

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	9.00	9/11/2024

**D. General Cost Report Year Information** 10/1/2022 - 9/30/2023

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 LUMPKIN**

10/1/2022 through 9/30/2023

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: **3/6/2024**

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MC LUMPKIN	Yes	
5. Medicaid Provider Number:	003229414A	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:	110237	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	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: (10/01/2022 - 09/30/2023)**

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)	\$ 596	\$ 225,681	\$226,277
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 104,194	\$ 1,499,602	\$1,603,796
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$104,790	\$1,725,283	\$1,830,073
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.57%	13.08%	12.36%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? **Yes**

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 \$ 185,450

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 \$185,450

<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.



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 (10/01/2022 - 09/30/2023)

### 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) 2,951

### 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	1,568,627
8. Outpatient Hospital Charity Care Charges	4,778,361
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 6,346,988

### 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			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 9,959,941	\$ -	\$ -	\$ 8,359,168	\$ -	\$ -	\$ 1,600,773
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	\$ 17,789,544	\$ 60,618,589	\$ -	\$ 14,930,388	\$ 50,875,901	\$ -	\$ 12,601,844
20. Outpatient Services	\$ -	\$ 44,486,906	\$ -	\$ -	\$ 37,336,920	\$ -	\$ 7,149,986
21. Home Health Agency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22. Ambulance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26. Other	\$ -	\$ -	\$ 289,354	\$ -	\$ -	\$ 242,849	\$ -
27. Total	\$ 27,749,485	\$ 105,105,495	\$ 289,354	\$ 23,289,556	\$ 88,212,821	\$ 242,849	\$ 21,352,603
28. Total Hospital and Non Hospital		Total from Above	\$ 133,144,334		Total from Above	\$ 111,745,226	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)			
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)			\$ 133,144,334			\$ 107,627,127	
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)						\$ 4,118,099	
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)"						\$ -	
36. Adjusted Contractual Adjustments						111,745,226	
37. Unreconciled Difference			\$ -			\$ -	
		Unreconciled Difference (Should be \$0)			Unreconciled Difference (Should be \$0)		



**G. Cost Report - Cost / Days / Charges**

Cost Report Year (10/01/2022-09/30/2023) NORTHEAST GEORGIA MC LUMPKIN

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
<b>Routine Cost Centers (list below):</b>									
1	03000 ADULTS & PEDIATRICS	\$ 6,135,407	\$ -	\$ -	\$ -	\$ 6,135,407	4,291	\$ 9,959,941	\$ 1,429.83
2	03100 INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
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	\$ 6,135,407	\$ -	\$ -	\$ -	\$ 6,135,407	4,291	\$ 9,959,941	\$ 1,429.83
19	Weighted Average								
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)	1,340	-	-	\$ 1,915,972	1,179,301	2,197,152	\$ 3,376,453	0.567451
		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
<b>Ancillary Cost Centers (from W/S C excluding Observation) (list below):</b>									
21	5400 RADIOLOGY-DIAGNOSTIC	\$ 1,976,183	\$ -	\$ -	\$ -	\$ 1,976,183	\$ 3,483,444	\$ 31,661,172	\$ 35,144,616
22	6000 LABORATORY	\$ 3,017,325	\$ -	\$ -	\$ -	\$ 3,017,325	\$ 3,479,102	\$ 12,263,397	\$ 15,742,499
23	6500 RESPIRATORY THERAPY	\$ 1,078,966	\$ -	\$ -	\$ -	\$ 1,078,966	\$ 3,115,588	\$ 3,235,797	\$ 6,351,385
24	6900 ELECTROCARDIOLOGY	\$ 349,526	\$ -	\$ -	\$ -	\$ 349,526	\$ 1,407,610	\$ 5,756,893	\$ 7,164,503
25	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 18,554	\$ -	\$ -	\$ -	\$ 18,554	\$ 51,763	\$ 41,014	\$ 92,777
26	7300 DRUGS CHARGED TO PATIENTS	\$ 3,563,157	\$ -	\$ -	\$ -	\$ 3,563,157	\$ 6,252,037	\$ 7,660,316	\$ 13,912,353
27	9100 EMERGENCY	\$ 7,106,094	\$ -	\$ -	\$ -	\$ 7,106,094	\$ 3,138,150	\$ 37,972,303	\$ 41,110,453
126	Total Ancillary	\$ 17,109,805	\$ -	\$ -	\$ -	\$ 17,109,805	\$ 22,106,995	\$ 100,788,044	\$ 122,895,039
127	Weighted Average								0.154813
128	Sub Totals	\$ 23,245,212	\$ -	\$ -	\$ -	\$ 23,245,212	\$ 32,066,936	\$ 100,788,044	\$ 132,854,980
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	\$ 23,245,212	\$ -	\$ -	\$ -	\$ 23,245,212	\$ 32,066,936	\$ 100,788,044	\$ 132,854,980
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 (10/01/2022-09/30/2023) NORTHEAST GEORGIA MC LUMPKIN

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (includes all payers)
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	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)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days			
1	03000 ADULTS & PEDIATRICS	\$ 1,429.83		215	30	357	114	-	-	-	-	135	716			28.91%
2	03100 INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-			
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			215	30	357	114	-	-	-	-	135	716			28.91%
19	Total Days per PS&R or Exhibit Detail			215	30	357	114	-	-	-	-	135				
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
21	Routine Charges			Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges			
21.01	Calculated Routine Charge Per Diem	\$ 365,715		\$ 51,030	\$ 1,701.00	\$ 607,257	\$ 1,701.00	\$ 195,887	\$ 1,718.31	\$ -	\$ -	\$ 229,635	\$ 1,703.76	\$ 1,219,889	\$ 1,703.76	14.59%
Ancillary Cost Centers (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	02020 Observation (Non-Distinct)	0.567451	\$ 83,265	\$ 25,200	\$ 19,215	\$ 65,565	\$ 182,700	\$ 120,330	\$ 49,035	\$ 247,438	\$ -	\$ 90,405	\$ 89,775	\$ 334,213	\$ 461,531	29.21%
23	5400 RADIOLOGY-DIAGNOSTIC	0.056230	\$ 306,633	\$ 835,176	\$ 50,466	\$ 2,471,320	\$ 472,646	\$ 1,558,249	\$ 170,451	\$ 1,806,025	\$ -	\$ 294,101	\$ 3,611,498	\$ 1,000,196	\$ 6,670,770	33.21%
24	6000 LABORATORY	0.191667	\$ 411,309	\$ 524,935	\$ 95,849	\$ 1,660,451	\$ 742,637	\$ 979,004	\$ 211,118	\$ 1,079,709	\$ -	\$ 370,502	\$ 1,909,387	\$ 1,461,113	\$ 4,244,099	51.21%
25	6600 RESPIRATORY THERAPY	0.168879	\$ 62,965	\$ 97,536	\$ 19,932	\$ 73,486	\$ 97,407	\$ 61,411	\$ 97,285	\$ 189,883	\$ -	\$ 152,106	\$ 73,016	\$ 277,549	\$ 432,321	14.79%
26	6900 ELECTROCARDIOLOGY	0.048786	\$ 57,829	\$ 41,469	\$ 11,888	\$ 132,992	\$ 239,723	\$ 306,296	\$ 46,792	\$ 254,497	\$ -	\$ 115,973	\$ 196,885	\$ 356,232	\$ 735,254	19.60%
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.199985	\$ 1,108	\$ -	\$ -	\$ 554	\$ 2,882	\$ 1,917	\$ 831	\$ 554	\$ -	\$ 506	\$ 554	\$ -8,821	\$ 3,025	9.60%
28	7300 DRUGS CHARGED TO PATIENTS	0.256115	\$ 389,509	\$ 102,024	\$ 138,400	\$ 567,482	\$ 915,587	\$ 410,082	\$ 329,284	\$ 511,748	\$ -	\$ 433,651	\$ 976,713	\$ 1,772,760	\$ 1,591,356	34.77%
29	9100 EMERGENCY	0.172854	\$ 347,454	\$ 1,201,048	\$ 108,848	\$ 5,403,354	\$ 660,636	\$ 1,888,933	\$ 205,490	\$ 2,133,062	\$ -	\$ 502,966	\$ 5,473,083	\$ 1,322,428	\$ 10,626,397	44.60%
Totals / Payments				1,660,062	2,827,390	444,598	10,378,207	3,314,418	5,326,222	1,110,236	6,232,934	-	1,960,409	12,330,911		
128	Total Charges (includes organ acquisition from Section J)	\$ 2,025,777	\$ 2,827,390	\$ 495,628	\$ 10,378,207	\$ 3,921,675	\$ 5,326,222	\$ 1,306,123	\$ 6,232,934	\$ -	\$ -	\$ 2,190,044	\$ 12,330,911	\$ 7,749,203	\$ 24,764,753	35.73%
129	Total Charges per PS&R or Exhibit Detail	\$ 2,025,777	\$ 2,827,390	\$ 495,628	\$ 10,378,207	\$ 3,921,675	\$ 5,326,222	\$ 1,306,123	\$ 6,232,934	\$ -	\$ -	(Agrees to Exhibit A)	\$ 2,190,044	\$ 12,330,911		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-					
131.01	Sampling Cost Adjustment (if applicable)															
131.02	Total Calculated Cost (includes organ acquisition from Section J)	\$ 624,284	\$ 414,203	\$ 133,234	\$ 1,594,538	\$ 1,160,585	\$ 800,841	\$ 379,694	\$ 995,167	\$ -	\$ -	\$ 561,532	\$ 1,838,299	\$ 2,297,807	\$ 3,804,749	36.91%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 336,302	\$ 356,977	\$ -	\$ -	\$ 56,081	\$ 55,102	\$ 6,508	\$ 35,713					\$ 398,891	\$ 447,792	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 72,403	\$ 805,739	\$ -	\$ -	\$ 33,342	\$ 17,300					\$ 105,745	\$ 823,039	
134	Private Insurance (including primary and third party liability)	\$ 11,642	\$ 8	\$ 27,152	\$ 352,379	\$ -	\$ -	\$ 32,503	\$ 231,957					\$ 71,357	\$ 584,344	
135	Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ 117	\$ -	\$ -	\$ -	\$ 2,110	\$ -	\$ -			\$ -	\$ 2,227	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 347,943	\$ 356,985	\$ 99,555	\$ 1,158,235											
137	Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (41,844)	\$ -	\$ -									\$ -	\$ (41,844)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -									\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	\$ -	\$ -	\$ -	\$ -	\$ 622,653	\$ 401,059	\$ 114,103	\$ 68,208	\$ -	\$ -	\$ -	\$ -	\$ 736,756	\$ 469,267	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 66,422	\$ 301,447	\$ -	\$ -	\$ -	\$ -	\$ 66,422	\$ 301,447	
141	Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ 26,889	\$ 6,637	\$ -	\$ -	\$ -	\$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 26,889	\$ 6,637	
142	Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ 361,304	\$ 62,767	\$ -	\$ -	\$ -	\$ -	\$ 596	\$ 225,681	\$ 361,304	\$ 62,767	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)															
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)	\$ 276,351	\$ 99,062	\$ 33,679	\$ 436,303	\$ 93,658	\$ 275,276	\$ 126,756	\$ 338,431	\$ -	\$ -	\$ 560,936	\$ 1,612,618	\$ 530,444	\$ 1,149,073	
146	Calculated Payments as a Percentage of Cost	56%	76%	75%	73%	92%	66%	67%	66%	0%	0%	0%	12%	77%	70%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					1,717										
148	Percent of cross-over days to total Medicare days from the cost report					21%										

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 F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for Inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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



**I. Out-of-State Medicaid Data:**

Cost Report Year (10/01/2022-09/30/2023) NORTHEAST GEORGIA MC LUMPKIN

		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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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)		
<b>Routine Cost Centers (list below):</b>											
1	03000 ADULTS & PEDIATRICS	\$ 1,429.83		Days 2		Days -		Days -		Days 2	
2	03100 INTENSIVE CARE UNIT	\$ -		-		-		-		-	
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	2		-		-		2	
19	Total Days per PS&R or Exhibit Detail			2		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-			
21	Routine Charges			Routine Charges \$ 3,402		Routine Charges \$ -		Routine Charges \$ -		Routine Charges \$ 3,402	
21.01	Calculated Routine Charge Per Diem			\$ 1,701.00		\$ -		\$ -		\$ 1,701.00	
<b>Ancillary Cost Centers (from W/S C) (list below):</b>											
22	09200 Observation (Non-Distinct)	0.567451		Ancillary Charges 6,720	Ancillary Charges 3,465	-	-	-	-	Ancillary Charges 6,720	Ancillary Charges 3,465
23	5400 RADIOLOGY-DIAGNOSTIC	0.056230		6,448	86,001	-	-	-	-	6,448	86,966
24	6000 LABORATORY	0.191667		8,976	67,451	-	-	-	2,965	8,976	67,451
25	6500 RESPIRATORY THERAPY	0.169879		-	1,739	-	-	-	-	-	1,739
26	6900 ELECTROCARDIOLOGY	0.048786		-	-	-	-	-	-	-	-
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.199985		-	-	-	-	-	-	-	-
28	7300 DRUGS CHARGED TO PATIENTS	0.256115		41,116	21,583	-	-	-	39	41,116	21,622
29	9100 EMERGENCY	0.172854		12,542	174,327	-	-	-	3,537	12,542	177,864
				75,802	354,566	-	-	-	6,541		
<b>Totals / Payments</b>											
128	Total Charges (includes organ acquisition from Section K)			\$ 79,204	\$ 354,566	\$ -	\$ -	\$ -	\$ -	\$ 6,541	\$ 79,204
129	Total Charges per PS&R or Exhibit Detail			\$ 79,204	\$ 354,566	\$ -	\$ -	\$ -	\$ -	\$ 6,541	
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	
131.01	Sampling Cost Adjustment (if applicable)										
131.02	Total Calculated Cost (includes organ acquisition from Section K)			\$ 21,454	\$ 55,686	\$ -	\$ -	\$ -	\$ -	\$ 788	\$ 21,454
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note B)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
134	Private Insurance (including primary and third party liability)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payment)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
137	Medicaid Cost Settlement Payments (See Note E)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note F)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note G)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductible)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payment			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			\$ 21,454	\$ 55,686	\$ -	\$ -	\$ -	\$ -	\$ (4,455)	\$ 21,454
144	Calculated Payments as a Percentage of Cost			0%	0%	0%	0%	0%	0%	665%	0%

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 F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).



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

Cost Report Year (10/01/2022-09/30/2023)

NORTHEAST GEORGIA MC LUMPKIN

	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-Over (with Medicaid Secondary)		In-State Other Medicaid Programs (not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	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 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
<b>Organ Acquisition Cost Centers (list below):</b>																	
1	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
3	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
4	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
5	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
8		\$ -	\$ -	\$ -	\$ -	0	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
9	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	<b>Total Cost</b>						-		-		-		-		-		-

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 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 (10/01/2022-09/30/2023)

NORTHEAST GEORGIA MC LUMPKIN

	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-Over (with Medicaid Secondary)		Included Elsewhere & with Medicaid Secondary	
						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)
<b>Organ Acquisition Cost Centers (list below):</b>													
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	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	<b>Total Cost</b>						-		-		-		-

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 (10/01/2022-09/30/2023) NORTHEAST GEORGIA MC LUMPKIN

### Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 190,713	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	358001-69000 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 190,713	5.01 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	0	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
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))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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	\$ 190,713	

### DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	32,954,267
19 Uninsured Hospital Charges Sec. G	14,520,955
20 Total Hospital Charges Sec. G	132,854,980
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	24.80%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.93%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	16,160,772
27 Uninsured Hospital Charges Sec. G	14,520,955
28 Total Hospital Charges Sec. G	132,854,980
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	12.16%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.93%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary 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.

\*\*\*For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.