



## 2008 Hospital Financial Survey

### Part A : General Information

#### 1. Identification

UID:HOSP532

**Facility Name:** Henry Medical Center

**County:** Henry

**Street Address:** 1133 Eagle's Landing Parkway

**City:** Stockbridge

**Zip:** 30281-5099

**Mailing Address:** 1133 Eagle's Landing Parkway

**Mailing City:** Stockbridge

**Mailing Zip:** 30281-5099

#### 2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2008 only.

**Do not use a different report period.**

**Please indicate your hospital fiscal year.**

From: 7/1/2007 To:6/30/2008

**Please indicate your cost report year.**

From: 07/01/2007 To:06/30/2008

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:** Walter Evans

**Contact Title:** Controller

**Phone:** 678-604-5363

**Fax:** 678-604-5048

**E-mail:** wevans@hmc-ga.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	261,871,410
Total Inpatient Admissions accounting for Inpatient Revenue	12,158
Outpatient Gross Patient Revenue	182,532,308
Total Outpatient Visits accounting for Outpatient Revenue	125,780
Medicare Contractual Adjustments	108,145,218
Medicaid Contractual Adjustments	42,695,157
Other Contractual Adjustments:	129,107,722
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	21,651,300
Uncompensated Indigent Care (net):	2,787,364
Uncompensated Charity Care (net):	5,955,116
Other Free Care:	12,348,544
Other Revenue/Gains:	7,212,924
Total Expenses:	135,494,313

### 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
<b>Total</b>	<b>0</b>

## 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 2008? (Check box if yes.)

### 2. Effective Date

What was the effective date of the policy or policies in effect during 2008?

11/29/2002

### 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 PATIENT FINANCIAL SERVICES

#### **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 2008? (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	2,042,825	3,105,613	5,148,438
Outpatient	1,813,685	2,849,503	4,663,188
<b>Total</b>	<b>3,856,510</b>	<b>5,955,116</b>	<b>9,811,626</b>

#### 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	1,069,146
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
<b>Total</b>	<b>1,069,146</b>

#### 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	0	0	0
Outpatient	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 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	1	127	0	0	1	320
Baker	0	0	0	0	1	1,112	0	0
Baldwin	0	0	0	0	1	605	2	467
Banks	0	0	0	0	0	0	1	7
Barrow	0	0	1	3	0	0	2	510
Bartow	0	0	1	3	0	0	0	0
Bibb	0	0	3	331	0	0	5	1,361
Brantley	0	0	0	0	0	0	1	392
Bulloch	0	0	2	170	0	0	1	47
Butts	11	67,200	118	47,611	23	46,974	159	86,238
Carroll	0	0	0	0	0	0	1	495
Catoosa	0	0	0	0	0	0	1	794
Chatham	0	0	0	0	0	0	1	31
Cherokee	0	0	0	0	0	0	2	3,862
Clarke	0	0	0	0	1	1,523	0	0
Clay	0	0	0	0	1	1,476	1	507
Clayton	54	392,002	604	225,699	143	541,928	1,007	558,310
Cobb	0	0	1	3	2	6,255	18	14,308
Colquitt	0	0	2	6	0	0	0	0
Columbia	0	0	0	0	0	0	1	120
Coweta	1	8,538	2	6	3	8,594	11	6,687
Crawford	0	0	0	0	0	0	1	60
Dawson	0	0	0	0	0	0	1	58
Decatur	0	0	0	0	0	0	1	1,205
DeKalb	6	35,189	26	1,256	14	86,522	105	56,941
Dodge	0	0	0	0	0	0	1	45
Dooly	0	0	0	0	0	0	1	578
Dougherty	0	0	0	0	0	0	2	1,794
Douglas	0	0	2	30	1	333	4	3,772
Early	0	0	1	74	0	0	0	0
Effingham	0	0	0	0	0	0	2	139
Elbert	0	0	0	0	0	0	1	60

Emanuel	0	0	0	0	0	0	1	42
Evans	0	0	0	0	0	0	1	263
Fayette	0	0	12	352	5	14,704	19	8,075
Forsyth	0	0	0	0	1	458	4	385
Fulton	6	42,416	47	11,479	16	34,905	82	39,044
Gilmer	0	0	2	130	0	0	1	60
Gwinnett	0	0	2	690	2	4,484	15	17,846
Habersham	0	0	0	0	1	8,277	0	0
Hall	1	5,092	1	570	0	0	0	0
Hancock	1	4,743	0	0	1	48	1	75
Haralson	0	0	0	0	0	0	1	1,809
Harris	0	0	3	868	0	0	4	3,115
Heard	0	0	1	108	0	0	1	190
Henry	227	1,333,754	2,788	1,440,848	450	2,073,960	3,358	1,734,147
Houston	0	0	3	543	0	0	8	2,432
Jackson	0	0	0	0	0	0	4	925
Jasper	0	0	3	3,367	1	734	4	622
Jefferson	0	0	1	3	0	0	0	0
Jones	0	0	0	0	0	0	1	174
Lamar	0	0	16	6,909	2	6,060	27	21,085
Lanier	0	0	3	460	0	0	0	0
Lee	0	0	1	3	0	0	1	183
Liberty	0	0	0	0	0	0	1	365
Lowndes	0	0	0	0	0	0	1	60
Macon	0	0	0	0	1	321	1	60
Madison	0	0	0	0	0	0	1	45
Meriwether	4	118,811	15	6,789	7	40,488	60	26,377
Monroe	0	0	18	2,088	2	357	30	15,152
Morgan	0	0	2	42	0	0	0	0
Muscogee	0	0	0	0	0	0	2	380
Newton	0	0	8	1,241	5	9,974	16	9,320
Other Out of State	4	28,849	40	16,571	13	58,715	117	85,877
Paulding	0	0	0	0	1	382	1	157
Pierce	0	0	0	0	0	0	1	155
Pike	0	0	10	535	3	9,422	9	15,560
Putnam	0	0	2	6	0	0	0	0
Richmond	0	0	0	0	1	160	1	500
Rockdale	1	5,277	8	7,968	2	14,844	20	22,819
Spalding	1	954	105	36,294	19	119,690	158	95,038
Stewart	0	0	1	3	0	0	1	60
Talbot	0	0	0	0	1	460	1	360
Taliaferro	0	0	0	0	1	469	1	97
Tattnall	0	0	1	30	0	0	0	0
Taylor	0	0	0	0	0	0	1	93

Tift	0	0	0	0	0	0	2	1,020
Troup	0	0	1	3	0	0	1	155
Upson	0	0	4	396	1	7,813	5	3,779
Walton	0	0	1	64	1	518	2	641
Washington	0	0	0	0	0	0	1	1,853
White	0	0	0	0	1	3,048	0	0
Wilcox	0	0	2	6	0	0	0	0
<b>Total</b>	<b>317</b>	<b>2,042,825</b>	<b>3,865</b>	<b>1,813,685</b>	<b>728</b>	<b>3,105,613</b>	<b>5,301</b>	<b>2,849,503</b>

## 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 2008?  
(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 2008.

Patient Category		SFY 2007	SFY2008	SFY2009
		7/1/06-6/30/07	7/1/07-6/30/08	7/1/08-6/30/09
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	3,856,510	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	5,955,116	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 2007	SFY2008	SFY2009
7/1/06-6/30/07	7/1/07-6/30/08	7/1/08-6/30/09
0	7,893	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:** Charles Scott

**Date:** 9/30/2009

**Title:** PRESIDENT AND 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:** CLAUDE CARRUTH

**Date:** 9/30/2009

**Title:** VICE PRESIDENT AND CFO

**Comments:**