



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2011 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP704

Facility Name: The Medical Center, Inc.

County: Muscogee

Street Address: 710 Center Street

City: Columbus

Zip: 31902

Mailing Address: P O Box 951

Mailing City: Columbus

Mailing Zip: 31902

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2011 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 7/1/2010 To:6/30/2011

Please indicate your cost report year.

From: 07/01/2010 To:06/30/2011

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: Joseph Lively

Contact Title: Director, Reimbursement

Phone: 706-660-6597

Fax: 706-660-6281

E-mail: Joe.Lively@crhs.net

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	351,355,866
Total Inpatient Admissions accounting for Inpatient Revenue	12,099
Outpatient Gross Patient Revenue	368,811,967
Total Outpatient Visits accounting for Outpatient Revenue	170,217
Medicare Contractual Adjustments	167,500,807
Medicaid Contractual Adjustments	115,055,855
Other Contractual Adjustments:	116,249,542
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	27,337,387
Uncompensated Indigent Care (net):	39,514,251
Uncompensated Charity Care (net):	2,149,515
Other Free Care:	2,609,626
Other Revenue/Gains:	12,929,070
Total Expenses:	259,614,582

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 2011? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2011?

01/01/2004

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.?

Senior Director 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.)?

225%

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 2011? (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	27,414,719	1,791,050	29,205,769
Outpatient	24,812,999	358,465	25,171,464
Total	52,227,718	2,149,515	54,377,233

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	12,713,467
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	12,713,467

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	39,514,251	2,149,515	41,663,766
Outpatient	0	0	0
Total	39,514,251	2,149,515	41,663,766

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
Bartow	2	330	2	229	0	0	0	0
Berrien	0	0	2	1,593	0	0	0	0
Bibb	7	10,953	6	7,040	0	0	0	0
Bulloch	0	0	1	317	0	0	0	0
Calhoun	1	154	0	0	0	0	0	0
Carroll	3	16,322	5	6,780	1	130	0	0
Chatham	2	1,177	0	0	0	0	0	0
Chattahoochee	136	357,563	212	130,646	10	11,524	5	26,800
Clay	1	10	3	156	0	0	0	0
Clayton	5	334	6	761	1	12,207	1	1,945
Cobb	6	2,042	6	5,448	0	0	0	0
Coffee	0	0	2	2,533	0	0	0	0
Cook	1	1,311	1	905	0	0	0	0
Coweta	8	47,836	7	903	0	0	0	0
Crisp	2	3,458	0	0	0	0	0	0
DeKalb	4	770	3	1,056	0	0	0	0
Dougherty	0	0	2	421	0	0	0	0
Douglas	3	56,004	4	3,705	0	0	0	0
Elbert	0	0	1	183	0	0	0	0
Fayette	3	1,474	3	353	0	0	0	0
Fulton	4	752	8	6,275	0	0	0	0
Glynn	0	0	0	0	0	0	1	225
Gwinnett	1	734	2	1,205	0	0	0	0
Hall	3	6,448	2	225	0	0	0	0
Haralson	1	946	2	160	0	0	0	0
Harris	506	648,662	622	451,965	46	222,484	24	8,024
Heard	2	30,059	4	3,217	0	0	0	0
Henry	0	0	16	2,888	0	0	0	0
Houston	1	231	14	1,805	0	0	0	0
Jackson	0	0	1	39	0	0	0	0
Jasper	0	0	1	420	0	0	0	0
Jenkins	1	322	0	0	0	0	0	0

Lamar	1	307	0	0	0	0	0	0
Laurens	1	2,419	2	600	0	0	0	0
Lee	0	0	5	8,863	0	0	0	0
Liberty	0	0	1	170	0	0	0	0
Long	0	0	1	460	0	0	0	0
Lumpkin	1	1,228	0	0	0	0	0	0
Macon	0	0	13	2,825	0	0	0	0
Marion	101	260,206	147	78,083	5	31,764	6	10,673
McDuffie	1	194	0	0	0	0	0	0
Meriwether	59	252,115	97	102,875	4	5,200	0	0
Mitchell	1	782	1	3	0	0	0	0
Muscogee	8,044	17,738,021	26,430	21,288,347	378	897,149	302	239,885
Other Out of State	1,964	6,551,306	2,541	2,134,923	131	494,499	74	33,795
Paulding	1	649	0	0	0	0	0	0
Peach	1	2,665	1	5,515	0	0	0	0
Pickens	1	612	0	0	0	0	0	0
Pike	0	0	2	4,097	0	0	0	0
Pulaski	2	44,525	0	0	0	0	0	0
Quitman	5	21,219	10	13,062	0	0	0	0
Rabun	0	0	1	6	0	0	0	0
Randolph	16	55,690	11	10,158	0	0	0	0
Richmond	1	361	2	1,145	0	0	0	0
Schley	7	948	7	12,633	4	1,452	0	0
Spalding	3	11,536	4	6,131	0	0	0	0
Stewart	99	184,599	101	118,949	9	29,657	5	15,914
Sumter	3	859	13	200	5	609	2	895
Talbot	203	347,159	339	221,023	15	37,434	17	8,815
Taylor	60	225,552	114	33,363	4	40,136	2	8,410
Terrell	2	952	2	5	0	0	0	0
Troup	85	402,937	109	120,444	7	6,805	12	2,696
Upson	14	68,268	7	15,404	0	0	1	28
Walker	1	244	0	0	0	0	0	0
Walton	0	0	1	424	0	0	0	0
Webster	19	42,461	13	1,964	0	0	1	360
Worth	4	9,013	4	99	0	0	0	0
Total	11,403	27,414,719	30,917	24,812,999	620	1,791,050	453	358,465

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 2011?
(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 2011.

Patient Category		SFY 2010 7/1/09-6/30/10	SFY2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
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	54,377,233	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 2010 7/1/09-6/30/10	SFY2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12
0	35,408	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: Ryan Chandler

Date: 7/12/2012

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: Roland Thacker

Date: 7/12/2012

Title: Chief Financial Officer

Comments: