GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2010 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP622

Facility Name: Saint Mary's Hospital

County: Clarke

Street Address: 1230 Baxter Street

City: Athens

Zip: 30606-3791

Mailing Address: 1230 Baxter Street

Mailing City: Athens

Mailing Zip: 30606-3791

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2010 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2010 To:12/31/2010

Please indicate your cost report year.
From: 01/01/2010 To:12/31/2010

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: Hal Mixon

Contact Title: Reimburserment Analyst 1

Phone: 706-389-2615

Fax: 706-389-2610

E-mail: hmixon@stmarysathens.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	256,186,039
Total Inpatient Admissions accounting for Inpatient Revenue	8,676
Outpatient Gross Patient Revenue	255,634,594
Total Outpatient Visits accounting for Outpatient Revenue	116,969
Medicare Contractual Adjustments	165,226,286
Medicaid Contractual Adjustments	39,514,304
Other Contractual Adjustments:	126,132,344
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	12,678,815
Uncompensated Indigent Care (net):	14,865,613
Uncompensated Charity Care (net):	4,510,807
Other Free Care:	2,666,154
Other Revenue/Gains:	2,204,923
Total Expenses:	143,273,115

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 2010? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2010?

12/31/2009

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 Financial Services

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 2010? (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	7,349,355	2,929,792	10,279,147
Outpatient	7,516,258	1,581,015	9,097,273
Total	**14,865,613**	**4,510,807**	**19,376,420**

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	7,349,355	2,929,792	10,279,147
Outpatient	7,516,258	1,581,015	9,097,273
Total	**14,865,613**	**4,510,807**	**19,376,420**

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
Appling	2	345	4	9,465	0	0	0	0
Baldwin	0	0	1	2,587	0	0	0	0
Banks	11	51,429	15	42,918	4	2,821	31	7,997
Barrow	34	772,300	328	789,679	43	403,131	138	303,151
Bartow	0	0	1	782	0	0	0	0
Bibb	0	0	3	1,630	0	0	0	0
Carroll	1	26,977	0	0	0	0	0	0
Cherokee	0	0	0	0	1	11,645	4	11,311
Clarke	128	2,615,029	1,916	3,462,800	72	781,276	433	534,093
Cobb	0	0	2	3,268	0	0	0	0
Coffee	0	0	0	0	0	0	1	2,477
Coweta	0	0	3	7,075	0	0	0	0
DeKalb	1	16,623	2	3,695	0	0	2	3,360
Elbert	7	144,809	64	202,041	9	197,026	37	59,743
Florida	3	30,402	2	7,721	2	1,772	2	361
Franklin	2	29,848	65	111,959	7	112,284	36	71,241
Fulton	1	770	2	6,283	0	0	7	4,708
Greene	11	325,577	33	46,605	14	144,017	12	24,716
Gwinnett	5	86,744	19	53,896	4	4,261	18	2,938
Habersham	2	1,048	7	6,515	0	0	4	4,487
Hall	0	0	15	37,911	1	318	4	191
Hancock	0	0	1	3,521	0	0	0	0
Hart	9	152,570	38	74,437	8	6,933	28	26,664
Henry	0	0	0	0	1	29,845	2	1,297
Houston	1	50,460	0	0	0	0	0	0
Jackson	28	467,050	228	509,044	21	174,650	100	84,719
Madison	29	423,730	313	677,290	23	96,371	101	164,249
McDuffie	0	0	1	2,607	0	0	0	0
Morgan	9	178,820	54	112,787	8	84,282	20	38,128
Muscogee	0	0	2	734	0	0	0	0
Newton	3	1,068	5	21,500	1	1,223	0	0
North Carolina	1	115,057	4	3,888	0	0	0	0

Oconee	11	465,893	210	407,617	10	10,190	91	59,613
Oglethorpe	20	338,724	220	216,999	10	113,090	60	65,518
Other Out of State	2	35,278	22	73,180	2	14,251	0	0
Pickens	0	0	0	0	0	0	2	72
Putnam	2	36,763	0	0	2	1,656	2	541
Rabun	0	0	1	3,913	0	0	1	82
South Carolina	3	3,268	4	1,183	1	0	0	0
Stephens	2	14,552	15	103,167	2	20,626	8	383
Sumter	0	0	1	2,209	0	0	0	0
Taliaferro	0	0	2	7,766	0	0	1	3,032
Toombs	0	0	1	1,219	0	0	0	0
Troup	0	0	1	28,037	0	0	0	0
Union	0	0	0	0	0	0	1	77
Walker	0	0	0	0	0	0	1	3,261
Walton	31	842,781	136	410,085	34	626,099	38	88,371
Warren	0	0	1	191	0	0	0	0
White	0	0	0	0	1	1,025	1	41
Wilkes	4	121,440	18	58,054	4	91,000	21	14,193
Total	**363**	**7,349,355**	**3,760**	**7,516,258**	**285**	**2,929,792**	**1,207**	**1,581,015**

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 2010? (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 2010.

	Patient Category	SFY 2010 7/1/09-6/30/10	SFY2010 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	14,232,753	632,857
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	3,978,883	531,923
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 2010 7/1/09-6/30/10	SFY2010 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
0	5,437	179

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: Don McKenna

Date: 7/7/2011

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: Martin Hutson

Date: 7/7/2011

Title: CFO

Comments: