



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2013 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP547

Facility Name: Southern Regional Medical Center

County: Clayton

Street Address: 11 Upper Riverdale Road SW

City: Riverdale

Zip: 30274

Mailing Address: 11 Upper Riverdale Road SW

Mailing City: Riverdale

Mailing Zip: 30274-2600

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: 7/1/2012 To:6/30/2013

Please indicate your cost report year.

From: 07/01/2012 To:06/30/2013

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: Gina Dickson

Contact Title: VP Finance & Accounting

Phone: 770-991-8367

Fax: 770-991-8591

E-mail: gina.dickson@southernregional.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	384,327,492
Total Inpatient Admissions accounting for Inpatient Revenue	13,459
Outpatient Gross Patient Revenue	387,232,463
Total Outpatient Visits accounting for Outpatient Revenue	132,406
Medicare Contractual Adjustments	221,176,837
Medicaid Contractual Adjustments	143,143,371
Other Contractual Adjustments:	117,346,268
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	51,708,877
Uncompensated Indigent Care (net):	19,647,050
Uncompensated Charity Care (net):	12,837,398
Other Free Care:	29,822,788
Other Revenue/Gains:	3,845,839
Total Expenses:	204,170,442

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	13,902,413
Admin Discounts	31,171
Employee Discounts	0
General Other Free Care	15,889,204
Total	29,822,788

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?

06/10/2010

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.?

Chief Financial Officer

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.)?

300

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	13,270,285	10,097,165	23,367,450
Outpatient	6,392,657	2,799,811	9,192,468
Total	19,662,942	12,896,976	32,559,918

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)	15,892
Federal Government	0
Non-Government Sources	59,578
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	75,470

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	13,270,285	10,097,165	23,367,450
Outpatient	6,376,765	2,740,233	9,116,998
Total	19,647,050	12,837,398	32,484,448

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
BARROW	0	0	0	0	0	0	7	38,883
BARTOW	1	39,832	0	0	0	0	0	0
BIBB	0	0	1	11,563	1	13,808	7	6,897
BUTTS	0	0	1	702	4	86,476	3	18,090
CARROLL	0	0	2	602	1	504	1	365
CLAY	0	0	0	2	0	0	0	0
CLAYTON	411	10,036,865	1,640	5,193,852	368	7,706,065	1,862	1,729,668
COBB	1	48,580	2	18,217	2	59,363	4	4,978
COWETA	2	50,231	2	24,780	8	90,344	36	33,694
DECATUR	1	29,275	0	0	0	0	0	0
DEKALB	10	307,359	26	51,309	10	224,706	24	28,978
DOUGLAS	0	0	1	6,738	0	0	1	554
EMANUEL	2	57,527	7	25,254	0	0	0	0
FAYETTE	5	124,419	15	66,394	6	139,565	36	32,031
FLORIDA	0	0	1	964	1	7,879	1	150
FULTON	72	1,737,154	239	595,250	46	899,542	183	228,710
GLYNN	0	0	0	0	3	39,129	6	4,934
GWINNETT	4	83,215	4	5,175	2	73,436	4	1,988
HALL	0	0	1	6,897	1	29,274	0	0
HEARD	0	0	2	21,963	0	0	0	0
HENRY	21	554,196	49	206,219	25	258,330	279	636,145
IRWIN	0	0	0	0	1	7,618	1	1,755
JEFFERSON	0	0	1	8,455	0	0	0	0
LAMAR	0	0	0	0	1	6,546	3	1,003
LOWNDES	0	0	1	108	0	0	0	0
MERIWETHER	0	0	0	0	0	0	1	1,967
MUSCOGEE	0	0	1	1,792	1	220	0	0
NEWTON	0	0	0	0	3	77,028	8	1,310
Other Out of State	3	43,883	7	10,615	1	11,828	1	488
PIKE	0	0	0	0	0	0	1	194
POLK	3	37,534	2	1,097	0	0	0	0
ROCKDALE	0	0	2	1,510	1	7,043	30	12,578

SPALDING	3	80,450	11	112,866	7	358,461	9	13,535
TROUP	1	38,095	2	3,776	0	0	1	48
UPSON	0	0	1	2,086	0	0	4	868
WALTON	1	1,670	4	14,471	0	0	0	0
Total	541	13,270,285	2,025	6,392,657	493	10,097,165	2,513	2,799,811

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	19,647,050	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	12,193,587	0
C.	Other Patients in accordance with the department approved policy.	0	643,811	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	2,924	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 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: James E. Crissey

Date: 7/31/2014

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: G.E. Hoffman Jr.

Date: 7/31/2014

Title: Sr VP and CFO

Comments:

1. During FY 2013 Southern Regional Medical Center (SRMC) received funds on behalf of Morehouse School of Medicine related to the "Medicaid Rate Adjustment for Medical Education Georgia Board for Physician Workforce". These funds were transferred to Morehouse based on a signed agreement. During FY 2013 the total funds transferred to Morehouse were \$7,388,003.79. Because of the nature of the funds transfer, these funds are not recorded in the operating financial statements of SRMC. 2. Based on reports provided by GHA that were run on 7-8-2014, SRMC received \$3,954,144.39 in Medicaid Add-on payments for FY 2013 dates of service. 3. Payments made to DCH related to the provider tax were \$3,252,342 for FY 2013.