



## 2009 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 calendar year 2009 only.

***Do not use a different report period.***

**Please indicate your hospital fiscal year.**

From: 8/1/2008 To:7/31/2009

**Please indicate your cost report year.**

From: 08/01/2008 To:07/31/2009

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:** 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	481,215,594
Total Inpatient Admissions accounting for Inpatient Revenue	19,921
Outpatient Gross Patient Revenue	578,364,526
Total Outpatient Visits accounting for Outpatient Revenue	243,130
Medicare Contractual Adjustments	323,041,143
Medicaid Contractual Adjustments	158,890,241
Other Contractual Adjustments:	89,582,556
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	50,712,498
Uncompensated Indigent Care (net):	27,304,579
Uncompensated Charity Care (net):	20,049,484
Other Free Care:	841,640
Other Revenue/Gains:	3,204,592
Total Expenses:	362,239,551

### 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
<b>Total</b>	<b>0</b>

## 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?

12/08/2008

### 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.?

ASST VP - BUSINESS AFFAIRS

#### **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 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	9,752,161	11,822,079	21,574,240
Outpatient	17,552,418	8,227,405	25,779,823
<b>Total</b>	<b>27,304,579</b>	<b>20,049,484</b>	<b>47,354,063</b>

#### 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
<b>Total</b>	<b>0</b>

#### 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	9,752,161	11,822,079	21,574,240
Outpatient	17,552,418	8,227,405	25,779,823
<b>Total</b>	<b>27,304,579</b>	<b>20,049,484</b>	<b>47,354,063</b>

## 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	665	22	125,918	0	0	2	7,846
Appling	0	0	17	2,994	0	0	1	806
Atkinson	0	0	0	0	0	0	2	26,463
Bacon	0	0	0	0	4	1,738	5	1,163
Baker	6	63,039	95	214,552	4	56,286	38	69,121
Ben Hill	4	50,492	23	26,650	8	113,099	12	71,949
Berrien	0	0	51	21,447	1	31,230	1	12,592
Bleckley	0	0	2	3,693	0	0	0	0
Brooks	0	0	0	0	0	0	2	724
Bulloch	0	0	0	0	0	0	1	58
Calhoun	28	326,371	217	248,444	17	413,976	83	127,770
Camden	0	0	0	0	0	0	1	332
Chattahoochee	0	0	0	0	0	0	1	1,191
Clay	3	1,490	42	56,321	0	0	0	0
Clayton	0	0	1	674	0	0	0	0
Cobb	0	0	1	1,774	0	0	0	0
Coffee	4	118,159	24	17,293	4	131,550	5	23,925
Colquitt	15	227,991	145	190,924	22	776,298	50	207,964
Cook	0	0	9	181	1	12,228	1	1,181
Crisp	11	45,524	100	204,588	17	283,925	109	231,991
Decatur	1	960	44	25,431	1	1,233	27	31,599
Dodge	0	0	21	14,047	0	0	0	0
Dooly	3	2,431	10	38,956	6	153,096	12	80,976
Dougherty	573	5,273,852	8,234	9,479,981	400	6,092,792	2,543	4,717,824
Early	8	44,065	62	66,809	1	9,825	8	18,055
Fannin	0	0	5	7,225	0	0	0	0
Fayette	0	0	0	0	0	0	4	1,311
Florida	0	0	10	19,450	1	16,579	9	36,122
Floyd	0	0	0	0	1	5,800	0	0
Fulton	1	4,259	7	16,262	0	0	2	11,526
Glynn	0	0	0	0	0	0	1	12,074
Grady	0	0	16	4,392	0	0	14	25,868

Gwinnett	0	0	1	231	0	0	1	2,910
Henry	0	0	1	728	0	0	0	0
Houston	0	0	39	7,967	0	0	1	262
Irwin	3	18,379	4	1,867	2	86,775	0	0
Jeff Davis	1	1,084	1	170	0	0	2	22,646
Lanier	0	0	0	0	1	6,120	1	2,849
Laurens	0	0	0	0	0	0	1	5,012
Lee	101	953,309	1,459	1,767,062	41	336,755	387	520,160
Liberty	0	0	1	24	0	0	0	0
Lowndes	0	0	1	767	1	485	2	10,314
Lumpkin	0	0	0	0	1	17,168	0	0
Macon	1	30,458	25	15,916	5	81,697	18	36,221
Marion	0	0	3	637	0	0	0	0
Miller	6	11,362	80	53,728	0	0	0	0
Mitchell	62	507,495	621	883,300	70	1,252,796	204	544,424
Muscogee	0	0	0	0	2	91,647	1	2,306
Other Out of State	3	3,857	24	10,784	5	162,138	28	29,131
Pulaski	0	0	0	0	3	1,129	25	22,504
Quitman	1	760	2	770	2	18,936	1	297
Randolph	20	239,524	254	902,705	8	32,757	24	32,511
Richmond	0	0	2	1,090	1	23,048	0	0
Rockdale	0	0	3	1,661	0	0	0	0
Schley	3	45,546	19	58,538	8	23,218	9	1,261
Seminole	0	0	17	33,768	0	0	4	21,563
Stewart	2	15,608	2	13,048	3	33,517	4	4,672
Sumter	43	580,376	467	788,235	49	720,708	152	313,225
Telfair	0	0	2	1,148	1	43,524	0	0
Tennessee	0	0	4	259	0	0	1	1,116
Terrell	88	683,194	867	1,069,022	25	175,580	206	264,138
Thomas	4	3,666	90	93,894	4	5,729	13	27,228
Tift	5	26,050	112	148,061	8	167,005	32	35,939
Turner	3	54,473	99	144,658	3	74,024	8	18,062
Upson	0	0	9	256	1	17,165	3	11,390
Webster	2	2,062	19	12,890	2	18,978	3	4,540
Wilcox	0	0	0	0	1	46,904	18	10,696
Wilkinson	0	0	0	0	0	0	1	875
Worth	53	415,661	657	751,228	28	284,620	209	560,722
<b>Total</b>	<b>1,059</b>	<b>9,752,162</b>	<b>14,043</b>	<b>17,552,418</b>	<b>763</b>	<b>11,822,078</b>	<b>4,293</b>	<b>8,227,405</b>

## 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	SFY2009	SFY2010
		7/1/07-6/30/08	7/1/08-6/30/09	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	20,740,281	6,564,298
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	8,543,888	11,505,596
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	SFY2009	SFY2010
7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10
0	16,227	3,931

## 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:** Joel Wernick

**Date:** 8/9/2010

**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:** 8/9/2010

**Title:** CFO

**Comments:**