

Georgia Department of Audits and Accounts  
Indigent Care Trust Fund Questionnaire  
For Data Reported on the 2003 Hospital Financial Survey

Hospital name: \_\_\_\_\_

- 1) Electronic data is needed for this review.
- a) Can you provide electronic data to support the Total Inpatient Charges and Total Outpatient charges on Part C, lines 1 and 2 of the HFS Survey?

\_\_\_\_\_

- b) Can you provide electronic data to support the amounts listed in Part G, section 2 of the survey?

\_\_\_\_\_

If no electronic data was saved at the time your survey was completed, you are going to need to run a query to extract this information out now. Ensure the following data fields are included: patient identifier, date of service, payor type, inpatient or outpatient, type of service, in-state vs. out-of-state, and amount.

- 2) Please select the most accurate statement regarding the electronic information you will provide for the review.
- a) The electronic data is accurate as of our hospital's fiscal year end general ledger closing.
  - b) The electronic data is accurate as of the date the HFS survey was completed and may reflect changes that have taken place between the fiscal year general ledger closing and the date in time the HFS survey was completed.
  - c) The electronic data is accurate as of the time the query was run and may reflect changes that have taken place since the time the HFS survey was completed.

- 3) Can the amounts in Part C, lines 1 and 2 be tied to your financial audit/ general ledger or Medicare Cost Report? If there are variances, can you explain them?

\_\_\_\_\_

- 4) What are your financial class categories and what are their codes in your accounting system?

\_\_\_\_\_

- 5) Did you obtain the amounts listed on G Part 2 for Medicaid and Uninsured charges using the financial class categories provided as Medicaid and Uninsured from the electronic detailed data? If not why not? Where was the information for G Part 2 obtained from?

\_\_\_\_\_

- 6) Are physician services, pharmacy services, home health, rural health clinics or hospice service revenues recorded in your charge and cash receipt amounts in Part G? If so, what are these services and how much charges and cash receipts are associated with each?

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- 7) Are physician services, pharmacy services, home health, rural health clinics or hospice service recorded in your charge and expense amounts in Part C? If so, what are these services and how much is associated with each?

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- 8) What happens when a person comes in the door without insurance - how are they recorded?

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\_\_\_\_\_  
\_\_\_\_\_

- 9) What happens when a payor source changes? What happens to the previous charges and payments? Are the revenues and cash receipts retroactively adjusted to the corrected payor source in your electronic accounting system?

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\_\_\_\_\_  
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- 10) What happens if a person says they have insurance and do not or vice versa? Where are these charges and cash receipts recorded?

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- 11) Did you include Medicaid non-covered services in Medicaid or Uninsured?

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- 12) Did you include insurance "over the limit" and "over lifetime benefit" charges in Insurance or Uninsured?

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- 13) Where did you include Medicaid Pending charges?

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- 14) Did you include cost report settlements in your cash receipts?

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\_\_\_\_\_  
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- 15) Did you include advance payments in your cash receipts?

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16) Do you have a cash receipts journal that records all cash receipts recorded during the hospital's fiscal year by payor type? Will this also allow you to break out the receipts by types of hospital service?

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\_\_\_\_\_  
\_\_\_\_\_

17) Is Peachcare recorded separately for charges and cash receipts? If not, how is Peachcare defined in your system?

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18) What will allow us to distinguish whether the cash receipt was for an in-state patient or out of state patient?

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19) Where did you include claims where Medicaid is the secondary payor? Did you include all of the charges and cash receipts in this category?

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\_\_\_\_\_  
\_\_\_\_\_

Questionnaire completed by:	
_____ signature	_____ date
_____ name	_____ title
_____ telephone no.	_____ e-mail address

When completed, return questionnaire by mail to:

Mr. Randy Rehn  
Audit Supervisor  
Georgia Department of Audits and Accounts  
Healthcare Audits Division  
254 Washington Street, Suite 214  
Atlanta Georgia 30334-8400