GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Contact Us for Survey Assistance

Health Planning Survey Instructions

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- Free-Standing Ambulatory Surgery Center Survey
- Open Heart Surgery Services Survey
- Home Health Survey
- Annual Nursing Home Questionnaire

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McDuffie Regional Medical Center

2019 Hospital Financial Submission Confirmation

Thank you for submitting your 2019 Annual Hospital Questionnaire. The submission was completed on 07/21/2020.

Completed Survey

- 2019 Hospital Financial Survey

LHM

Submitted 7/21/20 DCW

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2019 Hospital Financial Survey

Parts A-B | Part C | Part D | Part E | Part F | ICTF Addendum | Reconciliation Addendum | Nurse Employment Addendum | Signature Page

View & Print Survey PDF | View & Print Reconciliation Addendum PDF | View & Print Nurse Employment Addendum PDF | Save Survey

Electronic Signature

There are no critical errors on the form.
You may sign and submit the survey. If you do not submit the survey before exiting, your signature will not be saved.

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.

Do not sign the survey until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could through the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.

Signature of Chief Executive: [signature]

Date: 07/17/2020

Title: 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.

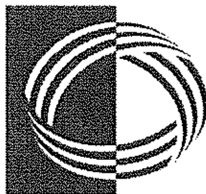
Signature of Financial Officer: [signature]

Date: 07/17/2020

Title: CFO

Comments:

Submit Survey



Georgia Department of Community Health

2019 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP321

Facility Name: University Hospital McDuffie

County: McDuffie

Street Address: 2460 Washington Road

City: Thomson

Zip: 30824-2922

Mailing Address: 2460 Washington Road

Mailing City: Thomson

Mailing Zip: 30824-2922

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: 1/1/2019 To:12/31/2019

Please indicate your cost report year.
From: 01/01/2019 To:12/31/2019

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: Sheri Poole

Contact Title: Dec Support Sr. Data Analyst--Reimbursement

Phone: 706-828-2446

Fax: 706-828-2490

E-mail: sheri_poole@uh.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	10,228,747
Total Inpatient Admissions accounting for Inpatient Revenue	568
Outpatient Gross Patient Revenue	63,834,526
Total Outpatient Visits accounting for Outpatient Revenue	37,814
Medicare Contractual Adjustments	23,598,529
Medicaid Contractual Adjustments	10,688,748
Other Contractual Adjustments:	7,527,982
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	3,597,186
Gross Indigent Care:	2,860,985
Gross Charity Care:	6,877,045
Uncompensated Indigent Care (net):	2,860,985
Uncompensated Charity Care (net):	6,877,045
Other Free Care:	4,678
Other Revenue/Gains:	223,090
Total Expenses:	18,047,880

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	4,678
Employee Discounts	0
	0
Total	**4,678**

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?

01/01/2019

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.?

Director of Collectons

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 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	192,051	674,459	866,510
Outpatient	2,668,934	6,202,586	8,871,520
Total	**2,860,985**	**6,877,045**	**9,738,030**

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	192,051	674,459	866,510
Outpatient	2,668,934	6,202,586	8,871,520
Total	**2,860,985**	**6,877,045**	**9,738,030**

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	0	0	1	5,917
Baldwin	0	0	4	4,598	0	0	3	9,948
Bibb	0	0	0	0	0	0	2	1,391
Bryan	0	0	0	0	0	0	1	1,157
Bulloch	0	0	0	0	0	0	2	186
Burke	0	0	5	6,622	1	14,077	8	40,449
Cherokee	0	0	0	0	0	0	1	595
Clayton	0	0	2	4,998	0	0	2	8,548
Cobb	0	0	3	1,093	0	0	3	3,237
Columbia	8	11,756	78	108,042	2	21,877	221	396,222
DeKalb	0	0	1	495	0	0	2	2,074
Elbert	0	0	3	1,105	0	0	3	6,267
Emanuel	0	0	2	849	0	0	3	1,956
Franklin	0	0	0	0	0	0	1	343
Fulton	0	0	5	7,937	0	0	8	9,701
Glascock	3	15,425	69	105,097	0	0	96	254,049
Glynn	0	0	0	0	0	0	2	5,476
Greene	1	9,995	4	10,533	0	0	5	3,907
Gwinnett	0	0	0	0	0	0	2	7,780
Habersham	0	0	0	0	0	0	2	733
Hall	0	0	1	1,493	0	0	0	0
Hancock	2	3,100	33	57,799	0	0	37	52,830
Heard	0	0	0	0	0	0	1	549
Henry	0	0	0	0	0	0	1	1,843
Jackson	0	0	0	0	0	0	2	3,585
Jefferson	5	35,005	72	83,795	3	30,627	114	212,533
Jenkins	0	0	0	0	0	0	1	552
Johnson	0	0	0	0	0	0	1	1,585
Laurens	0	0	1	118	0	0	0	0
Lincoln	0	0	137	182,001	9	87,115	218	489,610
Madison	0	0	1	1,455	0	0	0	0
McDuffie	46	50,829	609	1,590,410	19	448,083	966	3,347,767

Morgan	0	0	0	0	0	0	1	2,720
Newton	0	0	0	0	0	0	1	2,169
Oglethorpe	0	0	2	2,904	0	0	3	7,725
Other Out of State	0	0	26	28,361	0	0	75	139,280
Paulding	0	0	0	0	0	0	1	221
Putnam	0	0	0	0	0	0	1	580
Richmond	2	15,542	29	26,039	1	10,267	88	181,807
South Carolina	2	16,368	35	17,048	1	8,425	38	85,760
Taliaferro	2	5,312	0	0	1	20,471	22	31,842
Warren	11	16,390	238	378,319	3	33,517	317	700,446
Washington	1	5,126	4	6,556	0	0	4	9,202
Whitfield	0	0	1	717	0	0	0	0
Wilkes	5	7,203	47	40,550	0	0	89	170,044
Total	**88**	**192,051**	**1,412**	**2,668,934**	**40**	**674,459**	**2,349**	**6,202,586**

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	[illegible]
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	[illegible]
C.	Other Patients in accordance with the department approved policy.	0	4,869,015	4,869,01

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	1,945	1,944

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

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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: James Davis

Date: 7/21/2020

Title: 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: David A. Belkoski

Date: 7/21/2020

Title: CFO

Comments: