Georgia Department of Community Health

2010 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP626

Facility Name: Candler Hospital

County: Chatham

Street Address: 5353 Reynolds Street

City: Savannah

Zip: 31405

Mailing Address: 5353 Reynolds Street

Mailing City: Savannah

Mailing Zip: 31405

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: 7/1/2009 To:6/30/2010

Please indicate your cost report year.
From: 07/01/2009 To:06/30/2010

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: Tami Jeffers

Contact Title: Financial Analyst

Phone: 912-819-7578

Fax: 912-819-8664

E-mail: jeffersta@sjchs.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	322,355,608
Total Inpatient Admissions accounting for Inpatient Revenue	11,729
Outpatient Gross Patient Revenue	353,315,061
Total Outpatient Visits accounting for Outpatient Revenue	382,775
Medicare Contractual Adjustments	203,961,085
Medicaid Contractual Adjustments	65,996,977
Other Contractual Adjustments:	184,332,054
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	24,061,193
Uncompensated Indigent Care (net):	7,614,092
Uncompensated Charity Care (net):	12,405,428
Other Free Care:	0
Other Revenue/Gains:	2,596,766
Total Expenses:	173,554,520

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?

10/18/2007

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 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.)?

500%

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	5,173,252	5,283,160	10,456,412
Outpatient	2,440,840	7,122,268	9,563,108
Total	**7,614,092**	**12,405,428**	**20,019,520**

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	5,173,252	5,283,160	10,456,412
Outpatient	2,440,840	7,122,268	9,563,108
Total	**7,614,092**	**12,405,428**	**20,019,520**

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	24,023	0	0	1	2,425	2	9,141
Appling	1	44,554	9	9,360	5	40,182	6	4,906
Bacon	0	0	0	0	1	17,764	0	0
Bleckley	0	0	0	0	0	0	0	0
Brantley	0	0	0	0	0	0	1	878
Bryan	5	64,144	64	149,054	26	125,417	213	197,972
Bulloch	1	1,146	12	70,585	3	2,947	36	46,271
Burke	0	0	0	0	2	22,493	0	0
Calhoun	0	0	0	0	0	0	0	0
Camden	0	0	0	0	0	0	1	734
Candler	0	0	0	0	3	4,084	9	54,030
Charlton	0	0	0	0	0	0	1	596
Chatham	156	3,847,010	977	1,622,822	443	3,668,538	3,356	5,495,266
Cherokee	0	0	0	0	0	0	1	355
Clarke	0	0	0	0	0	0	1	2,549
Coffee	1	773	0	0	2	116,556	3	26,724
Effingham	12	119,343	95	285,802	51	396,701	341	367,789
Emanuel	3	1,809	0	0	4	46,188	11	27,292
Evans	3	42,802	4	668	3	30,453	22	108,415
Florida	2	56,512	4	5,147	0	0	0	0
Fulton	0	0	1	4,253	0	0	2	7,693
Glynn	0	0	0	0	0	0	10	24,848
Haralson	0	0	0	0	0	0	1	100
Jeff Davis	0	0	1	40	4	289,400	3	17,067
Jenkins	0	0	0	0	1	1,024	1	206
Johnson	0	0	0	0	1	14,323	1	175
Laurens	0	0	0	0	0	0	2	3,063
Liberty	9	213,367	27	227,387	13	44,757	143	184,770
Long	1	13,578	1	332	2	1,969	11	69,371
McIntosh	1	900	3	228	2	1,814	12	14,398
Montgomery	0	0	0	0	0	0	2	1,061
North Carolina	0	0	0	0	1	11,449	3	13,604

Other Out of State	1	51,040	2	6,055	3	42,751	17	30,758
Pierce	1	550	0	0	0	0	3	9,956
Richmond	0	0	0	0	0	0	1	382
Screven	7	132,031	5	2,369	0	0	33	68,868
South Carolina	0	0	7	27,849	16	242,910	66	172,029
Stephens	0	0	1	1,172	0	0	0	0
Sumter	0	0	0	0	0	0	1	311
Tattnall	3	106,314	7	18,746	8	73,814	38	42,847
Telfair	0	0	0	0	3	34,397	3	12,725
Tift	0	0	0	0	1	1,068	5	7,043
Toombs	1	431,039	1	7,091	30	44,574	22	55,691
Twiggs	0	0	2	1,622	0	0	0	0
Upson	1	21,337	1	216	0	0	0	0
Ware	0	0	0	0	0	0	4	357
Warren	0	0	0	0	0	0	1	2,779
Wayne	1	980	1	42	4	5,162	23	39,248
Total	**211**	**5,173,252**	**1,225**	**2,440,840**	**633**	**5,283,160**	**4,412**	**7,122,268**

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.	3,538,270	7,613,084	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 2010 7/1/09-6/30/10	SFY2010 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
1,259	1,435	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: Paul P Hinchey

Date: 6/21/2011

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: Greg Schaack

Date: 6/21/2011

Title:

Comments: