GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2008 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP616

Facility Name: Phoebe Putney Memorial Hospital

County: Dougherty

Street Address: 417 West Third Avenue

City: Albany

Zip: 31701-1960

Mailing Address: PO Box 1828

Mailing City: Albany

Mailing Zip: 31702-1828

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2008 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 8/1/2007 To:7/31/2008

Please indicate your cost report year.
From: 08/01/2007 To:07/31/2008

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.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Pam Deeter

Contact Title: VP-Controller

Phone: 229-312-6752

Fax: 229-312-6749

E-mail: pdeeter@ppmh.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	487,993,899
Total Inpatient Admissions accounting for Inpatient Revenue	23,042
Outpatient Gross Patient Revenue	473,929,848
Total Outpatient Visits accounting for Outpatient Revenue	183,694
Medicare Contractual Adjustments	294,023,838
Medicaid Contractual Adjustments	137,904,630
Other Contractual Adjustments:	82,789,914
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	56,904,560
Uncompensated Indigent Care (net):	20,473,965
Uncompensated Charity Care (net):	10,209,474
Other Free Care:	0
Other Revenue/Gains:	11,808,238
Total Expenses:	351,330,888

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 2008? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2008?

08/01/2000

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.?

Asst VP - Business Affiars

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 2008? (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	8,002,361	6,360,678	14,363,039
Outpatient	12,471,604	3,848,796	16,320,400
Total	**20,473,965**	**10,209,474**	**30,683,439**

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	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**

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	33	76,010	7	14,771	6	18,365
Appling	0	0	5	678	0	0	0	0
Atkinson	0	0	10	11,878	0	0	0	0
Baker	18	257,710	116	11,968	7	74,015	21	18,166
Baldwin	0	0	0	0	1	1,478	1	255
Ben Hill	7	177,418	48	35,056	11	41,115	25	22,879
Berrien	0	0	8	2,666	0	0	0	0
Bibb	1	2,297	0	0	0	0	0	0
Brantley	0	0	0	0	0	0	1	352
Brooks	0	0	1	917	0	0	0	0
Calhoun	17	93,104	250	208,176	26	976,977	85	97,827
Charlton	0	0	1	646	0	0	0	0
Chatham	0	0	0	0	2	632	0	0
Clay	2	1,093	28	38,707	0	0	1	24
Clayton	0	0	3	2,474	0	0	0	0
Clinch	0	0	2	232	1	140	0	0
Cobb	1	771	0	0	0	0	1	89
Coffee	3	19,455	38	5,940	2	5,396	3	180
Colquitt	23	486,923	128	85,781	16	242,735	52	28,814
Cook	0	0	9	16,103	6	106,887	3	22,478
Crisp	13	175,525	84	130,160	12	246,953	20	16,237
Decatur	7	12,449	47	48,851	4	1,008	23	38,778
DeKalb	0	0	2	1,161	0	0	0	0
Dooly	5	25,018	22	15,810	0	0	8	5,002
Dougherty	553	3,887,567	6,748	6,781,086	311	2,375,758	1,878	1,791,853
Douglas	0	0	0	0	0	0	1	170
Early	3	9,496	61	36,386	1	12,377	18	14,082
Florida	0	0	35	25,039	3	22,513	4	592
Fulton	2	1,008	0	0	0	0	0	0
Grady	1	7,227	89	50,518	0	0	4	257
Hancock	0	0	1	767	0	0	0	0
Henry	1	39,379	0	0	0	0	0	0

Irwin	1	992	7	4,778	0	0	0	0
Jackson	0	0	0	0	1	32	0	0
Lamar	0	0	4	87	0	0	0	0
Lanier	0	0	7	974	1	162	0	0
Lee	90	439,886	983	969,614	87	639,070	538	717,574
Liberty	0	0	2	422	0	0	0	0
Lowndes	0	0	0	0	11	111,632	6	3,414
Lumpkin	0	0	0	0	0	0	13	10,835
Macon	3	36,332	9	7,472	7	88,274	12	14,988
Marion	0	0	2	526	0	0	1	92
Miller	7	51,914	59	48,497	0	0	1	104
Mitchell	62	221,465	532	506,360	56	507,545	221	357,426
Monroe	0	0	0	0	0	0	12	16,640
Muscogee	0	0	2	4,543	1	7,225	5	14,637
Other Out of State	1	3,288	7	21,380	0	0	15	15,473
Peach	0	0	0	0	0	0	1	250
Quitman	0	0	7	287	0	0	0	0
Randolph	12	225,823	182	578,102	8	137,463	38	36,653
Rockdale	2	2,483	2	3,493	0	0	0	0
Schley	4	33,357	60	54,092	3	20,038	6	4,982
Seminole	0	0	27	80,254	3	2,008	7	1,022
South Carolina	0	0	0	0	1	140	0	0
Stephens	1	5,281	0	0	0	0	0	0
Stewart	1	1,133	15	28,422	2	2,177	8	6,742
Sumter	60	525,143	480	771,228	34	271,508	185	209,239
Tennessee	0	0	0	0	0	0	3	482
Terrell	81	748,520	741	663,847	46	202,091	156	113,068
Thomas	3	103,066	18	1,969	4	7,949	2	327
Tift	1	25,928	134	130,914	4	3,339	29	4,439
Turner	8	26,745	53	106,322	0	0	3	277
Upson	0	0	12	1,051	0	0	1	488
Webster	2	6,427	64	31,194	0	0	2	116
White	0	0	0	0	0	0	1	105
Wilcox	1	160	5	30,226	0	0	12	17,695
Worth	82	347,978	628	838,540	47	237,270	258	225,328
Total	**1,079**	**8,002,361**	**11,811**	**12,471,604**	**726**	**6,360,678**	**3,691**	**3,848,796**

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 2008? (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 2008.

	Patient Category	SFY 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	18,182,301	2,291,664
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	9,208,824	1,000,650
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 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
0	14,715	1,462

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: Joel Wernick

Date: 10/1/2009

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.

Signature of Financial Officer: Kerry Loudermilk

Date: 10/1/2009

Title: CFO

Comments: