



## 2012 Hospital Financial Survey

### Part A : General Information

#### 1. Identification

UID:HOSP521

**Facility Name:** Tift Regional Medical Center

**County:** Tift

**Street Address:** 901 East 18th Street

**City:** Tifton

**Zip:** 31794-3699

**Mailing Address:** PO Box 747

**Mailing City:** Tifton

**Mailing Zip:** 31793-0747

#### 2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2012 only.

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

**Please indicate your hospital fiscal year.**

From: 10/1/2011 To:9/30/2012

**Please indicate your cost report year.**

From: 10/01/2011 To:09/30/2012

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:** Tonia Waldrop

**Contact Title:** Controller

**Phone:** 229-353-3804

**Fax:** 229-353-3807

**E-mail:** tonia.waldrop@tiftregional.com

## 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	319,407,429
Total Inpatient Admissions accounting for Inpatient Revenue	11,962
Outpatient Gross Patient Revenue	411,927,500
Total Outpatient Visits accounting for Outpatient Revenue	157,894
Medicare Contractual Adjustments	316,526,949
Medicaid Contractual Adjustments	86,187,620
Other Contractual Adjustments:	27,596,933
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	30,032,214
Uncompensated Indigent Care (net):	43,945,558
Uncompensated Charity Care (net):	15,120,527
Other Free Care:	206,485
Other Revenue/Gains:	26,946,787
Total Expenses:	199,149,045

### 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 2012? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2012?

05/28/2007

### 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.?

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#### **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 2012? (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	17,601,688	6,137,588	23,739,276
Outpatient	26,624,961	8,982,939	35,607,900
<b>Total</b>	<b>44,226,649</b>	<b>15,120,527</b>	<b>59,347,176</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)	281,091
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>281,091</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	17,576,338	6,137,588	23,713,926
Outpatient	26,369,220	8,982,939	35,352,159
<b>Total</b>	<b>43,945,558</b>	<b>15,120,527</b>	<b>59,066,085</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
Appling	0	0	3	2,735	0	0	7	14,833
Atkinson	9	96,295	107	183,271	16	226,618	80	102,986
Bacon	0	0	0	0	0	0	1	13
Bartow	1	63,501	6	1,417	4	4,344	8	1,857
Ben Hill	43	1,154,244	605	1,334,383	56	298,561	312	478,268
Berrien	113	2,122,917	2,072	2,860,588	108	526,043	883	813,356
Bibb	3	57,149	6	9,604	0	0	1	35
Brooks	0	0	6	12,350	0	0	1	74
Camden	0	0	2	677	0	0	0	0
Charlton	0	0	1	1,830	0	0	1	7,928
Chatham	0	0	0	0	2	10,512	0	0
Cherokee	0	0	1	-3,670	0	0	1	4,847
Clinch	0	0	3	4,101	1	22	2	895
Coffee	30	749,198	245	515,185	27	163,992	145	106,067
Colquitt	37	658,109	594	1,053,502	34	81,057	307	328,044
Cook	92	1,314,701	1,594	1,943,496	74	452,426	646	511,063
Coweta	1	4,026	6	5,705	0	0	3	6,008
Crisp	4	79,063	50	125,067	2	115,580	36	34,012
Decatur	0	0	0	0	0	0	1	2,575
Dekalb	0	0	6	4,746	0	0	0	0
Dodge	0	0	2	294	2	1,623	5	720
Dooly	0	0	1	0	0	0	1	73
Dougherty	2	17,669	32	56,430	2	1,260	22	6,462
Early	0	0	3	15,610	0	0	0	0
Echols	0	0	2	1,693	0	0	0	0
Fayette	0	0	0	0	0	0	8	4,253
Fulton	0	0	4	1,760	0	0	2	19
Gilmer	0	0	3	9,070	0	0	1	9,721
Glynn	0	0	0	0	0	0	5	3,020
Grady	1	395	1	5,316	0	0	2	342
Gwinnett	0	0	18	19,643	0	0	0	0
Hall	0	0	0	0	0	0	1	5,663

Henry	0	0	2	975	0	0	1	859
Houston	4	4,614	28	10,882	1	56	5	3,738
Irwin	32	608,237	605	592,577	40	292,584	318	362,499
Jeff Davis	0	0	3	2,794	1	3,267	4	3,709
Lanier	0	0	8	18,847	0	0	24	7,903
Laurens	2	32,989	3	4,725	0	0	0	0
Lee	1	34,492	12	41,545	5	3,320	9	26,734
Liberty	0	0	3	1,682	0	0	3	1,480
Lowndes	5	123,500	146	235,450	3	2,260	21	45,446
Mitchell	0	0	1	332	0	0	5	3,953
Montgomery	2	25,056	3	1,795	0	0	0	0
Muscogee	0	0	0	0	0	0	1	90
Oconee	0	0	1	1,004	0	0	0	0
Oglethorpe	0	0	5	2,861	0	0	0	0
Other Out of State	11	173,504	49	57,044	15	145,748	38	16,489
Pierce	2	34,344	64	83,275	0	0	5	2,123
Pulaski	0	0	1	844	0	0	0	0
Schley	0	0	1	373	0	0	0	0
Sumter	1	1,152	1	989	0	0	1	33
Taylor	0	0	1	880	0	0	2	25
Telfair	2	110,318	6	2,768	3	2,790	1	903
Terrell	0	0	0	0	0	0	1	927
Thomas	0	0	7	17,023	0	0	6	6,431
Tift	488	8,554,118	12,956	14,700,049	523	2,423,190	5,952	4,808,256
Towns	1	22,162	0	0	0	0	0	0
Troup	1	38,351	0	0	2	75	2	67
Turner	83	1,309,695	1,696	2,111,269	97	425,447	1,194	775,786
Twiggs	0	0	0	0	0	0	1	154
Ware	1	19,882	9	582	1	1,156	8	2,607
Wayne	0	0	1	635	0	0	0	0
Wheeler	0	0	2	1,364	0	0	0	0
Wilcox	6	77,750	79	98,878	9	890,572	94	219,171
Worth	13	114,257	376	468,716	26	65,085	246	250,422
<b>Total</b>	<b>991</b>	<b>17,601,688</b>	<b>21,442</b>	<b>26,624,961</b>	<b>1,054</b>	<b>6,137,588</b>	<b>10,424</b>	<b>8,982,939</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 2012?  
(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 2012.

Patient Category		SFY 2011	SFY2012	SFY2013
		7/1/10-6/30/11	7/1/11-6/30/12	7/1/12-6/30/13
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	31,832,124	12,394,524
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	11,302,863	3,817,665
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 2011	SFY2012	SFY2013
7/1/10-6/30/11	7/1/11-6/30/12	7/1/12-6/30/13
0	26,771	7,141

## 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:** William T. Richardson

**Date:** 8/29/2013

**Title:** President/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:** Dennis L. Crum

**Date:** 8/29/2013

**Title:** Vice President Finance-CFO

**Comments:**