State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: NORTHEAST GEORGIA MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2016	09/30/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	000000888A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000000888S
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110029

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	9/1/1951

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Karen Wood, MD
Greg Martin, MD

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017** $ 6,443,041
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	**Yes**

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	Title	Date
	CFO - Northeast Georgia Health System	11/14/2018

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Brian D. Steines, MBA, CPA	770-219-7246	Brian.Steines@nghs.com

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	Linda Nicholson
Title	Vice President - Finance
Telephone Number	770-219-6622
E-Mail Address	Linda.Nicholson@nghs.com
Mailing Street Address	743 Spring Street, N.E.
Mailing City, State, Zip	Gainesville, GA 30501

Outside Preparer:	
Name	Jeffrey L. Askey, CPA
Title:	Partner
Firm Name:	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	jaskey@draffin-tucker.com

DSH Survey Submission Checklist

Please indicate with an "X" each item included or a "N/A" if not included. Consider a separate cover letter to explain any "N/A" answers avoid additional documentation requests.

X	1. Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2016 - 06/30/2017
X	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year 10/01/2016 - 09/30/2017
N/A	3. N/A
N/A	4. N/A
X	5 (a). Electronic copy of Exhibit A - Uninsured Charges / Days - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
X	5 (b). Description of logic used to compile Exhibit A. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
X	6 (a). Electronic copy of Exhibit B - Self-Pay Payments - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	6 (b). Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
X	7 (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report) - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	7 (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payor plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
N/A	8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
N/A	12. Documentation supporting out-of-state DSH payments received - Examples may include remittances, detailed general ledgers, or add-on rates.
X	13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
X	14. Revenue code cross-walk used to prepare cost report, or supporting grouping schedules
X	15a. A detailed working trial balance used to prepare each cost report (including revenues)
N/A	15b. A detailed revenue working trial balance by payor/contract. The schedule should show charges, contractual adjustments, and revenues by payor plan and contract (e.g., Medicare, each Medicaid agency payor, each Medicaid Managed care contract)
X	16. Electronic copy of all cost reports used to prepare each DSH Survey Part II
X	17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)
N/A	18. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

Please upload all checklist items above to the Myers and Stauffer Web Portal. If you are unable to access the Web Portal, please call or email.
Web Portal Address:

https://dsh.mslc.com

All electronic (CD or DVD - CDs or DVDs must be encryped and/or password protected) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
E-Mail:

Please Call Myers and Stauffer if you have any questions on completing the DSH survey.

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S) **	Insurance Status When Services Were Provided (Insured or Uninsured) (T) *	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0) *****
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

Notes for Completing Exhibit B:

* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Surve

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

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D. General Cost Report Year Information 10/1/2016 - 9/30/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	NORTHEAST GEORGIA MEDICAL CENTER		
	10/1/2016 through 9/30/2017		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	5/29/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000888A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000000888S	No	Remote Campus provider number (not Subprovider)
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110029	Yes	Both campuses - same Medicare provider number
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -		
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -		
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -		
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-		
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -		
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -		
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-		
8. **Out-of-State DSH Payments (See Note 2)**	$ -		
	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 693,560	$ 2,245,284	$2,938,844
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,406,282	$ 31,049,980	$39,456,262
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$9,099,842	$33,295,264	$42,395,106
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.62%	6.74%	6.93%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2016 - 09/30/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	188,783 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	90,886,697
8.	Outpatient Hospital Charity Care Charges	85,282,465
9.	Non-Hospital Charity Care Charges	804,984
10.	Total Charity Care Charges	$ 176,974,146

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$200,845,660.00			$ 145,796,050	$ -	$ -	$ 55,049,610
12.	Subprovider I (Psych or Rehab)	$19,842,893.00			$ 14,404,172	$ -	$ -	$ 5,438,721
13.	Subprovider II (Psych or Rehab)	$4,161,419.00			$ 3,020,819	$ -	$ -	$ 1,140,600
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$19,132,860.00			$ 13,888,751	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$1,592,805,329.00	$1,628,848,560.00		$ 1,156,234,722	$ 1,182,398,895	$ -	$ 883,020,272
20.	Outpatient Services		$207,194,561.00			$ 150,404,787	$ -	$ 56,789,774
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$12,347,988.00			$ 8,963,539	
26.	Other	$44,548,086.00	$452,760,872.00	$0.00	$ 32,337,940	$ 328,664,044	$ -	$ 136,306,973
27.	Total	$ 1,862,203,387	$ 2,288,803,993	$ 31,480,848	$ 1,351,793,704	$ 1,661,467,726	$ 22,852,290	$ 1,137,745,950
28.	Total Hospital and Non Hospital		Total from Above	$ 4,182,488,228		Total from Above	$ 3,036,113,720	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	4,182,488,228	Total Contractual Adj. (G-3 Line 2)	3,029,767,166
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	6,346,554
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				3,036,113,720

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 158,796,537	$ -	$ -	$0.00	$ 158,796,537	156,590	$172,071,339.00		$ 1,014.09
2	03100 INTENSIVE CARE UNIT	$ 28,005,493	$ -	$ -		$ 28,005,493	14,563	$30,942,181.00		$ 1,923.06
3	03200 CORONARY CARE UNIT	$ 21,657,174	$ -	$ -		$ 21,657,174	11,491	$21,836,452.00		$ 1,884.71
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 21,297,282	$ -	$ -		$ 21,297,282	16,799	$19,571,978.00		$ 1,267.77
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 229,756,486	$ -	$ -	$ -	$ 229,756,486	199,443	$ 244,421,950		
19	Weighted Average									$ 1,151.99

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	10,660	-	-	$ 10,810,199	$4,345,947.00	$16,179,281.00	$ 20,525,228	0.526679

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below)									
21	5000 OPERATING ROOM	$70,919,068.00	$ -	$0.00		$ 70,919,068	$225,812,846.00	$245,231,163.00	$ 471,044,009	0.150557
22	5200 DELIVERY ROOM & LABOR ROOM	$15,059,803.00	$ -	$0.00		$ 15,059,803	$52,709,178.00	$3,208,219.00	$ 55,917,397	0.269322
23	5300 ANESTHESIOLOGY	$4,410,349.00	$ -	$0.00		$ 4,410,349	$66,140,876.00	$59,484,685.00	$ 125,625,561	0.035107
24	5400 RADIOLOGY-DIAGNOSTIC	$35,939,212.00	$ -	$0.00		$ 35,939,212	$36,500,081.00	$164,091,270.00	$ 200,591,351	0.179166
25	5401 VASCULAR LAB	$2,540,190.00	$ -	$0.00		$ 2,540,190	$6,195,015.00	$11,326,465.00	$ 17,521,480	0.144976
26	5500 RADIOLOGY-THERAPEUTIC	$16,432,018.00	$ -	$0.00		$ 16,432,018	$2,647,505.00	$80,181,908.00	$ 82,829,413	0.198384
27	5700 CT SCAN	$12,305,496.00	$ -	$0.00		$ 12,305,496	$99,055,397.00	$221,259,595.00	$ 320,314,992	0.038417
28	5800 MRI	$5,492,822.00	$ -	$0.00		$ 5,492,822	$19,283,190.00	$60,393,542.00	$ 79,676,732	0.068939
29	6000 LABORATORY	$39,138,876.00	$ -	$0.00		$ 39,138,876	$176,677,326.00	$206,606,828.00	$ 383,284,154	0.102115
30	6500 RESPIRATORY THERAPY	$14,200,326.00	$ -	$0.00		$ 14,200,326	$108,374,364.00	$13,583,255.00	$ 121,957,619	0.116437
31	6600 PHYSICAL THERAPY	$18,966,629.00	$ -	$0.00		$ 18,966,629	$20,559,705.00	$21,898,060.00	$ 42,457,765	0.446718

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	6900	ELECTROCARDIOLOGY	$32,643,771.00	$ -	$0.00		$ 32,643,771	$96,961,492.00	$156,040,928.00	$ 253,002,420	0.129026
33	7000	ELECTROENCEPHALOGRAPHY	$3,302,242.00	$ -	$0.00		$ 3,302,242	$2,334,700.00	$11,806,736.00	$ 14,141,436	0.233515
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$78,067,686.00	$ -	$0.00		$ 78,067,686	$162,966,228.00	$88,180,044.00	$ 251,146,272	0.310845
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$70,275,946.00	$ -	$0.00		$ 70,275,946	$170,378,273.00	$78,834,598.00	$ 249,212,871	0.281992
36	7300	DRUGS CHARGED TO PATIENTS	$69,468,132.00	$ -	$0.00		$ 69,468,132	$332,627,589.00	$195,678,625.00	$ 528,306,214	0.131492
37	7400	RENAL DIALYSIS	$3,031,262.00	$ -	$0.00		$ 3,031,262	$13,325,740.00	$1,669,189.00	$ 14,994,929	0.202152
38	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	$87,961.00	$ -	$0.00		$ 87,961	$114,882.00	$0.00	$ 114,882	0.765664
39	7601	WOUND CARE CLINIC	$2,592,695.00	$ -	$0.00		$ 2,592,695	$139,943.00	$9,160,125.00	$ 9,300,068	0.278782
40	7602	DIABETIC EDUCATION	$949,913.00	$ -	$0.00		$ 949,913	$1,000.00	$213,325.00	$ 214,325	4.432115
41	9100	EMERGENCY	$43,451,812.00	$ -	$0.00		$ 43,451,812	$38,999,191.00	$147,670,142.00	$ 186,669,333	0.232774
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 539,276,209	$ -	$ -		$ 539,276,209	$ 1,636,150,468	$ 1,792,697,983	$ 3,428,848,451	
127		**Weighted Average**									0.160429
128		**Sub Totals**	$ 769,032,695	$ -	$ -		$ 769,032,695	$ 1,880,572,418	$ 1,792,697,983	$ 3,673,270,401	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$389,108.00				
131		NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 768,643,587				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2016-09/30/2017 | NORTHEAST GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,014.09		12,929		8,120		9,065		8,716		8,763		38,830		32.68%
2	03100 INTENSIVE CARE UNIT	$ 1,923.06		2,332		284		1,485		1,377		1,399		5,478		47.29%
3	03200 CORONARY CARE UNIT	$ 1,884.71		377		61		399		196		425		1,033		12.70%
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,267.77		2,911		8,372		-		1,319		355		12,602		77.13%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	18,549		16,837		10,949		11,608		10,942		57,943		34.59%
19	Total Days per PS&R or Exhibit Detail			18,549		16,837		10,949		11,608		10,942				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 22,086,698		$ 20,424,349		$ 16,026,173		$ 14,861,269		$ 13,008,651		$ 73,398,489		35.41%
21.01	Calculated Routine Charge Per Dien			$ 1,190.72		$ 1,213.06		$ 1,463.71		$ 1,280.26		$ 1,188.87		$ 1,266.74		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.526679	446,790	1,271,892	269,167	1,347,344	403,890	2,217,288	180,502	442,637	467,133	2,288,292	$ 1,300,349	$ 5,279,161	45.52%
23	5000 OPERATING ROOM		0.150557	14,398,708	6,521,937	11,564,371	12,784,669	14,789,980	12,984,747	9,937,816	3,207,114	10,873,660	10,838,942	$ 50,690,875	$ 35,498,467	22.95%
24	5200 DELIVERY ROOM & LABOR ROOM		0.269322	2,085,558	84,172	7,176,594	1,405,230	6,048	10,618	2,715,318	347,440	144,552	180,838	$ 11,983,518	$ 1,847,460	25.32%
25	5300 ANESTHESIOLOGY		0.035107	3,976,837	1,550,347	5,397,960	3,836,323	3,799,955	2,709,566	3,302,222	720,563	2,907,551	2,654,855	$ 16,476,974	$ 8,816,799	24.61%
26	5400 RADIOLOGY-DIAGNOSTIC		0.179166	3,149,099	7,156,244	1,024,785	6,702,614	2,939,973	8,334,526	1,330,850	1,792,638	2,633,948	11,188,720	$ 8,444,707	$ 23,986,022	23.07%
27	5401 VASCULAR LAB		0.144976	645,325	650,009	91,021	278,561	604,967	1,288,197	391,464	166,560	441,434	825,773	$ 1,732,777	$ 2,383,327	30.75%
28	5500 RADIOLOGY-THERAPEUTIC		0.198384	-	-	33,081	1,303,939	363,910	5,989,286	171,156	1,435,922	156,507	1,610,412	$ 568,147	$ 8,729,147	13.36%
29	5700 CT SCAN		0.038417	7,745,080	8,340,331	859,631	9,775,349	7,441,848	11,978,373	2,168,221	2,106,924	8,927,881	31,431,647	$ 18,214,780	$ 32,200,977	28.35%
30	5800 MRI		0.068939	1,607,180	1,701,130	221,897	2,640,939	1,566,290	3,033,326	557,122	491,923	1,545,084	2,509,011	$ 3,952,489	$ 7,867,318	19.93%
31	6000 LABORATORY		0.102115	18,579,571	9,330,424	6,843,361	13,625,532	15,933,345	9,573,210	8,499,987	4,868,535	14,514,998	23,719,631	$ 49,856,264	$ 37,397,700	32.77%
32	6500 RESPIRATORY THERAPY		0.116437	9,050,716	246,671	3,296,497	399,495	7,106,284	418,007	4,078,593	60,385	3,509,695	533,125	$ 23,532,090	$ 1,124,558	23.56%
33	6600 PHYSICAL THERAPY		0.446718	1,192,904	220,342	320,904	2,899,540	1,059,822	607,264	895,177	856,037	634,739	1,014,992	$ 3,468,807	$ 4,583,183	22.86%
34	6900 ELECTROCARDIOLOGY		0.129026	5,162,582	2,463,533	776,644	1,660,313	6,474,656	7,676,208	2,302,734	1,071,702	6,842,335	7,315,468	$ 14,716,616	$ 12,871,756	16.53%
35	7000 ELECTROENCEPHALOGRAPHY		0.233515	354,863	730,625	78,174	553,327	232,964	642,938	135,601	103,126	173,829	266,211	$ 801,602	$ 2,030,016	23.15%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.310845	9,515,502	1,612,780	4,241,925	3,464,067	11,156,142	4,449,765	6,551,916	930,594	6,676,317	3,838,061	$ 31,465,485	$ 10,457,206	20.91%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.281992	6,430,887	186,461	1,618,827	1,107,256	10,873,169	6,085,110	3,250,291	547,310	3,985,333	1,585,777	$ 22,173,174	$ 7,926,137	14.34%
38	7300 DRUGS CHARGED TO PATIENTS		0.131492	33,296,884	8,819,852	9,992,982	8,270,529	23,753,145	14,617,867	14,022,591	2,117,069	22,768,161	18,982,864	$ 81,065,603	$ 33,825,317	29.68%
39	7400 RENAL DIALYSIS		0.202152	850,176	-	52,559	-	1,303,148	313,572	1,421,867	38,114	320,522	666,133	$ 3,627,750	$ 351,686	33.17%
40	7501 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.765664	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
41	7601 WOUND CARE CLINIC		0.278782	24,830	622	39,360	2,710	-	16,338	5,904	25,833	492	153,376	$ 70,094	$ 45,503	2.90%
42	7602 DIABETIC EDUCATION		4.432115	-	-	-	8,890	-	9,026	240	9,026	-	17,580	$ 240	$ 26,942	20.89%
43	9100 EMERGENCY		0.232774	3,324,082	7,437,757	1,331,121	21,730,040	3,082,729	6,553,141	1,900,080	2,144,777	3,509,866	30,953,581	$ 9,638,012	$ 37,865,715	43.95%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2016-09/30/2017 | NORTHEAST GEORGIA MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
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124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 121,837,574	$ 58,325,129	$ 55,230,862	$ 93,796,667	$ 112,892,266	$ 99,508,373	$ 63,819,652	$ 23,484,229	$ 91,034,038	$ 152,575,289			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 143,924,272	$ 58,325,129	$ 75,655,211	$ 93,796,667	$ 128,918,439	$ 99,508,373	$ 78,680,921	$ 23,484,229	$ 104,042,689 (Agrees to Exhibit A)	$ 152,575,289 (Agrees to Exhibit A)	$ 427,178,843	$ 275,114,398	26.14%
129	Total Charges per PS&R or Exhibit Detail			$ 143,924,272	$ 58,325,129	$ 75,655,211	$ 93,796,667	$ 128,918,439	$ 99,508,373	$ 78,680,921	$ 23,484,229	$ 104,042,689	$ 152,575,289			
130	Unreconciled Charges (Explain Variance			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 40,502,392	$ 8,556,511	$ 28,531,150	$ 15,856,606	$ 30,911,522	$ 15,850,918	$ 24,018,830	$ 3,904,988	$ 26,041,229	$ 22,343,803	$ 123,963,894	$ 44,169,023	28.20%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 32,421,703	$ 8,497,472			$ 2,126,551	$ 1,220,856	$ 842,829	$ 277,898			$ 35,391,083	$ 9,996,226	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)					$ 14,784,289	$ 12,826,072			$ 36,542	$ 54,097			$ 14,820,831	$ 12,880,169	
134	Private Insurance (including primary and third party liability)			$ 168,481	$ 13,650	$ 2,335,317	$ 834,169	$ 10,020	$ 33,616	$ 15,856,005	$ 5,338,731			$ 18,369,823	$ 6,220,166	
135	Self-Pay (including Co-Pay and Spend-Down)				$ 19,677	$ 4,821	$ 14,090			$ 3,057	$ 9,072			$ 7,878	$ 42,839	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 32,590,184	$ 8,530,799	$ 17,124,427	$ 13,674,331									
137	Medicaid Cost Settlement Payments (See Note B)				$ (348,966)									$ -	$ (348,966)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 23,452,718	$ 10,944,562	$ 8,791,798	$ 575,134			$ 32,244,516	$ 11,519,696	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 162,059	$ 30,018			$ 162,059	$ 30,018	
141	Medicare Cross-Over Bad Debt Payments													$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 693,560	$ 2,245,284			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 7,912,208	$ 374,678	$ 11,406,723	$ 2,182,275	$ 5,322,233	$ 3,651,884	$ (1,673,460)	$ (2,379,962)	$ 25,347,669	$ 20,098,519	$ 22,967,704	$ 3,828,875	
146	**Calculated Payments as a Percentage of Cost**			80%	96%	60%	86%	83%	77%	107%	161%	3%	10%	81%	91%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**							91,888								
148	**Percent of cross-over days to total Medicare days from the cost report**							12%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with s
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include*all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payn

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,014.09								95		95	
2	03100 INTENSIVE CARE UNIT	$ 1,923.06								10		10	
3	03200 CORONARY CARE UNIT	$ 1,884.71								1		1	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,267.77										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		106		106	
19	Total Days per PS&R or Exhibit Detail			-		-		-		106			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 133,670		$ 133,670	
21.01	Calculated Routine Charge Per Dien			$ -		$ -		$ -		$ 1,261.04		$ 1,261.04	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.526679							-	8,712	$ -	$ 8,712
23	5000 OPERATING ROOM		0.150557							181,647	18,914	$ 181,647	$ 18,914
24	5200 DELIVERY ROOM & LABOR ROOM		0.269322							-	289	$ -	$ 289
25	5300 ANESTHESIOLOGY		0.035107							64,389	-	$ 64,389	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.179166							8,417	21,882	$ 8,417	$ 21,882
27	5401 VASCULAR LAB		0.144976							4,941	-	$ 4,941	$ -
28	5500 RADIOLOGY-THERAPEUTIC		0.198384							-	-	$ -	$ -
29	5700 CT SCAN		0.038417							15,209	28,647	$ 15,209	$ 28,647
30	5800 MRI		0.068939							7,148	-	$ 7,148	$ -
31	6000 LABORATORY		0.102115							96,127	31,423	$ 96,127	$ 31,423
32	6500 RESPIRATORY THERAPY		0.116437							29,094	640	$ 29,094	$ 640
33	6600 PHYSICAL THERAPY		0.446718							3,615	(360)	$ 3,615	$ (360)
34	6900 ELECTROCARDIOLOGY		0.129026							56,265	18,147	$ 56,265	$ 18,147
35	7000 ELECTROENCEPHALOGRAPHY		0.233515							1,439	-	$ 1,439	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.310845							70,578	2,294	$ 70,578	$ 2,294
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.281992							39,587	23,102	$ 39,587	$ 23,102
38	7300 DRUGS CHARGED TO PATIENTS		0.131492							139,439	21,995	$ 139,439	$ 21,995
39	7400 RENAL DIALYSIS		0.202152							7,473	-	$ 7,473	$ -
40	7501 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.765664							-	-	$ -	$ -
41	7601 WOUND CARE CLINIC		0.278782							-	-	$ -	$ -
42	7602 DIABETIC EDUCATION		4.432115							-	-	$ -	$ -
43	9100 EMERGENCY		0.232774							22,695	45,046	$ 22,695	$ 45,046
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
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80			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
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127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ 748,063	$ 220,731		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 881,733	$ 220,731	$ 881,733	$ 220,731		
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ 881,733	$ 220,731				
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-				
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 231,009	$ 38,604	$ 231,009	$ 38,604		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)							$ 1,315	$ 282	$ 1,315	$ 282		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -		
134	Private Insurance (including primary and third party liability)							$ 27,827	$ 47,164	$ 27,827	$ 47,164		
135	Self-Pay (including Co-Pay and Spend-Down)								$ (2,445)	$ -	$ (2,445)		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -								
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -		
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -		
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 123,095	$ 19,299	$ 123,095	$ 19,299		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 62,659		$ 62,659	$ -		
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -		
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -		
143	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,113	$ (25,696)	$ 16,113	$ (25,696)		
144	**Calculated Payments as a Percentage of Cos**	0%	0%	0%	0%	0%	0%	93%	167%	93%	167%		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

			Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																
1		Lung Acquisition	$0.00	$ -	$ -		0										
2		Kidney Acquisition	$0.00	$ -	$ -		0										
3		Liver Acquisition	$0.00	$ -	$ -		0										
4		Heart Acquisition	$0.00	$ -	$ -		0										
5		Pancreas Acquisition	$0.00	$ -	$ -		0										
6		Intestinal Acquisition	$0.00	$ -	$ -		0										
7		Islet Acquisition	$0.00	$ -	$ -		0										
8			$0.00	$ -	$ -		0										
9		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10		**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

			Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):														
11		Lung Acquisition	$ -	$ -	$ -	$ -	0								
12		Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13		Liver Acquisition	$ -	$ -	$ -	$ -	0								
14		Heart Acquisition	$ -	$ -	$ -	$ -	0								
15		Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16		Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17		Islet Acquisition	$ -	$ -	$ -	$ -	0								
18			$ -	$ -	$ -	$ -	0								
19		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20		**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 9,179,607		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	208001/258001-69760	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 9,179,607	5.05	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 9,179,607		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -	

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*