GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP547

Facility Name: Southern Regional Medical Center

County: Clayton

Street Address: 11 Upper Riverdale Road SW

City: Riverdale

Zip: 30274-2600

Mailing Address: 11 Upper Riverdale Road SW

Mailing City: Riverdale

Mailing Zip: 30274-2600

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2009 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 7/1/2008 To:6/30/2009

Please indicate your cost report year.
From: 07/01/2008 To:06/30/2009

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: Ken Leach

Contact Title: Director, Management Accounting

Phone: 770-991-8314

Fax: 770-991-8591

E-mail: ken.leach@southernregional.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	411,723,584
Total Inpatient Admissions accounting for Inpatient Revenue	16,597
Outpatient Gross Patient Revenue	325,825,681
Total Outpatient Visits accounting for Outpatient Revenue	147,850
Medicare Contractual Adjustments	178,378,151
Medicaid Contractual Adjustments	118,209,331
Other Contractual Adjustments:	140,509,656
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	45,316,638
Uncompensated Indigent Care (net):	12,042,120
Uncompensated Charity Care (net):	19,169,694
Other Free Care:	18,375,892
Other Revenue/Gains:	-5,826,098
Total Expenses:	221,879,024

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 2009? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2009?

11/05/2004

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.?

Chief Financial Officer

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.)?

400%

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 2009? (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	8,021,408	14,755,512	22,776,920
Outpatient	4,031,239	4,516,740	8,547,979
Total	**12,052,647**	**19,272,252**	**31,324,899**

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)	52,150
Federal Government	0
Non-Government Sources	60,935
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**113,085**

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	8,021,408	14,755,512	22,776,920
Outpatient	4,020,712	4,414,182	8,434,894
Total	**12,042,120**	**19,169,694**	**31,211,814**

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
Bacon	0	0	1	235	0	0	0	0
Baker	0	0	0	0	0	0	1	247
Barrow	0	0	5	82,280	0	0	1	352
Ben Hill	0	0	0	0	0	0	1	95
Burke	1	17,876	0	0	0	0	0	0
Butts	3	70,397	3	6,649	17	505,052	39	5,336
Carroll	0	0	8	4,921	3	489,672	3	971
Chatham	2	35,231	7	16,636	0	0	0	0
Cherokee	0	0	0	0	1	678	1	319
Clarke	0	0	0	0	0	0	1	247
Clayton	292	5,506,677	2,024	2,834,274	664	9,760,427	4,186	3,221,640
Clinch	0	0	0	0	0	0	1	734
Cobb	0	0	1	8,530	1	9,301	6	9,065
Coweta	0	0	1	55	17	24,547	34	23,563
Dawson	0	0	2	4,664	0	0	0	0
DeKalb	9	136,012	32	73,439	9	78,780	74	54,509
Dougherty	0	0	0	0	0	0	1	239
Douglas	0	0	11	20,572	0	0	15	60,337
Fayette	48	1,127,763	272	346,050	105	2,099,781	414	379,705
Fulton	7	142,973	30	36,713	27	127,763	125	147,173
Gordon	0	0	0	0	0	0	2	1,005
Gwinnett	1	6,170	5	7,923	2	64,124	2	390
Haralson	1	801	0	0	0	0	11	1,458
Henry	29	499,048	150	475,364	60	952,389	524	539,722
Jasper	0	0	0	0	1	176	0	0
Lamar	0	0	1	6,874	2	913	7	1,118
Lee	0	0	0	0	1	12,166	0	0
Lumpkin	0	0	1	324	0	0	0	0
McDuffie	0	0	0	0	0	0	1	125
Meriwether	3	40,336	2	622	1	15,149	1	11
Muscogee	0	0	0	0	1	73,691	1	94
Newton	0	0	2	74	0	0	4	1,377

Other Out of State	6	321,788	16	33,212	9	247,142	28	22,875
Paulding	0	0	0	0	0	0	1	85
Peach	1	7,679	1	16,512	0	0	0	0
Pike	1	287	1	143	1	292,459	3	2,362
Rockdale	0	0	1	1,384	0	0	3	5,697
Spalding	3	39,614	14	20,881	0	0	34	35,233
Sumter	0	0	1	5,586	0	0	0	0
Towns	0	0	0	0	2	1,302	0	0
Upson	0	0	1	6,163	0	0	4	656
Walton	3	68,756	13	21,159	0	0	0	0
Total	**410**	**8,021,408**	**2,606**	**4,031,239**	**924**	**14,755,512**	**5,529**	**4,516,740**

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 2009? (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 2009.

	Patient Category	SFY 2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09	SFY2010 7/1/09-6/30/10
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	12,042,120	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	16,730,911	0
C.	Other Patients in accordance with the department approved policy.	0	2,438,783	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09	SFY2010 7/1/09-6/30/10
0	3,584	0

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: Steve Mahan

Date: 8/6/2010

Title: President and 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: Lee Boles

Date: 8/6/2010

Title: Sr Vice President and CFO

Comments:

The CEO will review the survey next week, since he is unavailable. The survey has been reviewed and signed by the CFO.