GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Hospital Financial Survey

Part A : General Information

1. Identification

UID:Hosp317

Facility Name: Cook Medical Center a Campus of Tift Regional Medical Center

County: Cook

Street Address: 706 North Parrish Avenue

City: Adel

Zip: 31620-2604

Mailing Address: 706 North Parrish Avenue

Mailing City: Adel

Mailing Zip: 31620-2604

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2018 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 7/1/2017 To:6/30/2018

Please indicate your cost report year.
From: 07/01/2017 To:06/30/2018

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Jesus F. Ruiz
Contact Title: Reimbursement Consultant
Phone: 404-788-4861
Fax: 678-823-6919
E-mail: jesus.ruiz@rsgga.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	10,957,820
Total Inpatient Admissions accounting for Inpatient Revenue	749
Outpatient Gross Patient Revenue	11,163,515
Total Outpatient Visits accounting for Outpatient Revenue	10,652
Medicare Contractual Adjustments	9,196,091
Medicaid Contractual Adjustments	1,971,303
Other Contractual Adjustments:	4,302,019
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	0
Gross Indigent Care:	219,625
Gross Charity Care:	208,015
Uncompensated Indigent Care (net):	219,625
Uncompensated Charity Care (net):	208,015
Other Free Care:	17,315
Other Revenue/Gains:	524,435
Total Expenses:	7,925,347

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	17,315
Employee Discounts	0
	0
Total	**17,315**

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 2018? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2018?

07/01/2017

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.?

CEO

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 2018? (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	8,571	2,935	11,506
Outpatient	211,054	205,080	416,134
Total	**219,625**	**208,015**	**427,640**

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	8,571	2,935	11,506
Outpatient	211,054	205,080	416,134
Total	**219,625**	**208,015**	**427,640**

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
Berrien	0	0	13	16,737	0	0	21	31,939
Brooks	0	0	0	0	0	0	1	452
Colquitt	1	1,440	2	1,367	1	1,675	5	2,845
Cook	3	3,755	84	179,741	1	470	146	161,136
Lanier	0	0	2	5,329	0	0	1	200
Lowndes	0	0	9	5,248	0	0	9	7,932
Mitchell	1	851	0	0	0	0	0	0
Tift	2	2,525	0	0	1	790	1	576
Turner	0	0	2	2,632	0	0	0	0
Total	**7**	**8,571**	**112**	**211,054**	**3**	**2,935**	**184**	**205,080**

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 2018? (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 2018.

	Patient Category	SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	219,625	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	208,015	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 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
0	306	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:

Date: 7/15/2019

Title:

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:

Date: 7/15/2019

Title:

Comments:

2018 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum
Hosp317- Cook Medical Center a Campus of Tift Regional Medical Center

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):											
		Contractual Adj's, Hill Burton, Bad Debt, Gross Indigent and Charity Care, and Other Free Care									
HFS Source:	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part E, 1	Part E, 1	Part C, 1		
	Gross Patient Charges	Medicare Contractual Adjs	Medicaid Contractual Adjs	Other Contractual Adjs	Hill Burton Obligations	Bad Debt	Gross Indigent Care (IP & OP)	Gross Charity Care (IP & OP)	Other Free Care	Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	1	2	3	4	5	6	7	8	9	10	11
Inpatient Gross Patient Revenue	10,957,820										
Outpatient Gross Patient Revenue	11,163,515										
Per Part C, 1. Financial Table		9,196,091	1,971,303	4,302,019	0	0			17,315		
Per Part E, 1. Indigent and Charity Care							219,625	208,015			
Totals per HFS	22,121,335	9,196,091	1,971,303	4,302,019	0	0	219,625	208,015	17,315	15,914,368	6,206,967
Section 2: Reconciling Items to Financial Statements:									(B)		(B)
Non-Hospital Services:											
> Professional Fees	0									0	
> Home Health Agency	0									0	
> SNF/NF Swing Bed Services	650,948									607,254	
> Nursing Home	7,826,798									-25,852	
> Hospice	0									0	
> Freestanding Ambulatory Surg. Centers	0									0	
> RHC	2,450,213									300,538	
> n/a	0									0	
> n/a	0									0	
> n/a	0									0	
> n/a	0									0	
> n/a	0									0	
Bad Debt (Expense per Financials) (A)										265,379	
Indigent Care Trust Fund Income										-937,615	
Other Reconciling Items:											
> ICTF Revenue	111,428									0	
> Provider Fee Add On Payments	0									-77,250	
> n/a	0									0	
> Rounding	0									1	
Total Reconciling Items	11,039,387									132,455	10,906,932
Total Per Form	33,160,722									16,046,823	17,113,899
Total Per Financial Statements	33,160,722										17,113,899
Unreconciled Difference (Must be Zero)	0										0

(A) Due to specific differences in the presentation of data on the HFS, Bad Debt per Financials may differ from the amount reported on the HFS-proper (Part C).

(B) Taxable Net Patient Revenue will equal Net Patient Revenue in Section 1 column 11, plus Other Free Care in Section 1 column 9.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2018 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP521

Facility Name: Tift Regional Medical Center

County: Tift

Street Address: PO Box 747

City: Tifton

Zip: 31793-0747

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 calender year 2018 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2017 To:9/30/2018

Please indicate your cost report year.
From: 10/01/2017 To:09/30/2018

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Jesus F. Ruiz
Contact Title: Reimbursement Consultant
Phone: 404-788-4861
Fax: 678-823-6919
E-mail: jesus.ruiz@rsgga.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	391,029,295
Total Inpatient Admissions accounting for Inpatient Revenue	9,675
Outpatient Gross Patient Revenue	786,687,220
Total Outpatient Visits accounting for Outpatient Revenue	202,282
Medicare Contractual Adjustments	527,393,758
Medicaid Contractual Adjustments	118,807,074
Other Contractual Adjustments:	69,135,114
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	73,546,765
Gross Indigent Care:	44,286,353
Gross Charity Care:	15,014,312
Uncompensated Indigent Care (net):	44,286,353
Uncompensated Charity Care (net):	15,014,312
Other Free Care:	13,722,661
Other Revenue/Gains:	27,095,016
Total Expenses:	279,037,883

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	7,528,295
Admin Discounts	2,536,970
Employee Discounts	620,908
Non Covered Charges	3,036,488
Total	**13,722,661**

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 2018? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2018?

10/01/2017

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 2018? (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	13,259,927	4,735,334	17,995,261
Outpatient	31,026,426	10,278,978	41,305,404
Total	**44,286,353**	**15,014,312**	**59,300,665**

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	13,259,927	4,735,334	17,995,261
Outpatient	31,026,426	10,278,978	41,305,404
Total	**44,286,353**	**15,014,312**	**59,300,665**

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	0	0	0	0	1	3,600	0	0
Appling	0	0	0	0	1	1,800	0	0
Atkinson	8	125,678	120	230,780	3	4,124	17	6,316
Bacon	0	0	5	11,972	4	16,514	6	947
Ben Hill	34	836,271	529	1,258,916	32	90,010	427	656,166
Berrien	61	934,068	889	1,803,694	85	649,287	633	1,326,453
Bibb	0	0	1	650	0	0	1	35
Brooks	0	0	6	19,778	0	0	11	3,141
Butts	0	0	12	189,036	0	0	0	0
Camden	1	18,558	1	9,195	0	0	0	0
Catoosa	0	0	0	0	0	0	1	375
Clinch	0	0	0	0	0	0	1	249
Cobb	0	0	3	5,693	0	0	0	0
Coffee	15	235,976	211	1,085,154	13	43,129	123	182,441
Colquitt	25	482,389	369	1,120,703	15	252,500	226	464,512
Cook	64	1,483,263	941	2,385,982	88	781,336	580	849,576
Crisp	2	82,387	39	51,210	5	20,781	26	19,674
DeKalb	0	0	0	0	1	19,109	0	0
Dodge	0	0	0	0	2	0	4	2,773
Dooly	0	0	3	1,339	0	0	2	701
Dougherty	5	289,475	108	273,650	1	8,969	17	17,681
Douglas	0	0	3	8,807	0	0	0	0
Florida	0	0	3	4,101	1	1,965	22	54,346
Gilmer	0	0	1	2,833	0	0	0	0
Gordon	0	0	3	2,180	0	0	0	0
Hall	0	0	0	0	0	0	1	1,656
Henry	0	0	1	12,282	0	0	0	0
Houston	3	6,181	2	4,547	0	0	2	1,666
Irwin	26	252,330	450	948,824	27	114,602	224	186,018
Jasper	1	32,575	1	688	0	0	0	0
Jeff Davis	1	515	4	4,911	0	0	6	9,187
Lanier	0	0	45	133,633	1	1,340	29	13,100

Lee	1	500	8	2,467	1	293,074	4	4,707
Liberty	0	0	1	7,004	0	0	0	0
Lowndes	5	42,956	98	228,919	15	37,945	73	92,823
Mitchell	0	0	4	2,873	2	37,706	26	71,539
Monroe	0	0	3	1,700	0	0	0	0
North Carolina	0	0	1	4,009	0	0	0	0
Oconee	0	0	1	4,075	0	0	0	0
Other Out of State	0	0	10	17,248	1	1,316	11	35,325
Paulding	0	0	0	0	0	0	1	508
Putnam	0	0	0	0	1	1,316	0	0
Randolph	0	0	4	8,259	0	0	0	0
Seminole	0	0	13	23,832	0	0	0	0
South Carolina	0	0	1	8,340	0	0	0	0
Sumter	0	0	10	20,739	1	1,316	1	100
Telfair	1	6,300	10	44,152	1	1,340	1	377
Tennessee	0	0	10	95,230	0	0	1	6,841
Terrell	0	0	3	3,515	0	0	1	519
Thomas	0	0	13	51,479	0	17,410	3	3,118
Tift	354	6,678,889	6,733	16,482,230	309	1,617,529	3,152	5,206,239
Toombs	0	0	2	9,764	0	0	0	0
Turner	55	1,263,028	1,253	2,738,908	42	343,250	530	596,598
Walton	0	0	10	42,808	0	0	0	0
Ware	1	66	3	28,833	0	0	0	0
Wilcox	6	111,044	89	352,746	9	120,842	57	163,377
Wilkinson	0	0	1	1,387	0	0	0	0
Worth	22	377,478	341	1,275,351	30	253,224	237	299,894
Total	**691**	**13,259,927**	**12,372**	**31,026,426**	**692**	**4,735,334**	**6,457**	**10,278,978**

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 2018? (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 2018.

	Patient Category	SFY 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	31,410,023	10,470,008
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	11,019,176	3,673,059
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 2017 7/1/16-6/30/17	SFY2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19
0	14,057	4,686

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: Christopher K. Dorman

Date: 7/25/2019

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: Kim Wills

Date: 7/25/2019

Title: Senior Vice President & CFO

Comments: