GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2012 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP627

Facility Name: Mayo Clinic Health System in Waycross

County: Ware

Street Address: 1900 Tebeau Street

City: Waycross

Zip: 31501-5200

Mailing Address: 1900 Tebeau Street

Mailing City: Waycross

Mailing Zip: 31501-5200

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: Cheryl Dubose

Contact Title: Accounting Manager

Phone: 912-338-6334

Fax: 912-284-2403

E-mail: dubose.cheryl@mayo.edu

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	152,923,291
Total Inpatient Admissions accounting for Inpatient Revenue	7,301
Outpatient Gross Patient Revenue	179,903,900
Total Outpatient Visits accounting for Outpatient Revenue	126,248
Medicare Contractual Adjustments	113,130,470
Medicaid Contractual Adjustments	43,800,282
Other Contractual Adjustments:	19,195,691
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	27,514,135
Uncompensated Indigent Care (net):	17,588,843
Uncompensated Charity Care (net):	2,384,777
Other Free Care:	0
Other Revenue/Gains:	7,382,913
Total Expenses:	121,043,901

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?

02/01/2011

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.?

Collections Supervisor

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 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	6,741,286	1,087,581	7,828,867
Outpatient	10,847,557	1,297,196	12,144,753
Total	**17,588,843**	**2,384,777**	**19,973,620**

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	6,741,286	1,087,581	7,828,867
Outpatient	10,847,557	1,297,196	12,144,753
Total	**17,588,843**	**2,384,777**	**19,973,620**

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	2,545	0	0	0	0
Appling	7	33,413	90	111,943	0	0	2	903
Atkinson	12	69,876	136	131,563	3	47,172	12	38,493
Bacon	34	298,985	289	288,156	0	0	0	0
Ben Hill	0	0	8	2,288	0	0	0	0
Berrien	0	0	6	58	0	0	5	3,015
Bibb	0	0	1	3	0	0	0	0
Brantley	52	451,221	905	703,457	14	69,713	107	73,468
Brooks	0	0	1	3	0	0	0	0
Bulloch	0	0	6	45	0	0	0	0
Camden	1	13	22	12,766	0	0	3	166
Charlton	13	38,369	130	116,875	3	11,377	26	32,387
Chatham	0	0	9	7,258	0	0	0	0
Clinch	26	208,303	171	256,126	2	38,881	15	5,855
Coffee	31	270,737	461	437,051	17	245,738	67	58,695
Colquitt	0	0	3	7,209	0	0	0	0
Cook	0	0	1	6	0	0	0	0
DeKalb	0	0	0	0	0	0	1	596
Dooly	0	0	6	1,000	0	0	0	0
Echols	1	13	1	3	0	0	0	0
Emanuel	0	0	2	6	0	0	0	0
Fayette	0	0	1	3	0	0	0	0
Florida	0	0	29	11,967	1	965	12	10,045
Fulton	0	0	4	12	0	0	0	0
Gilmer	0	0	1	3	0	0	0	0
Glynn	2	9,717	54	12,269	0	0	11	2,805
Habersham	0	0	4	1,264	0	0	0	0
Hall	1	1,156	5	12,497	1	1,077	2	680
Irwin	0	0	1	3	0	0	0	0
Jeff Davis	6	363	76	207,730	0	0	2	1,175
Jefferson	0	0	1	9	0	0	0	0
Jones	0	0	1	135	0	0	0	0

Lanier	0	0	4	15	0	0	0	0
Laurens	0	0	4	12	0	0	0	0
Liberty	0	0	4	3	0	0	0	0
Long	0	0	2	6	0	0	0	0
Lowndes	2	117,105	17	8,173	0	0	0	0
McIntosh	0	0	8	24	0	0	0	0
Mitchell	0	0	1	1,068	0	0	0	0
Montgomery	8	145,256	15	10,733	0	0	0	0
Muscogee	0	0	1	1,882	0	0	0	0
North Carolina	3	21,658	8	12,316	0	0	2	226
Other Out of State	1	32,803	13	10,443	0	0	0	0
Peach	0	0	1	41	0	0	0	0
Pierce	243	1,297,579	3,468	2,760,956	53	286,277	525	397,074
Pulaski	0	0	1	957	0	0	0	0
Rabun	0	0	1	3	0	0	0	0
Richmond	0	0	4	18,319	0	0	0	0
South Carolina	0	0	9	13,516	0	0	0	0
Tattnall	0	0	2	6	0	0	0	0
Telfair	0	0	4	6,094	0	0	2	2,257
Thomas	0	0	1	1,322	0	0	0	0
Tift	0	0	2	6	0	0	0	0
Walton	1	13	2	9	0	0	0	0
Ware	523	3,694,471	8,876	5,602,706	115	375,468	1,155	667,476
Wayne	7	50,235	137	73,770	0	0	6	1,132
Wilcox	0	0	3	924	1	10,913	2	748
Total	**974**	**6,741,286**	**15,017**	**10,847,557**	**210**	**1,087,581**	**1,957**	**1,297,196**

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	8,410,343	9,178,500
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	1,326,987	1,057,790
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	8,806	9,352

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: Kenneth T. Calamia

Date: 3/5/2014

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: Mary J. Hoffman

Date: 3/5/2014

Title: Chief Financial Officer

Comments: