



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2013 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP622

Facility Name: St Mary's Hospital

County: Clarke

Street Address: 1230 Baxter Street

City: Athens

Zip: Athens

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 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: Hal Mixon

Contact Title: Reimbursement Analyst 1

Phone: 706-389-2617

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	270,269,412
Total Inpatient Admissions accounting for Inpatient Revenue	8,511
Outpatient Gross Patient Revenue	267,059,665
Total Outpatient Visits accounting for Outpatient Revenue	122,667
Medicare Contractual Adjustments	188,971,166
Medicaid Contractual Adjustments	37,859,328
Other Contractual Adjustments:	132,949,334
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	10,628,258
Uncompensated Indigent Care (net):	10,698,534
Uncompensated Charity Care (net):	7,944,785
Other Free Care:	2,053,835
Other Revenue/Gains:	2,408,383
Total Expenses:	146,012,879

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	2,038,351
Employee Discounts	-4,645
Small Balance writeoff	20,128
Total	2,053,834

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?

12/01/2000

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.?

Jonathan Roberts

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 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	5,417,302	3,429,245	8,846,547
Outpatient	5,281,232	4,515,540	9,796,772
Total	10,698,534	7,944,785	18,643,319

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	5,417,302	3,429,245	8,846,547
Outpatient	5,281,232	4,515,540	9,796,772
Total	10,698,534	7,944,785	18,643,319

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	0	0	1	25,292	0	0
Baldwin	0	0	0	0	1	920	0	0
Banks	0	0	9	11,646	11	14,034	45	37,151
Barrow	33	531,067	238	492,303	67	401,348	404	286,382
Bleckley	0	0	3	2,817	0	0	0	0
Burke	0	0	0	0	0	0	1	212
Calhoun	0	0	0	0	0	0	1	8,157
Carroll	0	0	1	681	0	0	1	327
Chatham	0	0	0	0	0	0	3	1,470
Cherokee	0	0	0	0	1	4,815	1	972
Clarke	147	1,717,789	1,455	1,973,360	170	1,342,691	2,900	1,969,800
Clayton	0	0	0	0	0	0	1	1,423
Cobb	0	0	4	7,824	1	45,330	7	2,394
Colquitt	1	3,971	0	0	0	0	0	0
Cook	0	0	0	0	0	0	1	6,154
Coweta	0	0	1	870	0	0	0	0
Dawson	0	0	0	0	0	0	1	33
DeKalb	3	103,637	3	12,138	0	0	0	0
Dougherty	0	0	1	414	0	0	0	0
Elbert	4	17,783	84	147,968	22	104,563	117	69,168
Forsyth	0	0	1	537	0	0	1	660
Franklin	3	28,982	23	65,154	18	55,007	86	107,801
Fulton	0	0	1	773	1	4,361	7	2,939
Gilmer	0	0	0	0	0	0	3	1,794
Glynn	0	0	2	1,003	0	0	3	1,029
Greene	40	1,113,406	45	208,025	32	160,748	77	119,197
Gwinnett	2	16,381	16	26,739	4	135,653	17	15,568
Habersham	0	0	2	5,246	2	1,979	11	1,598
Hall	1	15,077	1	927	2	2,286	21	10,634
Hancock	2	30,984	1	11,531	1	380	1	30
Hart	6	120,304	71	192,838	11	61,005	110	91,099
Henry	0	0	0	0	0	0	3	1,504

Houston	0	0	1	1,405	0	0	0	0
Jackson	24	398,127	234	393,239	44	188,645	353	310,887
Jasper	0	0	0	0	0	0	2	446
Jeff Davis	0	0	0	0	0	0	1	99
Jefferson	0	0	0	0	0	0	1	482
Jones	0	0	14	406	0	0	0	0
Lamar	0	0	0	0	2	2,890	0	0
Laurens	0	0	0	0	0	0	1	737
Lincoln	0	0	0	0	0	0	1	1,492
Lowndes	0	0	0	0	0	0	1	1,064
Madison	22	251,126	278	508,258	62	182,272	477	412,725
McDuffie	0	0	0	0	1	21,772	0	0
Miller	0	0	1	419	0	0	0	0
Monroe	0	0	0	0	0	0	2	1,948
Morgan	12	173,752	77	184,713	20	76,188	103	57,567
Newton	0	0	10	13,279	2	2,023	14	3,811
Oconee	14	226,829	172	322,596	37	182,699	289	181,226
Oglethorpe	10	118,059	115	160,288	26	71,173	157	141,661
Other Out of State	3	65,002	11	28,017	5	45,315	35	19,021
Paulding	0	0	5	8,820	0	0	0	0
Pickens	0	0	0	0	0	0	1	192
Putnam	6	114,760	7	49,187	7	30,410	20	13,593
Rabun	0	0	0	0	1	50,905	1	33
Richmond	0	0	1	397	0	0	2	1,084
Rockdale	0	0	2	1,211	3	29,026	3	764
South Carolina	0	0	0	0	0	0	1	726
Stephens	5	136,578	15	75,788	9	10,138	23	24,079
Sumter	0	0	0	0	0	0	2	1,285
Taliaferro	0	0	1	1,495	2	39,680	7	1,886
Thomas	0	0	0	0	0	0	2	1,770
Walton	21	233,688	166	345,229	45	132,797	318	589,001
Washington	0	0	0	0	0	0	2	2,152
Wayne	0	0	0	0	0	0	1	247
White	0	0	3	536	1	338	5	4,902
Wilkes	0	0	8	23,155	3	2,562	11	3,164
Total	359	5,417,302	3,083	5,281,232	615	3,429,245	5,659	4,515,540

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.	5,168,903	5,529,631	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.	2,803,912	5,140,873	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 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
2,704	7,012	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: Don McKenna

Date: 7/31/2014

Title: CEO/President

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: Marty Hutson

Date: 7/31/2014

Title: CFO/VP

Comments: