	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 y	ou 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 Receive	d: (10/01/2022 - 09/30/2023)		
	,		
Section 1011 Payment Related to Hospital Services Included in Ex Section 1011 Payment Related to Inpatient Hospital Services NOT Section 1011 Payment Related to Outpatient Hospital Services NC Total Section 1011 Payments Related to Hospital Services (Se	Included in Exhibits B & B-1 (See Note 1) T Included in Exhibits B & B-1 (See Note 1)		\$ - \$ - \$ - \$-
 Section 1011 Payment Related to Non-Hospital Services Included Section 1011 Payment Related to Non-Hospital Services NOT Inclu Total Section 1011 Payments Related to Non-Hospital Services 	in Exhibits B & B-1 (See Note 1) uded in Exhibits B & B-1 (See Note 1)		\$ <u>-</u> \$
8. Out-of-State DSH Payments (See Note 2)			\$-
			Inpatient Outpatient Total

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

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

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	<these and="" do="" flow="" h,="" not="" not<="" payments="" section="" th="" therefore="" to=""></these>
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$ -	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
16. Total Medicaid managed care non-claims payments (see question 13 above) received	\$185,450	Section H.

596

104,194

\$104,790

Yes

0.57%

225,681

13.08%

1,499,602

\$1,725,283

\$226,277

\$1,603,796

\$1,830,073

12.36%

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part II

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 Utilizat	ion 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)

	qes)		Contractual Adjustments								
	Inpat	ient Hospital	Outpatient Hospital	í Í Í	Non-Hospital	Inpat	tient Hospital	Outpatient Hospital	No	on-Hospital	Net Hospital Revenue
									-		
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	<u> </u>
29. Total Per Cost Report			t Revenues (G-3 Line 1)	\$	133,144,334		Total Cont	ractual Adj. (G-3 Line 2)	\$	107,627,127	
 Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED patient revenue) 	on worksheet	G-3, Line 2 (impa	ct is a decrease in net						+ ¢		
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT		on worksheet G-3	Line 2 (impact is a						Ψ		
decrease in net patient revenue)	INCLODED (in worksheet o o,									
• •									+ \$	-	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DS	H Revenue I	ICLUDED on wor	ksheet G-3, Line 2								
(impact is a decrease in net patient revenue)									+ \$	4,118,099	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Lo	cal Patient C	are Cash Subsidie	es INCLUDED on								
worksheet G-3, Line 2 (impact is a decrease in net patient reven	ue)										
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Ta			G 2 Line 2 (impact is an						Ψ		
increase in net patient revenue)		LD OIT WORKSHEET	0-5, Line 2 (impact is an								
									- \$	-	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove			d to insured patients								
INCLUDED on worksheet G-3, Line 2 (impact is an increase in n	et patient rev	enue)"							- \$	-	
36. Adjusted Contractual Adjustments										111,745,226	
37. Unreconciled Difference		Unreconciled D	ifference (Should be \$0)	\$			Unreconciled D	ifference (Should be \$0)	\$	-	

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 Co	ost Centers (list below):									
	JLTS & PEDIATRICS	\$ 6,135,407	\$-	\$-	-	\$ 6,135,407	4,291	\$ 9,959,941		\$ 1,429.83
	ENSIVE CARE UNIT	\$ -		\$ -		\$ -		\$ -		\$ -
	RONARY CARE UNIT	\$ -		s -		s -		<u>\$</u> -		\$ -
	RN INTENSIVE CARE UNIT RGICAL INTENSIVE CARE UNIT	<u>\$</u> - \$-	<u>\$</u> - \$-			\$ - \$ -		<u>\$</u> - \$-		\$- \$-
	HER SPECIAL CARE UNIT	\$ -		ş -		\$ -		\$ -		\$ -
	BPROVIDER I	\$ -		\$ -		s -		\$ -		\$ -
	BPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$ -		\$ -
	HER SUBPROVIDER	\$-	\$-	\$-		\$ -	-	\$-		\$-
04300 NUF				\$-		\$-		\$-		\$-
	Total Routine	\$ 6,135,407	\$-	\$ -	\$-	\$ 6,135,407	4,291	\$ 9,959,941		
	Weighted Average									\$ 1,429.83
			3, Pt. I, Line 28,	3, Pt. I, Line 28.01,	3, Pt. I, Line 28.02,	Multiplied by Days)	Worksheet C, Pt. I, Col. 6	Worksheet C, Pt. I, Col. 7	Worksheet C, Pt. I, Col. 8	Cost-to-Charge Ratio
	on Data (Non-Distinct)	1	Col. 8	Col. 8	Col. 8	¢ 4.045.072				0.567454
	on Data (Non-Distinct) servation (Non-Distinct)]	Col. 8	Col. 8	Col. 8	\$ 1,915,972	1,179,301	2,197,152	\$ 3,376,453	0.567451
		Cost Report Worksheet B, Part I, Col. 26		Col. 8 Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	\$ 1,915,972				Medicaid Calculated
09200 Obs	servation (Non-Distinct)	Worksheet B, Part I, Col. 26 servation) (list below	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY ;	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	Calculated	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Obs	servation (Non-Distinct) Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY :	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	Calculated	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616	Medicaid Calculated Cost-to-Charge Ratio 0.056230
09200 Obs	Servation (Non-Distinct) Cost Centers (from W/S C excluding Obs DioLOGY-DIAGNOSTIC DioLOGY-DIAGNOSTIC DioRATORY	Worksheet B, Part I, Col. 26	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$\$	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	Calculated	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.191667
09200 Obs	servation (Non-Distinct) Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC	Worksheet B, Part I, Col. 26 \$ 1,976,183 \$ 3,017,325 \$ 1,078,966	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	Calculated	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588	2,197,152 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,235,797	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385	Medicaid Calculated Cost-to-Charge Ratio 0.056233 0.19166 0.16987
09200 Obs Ancillary C 5400 RAD 6500 RAD 6500 RED 6900 ELE	Cost Centers (from WS C excluding Obs DIOLOGY-DIAGNOSTIC SORATORY SPIRATORY THERAPY	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4 \$ \$ \$	Col. 8	Calculated	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,235,197 \$ 5,756,893	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pr. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503	Medicaid Calculated Cost-to-Charge Ratio 0.056233 0.191667 0.169877 0.048781
09200 Obs Ancillary C 5400 RAD 6500 RES 6900 ELE 7100 MEE 7100 MED	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SORATORY SPIRATORY THERAPY COTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT DICAL SUPPLIES CHARGED TO PATIENTS	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,49,526 \$ 18,554 \$ 3,563,157	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY) S S S S S S S S S S S S S S S S S S	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Col. 8	Calculated \$ 1.976,183 \$ 3.017,325 \$ 1.078,966 \$ 349,526 \$ 18,554 \$ 3,653,157	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 5,1763 \$ 6,222,037	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,235,197 \$ 3,235,797 \$ 3,756,893 \$ 41,014 \$ 7,660,316	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 9,2777 \$ 13,912,353	Medicaid Calculated Cost-to-Charge Ratio 0.056231 0.19166 0.19987 0.048786 0.19998 0.256111
09200 Obs Ancillary C 5400 RAD 6500 RES 6900 ELE 7100 MEE 7100 MED	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SIGNATORY SPIRATORY THERAPY CICROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 18,554 \$ 3,563,157 \$ 7,106,094	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$		Col. 8	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,563,157 \$ 7,106,094	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,197 \$ 5,756,893 \$ 41,014 \$ 7,660,014 \$ 37,972,303	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,353 \$ 41,110,453	Medicaid Calculated Cost-to-Charge Ratio 0.056231 0.19166 0.19987 0.048786 0.19998 0.256111
09200 Obs Ancillary C 5400 RAD 6500 RES 6900 ELE 7100 MEE 7100 MED	Cost Centers (from WS C excluding Obs DiOLOGY-DIAGNOSTIC SORATORY SPIRATORY THERAPY CTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,49,526 \$ 18,554 \$ 3,563,157	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$	Cost Report Worksheet C, Part I, Col.2 and Col. 4 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Col. 8	Calculated \$ 1.976,183 \$ 3.017,325 \$ 1.078,966 \$ 349,526 \$ 18,554 \$ 3,653,157	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,197 \$ 5,756,893 \$ 41,014 \$ 7,660,014 \$ 37,972,303	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,353 \$ 41,110,453	Medicaid Calculated Cost-to-Charge Ratio 0.05623 0.19166 0.19186 0.19998 0.19998 0.25611 0.17285
09200 Obs Ancillary C 5400 RAD 6500 RES 6900 ELE 7100 MEE 7100 MED	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SIGNATORY SPIRATORY THERAPY CICROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 18,554 \$ 3,563,157 \$ 7,106,094	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$		Col. 8	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,563,157 \$ 7,106,094	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,197 \$ 5,756,893 \$ 41,014 \$ 7,660,014 \$ 37,972,303	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,353 \$ 41,110,453	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.19166 0.19186 0.199985 0.199985 0.256115 0.172854
09200 Obs Ancillary C 5400 RAD 6500 RES 6900 ELE 7100 MEE 7100 MED	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SIGNATORY SPIRATORY THERAPY CITROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary Weighted Average	Worksheet B, Part I, Col. 26 structure of the color of t	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$		Col. 8	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,563,157 \$ 7,106,994 \$ 17,109,805	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,553 \$ 41,110,453 \$ 41,110,453 \$ 122,895,039	
09200 Obs Ancillary C 5400 [RAC 6000 [AB 6000 [AB 6000 [AB 6000 [AB 6000 [AB 6000 [AB 7000]MB 7300 [DR 9100 EME	Cost Centers (from WS C excluding Obs DiOLOGY-DIAGNOSTIC SORATORY SPIRATORY THERAPY CTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary	Worksheet B, Part I, Col. 26 servation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 349,526 \$ 3,663,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 um of applicable Cost	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4 S S S S S S S S S S S S S S S S S S		Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,563,157 \$ 7,106,094	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,353 \$ 41,110,453 \$ 122,895,039	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.19166 0.19168 0.19986 0.19986 0.256115 0.172854
09200 Obs Ancillary C 5400 RAC 6000 LAB 6500 RES 6500 RES 6500 RES 6900 LBB 6500 RES 7100 MEC 7100 MEC 9100 EME 9100 EME	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC SPIRATORY THERAPY COTROCARDIOLOGY DIOLA. SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary Weighted Average Sub Totals SNF, and Swing Bed Cost for Medicaid (Si	Worksheet B, Part I, Col. 26 ervation) (list below \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 3,9526 \$ 18,554 \$ 3,63,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 um of applicable Cost # 200) um of applicable Cost	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$	Cost Report Worksheet C, Part I, Col.2 and Col. 4 S S S S S S S S S S S S S S S S S S S	Line 200 and	\$ 1.976,183 \$ 3.017,325 \$ 3.017,325 \$ 3.49,526 \$ 18,554 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,553 \$ 41,110,453 \$ 41,110,453 \$ 122,895,039	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.19166 0.19186 0.199985 0.199985 0.256115 0.172854
09200 Obs Ancillary C 5400 RAC 6000 LAE 6000 CAE 6000 LEE 7300 DRL 7300 DRL 9100 EME NF, Wor NF, Wor	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SIGRATORY SPIRATORY COTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary Weighted Average Sub Totals SNF, and Swing Bed Cost for Medicaid (Si Ksheet D, Part V, Title 19, Column 5-7, Lin SNF, and Swing Bed Cost for Medicaeid (Si Ksheet D, Part V, Title 19, Column 5-7, Lin SNF, and Swing Bed Cost for Medicaeid (Si	Worksheet B, Part I, Col. 26 \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 1,8554 \$ 3,653,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 um of applicable Cost e 200)	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4 S	Line 200 and	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,976,183 \$ 3,017,325 \$ 1,976,183 \$ 3,952,65 \$ 3,952,65 \$ 3,563,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 \$ -	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,553 \$ 41,110,453 \$ 41,110,453 \$ 122,895,039	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.19166 0.19168 0.19986 0.19986 0.256115 0.172854
09200 Obs Ancillary C 5400 RAL 6000 LAB 6000 LAB 6000 LEE 7300 DRL 7300 DRL 7300 DRL 9100 EME NF, Wor NF, Wor NF,	Cost Centers (from W/S C excluding Obs DIOLOGY-DIAGNOSTIC SIGNATORY SPIRATORY THERAPY CITROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UCS CHARGED TO PATIENTS ERGENCY Total Ancillary Weighted Average Sub Totals SNF, and Swing Bed Cost for Medicare (S rksheet D, Part V, Title 19, Column 5-7, Lin SNF, and Swing Bed Cost for Medicare (S rksheet D, Part V, Title 19, Column 5-7, Lin	Worksheet B, Part I, Col. 26 s 1.976,183 \$.077,325 \$.1,078,966 \$.349,526 \$.349,526 \$.3,563,157 \$.7,106,094 \$.3,563,157 \$.7,106,094 \$.17,109,805 \$.23,245,212 um of applicable Cost \$.200) um of applicable Cost \$.200) \$.400,5014 must calcu	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4 S	Line 200 and	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,078,966 \$ 349,526 \$ 3,563,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 \$ -	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,553 \$ 41,110,453 \$ 41,110,453 \$ 122,895,039	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.191667 0.191687 0.048766 0.199985 0.256115 0.172854
09200 Obs Ancillary C 5400 RAL 6000 LAB 6000 LAB 6000 LEE 7300 DRL 7300 DRL 7300 DRL 9100 EME NF, Wor NF, Wor NF,	Cost Centers (from W/S C excluding Obs DiOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC SIRATORY STRATORY THERAPY CTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENT UGS CHARGED TO PATIENTS ERGENCY Total Ancillary Weighted Average SUB Totals SNF, and Swing Bed Cost for Medicaid (St rksheet D, Part V, Title 18, Column 5-7, Lin SNF, and Swing Bed Cost for Other Payer SNF, and Swing Bed Cost for Other Payer	Worksheet B, Part I, Col. 26 s 1.976,183 \$.077,325 \$.1,078,966 \$.349,526 \$.349,526 \$.3,563,157 \$.7,106,094 \$.3,563,157 \$.7,106,094 \$.17,109,805 \$.23,245,212 um of applicable Cost \$.200) um of applicable Cost \$.200) \$.400,5014 must calcu	1,340 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY : \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Cost Report Worksheet C, Part I, Col.2 and Col. 4 S	Line 200 and	Calculated \$ 1,976,183 \$ 3,017,325 \$ 1,976,183 \$ 3,017,325 \$ 1,976,183 \$ 3,952,525 \$ 1,978,966 \$ 3,563,157 \$ 7,106,094 \$ 17,109,805 \$ 23,245,212 \$ - \$ - \$ - \$ -	1,179,301 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 3,483,444 \$ 3,479,102 \$ 3,115,588 \$ 1,407,610 \$ 51,763 \$ 6,252,037 \$ 3,138,150 \$ 22,106,995	2,197,152 Outpatient Charges Cost Report Worksheet C, Pt. I, Col. 7 \$ 31,661,172 \$ 12,263,397 \$ 3,225,797 \$ 5,756,893 \$ 41,014 \$ 7,660,316 \$ 37,972,303 \$ 100,788,044	\$ 3,376,453 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 35,144,616 \$ 15,742,499 \$ 6,351,385 \$ 7,164,503 \$ 92,777 \$ 13,912,553 \$ 41,110,453 \$ 41,110,453 \$ 122,895,039	Medicaid Calculated Cost-to-Charge Ratio 0.056230 0.19166 0.19186 0.199985 0.199985 0.256115 0.172854

* 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 Medic	aid FFS Primary	In-State Medicaid Ma	anaged Care Primary		FS Cross-Overs (with Secondary)	Included Elsewh Secondary - Exclud	edicaid Eligibles (Not ere & with Medicaid le Medicaid Exhausted n-Covered)		O Exhausted and Non- Included Elsewhere)	Unir	nsured	Medicaid FFS & MCO	dicaid (Days Include O Exhausted and Nor ered)	on-
Line # Cost	st 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 (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	% Survey Cost Rep Totals (Incl all payer
		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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis								
outine Cost Centers	s (from Section G):			Days		Days		Days		Days		Days		Days		Days		
03000 ADULTS & PE 03100 INTENSIVE CA	CARE UNIT	\$ 1,429.83 \$ -		- 215		- 30		357				-		- 135		- 716		
03200 CORONARY C 03300 BURN INTENS	CARE UNIT SIVE CARE UNIT	s - s -		-										-				
03400 SURGICAL INT	TENSIVE CARE UNIT	s -				-		-		-		-		-		-		4
03500 OTHER SPECI 04000 SUBPROVIDE	CIAL CARE UNIT	s - s -		-		-		-		-		-		-				A
04100 SUBPROVIDE 04200 OTHER SUBP	ER II	\$ ·		-		-		-		-		-		-		-		4
04300 NURSERY	PROVIDER	\$ -		-				-		-		-		-				8
			Total Days	215		30		357]	114]	-		135		716		
Total Days per PS&R or	or Exhibit Detail Unreconciled Days (E			215		30		357]	114]	-		135				
	Oneconciled Days (E	xpiain variance)							•		-							
Routine Charge	Des	1 1		Routine Charges \$ 365,715		Routine Charges		Routine Charges \$ 607,257	1	Routine Charges \$ 195.887	1	Routine Charges		Routine Charges \$ 229.635		Routine Charges		
Calculated Rou	outine Charge Per Diem			\$ 1,701.00		\$ 1,701.00		\$ 1,701.00	1	\$ 1,718.31		s -		\$ 1,701.00		\$ 1,703.76		.01
Ancillary Cost Centers	rs (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	å					
09200 Observation (N 5400 RADIOLOGY-E	Non-Distinct)	ļ	0.567451 0.056230	\$ 83,265 \$ 306,633	\$ 25,200 \$ 835,176	\$ 19,215 \$ 50,466	\$ 68,565 \$ 2,471,320	\$ 182,700 \$ 472,646	\$ 120,330 \$ 1,558,249	\$ 49,035 \$ 170,451	\$ 247,436 \$ 1,806,025	\$.	<u>s</u> -	\$ 90,405 \$ 294,101	\$ 89,775 \$ 3,611,498	\$ 334,215 \$ 1,000,196	\$ 461,531 \$ 6.670,770	1
6000 LABORATORY	Y		0.191667	\$ 411,309	\$ 524,935	\$ 95,849	\$ 1,660,451	\$ 742,837	\$ 979,004	\$ 211,118	\$ 1,079,709	\$ - \$ -	s -	\$ 370,502	\$ 1,909,387	\$ 1,461,113	\$ 4,244,099	9
6500 RESPIRATOR			0.169879	\$ 62,955 \$ 57,829	\$ 97,538 \$ 41,469	\$ 19,932 \$ 11,888	\$ 73,489 \$ 132,992	\$ 97,407 \$ 239,723	\$ 61,411 \$ 306,296	\$ 97,255 \$ 46,792	\$ 199,883 \$ 254,497	<u>\$</u>	<u>s</u> -	\$ 152,105 \$ 115,973	\$ 73,016 \$ 196,885	\$ 277,549 \$ 356,232	\$ 432,321 \$ 735,254	
7100 MEDICAL SUPP	PLIES CHARGED TO PATIENT		0.199985	\$ 1,108	\$-	\$ -	\$ 554	\$ 2,882	\$ 1,917	\$ 831	\$ 554	\$ -	s -	\$ 506	\$ 554	\$ 4,821	\$ 3,025	5
7300 DRUGS CHAR 9100 EMERGENCY			0.256115 0.172854	\$ 389,509 \$ 347,454	\$ 102,024 \$ 1,201,048	\$ 138,400 \$ 108,848	\$ 567,482 \$ 5,403,354	\$ 915,587 \$ 660,636	\$ 410,082 \$ 1,888,933	\$ 329,264 \$ 205,490	\$ 511,768 \$ 2,133,062	\$ - \$ -	s - s -	\$ 433,851 \$ 502,966	\$ 976,713 \$ 5,473,083	\$ 1,772,760 \$ 1,322,428	\$ 1,591,356 \$ 10,626,397	
				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			-
Totals / Payments																		
Т	Fotal 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	s .	s -	\$ 2,190,044 (Agrees to Exhibit A)	\$ 12,330,911 (Agrees to Exhibit A)	\$ 7,749,203	\$ 24,764,753	5
Total Charges per PS&F	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	\$ -	s -	\$ 2,190,044	\$ 12,330,911			
	Unreconciled Charges	Explain Variance)						-					. — — ·	-	· ·		-	-
Sampling Cost Adjust	itment (if applicable) alculated Cost (includes org	an acquisition from Se	ection I)	\$ 624.294	\$ 414,203	\$ 133.234	\$ 1,594,538	\$ 1.160.585	\$ 800.841	\$ 379.694	\$ 995.167	<u>د</u> .	s .	\$ 561.532	\$ 1.838.299	\$ - \$ 2.297.807	\$ 3,804,749	<u>.</u>
			,	\$ 336.302	\$ 356.977		• ••••	\$ 56.081			\$ 35,713		÷	1				-
	mount (excludes TPL, Co-Pay ed Care Paid Amount (exclude		nd-Down) (See Note E)	\$ 336,302 \$ -	\$ 356,977 \$ -	\$ 72.403	\$ 805,739	\$ 56,081	\$ 55,102 \$ -	\$ 6,508	\$ 35,713 \$ 17,300					\$ 398,891 \$ 105,745	\$ 447,792 \$ 823.039	
	uding primary and third party li	ability)		\$ 11,642	\$ 8	\$ 27,152	\$ 352,379	\$ -	\$ -	\$ 32,563	\$ 231,957					\$ 71,357	\$ 584,344	
	-Pay and Spend-Down) from Medicaid PS&R or RA De	toil (All Poursonto)		\$ - \$ 347.943	\$ - \$ 356.985	\$ - \$ 99.555	\$ 117 \$ 1,158,235	\$ -	\$-	\$ -	\$ 2,110	\$-	\$ -			s -	\$ 2,227	1
	ent Payments (See Note B)	ian (rai rayinchis)		\$ -	\$ (41,844)	\$ -	\$ -									s -	\$ (41,844	4)
	ents Reported on Cost Report ' non-HMO) Paid Amount (exclu			s -	\$ -	s -	ş -	\$ 622.653	\$ 401.059	\$ 114.103	\$ 68.208					\$ - \$ 736,756	\$	1
	ire (HMO) Paid Amount (exclu are (HMO) Paid Amount (exclu			5 -		5 -		\$ 622,653	\$ 401,059	\$ 114,103 \$ 66,422	\$ 68,208	5 -		\$		\$ 736,756	\$ 469,267 \$ 301,447	
Medicare Cross-Over B								\$ 26,889	\$ 6,637	\$ -	\$ -			(Agrees to Exhibit B and	(Agrees to Exhibit B and	\$ 26,889	\$ 6,637	
	Over Payments (See Note D) Uninsured During Cost Report	t Year (Cash Rasis)						\$ 361,304	\$ 62,767	s -	\$ -			B-1)	B-1) \$ 225.681	\$ 361,304	\$ 62,767	<u></u>
	Related to Inpatient Hospital		n Exhibits B & B-1 (from	Section E)										\$ -	\$ -	f		
								-		-	1.			-	-		-	-
Calculated Payment S	Shortfall / (Longfall) (PRIOR Calculated Payments as a		PAYMENTS AND DSH)	\$ 276,351 56%	\$ 99,062 76%	\$ 33,679 75%	\$ 436,303 73%	\$ 93,658 92%	\$ 275,276 66%	\$ 126,756 67%	\$ 338,431 66%	\$ -0%	\$ -	\$ 560,936 0%	\$ 1,612,618 12%	\$ 530,444 77%	\$ 1,149,073 709	
Total Medicare Dave fr	from W/S S-3 of the Cost Re	-	Bed (C/R. W/S S-3 Pt 1	Col. 6. Sum of Los 2	4 14 16 17 18 loce	lines 5 & 6)		1,717										
	r days to total Medicare days		(Sitt, 100 0 0, Pt. I,	,	., .,, ., ., ., .,			21%										
	its must agree to your inpatient							ries are not available (su	bmit logs with survey).						sured payment rate is	s outside normal range	es, please verify	
Note B - Medicaid cost s	t settlement payments refer to id Payments such as Outliers	payments made by Medi	icaid during a cost report	t settlement that are not r	effected on the claims or	aid summary (RA summa	inv or PS&P)							this is correct.				

Note D - should include onther Meacare cross-over payments in included in me paid camp address proteined to the services provided, including, including, including address payments in a contrast cost report estimation (e.g., metacare vralauate websical cucation payments). This is provided, including, including address payments in a cost payment in the contrast cost report estimation (e.g., metacare vralauate websical cucation payments). This provided, including in the paid camp against included to the services provided, including, including, including address payments in the cost report estimation of the services provided, including and the paid camp against included to the services provided, including included in the paid camp against included to the services provided, including and the paid to the services provided and the paid to the services provided, including and the paid to the services provided and the paid to the paid to the services provided and the paid to the paid to the paid to the paid

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 B benefits (due to no coverage or exhausted benefits).

	ort Year (10/01/2022-09/30/2023)	NORTHEAST GEOR	GIA MC LUMPKIN										
									FFS Cross-Overs (with	Included Elsewhe	Medicaid Eligibles (Nol ere & with Medicaid		
				Out-of-State Med	licaid FFS Primary	Out-of-State Medicaid	Managed Care Primary	Medicaid	Secondary)	Seco	ndary)	Total Out-Of-St	ate Medicai
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	Outpati
		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)		
	Cost Centers (list below):			Days		Days		Days		Days		Days	
	ADULTS & PEDIATRICS	\$ 1,429.83		2		-		-		-		2	
03100 I 03200 0	NTENSIVE CARE UNIT	\$ - \$ -		-		-		-		-			
	BURN INTENSIVE CARE UNIT	\$ -		-				-		-			
03400 \$	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		· .	
03500	OTHER SPECIAL CARE UNIT	\$ -		-						-			
	SUBPROVIDER I	\$ -		-				-		-		· ·	
	SUBPROVIDER II OTHER SUBPROVIDER	\$ - \$ -		-		-		-		-			
	NURSERY	\$ -				-							
L			Total Days	2				-		-		2	
Total Day	s per PS&R or Exhibit Detail			2		-		-		-			
,	Unreconciled Days	(Explain Variance				-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
l.	Routine Charges	1		\$ 3,402		s .		s .		s .		\$ 3,402	
	Calculated Routine Charge Per Dier			\$ 1,701.00		\$ -		\$ -		\$ -		\$ 1,701.00	
	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 C
09200	Observation (Non-Distinct) RADIOLOGY-DIAGNOSTIC	_	0.567451	6,720 6,448	3,465 86.001	-	-	-	-	-	-	\$ 6,720 \$ 6,448	\$
	ABORATORY		0.056230	6,448	67,451			-	-		2,965	\$ 6,448	\$\$
	RESPIRATORY THERAPY	-	0.169879	-	1,739	-	-		-	-	-	\$ 0,370	ş S
	ELECTROCARDIOLOGY		0.048786	-	-	-	-	-	-	-	-	\$ -	\$
	MEDICAL SUPPLIES CHARGED TO PATIE	T	0.199985	-		-		-	-	-	-	\$-	\$
	DRUGS CHARGED TO PATIENTS		0.256115	41,116	21,583	-	-	-	-	-	39		\$
9100 E	EMERGENCY		0.172854	12,542	174,327						3,537	\$ 12,542	\$
				75,802	354,566			-	-	-	6,541		
Totals / F	Payments												
	Total Charges (includes orga	acquisition from Sect	ion K)	\$ 79,204	\$ 354,566	\$ -	5 -	\$-	\$ -	\$ -	\$ 6,541	\$ 79,204	\$:
	arges per PS&R or Exhibit Detail			\$ 79,204	\$ 354,566	\$ -	\$-	\$ -	\$-	\$ -	\$ 6,541		
Total Cha	Unreconciled Charge	s (Explain Variance		· · · · · ·	· · · · · · · · · · · · · · · · · · ·	i	· · ·		-	· · · · · ·	i	,	
	Cost Adjustment (if applicable)					L					L	\$ -	\$ \$
		rgan acquisition from S	Section K)	\$ 21,454	\$ 55,686	\$-	\$-	\$-	ş -	\$ -	\$ 788	\$ 21,454	\$
	Total Calculated Cost (includes o			s -	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$ -	\$
Sampling	Total Calculated Cost (Includes o dicaid Paid Amount (excludes TPL, Co-Pay	and Spend-Dow					s .	\$-	\$-	\$-	\$-	\$ -	\$
Sampling Total Mee Total Mee	dicaid Paid Amount (excludes TPL, Co-Pay dicaid Managed Care Paid Amount (exclude	s TPL, Co-Pay and Sper	nd-Down) (See Note	\$ -	\$ -	\$ -	Ŷ		\$.	S -	\$ 5,243	\$ -	\$
Sampling Total Mee Total Mee Private In	dicaid Paid Amount (excludes TPL, Co-Pay dicaid Managed Care Paid Amount (exclude surance (including primary and third party I	s TPL, Co-Pay and Sper	nd-Down) (See Note	\$ - \$ -	\$ - \$ -	s - s -	\$ -	\$-	-				\$
Sampling Total Med Total Med Private In Self-Pay	dicaid Paid Amount (excludes TPL, Co-Pay dicaid Managed Care Paid Amount (exclude surrance (including primary and third party I (including Co-Pay and Spend-Down	s TPL, Co-Pay and Sper ability	nd-Down) (See Note		\$ - \$ - \$ -	\$- \$- \$-	\$- \$-	\$ - \$ -	\$ -	\$ -	\$-	\$-	
Sampling Total Mee Total Mee Private In Self-Pay Total Allo	dicaid Paid Amount (excludes TPL, Co-Pay dicaid Managed Care Paid Amount (exclude surance (including primary and third party I (including Co-Pay and Spend-Down wed Amount from Medicaid PS&R or RA D	s TPL, Co-Pay and Sper ability	nd-Down) (See Note		\$- \$- \$- \$-	\$- \$- \$- \$-	\$- \$- \$-	<u>\$</u> - \$-	\$-	\$-	\$-	s -	¢
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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 F - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, capitation and sub-capitation payments. Note F - Medicare payments reported in FFS, MCO, MOD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicare View and sub-capitation payments. 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	Total Additional Add-In Total Adiusted		Revenue for		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Orner intericant Englotes (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	
		Organ Acquisition Cos	Intern/Resident	n Total Adjusted Organ Acquisition Cost		Useable Organs (Count)	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 Tota Cost Report Organ Acquisition Cost		66 (substitute	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
C	Organ Acquisition Cost Centers (list below):											,						
	Lung Acquisition	S -	\$.	\$ -	<u>\$</u> -	0	\$ -	0	<u>\$</u> -	0	\$ -	0	S -	0	S -	0	\$ -	0
	Kidney Acquisition	<u>\$</u> -	\$.	\$.	<u>\$</u> -	0	<u>s</u> -	0	<u>\$</u>	0	<u>s</u> -	0	<u>\$</u> -	0	<u>\$</u> -	0	<u>\$</u> -	0
	Liver Acquisition	\$ -	\$ ·	\$ -	<u>s</u> -	0	s -	0	<u>s</u> -	0	\$ -	0	s -	0	<u>s</u> -	0	<u>s</u> -	0
-	Heart Acquisition	\$ -	\$.	- S -	<u>s</u> -	0	<u>s</u> -	0	<u>s</u> -	0	<u>s</u> -	0	\$ -	0	<u>s</u> -	0	<u>\$</u> -	0
-	Pancreas Acquisition Intestinal Acquisition	3 ·	3 ·	· > ·	3 -	0	<u> </u>	0	<u> </u>	0	3 ·	0	<u> </u>	0	3 ·	0	3 ·	0
-						0	s -	0	<u> </u>	0	s -	0	s -	0	s -	0	3 ·	0
_	Islet Acquisition		3 ·	- 3	3 ·	0	3 ·	0	3 -	0	3 ·	0	3 ·	0	3 ·	0	3 · ·	0
·		3 -	<u>ې</u>	ъ -	- پ	U	ə -	v	- ¢	U	، -	v	ə -	U	ۍ د د	v	ə -	U
9	Totals	s -	s .	s -	s -		s -	-	s -	-	s -		s -	-	s -		s -	
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n	Total Cost	7						-	1									

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 (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 (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 (but where organs transplanted into and have a 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			Revenue for	Total	Out-of-State Me	dicaid FFS Primary		icaid Managed Care nary		are FFS Cross-Overs id Secondary)	Included Elsewhe Secor	re & with Medicaid ndary)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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)							
Or	an Acquisition Cost Centers (list below):													
	Lung Acquisition	\$-	\$-	\$-	\$-	0	\$ -	0	\$ -	0	\$ -	0	\$ -	
	Kidney Acquisition	s -	\$-	\$-	\$-	0	S -	0	\$ -	0	s -	0	S -	
	Liver Acquisition	s -	\$-	\$-	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	
	Heart Acquisition	s -	\$-	\$-	\$-	0	S -	0	\$ -	0	s -	0	S -	
	Pancreas Acquisition	s -	\$-	\$-	\$ -	0	S -	0	\$ -	0	\$ -	0	S -	
	Intestinal Acquisition	\$ -	\$-	\$-	\$-	0	S -	0	\$ -	0	s -	0	S -	
	Islet Acquisition	\$ -	\$-	\$-	\$ -	0	S -	0	s -	0	s -	0	s -	
		s -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	
	Totals	ş .	ş -	ş .	\$-	-	ş .	-	\$-	-	\$-		S -	
	Total Cost	1												

Version 9.00

L. Provider Tax Assessment Reconciliation / Adjustment

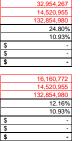
An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included 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.



Worksheet A Provider Tax Assessment Reconciliation:

I Hospital Gross Provider Tax Assessment (from general ledger)" Ime I Hospital Gross Provider Tax Assessment (from def is Expense on the Cost Report WS A, Col 2, 100,713) Sol 100,713 I Difference (Explain Here						W/S A Cost Center	
a Working Trial Balance Account # Pait Indudes Gross Provider Tax Assessment Expense 2 Hospital Gross Provider Tax Assessment Induded in Expense on the Cost Report (WS A, Col. 2) 5 3 Difference (Explain Here>) 0 9 Difference (Explain Here>) 0 10 Reason for adjustment i 0 11 Reason for adjustment i 0 12 Reason for adjustment i						Line	
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (WS A, Col. 2) § 190,713 5.01 (Where is the cost included on wis A?) 3 Difference (Explain Here) 0 s - Provider Tax Assessment Reliassifications (from wis A & of the Medicare cost report) 6 Relassification Code 0 7 Reclassification Code 0 - 7 Reclassification Code 0 - 8 Resource (Code Tax Assessment Adjustments (from wis A & of the Medicare cost report) - - 9 Resource (Code Tax Assessment Adjustments (from wis A & of the Medicare cost report) - - - 9 Resource (Code Tax Assessment Adjustments (from wis A & of the Medicare cost report) -				· ·	190,713		T
3 Difference (Explain Here				Expense			
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Provider Tax Assessment Reclassification Code 0 4 Reclassification Code 0 5 Reclassification Code 0 6 Reclassification Code 0 7 Reclassification Code 0 8 Reclassification Code 0 9 Reclassification Code 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 Reclassified to / (from)) 0 0 0 0 0 10 Reason for adjustment 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
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DSH UCC Provider Tax Assessment Adjustment: 17 Gross Allowable Assessment Not Included in the Cost Report \$ Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured: \$ 18 Medicaid Eligible*** Charges Sec. G 19 Uninsured Hospital Charges Sec. G 20 Total Hospital Charges Sec. G 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 UCC 10.93%	16 Total	Net Provider Tax Assessment Expense Inc	sluded in the Cost Report	\$	190 713		
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24 Uninsured Provider Tax Assessment Adjustment to DSH UCC \$ -					-		

2	9 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**
3	0 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC
3	1 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***
3	2 Uninsured Provider Tax Assessment Adjustment to DSH UCC
3	3 Medicaid Primary Tax Assessment Adjustment to DSH UCC***



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

25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles*** Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:

Charges Sec. G

Charges Sec. G

Charges Sec. G

Medicaid Primary***

Uninsured Hospital

Total Hospital

** 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 costto-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.

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