



## 2021 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 calendar year 2021 only.

**Do not use a different report period.**

**Please indicate your hospital fiscal year.**

From: 9/1/2020 To:8/31/2021

**Please indicate your cost report year.**

From: 09/01/2020 To:08/31/2021

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	156,253,137
Total Inpatient Admissions accounting for Inpatient Revenue	4,768
Outpatient Gross Patient Revenue	251,746,025
Total Outpatient Visits accounting for Outpatient Revenue	80,875
Medicare Contractual Adjustments	113,352,231
Medicaid Contractual Adjustments	61,388,426
Other Contractual Adjustments:	82,405,436
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	29,120,080
Gross Indigent Care:	1,212,385
Gross Charity Care:	27,211,428
Uncompensated Indigent Care (net):	1,212,385
Uncompensated Charity Care (net):	27,211,428
Other Free Care:	88,763
Other Revenue/Gains:	356,230
Total Expenses:	85,700,404

### 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	9,161
Employee Discounts	0
Prompt Pay Discounts/Small Balance WO	79,602
<b>Total</b>	<b>88,763</b>

## 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 2021? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2021?

07/11/2019

### 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 2021? (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	380,815	8,318,741	8,699,556
Outpatient	831,570	18,892,687	19,724,257
<b>Total</b>	<b>1,212,385</b>	<b>27,211,428</b>	<b>28,423,813</b>

#### 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
<b>Total</b>	<b>0</b>

#### 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	380,815	8,318,741	8,699,556
Outpatient	831,570	18,892,687	19,724,257
<b>Total</b>	<b>1,212,385</b>	<b>27,211,428</b>	<b>28,423,813</b>

## 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	0	0	38	42,645
BALDWIN	0	0	0	0	0	0	1	942
BANKS	0	0	0	0	0	0	1	2,964
BARROW	0	0	0	0	1	8,977	8	9,794
BARTOW	0	0	0	0	0	0	3	4,090
BIBB	0	0	0	0	2	24,064	7	6,014
BULLOCH	0	0	0	0	0	0	2	7,414
BURKE	0	0	0	0	0	0	1	611
BUTTS	0	0	0	0	1	8,240	2	1,044
CARROLL	0	0	0	0	0	0	4	5,355
CHATHAM	0	0	0	0	0	0	9	10,460
CHEROKEE	0	0	0	0	0	0	5	10,174
CLARKE	0	0	0	0	0	0	7	7,133
CLAY	0	0	0	0	0	0	1	660
CLAYTON	0	0	3	3,560	9	77,326	233	356,930
COBB	0	0	1	485	3	129,984	63	75,338
COLQUITT	0	0	0	0	1	48,211	0	0
COOK	0	0	0	0	0	0	2	8,361
COWETA	0	0	0	0	1	21,562	9	7,215
DECATUR	0	0	0	0	3	49,773	16	24,537
DEKALB	24	372,200	145	726,887	496	6,662,682	10,548	15,361,587
DODGE	0	0	1	175	0	0	0	0
DOUGHERTY	0	0	0	0	1	28,883	7	13,973
DOUGLAS	0	0	0	0	3	19,366	28	49,094
FAYETTE	0	0	0	0	0	0	6	8,514
FLORIDA	0	0	0	0	3	36,585	79	104,764
FLOYD	0	0	0	0	0	0	1	5,478
FORSYTH	0	0	0	0	0	0	1	909
FULTON	0	0	2	15,209	44	535,193	663	1,015,824
GLYNN	0	0	0	0	1	15,523	4	5,188
GREENE	0	0	0	0	0	0	1	2,192
GWINNETT	0	0	7	30,303	8	172,699	262	328,278

HALL	0	0	0	0	0	0	3	10,754
HARALSON	0	0	0	0	0	0	1	842
HENRY	0	0	1	250	4	48,084	118	159,917
HOUSTON	0	0	0	0	0	0	2	2,450
JACKSON	0	0	0	0	0	0	2	2,906
JASPER	0	0	0	0	0	0	3	3,741
JEFF DAVIS	0	0	0	0	0	0	1	1,936
JEFFERSON	0	0	0	0	0	0	1	715
LIBERTY	0	0	0	0	0	0	2	1,787
LOWNDES	0	0	0	0	0	0	5	3,764
LUMPKIN	0	0	0	0	0	0	1	1,560
MACON	0	0	0	0	0	0	1	235
MCDUFFIE	0	0	0	0	0	0	2	1,978
MERIWETHER	0	0	0	0	0	0	2	1,719
MONROE	0	0	0	0	0	0	1	7,948
MONTGOMERY	0	0	0	0	0	0	1	714
MUSCOGEE	0	0	0	0	0	0	10	8,916
NEWTON	0	0	5	24,542	6	40,950	165	261,770
NORTH CAROLINA	0	0	0	0	3	19,133	27	27,781
OCONEE	0	0	0	0	0	0	3	4,043
OTHER OUT OF STAT	0	0	0	0	12	180,366	234	279,303
PAULDING	0	0	0	0	1	8,659	7	7,535
PIKE	0	0	0	0	0	0	1	572
POLK	0	0	0	0	0	0	1	1,626
PUTNAM	0	0	0	0	0	0	5	3,984
RICHMOND	0	0	0	0	0	0	7	6,116
ROCKDALE	1	8,615	3	18,166	11	128,923	350	487,909
SCHLEY	0	0	0	0	0	0	2	1,353
SOUTH CAROLINA	0	0	0	0	1	23,830	28	30,818
SPALDING	0	0	0	0	0	0	6	8,621
STEPHENS	0	0	0	0	0	0	1	396
SUMTER	0	0	0	0	0	0	2	2,183
TALBOT	0	0	0	0	0	0	1	648
TENNESSEE	0	0	0	0	1	7,234	23	24,322
TERRELL	0	0	0	0	0	0	1	235
TIFT	0	0	0	0	0	0	1	2,739
TROUP	0	0	0	0	0	0	2	1,647
UPSON	0	0	0	0	0	0	3	5,898
WALTON	0	0	2	11,993	3	22,494	36	42,785
WILKES	0	0	0	0	0	0	1	1,039
<b>Total</b>	<b>25</b>	<b>380,815</b>	<b>170</b>	<b>831,570</b>	<b>619</b>	<b>8,318,741</b>	<b>13,075</b>	<b>18,892,687</b>

## 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 2021?  
(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 2021.

Patient Category		SFY 2020	SFY2021	SFY2022
		7/1/19-6/30/20	7/1/20-6/30/21	7/1/21-6/30/22
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	1,031,730	180,655
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	23,267,808	3,943,620
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 2020	SFY2021	SFY2022
7/1/19-6/30/20	7/1/20-6/30/21	7/1/21-6/30/22
0	8,775	1,553

## 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:** Jen Schuck

**Date:** 7/29/2022

**Title:** Interim 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:** Lisa Urbistondo

**Date:** 7/29/2022

**Title:** Chief Financial Officer

**Comments:**