GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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- Home Health Survey
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University Hospital

2019 Hospital Financial Submission Confirmation

Thank you for submitting your 2019 Annual Hospital Questionnaire. The submission was completed on 07/21/2020.

Completed Survey

- 2019 Hospital Financial Survey

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GHS

2019 Hospital Financial Survey

Parts A-B | Part C | Part D | Part E | Part F | ICTF Addendum | Reconciliation Addendum | Nurse Employment Addendum | Signature Page

View & Print Survey PDF | View & Print Reconciliation Addendum PDF | View & Print Nurse Employment Addendum PDF | Save Survey

Electronic Signature

There are no critical errors on the form.
You may sign and submit the survey. If you do not submit the survey before exiting, your signature will not be saved.

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.

Do not sign the survey until you are ready to submit. Signed surveys will be locked to prevent post-validation revisions that could through the survey out of balance. If you sign the survey, you will need to contact us to unlock it for revision.

Signature of Chief Executive: [signature] ***Required field- please enter a value.***

Date: 07/17/2020

Title: 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: [signature]

Date: 07/17/2020

Title: CFO

Comments:

Submit Survey

GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2019 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP716

Facility Name: University Hospital

County: Richmond

Street Address: 1350 Walton Way

City: Augusta

Zip: 30901-2629

Mailing Address: 1350 Walton Way

Mailing City: Augusta

Mailing Zip: 30901-2629

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2019 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 1/1/2019 To:12/31/2019

Please indicate your cost report year.
From: 01/01/2019 To:12/31/2019

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.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Sheri Poole

Contact Title: Dec. Support Sr. Data Analyst--Reimbursement

Phone: 706-828-2446

Fax: 706-828-2490

E-mail: sheri_poole@uh.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	895,488,302
Total Inpatient Admissions accounting for Inpatient Revenue	26,220
Outpatient Gross Patient Revenue	776,354,070
Total Outpatient Visits accounting for Outpatient Revenue	426,320
Medicare Contractual Adjustments	679,867,371
Medicaid Contractual Adjustments	127,967,988
Other Contractual Adjustments:	233,502,853
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	26,254,738
Gross Indigent Care:	35,558,704
Gross Charity Care:	60,558,903
Uncompensated Indigent Care (net):	35,558,704
Uncompensated Charity Care (net):	60,558,903
Other Free Care:	102,139
Other Revenue/Gains:	16,096,459
Total Expenses:	478,997,831

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	102,139
Employee Discounts	0
	0
Total	**102,139**

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 2019? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2019?

01/01/2019

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 Collections

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 2019? (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	20,546,651	30,610,234	51,156,885
Outpatient	15,012,053	29,948,669	44,960,722
Total	**35,558,704**	**60,558,903**	**96,117,607**

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	20,546,651	30,610,234	51,156,885
Outpatient	15,012,053	29,948,669	44,960,722
Total	**35,558,704**	**60,558,903**	**96,117,607**

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	2	2,140	2	24,564	3	5,520
Baldwin	0	0	4	7,449	0	0	6	16,955
Banks	0	0	0	0	0	0	1	88
Barrow	0	0	2	3,345	0	0	4	8,985
Ben Hill	0	0	0	0	0	0	1	102
Berrien	0	0	0	0	0	0	1	248
Bibb	0	0	4	1,621	1	13,341	14	10,588
Brantley	0	0	0	0	0	0	1	2,532
Bryan	0	0	3	29,970	1	51,964	0	0
Bulloch	7	82,907	12	26,619	2	28,510	24	36,661
Burke	115	95,393	204	390,303	44	813,113	323	523,398
Butts	0	0	0	0	0	0	1	800
Calhoun	0	0	0	0	0	0	1	62
Camden	0	0	0	0	0	0	1	1,980
Candler	1	1,675	1	297	1	13,665	7	11,311
Carroll	0	0	0	0	0	0	1	1,928
Charlton	2	2,815	4	3,940	0	0	0	0
Chatham	2	121,212	5	8,721	1	8,083	12	16,041
Chattahoochee	0	0	0	0	0	0	1	1,905
Cherokee	0	0	0	0	0	0	1	1,839
Clarke	0	0	3	8,333	0	0	5	17,856
Clayton	0	0	5	3,031	0	0	10	18,974
Cobb	0	0	3	1,846	0	0	9	11,150
Coffee	0	0	0	0	0	0	1	138
Columbia	233	2,303,106	680	1,721,631	149	2,341,885	2,221	2,904,361
Coweta	0	0	0	0	1	7,121	1	5,388
Crisp	0	0	0	0	0	0	2	7,031
Decatur	0	0	0	0	0	0	2	41
DeKalb	2	25,337	3	18,815	1	4,552	15	20,916
Dodge	0	0	1	3,215	0	0	0	0
Dooly	0	0	0	0	0	0	1	2,575
Dougherty	0	0	0	0	0	0	3	1,805

Douglas	1	4,957	0	0	0	0	1	5,143
Early	0	0	1	818	0	0	1	1,908
Effingham	0	0	0	0	0	0	2	5,044
Elbert	0	0	2	3,556	0	0	5	4,126
Emanuel	12	75,716	21	84,158	2	36,188	34	30,711
Evans	1	13	1	318	0	0	5	14,554
Fayette	0	0	0	0	0	0	1	23
Floyd	0	0	0	0	0	0	2	2,054
Franklin	0	0	1	543	0	0	2	3,036
Fulton	2	7,463	4	8,346	2	17,415	26	15,980
Glascock	18	20,304	27	50,872	9	203,720	34	68,509
Glynn	0	0	2	2,169	0	0	3	7,208
Gordon	0	0	1	753	0	0	0	0
Grady	0	0	0	0	0	0	2	641
Greene	2	53,041	5	66,761	1	5,986	0	0
Gwinnett	1	1,364	2	1,474	0	0	8	13,387
Habersham	0	0	0	0	0	0	1	338
Hall	1	9,328	0	0	0	0	3	2,535
Hancock	9	59,640	8	22,734	0	0	8	11,250
Hart	1	1,364	1	528	2	18,910	2	1,609
Henry	0	0	0	0	0	0	7	14,529
Houston	0	0	1	4,097	0	0	3	6,572
Jackson	0	0	1	33	0	0	4	13,953
Jeff Davis	0	0	2	2,710	0	0	3	530
Jefferson	92	1,407,700	151	551,191	29	363,062	187	385,691
Jenkins	25	38,589	38	75,156	4	33,403	55	162,137
Johnson	1	14,605	7	12,280	0	0	6	20,484
Lamar	0	0	0	0	0	0	1	710
Lanier	0	0	0	0	1	11,955	0	0
Laurens	0	0	8	9,904	1	25,304	12	24,478
Lee	0	0	1	4,534	0	0	0	0
Liberty	0	0	2	3,073	0	0	4	1,285
Lincoln	53	444,714	63	70,066	20	353,524	100	159,652
Lowndes	0	0	1	720	0	0	0	0
Madison	0	0	2	2,233	0	0	1	2,571
McDuffie	208	1,483,774	259	489,586	78	1,007,849	286	502,737
McIntosh	0	0	0	0	0	0	1	29
Monroe	0	0	0	0	0	0	2	1,527
Montgomery	2	1,193	2	2,436	0	0	2	384
Morgan	0	0	0	0	0	0	1	1,821
Muscogee	0	0	2	1,761	0	0	4	6,734
Newton	0	0	1	2,099	0	0	7	20,506
Oconee	0	0	1	560	0	0	2	1,126
Other Out of State	15	153,682	75	101,097	33	587,469	383	513,466

Paulding	0	0	0	0	0	0	3	1,180
Peach	0	0	1	664	0	0	1	1,666
Pierce	0	0	0	0	0	0	1	177
Pulaski	0	0	0	0	0	0	1	77
Putnam	0	0	3	9,135	2	32,899	6	24,481
Richmond	830	10,865,533	3,598	9,309,720	418	14,585,608	6,573	17,656,920
Rockdale	0	0	2	944	0	0	4	3,232
Screven	0	0	14	14,799	5	109,799	24	51,346
South Carolina	563	2,419,696	1,359	1,523,730	380	8,980,746	3,828	6,224,888
Taliaferro	5	17,405	6	15,658	4	38,446	4	23,813
Tattnall	1	1,364	0	0	0	0	5	7,660
Taylor	0	0	0	0	0	0	1	335
Telfair	0	0	2	2,593	1	72,980	0	0
Terrell	0	0	0	0	0	0	1	206
Toombs	1	2,351	0	0	1	8,180	18	6,085
Towns	1	11,373	1	2,029	0	0	0	0
Treutlen	0	0	0	0	0	0	2	1,330
Troup	0	0	0	0	0	0	1	1,317
Union	0	0	0	0	0	0	1	65
Upson	0	0	0	0	0	0	1	551
Walton	0	0	1	3,452	2	18,619	5	7,494
Ware	1	66,259	1	5,829	0	0	0	0
Warren	66	275,552	80	235,588	26	319,049	64	124,950
Washington	28	345,877	38	37,099	5	66,855	45	91,685
Wayne	0	0	0	0	0	0	2	6,339
Wheeler	1	3,410	0	0	0	0	0	0
Wilcox	0	0	0	0	1	11,087	0	0
Wilkes	20	127,939	37	42,164	9	394,383	48	50,715
Wilkinson	0	0	1	807	0	0	3	1,630
Worth	0	0	0	0	0	0	1	371
Total	**2,323**	**20,546,651**	**6,773**	**15,012,053**	**1,239**	**30,610,234**	**14,527**	**29,948,669**

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 2019? (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 2019.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	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	0	(
C.	Other Patients in accordance with the department approved policy.	0	48,058,804	48,058,80

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2018 7/1/17-6/30/18	SFY2019 7/1/18-6/30/19	SFY2019 7/1/19-6/30/20
0	12,431	12,431

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Nurse Employment Addendum

This section is printed on a separate PDF file.

Electronic Signature

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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:

Date: 7/17/2020

Title:

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:

Date: 7/17/2020

Title:

Comments: