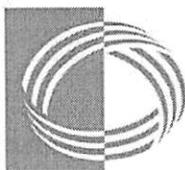


**2018 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum
HOSP614- John D. Archbold Memorial Hospital**

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):												
HFS Source:	Contractual Adj's, Hill Burton, Bad Debt, Gross Indigent and Charity Care, and Other Free Care										Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	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	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			
	1	2	3	4	5	6	7	8	9	10	11	
Inpatient Gross Patient Revenue	359,194,881											
Outpatient Gross Patient Revenue	391,524,182											
Per Part C, 1. Financial Table		329,477,045	69,900,190	30,431,987	0	44,533,602			0			
Per Part E, 1. Indigent and Charity Care							23,864,258	771,317				
Totals per HFS	750,719,063	329,477,045	69,900,190	30,431,987	0	44,533,602	23,864,258	771,317	0	498,978,399	251,740,664	
Section 2: Reconciling Items to Financial Statements:										(B)	(B)	
Non-Hospital Services:												
> Professional Fees	21106319.0										12,065,771	
> Home Health Agency	0										0	
> SNF/NF Swing Bed Services	0										0	
> Nursing Home	4,777,669										322,256	
> Hospice	0										0	
> Freestanding Ambulatory Surg. Centers	0										0	
> Reference Lab	642,107										0	
> Nutrition Fees	318048.0										0	
> EAP Services	174133.0										0	
> N/A	0										0	
> N/A	0										0	
> N/A	0										0	
Bad Debt (Expense per Financials) (A)											1,250,165	
Indigent Care Trust Fund Income											-2,680,576	
Other Reconciling Items:												
> Indigent/Charity PF	0.0										978919.0	
> CCC	0										8,806	
> N/A	0										0	
> N/A	0										0	
Total Reconciling Items	27,018,276										11,945,341	15,072,935
Total Per Form	777,737,339										510,923,740	266,813,599
Total Per Financial Statements	777,737,339.0										510,923,740	266,813,599
Unreconciled Difference (Must be Zero)	0										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.												



2018 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP614

Facility Name: John D. Archbold Memorial Hospital

County: Thomas

Street Address: 915 Gordon Ave

City: Thomasville

Zip: 31792-6614

Mailing Address: PO Box 1018

Mailing City: Thomasville

Mailing Zip: 31799-1018

2. Report Period

Please report data for the hospital fiscal year ending during calendar 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: 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	359,194,881
Total Inpatient Admissions accounting for Inpatient Revenue	11,588
Outpatient Gross Patient Revenue	391,524,182
Total Outpatient Visits accounting for Outpatient Revenue	267,992
Medicare Contractual Adjustments	329,477,045
Medicaid Contractual Adjustments	69,900,190
Other Contractual Adjustments:	30,431,987
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	44,533,602
Gross Indigent Care:	23,864,258
Gross Charity Care:	771,317
Uncompensated Indigent Care (net):	23,864,258
Uncompensated Charity Care (net):	771,317
Other Free Care:	0
Other Revenue/Gains:	3,831,703
Total Expenses:	226,444,428

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 2018? (Check box if yes.)

2. Effective Date

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

06/01/2015

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 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	12,297,373	446,855	12,744,228
Outpatient	11,566,885	324,462	11,891,347
Total	23,864,258	771,317	24,635,575

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	12,297,373	446,855	12,744,228
Outpatient	11,566,885	324,462	11,891,347
Total	23,864,258	771,317	24,635,575

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	2	88	0	0	1	2,200
Atkinson	0	0	0	0	0	0	1	1,298
Baker	3	2,036	17	284	0	0	0	0
Ben Hill	0	0	1	82	0	0	0	0
Brooks	34	300,142	313	411,982	5	1,244	54	15,076
Clarke	0	0	3	26,408	0	0	0	0
Clayton	0	0	6	9,873	0	0	0	0
Coffee	2	11,320	9	1,448	0	0	1	325
Colquitt	63	1,151,583	373	488,903	5	56,114	40	18,602
Cook	4	87,296	36	160,927	0	0	0	0
Decatur	59	1,204,690	391	958,423	3	54,665	37	21,648
DeKalb	0	0	0	0	0	0	0	0
Dougherty	5	69,466	27	47,722	0	0	4	2,684
Douglas	0	0	0	0	1	37	0	0
Early	0	0	0	0	0	0	0	0
Florida	13	775,884	74	163,621	1	728	9	3,774
Franklin	0	0	7	1,632	0	0	0	0
Grady	133	1,201,081	728	1,088,735	7	36,721	105	82,943
Gwinnett	1	818	3	319	0	0	9	1,771
Hall	0	0	0	0	0	0	1	195
Harris	1	1,288	1	18	0	0	0	0
Lanier	1	1,189	3	938	0	0	0	0
Lee	1	52	1	2,060	0	0	1	95
Lowndes	14	114,593	87	221,218	0	0	12	10,686
Miller	3	5,109	5	22,205	0	0	0	0
Mitchell	87	1,822,062	424	1,317,058	11	69,311	81	27,015
Other Out of State	3	8,343	10	17,633	0	0	1	3
Putnam	0	0	0	0	0	0	1	37
Randolph	0	0	3	2,698	0	0	0	0
Richmond	2	2,831	0	0	0	0	0	0
Seminole	7	37,067	44	117,988	0	0	6	3,688
Terrell	0	0	2	745	2	1,374	8	511

Thomas	443	5,323,808	3,699	6,409,510	54	226,435	688	131,785
Tift	6	173,274	20	33,448	0	0	1	46
Turner	0	0	1	2,287	0	0	0	0
Whitfield	0	0	1	2,040	0	0	0	0
Worth	3	3,441	10	56,598	1	226	1	70
Total	888	12,297,373	6,301	11,566,885	90	446,855	1,042	324,462

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	SFY2018	SFY2019
		7/1/16-6/30/17	7/1/17-6/30/18	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	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 2017	SFY2018	SFY2019
7/1/16-6/30/17	7/1/17-6/30/18	7/1/18-6/30/19
0	0	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:

Date: 7/19/2019

Title: Chief Executive Officer

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: 7/19/2019

Title: Chief Financial Officer

Comments: