GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP521

Facility Name: Tift Regional Medical Center

County: Tift

Street Address: PO Box 747

City: Tifton

Zip: 31793-0747

Mailing Address: PO Box 747

Mailing City: Tifton

Mailing Zip: 31793-0747

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2019 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2018 To:9/30/2019

Please indicate your cost report year.
From: 10/01/2018 To:09/30/2019

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: Jesus F. Ruiz
Contact Title: Reimbursement Consultant
Phone: 404-788-4861
Fax: 678-823-6919
E-mail: jesus.ruiz@rsgga.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	395,210,508
Total Inpatient Admissions accounting for Inpatient Revenue	10,638
Outpatient Gross Patient Revenue	842,520,938
Total Outpatient Visits accounting for Outpatient Revenue	220,021
Medicare Contractual Adjustments	533,140,257
Medicaid Contractual Adjustments	145,293,332
Other Contractual Adjustments:	69,343,077
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	57,497,457
Gross Indigent Care:	52,014,269
Gross Charity Care:	15,507,596
Uncompensated Indigent Care (net):	52,014,269
Uncompensated Charity Care (net):	15,507,596
Other Free Care:	10,158,366
Other Revenue/Gains:	27,038,241
Total Expenses:	304,607,782

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	6,911,740
Admin Discounts	579,212
Employee Discounts	336,165
Non Covered Charges	2,331,249
Total	**10,158,366**

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 2019? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2019?

10/01/2018

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.?

VP of Revenue Cycle

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.)?

200%

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 2019? (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	16,970,750	6,164,402	23,135,152
Outpatient	35,043,519	9,343,194	44,386,713
Total	**52,014,269**	**15,507,596**	**67,521,865**

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	16,970,750	6,164,402	23,135,152
Outpatient	35,043,519	9,343,194	44,386,713
Total	**52,014,269**	**15,507,596**	**67,521,865**

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
Atkinson	19	138,230	136	320,050	12	148,817	48	62,480
Bacon	0	0	7	1,765	0	0	2	844
Bartow	0	0	1	963	0	0	0	0
Ben Hill	95	1,075,593	1,103	2,498,819	56	411,502	410	333,363
Berrien	106	1,483,928	1,891	3,042,758	99	803,735	905	1,083,540
Bibb	0	0	0	0	0	0	2	133
Bleckley	0	0	5	3,496	0	0	0	0
Brooks	3	325,606	14	21,447	0	0	14	16,815
Bulloch	2	28,887	1	166	0	0	0	0
Carroll	0	0	3	8,632	0	0	0	0
Charlton	0	0	2	229	0	0	0	0
Cherokee	6	166,151	0	0	0	0	0	0
Clay	0	0	4	31,202	4	129,093	0	0
Clinch	0	0	3	19,405	1	35,965	3	4,153
Cobb	0	0	2	3,075	0	0	0	0
Coffee	18	176,464	333	893,451	14	63,118	194	154,707
Colquitt	48	444,780	882	1,825,511	44	314,000	474	634,214
Columbia	0	0	0	0	1	191,643	11	81,183
Cook	102	1,065,730	1,424	2,358,428	102	260,638	727	709,162
Crawford	6	158,756	12	123,292	0	0	0	0
Crisp	15	43,394	80	215,430	9	337,197	60	121,327
Decatur	1	20,953	23	13,572	0	0	0	0
DeKalb	1	19,109	0	0	1	-19,109	0	0
Dodge	1	220	5	3,949	4	2,111	4	596
Dooly	0	0	20	24,930	4	3,034	6	457
Dougherty	5	39,901	137	267,681	2	82,084	34	15,028
Douglas	0	0	7	8,193	0	0	0	0
Echols	0	0	3	4,074	0	0	4	4,054
Fayette	0	0	1	1,413	0	0	0	0
Florida	18	31,847	18	19,872	1	696	16	0
Fulton	0	0	0	0	0	0	1	1,370
Gwinnett	0	0	2	531	2	2,656	9	1,686

Harris	4	22,663	1	166	0	0	0	0
Henry	0	0	5	7,429	0	0	0	0
Houston	0	0	23	17,251	0	0	4	24,182
Irwin	66	1,180,621	949	1,751,131	39	59,171	422	594,118
Jeff Davis	0	0	10	9,895	1	720	10	338
Johnson	0	0	2	3,409	0	0	0	0
Lanier	10	113,810	97	187,419	0	0	51	122,987
Laurens	0	0	7	13,146	0	0	0	0
Lee	3	52,110	10	9,534	0	0	15	31,086
Lowndes	14	107,325	149	350,197	4	26,681	55	91,997
Madison	0	0	2	16,938	0	0	0	0
Marion	0	0	1	7,534	3	142,385	3	2,820
Miller	0	0	3	7,489	0	0	0	0
Mitchell	0	0	16	47,157	0	0	3	5,948
Morgan	0	0	2	8,204	0	0	0	0
North Carolina	2	51,489	0	0	0	0	0	0
Other Out of State	10	280,808	4	11,157	4	5,018	10	98,634
Pierce	0	0	3	625	0	0	1	676
Pulaski	0	0	1	689	0	0	0	0
Quitman	0	0	0	0	0	0	2	2,328
South Carolina	0	0	8	9,884	0	0	0	0
Spalding	0	0	4	1,840	0	0	0	0
Sumter	0	0	27	44,326	0	0	12	12,455
Tattnall	0	0	4	61,556	0	0	0	0
Telfair	1	18,691	8	7,546	2	215	1	641
Tennessee	0	0	2	9,818	0	0	0	0
Terrell	0	0	3	667	0	0	6	29,110
Thomas	2	0	16	43,160	1	1,316	7	3,942
Tift	658	7,670,838	10,747	16,133,218	418	1,769,879	4,627	3,863,576
Turner	128	1,503,666	1,891	3,212,426	83	845,088	652	660,626
Ware	0	0	9	17,176	3	137,346	25	7,007
Washington	0	0	0	0	0	0	17	35,221
Wheeler	0	0	1	6,583	0	0	0	0
Wilcox	13	129,100	98	183,688	9	29,075	45	10,655
Worth	44	620,080	700	1,149,927	51	380,328	494	519,735
Total	**1,401**	**16,970,750**	**20,922**	**35,043,519**	**974**	**6,164,402**	**9,386**	**9,343,194**

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 2019? (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 2019.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 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	39,010,702	13,003,567
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	11,630,697	3,876,899
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	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
0	24,512	8,171

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Nurse Employment Addendum

This section is printed 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: Christopher Dorman

Date: 7/22/2020

Title: President 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: Kim Wills

Date: 7/22/2020

Title: SVP Chief Financial Officer

Comments:

Georgia Department of Community Health

2019 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP317

Facility Name: Southwell Medical Center a Campus of Tift Regional Medical Center

County: Cook

Street Address: 260 MJ Road

City: Adel

Zip: 31620

Mailing Address: 260 MJ Taylor Road

Mailing City: Adel

Mailing Zip: 31620

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2019 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 7/1/2018 To:6/30/2019

Please indicate your cost report year.
From: 07/01/2018 To:06/30/2019

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: Jesus F. Ruiz, CPA
Contact Title: Reimbursement Consultant
Phone: 404-788-4861
Fax: 678-823-6919
E-mail: jesus.ruiz@rsgga.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	9,754,907
Total Inpatient Admissions accounting for Inpatient Revenue	331
Outpatient Gross Patient Revenue	11,423,519
Total Outpatient Visits accounting for Outpatient Revenue	10,900
Medicare Contractual Adjustments	10,689,560
Medicaid Contractual Adjustments	1,118,639
Other Contractual Adjustments:	3,325,979
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	1,285,045
Gross Indigent Care:	468,138
Gross Charity Care:	364,783
Uncompensated Indigent Care (net):	468,138
Uncompensated Charity Care (net):	364,783
Other Free Care:	170,505
Other Revenue/Gains:	860,057
Total Expenses:	8,145,298

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	170,505
Employee Discounts	0
	0
Total	**170,505**

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 2019? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2019?

07/01/2018

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.?

CEO

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.)?

200%

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 2019? (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	15,676	81,818	97,494
Outpatient	452,462	282,965	735,427
Total	**468,138**	**364,783**	**832,921**

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	15,676	81,818	97,494
Outpatient	452,462	282,965	735,427
Total	**468,138**	**364,783**	**832,921**

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
Atkinson	0	0	1	1,618	0	0	0	0
Berrien	2	13,227	52	69,422	1	11,496	28	51,013
Brooks	0	0	2	1,851	0	0	0	0
Clayton	0	0	1	495	0	0	0	0
Clinch	0	0	1	1,331	0	0	0	0
Colquitt	1	540	3	5,122	0	0	1	53
Cook	1	72	411	320,558	6	70,322	150	163,609
Crisp	0	0	0	0	0	0	1	75
Lanier	0	0	6	7,117	0	0	5	5,996
Lowndes	1	346	32	26,931	0	0	7	7,287
Marion	0	0	0	0	0	0	10	25,052
Other Out of State	0	0	8	4,619	0	0	8	12,258
Tift	1	1,491	15	11,387	0	0	3	13,354
Turner	0	0	3	1,810	0	0	1	3,250
Worth	0	0	1	201	0	0	2	1,018
Total	**6**	**15,676**	**536**	**452,462**	**7**	**81,818**	**216**	**282,965**

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 2019? (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 2019.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 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	468,137	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	364,782	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.

SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
0	765	0

Reconciliation Addendum

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Nurse Employment Addendum

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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 M. Smith

Date: 7/22/2020

Title: COO

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: Kim Wills

Date: 7/22/2020

Title: Senior VP & CFO

Comments: