



2020 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP720

Facility Name: Emory Decatur Hospital

County: DeKalb

Street Address: 2701 North Decatur Road

City: Decatur

Zip: 30033-5995

Mailing Address: 2701 North Decatur Road

Mailing City: Decatur

Mailing Zip: 30033-5995

2. Report Period

Please report data for the hospital fiscal year ending during calendar 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	620,885,521
Total Inpatient Admissions accounting for Inpatient Revenue	18,085
Outpatient Gross Patient Revenue	545,645,829
Total Outpatient Visits accounting for Outpatient Revenue	126,345
Medicare Contractual Adjustments	374,673,820
Medicaid Contractual Adjustments	179,362,229
Other Contractual Adjustments:	213,416,533
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	46,407,015
Gross Indigent Care:	2,239,995
Gross Charity Care:	49,279,474
Uncompensated Indigent Care (net):	2,239,995
Uncompensated Charity Care (net):	49,279,474
Other Free Care:	0
Other Revenue/Gains:	10,695,352
Total Expenses:	361,992,881

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.?

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	1,111,217	22,375,609	23,486,826
Outpatient	1,128,778	26,903,865	28,032,643
Total	2,239,995	49,279,474	51,519,469

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	1,111,217	22,375,609	23,486,826
Outpatient	1,128,778	26,903,865	28,032,643
Total	2,239,995	49,279,474	51,519,469

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	8	56,850	108	49,357
BANKS	0	0	0	0	0	0	1	357
BARROW	2	815	0	0	1	0	9	9,861
BARTOW	0	0	0	0	1	3,524	4	4,124
BIBB	0	0	0	0	1	6,635	12	18,086
BRYAN	0	0	0	0	1	3,699	2	1,560
BULLOCH	0	0	0	0	0	0	1	6,945
BUTTS	0	0	0	0	0	0	5	7,664
CALHOUN	0	0	0	0	0	0	2	2,728
CAMDEN	0	0	0	0	1	8,231	1	7,175
CARROLL	0	0	0	0	2	5,100	17	20,664
CATOOSA	0	0	0	0	0	0	1	881
CHATHAM	0	0	0	0	3	18,795	11	31,574
CHEROKEE	0	0	0	0	2	21,939	13	15,115
CLARKE	0	0	0	0	1	9,008	5	7,164
CLAY	0	0	0	0	0	0	1	2,034
CLAYTON	0	0	7	21,113	34	293,441	276	520,657
COBB	0	0	5	12,856	23	425,768	135	191,419
COFFEE	0	0	0	0	0	0	1	642
COLQUITT	0	0	1	32,644	0	0	0	0
COLUMBIA	0	0	0	0	0	0	1	360
COOK	0	0	0	0	0	0	2	2,364
COWETA	0	0	0	0	2	5,583	13	20,045
CRISP	0	0	0	0	0	0	3	3,850
DADE	0	0	0	0	0	0	1	1,481
DAWSON	0	0	0	0	0	0	4	5,476
DECATUR	0	0	0	0	1	26,753	23	33,813
DEKALB	47	952,831	224	927,522	1,315	17,559,009	11,249	20,918,114
DODGE	0	0	0	0	0	0	1	947
DOUGHERTY	0	0	0	0	0	0	8	8,348
DOUGLAS	0	0	0	0	8	87,876	33	102,432
EARLY	0	0	6	2,629	0	0	0	0

ELBERT	0	0	0	0	0	0	1	317
EVANS	0	0	0	0	0	0	1	111
FANNIN	0	0	0	0	0	0	2	2,413
FAYETTE	0	0	2	4,031	2	7,856	18	23,749
FLORIDA	0	0	0	0	9	36,939	63	75,754
FLOYD	0	0	0	0	0	0	6	81,158
FORSYTH	0	0	1	2,356	0	0	13	21,692
FRANKLIN	0	0	0	0	1	7,212	1	1,048
FULTON	3	53,599	29	61,085	147	2,031,485	1,272	2,482,372
GLYNN	0	0	0	0	0	0	3	7,367
GORDON	0	0	0	0	0	0	2	3,917
GWINNETT	8	69,916	23	47,962	82	888,277	574	943,500
HABERSHAM	0	0	0	0	0	0	2	1,971
HALL	0	0	0	0	2	16,901	26	35,772
HANCOCK	0	0	0	0	0	0	2	2,707
HARALSON	0	0	0	0	0	0	2	2,276
HARRIS	0	0	0	0	0	0	3	1,300
HART	0	0	0	0	0	0	3	2,150
HEARD	0	0	0	0	0	0	1	1,118
HENRY	0	0	3	2,688	18	133,282	103	147,689
HOUSTON	0	0	0	0	1	16,050	8	15,366
IRWIN	0	0	0	0	0	0	2	1,692
JACKSON	0	0	0	0	0	0	9	8,878
JASPER	0	0	0	0	0	0	3	8,178
JEFFERSON	0	0	0	0	1	2,857	3	2,839
JENKINS	0	0	0	0	0	0	1	5,142
LAMAR	0	0	0	0	0	0	1	589
LAURENS	0	0	0	0	0	0	2	2,894
LIBERTY	0	0	0	0	0	0	3	6,857
LINCOLN	0	0	0	0	0	0	1	4,784
LONG	0	0	0	0	0	0	1	1,394
LOWNDES	0	0	0	0	0	0	5	9,057
LUMPKIN	0	0	0	0	0	0	3	8,409
MACON	0	0	0	0	0	0	6	4,717
MADISON	0	0	0	0	0	0	1	2,641
MCDUFFIE	0	0	0	0	0	0	1	597
MONROE	0	0	0	0	1	5,925	4	4,180
MORGAN	0	0	0	0	0	0	4	6,736
MURRAY	0	0	0	0	0	0	1	986
MUSCOGEE	0	0	0	0	2	43,793	15	21,343
NEWTON	0	0	2	2,106	9	201,502	83	118,976
NORTH CAROLINA	0	0	0	0	3	12,922	44	71,871
OTHER OUT OF STAT	1	32,700	0	0	27	157,045	224	241,422
PAULDING	0	0	0	0	0	0	20	40,740

PEACH	0	0	0	0	0	0	1	1,250
PICKENS	0	0	0	0	0	0	3	1,770
PIKE	0	0	0	0	0	0	1	124
POLK	0	0	0	0	0	0	4	6,148
PUTNAM	1	1,358	0	0	0	0	3	4,611
RICHMOND	0	0	0	0	2	15,484	21	36,107
ROCKDALE	0	0	0	0	13	106,432	109	175,819
SOUTH CAROLINA	0	0	0	0	5	18,946	37	26,922
SPALDING	0	0	0	0	0	0	13	14,048
STEPHENS	0	0	0	0	0	0	3	6,590
SUMTER	0	0	0	0	0	0	2	3,291
TALBOT	0	0	0	0	1	78,315	0	0
TALIAFERRO	0	0	0	0	0	0	4	10,028
TENNESSEE	0	0	0	0	3	18,565	45	47,076
TERRELL	0	0	0	0	1	14,917	2	8,334
THOMAS	0	0	0	0	0	0	1	5,754
TOOMBS	0	0	0	0	0	0	1	1,723
TOWNS	0	0	0	0	1	2,812	0	0
TROUP	0	0	0	0	1	1,314	3	14,478
UNION	0	0	0	0	0	0	1	89
WALKER	0	0	0	0	0	0	2	2,494
WALTON	0	0	3	11,786	3	24,565	40	75,898
WAYNE	0	0	0	0	0	0	1	167
WHITE	0	0	0	0	0	0	3	26,334
WHITFIELD	0	0	0	0	0	0	4	5,806
WILCOX	0	0	0	0	0	0	2	1,653
WILKES	0	0	0	0	0	0	1	689
WORTH	0	0	0	0	0	0	1	2,756
Total	62	1,111,219	306	1,128,778	1,739	22,375,607	14,794	26,903,865

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	SFY2020	SFY2020
		7/1/17-6/30/18	7/1/18-6/30/19	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	1,999,637	240,358
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	41,798,023	7,481,451
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	SFY2020	SFY2020
7/1/17-6/30/18	7/1/18-6/30/19	7/1/19-6/30/20
0	10,354	1,582

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: 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: