GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP439

Facility Name: Houston Medical Center

County: Houston

Street Address: 1601 Watson Boulevard

City: Warner Robins

Zip: 31093-3452

Mailing Address: P O Box 2886

Mailing City: Warner Robins

Mailing Zip: 31099-2886

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2012 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2012 To:12/31/2012

Please indicate your cost report year.
From: 01/01/2012 To:12/31/2012

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: JENNIFER JOHNSON

Contact Title: DECISION SUPPORT MANAGER

Phone: 478-542-7817

Fax: 478-542-7795

E-mail: JEJOHNSON@HHC.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	294,516,098
Total Inpatient Admissions accounting for Inpatient Revenue	14,179
Outpatient Gross Patient Revenue	332,717,566
Total Outpatient Visits accounting for Outpatient Revenue	223,752
Medicare Contractual Adjustments	177,171,957
Medicaid Contractual Adjustments	58,763,590
Other Contractual Adjustments:	126,379,876
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	33,345,962
Uncompensated Indigent Care (net):	23,915,965
Uncompensated Charity Care (net):	9,564,277
Other Free Care:	2,400,709
Other Revenue/Gains:	45,070,123
Total Expenses:	186,323,344

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 2012? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2012?

01/05/09

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.)?

300%

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 2012? (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	9,867,818	4,000,339	13,868,157
Outpatient	14,048,147	5,636,894	19,685,041
Total	**23,915,965**	**9,637,233**	**33,553,198**

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	72,956
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**72,956**

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	9,867,818	4,000,339	13,868,157
Outpatient	14,048,147	5,563,938	19,612,085
Total	**23,915,965**	**9,564,277**	**33,480,242**

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	4	2,682	0	0	2	76
APPLING	0	0	0	0	0	0	1	3,751
BALDWIN	3	32,857	12	4,425	0	0	0	0
BEN HILL	0	0	0	0	0	0	2	1,062
BIBB	28	234,370	251	267,177	15	24,203	197	57,944
BLECKLEY	4	64,383	84	58,031	3	338	56	29,813
BULLOCH	0	0	1	198	0	0	0	0
BUTTS	0	0	0	0	0	0	2	451
CAMDEN	0	0	1	391	0	0	0	0
CLAYTON	0	0	3	6,509	0	0	4	8,472
COBB	0	0	0	0	0	0	12	33,332
COFFEE	0	0	0	0	6	11,121	0	0
COLQUITT	0	0	0	0	0	0	1	8,350
COLUMBIA	0	0	1	157	0	0	1	5,252
COWETA	0	0	1	1,153	0	0	0	0
Crawford	6	44,557	10	24,946	0	0	38	25,195
CRISP	0	0	5	1,795	1	945	3	1,279
DEKALB	0	0	0	0	0	0	1	130
DODGE	3	9,760	45	83,347	0	0	16	14,237
DOOLY	7	24,588	22	27,388	0	0	29	28,130
DOUGHERTY	0	0	1	214	1	380	1	282
EFFINGHAM	0	0	0	0	0	0	3	1,646
EMANUEL	0	0	1	-2,485	0	0	1	229
FAYETTE	0	0	2	334	0	0	0	0
FLORIDA	1	18,989	8	16,288	1	81	4	12,749
FLOYD	0	0	5	5,420	0	0	0	0
FULTON	0	0	3	3,173	0	0	2	2,610
GLYNN	0	0	0	0	0	0	1	219
GWINNETT	0	0	5	2,956	1	1,134	10	4,533
HANCOCK	0	0	4	1,795	0	0	0	0
HEARD	0	0	0	0	1	1,699	1	30
HENRY	1	3,426	1	92	0	0	10	771

HOUSTON	742	7,403,685	11,188	10,747,704	540	2,566,083	7,081	4,317,669
JEFF DAVIS	0	0	2	2,637	0	0	0	0
JONES	0	0	2	1,687	0	0	4	1,185
LAURENS	5	20,278	40	33,130	0	0	6	3,617
LEE	0	0	2	1,701	0	0	0	0
LOWNDES	1	401	2	605	0	0	1	497
MACON	4	18,107	55	52,534	10	56,893	58	31,977
MITCHELL	0	0	1	767	0	0	0	0
MONROE	0	0	9	5,241	0	0	0	0
Muscogee	1	601	0	0	1	1,185	2	0
NEWTON	2	40,562	8	17,757	2	0	0	0
NORTH CAROLINA	1	1,139	4	8,813	0	0	2	1,601
OTHER OUT OF STAT	6	75,672	61	51,879	4	15,958	21	9,223
PEACH	179	1,537,190	1,902	2,168,864	97	1,115,394	1,040	870,957
PIKE	0	0	5	2,794	0	0	0	0
PULASKI	16	106,763	191	160,811	6	22,672	89	55,150
PUTNAM	0	0	1	198	0	0	1	4,790
RICHMOND	0	0	1	8,813	0	0	0	0
ROCKDALE	0	0	0	0	0	0	1	25
SCHLEY	1	12,915	0	0	0	0	4	811
SOUTH CAROLINA	0	0	5	2,159	1	5,790	0	0
SUMTER	0	0	1	621	3	2,231	9	4,541
TATTNALL	0	0	1	226	0	0	0	0
TAYLOR	25	174,332	152	106,381	13	170,228	104	70,584
TELFAIR	0	0	26	41,383	5	637	7	829
TENNESSEE	1	17,569	0	0	1	1,132	3	138
TIFT	0	0	6	5,875	0	0	0	0
TOOMBS	0	0	1	1,506	0	0	1	179
TURNER	0	0	1	618	0	0	0	0
TWIGGS	1	17,345	64	71,241	6	1,045	18	10,745
UPSON	0	0	2	8,497	1	600	4	3,800
WALTON	0	0	0	0	0	0	1	594
WARE	0	0	1	1,996	0	0	0	0
WILCOX	2	8,329	20	35,726	2	590	20	3,400
WILKINSON	0	0	0	0	0	0	6	4,036
Total	**1,040**	**9,867,818**	**14,224**	**14,048,150**	**721**	**4,000,339**	**8,881**	**5,636,891**

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 2012? (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 2012.

	Patient Category	SFY 2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	1,275,981	1,963,080
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 2011 7/1/10-6/30/11	SFY2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13
0	1,461	2,080

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 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: Cary Martin

Date: 7/29/2013

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: Sean Whilden

Date: 7/29/2013

Title: Chief Financial Officer

Comments: