GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP902

Facility Name: Emory Hillandale Hospital

County: DeKalb

Street Address: 2801 Dekalb Medical Parkway

City: Lithonia

Zip: 30058-4996

Mailing Address: 2801 Dekalb Medical Parkway

Mailing City: Lithonia

Mailing Zip: 30058-4996

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2020 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 9/1/2019 To:8/31/2020

Please indicate your cost report year.
From: 09/01/2019 To:08/31/2020

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Dawn Stone
Contact Title: Controller
Phone: 404-501-5686
Fax: 404-501-2891
E-mail: dawn.stone@emoryhealthcare.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	133,375,694
Total Inpatient Admissions accounting for Inpatient Revenue	4,411
Outpatient Gross Patient Revenue	233,525,549
Total Outpatient Visits accounting for Outpatient Revenue	79,063
Medicare Contractual Adjustments	102,643,729
Medicaid Contractual Adjustments	58,588,325
Other Contractual Adjustments:	65,938,007
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	30,506,179
Gross Indigent Care:	1,988,897
Gross Charity Care:	31,140,384
Uncompensated Indigent Care (net):	1,988,897
Uncompensated Charity Care (net):	31,140,384
Other Free Care:	0
Other Revenue/Gains:	1,010,667
Total Expenses:	70,548,773

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 2020? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2020?

06/01/2019

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 Financial Services

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.)?

225%

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 2020? (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	1,014,015	8,889,028	9,903,043
Outpatient	974,882	22,251,356	23,226,238
Total	**1,988,897**	**31,140,384**	**33,129,281**

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	1,014,015	8,889,028	9,903,043
Outpatient	974,882	22,251,356	23,226,238
Total	**1,988,897**	**31,140,384**	**33,129,281**

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	2	19,166	34	41,720
BAKER	0	0	0	0	0	0	1	2,089
BALDWIN	0	0	0	0	0	0	2	1,137
BARROW	0	0	0	0	0	0	7	5,304
BARTOW	0	0	0	0	0	0	5	7,988
BEN HILL	0	0	0	0	0	0	2	770
BIBB	0	0	0	0	1	4,248	13	21,824
BULLOCH	0	0	0	0	0	0	2	861
BUTTS	0	0	0	0	0	0	5	10,624
CALHOUN	0	0	0	0	0	0	1	1,152
CANDLER	0	0	0	0	0	0	1	490
CARROLL	0	0	0	0	0	0	6	6,156
CATOOSA	0	0	0	0	0	0	1	718
CHATHAM	0	0	0	0	0	0	6	3,897
CHATTOOGA	0	0	0	0	0	0	3	4,948
CHEROKEE	0	0	0	0	1	7,632	5	3,717
CLARKE	0	0	0	0	0	0	6	9,780
CLAYTON	1	9,971	1	19,332	11	123,842	262	408,212
COBB	0	0	0	0	3	12,813	90	89,688
COWETA	0	0	0	0	0	0	3	1,403
CRAWFORD	0	0	0	0	0	0	1	677
CRISP	0	0	0	0	0	0	2	1,698
DAWSON	0	0	0	0	0	0	1	460
DECATUR	0	0	0	0	1	45,045	23	38,242
DEKALB	32	979,254	244	891,959	556	7,522,566	12,385	18,092,259
DODGE	0	0	0	0	0	0	1	157
DOUGHERTY	0	0	0	0	0	0	4	3,631
DOUGLAS	0	0	0	0	1	18,507	24	28,436
EFFINGHAM	0	0	0	0	0	0	2	2,918
FAYETTE	0	0	0	0	0	0	16	11,958
FLORIDA	0	0	0	0	4	38,430	62	77,524
FLOYD	0	0	0	0	0	0	5	5,328

FORSYTH	0	0	0	0	0	0	3	4,829
FRANKLIN	0	0	0	0	0	0	1	617
FULTON	0	0	2	5,516	19	386,848	782	1,414,522
GREENE	0	0	0	0	0	0	6	14,195
GWINNETT	0	0	8	14,931	13	164,211	310	445,601
HALL	0	0	0	0	0	0	8	7,995
HANCOCK	0	0	0	0	0	0	3	2,189
HARALSON	0	0	0	0	0	0	1	590
HARRIS	0	0	0	0	0	0	1	225
HENRY	1	1,836	2	12,304	5	29,484	138	196,061
HOUSTON	0	0	0	0	1	37,052	2	868
JACKSON	0	0	0	0	0	0	3	2,898
JASPER	0	0	0	0	0	0	3	1,888
JEFFERSON	0	0	0	0	0	0	1	986
LEE	0	0	0	0	0	0	2	2,376
LIBERTY	0	0	0	0	0	0	8	14,595
LOWNDES	0	0	0	0	1	10,507	6	10,626
LUMPKIN	0	0	0	0	0	0	2	3,060
MCINTOSH	0	0	0	0	0	0	1	842
MERIWETHER	0	0	0	0	0	0	3	7,737
MITCHELL	0	0	0	0	1	13,351	3	4,383
MONROE	0	0	0	0	0	0	4	9,938
MORGAN	0	0	0	0	0	0	3	2,822
MUSCOGEE	0	0	0	0	0	0	11	21,994
NEWTON	0	0	0	0	4	71,459	191	262,461
NORTH CAROLINA	0	0	0	0	4	18,330	24	28,939
OTHER OUT OF STAT	1	9,000	1	6,596	9	84,902	194	233,379
PAULDING	0	0	0	0	0	0	9	23,053
PIERCE	0	0	0	0	0	0	3	4,183
PUTNAM	0	0	0	0	0	0	2	2,022
RICHMOND	0	0	0	0	0	0	11	13,999
ROCKDALE	1	13,953	6	17,423	12	225,855	370	484,520
SCHLEY	0	0	0	0	0	0	2	744
SOUTH CAROLINA	0	0	0	0	3	18,574	31	38,040
SPALDING	0	0	0	0	0	0	17	19,247
STEPHENS	0	0	0	0	0	0	1	225
SUMTER	0	0	0	0	0	0	2	3,393
TALBOT	0	0	0	0	0	0	3	2,964
TALIAFERRO	0	0	0	0	1	13,332	0	0
TENNESSEE	0	0	0	0	2	22,875	15	15,880
THOMAS	0	0	0	0	0	0	1	806
TROUP	0	0	0	0	0	0	7	10,933
UNION	0	0	0	0	0	0	1	157
UPSON	0	0	0	0	0	0	4	14,401

WALTON	0	0	1	6,822	0	0	25	26,478
WARREN	0	0	0	0	0	0	1	1,988
WASHINGTON	0	0	0	0	0	0	1	1,049
WHITE	0	0	0	0	0	0	1	2,913
WHITFIELD	0	0	0	0	0	0	1	1,978
Total	**36**	**1,014,014**	**265**	**974,883**	**655**	**8,889,029**	**15,203**	**22,251,355**

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 2020? (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 2020.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2020 7/1/18-6/30/19	SFY2020 7/1/19-6/30/20
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	1,904,459	84,438
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	26,337,853	4,802,531
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2018 7/1/17-6/30/18	SFY2020 7/1/18-6/30/19	SFY2020 7/1/19-6/30/20
0	10,232	1,583

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 Forstner

Date: 7/26/2021

Title: 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: Liz Daunt-Samford

Date: 7/26/2021

Title: Chief Financial Officer

Comments: