



2024 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP347

Facility Name: Clinch Memorial Hospital

County: Clinch

Street Address: 1050 Valdosta Highway

City: Homerville

Zip: 31634

Mailing Address: PO Box 516

Mailing City: Homerville

Mailing Zip: 31634

Medicaid Provider Number: 415A

Medicare Provider Number: 11-1308

2. Report Period

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

Please indicate your hospital fiscal year.

From: 7/1/2023 To:6/30/2024

Please indicate your cost report year.

From: 07/01/2023 To:06/30/2024

☐

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: Madison Pope

Contact Title: CFO

Phone: 912-487-5211

Fax: 912-470-2782

E-mail: mpope@clinchmh.org

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	248,472
Total Inpatient Admissions accounting for Inpatient Revenue	44
Outpatient Gross Patient Revenue	9,719,522
Total Outpatient Visits accounting for Outpatient Revenue	8,660
Medicare Contractual Adjustments	602,602
Medicaid Contractual Adjustments	899,446
Other Contractual Adjustments:	296,256
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	1,408,600
Gross Indigent Care:	61,154
Gross Charity Care:	0
Uncompensated Indigent Care (net):	61,154
Uncompensated Charity Care (net):	0
Other Free Care:	105,689
Other Revenue/Gains:	3,299,795
Total Expenses:	6,095,709

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	105,195
Employee Discounts	0
Small Balance Write Off	494
Total	105,689

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?

02/01/2023

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.?

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	0	0	0
Outpatient	61,154	0	61,154
Total	61,154	0	61,154

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	61,154	0	61,154
Total	61,154	0	61,154

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
Camden	0	0	1	226	0	0	0	0
Clinch	0	0	88	57,772	0	0	0	0
Columbia	0	0	1	358	0	0	0	0
Florida	0	0	1	2,730	0	0	0	0
Ware	0	0	1	68	0	0	0	0
Total	0	0	92	61,154	0	0	0	0

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	61,154	0
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	0	0
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	92	0

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: Angela Handley

Date: 7/24/2025

Title: CEO

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: Madison Pope

Date: 7/24/2025

Title: CFO

Comments:

2024 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum

HOSP347- Clinch Memorial Hospital

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):											
HFS Source:	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part E, 1	Part E, 1	Part C, 1		
	Gross Patient Charges	Medicare Contractual Adjs	Medicaid Contractual Adjs	Other Contractual Adjs	Hill Burton Obligations	Bad Debt	Gross Indigent Care (IP & OP)	Gross Charity Care (IP & OP)	Other Free Care	Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	1	2	3	4	5	6	7	8	9	10	11
Inpatient Gross Patient Revenue	248,472										
Outpatient Gross Patient Revenue	9,719,522										
Per Part C, 1. Financial Table		602,602	899,446	296,256	0	1,408,600			105,689		
Per Part E, 1. Indigent and Charity Care							61,154	0			
Totals per HFS	9,967,994	602,602	899,446	296,256	0	1,408,600	61,154	0	105,689	3,373,747	6,594,247
Section 2: Reconciling Items to Financial Statements:									(B)		(B)
Non-Hospital Services:											
> Professional Fees	790104.0									266320.0	
> Home Health Agency	0.0									0.0	
> SNF/NF Swing Bed Services	5951392.0									-2869029.0	
> Nursing Home	0.0									0.0	
> Hospice	0.0									0.0	
> Freestanding Ambulatory Surg. Centers	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
Bad Debt (Expense per Financials) (A)										0.0	
Indigent Care Trust Fund Income										-1140226.0	
Other Reconciling Items:											
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
> N/A	0.0									0.0	
Total Reconciling Items	6,741,496									-3,742,935	10,484,431
Total Per Form	16,709,490									-369,188	17,078,678
Total Per Financial Statements	16709490.0										17078678.0
Unreconciled Difference (Must be Zero)	0										0
(A) Due to specific differences in the presentation of data on the HFS, Bad Debt per Financials may differ from the amount reported on the HFS-proper (Part C).											
(B) Taxable Net Patient Revenue will equal Net Patient Revenue in Section 1 column 11, plus Other Free Care in Section 1 column 9.											