



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2013 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

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 calendar year 2013 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 1/1/2013 To:12/31/2013

Please indicate your cost report year.

From: 01/01/2013 To:12/31/2013

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: Manager, Decision Support

Phone: 478-542-7817

Fax: 478-975-6358

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	318,336,251
Total Inpatient Admissions accounting for Inpatient Revenue	17,153
Outpatient Gross Patient Revenue	338,981,926
Total Outpatient Visits accounting for Outpatient Revenue	214,088
Medicare Contractual Adjustments	217,219,891
Medicaid Contractual Adjustments	63,158,310
Other Contractual Adjustments:	113,656,770
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	28,880,474
Uncompensated Indigent Care (net):	29,297,966
Uncompensated Charity Care (net):	11,245,779
Other Free Care:	2,500,692
Other Revenue/Gains:	19,031,379
Total Expenses:	192,989,996

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	2,483,857
Employee Discounts	16,835
	0
Total	2,500,692

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 2013? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2013?

01/05/2009

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 2013? (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	11,991,035	4,192,023	16,183,058
Outpatient	17,306,931	7,102,408	24,409,339
Total	29,297,966	11,294,431	40,592,397

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	48,652
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	48,652

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	11,991,035	4,192,023	16,183,058
Outpatient	17,306,931	7,053,756	24,360,687
Total	29,297,966	11,245,779	40,543,745

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	6	9,839	1	232	3	4,634
BALDWIN	2	23,257	2	355	0	0	21	20,638
BARTOW	0	0	2	2,799	0	0	0	0
BEN HILL	0	0	0	0	1	2,000	1	232
BIBB	29	376,844	417	565,323	29	178,987	263	138,753
BLECKLEY	1	39,958	96	97,560	5	36,341	51	12,318
CANDLER	0	0	0	0	0	0	2	475
CHATHAM	0	0	5	23,913	0	0	0	0
CHEROKEE	1	6,119	1	362	0	0	0	0
CLAYTON	0	0	2	697	1	13,581	0	0
COBB	0	0	3	3	0	0	12	7,649
COLUMBIA	0	0	0	0	0	0	3	1,390
COOK	0	0	0	0	0	0	1	15,582
COWETA	0	0	1	1,122	0	0	0	0
CRAWFORD	6	71,258	31	27,564	5	7,131	31	19,323
CRISP	1	1,527	17	10,829	2	-25	27	28,751
DADE	0	0	0	0	0	0	1	914
DEKALB	0	0	2	1,203	0	0	0	0
DODGE	2	0	67	120,748	2	2,399	15	8,618
DOOLY	2	21,451	37	29,648	15	340,756	56	276,570
DOUGHERTY	0	0	1	830	0	0	3	4,022
Douglas	0	0	2	2,821	0	0	0	0
EARLY	1	4,611	0	0	0	0	0	0
FANNIN	1	69,299	6	3,578	0	0	0	0
FAYETTE	0	0	0	0	0	0	1	369
FLORIDA	5	35,695	39	35,272	1	660	3	3,412
FULTON	0	0	6	5,789	1	36,715	0	0
Glynn	0	0	1	282	0	0	14	22,357
GREENE	0	0	0	0	0	0	1	9
GWINNETT	0	0	5	2,066	2	26,161	1	1,407
HENRY	0	0	4	1,906	1	23,538	1	918
HOUSTON	930	9,062,397	13,290	13,410,905	617	2,802,274	7,403	5,145,496

JASPER	0	0	3	20,866	0	0	0	0
JEFF DAVIS	0	0	4	10,340	0	0	0	0
JONES	1	27	7	4,053	0	0	3	567
LAMAR	0	0	0	0	1	11,487	2	3,389
LAURENS	6	48,182	19	32,611	3	1,754	11	10,243
LEE	0	0	6	5,525	0	0	1	5,547
LIBERTY	0	0	1	250	0	0	2	715
MACON	10	110,218	138	213,152	9	13,385	73	73,820
MERIWETHER	0	0	1	2,585	0	0	0	0
Miller	0	0	0	0	1	500	0	0
MITCHELL	0	0	10	1,986	0	0	0	0
MONROE	0	0	13	2,711	0	0	2	213
Muscogee	0	0	2	7,289	1	65	0	0
NEWTON	0	0	0	0	0	0	2	11,241
NORTH CAROLINA	1	8,877	6	28,671	0	0	2	327
OCONEE	0	0	0	0	0	0	1	100
Other Out of State	10	144,587	62	86,383	1	1,132	21	20,976
PEACH	163	1,448,596	1,720	1,872,644	140	553,112	1,152	1,010,325
PIKE	0	0	1	4,257	0	0	3	7,856
POLK	0	0	0	0	0	0	2	300
PULASKI	16	282,780	140	193,715	15	66,619	70	56,608
PUTNAM	0	0	3	5,901	0	0	0	0
RICHMOND	0	0	1	1,588	0	0	0	0
ROCKDALE	1	10,256	0	0	0	0	0	0
SCHLEY	0	0	1	1,273	0	0	15	3,036
SOUTH CAROLINA	0	0	15	11,322	0	0	0	0
SUMTER	1	24,254	3	35	7	1,868	6	389
TAYLOR	5	57,059	164	223,454	13	34,011	93	73,011
TELFAIR	0	0	24	19,229	1	28,560	3	4,224
TENNESSEE	0	0	2	5,440	0	0	4	10,930
TIFT	2	19,567	20	35,768	0	0	0	0
TOOMBS	0	0	0	0	0	0	1	50
TREUTLEN	0	0	6	5,327	0	0	0	0
TWIGGS	6	90,938	67	104,076	5	5,244	65	77,185
UNION	0	0	0	0	0	0	5	6,934
UPSON	3	10,285	1	821	0	0	10	6,398
WASHINGTON	0	0	0	0	0	0	2	100
WAYNE	1	22,991	14	18,919	0	0	0	0
WHEELER	0	0	7	7,416	0	0	0	0
WILCOX	0	0	10	23,126	2	3,538	6	4,087
WILKINSON	0	0	1	784	0	0	0	0
Total	1,207	11,991,033	16,515	17,306,931	882	4,192,025	9,471	7,102,408

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 2013?
(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 2013.

Patient Category		SFY 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	13,603,362	15,694,604
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	5,520,401	5,774,030

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2012 7/1/11-6/30/12	SFY2013 7/1/12-6/30/13	SFY2014 7/1/13-6/30/14
0	3,741	3,166

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: Cary Martin

Date: 7/31/2014

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: Sean Whilden

Date: 7/31/2014

Title: VP / Chief Financial Officer

Comments: