Georgia Department of Community Health

2024 Hospital Financial Survey

Part A : General Information

1. Identification

UID:Hosp540

Facility Name: Washington County Regional Medical Center

County: Washington

Street Address: 610 Sparta Rd

City: Sandersville

Zip: 31082

Mailing Address: PO Box 636

Mailing City: Sandersville

Mailing Zip: 31082

Medicaid Provider Number: 00001218A

Medicare Provider Number: 110086

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2024 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 9/1/2023 To:8/31/2024

Please indicate your cost report year.
From: 09/01/2023 To:08/01/2024

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: Jesus F Ruiz

Contact Title: Reimbursement Consultant

Phone: 404-788-4861

Fax: 678-823-6919

E-mail: jesus.ruiz@rsgga.com

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	3,459,540
Total Inpatient Admissions accounting for Inpatient Revenue	411
Outpatient Gross Patient Revenue	64,926,107
Total Outpatient Visits accounting for Outpatient Revenue	26,195
Medicare Contractual Adjustments	8,365,631
Medicaid Contractual Adjustments	11,946,734
Other Contractual Adjustments:	13,567,594
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	2,107,471
Gross Indigent Care:	627,946
Gross Charity Care:	65,633
Uncompensated Indigent Care (net):	627,946
Uncompensated Charity Care (net):	65,633
Other Free Care:	3,441,997
Other Revenue/Gains:	4,585,271
Total Expenses:	24,082,559

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	312,628
Employee Discounts	21,661
Denied Claims	3,107,708
Total	**3,441,997**

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 2024? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2024?

09/01/2023

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.?

Financial Counseling

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 2024? (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	31,580	9,642	41,222
Outpatient	596,366	55,991	652,357
Total	**627,946**	**65,633**	**693,579**

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	31,580	9,642	41,222
Outpatient	596,366	55,991	652,357
Total	**627,946**	**65,633**	**693,579**

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
Baldwin	0	0	4	1,619	0	0	0	0
Cherokee	0	0	1	10,232	0	0	0	0
Glascock	0	0	4	1,241	0	0	0	0
Hancock	0	0	16	4,273	0	0	0	0
Houston	0	0	0	0	0	0	1	23,800
Jefferson	0	0	3	11,774	0	0	0	0
Johnson	0	0	9	8,990	0	0	1	9,894
Laurens	0	0	2	28,549	0	0	3	8,474
Montgomery	0	0	1	21,058	0	0	0	0
Other Out of State	0	0	2	12,040	0	0	0	0
Washington	5	31,580	269	496,590	3	9,642	36	13,823
Total	**5**	**31,580**	**311**	**596,366**	**3**	**9,642**	**41**	**55,991**

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 2024? (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 2024.

	Patient Category	SFY 2022 7/1/21-6/30/22	SFY2024 7/1/22-6/30/23	SFY2024 7/1/23-6/30/24
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	523,288	104,658
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	54,694	10,939
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY2022 7/1/21-6/30/22	SFY2024 7/1/22-6/30/23	SFY2024 7/1/23-6/30/24
0	300	60

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:

Date: 7/15/2025

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: 7/15/2025

Title:

Comments: