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 MEDICAL CENTER

	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:	5/17/2021		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MEDICAL CENTER	-	
5. Medicaid Provider Number:	000000888A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000000888S	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110029	-	

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)	$ 1,594,259	$ 4,449,484	$6,043,743
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 9,161,975	$ 32,273,804	$41,435,779
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$10,756,234	$36,723,288	$47,479,522
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.82%	12.12%	12.73%

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)	201,806

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	147,762,597
8. Outpatient Hospital Charity Care Charges	167,255,733
9. Non-Hospital Charity Care Charges	1,170,713
10. Total Charity Care Charges	$ 316,189,043

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	$ 391,670,239	$ -	$ -	$ 303,628,386	$ -	$ -	$ 88,041,853
12. Psych Subprovider	$ 25,411,758	$ -	$ -	$ 19,699,559	$ -	$ -	$ 5,712,199
13. Rehab. Subprovider	$ 9,406,119	$ -	$ -	$ 7,291,758	$ -	$ -	$ 2,114,361
14. Swing Bed - SNF			$ -			$ -	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ 17,247,665			$ 13,370,637	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 2,183,968,776	$ 1,975,636,052	$ -	$ 1,693,043,913	$ 1,531,541,398	$ -	$ 935,019,516
20. Outpatient Services		$ 353,926,637	$ -		$ 274,369,004	$ -	$ 79,557,633
21. Home Health Agency			$ -			$ -	
22. Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	-
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ 20,932,409			$ 16,227,104	
26. Other	$ 26,390,781	$ 6,644,580	$ -	$ 20,458,512	$ 5,150,974	$ -	$ 7,425,875
28. Total Hospital and Non Hospital		Total from Above	$ 5,011,235,016		Total from Above	$ 3,884,781,246	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	$ 5,011,235,016		Total Contractual Adj. (G-3 Line 2)	$ 3,877,168,489	
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)					+	$ 7,612,757	
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						3,884,781,246	
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 MEDICAL CENTER

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
								2002	2002		
			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	$ 198,341,397	$ 4,542,059	$ -	$ -	**$ 202,883,456**	**172,435**	**$ 316,979,720**		**$ 1,176.58**
2	03100	INTENSIVE CARE UNIT	$ 62,091,494	$ 1,532,751	$ -		**$ 63,624,245**	30,313	$ 109,508,396		**$ 2,098.91**
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	$ 24,677,594	$ -	$ -		**$ 24,677,594**	17,460	$ 24,192,234		**$ 1,413.38**
18		Total Routine	$ 285,110,485	$ 6,074,810	$ -	$ -	$ 291,185,295	220,208	$ 450,680,350		
19		Weighted Average									$ 1,322.32

Line #		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)		18,402	-	-	**$ 21,651,425**	$ 11,964,650	$ 25,588,525	$ 37,553,175	**0.576554**

Line #		Cost Center Description	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	$ 86,677,383	$ 1,108,506	$ -		**$ 87,785,889**	$ 268,201,929	$ 340,612,131	$ 608,814,060	**0.144192**
22	5200	DELIVERY ROOM & LABOR ROOM	$ 17,920,929	$ 31,066	$ -		**$ 17,951,995**	$ 53,265,095	$ 3,782,896	$ 57,047,991	**0.314682**
23	5300	ANESTHESIOLOGY	$ 4,891,301	$ -	$ -		**$ 4,891,301**	$ 93,120,159	$ 97,383,263	$ 190,503,422	**0.025676**
24	5400	RADIOLOGY-DIAGNOSTIC	$ 34,634,453	$ 38,659	$ -		**$ 34,673,112**	$ 46,434,853	$ 163,597,482	$ 210,032,335	**0.165085**
25	5500	RADIOLOGY-THERAPEUTIC	$ 15,844,372	$ -	$ -		**$ 15,844,372**	$ 2,464,657	$ 123,767,151	$ 126,231,808	**0.125518**
26	5700	CT SCAN	$ 12,199,848	$ -	$ -		**$ 12,199,848**	$ 129,874,373	$ 237,210,134	$ 367,084,507	**0.033234**
27	5800	MRI	$ 5,290,654	$ -	$ -		**$ 5,290,654**	$ 24,479,843	$ 63,375,273	$ 87,855,116	**0.060220**
28	6000	LABORATORY	$ 52,283,859	$ -	$ -		**$ 52,283,859**	$ 245,725,412	$ 222,022,417	$ 467,747,829	**0.111778**
29	6500	RESPIRATORY THERAPY	$ 18,126,405	$ -	$ -		**$ 18,126,405**	$ 168,588,021	$ 22,919,238	$ 191,507,259	**0.094651**
30	6600	PHYSICAL THERAPY	$ 21,841,614	$ -	$ -		**$ 21,841,614**	$ 32,395,556	$ 23,798,632	$ 56,194,188	**0.388681**
31	6900	ELECTROCARDIOLOGY	$ 41,549,004	$ -	$ -		**$ 41,549,004**	$ 143,911,384	$ 187,359,622	$ 331,271,006	**0.125423**
32	7000	ELECTROENCEPHALOGRAPHY	$ 4,316,922	$ 1,864	$ -		**$ 4,318,786**	$ 2,953,988	$ 9,589,251	$ 12,543,239	**0.344312**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) 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)		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
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 94,693,615	$ -	$ -		$ 94,693,615	$ 276,083,344	$ 141,106,872	$ 417,190,216	0.226979
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 81,608,020	$ -	$ -		$ 81,608,020	$ 191,352,948	$ 107,273,495	$ 298,626,443	0.273278
35	7300	DRUGS CHARGED TO PATIENTS	$ 94,193,876	$ -	$ -		$ 94,193,876	$ 474,492,002	$ 214,133,883	$ 688,625,885	0.136785
36	7400	RENAL DIALYSIS	$ 4,944,261	$ -	$ -		$ 4,944,261	$ 30,510,321	$ 7,285,586	$ 37,795,907	0.130815
37	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	$ 52,271	$ -	$ -		$ 52,271	$ 72,072	$ -	$ 72,072	0.725261
38	7601	WOUND CARE CLINIC	$ 2,781,963	$ -	$ -		$ 2,781,963	$ 41,357	$ 10,178,565	$ 10,219,922	0.272210
39	7602	DIABETIC EDUCATION	$ 1,312,412	$ -	$ -		$ 1,312,412	$ 1,463	$ 240,163	$ 241,626	5.431584
40	9100	EMERGENCY	$ 60,974,044	$ 1,560,329	$ -		$ 62,534,373	$ 85,347,681	$ 231,025,781	$ 316,373,462	0.197660
126		Total Ancillary	$ 656,137,206	$ 2,740,424	$ -		$ 658,877,630	$ 2,281,281,108	$ 2,232,250,360	$ 4,513,531,468	
127		Weighted Average									0.150775
128		Sub Totals	$ 941,247,691	$ 8,815,234	$ -		$ 950,062,925	$ 2,731,961,458	$ 2,232,250,360	$ 4,964,211,818	
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)					$ 322,032				
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					$ 949,740,893				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.94%				

* 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 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	$ 1,176.58		14,358		7,217		10,695		7,099		11,918		39,369		33.45%
2	03100	INTENSIVE CARE UNIT	$ 2,098.91		3,686		380		2,125		1,561		2,105		7,752		32.84%
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	$ 1,413.38		2,353		8,524		-		251		189		11,128		65.22%
18				**Total Days**	20,397		16,121		12,820		8,911		14,212		58,249		36.11%
19		Total Days per PS&R or Exhibit Detail			20,397		16,121		12,820		8,911		14,212				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 35,605,963		$ 27,082,278		$ 23,111,928		$ 17,355,308		$ 27,723,269		$ 103,155,477		29.23%
21.01		Calculated Routine Charge Per Diem			$ 1,745.65		$ 1,679.94		$ 1,802.80		$ 1,947.63		$ 1,950.69		$ 1,770.94		
		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)		0.576554	$ 3,002,279	$ 1,329,627	$ 916,589	$ 1,647,003	$ 1,431,946	$ 1,930,500	$ 707,183	$ 604,281	$ 1,861,206	$ 3,790,487	$ 6,057,997	$ 5,511,411	46.07%
23	5000	OPERATING ROOM		0.144192	$ 19,640,986	$ 9,530,921	$ 14,478,908	$ 18,647,149	$ 15,341,220	$ 18,906,828	$ 7,311,379	$ 3,917,108	$ 23,197,087	$ 21,581,291	$ 56,772,493	$ 51,002,006	25.15%
24	5200	DELIVERY ROOM & LABOR ROOM		0.314682	$ 2,658,954	$ 24,158	$ 9,320,902	$ 1,009,574	$ 103,977	$ 8,956	$ 1,766,183	$ 201,116	$ 425,995	$ 189,036	$ 13,850,016	$ 1,243,804	27.56%
25	5300	ANESTHESIOLOGY		0.025676	$ 5,438,354	$ 2,512,663	$ 3,703,878	$ 5,617,934	$ 4,879,425	$ 4,879,903	$ 2,206,335	$ 1,096,497	$ 7,676,517	$ 6,327,357	$ 16,227,992	$ 14,106,997	23.37%
26	5400	RADIOLOGY-DIAGNOSTIC		0.165085	$ 4,014,190	$ 7,984,187	$ 1,547,402	$ 6,628,191	$ 3,163,830	$ 8,811,732	$ 1,705,610	$ 1,587,168	$ 3,832,685	$ 12,573,417	$ 10,431,032	$ 25,011,278	24.79%
27	5500	RADIOLOGY-THERAPEUTIC		0.125518	$ -	$ -	$ 34,838	$ 2,268,913	$ 144,811	$ 7,215,001	$ 127,000	$ 539,201	$ 6,103	$ 4,237,171	$ 306,649	$ 10,023,115	11.54%
28	5700	CT SCAN		0.033234	$ 10,056,088	$ 7,470,542	$ 2,152,988	$ 10,732,178	$ 8,737,745	$ 13,245,389	$ 4,443,538	$ 1,926,434	$ 13,165,734	$ 32,202,960	$ 25,390,359	$ 33,374,543	28.49%
29	5800	MRI		0.060220	$ 1,803,108	$ 1,578,002	$ 364,345	$ 1,931,818	$ 1,633,904	$ 3,408,683	$ 694,442	$ 478,650	$ 2,827,814	$ 4,473,152	$ 4,495,799	$ 7,397,152	21.96%
30	6000	LABORATORY		0.111778	$ 26,832,991	$ 8,141,062	$ 11,271,412	$ 13,349,400	$ 18,748,741	$ 10,363,611	$ 12,341,345	$ 7,068,256	$ 22,852,014	$ 28,651,962	$ 69,194,489	$ 38,922,329	34.34%
31	6500	RESPIRATORY THERAPY		0.094651	$ 13,486,588	$ 391,232	$ 4,800,562	$ 592,375	$ 9,714,173	$ 593,827	$ 7,300,234	$ 195,993	$ 6,804,155	$ 836,058	$ 35,301,557	$ 1,773,427	23.54%
32	6600	PHYSICAL THERAPY		0.388681	$ 1,858,141	$ 653,687	$ 420,593	$ 1,682,203	$ 1,590,645	$ 746,842	$ 916,888	$ 314,524	$ 958,977	$ 1,593,674	$ 4,786,267	$ 3,397,256	19.16%
33	6900	ELECTROCARDIOLOGY		0.125423	$ 9,346,917	$ 3,687,731	$ 1,329,591	$ 2,592,731	$ 9,546,573	$ 9,977,415	$ 3,416,291	$ 1,771,789	$ 12,204,999	$ 12,035,784	$ 23,639,372	$ 18,029,666	20.02%
34	7000	ELECTROENCEPHALOGRAPHY		0.344312	$ 319,915	$ 532,761	$ 920,354	$ 1,006,825	$ 204,790	$ 527,698	$ 174,309	$ 76,816	$ 218,168	$ 733,403	$ 1,619,368	$ 2,144,100	37.75%
35	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.226979	$ 18,750,338	$ 2,563,113	$ 9,556,247	$ 5,582,975	$ 16,608,645	$ 7,849,600	$ 9,157,880	$ 1,551,231	$ 17,167,932	$ 8,229,155	$ 54,073,110	$ 17,546,919	23.39%
36	7200	IMPL. DEV. CHARGED TO PATIENTS		0.273278	$ 8,750,674	$ 333,277	$ 2,352,159	$ 2,230,785	$ 10,565,670	$ 5,658,504	$ 2,757,674	$ 1,001,668	$ 9,649,038	$ 4,051,802	$ 24,426,177	$ 9,224,235	15.91%
37	7300	DRUGS CHARGED TO PATIENTS		0.136785	$ 50,069,621	$ 11,629,967	$ 19,020,519	$ 14,246,495	$ 34,047,908	$ 20,541,469	$ 22,751,608	$ 3,005,479	$ 40,442,248	$ 36,242,726	$ 125,889,657	$ 49,423,410	36.85%
38	7400	RENAL DIALYSIS		0.130815	$ 2,417,038	$ -	$ 352,185	$ 153,153	$ 3,068,687	$ 818,198	$ 2,338,190	$ 59,672	$ 1,556,243	$ 5,153,411	$ 8,176,100	$ 1,031,023	42.47%
39	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.725261	$ -	$ -	$ 23,232	$ -	$ -	$ -	$ 726	$ -	$ 1,452	$ -	$ 23,958	$ -	35.26%
40	7601	WOUND CARE CLINIC		0.272210	$ 93,233	$ 23,361	$ 286,347	$ 243,322	$ 2,402	$ 639,795	$ 43,751	$ 475,576	$ 5,424	$ 481,977	$ 425,733	$ 1,382,054	22.46%
41	7602	DIABETIC EDUCATION		5.431584	$ -	$ -	$ -	$ 16,234	$ -	$ 3,491	$ -	$ 9,832	$ -	$ 28,665	$ -	$ 29,557	24.10%
42	9100	EMERGENCY		0.197660	$ 4,497,164	$ 7,326,386	$ 1,370,269	$ 22,280,102	$ 3,668,103	$ 7,265,479	$ 2,003,642	$ 1,773,101	$ 5,782,819	$ 37,981,984	$ 11,539,178	$ 38,645,068	29.84%
					183,036,579	65,712,678	84,223,319	112,459,360	143,203,194	123,392,921	82,164,209	27,654,393	170,636,611	221,395,472			
		Totals / Payments															
128		**Total Charges** ***(includes organ acquisition from Section J)***			**$ 218,642,542**	**$ 65,712,678**	**$ 111,305,597**	**$ 112,459,360**	**$ 166,315,122**	**$ 123,392,921**	**$ 99,519,517**	**$ 27,654,393**	**$ 198,359,880** (Agrees to Exhibit A)	**$ 221,395,472** (Agrees to Exhibit A)	**$ 595,782,778**	**$ 329,219,351**	27.24%
129		Total Charges per PS&R or Exhibit Detail			$ 218,642,542	$ 65,712,678	$ 111,305,597	$ 112,459,360	$ 166,315,122	$ 123,392,921	$ 99,519,517	$ 27,654,393	$ 198,359,880	$ 221,395,472			
130		Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01		**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02		**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 55,607,576**	**$ 9,439,582**	**$ 35,521,057**	**$ 17,230,117**	**$ 38,511,468**	**$ 17,785,186**	**$ 24,119,136**	**$ 4,184,822**	**$ 43,289,894**	**$ 31,530,787**	$ 153,759,237	$ 48,639,707	29.35%
132		Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 37,606,737	$ 8,524,256	$ -	$ -	$ 1,185,890	$ 1,176,511	$ 123,692	$ 20,271			$ 38,916,319	$ 9,721,038	
133		Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 20,791,909	$ 13,443,287	$ -	$ -	$ 219,367	$ 109,303			$ 21,011,276	$ 13,552,590	
134		Private Insurance (including primary and third party liability)			$ 417,282	$ 8,576	$ 389,971	$ 58,535	$ 3,269	$ 686	$ 5,982,085	$ 2,790,690			$ 6,792,607	$ 2,858,487	
135		Self-Pay (including Co-Pay and Spend-Down)			$ 938	$ 9,664	$ 2,904	$ 28,923	$ 613	$ 7,819	$ 988	$ 2,749			$ 5,443	$ 49,155	
136		Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 38,024,957	$ 8,542,496	$ 21,184,784	$ 13,530,745									
137		Medicaid Cost Settlement Payments (See Note B)			$ -	$ 44,137	$ -	$ -							$ -	$ 44,137	
138		Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ 6,417							$ -	$ 6,417	
139		Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 25,517,875	$ 11,310,367	$ 7,456,627	$ 439,616			$ 32,974,502	$ 11,749,983	
140		Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 5,774,274	$ 1,572,034			$ 5,774,274	$ 1,572,034	
141		Medicare Cross-Over Bad Debt Payments							$ 313,461	$ 356,561	$ -	$ -	(Agrees to Exhibit B	(Agrees to Exhibit B	$ 313,461	$ 356,561	

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

Cost Report Year (10/01/2019-09/30/2020) NORTHEAST GEORGIA MEDICAL CENTER

Line	Description	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		%
										and B-1)	and B-1)			
142	Other Medicare Cross-Over Payments (See Note D)					$ 5,630,097	$ 1,347,909	$ -	$ -			$ 5,630,097	$ 1,347,909	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,594,259	$ 4,449,484			
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)**	$ 17,582,619	$ 852,949	$ 14,336,273	$ 3,692,955	$ 5,860,263	$ 3,585,333	$ 4,562,103	$ (749,841)	$ 41,695,635	$ 27,081,303	$ 42,341,258	$ 7,381,396	
146	**Calculated Payments as a Percentage of Cost**	68%	91%	60%	79%	85%	80%	81%	118%	4%	14%	72%	85%	
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)**					100,846								
148	**Percent of cross-over days to total Medicare days from the cost report**					13%								

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 (10/01/2019-09/30/2020) 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	$ 1,176.58		164		-		-		76		240	
2	03100	INTENSIVE CARE UNIT	$ 2,098.91		41		-		-		56		97	
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	$ 1,413.38		70		-		-		-		70	
18				**Total Days**	275		-		-		132		407	
19	Total Days per PS&R or Exhibit Detail				275		-		-		132			
20	Unreconciled Days (Explain Variance)				-		-		-		-			
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges				$ 530,184		$ -		$ -		$ 302,441		$ 832,625	
21.01	Calculated Routine Charge Per Diem				$ 1,927.94		$ -		$ -		$ 2,291.22		$ 2,045.76	
	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)		0.576554	11,983	36,978	-	-	-	-	14,983	14,705	$ 26,966	$ 51,683
23	5000	OPERATING ROOM		0.144192	304,398	55,603	-	-	-	-	177,264	25,442	$ 481,662	$ 81,045
24	5200	DELIVERY ROOM & LABOR ROOM		0.314682	10,502	1,195	-	-	-	-	1,549	1,271	$ 12,051	$ 2,466
25	5300	ANESTHESIOLOGY		0.025676	102,266	18,739	-	-	-	-	59,200	7,528	$ 161,466	$ 26,267
26	5400	RADIOLOGY-DIAGNOSTIC		0.165085	60,555	94,385	-	-	-	-	29,146	35,543	$ 89,701	$ 129,928
27	5500	RADIOLOGY-THERAPEUTIC		0.125518	-	95	-	-	-	-	-	(1)	$ -	$ 94
28	5700	CT SCAN		0.033234	70,352	239,476	-	-	-	-	63,577	92,108	$ 133,929	$ 331,584
29	5800	MRI		0.060220	48,999	27,039	-	-	-	-	13,103	10,253	$ 62,102	$ 37,292
30	6000	LABORATORY		0.111778	401,360	217,459	-	-	-	-	348,522	56,989	$ 749,882	$ 274,448
31	6500	RESPIRATORY THERAPY		0.094651	181,659	10,142	-	-	-	-	167,896	-	$ 349,555	$ 10,142
32	6600	PHYSICAL THERAPY		0.388681	18,313	477	-	-	-	-	8,495	4,156	$ 26,808	$ 4,633
33	6900	ELECTROCARDIOLOGY		0.125423	157,876	97,554	-	-	-	-	120,869	29,469	$ 278,745	$ 127,023
34	7000	ELECTROENCEPHALOGRAPHY		0.344312	7,219	6,428	-	-	-	-	4,258	1,931	$ 11,477	$ 8,359
35	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.226979	278,063	65,113	-	-	-	-	200,276	8,335	$ 478,339	$ 73,448
36	7200	IMPL. DEV. CHARGED TO PATIENTS		0.273278	101,096	16,318	-	-	-	-	53,098	-	$ 154,194	$ 16,318
37	7300	DRUGS CHARGED TO PATIENTS		0.136785	767,904	359,151	-	-	-	-	599,031	48,229	$ 1,366,935	$ 407,380
38	7400	RENAL DIALYSIS		0.130815	69,895	2,770	-	-	-	-	61,116	-	$ 131,011	$ 2,770
39	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.725261	-	-	-	-	-	-	-	-	$ -	$ -
40	7601	WOUND CARE CLINIC		0.272210	-	481	-	-	-	-	-	-	$ -	$ 481
41	7602	DIABETIC EDUCATION		5.431584	-	-	-	-	-	-	-	-	$ -	$ -
42	9100	EMERGENCY		0.197660	41,439	371,080	-	-	-	-	16,279	35,812	$ 57,718	$ 406,892
					2,633,880	1,620,483	-	-	-	-	1,938,662	371,770		
	Totals / Payments													
128	**Total Charges (includes organ acquisition from Section K)**				$ 3,164,064	$ 1,620,483	$ -	$ -	$ -	$ -	$ 2,241,103	$ 371,770	$ 5,405,166	$ 1,992,253
129	Total Charges per PS&R or Exhibit Detail				$ 3,164,064	$ 1,620,483	$ -	$ -	$ -	$ -	$ 2,241,103	$ 371,770		
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)												$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**				$ 754,544	$ 237,482	$ -	$ -	$ -	$ -	$ 478,775	$ 50,200	$ 1,233,319	$ 287,682
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ 286,208	$ 17,863	$ -	$ -	$ -	$ -	$ 2	$ 890	$ 286,210	$ 18,753
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ -	$ 461	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 461
134	Private Insurance (including primary and third party liability)				$ 78,062	$ 27,290	$ -	$ -	$ -	$ -	$ -	$ 35,024	$ 78,062	$ 62,314
135	Self-Pay (including Co-Pay and Spend-Down)				$ -	$ 15	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 15
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				$ 364,270	$ 45,629	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)				$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				$ -	$ -	$ -	$ -					$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2019-09/30/2020) NORTHEAST GEORGIA MEDICAL CENTER

Line	Description	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	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 208,798	$ 9,076	$ 208,798	$ 9,076
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 168,894	$ 8,397	$ 168,894	$ 8,397
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)**	$ 390,274	$ 191,853	$ -	$ -	$ -	$ -	$ 101,081	$ (3,187)	$ 491,355	$ 188,666
144	**Calculated Payments as a Percentage of Cost**	48%	19%	0%	0%	0%	0%	79%	106%	60%	34%

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

Cost Report Year (10/01/2019-09/30/2020) NORTHEAST GEORGIA MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description	Explanation	Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 13,346,021		
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)		$ 13,346,021	5.05	*(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		$ 13,346,021		

DSH UCC Provider Tax Assessment Adjustment:

Line	Description		Dollar Amount
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**	932,399,549
19	Uninsured Hospital	**Charges Sec. G**	419,755,352
20	Total Hospital	**Charges Sec. G**	4,964,211,818
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		18.78%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.46%
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.*