



2009 Hospital Financial Survey

Part A : General Information

1. Identification

UID:

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 2009 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 (net of recoveries):	
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 2009? (Check box if yes.)

2. Effective Date

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

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 2009? (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			
Outpatient			
Total			

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

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			
Outpatient			
Total			

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								
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								
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								
Glascok								
Glynn								
Gordon								
Grady								
Greene								
Gwinnett								
Habersham								
Hall								
Hancock								
Haralson								
Harris								
Hart								
Heard								
Henry								
Houston								
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								
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 2009?
(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 2009.

Patient Category		SFY 2008	SFY2009	SFY2010
		7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10
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 2008	SFY2009	SFY2010
7/1/07-6/30/08	7/1/08-6/30/09	7/1/09-6/30/10

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:

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: