



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2013 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: Tifton

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 2013 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 10/1/2012 To:9/30/2013

Please indicate your cost report year.

From: 10/01/2012 To:09/30/2013

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	335,021,211
Total Inpatient Admissions accounting for Inpatient Revenue	11,042
Outpatient Gross Patient Revenue	486,611,195
Total Outpatient Visits accounting for Outpatient Revenue	377,114
Medicare Contractual Adjustments	294,004,913
Medicaid Contractual Adjustments	102,027,362
Other Contractual Adjustments:	106,265,358
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	41,080,880
Uncompensated Indigent Care (net):	46,626,635
Uncompensated Charity Care (net):	16,442,858
Other Free Care:	1,146,761
Other Revenue/Gains:	19,921,568
Total Expenses:	258,606,517

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	246,007
Admin Discounts	381,070
Employee Discounts	126,356
Related Entity Discounts	393,328
Total	1,146,761

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 2013? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2013?

10/01/2012

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.?

VP of Revenue Cycle

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 2013? (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	17,006,339	6,310,873	23,317,212
Outpatient	29,620,296	10,131,985	39,752,281
Total	46,626,635	16,442,858	63,069,493

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	17,006,339	6,310,873	23,317,212
Outpatient	29,620,296	10,131,985	39,752,281
Total	46,626,635	16,442,858	63,069,493

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	1	4,215	0	0	3	1,491
Atkinson	9	113,089	59	95,209	6	74,521	39	169,551
Baker	0	0	0	0	0	0	4	29,893
Baldwin	0	0	1	3,106	0	0	0	0
Barrow	0	0	0	0	1	534	3	763
Ben Hill	44	408,908	321	412,597	27	340,133	122	233,851
Berrien	102	1,222,528	949	1,949,571	48	224,883	329	485,524
Bibb	0	0	0	0	1	1,184	0	0
Brooks	0	0	6	27,102	0	0	2	1,581
Butts	0	0	0	0	0	0	1	2,068
Catoosa	0	0	0	0	1	786	0	0
Chatham	0	0	1	3,111	0	0	0	0
Cherokee	0	0	4	42,233	0	0	0	0
Clayton	0	0	1	1	0	0	0	0
Clinch	1	86	3	43,733	0	0	3	1,174
Cobb	0	0	5	21,378	0	0	0	0
Coffee	16	401,839	117	282,293	24	167,233	91	182,843
Colquitt	37	546,134	362	813,083	14	247,358	146	292,123
Cook	96	923,943	620	1,390,415	39	462,282	254	435,197
Coweta	0	0	1	479	0	0	1	445
Crawford	0	0	1	1,577	0	0	0	0
Crisp	8	163,647	29	28,614	4	13,991	29	21,754
Decatur	0	0	0	0	2	1,495	0	0
DeKalb	548	3,907,035	5,204	7,973,698	389	2,141,072	4,100	3,763,411
Dodge	0	0	9	61,272	1	1,156	3	243
Dooly	2	118,558	7	4,517	1	885	4	1,282
Dougherty	3	41,036	57	117,577	1	1,156	17	26,079
Douglas	1	29,503	0	0	0	0	0	0
Early	0	0	1	1,625	0	0	0	0
Echols	1	2	0	0	0	0	0	0
Effingham	0	0	1	2,348	0	0	0	0
Fayette	0	0	4	2,183	0	0	0	0

Fulton	1	137,998	7	4,811	0	0	1	77
Gilmer	0	0	0	0	0	0	1	10,000
Glynn	0	0	2	888	0	0	0	0
Grady	1	5,445	3	1,061	0	0	0	0
Gwinnett	1	1,725	1	5,930	0	0	3	6,404
Hall	0	0	0	0	0	0	1	3,798
Henry	0	0	0	0	0	0	1	99
Houston	2	4,141	2	3,229	2	1,917	1	12,063
Irwin	29	346,686	334	509,006	21	170,790	164	225,793
Jeff Davis	0	0	8	23,337	0	0	1	317
Lamar	0	0	1	3,488	0	0	0	0
Lanier	1	45	7	4,915	0	0	1	727
Lee	0	0	1	42	7	6,440	3	4,279
Long	1	68,790	0	0	0	0	0	0
Lowndes	5	138,627	119	249,915	2	3,803	13	6,515
Meriwether	0	0	0	0	1	1,184	0	0
Mitchell	0	0	4	3,353	0	0	5	7,994
Muscogee	13	236,310	35	90,398	11	234,848	53	60,109
Other Out of State	12	90,846	43	42,862	1	1,156	2	784
Quitman	0	0	1	99	0	0	1	356
Rabun	0	0	1	4,438	0	0	0	0
Randolph	0	0	1	434	0	0	0	0
Spalding	0	0	5	9,037	1	1,244	0	0
Stewart	0	0	1	40	0	0	0	0
Sumter	3	1,384	7	13,139	0	0	9	9,619
Telfair	0	0	2	12,131	0	0	2	287
Terrell	0	0	1	1,219	0	0	1	1,212
Thomas	4	33,126	36	55,313	1	5,948	1	80
Tift	507	6,958,042	7,504	13,144,952	226	1,866,892	2,429	3,470,487
Toombs	0	0	8	1,971	0	0	1	3,792
Troup	0	0	3	17,986	0	0	0	0
Turner	100	683,983	974	1,825,859	34	177,225	435	464,792
Twiggs	0	0	0	0	0	0	1	125
Walton	0	0	0	0	0	0	3	1,417
Ware	0	0	0	0	0	0	2	854
Wayne	0	0	8	22,253	0	0	0	0
Whitfield	0	0	0	0	3	60,620	0	0
Wilcox	11	34,137	33	63,215	2	61,011	45	40,083
Worth	30	388,746	176	223,038	14	39,126	110	150,649
Total	1,589	17,006,339	17,092	29,620,296	885	6,310,873	8,441	10,131,985

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 2013?
(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 2013.

Patient Category		SFY 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	34,969,976	11,656,659
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	12,332,144	4,110,714
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 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
0	288,114	100,042

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: 7/31/2014

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: 7/31/2014

Title: Senior VP/CFO

Comments:

1.Provider Fee add-on payments of 11.8% were obtained from GHA and have been added as an adjustment to Medicaid contractual and disclosed on the reconciliation addendum. 2.Actual Indigent/Charity exceeded the reported charity on the financial statements by \$5,725. This variance has been deducted from total bad debts.