,539
Jenkins	0	0	0	0	0	0	1	342
Johnson	0	0	0	0	0	0	1	3,790
Lumpkin	33	1,080,395	292	981,514	54	1,045,255	470	1,280,721
Madison	2	60,272	0	0	0	0	12	17,038
Monroe	0	0	0	0	0	0	2	6,603
Newton	0	0	0	0	0	0	7	9,099
North Carolina	1	67,970	3	52,069	3	57,071	15	21,537
Oconee	0	0	1	1,125	1	36,043	2	1,797
Other Out of State	14	742,193	10	28,748	12	229,755	187	310,649
Paulding	0	0	0	0	0	0	1	342
Pickens	0	0	0	0	1	35,416	11	13,215
Rabun	17	334,121	171	653,055	15	342,478	98	323,278
Richmond	0	0	0	0	0	0	0	0
Rockdale	0	0	0	0	0	0	1	1,053
South Carolina	0	0	0	0	3	50,659	16	37,164
Spalding	0	0	0	0	0	0	1	975
Stephens	21	517,705	98	500,435	22	613,920	170	505,613
Tattnall	0	0	0	0	0	0	1	1,495
Tennessee	0	0	2	75	0	0	2	684
Towns	8	22,837	26	150,081	8	214,491	12	23,963
Union	7	86,190	29	117,856	10	277,370	23	109,563
Walton	1	22,750	1	1,827	1	10,190	11	14,241
Wayne	0	0	0	0	0	0	1	5,359
White	76	1,488,675	601	1,539,027	98	1,568,654	848	2,476,376
Total	**880**	**19,542,915**	**11,007**	**29,658,371**	**1,149**	**20,168,314**	**14,663**	**30,763,657**

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 2011? (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 2011.

	Patient Category	SFY 2010 7/1/09-6/30/10	SFY2011 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	38,432,317	10,768,969
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	9,080,338	2,675,164
C.	Other Patients in accordance with the department approved policy.	0	26,969,052	12,207,417

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2010 7/1/09-6/30/10	SFY2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
0	9,922	2,965

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: 7/13/2012

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: 7/13/2012

Title: Vice President Finance & Systems / CFO

Comments: