State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

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	10/01/2018	09/30/2019	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	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 (07/01/18 - 06/30/19)
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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 11,748,399
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2018 - 06/30/2019** — $ 11,748,399

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	CFO - Northeast Georgia Health System Title	10/27/2020 Date
Brian D. Steines, MBA, CPA Hospital CEO or CFO Printed Name	770-219-7246 Hospital CEO or CFO Telephone Number	Brian.Steines@nghs.com Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Steven Slusser
Title	Director of Reimbursement
Telephone Number	770-219-3030
E-Mail Address	Steven.Slusser@nghs.com
Mailing Street Address	743 Spring Street, NE
Mailing City, State, Zip	Gainesville, GA 30501-3715

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

DSH Version 8.00 3/31/2020

D. General Cost Report Year Information 10/1/2018 - 9/30/2019

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		
		10/1/2018 through 9/30/2019		
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:	3/5/2020		

		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	Yes	
7.	Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8.	Medicare Provider Number:	110029	Yes	
	Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
	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		
14.	State Name & Number		
15.	State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2018 - 09/30/2019)

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)	$ 1,233,338	$ 4,342,096	$5,575,434
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,804,612	$ 36,230,340	$45,034,952
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)	$10,037,950	$40,572,436	$50,610,386
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.29%	10.70%	11.02%

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 (10/01/2018 - 09/30/2019)

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)	195,037	**(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	125,134,006
8.	Outpatient Hospital Charity Care Charges	139,707,205
9.	Non-Hospital Charity Care Charges	4,135,550
10.	Total Charity Care Charges	$ 268,976,761

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)			
11.	Hospital	$355,987,779.00			$ 272,024,814	$ -	$ -	$ 83,962,965
12.	Subprovider I (Psych or Rehab)	$21,734,841.00			$ 16,608,480	$ -	$ -	$ 5,126,361
13.	Subprovider II (Psych or Rehab)	$7,276,634.00			$ 5,560,373	$ -	$ -	$ 1,716,261
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$18,192,968.00			$ 13,901,991	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$1,984,183,757.00	$2,095,440,488.00		$ 1,516,195,917	$ 1,601,211,733	$ -	$ 962,216,595
20.	Outpatient Services		$355,913,342.00			$ 271,967,933	$ -	$ 83,945,409
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$19,822,425.00			$ 15,147,125	
26.	Other	$25,550,168.00	$5,715,991.00	$0.00	$ 19,523,928	$ 4,367,822	$ -	$ 7,374,409
27.	Total	$ 2,394,733,179	$ 2,457,069,821	$ 38,015,393	$ 1,829,913,512	$ 1,877,547,489	$ 29,049,116	$ 1,144,341,999

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	4,889,818,393	Total Contractual Adj. (G-3 Line 2)	3,729,153,800
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)			+	7,356,317
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				3,736,510,117
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) | 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	$ 160,335,718	$ -	$ -	$0.00	$ 160,335,718	150,949	$269,566,315.00		$ 1,062.18
2	03100	INTENSIVE CARE UNIT	$ 54,460,877	$ 826,697	$ -		$ 55,287,574	25,335	$86,421,464.00		$ 2,182.26
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
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	$ 17,330,114	$ -	$ -		$ 17,330,114	11,006	$21,734,841.00		$ 1,574.61
8	04100	SUBPROVIDER II	$ 5,176,976	$ -	$ -		$ 5,176,976	5,153	$7,276,634.00		$ 1,004.65
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 23,102,236	$ -	$ -		$ 23,102,236	18,451	$23,248,234.00		$ 1,252.09
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 260,405,921	$ 826,697	$ -	$ -	$ 261,232,618	210,894	$ 408,247,488		
19		Weighted Average									$ 1,238.69

		Observation Data (Non-Distinct)	*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*
20	09200	Observation (Non-Distinct)	15,857	-	-	$ 16,842,988	$7,725,280.00	$22,719,440.00	$ 30,444,720	0.553232

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5000	OPERATING ROOM	$82,891,067.00	$ 1,103,641	$0.00		$ 83,994,708	$265,978,824.00	$364,149,869.00	$ 630,128,693	0.133298
22	5200	DELIVERY ROOM & LABOR ROOM	$17,745,417.00	$ -	$0.00		$ 17,745,417	$52,987,069.00	$4,568,931.00	$ 57,556,000	0.308316
23	5300	ANESTHESIOLOGY	$4,437,140.00	$ -	$0.00		$ 4,437,140	$93,024,726.00	$96,901,451.00	$ 189,926,177	0.023362
24	5400	RADIOLOGY-DIAGNOSTIC	$36,117,536.00	$ -	$0.00		$ 36,117,536	$44,516,531.00	$189,365,636.00	$ 233,882,167	0.154426
25	5401	VASCULAR LAB	$423,339.00	$ -	$0.00		$ 423,339	$10,822.00	$956,913.00	$ 967,735	0.437453
26	5500	RADIOLOGY-THERAPEUTIC	$16,016,218.00	$ -	$0.00		$ 16,016,218	$2,276,398.00	$112,014,546.00	$ 114,290,944	0.140135
27	5700	CT SCAN	$13,273,267.00	$ -	$0.00		$ 13,273,267	$123,349,417.00	$258,973,695.00	$ 382,323,112	0.034717
28	5800	MRI	$6,683,941.00	$ -	$0.00		$ 6,683,941	$22,982,221.00	$69,049,313.00	$ 92,031,534	0.072627
29	6000	LABORATORY	$43,477,824.00	$ -	$0.00		$ 43,477,824	$226,079,204.00	$229,559,794.00	$ 455,638,998	0.095422
30	6500	RESPIRATORY THERAPY	$15,048,384.00	$ -	$0.00		$ 15,048,384	$130,708,932.00	$23,434,192.00	$ 154,143,124	0.097626

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) 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
31	6600	PHYSICAL THERAPY	$20,414,470.00	$ -	$0.00		$ 20,414,470	$29,455,744.00	$25,545,951.00	$ 55,001,695	0.371161
32	6900	ELECTROCARDIOLOGY	$43,083,410.00	$ -	$0.00		$ 43,083,410	$146,366,578.00	$220,546,503.00	$ 366,913,081	0.117421
33	7000	ELECTROENCEPHALOGRAPHY	$4,371,232.00	$ -	$0.00		$ 4,371,232	$2,427,129.00	$14,282,091.00	$ 16,709,220	0.261606
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$90,208,745.00	$ -	$0.00		$ 90,208,745	$248,893,719.00	$147,241,736.00	$ 396,135,455	0.227722
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$91,527,527.00	$ -	$0.00		$ 91,527,527	$194,524,726.00	$120,413,182.00	$ 314,937,908	0.290621
36	7300	DRUGS CHARGED TO PATIENTS	$84,644,016.00	$ -	$0.00		$ 84,644,016	$380,205,403.00	$203,063,049.00	$ 583,268,452	0.145120
37	7400	RENAL DIALYSIS	$4,477,440.00	$ -	$0.00		$ 4,477,440	$20,130,400.00	$4,631,049.00	$ 24,761,449	0.180823
38	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	$88,924.00	$ -	$0.00		$ 88,924	$111,804.00	$0.00	$ 111,804	0.795356
39	7601	WOUND CARE CLINIC	$2,539,441.00	$ -	$0.00		$ 2,539,441	$153,484.00	$10,503,003.00	$ 10,656,487	0.238300
40	7602	DIABETIC EDUCATION	$1,349,629.00	$ -	$0.00		$ 1,349,629	$627.00	$239,584.00	$ 240,211	5.618515
41	9100	EMERGENCY	$61,410,736.00	$ 950,112	$0.00		$ 62,360,848	$84,053,995.00	$241,414,627.00	$ 325,468,622	0.191603
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) 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
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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**	$ 640,229,703	$ 2,053,753	$ -		$ 642,283,456	$ 2,075,963,033	$ 2,359,574,555	$ 4,435,537,588	
127		**Weighted Average**									0.148601
128		**Sub Totals**	$ 900,635,624	$ 2,880,450	$ -		$ 903,516,074	$ 2,484,210,521	$ 2,359,574,555	$ 4,843,785,076	
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)*					$416,740.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 903,099,334				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.32%				

* 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 (10/01/2018-09/30/2019) 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	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	$ 1,062.18		14,812		6,441		9,034		8,250		9,496		38,537		35.64%
2	03100 INTENSIVE CARE UNIT	$ 2,182.26		3,100		369		2,345		1,298		1,661		7,112		34.98%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ 1,574.61				1,393				1,015		897		2,408		30.25%
8	04100 SUBPROVIDER II	$ 1,004.65												-		0.00%
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,252.09		2,478		8,116				1,773		226		12,367		68.25%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	20,390		16,319		11,379		12,336		12,280		60,424		34.58%
19	Total Days per PS&R or Exhibit Detail			20,390		16,319		11,379		12,336		12,280				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 30,122,103		$ 24,265,984		$ 17,747,718		$ 19,752,454		$ 19,379,312		$ 91,888,259		27.37%
21.01	Calculated Routine Charge Per Diem			$ 1,477.30		$ 1,486.98		$ 1,559.69		$ 1,601.20		$ 1,578.12		$ 1,520.72		
	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)		0.553232	2,053,648	1,412,369	856,346	1,786,114	1,908,749	3,120,567	500,006	582,625	1,061,155	3,174,911	$ 5,318,749	$ 6,901,675	54.19%
23	5000 OPERATING ROOM		0.133298	17,192,673	10,903,462	14,300,301	19,220,040	13,499,032	16,018,837	11,640,163	5,104,944	17,649,995	20,059,361	$ 56,632,168	$ 51,247,283	23.17%
24	5200 DELIVERY ROOM & LABOR ROOM		0.308316	2,158,731	36,552	8,687,246	1,189,484	228,591	4,795	3,428,388	459,542	540,699	222,837	$ 14,502,956	$ 1,690,373	29.50%
25	5300 ANESTHESIOLOGY		0.023362	4,697,056	2,630,798	3,866,485	5,284,219	4,511,624	4,590,479	3,396,173	1,331,710	5,551,171	5,440,413	$ 16,471,338	$ 13,837,206	21.79%
26	5400 RADIOLOGY-DIAGNOSTIC		0.154426	3,341,701	6,989,612	1,405,040	9,304,812	2,735,486	8,414,573	1,940,998	2,451,787	3,301,928	13,029,937	$ 9,423,225	$ 27,160,784	22.69%
27	5401 VASCULAR LAB		0.437453	-	-	-	12,972	-	64,805	-	13,267	-	49,603	$ -	$ 91,044	14.58%
28	5500 RADIOLOGY-THERAPEUTIC		0.140135	-	-	48,211	2,092,320	1,006,735	4,953,768	74,150	1,923,195	30,032	2,150,603	$ 1,129,096	$ 8,969,283	10.74%
29	5700 CT SCAN		0.034717	8,882,399	8,540,314	2,110,597	13,013,620	8,215,109	11,873,047	4,751,759	3,499,840	10,698,175	33,718,522	$ 23,959,864	$ 36,926,821	27.66%
30	5800 MRI		0.072627	1,653,746	1,791,050	377,446	2,301,693	1,415,990	2,835,938	715,638	847,768	2,283,671	4,342,267	$ 4,162,820	$ 7,776,449	20.27%
31	6000 LABORATORY		0.095422	22,020,425	8,538,654	10,531,602	15,837,159	17,157,019	9,531,489	13,454,842	8,001,056	19,464,344	29,156,482	$ 63,163,887	$ 41,908,357	33.90%
32	6500 RESPIRATORY THERAPY		0.097626	11,083,742	306,984	4,644,326	752,683	7,297,102	651,752	6,882,330	245,738	3,951,347	823,137	$ 29,907,500	$ 1,957,157	24.05%
33	6600 PHYSICAL THERAPY		0.371161	1,967,454	469,760	368,464	1,605,529	1,333,699	882,583	911,872	409,882	631,362	1,735,984	$ 4,581,489	$ 3,367,754	18.79%
34	6900 ELECTROCARDIOLOGY		0.117421	7,448,616	4,121,991	1,891,155	2,882,989	7,373,991	9,627,044	3,953,571	2,040,171	10,725,169	12,776,338	$ 20,667,333	$ 18,672,195	17.21%
35	7000 ELECTROENCEPHALOGRAPHY		0.261606	208,402	670,730	793,881	1,222,236	185,868	849,402	92,373	196,090	197,452	914,632	$ 1,280,524	$ 2,938,458	31.95%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.227722	15,636,499	2,530,438	7,645,424	5,561,872	13,649,264	6,491,977	9,801,968	1,746,291	12,957,937	7,029,580	$ 46,733,155	$ 16,330,578	21.10%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.290621	7,180,273	282,748	2,353,024	1,897,625	9,925,289	5,929,602	3,813,242	1,032,548	5,825,942	3,506,647	$ 23,271,828	$ 9,142,522	13.27%
38	7300 DRUGS CHARGED TO PATIENTS		0.145120	37,899,529	11,344,652	16,069,676	15,627,785	26,536,548	16,077,422	21,751,881	4,603,640	31,951,409	32,282,790	$ 102,257,634	$ 47,653,498	36.91%
39	7400 RENAL DIALYSIS		0.180823	1,917,098	-	69,156	68,195	1,762,040	305,869	1,583,592	12,729	408,662	3,365,011	$ 5,331,886	$ 386,793	38.68%
40	7501 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.795356	-	-	36,707	-	-	-	2,464	-	1,232	-	$ 39,171	$ -	36.41%
41	7601 WOUND CARE CLINIC		0.238300	86,450	43,900	1,139	243,548	754	731,101	3,347	205,956	337	514,161	$ 91,690	$ 1,224,505	17.18%
42	7602 DIABETIC EDUCATION		5.618515	127	-	-	13,067	53	2,313	-	15,400	-	40,951	$ 180	$ 30,780	29.94%
43	9100 EMERGENCY		0.191603	4,034,600	8,245,537	2,005,731	25,711,809	3,403,611	6,684,970	3,352,800	3,190,560	5,462,290	37,330,741	$ 12,796,742	$ 43,832,876	30.71%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
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52			-											$ -	$ -	
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58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2018-09/30/2019) 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		%
61				-											$ -	$ -	-
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
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123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 149,463,167	$ 68,859,551	$ 78,061,957	$ 125,629,770	$ 122,146,553	$ 109,642,334	$ 92,051,556	$ 37,914,739	$ 132,694,310	$ 211,664,908			

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

Cost Report Year (10/01/2018-09/30/2019) NORTHEAST GEORGIA MEDICAL CENTER

	Totals / Payments	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		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 179,585,270	$ 68,859,551	$ 102,327,941	$ 125,629,770	$ 139,894,271	$ 109,642,334	$ 111,804,010	$ 37,914,739	$ 152,073,622 (Agrees to Exhibit A)	$ 211,664,908 (Agrees to Exhibit A)	$ 533,611,493	$ 342,046,393	25.70%
129	Total Charges per PS&R or Exhibit Detail	$ 179,585,270	$ 68,859,551	$ 102,327,941	$ 125,629,770	$ 139,894,271	$ 109,642,334	$ 111,804,010	$ 37,914,739	$ 152,073,622	$ 211,664,908			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 47,879,598	$ 9,387,111	$ 32,683,307	$ 18,390,133	$ 33,269,942	$ 16,322,056	$ 29,116,524	$ 5,358,119	$ 33,884,852	$ 29,112,223	$ 142,949,371	$ 49,457,419	28.40%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 33,438,995	$ 9,089,152			$ 2,664,749	$ 1,225,010	$ 363,409	$ 140,938			$ 36,467,153	$ 10,455,100	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 19,631,974	$ 15,271,030		$ 2,111	$ 608,438	$ 202,780			$ 20,240,412	$ 15,475,921	
134	Private Insurance (including primary and third party liability)	$ 302,176	$ 30,756	$ 155,832	$ 84,010	$ -	$ 6,672	$ 13,319,308	$ 5,498,702			$ 13,777,316	$ 5,620,140	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 18,865			$ -	$ -					$ -	$ 18,865	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 33,741,171	$ 9,138,773	$ 19,787,806	$ 15,355,040									
137	Medicaid Cost Settlement Payments (See Note B)		$ (500,229)									$ -	$ (500,229)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 13,241,838	$ 6,574,428	$ 7,849,088	$ 486,833			$ 21,090,926	$ 7,061,261	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 6,891,340	$ 3,839,388	$ 5,219,520	$ 1,670,243			$ 12,110,860	$ 5,509,631	
141	Medicare Cross-Over Bad Debt Payments					$ 326,379	$ 414,540					$ 326,379	$ 414,540	
142	Other Medicare Cross-Over Payments (See Note D)					$ 990,569	$ 474,977			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 990,569	$ 474,977	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,233,338	$ 4,342,096			
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)**	$ 14,138,427	$ 748,567	$ 12,895,501	$ 3,035,093	$ 9,155,067	$ 3,784,930	$ 1,756,761	$ (2,641,377)	$ 32,651,514	$ 24,770,127	$ 37,945,756	$ 4,927,213	
146	**Calculated Payments as a Percentage of Cost**	70%	92%	61%	83%	72%	77%	94%	149%	4%	15%	73%	90%	
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)**					100,099								
148	**Percent of cross-over days to total Medicare days from the cost report**					11%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) 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	$ 1,062.18		75						42		117	
2	03100 INTENSIVE CARE UNIT	$ 2,182.26		76						13		89	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ 1,574.61		15						9		24	
8	04100 SUBPROVIDER II	$ 1,004.65										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,252.09										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	166		-		-		64		230	
19	Total Days per PS&R or Exhibit Detail			166		-		-		64			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 338,591						$ 113,190		$ 451,781	
21.01	Calculated Routine Charge Per Diem			$ 2,039.70		$ -		$ -		$ 1,768.59		$ 1,964.27	
	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)		0.553232	10,767	25,360					3,973	1,200	$ 14,740	$ 26,560
23	5000 OPERATING ROOM		0.133298	202,731	57,206					86,425	45,872	$ 289,156	$ 103,078
24	5200 DELIVERY ROOM & LABOR ROOM		0.308316	18,865	698					-	-	$ 18,865	$ 698
25	5300 ANESTHESIOLOGY		0.023362	40,824	15,176					24,412	13,288	$ 65,236	$ 28,464
26	5400 RADIOLOGY-DIAGNOSTIC		0.154426	28,845	93,726					10,224	14,861	$ 39,069	$ 108,587
27	5401 VASCULAR LAB		0.437453	-	429					-	-	$ -	$ 429
28	5500 RADIOLOGY-THERAPEUTIC		0.140135	-	1,368					-	-	$ -	$ 1,368
29	5700 CT SCAN		0.034717	143,741	241,830					39,030	38,921	$ 182,771	$ 280,751
30	5800 MRI		0.072627	23,678	43,686					17,929	2,565	$ 41,607	$ 46,251
31	6000 LABORATORY		0.095422	466,995	221,255					74,984	22,459	$ 541,979	$ 243,714
32	6500 RESPIRATORY THERAPY		0.097626	382,157	19,322					25,154	-	$ 407,311	$ 19,322
33	6600 PHYSICAL THERAPY		0.371161	11,894	1,212					4,996	637	$ 16,890	$ 1,849
34	6900 ELECTROCARDIOLOGY		0.117421	202,301	67,139					20,280	22,798	$ 222,581	$ 89,937
35	7000 ELECTROENCEPHALOGRAPHY		0.261606	5,384	-					1,954	-	$ 7,338	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.227722	413,391	25,597					60,734	14,208	$ 474,126	$ 39,806
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.290621	47,586	5,781					492	1,630	$ 48,078	$ 7,411
38	7300 DRUGS CHARGED TO PATIENTS		0.145120	799,094	225,362					105,747	27,276	$ 904,841	$ 252,638
39	7400 RENAL DIALYSIS		0.180823	85,431	87					-	-	$ 85,431	$ 87
40	7501 PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.795356	308	-					-	-	$ 308	$ -
41	7601 WOUND CARE CLINIC		0.238300	-	-					-	-	$ -	$ -
42	7602 DIABETIC EDUCATION		5.618515	-	-					-	-	$ -	$ -
43	9100 EMERGENCY		0.191603	89,597	403,303					16,266	21,944	$ 105,863	$ 425,247
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) 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	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
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106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) 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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 2,973,590	$ 1,448,537	$ -	$ -	$ -	$ -	$ 492,600	$ 227,659		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 3,312,181	$ 1,448,537	$ -	$ -	$ -	$ -	$ 605,790	$ 227,659	$ 3,917,971	$ 1,676,197
129	Total Charges per PS&R or Exhibit Detail	$ 3,312,181	$ 1,448,537	$ -	$ -	$ -	$ -	$ 605,790	$ 227,659		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 688,289	$ 197,482	$ -	$ -	$ -	$ -	$ 152,471	$ 27,850	$ 840,760	$ 225,332
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 15,601	$ 36,662						$ 253	$ 15,601	$ 36,915
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 10,276	$ 2,944							$ 10,276	$ 2,944
134	Private Insurance (including primary and third party liability)	$ 173,070	$ 35,467						$ 31,618	$ 173,070	$ 67,085
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 198,947	$ 75,073	$ -	$ -						
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)							$ 81,185	$ 11,593	$ 81,185	$ 11,593
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 28,982	$ 1,768	$ 28,982	$ 1,768
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 489,342	$ 122,409	$ -	$ -	$ -	$ -	$ 42,304	$ (17,382)	$ 531,646	$ 105,027
144	**Calculated Payments as a Percentage of Cost**	29%	38%	0%	0%	0%	0%	72%	162%	37%	53%

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 (10/01/2018-09/30/2019) 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 Acquisition 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 (10/01/2018-09/30/2019) 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 Acquisition 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 (10/01/2018-09/30/2019) 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)*		$ 12,148,505		
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)		$ 12,148,505	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		$ 12,148,505		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	881,252,054
19	Uninsured Hospital	**Charges Sec. G**	363,738,529
20	Total Hospital	**Charges Sec. G**	4,843,785,076
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		18.19%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.51%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*