GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 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 2020 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2019 To:9/30/2020

Please indicate your cost report year.
From: 10/01/2019 To:09/30/2020

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: 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	382,072,012
Total Inpatient Admissions accounting for Inpatient Revenue	9,416
Outpatient Gross Patient Revenue	797,340,628
Total Outpatient Visits accounting for Outpatient Revenue	205,225
Medicare Contractual Adjustments	516,156,567
Medicaid Contractual Adjustments	127,198,264
Other Contractual Adjustments:	76,498,500
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	65,879,609
Gross Indigent Care:	29,755,591
Gross Charity Care:	16,192,127
Uncompensated Indigent Care (net):	29,755,591
Uncompensated Charity Care (net):	16,192,127
Other Free Care:	11,456,381
Other Revenue/Gains:	36,095,419
Total Expenses:	330,891,316

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	9,709,595
Admin Discounts	389,374
Employee Discounts	0
Non Allowable Charges	1,357,412
Total	**11,456,381**

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?

10/01/2019

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.?

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 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	7,296,915	4,136,474	11,433,389
Outpatient	22,458,676	12,055,653	34,514,329
Total	**29,755,591**	**16,192,127**	**45,947,718**

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	7,296,915	4,136,474	11,433,389
Outpatient	22,458,676	12,055,653	34,514,329
Total	**29,755,591**	**16,192,127**	**45,947,718**

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
Appling	1	1,408	17	14,740	0	0	1	1,102
Atkinson	3	51,935	79	242,183	4	5,087	32	52,206
Bacon	3	84,611	12	55,032	0	0	1	45
Baker	0	0	2	2,198	0	0	0	0
Bartow	0	0	1	3,808	0	0	0	0
Ben Hill	12	144,784	529	1,299,275	27	93,192	374	607,524
Berrien	28	790,727	728	1,569,059	68	434,668	559	907,830
Bibb	0	0	2	1,054	0	0	1	42
Brooks	0	0	9	3,363	0	0	1	42
Camden	0	0	0	0	0	0	4	1,687
Cherokee	0	0	2	381	1	1,005	2	96
Clinch	1	870	24	28,287	0	0	9	9,180
Cobb	0	0	0	0	0	0	1	278
Coffee	1	57	149	555,223	4	30,561	120	192,358
Colquitt	19	535,209	301	928,346	13	50,930	266	1,573,643
Columbia	0	0	1	68	0	0	11	1,901
Cook	49	1,563,588	778	3,089,502	63	308,758	489	932,630
Crisp	3	14,353	51	72,552	1	23,362	19	49,145
Decatur	0	0	1	43,091	0	0	6	193,833
DeKalb	2	43,010	0	0	0	0	0	0
Dodge	0	0	6	15,401	3	3,886	5	626
Dooly	0	0	3	2,449	0	0	11	6,137
Dougherty	1	3,546	53	205,777	2	2,632	29	47,269
Douglas	0	0	4	57,100	0	0	3	3,280
Early	0	0	0	0	0	0	2	284
Emanuel	0	0	0	0	3	3,864	13	5,807
Florida	1	27,402	11	36,991	0	0	6	32,207
Floyd	0	0	1	4,290	0	0	0	0
Glynn	0	0	1	2,563	0	0	0	0
Houston	0	0	7	9,683	0	0	9	11,390
Irwin	9	194,459	248	764,971	22	155,715	261	842,161
Jeff Davis	0	0	8	42,856	0	0	0	0

Lanier	0	0	18	24,040	0	0	43	54,556
Lee	1	66,700	20	27,680	0	0	4	3,956
Lowndes	3	66,423	104	695,572	4	57,099	77	176,905
Mitchell	0	0	0	0	2	1,444	3	2,400
North Carolina	0	0	0	0	1	35	2	1,168
Other Out of State	0	0	3	12,749	2	871	5	5,384
Paulding	0	0	0	0	0	0	2	196
Quitman	0	0	0	0	0	0	1	120
Schley	0	0	1	1,920	0	0	3	3,101
Screven	0	0	1	300	0	0	0	0
Spalding	0	0	1	140	0	0	0	0
Sumter	0	0	6	5,780	1	1,153	2	2,881
Tattnall	1	1,288	16	11,312	0	0	0	0
Telfair	1	1,354	7	10,359	0	0	0	0
Terrell	0	0	0	0	0	0	3	488
Thomas	1	1,408	18	11,169	0	0	3	1,444
Tift	130	3,235,736	4,213	10,435,845	139	1,555,043	2,547	5,165,128
Turner	25	351,385	862	1,465,888	63	1,032,110	414	669,265
Ware	0	0	3	6,215	0	0	3	223
Washington	0	0	0	0	0	0	1	100
Whitfield	0	0	1	4,458	0	0	0	0
Wilcox	1	29,193	99	258,426	4	140,746	38	34,667
Worth	14	87,469	246	436,580	19	234,313	230	460,968
Total	**310**	**7,296,915**	**8,647**	**22,458,676**	**446**	**4,136,474**	**5,616**	**12,055,653**

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	22,316,693	7,438,898
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	12,144,095	4,084,032
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	11,264	3,755

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: Christopher Dorman

Date: 7/21/2021

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: 7/21/2021

Title: SVP Chief Financial Officer

Comments:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2020 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 2020 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 7/1/2019 To:6/30/2020

Please indicate your cost report year.
From: 07/01/2019 To:06/30/2020

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: 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	10,322,498
Total Inpatient Admissions accounting for Inpatient Revenue	414
Outpatient Gross Patient Revenue	23,114,848
Total Outpatient Visits accounting for Outpatient Revenue	14,522
Medicare Contractual Adjustments	15,993,487
Medicaid Contractual Adjustments	2,317,571
Other Contractual Adjustments:	5,063,117
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	820,453
Gross Indigent Care:	205,282
Gross Charity Care:	84,924
Uncompensated Indigent Care (net):	205,282
Uncompensated Charity Care (net):	84,924
Other Free Care:	299,641
Other Revenue/Gains:	1,523,920
Total Expenses:	14,454,376

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	299,641
Employee Discounts	0
	0
Total	**299,641**

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?

07/01/2019

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.?

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 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	24,141	10,275	34,416
Outpatient	181,141	74,649	255,790
Total	**205,282**	**84,924**	**290,206**

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	24,141	10,275	34,416
Outpatient	181,141	74,649	255,790
Total	**205,282**	**84,924**	**290,206**

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	0	0	0	0	1	2,426
Berrien	0	0	32	18,344	2	2,628	21	8,520
Brantley	0	0	0	0	0	0	1	1,227
Brooks	0	0	1	575	1	630	6	3,113
Clinch	0	0	0	0	0	0	1	73
Colquitt	1	87	8	21,969	0	0	2	320
Cook	6	24,054	105	110,464	7	6,711	89	46,413
Dougherty	0	0	1	704	0	0	0	0
Florida	0	0	8	0	0	0	0	0
Hall	0	0	0	0	0	0	1	314
Irwin	0	0	0	0	0	0	3	2,309
Lanier	0	0	0	0	0	0	1	2,842
Lowndes	0	0	19	25,513	1	224	8	1,445
Other Out of State	0	0	0	0	0	0	1	250
South Carolina	0	0	0	0	0	0	1	159
Tift	2	0	3	3,572	2	82	4	5,044
Upson	0	0	0	0	0	0	1	194
Total	**9**	**24,141**	**177**	**181,141**	**13**	**10,275**	**141**	**74,649**

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	84,294	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	205,282	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	SFY2020 7/1/18-6/30/19	SFY2020 7/1/19-6/30/20
0	340	0

Reconciliation 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: Jay E. Carmichael

Date: 7/21/2021

Title: COO Southwell Medical

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: 7/21/2021

Title: SVP Chief Financial Officer

Comments: