

**GA DSH Payment Results for SFY 2026 - Pool 2**  
**DSH Uncompensated Care Cost & Allocation Factor Summary**  
**Preliminary Results**

5/7/2026 15:39

Provider Name	NORTHEAST GEORGIA MC GAINSVILLE
Mcaid Provider Number	00000888A
Mcare Provider Number	110029

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2026 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

**NOTE: These are initial results only.**

<b>GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year:</b>	<b>7/1/2025</b>	<b>-</b>	<b>6/30/2026</b>
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	(A)	(B)	(C)	(D)	(E)
	Cost Report Year Begin	Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
<b>Cost Report Year UCC:</b>	<u>10/1/2023</u>	-	<u>\$ 109,768,630</u>	<u>\$ 250,975</u>	<u>\$ 110,022,130</u>
<b>Less: 2024 Net UPL Payments</b>					\$ 15,397,748
<b>Less: 2026 Net DPP Payments</b>					\$ 103,310,071
<b>Less: GME Payments</b>					\$ 1,950,336
<b>Add: Net OP Settlement (Difference between provider submitted and estimated)</b>					\$ 488,899
<b>Add: Provider tax excluded from the cost report (Medicaid primary &amp; uninsured portion)</b>					\$ -
<b>Uncompensated Care Allocation Factor</b>					\$ (10,147,126)
<b>Hospital Specific DSH Limit</b>					\$ (80,281,684)
<b>2026 Eligibility</b>					<b>Not Eligible</b>

**Note: If the Hospital Specific DSH Limit (i.e. UCC) is negative, the hospital does not qualify for a DSH payment even if the Uncompensated Care Allocation Factor is positive.**

<b>DSH Year Low Income Utilization Ratio (LIUR):</b>	20.11%
<b>DSH Year Medicaid Inpatient Utilization Ratio (MIUR):</b>	23.73%

**If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.**

All inquiries and additional documentation should be sent to the following:

- e-mail: [gadsh@mslc.com](mailto:gadsh@mslc.com)
- Fax: 816-945-5301
- Web Portal Address: <https://DSH.MSLC.com>
- Phone Inquiries: 800-374-6858

**EXAMINER ADJUSTED SURVEY**

Workpaper #:		Reviewer:	
Examiner:			
Date:			
DSH Version 9.02		4/22/2025	

**D. General Cost Report Year Information** **10/1/2023 - 9/30/2024**

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 GAINSVILLE**

10/1/2023 through 9/30/2024		
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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: **3/4/2025**

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MC GAINSVILLE	Yes	
5. Medicaid Provider Number:	000000888A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000000888S	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110029	Yes	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	-	
11. Rural Referral Center (Yes or No)	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.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2023 - 09/30/2024)**

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)	\$ 2,121,300	\$ 7,476,910	\$9,598,210
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 10,110,027	\$ 39,339,490	\$49,449,517
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$12,231,327	\$46,816,400	\$59,047,727
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	17.34%	15.97%	16.26%

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	\$ 69,486,732
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	\$69,486,732

<--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 (10/01/2023 - 09/30/2024)**

**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) 253,025

**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	169,805,276
8. Outpatient Hospital Charity Care Charges	172,116,366
9. Non-Hospital Charity Care Charges	996,891
10. Total Charity Care Charges	\$ 342,918,533

**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	\$ 545,120,098	\$ -	\$ -	\$ 423,017,016	\$ -	\$ -	\$ 122,103,082
12. Psych Subprovider	\$ 42,510,513	\$ -	\$ -	\$ 32,988,456	\$ -	\$ -	\$ 9,522,057
13. Rehab. Subprovider	\$ 13,664,259	\$ -	\$ -	\$ 10,603,561	\$ -	\$ -	\$ 3,060,698
14. Swing Bed - SNF							
15. Swing Bed - NF							
16. Skilled Nursing Facility			\$ 21,316,574			\$ 16,541,811	
17. Nursing Facility							
18. Other Long-Term Care							
19. Ancillary Services	\$ 3,325,132,883	\$ 3,324,609,927	\$ -	\$ 2,580,326,419	\$ 2,579,920,602	\$ -	\$ 1,489,495,789
20. Outpatient Services		\$ 738,603,454	\$ -		\$ 573,161,456	\$ -	\$ 165,441,998
21. Home Health Agency							
22. Ambulance							
23. Outpatient Rehab Providers							
24. ASC							
25. Hospice			\$ 28,682,290			\$ 22,257,658	
26. Other	\$ 13,225,500	\$ -	\$ 12,804,603	\$ 10,263,081	\$ -	\$ 9,936,462	\$ 2,962,419
27. Total	\$ 3,939,653,253	\$ 4,063,213,381	\$ 62,803,467	\$ 3,057,198,533	\$ 3,153,082,058	\$ 48,735,931	\$ 1,792,586,044
28. Total Hospital and Non Hospital		Total from Above	\$ 8,065,670,101	Total from Above	\$ 6,259,016,521		
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 8,065,670,101	Total Contractual Adj. (G-3 Line 2)	\$ 6,260,412,404		
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					\$ -		
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					\$ -		
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					\$ -		
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					\$ -		
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)					\$ 1,395,883		
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					\$ 6,259,016,521		
37. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -		

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

Cost Report Year (10/01/2023-09/30/2024) **NORTHEAST GEORGIA MC GAINSVILLE**

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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

**Routine Cost Centers (list below):**

1	03000 ADULTS & PEDIATRICS	\$ 308,681,610	\$ 13,032,160	\$ -	\$ -	\$ 321,713,770	236,902	\$ 401,981,017	\$ 1,358.00
2	03100 INTENSIVE CARE UNIT	\$ 67,044,105	\$ 3,983,033	\$ -	\$ -	\$ 71,027,138	38,157	\$ 153,740,628	\$ 1,861.44
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ 11,970,428	\$ -	\$ -	\$ -	\$ 11,970,428	5,186	\$ 45,573,225	\$ 2,308.22
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	04300 NURSERY	\$ 16,119,310	\$ 42,533	\$ -	\$ -	\$ 16,161,843	16,834	\$ 13,225,500	\$ 960.07
11	3501 PSYCHIATRIC INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12	3502 DETOXIFICATION INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18	Total Routine	\$ 403,815,453	\$ 17,057,726	\$ -	\$ -	\$ 420,873,179	297,079	\$ 614,520,370	\$ 1,416.70
19	Weighted Average								

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		44,054	-	-	\$ 59,825,332	42,235,056	75,123,191	\$ 117,358,247	0.509767
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Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio

**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

21	5000 OPERATING ROOM	\$ 122,424,136	\$ 3,198,157	\$ -	\$ -	\$ 125,622,293	\$ 484,049,272	\$ 681,533,155	\$ 1,165,582,427	0.107776
22	5200 DELIVERY ROOM & LABOR ROOM	\$ 21,687,477	\$ -	\$ -	\$ -	\$ 21,687,477	\$ 71,041,441	\$ 6,243,102	\$ 77,284,543	0.280619
23	5300 ANESTHESIOLOGY	\$ 6,026,137	\$ -	\$ -	\$ -	\$ 6,026,137	\$ 176,215,584	\$ 188,438,644	\$ 364,654,228	0.016526
24	5400 RADIOLOGY-DIAGNOSTIC	\$ 45,781,136	\$ 40,168	\$ -	\$ -	\$ 45,821,304	\$ 60,497,016	\$ 253,036,004	\$ 313,533,020	0.146145
25	5500 RADIOLOGY-THERAPEUTIC	\$ 16,092,827	\$ 9,005	\$ -	\$ -	\$ 16,101,832	\$ 39,382,472	\$ 214,219,593	\$ 253,602,065	0.063493
26	5700 CT SCAN	\$ 16,435,453	\$ 158,028	\$ -	\$ -	\$ 16,593,481	\$ 168,232,393	\$ 288,864,629	\$ 457,097,022	0.036302
27	5800 MRI	\$ 9,681,475	\$ -	\$ -	\$ -	\$ 9,681,475	\$ 30,744,502	\$ 100,955,266	\$ 131,699,768	0.073512
28	6000 LABORATORY	\$ 64,890,638	\$ -	\$ -	\$ -	\$ 64,890,638	\$ 423,139,784	\$ 370,838,817	\$ 793,978,601	0.081728
29	6500 RESPIRATORY THERAPY	\$ 23,214,927	\$ -	\$ -	\$ -	\$ 23,214,927	\$ 173,974,266	\$ 17,392,965	\$ 191,367,231	0.121311
30	6600 PHYSICAL THERAPY	\$ 37,427,259	\$ -	\$ -	\$ -	\$ 37,427,259	\$ 40,409,899	\$ 34,713,024	\$ 75,122,923	0.498214
31	6900 ELECTROCARDIOLOGY	\$ 65,475,655	\$ -	\$ -	\$ -	\$ 65,475,655	\$ 259,865,843	\$ 313,962,358	\$ 573,828,201	0.114103
32	7000 ELECTROENCEPHALOGRAPHY	\$ 8,415,088	\$ 5,558	\$ -	\$ -	\$ 8,420,646	\$ 8,004,741	\$ 13,952,344	\$ 21,957,085	0.383505

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

Cost Report Year (10/01/2023-09/30/2024) **NORTHEAST GEORGIA MC GAINSVILLE**

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 94,163,076	\$ -	\$ -	\$ 94,163,076	\$ 310,598,867	\$ 251,234,431	\$ 561,833,298	0.167600
34	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 116,173,584	\$ -	\$ -	\$ 116,173,584	\$ 373,758,696	\$ 222,345,702	\$ 596,104,398	0.194888
35	7300 DRUGS CHARGED TO PATIENTS	\$ 107,538,840	\$ -	\$ -	\$ 107,538,840	\$ 633,869,256	\$ 315,777,967	\$ 949,647,223	0.113241
36	7400 RENAL DIALYSIS	\$ 4,961,843	\$ -	\$ -	\$ 4,961,843	\$ 42,798,642	\$ 7,559,925	\$ 50,358,567	0.098530
37	7601 WOUND CARE CLINIC	\$ 3,513,456	\$ -	\$ -	\$ 3,513,456	\$ 28,549,955	\$ 43,258,716	\$ 71,808,671	0.048928
38	7602 DIABETIC EDUCATION	\$ 1,659,028	\$ -	\$ -	\$ 1,659,028	\$ 254	\$ 283,285	\$ 283,539	5.851146
39	9100 EMERGENCY	\$ 66,859,337	\$ 7,896,353	\$ -	\$ 74,755,690	\$ 195,481,417	\$ 425,763,790	\$ 621,245,207	0.120332
126	<b>Total Ancillary</b>	\$ 832,421,372	\$ 11,307,269	\$ -	\$ 843,728,641	\$ 3,562,849,356	\$ 3,825,496,908	\$ 7,388,346,264	
127	<b>Weighted Average</b>								<b>0.122294</b>
128	<b>Sub Totals</b>	\$ 1,236,236,825	\$ 28,364,995	\$ -	\$ 1,264,601,820	\$ 4,177,369,726	\$ 3,825,496,908	\$ 8,002,866,634	
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)				\$ 223,353				
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	<b>Grand Total</b>				\$ 1,264,378,467				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost								2.29%

\* 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 (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC GAINSVILLE

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & 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)														
				Inpatient		Outpatient		Inpatient		Outpatient		Inpatient		Outpatient		Inpatient			Outpatient													
				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 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		Inpatient	Outpatient												
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>																
1	03000 ADULTS & PEDIATRICS	\$ 1,358.00		12,378		7,673		12,919		6,052		1,028		15,600		40,050		29.13%														
2	03100 INTENSIVE CARE UNIT	\$ 1,861.44		427		265		1,908		860		64		1,928		3,524		14.63%														
3	03200 CORONARY CARE UNIT	\$ -		-		-		-		-		-		-		-																
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-																
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-																
6	03500 OTHER SPECIAL CARE UNIT	\$ 2,308.22		3,547		-		-		-		-		-		-																
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-		-		-		68.40%														
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-		-		-																
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-		-		-																
10	04300 NURSERY	\$ 960.07		3,492		8,474		-		145		136		358		12,247		75.04%														
11	3501 PSYCHIATRIC INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-																
12	3502 DETOXIFICATION INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-																
18			<b>Total Days</b>	19,844		16,412		14,827		7,057		1,228		17,886		59,368		30.80%														
19	Total Days per PS&R or Exhibit Detail			19,844		16,412		14,827		7,057		1,228		17,886																		
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-		-																
21	Routine Charges	\$ 62,321,594		\$ 45,488,037		\$ 36,080,598		\$ 17,355,598		\$ 2,921,845		\$ 45,072,201		\$ 181,234,725				32.25%														
21.01	Calculated Routine Charge Per Diem	\$ 2,636.65		\$ 2,771.63		\$ 2,432.69		\$ 2,459.34		\$ 2,317.46		\$ 2,519.97		\$ 2,547.41																		
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>																
22	09200 Observation (Non-Distinct)	\$ 0.509767		\$ 3,965,050		\$ 2,203,066		\$ 4,378,350		\$ 4,252,491		\$ 4,998,936		\$ 2,599,427		\$ 2,416,182		\$ 205,922		\$ 372,863		\$ 5,063,855		\$ 8,047,074		\$ 12,802,974		\$ 13,984,535		34.75%		
23	5000 OPERATING ROOM	\$ 0.107776		\$ 28,508,508		\$ 13,701,113		\$ 21,145,984		\$ 24,160,874		\$ 25,314,083		\$ 28,277,915		\$ 4,712,110		\$ 1,628,903		\$ 1,981,591		\$ 33,399,430		\$ 38,604,158		\$ 80,494,478		\$ 70,852,012		18.55%		
24	5200 DELIVERY ROOM & LABOR ROOM	\$ 0.280619		\$ 6,324,907		\$ 78,176		\$ 14,857,215		\$ 1,794,852		\$ 24,648		\$ 45,521		\$ 1,161		\$ 288,030		\$ 172,248		\$ 628,556		\$ 153,410		\$ 20,230,103		\$ 1,899,810		30.14%		
25	5300 ANESTHESIOLOGY	\$ 0.016526		\$ 8,197,914		\$ 3,932,936		\$ 9,893,239		\$ 6,693,357		\$ 7,547,540		\$ 7,356,976		\$ 2,342,366		\$ 482,613		\$ 10,281,464		\$ 10,583,632		\$ 10,281,464		\$ 10,583,632		\$ 27,981,059		\$ 19,188,370		19.05%
26	5400 RADIOLOGY-DIAGNOSTIC	\$ 0.146145		\$ 4,843,339		\$ 10,528,543		\$ 1,821,509		\$ 4,728,380		\$ 8,758,410		\$ 12,461,712		\$ 2,018,728		\$ 2,561,564		\$ 635,614		\$ 4,623,271		\$ 15,781,083		\$ 13,411,956		\$ 34,310,229		\$ 22,116		22.11%
27	5500 RADIOLOGY-THERAPEUTIC	\$ 0.063493		\$ 7,335,993		\$ 977,760		\$ 1,367,746		\$ 3,677,174		\$ 631,121		\$ 8,805,445		\$ 1,389,987		\$ 1,775,558		\$ 92,782		\$ 2,794,837		\$ 7,793,039		\$ 10,924,847		\$ 15,157,037		\$ 14,766		14.76%
28	5700 CT SCAN	\$ 0.036302		\$ 9,569,582		\$ 5,944,236		\$ 1,729,021		\$ 8,758,262		\$ 11,712,417		\$ 14,658,195		\$ 4,470,757		\$ 2,177,411		\$ 287,056		\$ 601,431		\$ 13,674,554		\$ 29,718,326		\$ 27,480,777		\$ 31,538,104		22.77%
29	5800 MRI	\$ 0.073512		\$ 1,876,691		\$ 1,717,427		\$ 494,122		\$ 2,704,376		\$ 1,978,806		\$ 3,684,480		\$ 620,719		\$ 651,243		\$ 54,214		\$ 198,530		\$ 3,002,541		\$ 4,437,188		\$ 4,973,338		\$ 8,737,526		16.39%
30	6000 LABORATORY	\$ 0.081728		\$ 29,526,417		\$ 11,968,400		\$ 14,405,646		\$ 16,285,922		\$ 16,094,183		\$ 12,927,098		\$ 8,795,692		\$ 1,295,572		\$ 30,077,907		\$ 30,989,942		\$ 84,851,081		\$ 53,104,197		\$ 88,651,081		\$ 53,104,197		25.83%
31	6500 RESPIRATORY THERAPY	\$ 0.121311		\$ -		\$ -		\$ 6,577,026		\$ 1,402,877		\$ 5,814,225		\$ 684,327		\$ 7,833,244		\$ 675,337		\$ 283,366		\$ 71,133		\$ 7,275,706		\$ 1,021,075		\$ 20,224,495		\$ 2,762,641		17.03%
32	6600 PHYSICAL THERAPY	\$ 0.499574		\$ 1,886,831		\$ 603,753		\$ 773,616		\$ 1,650,847		\$ 1,960,574		\$ 1,154,579		\$ 784,493		\$ 244,673		\$ 59,399		\$ 196,389		\$ 1,636,975		\$ 1,950,094		\$ 5,363,914		\$ 3,653,892		17.30%
33	6900 ELECTROCARDIOLOGY	\$ 0.114103		\$ 12,439,967		\$ 5,825,860		\$ 2,426,144		\$ 3,943,656		\$ 14,146,950		\$ 15,725,096		\$ 5,339,916		\$ 2,190,881		\$ 337,186		\$ 449,264		\$ 15,441,912		\$ 14,557,978		\$ 34,352,976		\$ 27,685,493		16.37%
34	7000 ELECTROENCEPHALOGRAPHY	\$ 0.383505		\$ 602,600		\$ 270,540		\$ 1,371,272		\$ 1,601,396		\$ 679,680		\$ 632,461		\$ 112,022		\$ 24,864		\$ 96,639		\$ 627,545		\$ 791,251		\$ 2,939,164		\$ 2,616,419		\$ 2,616,419		32.52%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 0.167690		\$ 12,948,165		\$ 2,971,058		\$ 10,969,268		\$ 6,602,639		\$ 13,604,550		\$ 10,133,894		\$ 5,086,271		\$ 1,271,486		\$ 698,455		\$ 687,078		\$ 18,292,467		\$ 11,771,321		\$ 42,608,354		\$ 20,979,067		17.00%
36	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 0.194888		\$ 14,322,734		\$ 499,099		\$ 2,892,100		\$ 3,818,685		\$ 17,633,461		\$ 12,043,071		\$ 5,615,174		\$ 3,933,012		\$ 434,601		\$ 398,366		\$ 15,647,110		\$ 8,668,757		\$ 40,263,470		\$ 17,754,468		14.00%
37	7300 DRUGS CHARGED TO PATIENTS	\$ 0.113241		\$ 50,089,685		\$ 21,300,568		\$ 17,310,441		\$ 47,235,654		\$ 21,288,357		\$ 22,130,735		\$ 5,156,012		\$ 1,902,218		\$ 1,184,738		\$ 53,313,261		\$ 34,950,630		\$ 140,756,651		\$ 53,073,441		\$ 53,073,441		30.39%
38	7400 RENAL DIALYSIS	\$ 0.098530		\$ 2,856,837		\$ -		\$ 685,838		\$ 578,613		\$ 3,650,742		\$ 898,746		\$ 4,309,511		\$ 736,241		\$ 71,564		\$ 101,051		\$ 2,225,767		\$ 1,549,359		\$ 11,502,928		\$ 2,213,600		35.54%
39	7600 WOUND CARE CLINIC	\$ 0.048928		\$ 116,632		\$ 48,844		\$ 654,008		\$ 17,927		\$ 2,944		\$ 599,304		\$ 1,581		\$ 158,693		\$ 13,071		\$ 18,033		\$ 21,323		\$ 775,165		\$ 824,788		\$ 2,544		2.54%
40	7602 DIABETIC EDUCATION	\$ 5.851146		\$ -		\$ -		\$ 29,225		\$ 202		\$ 635		\$ -		\$ 15,772		\$ -		\$ 46,405		\$ 32,079		\$ -		\$ 202		\$ 45,532		\$ -		43.80%
41	9100 EMERGENCY	\$ 0.120332		\$ 6,027,047		\$ 10,701,032		\$ 2,071,890		\$ 30,187,541		\$ 7,022,366		\$ 13,394,502		\$ 2,923,516		\$ 2,203,797		\$ 337,016		\$ 1,353,715		\$ 9,447,693		\$ 46,510,308		\$ 18,044,819		\$ 56,486,876		21.40%
				197,640,897		81,191,075		117,222,216		144,355,624		195,733,243		172,886,329		89,207,772		38,415,948		8,689,576		11,239,450		227,376,074		268,090,918						

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

Cost Report Year (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC GAINSVILLE

	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere & 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)								
<b>Totals / Payments</b>															
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 249,962,491	\$ 81,191,075	\$ 162,710,253	\$ 144,355,624	\$ 231,802,749	\$ 172,886,329	\$ 106,563,360	\$ 38,415,948	\$ 11,511,221	\$ 11,239,450	\$ 272,448,275	\$ 268,090,918	\$ 751,038,854	\$ 436,848,977	21.79%
129 Total Charges per PS&R or Exhibit Detail	\$ 249,962,491	\$ 81,191,075	\$ 162,710,253	\$ 144,355,624	\$ 231,802,749	\$ 172,886,329	\$ 106,563,360	\$ 38,415,948	\$ 11,511,221	\$ 11,239,450	\$ 272,448,275	\$ 268,090,918			
130 Unreconciled Charges (Explain Variance)															
131.01 <b>Sampling Cost Adjustment (if applicable)</b>															
131.02 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 53,865,839	\$ 9,611,205	\$ 35,412,580	\$ 18,540,730	\$ 45,625,136	\$ 21,100,410	\$ 21,174,918	\$ 5,092,514	\$ 2,739,781	\$ 1,724,788	\$ 52,855,627	\$ 31,849,293	\$ 155,978,473	\$ 54,344,859	23.54%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 37,591,911	\$ 8,623,819	\$ -	\$ 1,498	\$ 1,881,174	\$ 1,456,820	\$ 93,154	\$ 4,721					\$ 39,586,239	\$ 10,086,658	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 27,310,598	\$ 14,378,584	\$ -	\$ -	\$ 1,070	\$ 28,891					\$ 27,311,677	\$ 14,407,475	
134 Private Insurance (including primary and third party liability)	\$ 595,144	\$ 19,098	\$ 53,937	\$ 1,448	\$ 26,463	\$ 21,944	\$ 50,830	\$ 66,511					\$ 726,383	\$ 109,002	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 725	\$ 9,685	\$ 1,288	\$ 4,765	\$ 613	\$ 6,822	\$ 6,306	\$ 3,040	\$ -	\$ 9,203			\$ 8,931	\$ 24,312	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 38,187,780	\$ 8,652,402	\$ 27,365,823	\$ 14,386,294											
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ 297,545	\$ -	\$ -										\$ 297,545	
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)	\$ -	\$ -	\$ -	\$ -	\$ 31,624,897	\$ 14,975,598	\$ 6,636,846	\$ 286,405	\$ -	\$ -	\$ -	\$ -	\$ 38,261,743	\$ 15,262,003	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,008,881	\$ 2,699,654	\$ -	\$ -	\$ -	\$ -	\$ 8,008,881	\$ 2,699,694	
141 Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ 275,749	\$ 388,671	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 275,749	\$ 388,671	
142 Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ 8,316,330	\$ 3,414,436	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,316,330	\$ 3,414,436	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											\$ 2,121,300	\$ 7,476,910			
145 <b>Calculated Payment Shortfall (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 15,678,059	\$ 661,258	\$ 8,046,757	\$ 4,154,436	\$ 3,399,911	\$ 836,119	\$ 6,377,814	\$ 2,003,251	\$ 2,739,781	\$ 1,715,585	\$ 50,734,327	\$ 24,372,383	\$ 33,502,541	\$ 7,655,064	
146 <b>Calculated Payments as a Percentage of Cost</b>	71%	93%	77%	78%	93%	96%	70%	61%	0%	1%	4%	23%	79%	86%	
147 <b>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 &amp; 6)</b>					124,769										12%
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>															

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).

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

Cost Report Year (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC GAINSVILLE

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				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 PS&R Summary (Note A)	From PS&R Summary (Note A)
<b>Routine Cost Centers (list below):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>	
03000	ADULTS & PEDIATRICS	\$ 1,358.00		373		-		149		-		522	
03100	INTENSIVE CARE UNIT	\$ 1,861.44		99		-		31		-		130	
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-	
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03500	OTHER SPECIAL CARE UNIT	\$ 2,308.22		-		-		-		-		-	
04000	SUBPROVIDER I	\$ -		-		-		-		-		-	
04100	SUBPROVIDER II	\$ -		-		-		-		-		-	
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
04300	NURSERY	\$ 960.07		27		-		-		-		27	
3501	PSYCHIATRIC INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
3502	DETOXIFICATION INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
	<b>Total Days</b>			<b>499</b>		<b>-</b>		<b>180</b>		<b>-</b>		<b>679</b>	
19	Total Days per PS&R or Exhibit Detail			499		-		180		-		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	<b>Routine Charges</b>			<b>\$ 1,453,135</b>		<b>\$ -</b>		<b>\$ 446,090</b>		<b>\$ -</b>		<b>\$ 1,899,225</b>	
21.01	Calculated Routine Charge Per Diem			\$ 2,912.09		\$ -		\$ 2,478.28		\$ -		\$ 2,797.09	
<b>Ancillary Cost Centers (from WIS C) (list below):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>	
02200	Observation (Non-Distinct)	0.599767		128,237	109,616	-	-	20,975	48,970	-	-	149,212	158,586
5000	OPERATING ROOM	0.107776		789,225	87,196	-	-	413,095	72,772	-	-	1,202,320	159,968
5200	DELIVERY ROOM & LABOR ROOM	0.280619		20,232	2,215	-	-	-	-	-	-	20,232	2,215
5300	ANESTHESIOLOGY	0.016526		249,935	27,229	-	-	130,446	25,249	-	-	380,381	52,478
5400	RADIOLOGY-DIAGNOSTIC	0.146145		139,527	129,753	-	-	79,167	26,648	-	-	218,694	156,401
5500	RADIOLOGY-THERAPEUTIC	0.063493		338,950	-	-	-	28,238	-	-	-	81,164	-
5700	CT SCAN	0.036302		99,073	315,973	-	-	70,607	61,662	-	-	409,757	377,635
5800	MRI	0.073512		1,013,513	301,681	-	-	25,211	2,040	-	-	1,24,284	57,178
6000	LABORATORY	0.081728		731,507	13,759	-	-	429,512	73,151	-	-	1,443,025	374,832
6500	RESPIRATORY THERAPY	0.121311		82,747	3,356	-	-	19,500	12,349	-	-	923,991	26,108
6600	PHYSICAL THERAPY	0.498214		516,101	116,117	-	-	349,390	104,933	-	-	1,02,247	3,356
6900	ELECTROCARDIOLOGY	0.114103		29,461	11,884	-	-	2,495	-	-	-	865,491	221,050
7000	ELECTROENCEPHALOGRAPHY	0.383505		502,652	57,139	-	-	362,537	28,320	-	-	31,956	11,884
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.167600		550,937	2,942	-	-	233,313	26,136	-	-	865,189	85,459
7200	IMPL. DEV. CHARGED TO PATIENTS	0.194888		2,044,373	343,671	-	-	905,632	80,081	-	-	2,950,005	423,752
7300	DRUGS CHARGED TO PATIENTS	0.098530		156,901	17,432	-	-	54,120	4,358	-	-	211,021	21,790
7400	RENAL DIALYSIS	0.048928		1,578	-	-	-	-	-	-	-	1,578	-
7601	WOUND CARE CLINIC	5.851146		-	-	-	-	-	-	-	-	-	-
7602	DIABETIC EDUCATION	0.120332		-	-	-	-	-	-	-	-	-	-
9100	EMERGENCY			145,494	520,670	-	-	36,769	52,355	-	-	182,263	573,025
				7,593,370	2,115,772	-	-	3,353,691	619,024	-	-	-	-
<b>Totals / Payments</b>													
128	<b>Total Charges (includes organ acquisition from Section K)</b>			<b>\$ 9,046,505</b>	<b>\$ 2,115,772</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 3,799,781</b>	<b>\$ 619,024</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 12,846,286</b>	<b>\$ 2,734,796</b>
129	Total Charges per PS&R or Exhibit Detail			\$ 9,046,505	\$ 2,115,772	\$ -	\$ -	\$ 3,799,781	\$ 619,024	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-
131.01	Sampling Cost Adjustment (if applicable)			-	-	-	-	-	-	-	-	-	-
131.02	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>			<b>\$ 1,659,468</b>	<b>\$ 260,077</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 662,738</b>	<b>\$ 84,594</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 2,322,206</b>	<b>\$ 344,671</b>
132	Total Medicaid Paid Amount (excludes TPL Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,076	\$ -	\$ -	\$ -	\$ 1,076
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
134	Private Insurance (including primary and third party liability)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,229	\$ -	\$ -	\$ -	\$ 1,229
135	Self-Pay (including Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
137	Medicaid Cost Settlement Payments (See Note B)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)			\$ -	\$ -	\$ -	\$ -	\$ 260,765	\$ 16,195	\$ -	\$ -	\$ 260,765	\$ 16,195

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

Cost Report Year (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC GAINSVILLE

	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	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 286,526	\$ 28,689	\$ -	\$ -	\$ 286,526	\$ 28,689
141 Medicare Cross-Over Bad Debt Payments					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 1,659,468	\$ 260,077	\$ -	\$ -	\$ 115,448	\$ 37,405	\$ -	\$ -	\$ 1,774,916	\$ 297,482
144 <b>Calculated Payments as a Percentage of Cost</b>	0%	0%	0%	0%	83%	56%	0%	0%	24%	14%

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 Uninsured**

Cost Report Year (10/01/2023-09/30/2024)

NORTHEAST GEORGIA MC GAINSVILLE

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & 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>	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
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 organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

**K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid**

Cost Report Year (10/01/2023-09/30/2024)

NORTHEAST GEORGIA MC GAINSVILLE

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		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)	
<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>	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
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 (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC GAINSVILLE

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	WS A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 20,172,833	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	69000 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 20,172,833	5.05 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code	\$ -	- (Reclassified to / (from))
5 Reclassification Code	\$ -	- (Reclassified to / (from))
6 Reclassification Code	\$ -	- (Reclassified to / (from))
7 Reclassification Code	\$ -	- (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	\$ -	- (Adjusted to / (from))
9 Reason for adjustment	\$ -	- (Adjusted to / (from))
10 Reason for adjustment	\$ -	- (Adjusted to / (from))
11 Reason for adjustment	\$ -	- (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	\$ -	-
13 Reason for adjustment	\$ -	-
14 Reason for adjustment	\$ -	-
15 Reason for adjustment	\$ -	-
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 20,172,833	

**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	1,226,219,583
19 Uninsured Hospital Charges Sec. G	540,539,194
20 Total Hospital Charges Sec. G	8,002,866,634
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	15.32%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.75%
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	649,381,720
27 Uninsured Hospital Charges Sec. G	563,289,865
28 Total Hospital Charges Sec. G	8,002,866,634
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	8.11%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.04%
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.

**DSH Examination Eligibility Summary**

Hospital Name	<b>NORTHEAST GEORGIA MC GAINSVILLE</b>			
Hospital Medicaid Number	<b>000000888A</b>			
Cost Report Period	From	<b>10/1/2023</b>	To	<b>9/30/2024</b>

		As-Reported	Adjustments	As-Adjusted
<b>LIUR</b>				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 92,356,759	\$ -	\$ 92,356,759
2 Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
3 Total		\$ 92,356,759	\$ -	\$ 92,356,759
4 Net Hospital Patient Revenue	Survey F-3	\$ 1,795,454,185	\$ (2,868,141)	\$ 1,792,586,044
5 Medicaid Fraction		5.14%	0.01%	5.15%
6 Inpatient Charity Care Charges	Survey F-2	\$ 169,805,276	\$ -	\$ 169,805,276
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9 Adjusted Inpatient Charity Care		\$ 169,805,276	\$ -	\$ 169,805,276
10 Inpatient Hospital Charges	Survey F-3	\$ 3,941,106,414	\$ (1,453,161)	\$ 3,939,653,253
11 Inpatient Charity Fraction		4.31%	0.00%	4.31%
12 LIUR		9.45%	0.01%	9.46%
<b>MIUR</b>				
13 In-State Medicaid Eligible Days	Survey H	59,368	-	59,368
14 Out-of-State Medicaid Eligible Days	Survey I	679	-	679
15 Total Medicaid Eligible Days		60,047	-	60,047
16 Total Hospital Days (excludes swing-bed)	Survey F-1	253,025	-	253,025
17 MIUR		23.73%	0.00%	23.73%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name: **NORTHEAST GEORGIA MC GAINSVILLE**  
 Hospital Medicaid Number: **00000888A**  
 Cost Report Period: From **10/1/2023** To **9/30/2024**

As-Reported:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	53,790,127	37,591,911	-	595,144	725	-	-	-	-	-	-	-	-	38,187,780	15,602,347	70.99%
2 Medicaid Fee for Service	Outpatient	9,606,689	8,623,619	-	19,098	9,685	297,545	-	-	-	-	-	-	-	8,949,947	656,742	93.16%
3 Medicaid Managed Care	Inpatient	35,367,129	-	27,310,598	53,937	1,288	-	-	-	-	-	-	-	-	27,365,823	8,001,306	77.38%
4 Medicaid Managed Care	Outpatient	18,531,755	1,498	14,378,584	1,448	4,765	-	-	-	-	-	-	-	-	14,386,294	4,145,461	77.63%
5 Medicare Cross-over (FFS)	Inpatient	45,447,100	1,881,174	-	26,463	613	-	-	31,624,897	-	275,749	8,316,330	-	-	42,125,225	3,321,875	92.69%
6 Medicare Cross-over (FFS)	Outpatient	21,090,187	1,456,820	-	21,944	6,822	-	-	14,975,598	-	388,671	3,414,436	-	-	20,264,291	825,896	96.08%
7 Other Medicaid Eligibles	Inpatient	21,136,545	93,154	1,079	50,839	6,306	-	-	6,636,846	8,008,881	-	-	-	-	14,797,104	6,339,441	70.01%
8 Other Medicaid Eligibles	Outpatient	5,087,561	4,721	28,891	66,511	3,040	-	-	286,405	2,699,694	-	-	-	-	3,089,263	1,998,298	60.72%
9 Uninsured	Inpatient	55,496,348	-	-	-	-	-	-	-	-	-	-	2,121,300	-	2,121,300	53,375,048	3.82%
10 Uninsured	Outpatient	33,556,820	-	-	-	9,203	-	-	-	-	-	-	7,476,910	-	7,486,113	26,070,707	22.31%
11 In-State Sub-total	Inpatient	211,237,249	39,566,239	27,311,677	726,383	8,931	-	-	38,261,743	8,008,881	275,749	8,316,330	2,121,300	-	124,597,232	86,640,017	58.98%
12 In-State Sub-total	Outpatient	87,873,012	10,086,658	14,407,475	109,002	33,515	297,545	-	15,262,003	2,699,694	388,671	3,414,436	7,476,910	-	54,175,908	33,697,104	61.65%
13 Out-of-State Medicaid	Inpatient	2,319,049	-	-	-	-	-	-	260,765	286,526	-	-	-	-	547,290	1,771,759	23.60%
14 Out-of-State Medicaid	Outpatient	344,346	1,076	-	1,229	-	-	-	16,195	28,689	-	-	-	-	47,189	297,157	13.70%
15 Sub-Total	I/P and O/P	301,773,656	49,653,973	41,719,152	836,613	42,446	297,545	-	53,800,706	11,023,790	664,420	11,730,766	9,598,210	-	179,367,620	122,406,036	59.44%

Adjustments:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		1 Medicaid Fee for Service	Inpatient	75,712	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	4,516	-	-	-	-	-	-	-	-	-	-	-	-	-	4,516	-0.04%
3 Medicaid Managed Care	Inpatient	45,451	-	-	-	-	-	-	-	-	-	-	-	-	-	45,451	-0.10%
4 Medicaid Managed Care	Outpatient	8,975	-	-	-	-	-	-	-	-	-	-	-	-	-	8,975	-0.04%
5 Medicare Cross-over (FFS)	Inpatient	78,036	-	-	-	-	-	-	-	-	-	-	-	-	-	78,036	-0.16%
6 Medicare Cross-over (FFS)	Outpatient	10,223	-	-	-	-	-	-	-	-	-	-	-	-	-	10,223	-0.05%
7 Other Medicaid Eligibles	Inpatient	38,373	-	-	-	-	-	-	-	-	-	-	-	-	-	38,373	-0.13%
8 Other Medicaid Eligibles	Outpatient	4,953	-	-	-	-	-	-	-	-	-	-	-	-	-	4,953	-0.06%
9 Uninsured	Inpatient	99,060	-	-	-	-	-	-	-	-	-	-	-	-	-	99,060	-0.01%
10 Uninsured	Outpatient	17,261	-	-	-	-	-	-	-	-	-	-	-	-	-	17,261	-0.01%
11 In-State Sub-total	Inpatient	336,632	-	-	-	-	-	-	-	-	-	-	-	-	-	336,632	-0.09%
12 In-State Sub-total	Outpatient	45,928	-	-	-	-	-	-	-	-	-	-	-	-	-	45,928	-0.03%
13 Out-of-State Medicaid	Inpatient	3,157	-	-	-	-	-	-	-	-	-	-	-	-	-	3,157	-0.03%
14 Out-of-State Medicaid	Outpatient	325	-	-	-	-	-	-	-	-	-	-	-	-	-	325	-0.01%
15 Sub-Total	I/P and O/P	386,042	-	-	-	-	-	-	-	-	-	-	-	-	-	386,042	-0.08%

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name: **NORTHEAST GEORGIA MC GAINSVILLE**  
 Hospital Medicaid Number: **00000888A**  
 Cost Report Period: From **10/1/2023** To **9/30/2024**

As-Adjusted:	Service Type		A		B		C		D	E	F	G	H	I	J	K	L	M	N	O	P			
			Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)						
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E						
1	Medicaid Fee for Service	Inpatient	53,865,839	37,591,911	-	595,144	725	-	-	-	-	-	-	-	-	-	-	-	38,187,780	15,678,059	70.89%			
2	Medicaid Fee for Service	Outpatient	9,611,205	8,623,619	-	19,098	9,685	-	297,545	-	-	-	-	-	-	-	-	-	8,949,947	661,258	93.12%			
3	Medicaid Managed Care	Inpatient	35,412,580	-	27,310,598	53,937	1,288	-	-	-	-	-	-	-	-	-	-	-	27,365,823	8,046,757	77.28%			
4	Medicaid Managed Care	Outpatient	18,540,730	1,498	14,378,584	1,448	4,765	-	-	-	-	-	-	-	-	-	-	-	14,386,294	4,154,436	77.59%			
5	Medicare Cross-over (FFS)	Inpatient	45,525,136	1,881,174	-	26,463	613	-	-	31,624,897	-	-	-	-	275,749	8,316,330	-	-	42,125,225	3,399,911	92.53%			
6	Medicare Cross-over (FFS)	Outpatient	21,100,410	1,456,820	-	21,944	6,822	-	-	14,975,598	-	-	-	-	388,671	3,414,436	-	-	20,264,291	836,119	96.04%			
7	Other Medicaid Eligibles	Inpatient	21,174,918	93,154	1,079	50,839	6,306	-	-	6,636,846	8,008,881	-	-	-	-	-	-	-	14,797,104	6,377,814	69.88%			
8	Other Medicaid Eligibles	Outpatient	5,092,514	4,721	28,891	66,511	3,040	-	-	286,405	2,699,694	-	-	-	-	-	-	-	3,089,263	2,003,251	60.66%			
9	Uninsured	Inpatient	55,595,408	-	-	-	-	-	-	-	-	-	-	-	-	-	2,121,300	-	2,121,300	53,474,108	3.82%			
10	Uninsured	Outpatient	33,574,081	-	-	-	9,203	-	-	-	-	-	-	-	-	-	7,476,910	-	7,486,113	26,087,968	22.30%			
11	In-State Sub-total	Inpatient	211,573,881	39,566,239	27,311,677	726,383	8,931	-	-	38,261,743	8,008,881	-	-	-	275,749	8,316,330	2,121,300	-	124,597,232	86,976,649	58.89%			
12	In-State Sub-total	Outpatient	87,918,940	10,086,658	14,407,475	109,002	33,515	-	297,545	-	15,262,003	2,699,694	-	-	388,671	3,414,436	7,476,910	-	54,175,908	33,743,032	61.62%			
13	Out-of-State Medicaid	Inpatient	2,322,206	-	-	-	-	-	-	260,765	286,526	-	-	-	-	-	-	-	547,290	1,774,916	23.57%			
14	Out-of-State Medicaid	Outpatient	344,671	1,076	-	1,229	-	-	-	16,195	28,689	-	-	-	-	-	-	-	47,189	297,482	13.69%			
15	Cost Report Year Sub-Total	I/P and O/P	302,159,698	49,653,973	41,719,152	836,613	42,446	-	297,545	-	53,800,706	11,023,790	-	-	664,420	11,730,766	9,598,210	-	179,367,620	122,792,078	59.36%			
16																								
17																					Less: Out of State DSH Payments from Adjusted Survey	-		
																						Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments	122,792,078	
18																							Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments	12,769,948
19																							Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments	110,022,130

Medicaid DSH Survey Adjustments

PROVIDER: NORTHEAST GEORGIA MC GAINSVILLE  
FROM: 10/1/2023

TO: 9/30/2024

Mcaid Number: 00000888A  
Mcare Number: 110029

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	F - MIUR/LIUR Data	26	Other	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 14,678,661	\$ (1,453,161)	\$ 13,225,500	2002
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjusted to cost report.	\$ 11,351,442	\$ (11,351,442)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjusted to cost report.	\$ -	\$ 12,804,603	\$ 12,804,603	2002
	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 11,390,744	\$ (1,127,663)	\$ 10,263,081	2002
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjusted to cost report.	\$ 8,808,799	\$ (8,808,799)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjusted to cost report.	\$ -	\$ 9,936,462	\$ 9,936,462	2002
2	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Adjusted for sub-provider roll up.	\$ 280,752,006.00	\$ 27,929,604	\$ 308,681,610.00	1405.20
2	G - CR Data	7	SUBPROVIDER I	3.00	Total Allowable Cost	Adjusted for sub-provider roll up.	\$ 20,838,161.00	\$ (20,838,161)	\$ -	1405.20
2	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Adjusted for sub-provider roll up.	\$ 7,091,443.00	\$ (7,091,443)	\$ -	1405.20
2	G - CR Data	1	ADULTS & PEDIATRICS	4.00	Intern & Resident Costs Removed on Cost Report *	Adjusted for sub-provider roll up.	\$ 12,468,883.00	\$ 563,277	\$ 13,032,160.00	1405.20
2	G - CR Data	7	SUBPROVIDER I	4.00	Intern & Resident Costs Removed on Cost Report *	Adjusted for sub-provider roll up.	\$ 563,277.00	\$ (563,277)	\$ -	1405.20
2	G - CR Data	1	ADULTS & PEDIATRICS	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjusted for sub-provider roll up.	216,792	20,110	236,902	1405.20
2	G - CR Data	7	SUBPROVIDER I	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjusted for sub-provider roll up.	15,293	(15,293)	-	1405.20
2	G - CR Data	8	SUBPROVIDER II	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjusted for sub-provider roll up.	4,817	(4,817)	-	1405.20
2	G - CR Data	1	ADULTS & PEDIATRICS	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Adjusted for sub-provider roll up.	\$ 345,806,245.00	\$ 56,174,772	\$ 401,981,017.00	1405.20
2	G - CR Data	7	SUBPROVIDER I	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Adjusted for sub-provider roll up.	\$ 42,510,513.00	\$ (42,510,513)	\$ -	1405.20
2	G - CR Data	8	SUBPROVIDER II	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Adjusted for sub-provider roll up.	\$ 13,664,259.00	\$ (13,664,259)	\$ -	1405.20
	H - In-State	1	ADULTS & PEDIATRICS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjusted for sub-provider roll up.	7,662	11	7,673	1405.20
	H - In-State	7	SUBPROVIDER I	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjusted for sub-provider roll up.	11	(11)	-	1405.20
	H - In-State	1	ADULTS & PEDIATRICS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjusted for sub-provider roll up.	12,893	26	12,919	1405.20
	H - In-State	7	SUBPROVIDER I	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjusted for sub-provider roll up.	26	(26)	-	1405.20
	H - In-State	1	ADULTS & PEDIATRICS	19.00	Inpatient Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Adjusted for sub-provider roll up.	1,027	1	1,028	1405.20
	H - In-State	7	SUBPROVIDER I	19.00	Inpatient Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Adjusted for sub-provider roll up.	1	(1)	-	1405.20
	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjusted for sub-provider roll up.	15,547	53	15,600	1405.20
	H - In-State	7	SUBPROVIDER I	13.00	Inpatient Uninsured	Adjusted for sub-provider roll up.	53	(53)	-	1405.20

**Medicaid DSH Report Notes**

PROVIDER: NORTHEAST GEORGIA MC GAINSVILLE  
 FROM: 10/1/2023 TO: 9/30/2024

Mcaid Number: 000000888A  
 Mcare Number: 110029

**Myers and Stauffer DSH Report Notes**

Note #	Note for Report	Amounts
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