



2008 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP703

Facility Name: Memorial Health University Medical Center

County: Chatham

Street Address: 4700 Waters Avenue

City: Savannah

Zip: 31404

Mailing Address: P O Box 23089

Mailing City: Savannah

Mailing Zip: 31403

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2008 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 1/1/2008 To:12/31/2008

Please indicate your cost report year.

From: 01/01/2008 To:12/31/2008

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: George Harvey

Contact Title: Reimbursement Analyst

Phone: 912-350-8918

Fax: 912-350-8126

E-mail: harvege1@memorialhealth.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	797,253,704
Total Inpatient Admissions accounting for Inpatient Revenue	26,796
Outpatient Gross Patient Revenue	502,707,263
Total Outpatient Visits accounting for Outpatient Revenue	206,676
Medicare Contractual Adjustments	314,890,627
Medicaid Contractual Adjustments	160,170,572
Other Contractual Adjustments:	290,410,330
Hill Burton Obligations:	250,532
Bad Debt (net of recoveries):	43,232,602
Uncompensated Indigent Care (net):	77,375,252
Uncompensated Charity Care (net):	13,114,138
Other Free Care:	7,566,653
Other Revenue/Gains:	0
Total Expenses:	421,641,121

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?

01/01/2007

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.?

Director of Patient Intake

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 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	50,767,825	9,918,855	60,686,680
Outpatient	26,607,427	4,682,561	31,289,988
Total	77,375,252	14,601,416	91,976,668

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)	1,329,315
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	157,963
Total	1,487,278

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	1	2,113	1	128	0	0	10	9,555
APPLING	16	474,677	18	32,480	5	156,825	7	8,685
ATKINSON	4	114,571	0	0	1	77,169	0	0
BACON	13	302,508	14	37,259	3	182,025	0	0
BALDWIN	4	1,906	3	3,168	0	0	0	0
BIBB	1	11,513	2	3,665	0	0	1	455
BRANTLEY	3	162,840	5	1,358	0	0	1	84
BRYAN	67	1,721,935	677	1,405,699	19	221,062	97	371,003
BULLOCH	48	2,001,322	140	300,094	3	48,371	10	40,399
BURKE	2	32,080	2	3,176	0	0	0	0
CALHOUN	0	0	0	0	0	0	1	0
CAMDEN	2	29,909	1	22,790	3	1,671	5	1,919
CANDLER	11	275,496	24	182,138	3	35,645	8	67,669
CARROLL	0	0	2	4,047	0	0	0	0
CHARLTON	3	203,888	8	43,495	1	30,590	0	0
CHATHAM	1,345	27,785,756	11,317	19,345,433	145	3,028,427	1,426	2,188,646
CLARKE	0	0	1	1,888	0	0	0	0
CLAYTON	0	0	3	3,308	0	0	1	1,295
CLINCH	2	27,000	3	14,061	0	0	0	0
COBB	2	26,073	1	120	0	0	0	0
COFFEE	20	1,014,322	11	29,785	6	368,036	10	14,653
COLUMBIA	0	0	1	2,963	0	0	0	0
COWETA	0	0	1	195	0	0	0	0
DEKALB	0	0	10	10,181	0	0	3	2,451
DODGE	1	14,691	3	5,330	0	0	8	11,843
EFFINGHAM	115	2,960,046	633	1,483,632	26	454,625	111	240,256
EMANUEL	14	537,102	49	268,524	1	40,055	18	155,905
EVANS	15	264,958	82	175,282	0	0	5	17,908
FLORIDA	13	398,553	21	22,857	6	144,843	35	57,023
FORSYTH	0	0	0	0	1	9,290	0	0
FULTON	2	60,758	2	596	0	0	1	1,538
GLYNN	12	258,089	45	94,156	5	432,251	16	71,651

GORDON	0	0	4	9,352	0	0	0	0
GWINNETT	1	334	2	2,607	0	0	2	4,829
HENRY	0	0	3	4,743	0	0	0	0
HOUSTON	1	22,412	1	970	0	0	0	0
IRWIN	0	0	3	27,717	0	0	0	0
JACKSON	0	0	2	25,004	0	0	0	0
JEFF DAVIS	9	132,938	17	93,149	2	79,034	1	542
Jefferson	0	0	0	0	0	0	1	1,422
JENKINS	0	0	2	1,069	0	0	4	65,440
LAURENS	5	222,960	5	6,505	0	0	1	23,494
LEE	0	0	0	0	0	0	1	316
LIBERTY	87	2,487,921	357	814,579	9	234,798	62	151,654
LONG	7	209,906	27	54,561	1	13,556	2	283
LOWNDES	1	9,106	1	152	0	0	0	0
MCINTOSH	4	64,415	22	63,118	0	0	7	7,040
MITCHELL	0	0	0	0	2	13,662	0	0
MONTGOMERY	10	337,040	25	107,930	1	24,545	10	34,953
NEWTON	0	0	0	0	1	511,546	2	1,973
NORTH CAROLINA	8	151,212	15	18,628	2	12,280	9	12,881
OTHER OUT OF STAT	20	411,793	44	85,890	7	150,624	67	75,177
PEACH	0	0	1	685	0	0	0	0
PIERCE	11	567,831	12	23,889	5	240,262	4	35,421
RICHMOND	0	0	1	205	0	0	0	0
ROCKDALE	0	0	1	5,915	0	0	0	0
SCREVEN	27	669,577	48	140,677	5	158,662	6	8,459
SOUTH CAROLINA	103	3,155,148	213	727,245	141	2,723,825	503	903,433
SPALDING	2	55,733	5	3,130	0	0	0	0
SUMTER	0	0	1	0	0	0	0	0
TATTNALL	20	792,486	79	113,544	3	83,343	20	36,237
TELFAIR	4	33,256	5	15,507	0	0	0	0
TENNESSEE	1	9,633	14	42,338	1	1,129	3	1,385
THOMAS	0	0	5	11,922	0	0	0	0
TOOMBS	15	601,562	36	152,138	4	171,785	7	21,376
TREUTLEN	2	49,915	0	0	1	176,352	1	166
WARE	13	500,008	26	126,761	3	60,329	5	9,213
WASHINGTON	1	14,020	0	0	0	0	1	164
WAYNE	34	1,406,472	83	396,098	1	32,238	5	23,765
WHEELER	2	179,478	1	32,676	0	0	0	0
WHITE	0	0	1	915	0	0	0	0
WORTH	1	563	0	0	0	0	0	0
Total	2,105	50,767,825	14,142	26,607,427	417	9,918,855	2,498	4,682,561

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	SFY2008	SFY2009
		7/1/06-6/30/07	7/1/07-6/30/08	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	32,611,353	30,702,134
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	4,779,477	4,844,811
C.	Other Patients in accordance with the department approved policy.	0	2,927,830	2,948,642

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2007	SFY2008	SFY2009
7/1/06-6/30/07	7/1/07-6/30/08	7/1/08-6/30/09
0	8,469	7,439

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: Phil Schaengold

Date: 9/30/2009

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: Jeffrey Treasure

Date: 9/30/2009

Title: CFO

Comments: