Georgia Department of Community Health

2008 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP315

Facility Name: Jasper Memorial Hospital

County: Jasper

Street Address: 898 College Street

City: Monticello

Zip: 31064-1298

Mailing Address: 898 College Street

Mailing City: Monticello

Mailing Zip: 31064-1298

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2008 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2007 To:9/30/2008

Please indicate your cost report year.
From: 10/01/2007 To:09/30/2008

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: Stuart Abney

Contact Title: Controller

Phone: 706-468-9802

Fax: 706-468-9880

E-mail: stuart@jaspermemorial.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	1,165,024
Total Inpatient Admissions accounting for Inpatient Revenue	188
Outpatient Gross Patient Revenue	7,220,757
Total Outpatient Visits accounting for Outpatient Revenue	13,723
Medicare Contractual Adjustments	592,354
Medicaid Contractual Adjustments	528,758
Other Contractual Adjustments:	984,663
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	805,968
Uncompensated Indigent Care (net):	177,046
Uncompensated Charity Care (net):	7,112
Other Free Care:	0
Other Revenue/Gains:	541,004
Total Expenses:	5,989,382

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	0
Employee Discounts	0
	0
Total	**0**

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 2008? (Check box if yes.) ☑

2. Effective Date

What was the effective date of the policy or policies in effect during 2008?

10/01/2006

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.?

Patient Access Manager

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.)?

185%

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 2008? (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	11,898	0	11,898
Outpatient	165,148	7,112	172,260
Total	**177,046**	**7,112**	**184,158**

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	0	0	0
Outpatient	0	0	0
Total	**0**	**0**	**0**

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	6	4,579	0	0	0	0
DeKalb	0	0	19	13,430	0	0	0	0
Jasper	4	11,898	262	137,454	0	0	26	5,837
Newton	0	0	17	9,100	0	0	4	1,275
Putnam	0	0	1	144	0	0	0	0
Rockdale	0	0	1	114	0	0	0	0
Walton	0	0	1	327	0	0	0	0
Total	**4**	**11,898**	**307**	**165,148**	**0**	**0**	**30**	**7,112**

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 2008? (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 2008.

	Patient Category	SFY 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	126,352	50,694
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	4,999	2,113
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2007 7/1/06-6/30/07	SFY2008 7/1/07-6/30/08	SFY2009 7/1/08-6/30/09
0	278	63

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: Jan Gaston

Date: 8/19/2009

Title: Administrator

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: Stuart Abney

Date: 8/19/2009

Title: Controller

Comments: