GEORGIA DEPARTMENT OF COMMUNITY HEALTH

# Part A: General Information

**UID: HOSP408**

## 1. Identification

Facility Name:

Emanuel Medical Center

County:

Emanuel

Street Address:

117 Kite Road

City:

Swainsboro

Zip:

30401

Mailing Address:

PO Box 879

Mailing City:

Swainsboro

Mailing Zip:

30401

Medicaid Provider Number:

000000701A

Medicare Provider Number:

11-0109

## 2. Report Period

**Please report data for the hospital fiscal year ending during calender year 2025 only. Do not use a different report period**

## Please indicate your Hospital Fiscal Year

From:

07/01/2024

To:

06/30/2025

## Please indicate your Cost Report Year

From:

07/01/2024

To:

06/30/2025

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 experienced a trauma center designation change, 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:

Cynthia Hutcheson, CPA

Contact Title:

Chief Financial Officer

Phone:

478-289-1376

Fax:

478-289-1248

Email:

cindy.hutcheson@emanuelmedical.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 | 21,543,908 |
| Total Inpatient Admissions accounting for Inpatient Revenue | 1,298 |
| Outpatient Gross Patient Revenue | 116,676,009 |
| Total Outpatient Visits accounting for Outpatient Revenue | 31,420 |
| Medicare Contractual Adjustments | 45,714,022 |
| Medicaid Contractual Adjustments | 13,006,292 |
| Other Contractual Adjustments | 33,475,648 |
| Hill Burton Obligations | 0 |
| Bad Debt (net of recoveries) | 14,172,582 |
| Gross Indigent Care | 2,917,372 |
| Gross Charity Care | 447,854 |
| Uncompensated Indigent Care (net) | 2,917,372 |
| Uncompensated Charity Care (net) | 447,854 |
| Other Free Care | 1,437,115 |
| Other Revenue/Gains | 3,114,414 |
| Total Expenses | 25,894,825 |

## 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 | Amount |
|---|---|
| Self-Pay/Uninsured Discounts | 0 |
| Admin Discounts | 1,386,688 |
| Employee Discounts | 50,427 |
| | 0 |
| Total | 1,437,115 |

# 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 2025? (Check box if yes.) ☑

**If the hospital had a formal written policy(ies) during the reporting period, you are required to file a copy of the policy(ies) with the Department. Please e-mail a copy of the policy(ies) to Steve.Cappel@dch.ga.gov**

## 2. Effective Date

What was the effective date of the policy or policies in effect during 2025?

07/16/2024

## 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.

Patient Financial Services Manager

## 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.)

250%

## 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 2025? (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 | 310,561 | 81,476 | 392,037 |
| Outpatient | 2,606,811 | 366,378 | 2,973,189 |
| Total | 2,917,372 | 447,854 | 3,365,226 |

## 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 Fund) | 0 |
| Federal Government | 0 |
| Non-Government Sources | 0 |
| Charitable Contributions | 0 |
| Trust Fund From Sale of Public Hospital | 0 |
| All Other | 0 |
| Total | 0 |

**The fields below must equal**

| Gross Uncompensated I/C Charges - Compensation | Net I/C Charges Reported in Part C |
|---|---|
| 3,365,226 | 3,365,226 |

## 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 | 310,561 | 81,476 | 392,037 |
| Outpatient | 2,606,811 | 366,378 | 2,973,189 |
| Total | 2,917,372 | 447,854 | 3,365,226 |

# Part F: Patient Origin

## 1. Total Gross Indigent/Charity Care By Charges County

- 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)

**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.)**

| 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 |
|---|---|---|---|---|---|---|---|---|
| Appling | 0 | 0 | 1 | 1,876 | 0 | 0 | 0 | 0 |
| Bacon | 0 | 0 | 3 | 29,077 | 0 | 0 | 0 | 0 |
| Bibb | 0 | 0 | 5 | 341 | 0 | 0 | 0 | 0 |
| Bulloch | 0 | 0 | 45 | 405,766 | 0 | 0 | 3 | 16,295 |
| Burke | 4 | 48,336 | 23 | 60,473 | 2 | 10,548 | 17 | 11,144 |
| Camden | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 1,214 |
| Candler | 0 | 0 | 7 | 55,717 | 0 | 0 | 0 | 0 |
| Clayton | 0 | 0 | 3 | 20,153 | 0 | 0 | 0 | 0 |
| Cobb | 0 | 0 | 1 | 7,617 | 0 | 0 | 0 | 0 |
| Columbia | 0 | 0 | 1 | 9,921 | 0 | 0 | 0 | 0 |
| Dawson | 0 | 0 | 1 | 3,194 | 0 | 0 | 0 | 0 |
| Effingham | 0 | 0 | 2 | 3,892 | 0 | 0 | 0 | 0 |
| Emanuel | 24 | 237,342 | 622 | 1,605,614 | 16 | 65,523 | 287 | 255,630 |
| Henry | 1 | 1,580 | 0 | 0 | 0 | 0 | 0 | 0 |
| Jefferson | 0 | 0 | 6 | 20,215 | 1 | 826 | 2 | 11,363 |
| Jenkins | 2 | 3,550 | 35 | 111,764 | 0 | 0 | 8 | 3,752 |
| Johnson | 0 | 0 | 53 | 146,093 | 2 | 1,934 | 18 | 20,038 |
| Laurens | 0 | 0 | 4 | 890 | 1 | 1,580 | 0 | 0 |
| Montgomery | 0 | 0 | 1 | 10,386 | 0 | 0 | 0 | 0 |
| Muscogee | 0 | 0 | 2 | 6,925 | 0 | 0 | 0 | 0 |
| Oconee | 1 | 7,705 | 0 | 0 | 0 | 0 | 0 | 0 |
| Screven | 0 | 0 | 2 | 26,639 | 0 | 0 | 1 | 596 |
| Tattnall | 0 | 0 | 6 | 13,370 | 0 | 0 | 0 | 0 |
| Telfair | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 270 |
| Toombs | 1 | 12,048 | 26 | 48,102 | 0 | 0 | 14 | 20,872 |
| Treutlen | 0 | 0 | 15 | 18,463 | 1 | 1,065 | 48 | 25,204 |
| Washington | 0 | 0 | 2 | 323 | 0 | 0 | 0 | 0 |
| Totals | **33** | **310,561** | **866** | **2,606,811** | **23** | **81,476** | **404** | **366,378** |

| Total I/C Charges for Outpatients | Total I/C Charges for Inpatients | Total I/C Charges |
|---|---|---|
| 2,973,189 | 392,037 | 3,365,226 |

# 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 2025? (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 2025.**

| Patient Category | SFY2024 7/1/2023-6/30/2024 | SFY2025 7/1/2024-6/30/2025 | SFY2026 7/1/2025-6/30/2026 |
|---|---|---|---|
| A Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge | 0 | 447,854 | 0 |
| 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 | 2,917,372 | 0 |
| C Other Patients in accordance with the department approved policy | 0 | 0 | 0 |

## 3. Patients Served

**Indicate the number of patients served by SFY.**

SFY2024 7/1/2023-6/30/2024

0

SFY2025 7/1/2024-6/30/2025

532

SFY2026 7/1/2025-6/30/2026

0

# 2025 HFS Hospital Financial Statements Reconciliation Addendum

## Section one is pre-filled from the answers in Part C and Part E.

**You may not complete this section until Part C and Part E, question 1 are complete. Every field in this section is a required field. Enter zeroes in numeric fields and "Not Applicable" or "N/A" in the description fields for "Other Non-Hospital" and "Other Reconciling Items" if not applicable.**

# Reconciliation Addendum

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):

| HFS Source | Part C, 1 | Part C, 1 | Part C, 1 | Part C, 1 | Part C, 1 | Part C, 1 | Part E, 1 | Part E, 1 | Part C, 1 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Gross Patient Charges | Medicare Contractural Adjs | Medicaid Contractural Adjs | Other Contractural Adjs | Hill Burton Obligations | Bad Debt | Gross Indigent Care (IP & OP | Gross Charity Care (IP & OP | Other Free Care | Total Deductions of All Types (Sum Col 2-9) | Net Patient Revenue (Col 1 - 10) |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| **Inpatient Gross Patient Revenue** | 21,543,908 | | | | | | | | | | |
| **Outpatient Gross Patient Revenue** | 116,676,009 | | | | | | | | | | |
| **Per Part C, 1 Financial Table** | | 45,714,022 | 13,006,292 | 33,475,648 | 0 | 14,172,582 | | | 1,437,115 | | |
| **Per Part E, 1 Indigent and Charity Care** | | | | | | | 2,917,372 | 447,854 | | | |
| **Totals per HFS** | 138,219,917 | 45,714,022 | 13,006,292 | 33,475,648 | 0 | 14,172,582 | 2,917,372 | 447,854 | 1,437,115 | 111,170,885 | 27,049,032 |
| **Section 2: Reconciling Items to Financial Statements:** | | | | | | | | | | | |
| **Non-Hospital Services:** | | | | | | | | | | | |
| **> Professional Fees** | 8,251,423 | | | | | | | | | 5,031,312 | |
| **> Home Health Agency** | 0 | | | | | | | | | 0 | |
| **> SNF/NF Swing Bed Services** | 55,890 | | | | | | | | | 37,997 | |
| **> Nursing Home** | 4,824,200 | | | | | | | | | 2,783,468 | |
| **> Hospice** | 94,300 | | | | | | | | | 28,100 | |
| **> Freestanding Ambulatory Surg Centers** | 0 | | | | | | | | | 0 | |
| Other Non-Hospital<br>Rural Health Clinics | 8,101,933 | | | | | | | | | 4,674,654 | |
| Other Non-Hospital<br>Ambulance | 1,582,881 | | | | | | | | | 913,291 | |
| Other Non-Hospital<br>Private Phys Office | 3,881,615 | | | | | | | | | 2,239,615 | |
| Other Non-Hospital<br>N/A | 0 | | | | | | | | | 0 | |
| Other Non-Hospital<br>N/A | 0 | | | | | | | | | 0 | |
| Other Non-Hospital<br>N/A | 0 | | | | | | | | | 0 | |
| **Bad Debt (Expense per Financials)(A)** | | | | | | | | | | 0 | |
| **Indigent Care Trust Fund Income** | | | | | | | | | | -1,075,092 | |
| **Other Reconciling Items:** | | | | | | | | | | | |
| Other Recon Items<br>Net provider Fee tax | 0 | | | | | | | | | 155,892 | |
| Other Recon Items<br>rounding | 0 | | | | | | | | | -1 | |
| Other Recon Items<br>N/A | 0 | | | | | | | | | 0 | |
| Other Recon Items<br>N/A | 0 | | | | | | | | | 0 | |
| **Total Reconciling Items** | 26,792,242 | | | | | | | | | 14,789,236 | 12,003,006 |
| | | | | | | | | | | | |
| **Total Per Form** | 165,012,159 | | | | | | | | | 125,960,121 | 39,052,038 |
| **Total Per Financial Statements** | 165,012,159 | | | | | | | | | | 39,052,038 |
| **Unreconciled Difference (Must be Zero)** | 0 | | | | | | | | | | 0 |
| | | | | | | | | | | | |

**(A) Due to specific differences in the presentation of data on the HFS, Bad Debt per Financials may differ from the amount reported on the HFS-proper (Part C).**

**(B) Taxable Net Patient Revenue will equal Net Patient Revenue in Section 1 column 11, plus Other Free Care in Section 1 column 9.**

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. **Do not sign until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could throw the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.**

Authorized Signature

Damien Scott

Date

07/23/2026

Title

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.

Financial Officer Signature

Cynthia Hutcheson

Financial Officer Date

07/24/2026

Financial Officer Title

CFO

Comments