2019 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum
HOSP421- Mitchell County Hospital

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	1,535,375										
Outpatient Gross Patient Revenue	27,881,313										
Per Part C, 1. Financial Table		5,548,078	825,690	1,179,945	0	4,785,873			0		
Per Part E, 1. Indigent and Charity Care							555,938	1,961,255			
Totals per HFS	29,416,688	5,548,078	825,690	1,179,945	0	4,785,873	555,938	1,961,255	0	14,856,779	14,559,909
Section 2: Reconciling Items to Financial Statements:									(B)		(B)
Non-Hospital Services:											
> Professional Fees	1545801.0									2,417,835	
> Home Health Agency	0									0	
> SNF/NF Swing Bed Services	13,207,410									7,717,552	
> Nursing Home	11,579,500									3,854,514	
> Hospice	0									0	
> Freestanding Ambulatory Surg. Centers	0									0	
> Physician Offices	5,926,108									0	
> N/A	0.0									0	
> N/A	0.0									0	
> N/A	0.0									0.0	
> N/A	0									0	
> N/A	0									0	
Bad Debt (Expense per Financials) (A)										929,418	
Indigent Care Trust Fund Income										0	
Other Reconciling Items:											
> Indigent/Charity	0.0									-58380.0	
> Indigent/Charity PF	0									372,600	
> Indigent/Charity NH	0									187,727	
> Indigent/Charity Phys Offices	0									56,420	
Total Reconciling Items	32,258,819									15,477,686	16,781,133
Total Per Form	61,675,507									30,334,465	31,341,042
Total Per Financial Statements	61675507.0										31,341,042
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

2019 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP421

Facility Name: Mitchell County Hospital

County: Mitchell

Street Address: 90 E Stephens St

City: Camilla

Zip: 31730-1836

Mailing Address: 90 E Stephens St

Mailing City: Camilla

Mailing Zip: 31730-1836

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2019 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2018 To:9/30/2019

Please indicate your cost report year.
From: 10/01/2018 To:09/30/2019

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: Patricia L. Barrett
Contact Title: Director of Reimbursement
Phone: 229-228-8857
Fax: 229-228-8891
E-mail: pbarrett@archbold.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	1,535,375
Total Inpatient Admissions accounting for Inpatient Revenue	358
Outpatient Gross Patient Revenue	27,881,313
Total Outpatient Visits accounting for Outpatient Revenue	37,648
Medicare Contractual Adjustments	5,548,078
Medicaid Contractual Adjustments	825,690
Other Contractual Adjustments:	1,179,945
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	4,785,873
Gross Indigent Care:	555,938
Gross Charity Care:	1,961,255
Uncompensated Indigent Care (net):	500,724
Uncompensated Charity Care (net):	1,766,469
Other Free Care:	0
Other Revenue/Gains:	610,418
Total Expenses:	13,147,132

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
Total	**0**

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 2019? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2019?

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.)?

325%

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 2019? (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	51,612	22,310	73,922
Outpatient	504,326	1,938,945	2,443,271
Total	**555,938**	**1,961,255**	**2,517,193**

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	250,000
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	**250,000**

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	46,486	20,094	66,580
Outpatient	454,238	1,746,375	2,200,613
Total	**500,724**	**1,766,469**	**2,267,193**

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	0	0	2	5,374
Baker	0	0	14	8,249	0	0	75	39,265
Berrien	0	0	0	0	0	0	1	4,480
Brooks	0	0	0	0	0	0	8	8,867
Calhoun	1	631	4	10,853	0	0	12	13,837
Carroll	0	0	0	0	0	0	1	348
Charlton	0	0	0	0	0	0	1	2,123
Chattooga	0	0	0	0	0	0	1	4,464
Clay	0	0	1	3,398	0	0	2	2,368
Cobb	0	0	0	0	0	0	1	260
Coffee	0	0	9	17,379	0	0	1	3
Colquitt	1	12,350	30	20,342	0	0	48	38,507
Cook	0	0	0	0	0	0	1	3,118
Crisp	0	0	0	0	1	518	0	0
Dawson	0	0	0	0	0	0	1	232
Decatur	0	0	0	0	0	0	22	12,505
DeKalb	0	0	0	0	0	0	1	26
Dougherty	0	0	0	0	0	0	107	65,388
Florida	0	0	2	36	0	0	17	6,616
Fulton	0	0	0	0	0	0	4	4,547
Grady	0	0	6	833	1	16,531	33	16,062
Lee	0	0	0	0	0	0	5	930
Lowndes	0	0	0	0	0	0	6	5,883
Miller	0	0	0	0	0	0	7	5,617
Mitchell	4	38,631	484	416,671	4	5,261	2,490	1,569,718
North Carolina	0	0	0	0	0	0	1	542
Other Out of State	0	0	4	11,949	0	0	13	16,430
Seminole	0	0	0	0	0	0	1	232
South Carolina	0	0	0	0	0	0	1	100
Sumter	0	0	0	0	0	0	2	541
Thomas	0	0	47	13,942	0	0	138	101,443
Tift	0	0	0	0	0	0	1	3,273

Turner	0	0	1	674	0	0	1	242
Walton	0	0	0	0	0	0	2	2,359
Ware	0	0	0	0	0	0	3	797
Worth	0	0	0	0	0	0	2	2,448
Total	**6**	**51,612**	**602**	**504,326**	**6**	**22,310**	**3,012**	**1,938,945**

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 2019? (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 2019.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	0	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	0	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 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
0	0	0

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Nurse Employment Addendum

This section is printed 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: 7/15/2020

Title: System Administrator CAH & LTC Facilities

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: 7/15/2020

Title: Senior Vice President/CFO

Comments: