



2007 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP998

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2007 only.
Do not use a different report period.

Please indicate your hospital fiscal year.

From: To:

Please indicate your cost report year.

From: To:

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:

Contact Title:

Phone:

Fax:

E-mail:

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 | |
| Total Inpatient Admissions accounting for Inpatient Revenue | |
| Outpatient Gross Patient Revenue | |
| Total Outpatient Visits accounting for Outpatient Revenue | |
| Medicare Contractual Adjustments | |
| Medicaid Contractual Adjustments | |
| Other Contractual Adjustments: | |
| Hill Burton Obligations: | |
| Bad debt: | |
| Uncompensated Indigent Care (net): | |
| Uncompensated Charity Care (net): | |
| Other Free Care: | |
| Other Revenue/Gains: | |
| Total Expenses: | |

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 2007? (Check box if yes.)

2. Effective Date

What was the effective date of the policy or policies in effect during 2007?

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.?

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.)?

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 2007? (Check box if yes.)

Part E : Indigent And Charity Care

1. Indigent and Charity Care

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 | | | |
| Outpatient | | | |
| | | | |

2. Source of Funding

Please indicate the source of funding in the table below.

| Source of Funding | Amount |
|---|--------|
| Home County | |
| Other Counties | |
| City Or Cities | |
| Hospital Authority | |
| State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Fund) | |
| Federal Government | |
| Non-Government Sources | |
| Charitable Contributions | |
| Trust Fund From Sale Of Public Hospital | |
| All Other | |
| | |

Part F : Patient Origin

1. Total Indigent/Charity Care By County

Please report Indigent/Charity Care by County in the following categories.

To add a row press the button. To delete a row press the minus button at the end of the row.

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 | | | | | | | | |
| Appling | | | | | | | | |
| Atkinson | | | | | | | | |
| Bacon | | | | | | | | |
| Baker | | | | | | | | |
| Baldwin | | | | | | | | |
| Banks | | | | | | | | |
| Barrow | | | | | | | | |
| Bartow | | | | | | | | |
| Ben Hill | | | | | | | | |
| Berrien | | | | | | | | |
| Bibb | | | | | | | | |
| Bleckley | | | | | | | | |
| Brantley | | | | | | | | |
| Brooks | | | | | | | | |
| Bryan | | | | | | | | |
| Bulloch | | | | | | | | |
| Burke | | | | | | | | |
| Butts | | | | | | | | |
| Calhoun | | | | | | | | |
| Camden | | | | | | | | |
| Candler | | | | | | | | |
| Carroll | | | | | | | | |
| Catoosa | | | | | | | | |
| Charlton | | | | | | | | |
| Chatham | | | | | | | | |
| Chattahoochee | | | | | | | | |
| Chattooga | | | | | | | | |
| Cherokee | | | | | | | | |
| Clarke | | | | | | | | |
| Clay | | | | | | | | |
| Clayton | | | | | | | | |
| Clinch | | | | | | | | |
| Cobb | | | | | | | | |

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|-----------|--|--|--|--|--|--|--|--|
| Coffee | | | | | | | | |
| Colquitt | | | | | | | | |
| Columbia | | | | | | | | |
| Cook | | | | | | | | |
| Coweta | | | | | | | | |
| Crawford | | | | | | | | |
| Crisp | | | | | | | | |
| Dade | | | | | | | | |
| Dawson | | | | | | | | |
| Decatur | | | | | | | | |
| DeKalb | | | | | | | | |
| Dodge | | | | | | | | |
| Dooly | | | | | | | | |
| Dougherty | | | | | | | | |
| Douglas | | | | | | | | |
| Early | | | | | | | | |
| Echols | | | | | | | | |
| Effingham | | | | | | | | |
| Elbert | | | | | | | | |
| Emanuel | | | | | | | | |
| Evans | | | | | | | | |
| Fannin | | | | | | | | |
| Fayette | | | | | | | | |
| Florida | | | | | | | | |
| Floyd | | | | | | | | |
| Forsyth | | | | | | | | |
| Franklin | | | | | | | | |
| Fulton | | | | | | | | |
| Gilmer | | | | | | | | |
| Glascock | | | | | | | | |
| Glynn | | | | | | | | |
| Gordon | | | | | | | | |
| Grady | | | | | | | | |
| Greene | | | | | | | | |
| Gwinnett | | | | | | | | |
| Habersham | | | | | | | | |
| Hall | | | | | | | | |
| Hancock | | | | | | | | |
| Haralson | | | | | | | | |
| Harris | | | | | | | | |
| Hart | | | | | | | | |
| Heard | | | | | | | | |
| Henry | | | | | | | | |
| Houston | | | | | | | | |

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|--------------------|--|--|--|--|--|--|--|--|
| Irwin | | | | | | | | |
| Jackson | | | | | | | | |
| Jasper | | | | | | | | |
| Jeff Davis | | | | | | | | |
| Jefferson | | | | | | | | |
| Jenkins | | | | | | | | |
| Johnson | | | | | | | | |
| Jones | | | | | | | | |
| Lamar | | | | | | | | |
| Lanier | | | | | | | | |
| Laurens | | | | | | | | |
| Lee | | | | | | | | |
| Liberty | | | | | | | | |
| Lincoln | | | | | | | | |
| Long | | | | | | | | |
| Lowndes | | | | | | | | |
| Lumpkin | | | | | | | | |
| Macon | | | | | | | | |
| Madison | | | | | | | | |
| Marion | | | | | | | | |
| McDuffie | | | | | | | | |
| McIntosh | | | | | | | | |
| Meriwether | | | | | | | | |
| Miller | | | | | | | | |
| Mitchell | | | | | | | | |
| Monroe | | | | | | | | |
| Montgomery | | | | | | | | |
| Morgan | | | | | | | | |
| Murray | | | | | | | | |
| Muscogee | | | | | | | | |
| Newton | | | | | | | | |
| North Carolina | | | | | | | | |
| Oconee | | | | | | | | |
| Oglethorpe | | | | | | | | |
| Other Out of State | | | | | | | | |
| Paulding | | | | | | | | |
| Peach | | | | | | | | |
| Pickens | | | | | | | | |
| Pierce | | | | | | | | |
| Pike | | | | | | | | |
| Polk | | | | | | | | |
| Pulaski | | | | | | | | |
| Putnam | | | | | | | | |
| Quitman | | | | | | | | |

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|----------------|--|--|--|--|--|--|--|--|
| Rabun | | | | | | | | |
| Randolph | | | | | | | | |
| Richmond | | | | | | | | |
| Rockdale | | | | | | | | |
| Schley | | | | | | | | |
| Screven | | | | | | | | |
| Seminole | | | | | | | | |
| South Carolina | | | | | | | | |
| Spalding | | | | | | | | |
| Stephens | | | | | | | | |
| Stewart | | | | | | | | |
| Sumter | | | | | | | | |
| Talbot | | | | | | | | |
| Taliaferro | | | | | | | | |
| Tattnall | | | | | | | | |
| Taylor | | | | | | | | |
| Telfair | | | | | | | | |
| Tennessee | | | | | | | | |
| Terrell | | | | | | | | |
| Thomas | | | | | | | | |
| Tift | | | | | | | | |
| Toombs | | | | | | | | |
| Towns | | | | | | | | |
| Treutlen | | | | | | | | |
| Troup | | | | | | | | |
| Turner | | | | | | | | |
| Twiggs | | | | | | | | |
| Union | | | | | | | | |
| Upson | | | | | | | | |
| Walker | | | | | | | | |
| Walton | | | | | | | | |
| Ware | | | | | | | | |
| Warren | | | | | | | | |
| Washington | | | | | | | | |
| Wayne | | | | | | | | |
| Webster | | | | | | | | |
| Wheeler | | | | | | | | |
| White | | | | | | | | |
| Whitfield | | | | | | | | |
| Wilcox | | | | | | | | |
| Wilkes | | | | | | | | |
| Wilkinson | | | | | | | | |
| Worth | | | | | | | | |
| Total | | | | | | | | |

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 2007?
(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 2007.

| Patient Category | | SFY 2006 | SFY2007 | SFY2008 |
|------------------|--|----------------|----------------|----------------|
| | | 7/1/05-6/30/06 | 7/1/06-6/30/07 | 7/1/07-6/30/08 |
| A. | Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge. | | | |
| 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. | | | |
| C. | Other Patients in accordance with the department approved policy. | | | |

3. Patients Served

Indicate the number of patients served by SFY.

| SFY 2006 | SFY2007 | SFY2008 |
|----------------|----------------|----------------|
| 7/1/05-6/30/06 | 7/1/06-6/30/07 | 7/1/07-6/30/08 |
| | | |

4. Expenditure Report for Indigent Care Trust Fund Primary Care Project Plans

Report utilization of ICTF Primary Care Project Plan funds by project as approved by DCH if there was any unspent primary care obligation remaining after HFY 2006. For completed projects, please provide financial detail to allow for project closeout. Questions regarding data in this addendum should be directed to Margaret Price at (404) 651-7898 or by email to mprice@dch.ga.gov.

HFY: Expenditures for each project should reflect activities for Hospital Fiscal Year 2007.

SFY: Select the State Fiscal Year from which the funds were drawn for each project.

Column A: Total budgeted expenditures for the project.

Column B: Amount of the ICTF Primary Care Project Plan funds that were in the total budgeted expenditures for the project.

Column C: Total project expenditures prior to the current report period (prior to HFY 2007).

Column D: Total project expenditures during this report period (during HFY 2007).

| HFY | SFY | Project Name | Provider | Column A | Column B | Column C | Column D |
|-----|-----|--------------|----------|----------|----------|----------|----------|
| | | | | | | | |

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:

Date:

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:

Title:

Comments: