Georgia Department of Community Health

2009 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP606

Facility Name: Floyd Medical Center

County: Floyd

Street Address: 304 Turner McCall Boulevard SW

City: Rome

Zip: 30165-5621

Mailing Address: P O Box 233

Mailing City: Rome

Mailing Zip: 30162-0233

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: Richard T. Sheerin

Contact Title: VP and CFO

Phone: 706-509-6079

Fax: 706-509-6071

E-mail: rsheerin@floyd.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	357,198,939
Total Inpatient Admissions accounting for Inpatient Revenue	12,944
Outpatient Gross Patient Revenue	344,642,297
Total Outpatient Visits accounting for Outpatient Revenue	197,769
Medicare Contractual Adjustments	189,338,456
Medicaid Contractual Adjustments	103,001,021
Other Contractual Adjustments:	132,146,129
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	21,223,844
Uncompensated Indigent Care (net):	42,523,516
Uncompensated Charity Care (net):	6,334,274
Other Free Care:	0
Other Revenue/Gains:	7,654,924
Total Expenses:	206,720,710

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?

07/01/2008

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.?

Manager Financial Counseling

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.)?

325%

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	18,297,904	2,533,228	20,831,132
Outpatient	24,425,612	3,801,046	28,226,658
Total	**42,723,516**	**6,334,274**	**49,057,790**

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	200,000
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	**200,000**

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	18,097,904	2,533,228	20,631,132
Outpatient	24,425,612	3,801,046	28,226,658
Total	**42,523,516**	**6,334,274**	**48,857,790**

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	37	749,641	196	590,664	14	69,228	97	112,750
Bartow	77	795,090	666	1,431,293	45	226,095	309	296,938
Ben Hill	2	168,271	1	1,098	0	0	0	0
Bibb	0	0	0	0	0	0	1	6,609
Bryan	0	0	1	2,700	0	0	0	0
Carroll	1	46,075	11	22,973	4	6,946	8	9,484
Catoosa	2	100,596	1	379	0	0	0	0
Chattooga	131	1,929,017	995	2,362,769	60	284,769	385	424,535
Cherokee	4	37,659	9	42,069	0	0	0	0
Clarke	0	0	3	13,360	0	0	0	0
Cobb	2	33,444	31	70,103	3	748	15	4,050
Columbia	0	0	2	2,276	0	0	0	0
Coweta	0	0	0	0	1	27,539	0	0
Dade	0	0	0	0	1	23,041	2	8,126
DeKalb	2	89,777	0	0	0	0	0	0
Douglas	0	0	1	4,621	5	97,147	4	7,713
Fannin	0	0	1	7,458	0	0	1	333
Florida	1	16,376	3	10,959	0	0	2	34,671
Floyd	761	10,368,436	10,382	15,659,331	246	1,188,476	2,203	2,044,511
Forsyth	0	0	5	14,587	1	46,578	0	0
Franklin	0	0	2	13,922	0	0	0	0
Fulton	1	17,671	3	1,901	0	0	0	0
Gilmer	1	889	10	7,584	0	0	1	244
Gordon	36	598,685	366	804,445	32	229,520	167	195,695
Gwinnett	0	0	1	559	1	21,434	0	0
Hall	0	0	1	1,350	0	0	0	0
Haralson	15	410,483	52	83,703	8	11,416	28	32,239
Hart	1	550	0	0	0	0	0	0
Henry	0	0	1	2,802	0	0	2	1,098
Jackson	0	0	1	4,451	0	0	0	0
Lumpkin	1	1,200	1	75	0	0	0	0
Murray	4	160,271	7	24,717	0	0	15	26,380

Muscogee	0	0	1	991	0	0	0	0
Newton	3	52,420	4	3,800	0	0	0	0
Other Out of State	2	42,996	7	3,630	3	65,924	14	14,623
Paulding	2	62,600	23	67,480	1	1,255	6	4,124
Pickens	0	0	2	3,355	0	0	1	1,536
Polk	173	2,393,796	1,280	2,959,533	70	231,611	483	545,179
Rockdale	0	0	2	627	0	0	0	0
Seminole	0	0	3	1,163	0	0	0	0
Stephens	0	0	2	5,679	0	0	0	0
Tennessee	1	54,807	4	6,056	0	0	1	373
Tift	0	0	2	1,365	0	0	0	0
Union	0	0	2	9,473	0	0	0	0
Upson	0	0	0	0	0	0	1	798
Walker	4	70,537	30	137,279	1	819	13	7,332
Ware	1	23,054	0	0	0	0	0	0
Whitfield	4	73,563	18	43,032	1	682	27	21,705
Total	**1,269**	**18,297,904**	**14,133**	**24,425,612**	**497**	**2,533,228**	**3,786**	**3,801,046**

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	7,136,462	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	0	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 2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09	SFY2010 7/1/09-6/30/10
0	1,031	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: Kurt M. Stuenkel

Date: 8/5/2010

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: Richard T. Sheerin

Date: 8/5/2010

Title: Vice President and CFO

Comments: