EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.00	1/28/2021

D. General Cost Report Year Information 10/1/2019 - 9/30/2020

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 MC BARROW**

	10/1/2019 through 9/30/2020		
2. Select Cost Report Year Covered by this Survey:	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: 5/4/2021

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Northeast Georgia MC BARROW	No	NGMC Barrow
5. Medicaid Provider Number:	000002098A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110045	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: (10/01/2019 - 09/30/2020)

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)	$ 9,614	$ 288,298	$297,912
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 91,523	$ 1,534,059	$1,625,582
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$101,137	$1,822,357	$1,923,494
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.51%	15.82%	15.49%

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 (10/01/2019 - 09/30/2020)

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)	5,456

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	4,194,104
8.	Outpatient Hospital Charity Care Charges	12,650,706
9.	Non-Hospital Charity Care Charges	10,486
10.	Total Charity Care Charges	$ 16,855,296

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 14,869,390	$ -	$ -	$ 12,365,514	$ -	$ -	$ 2,503,876
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 31,662,029	$ 107,382,923	$ -	$ 26,330,419	$ 89,300,575	$ -	$ 23,413,958
20.	Outpatient Services		$ 41,138,632	$ -		$ 34,211,245	$ -	$ 6,927,387
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 72,150	$ 310,250	$ -	$ 60,001	$ 258,007	$ -	$ 64,393

28.	Total Hospital and Non Hospital	Total from Above	$ 195,435,374		Total from Above	$ 162,525,761	
29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 195,435,374		Total Contractual Adj. (G-3 Line 2)	$ 162,525,761	
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)					+ $ -	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+ $ -	
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.	Adjusted Contractual Adjustments					162,525,761	
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) | Northeast Georgia MC BARROW

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net 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	$ 8,202,521	$ -	$ -	$ -	**$ 8,202,521**	6,595	$ 13,050,584		**$ 1,243.75**
2	03100 INTENSIVE CARE UNIT	$ 1,669,794	$ -	$ -		**$ 1,669,794**	486	$ 1,818,806		**$ 3,435.79**
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	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 9,872,315	$ -	$ -	$ -	$ 9,872,315	7,081	$ 14,869,390		
19	Weighted Average									$ 1,394.20

			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)		1,625	-	-	**$ 2,021,094**	$ 775,521	$ 2,539,698	$ 3,315,219	**0.609641**

		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	$ 4,362,452	$ -	$ -		**$ 4,362,452**	$ 1,150,026	$ 5,927,846	$ 7,077,872	**0.616351**
22	5300 ANESTHESIOLOGY	$ 729,637	$ -	$ -		**$ 729,637**	$ 652,316	$ 7,413,654	$ 8,065,970	**0.090459**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 1,965,211	$ -	$ -		**$ 1,965,211**	$ 492,674	$ 6,262,943	$ 6,755,617	**0.290900**
24	5401 ULTRASOUND	$ 736,447	$ -	$ -		**$ 736,447**	$ 1,680,653	$ 5,452,670	$ 7,133,323	**0.103240**
25	5600 RADIOISOTOPE	$ 786,829	$ -	$ -		**$ 786,829**	$ 442,260	$ 2,670,988	$ 3,113,248	**0.252736**
26	5700 CT SCAN	$ 797,786	$ -	$ -		**$ 797,786**	$ 4,689,213	$ 34,408,565	$ 39,097,778	**0.020405**
27	5800 MRI	$ 773,072	$ -	$ -		**$ 773,072**	$ 495,475	$ 4,178,811	$ 4,674,286	**0.165388**
28	6000 LABORATORY	$ 3,279,378	$ -	$ -		**$ 3,279,378**	$ 5,314,698	$ 14,379,453	$ 19,694,151	**0.166515**
29	6500 RESPIRATORY THERAPY	$ 1,800,458	$ -	$ -		**$ 1,800,458**	$ 4,409,659	$ 5,017,676	$ 9,427,335	**0.190983**
30	6600 PHYSICAL THERAPY	$ 342,518	$ -	$ -		**$ 342,518**	$ 549,224	$ 124,667	$ 673,891	**0.508269**
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 2,160,874	$ -	$ -		**$ 2,160,874**	$ 3,007,207	$ 3,088,032	$ 6,095,239	**0.354518**
32	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 2,341,593	$ -	$ -		**$ 2,341,593**	$ 730,791	$ 5,257,361	$ 5,988,152	**0.391038**
33	7300 DRUGS CHARGED TO PATIENTS	$ 4,070,422	$ -	$ -		**$ 4,070,422**	$ 7,890,165	$ 10,705,259	$ 18,595,424	**0.218894**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) Northeast Georgia MC BARROW

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net 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
34	7600 WOUND CARE	$ 986,421	$ -	$ -	**$ 986,421**	$ 157,668	$ 2,494,999	$ 2,652,667	**0.371860**
35	9100 EMERGENCY	$ 7,434,179	$ -	$ -	**$ 7,434,179**	$ 3,593,179	$ 34,230,234	$ 37,823,413	**0.196550**
126	**Total Ancillary**	$ 32,567,277	$ -	$ -	$ 32,567,277	$ 36,030,729	$ 144,152,856	$ 180,183,585	
127	**Weighted Average**								**0.191962**
128	**Sub Totals**	$ 42,439,592	$ -	$ -	$ 42,439,592	$ 50,900,119	$ 144,152,856	$ 195,052,975	
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)				$ -				
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)				$ -				
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**				**$ 42,439,592**				
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 (10/01/2019-09/30/2020) | Northeast Georgia MC BARROW

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	$ 1,243.75		680		103		414		546		520		**1,743**		45.71%
2	03100 INTENSIVE CARE UNIT	$ 3,435.79		59		8		36		25		72		**128**		41.36%
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	$ -		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300 NURSERY	$ -		-		-		-		-		-		-		
18			**Total Days**	739		111		450		571		592		1,871		45.33%
19	Total Days per PS&R or Exhibit Detail			739		111		450		571		592				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,112,123		$ 165,093		$ 675,098		$ 829,714		$ 924,584		$ 2,782,028		25.03%
21.01	Calculated Routine Charge Per Diem			$ 1,504.90		$ 1,487.32		$ 1,500.22		$ 1,453.09		$ 1,561.80		$ 1,486.92		
	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)		0.609641	$ 113,125	$ 353,807	$ 25,245	$ 95,370	$ 104,210	$ 249,305	$ 54,145	$ 92,650	$ 151,980	$ 455,685	$ 296,725	$ 791,132	51.54%
23	5000 OPERATING ROOM		0.616351	$ 156,304	$ 889,324	$ 63,687	$ 672,828	$ 178,604	$ 503,782	$ 118,934	$ 225,836	$ 44,999	$ 237,259	$ 517,529	$ 2,291,770	43.98%
24	5300 ANESTHESIOLOGY		0.090459	$ 42,209	$ 231,564	$ 41,797	$ 997,883	$ 94,329	$ 350,386	$ 34,118	$ 182,167	$ 20,914	$ 202,009	$ 212,453	$ 1,762,000	27.42%
25	5400 RADIOLOGY-DIAGNOSTIC		0.290900	$ 87,156	$ 485,382	$ 17,316	$ 809,793	$ 90,307	$ 467,261	$ 64,197	$ 225,096	$ 93,720	$ 1,077,208	$ 258,976	$ 1,987,532	50.87%
26	5401 ULTRASOUND		0.103240	$ 148,197	$ 217,044	$ 23,098	$ 296,807	$ 174,580	$ 261,387	$ 86,338	$ 62,389	$ 201,464	$ 459,846	$ 432,213	$ 837,627	27.30%
27	5600 RADIOISOTOPE		0.252736	$ 36,804	$ 174,005	$ -	$ 67,481	$ 54,639	$ 202,836	$ 11,270	$ 50,520	$ 63,676	$ 301,488	$ 102,713	$ 494,842	31.21%
28	5700 CT SCAN		0.020405	$ 440,882	$ 2,111,192	$ 133,858	$ 2,819,644	$ 583,065	$ 2,440,597	$ 253,019	$ 512,774	$ 745,347	$ 6,521,625	$ 1,410,825	$ 7,884,207	42.60%
29	5800 MRI		0.165388	$ 44,611	$ 218,214	$ 8,197	$ 183,477	$ 82,257	$ 321,139	$ 16,177	$ 61,235	$ 67,214	$ 273,904	$ 151,242	$ 784,065	27.54%
30	6000 LABORATORY		0.166515	$ 755,631	$ 1,390,391	$ 152,757	$ 1,868,951	$ 719,327	$ 1,469,847	$ 550,994	$ 533,737	$ 1,083,797	$ 3,574,319	$ 2,178,709	$ 5,262,926	61.87%
31	6500 RESPIRATORY THERAPY		0.190983	$ 574,413	$ 394,497	$ 32,511	$ 240,923	$ 435,730	$ 352,739	$ 273,629	$ 115,957	$ 325,684	$ 592,376	$ 1,316,283	$ 1,104,116	35.74%
32	6600 PHYSICAL THERAPY		0.508269	$ 54,032	$ 7,930	$ 7,163	$ 2,823	$ 65,107	$ 15,892	$ 56,090	$ 8,135	$ 32,613	$ 5,597	$ 182,392	$ 34,780	37.97%
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.354518	$ 392,463	$ 224,515	$ 74,777	$ 240,656	$ 388,245	$ 270,481	$ 209,311	$ 125,337	$ 169,555	$ 121,492	$ 1,064,798	$ 860,990	36.68%
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.391038	$ 119,499	$ 4,934	$ 103,518	$ 246,907	$ 63,679	$ 456,279	$ 33,931	$ 144,351	$ 29,664	$ 148,302	$ 320,628	$ 852,471	23.45%
35	7300 DRUGS CHARGED TO PATIENTS		0.218894	$ 1,282,924	$ 1,801,984	$ 376,268	$ 1,892,772	$ 1,173,210	$ 1,906,237	$ 845,636	$ 530,221	$ 1,725,208	$ 4,217,233	$ 3,678,038	$ 6,131,214	85.50%
36	7600 WOUND CARE		0.371860	$ 665	$ 10,212	$ 2,994	$ 88,771	$ 19,500	$ 257,757	$ 11,748	$ 71,831	$ 14,695	$ 172,270	$ 34,907	$ 428,571	25.40%
37	9100 EMERGENCY		0.196550	$ 245,528	$ 2,189,407	$ 50,604	$ 4,752,461	$ 227,412	$ 1,601,952	$ 148,565	$ 446,694	$ 404,344	$ 6,504,845	$ 672,109	$ 8,990,514	44.09%
				4,494,443	10,704,403	1,113,791	15,277,548	4,454,202	11,127,876	2,768,103	3,388,930	5,174,874	24,865,459			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			**$ 5,606,566**	**$ 10,704,403**	**$ 1,278,884**	**$ 15,277,548**	**$ 5,129,300**	**$ 11,127,876**	**$ 3,597,817**	**$ 3,388,930**	**$ 6,099,458** (Agrees to Exhibit A)	**$ 24,865,459** (Agrees to Exhibit A)	**$ 15,612,567**	**$ 40,498,756**	**44.99%**
129	Total Charges per PS&R or Exhibit Detail			$ 5,606,566	$ 10,704,403	$ 1,278,884	$ 15,277,548	$ 5,129,300	$ 11,127,876	$ 3,597,817	$ 3,388,930	$ 6,099,458	$ 24,865,459			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 2,062,097**	**$ 2,292,516**	**$ 421,224**	**$ 2,856,199**	**$ 1,611,739**	**$ 2,233,763**	**$ 1,391,321**	**$ 764,044**	**$ 1,900,419**	**$ 4,135,652**	$ 5,486,381	$ 8,146,522	46.72%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,038,306	$ 1,725,503	$ -	$ -	$ 49,020	$ 137,269	$ 1,249	$ 1,531			$ 1,088,575	$ 1,864,303	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 258,792	$ 2,088,638	$ -	$ -	$ 10	$ 11,583			$ 258,802	$ 2,100,221	
134	Private Insurance (including primary and third party liability)			$ 19,437	$ 846	$ -	$ 14,535	$ 1,087	$ -	$ 130,129	$ 290,597			$ 150,653	$ 305,978	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 1,272	$ -	$ 1,374	$ -	$ 717	$ -	$ 1,425			$ -	$ 4,788	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,057,743	$ 1,727,621	$ 258,792	$ 2,104,547									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ 130,210	$ -	$ -							$ -	$ 130,210	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 963,404	$ 921,590	$ 358,874	$ 38,547			$ 1,322,278	$ 960,137	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 336,347	$ 194,700			$ 336,347	$ 194,700	
141	Medicare Cross-Over Bad Debt Payments							$ 30,158	$ 20,257	$ -	$ -			$ 30,158	$ 20,257	
142	Other Medicare Cross-Over Payments (See Note D)							$ 244,831	$ 81,142	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 244,831	$ 81,142	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 9,614	$ 288,298			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			

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

Cost Report Year (10/01/2019-09/30/2020) Northeast Georgia MC BARROW

		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		%
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 1,004,354	$ 434,685	$ 162,432	$ 751,652	$ 323,239	$ 1,072,788	$ 564,712	$ 225,661	$ 1,890,805	$ 3,847,354	$ 2,054,737	$ 2,484,786	
146	**Calculated Payments as a Percentage of Cost**	51%	81%	61%	74%	80%	52%	59%	70%	1%	7%	63%	69%	
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)**					2,488								
148	**Percent of cross-over days to total Medicare days from the cost report**					18%								

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.

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

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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 Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 1,243.75		9		-		-		-		9	
2	03100 INTENSIVE CARE UNIT	$ 3,435.79		1		-		-		-		1	
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	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
18			**Total Days**	10		-		-		-		10	
19	Total Days per PS&R or Exhibit Detail			10		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 15,293		$ -		$ -		$ -		$ 15,293	
21.01	Calculated Routine Charge Per Diem			$ 1,529.30		$ -		$ -		$ -		$ 1,529.30	
	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)		0.609641	3,740	8,670	-	-	-	-	-	765	$ 3,740	$ 9,435
23	5000 OPERATING ROOM		0.616351	-	21,622	-	-	-	-	-	-	$ -	$ 21,622
24	5300 ANESTHESIOLOGY		0.090459	-	14,543	-	-	-	-	-	-	$ -	$ 14,543
25	5400 RADIOLOGY-DIAGNOSTIC		0.290900	3,420	13,460	-	-	-	-	-	2,165	$ 3,420	$ 15,625
26	5401 ULTRASOUND		0.103240	7,631	8,547	-	-	-	-	-	-	$ 7,631	$ 8,547
27	5600 RADIOISOTOPE		0.252736	-	8,790	-	-	-	-	-	-	$ -	$ 8,790
28	5700 CT SCAN		0.020405	17,892	69,480	-	-	-	-	-	5,303	$ 17,892	$ 74,783
29	5800 MRI		0.165388	3,390	7,255	-	-	-	-	-	-	$ 3,390	$ 7,255
30	6000 LABORATORY		0.166515	30,053	51,793	-	-	-	-	-	4,044	$ 30,053	$ 55,837
31	6500 RESPIRATORY THERAPY		0.190983	20,760	9,481	-	-	-	-	-	645	$ 20,760	$ 10,126
32	6600 PHYSICAL THERAPY		0.508269	-	477	-	-	-	-	-	-	$ -	$ 477
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.354518	8,487	10,109	-	-	-	-	-	-	$ 8,487	$ 10,109
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.391038	-	53,164	-	-	-	-	-	-	$ -	$ 53,164
35	7300 DRUGS CHARGED TO PATIENTS		0.218894	60,063	81,409	-	-	-	-	-	5,747	$ 60,063	$ 87,156
36	7600 WOUND CARE		0.371860	-	23,439	-	-	-	-	-	-	$ -	$ 23,439
37	9100 EMERGENCY		0.196550	9,645	89,281	-	-	-	-	-	5,251	$ 9,645	$ 94,532
				165,081	471,519	-	-	-	-	-	23,920		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 180,374**	**$ 471,519**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 23,920**	**$ 180,374**	**$ 495,439**
129	Total Charges per PS&R or Exhibit Detail			$ 180,374	$ 471,519	$ -	$ -	$ -	$ -	$ -	$ 23,920		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 46,639**	**$ 108,699**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 4,291**	**$ 46,639**	**$ 112,990**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 11,469	$ 2,340	$ -	$ -	$ -	$ -	$ -	$ -	$ 11,469	$ 2,340
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ 529	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 529
134	Private Insurance (including primary and third party liability)			$ -	$ 1,346	$ -	$ -	$ -	$ -	$ -	$ 7,406	$ -	$ 8,752
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 15	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 11,469	$ 4,230	$ -	$ -						
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)							$ -	$ -	$ -	$ 445	$ -	$ 445
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -	$ -	$ -

I. Out-of-State Medicaid Data:

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		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	
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 35,170	$ 104,469	$ -	$ -	$ -	$ -	$ -	$ (3,560)	$ 35,170	$ 100,909
144	**Calculated Payments as a Percentage of Cost**	25%	4%	0%	0%	0%	0%	0%	183%	25%	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.

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

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		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	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 D 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 (10/01/2019-09/30/2020) Northeast Georgia MC BARROW

		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 Primar		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	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 E 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.

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Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 240,655		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	308001-69760	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 240,655	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 240,655		

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**	56,787,137
19	Uninsured Hospital	**Charges Sec. G**	30,964,917
20	Total Hospital	**Charges Sec. G**	195,052,975
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.11%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		15.88%
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.*