

GA DSH Payment Results for SFY 2026 - Pool 1
DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

5/7/2026 15:45

Provider Name	HABERSHAM COUNTY MEDICAL CENTER
Mcaid Provider Number	000000877A
Mcare Provider Number	110041

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.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year:					7/1/2025	-	6/30/2026
	(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)		
Cost Report Year UCC:	<u>10/1/2023</u>	- <u>9/30/2024</u>	\$ 6,350,477	\$ -	\$ 6,350,477		
Less: 2024 Gross UPL Payments					\$ 571,300		
Less: 2026 Gross DPP Payments					\$ 6,191,977		
Less: GME Payments					\$ -		
Add: Net OP Settlement (Difference between provider submitted and estimated)					\$ (37,096)		
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)					\$ -		
Hospital Specific DSH Limit (Total UCC)					<u>\$ (449,896)</u>		
2026 Eligibility					Not Eligible		
DSH Year Low Income Utilization Ratio (LIUR):					<u>20.94%</u>		
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):					<u>35.56%</u>		

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
 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 7/1/2023 - 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:

7/1/2023 through 9/30/2023	10/1/2023 through 9/30/2024	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Select Cost Report Year Covered by this Survey:

3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MC HABERSHAM	-	
5. Medicaid Provider Number:	00000877A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110041	-	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	-	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 1	-	
11. Rural Referral Center (Yes or No)	No	-	

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: (07/01/2023 - 09/30/2023)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-	
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)	\$	-	
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-	
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)	\$	-	
8. Out-of-State DSH Payments (See Note 2)	\$	-	
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	Inpatient	Outpatient	Total
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 250	\$ 37,033	\$37,283
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$ 8,419	\$ 209,415	\$217,834
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	\$8,669	\$246,448	\$255,117
	2.88%	15.03%	14.61%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? <i>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.</i>	<input type="text" value="No"/>		
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	\$	-	
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$	-	
16. Total Medicaid managed care non-claims payments (see question 13 above) received	\$	-	

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2023 - 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) 741

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	405,838
8. Outpatient Hospital Charity Care Charges	1,846,259
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 2,252,097

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (WS 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	\$ 3,687,846	\$ -	\$ -	\$ 3,298,686	\$ -	\$ -	\$ 389,160
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15. Swing Bed - NF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16. Skilled Nursing Facility	\$ -	\$ -	\$ 1,608,885	\$ -	\$ -	\$ 1,439,107	\$ -
17. Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18. Other Long-Term Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19. Ancillary Services	\$ 8,410,673	\$ 40,526,646	\$ -	\$ 7,523,136	\$ 36,250,067	\$ -	\$ 5,164,116
20. Outpatient Services	\$ -	\$ 19,079,762	\$ -	\$ -	\$ 17,066,368	\$ -	\$ 2,013,394
21. Home Health Agency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22. Ambulance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26. Other	\$ 270,250	\$ -	\$ 112,700	\$ 241,732	\$ -	\$ 100,807	\$ 28,518
27. Total	\$ 12,368,769	\$ 59,606,408	\$ 1,721,585	\$ 11,063,553	\$ 53,316,435	\$ 1,539,915	\$ 7,595,189
28. Total Hospital and Non Hospital		Total from Above	\$ 73,696,762		Total from Above	\$ 65,919,903	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 73,696,762		Total Contractual Adj. (G-3 Line 2)	\$ 65,919,903	
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)						\$ -	
35. 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						65,919,903	
37. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-09/30/2023) **NORTHEAST GEORGIA MC HABERSHAM**

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	I/P Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

Routine Cost Centers (list below):

1	03000 ADULTS & PEDIATRICS	\$ 2,572,510	\$ -	\$ -	\$ -	\$ 2,572,510	1,278	\$ 3,687,846	\$ 2,012.92
2	03100 INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -
10	04300 NURSERY	\$ 172,346	\$ -	\$ -	\$ -	\$ 172,346	216	\$ 259,200	\$ 797.90
18	Total Routine	\$ 2,744,856	\$ -	\$ -	\$ -	\$ 2,744,856	1,494	\$ 3,947,046	
19	Weighted Average								\$ 1,837.25

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		753	-	-	\$ 1,515,729	434,070	\$ 1,464,330	\$ 1,898,400	0.798424
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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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$ 1,208,267	\$ -	\$ -	\$ -	\$ 1,208,267	\$ 1,836,305	\$ 5,029,275	\$ 6,865,580	0.175989
22	5200 DELIVERY ROOM & LABOR ROOM	\$ 696,733	\$ -	\$ -	\$ -	\$ 696,733	\$ 1,297,049	\$ 246,381	\$ 1,543,430	0.451419
23	5400 RADIOLOGY-DIAGNOSTIC	\$ 632,803	\$ -	\$ -	\$ -	\$ 632,803	\$ 191,305	\$ 4,836,089	\$ 5,027,394	0.125871
24	5700 CT SCAN	\$ 221,447	\$ -	\$ -	\$ -	\$ 221,447	\$ 678,029	\$ 12,115,021	\$ 12,793,050	0.017310
25	5800 MRI	\$ 41,675	\$ -	\$ -	\$ -	\$ 41,675	\$ 72,493	\$ 786,136	\$ 858,629	0.048537
26	6000 LABORATORY	\$ 1,235,494	\$ -	\$ -	\$ -	\$ 1,235,494	\$ 1,000,348	\$ 6,399,688	\$ 7,400,036	0.166958
27	6500 RESPIRATORY THERAPY	\$ 469,258	\$ -	\$ -	\$ -	\$ 469,258	\$ 565,789	\$ 1,013,133	\$ 1,578,922	0.297202
28	6600 PHYSICAL THERAPY	\$ 850,331	\$ -	\$ -	\$ -	\$ 850,331	\$ 227,066	\$ 1,480,852	\$ 1,707,918	0.497876
29	6900 ELECTROCARDIOLOGY	\$ 371,899	\$ -	\$ -	\$ -	\$ 371,899	\$ 285,395	\$ 2,992,344	\$ 3,277,739	0.113462
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 297,980	\$ -	\$ -	\$ -	\$ 297,980	\$ 338,799	\$ 545,590	\$ 884,389	0.336933
31	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 430,088	\$ -	\$ -	\$ -	\$ 430,088	\$ 316,953	\$ 1,331,056	\$ 1,648,009	0.260974
32	7300 DRUGS CHARGED TO PATIENTS	\$ 1,480,537	\$ -	\$ -	\$ -	\$ 1,480,537	\$ 1,601,142	\$ 3,751,081	\$ 5,352,223	0.276621
33	9100 EMERGENCY	\$ 2,388,235	\$ -	\$ -	\$ -	\$ 2,388,235	\$ 773,328	\$ 16,408,034	\$ 17,181,362	0.139001
126	Total Ancillary	\$ 10,324,747	\$ -	\$ -	\$ -	\$ 10,324,747	\$ 9,618,071	\$ 58,399,010	\$ 68,017,081	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

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
127	Weighted Average								0.174081
128	Sub Totals	\$ 13,069,603	\$ -	\$ -	\$ 13,069,603	\$ 13,565,117	\$ 58,399,010	\$ 71,964,127	
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)				\$ 7,338				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				\$ -				
131.01	Other Cost Adjustments (support must be submitted)				\$ -				
132	Grand Total				\$ 13,062,265				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				0.00%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

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	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
03000	ADULTS & PEDIATRICS	\$ 2,012.92		38		23		28		63		111		71		263		64.00%
03100	INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-		
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-		-		-		
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-		
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-		
03500	OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-		-		-		
04000	SUBPROVIDER I	\$ -		-		-		-		-		-		-		-		
04100	SUBPROVIDER II	\$ -		-		-		-		-		-		-		-		
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-		-		-		
04300	NURSERY	\$ 797.90		23		16		15		125		5		179		412		85.65%
Total Days				61	39	28	78	236	76	236	76	412	78	412		78.31%		
Total Days per PS&R or Exhibit Detail				61	39	28	78	236	76	236	76	412	78	412				
Unreconciled Days (Explain Variance)																		
Routine Charges				\$ 102,738	\$ 72,859	\$ 48,892	\$ 152,749	\$ 408,963	\$ 132,059	\$ 377,238	\$ 653,48	\$ 377,238	\$ 653,48					13.05%
Calculated Routine Charge Per Diem				1,684.23	1,868.18	1,746.14	1,958.32	1,732.89	1,732.89	1,732.89	1,732.89	1,732.89	1,732.89	1,732.89	1,732.89			
Ancillary Cost Centers (from WIS C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
09200	Observation (Non-Distinct)	0.798424	\$ 19,110	\$ 25,494	\$ -	\$ 11,760	\$ 28,770	\$ 47,250	\$ 20,265	\$ 176,820	\$ 2,100	\$ 22,890	\$ 58,905	\$ 69,195	\$ 68,145	\$ 261,324	25.42%	
5000	OPERATING ROOM	0.175989	\$ 65,420	\$ 115,750	\$ 63,208	\$ 17,274	\$ -	\$ 244,448	\$ 138,596	\$ 292,663	\$ 433,044	\$ 104,192	\$ 68,841	\$ 302,737	\$ 267,224	\$ 670,135	26.94%	
5200	DELIVERY ROOM & LABOR ROOM	0.451419	\$ 75,270	\$ 1,894	\$ 104,625	\$ 22,918	\$ -	\$ 1,146	\$ 131,391	\$ 28,890	\$ 501,901	\$ 68,264	\$ 13,420	\$ 8,249	\$ 311,286	\$ 54,848	62.60%	
5400	RADIOLOGY-DIAGNOSTIC	0.125871	\$ 7,359	\$ 133,289	\$ 1,633	\$ 205,256	\$ 8,559	\$ 113,100	\$ 8,711	\$ 257,279	\$ 4,314	\$ 317,637	\$ 25,306	\$ 383,516	\$ 26,255	\$ 709,424	28.30%	
5700	CT SCAN	0.017310	\$ 31,865	\$ 381,756	\$ 378,468	\$ 45,517	\$ 509,432	\$ 42,786	\$ 576,719	\$ -	\$ 433,274	\$ 112,306	\$ 1,429,524	\$ 120,168	\$ 1,846,375	\$ 1,846,375	31.11%	
5800	MRI	0.048537	\$ 4,145	\$ 20,135	\$ -	\$ 3,256	\$ -	\$ 24,849	\$ -	\$ 53,638	\$ -	\$ 33,354	\$ 17,811	\$ 28,072	\$ 4,145	\$ 101,878	21.58%	
6000	LABORATORY	0.166958	\$ 95,165	\$ 354,953	\$ 31,619	\$ 396,118	\$ 59,998	\$ 265,085	\$ 139,434	\$ 665,308	\$ 187,485	\$ 517,112	\$ 185,294	\$ 885,637	\$ 326,216	\$ 1,681,464	51.33%	
6500	RESPIRATORY THERAPY	0.297202	\$ 4,909	\$ 8,167	\$ -	\$ 6,122	\$ 4,966	\$ 15,902	\$ 63,659	\$ 54,531	\$ 5,593	\$ 10,652	\$ 6,978	\$ 10,646	\$ 73,534	\$ 84,722	12.17%	
6600	PHYSICAL THERAPY	0.487676	\$ 3,138	\$ 4,479	\$ -	\$ 290	\$ 6,550	\$ 31,412	\$ 6,059	\$ 37,215	\$ -	\$ 10,799	\$ 21,944	\$ 27,004	\$ 14,756	\$ 73,996	8.66%	
6900	ELECTROCARDIOLOGY	0.113462	\$ 7,300	\$ 86,699	\$ 404	\$ 38,693	\$ 24,773	\$ 103,056	\$ 26,977	\$ 190,788	\$ -	\$ 68,583	\$ 33,206	\$ 182,057	\$ 59,454	\$ 419,216	23.30%	
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.336933	\$ 22,766	\$ 20,960	\$ 9,472	\$ 4,348	\$ -	\$ 26,593	\$ 19,271	\$ 40,253	\$ 87,019	\$ 37,745	\$ 15,337	\$ 38,707	\$ 51,510	\$ 92,154	36.53%	
7200	IMPL. DEV. CHARGED TO PATIENTS	0.260874	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 119,748	\$ -	\$ 139,842	\$ -	\$ -	\$ 1,921	\$ 60,587	\$ -	\$ 250,590	19.00%	
7300	DRUGS CHARGED TO PATIENTS	0.276621	\$ 110,771	\$ 56,588	\$ 41,783	\$ 95,706	\$ 56,173	\$ 179,224	\$ 158,552	\$ 240,776	\$ 257,025	\$ 159,376	\$ 157,612	\$ 392,501	\$ 369,279	\$ 571,294	38.97%	
9100	EMERGENCY	0.139001	\$ 94,595	\$ 798,443	\$ 11,996	\$ 1,304,384	\$ 85,479	\$ 637,968	\$ 95,070	\$ 1,101,904	\$ 29,144	\$ 1,622,634	\$ 268,943	\$ 2,521,559	\$ 287,140	\$ 3,842,699	50.20%	
				541,813	2,008,606	264,740	2,485,093	322,787	2,309,214	849,771	3,856,606	1,507,625	3,406,512	987,815	6,329,991			

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

Cost Report Year (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

	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)								
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 644,551	\$ 2,008,606	\$ 337,599	\$ 2,485,093	\$ 371,679	\$ 2,309,214	\$ 1,002,520	\$ 3,856,606	\$ 1,916,588	\$ 3,406,512	\$ 1,119,874	\$ 6,329,991	\$ 2,356,350	\$ 10,659,519	28.66%
129 Total Charges per PS&R or Exhibit Detail	\$ 644,551	\$ 2,008,606	\$ 337,599	\$ 2,485,093	\$ 371,679	\$ 2,309,214	\$ 1,002,520	\$ 3,856,606	\$ 1,916,588	\$ 3,406,512	\$ 1,119,874	\$ 6,329,991			
130 Unreconciled Charges (Explain Variance)															
131.01 Sampling Cost Adjustment (if applicable)															
131.02 Total Calculated Cost (includes organ acquisition from Section J)	\$ 228,470	\$ 273,400	\$ 139,365	\$ 337,122	\$ 126,740	\$ 357,681	\$ 351,849	\$ 687,980	\$ 765,603	\$ 501,540	\$ 352,458	\$ 856,920	\$ 846,424	\$ 1,656,183	28.64%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 138,691	\$ 363,353	\$ -	\$ -	\$ 2,412	\$ 32,925	\$ 1,800	\$ 1,258					\$ 142,712	\$ 397,736	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 67,319	\$ 101,445	\$ -	\$ -	\$ -	\$ 264					\$ 67,319	\$ 101,709	
134 Private Insurance (including primary and third party liability)	\$ -	\$ 1,859	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 176,798	\$ 245,218				\$ 176,798	\$ 247,077	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ 4,129	\$ -	\$ -	\$ -	\$ 1,250	\$ -	\$ -			\$ -	\$ 5,379	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 138,691	\$ 365,412	\$ 67,319	\$ 105,574	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (164,215)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ (164,215)	
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)	\$ -	\$ -	\$ -	\$ -	\$ 80,171	\$ 180,363	\$ 28,080	\$ 9,261	\$ -	\$ -			\$ 108,251	\$ 189,624	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 61,428	\$ 161,176	\$ -	\$ -			\$ 61,428	\$ 161,176	
141 Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
142 Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ 32,795	\$ 15,287	\$ -	\$ -	\$ -	\$ -			\$ 32,795	\$ 15,287	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 89,779	\$ 72,203	\$ 72,046	\$ 231,548	\$ 11,362	\$ 129,107	\$ 83,934	\$ 269,553	\$ 765,603	\$ 501,540	\$ 352,208	\$ 819,887	\$ 257,121	\$ 702,411	
146 Calculated Payments as a Percentage of Cost	61%	74%	48%	31%	91%	64%	76%	61%	0%	0%	0%	4%	70%	58%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					341										8%
148 Percent of cross-over days to total Medicare days from the cost report															

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

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 (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

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)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 2,012.92		-		-		-		2		2	
2	03100 INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	\$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
10	04300 NURSERY	\$ 797.90		1		-		-		-		1	
18			Total Days	1		-		-		2		3	
19	Total Days per PS&R or Exhibit Detail			1		-		-		2		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	Routine Charges			\$ 1,200		\$ -		\$ -		\$ 4,666		\$ 5,866	
21.01	Calculated Routine Charge Per Diem			\$ 1,200.00		\$ -		\$ -		\$ 2,333.00		\$ 1,955.33	
Ancillary Cost Centers (from W/S C) (list below):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.798424	-	-	-	-	-	-	-	-	-	-
23	5000 OPERATING ROOM		0.175989	-	-	-	-	-	-	3,517	-	3,517	-
24	5200 DELIVERY ROOM & LABOR ROOM		0.451419	-	-	-	-	-	-	9,054	-	9,054	-
25	5400 RADIOLOGY-DIAGNOSTIC		0.125871	-	5,617	-	-	-	-	-	918	-	6,535
26	5700 CT SCAN		0.017310	-	32,101	-	-	-	-	-	6,185	-	38,286
27	5800 MRI		0.048537	-	-	-	-	-	-	-	-	-	-
28	6000 LABORATORY		0.166958	176	12,852	-	-	-	-	1,085	1,172	1,261	14,024
29	6500 RESPIRATORY THERAPY		0.297202	-	-	-	-	-	-	-	-	-	-
30	6600 PHYSICAL THERAPY		0.497876	-	-	-	-	-	-	-	-	-	-
31	6900 ELECTROCARDIOLOGY		0.113462	-	1,212	-	-	-	-	-	-	-	1,212
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.336933	380	-	-	-	-	-	243	-	623	-
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.260974	-	-	-	-	-	-	-	-	-	-
34	7300 DRUGS CHARGED TO PATIENTS		0.276621	153	24,419	-	-	-	-	1,684	1,990	1,837	26,409
35	9100 EMERGENCY		0.139001	-	45,420	-	-	-	-	-	7,293	-	52,713
				709	121,621	-	-	-	-	15,583	17,558	-	-
Totals / Payments													
128	Total Charges (includes organ acquisition from Section K)			\$ 1,909	\$ 121,621	\$ -	\$ -	\$ -	\$ -	\$ 20,249	\$ 17,558	\$ 22,158	\$ 139,179
129	Total Charges per PS&R or Exhibit Detail			\$ 1,909	\$ 121,621	\$ -	\$ -	\$ -	\$ -	\$ 20,249	\$ 17,558	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-
131.01	Sampling Cost Adjustment (if applicable)			-	-	-	-	-	-	-	-	-	-
131.02	Total Calculated Cost (includes organ acquisition from Section K)			\$ 998	\$ 16,614	\$ -	\$ -	\$ -	\$ -	\$ 9,461	\$ 1,982	\$ 10,459	\$ 18,596
132	Total Medicaid Paid Amount (excludes TPL Co-Pay and Spend-Down)			\$ -	\$ 50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 50
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)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,641	\$ 1,651	\$ 8,641	\$ 1,651
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ -	\$ 50	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 252	\$ -	\$ 252
141	Medicare Cross-Over Bad Debt Payments			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)			\$ 998	\$ 16,564	\$ -	\$ -	\$ -	\$ -	\$ 820	\$ 79	\$ 1,818	\$ 16,643
144	Calculated Payments as a Percentage of Cost			0%	0%	0%	0%	0%	0%	91%	96%	83%	11%

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

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
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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 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 (07/01/2023-09/30/2023)

NORTHEAST GEORGIA MC HABERSHAM

	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
Organ Acquisition Cost Centers (list below):																	
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	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
10	Total Cost																

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.

Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (07/01/2023-09/30/2023)

NORTHEAST GEORGIA MC HABERSHAM

	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)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18		\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2023-09/30/2023) NORTHEAST GEORGIA MC HABERSHAM

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	WS A Cost Center Line	
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 132,607		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	408001-69000	(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 132,607	5.00	(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -		
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)			
4 Reclassification Code	\$ -	-	(Reclassified to / (from))
5 Reclassification Code	\$ -	-	(Reclassified to / (from))
6 Reclassification Code	\$ -	-	(Reclassified to / (from))
7 Reclassification Code	\$ -	-	(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
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))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
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	\$ 132,607		

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	18,500,305
19 Uninsured Hospital Charges Sec. G	7,449,865
20 Total Hospital Charges Sec. G	71,964,127
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	25.71%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.35%
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***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	5,599,380
27 Uninsured Hospital Charges Sec. G	12,772,964
28 Total Hospital Charges Sec. G	71,964,127
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	7.78%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	17.75%
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	NORTHEAST GEORGIA MC HABERSHAM			
Hospital Medicaid Number	000000877A			
Cost Report Period	From	7/1/2023	To	9/30/2023

		As-Reported	Adjustments	As-Adjusted
LIUR				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 551,299	\$ -	\$ 551,299
2 Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
3 Total		\$ 551,299	\$ -	\$ 551,299
4 Net Hospital Patient Revenue	Survey F-3	\$ 7,607,081	\$ (11,893)	\$ 7,595,189
5 Medicaid Fraction		7.25%	0.01%	7.26%
6 Inpatient Charity Care Charges	Survey F-2	\$ 405,838	\$ -	\$ 405,838
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9 Adjusted Inpatient Charity Care		\$ 405,838	\$ -	\$ 405,838
10 Inpatient Hospital Charges	Survey F-3	\$ 12,368,769	\$ -	\$ 12,368,769
11 Inpatient Charity Fraction		3.28%	0.00%	3.28%
12 LIUR		10.53%	0.01%	10.54%
MIUR				
13 In-State Medicaid Eligible Days	Survey H	442	-	442
14 Out-of-State Medicaid Eligible Days	Survey I	3	-	3
15 Total Medicaid Eligible Days		445	-	445
16 Total Hospital Days (excludes swing-bed)	Survey F-1	741	-	741
17 MIUR		60.05%	0.00%	60.05%

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 HABERSHAM**
 Hospital Medicaid Number: **00000877A**
 Cost Report Period: From **7/1/2023** To **9/30/2023**

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 H & I	Survey E		
1 Medicaid Fee for Service	Inpatient	228,470	138,691	-	-	-	-	-	-	-	-	-	-	-	138,691	89,779	60.70%
2 Medicaid Fee for Service	Outpatient	273,400	363,553	-	1,859	-	(164,215)	-	-	-	-	-	-	-	201,197	72,203	73.59%
3 Medicaid Managed Care	Inpatient	139,365	-	67,319	-	-	-	-	-	-	-	-	-	-	67,319	72,046	48.30%
4 Medicaid Managed Care	Outpatient	337,122	-	101,445	-	4,129	-	-	-	-	-	-	-	-	105,574	231,548	31.32%
5 Medicare Cross-over (FFS)	Inpatient	126,740	2,412	-	-	-	-	-	80,171	-	-	32,795	-	-	115,378	11,362	91.04%
6 Medicare Cross-over (FFS)	Outpatient	357,681	32,925	-	-	-	-	-	180,363	-	-	15,287	-	-	228,574	129,107	63.90%
7 Other Medicaid Eligibles	Inpatient	351,849	1,609	-	176,798	-	-	-	28,080	61,428	-	-	-	-	267,915	83,934	76.14%
8 Other Medicaid Eligibles	Outpatient	687,980	1,258	264	245,218	1,250	-	9,261	161,176	-	-	-	-	418,427	269,553	60.82%	
9 Uninsured	Inpatient	1,118,061	-	-	-	-	-	-	-	-	-	-	250	-	250	1,117,811	0.02%
10 Uninsured	Outpatient	1,358,460	-	-	-	-	-	-	-	-	-	-	37,033	-	37,033	1,321,427	2.73%
11 In-State Sub-total	Inpatient	1,964,485	142,712	67,319	176,798	-	-	-	108,251	61,428	-	32,795	250	-	589,554	1,374,932	30.01%
12 In-State Sub-total	Outpatient	3,014,643	397,736	101,709	247,077	5,379	(164,215)	-	189,624	161,176	-	15,287	37,033	-	990,805	2,023,838	32.87%
13 Out-of-State Medicaid	Inpatient	10,459	-	-	8,641	-	-	-	-	-	-	-	-	-	8,641	1,818	82.62%
14 Out-of-State Medicaid	Outpatient	18,596	50	-	1,651	-	-	-	-	252	-	-	-	-	1,953	16,643	10.50%
15 Sub-Total	I/P and O/P	5,008,183	540,498	169,028	434,167	5,379	(164,215)	-	297,875	222,856	-	48,082	37,283	-	1,590,953	3,417,230	31.77%

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	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name: **NORTHEAST GEORGIA MC HABERSHAM**
 Hospital Medicaid Number: **000000877A**
 Cost Report Period: From **7/1/2023** To **9/30/2023**

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)																
	1 Medicaid Fee for Service	Inpatient	228,470	138,691	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	138,691	89,779	60.70%				
	2 Medicaid Fee for Service	Outpatient	273,400	363,553	-	1,859	-	-	-	(164,215)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	201,197	72,203	73.59%				
	3 Medicaid Managed Care	Inpatient	139,365	-	67,319	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	67,319	72,046	48.30%				
	4 Medicaid Managed Care	Outpatient	337,122	-	101,445	-	4,129	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	105,574	231,548	31.32%					
	5 Medicare Cross-over (FFS)	Inpatient	126,740	2,412	-	-	-	-	-	-	80,171	-	-	-	-	-	-	-	-	-	-	32,795	-	-	-	-	115,378	11,362	91.04%				
	6 Medicare Cross-over (FFS)	Outpatient	357,681	32,925	-	-	-	-	-	-	180,363	-	-	-	-	-	-	-	-	-	-	15,287	-	-	-	-	228,574	129,107	63.90%				
	7 Other Medicaid Eligibles	Inpatient	351,849	1,609	-	176,798	-	-	-	-	-	-	28,080	61,428	-	-	-	-	-	-	-	-	-	-	-	-	267,915	83,934	76.14%				
	8 Other Medicaid Eligibles	Outpatient	687,980	1,258	264	245,218	1,250	-	-	-	9,261	-	161,176	-	-	-	-	-	-	-	-	-	-	-	-	-	418,427	269,553	60.82%				
	9 Uninsured	Inpatient	1,118,061	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	250	-	-	250	1,117,811	1,117,811	0.02%				
	10 Uninsured	Outpatient	1,358,460	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	37,033	-	-	37,033	1,321,427	1,321,427	2.73%				
	11 In-State Sub-total	Inpatient	1,964,485	142,712	67,319	176,798	-	-	-	-	108,251	-	61,428	-	-	-	-	-	-	-	-	32,795	250	-	-	-	589,554	1,374,932	30.01%				
	12 In-State Sub-total	Outpatient	3,014,643	397,736	101,709	247,077	5,379	-	-	(164,215)	-	-	189,624	161,176	-	-	-	-	-	-	-	15,287	37,033	-	-	-	990,805	2,023,838	32.87%				
	13 Out-of-State Medicaid	Inpatient	10,459	-	-	8,641	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	8,641	1,818	82.62%				
	14 Out-of-State Medicaid	Outpatient	18,596	50	-	1,651	-	-	-	-	-	-	252	-	-	-	-	-	-	-	-	-	-	-	-	-	1,953	16,643	10.50%				
	15 Cost Report Year Sub-Total	I/P and O/P	5,008,183	540,498	169,028	434,167	5,379	-	-	(164,215)	-	-	297,875	222,856	-	-	-	-	-	-	-	48,082	37,283	-	-	-	1,590,953	3,417,230	31.77%				
16																																	
17																																	
18																																	
19																																	

Medicaid DSH Survey Adjustments

PROVIDER: NORTHEAST GEORGIA MC HABERSHAM
 FROM: 7/1/2023

TO: 9/30/2023

Mcaid Number: 00000877A
 Mcare Number: 110041

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.
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 112,700	\$ (112,700)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ -	\$ 112,700	\$ 112,700	2002
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 100,807	\$ (100,807)	\$ -	2002
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ -	\$ 100,807	\$ 100,807	2002

Medicaid DSH Report Notes

PROVIDER: NORTHEAST GEORGIA MC HABERSHAM

Mcaid Number: 00000877A

FROM: 7/1/2023 TO: 9/30/2023

Mcare Number: 110041

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
1		
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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:

7/1/2023 through 9/30/2023	10/1/2023 through 9/30/2024	
	X	

2. Select Cost Report Year Covered by this Survey:

3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MC HABERSHAM	-	
5. Medicaid Provider Number:	00000877A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110041	-	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	-	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 1	-	
11. Rural Referral Center (Yes or No)	No	-	

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)	\$ 76,012	\$ 616,831	\$692,843
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 245,678	\$ 2,751,763	\$2,997,441
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$321,690	\$3,368,594	\$3,690,284
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	23.63%	18.31%	18.77%

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	\$ 781,574
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	\$781,574

<--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) 5,503

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	-
3. Outpatient Hospital Subsidies	-
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	1,923,214
8. Outpatient Hospital Charity Care Charges	14,124,276
9. Non-Hospital Charity Care Charges	42,780
10. Total Charity Care Charges	\$ 16,090,270

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	\$ 19,928,932	\$ -	\$ -	\$ 16,350,991	\$ -	\$ -	\$ 3,577,941
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15. Swing Bed - NF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16. Skilled Nursing Facility	\$ -	\$ -	\$ 5,976,073	\$ -	\$ -	\$ 4,903,159	\$ -
17. Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18. Other Long-Term Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19. Ancillary Services	\$ 45,937,731	\$ 201,546,035	\$ -	\$ 37,690,301	\$ 165,361,469	\$ -	\$ 44,431,997
20. Outpatient Services	\$ -	\$ 96,421,710	\$ -	\$ -	\$ 79,110,639	\$ -	\$ 17,311,071
21. Home Health Agency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22. Ambulance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26. Other	\$ 1,179,250	\$ -	\$ 216,550	\$ 967,533	\$ -	\$ 177,672	\$ 211,717
27. Total	\$ 67,045,913	\$ 297,967,745	\$ 6,192,623	\$ 55,008,825	\$ 244,472,107	\$ 5,080,830	\$ 65,532,725
28. Total Hospital and Non Hospital		Total from Above	\$ 371,206,281		Total from Above	\$ 304,561,763	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 371,206,281		Total Contractual Adj. (G-3 Line 2)	\$ 302,705,744	
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)						\$ 1,856,019	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)						\$ -	
35. 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						304,561,763	
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 HABERSHAM**

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 & 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 & 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	\$ 11,461,730	\$ -	\$ -	\$ -	\$ 11,461,730	8,286	\$ 19,928,932	\$ 1,383.26
2	03100 INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	04300 NURSERY	\$ 740,465	\$ -	\$ -	\$ -	\$ 740,465	795	\$ 1,154,750	\$ 931.40
18	Total Routine	\$ 12,202,195	\$ -	\$ -	\$ -	\$ 12,202,195	9,081	\$ 21,083,682	
19	Weighted Average								\$ 1,343.70

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		3,578	-	-	\$ 4,949,304	2,720,037	\$ 6,810,556	\$ 9,530,593	0.519307
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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	\$ 4,226,680	\$ -	\$ -	\$ -	\$ 4,226,680	\$ 4,184,541	\$ 24,577,851	\$ 28,762,392	0.146952
22	5200 DELIVERY ROOM & LABOR ROOM	\$ 3,110,519	\$ -	\$ -	\$ -	\$ 3,110,519	\$ 6,207,814	\$ 1,096,797	\$ 7,304,611	0.425830
23	5300 ANESTHESIOLOGY	\$ 956,574	\$ -	\$ -	\$ -	\$ 956,574	\$ 1,495,727	\$ 8,312,328	\$ 9,808,055	0.097529
24	5400 RADIOLOGY-DIAGNOSTIC	\$ 2,532,521	\$ -	\$ -	\$ -	\$ 2,532,521	\$ 1,067,018	\$ 24,750,065	\$ 25,817,083	0.098095
25	5700 CT SCAN	\$ 1,163,730	\$ -	\$ -	\$ -	\$ 1,163,730	\$ 4,037,845	\$ 48,680,149	\$ 52,717,994	0.022075
26	5800 MRI	\$ 181,049	\$ -	\$ -	\$ -	\$ 181,049	\$ 372,164	\$ 3,748,778	\$ 4,120,942	0.043934
27	6000 LABORATORY	\$ 4,683,264	\$ -	\$ -	\$ -	\$ 4,683,264	\$ 7,196,717	\$ 31,224,403	\$ 38,421,120	0.121893
28	6500 RESPIRATORY THERAPY	\$ 2,181,098	\$ -	\$ -	\$ -	\$ 2,181,098	\$ 4,888,034	\$ 7,629,618	\$ 12,517,652	0.174242
29	6600 PHYSICAL THERAPY	\$ 3,371,638	\$ -	\$ -	\$ -	\$ 3,371,638	\$ 2,123,523	\$ 6,594,859	\$ 8,718,382	0.386727
30	6900 ELECTROCARDIOLOGY	\$ 1,936,164	\$ -	\$ -	\$ -	\$ 1,936,164	\$ 2,367,726	\$ 17,097,673	\$ 19,465,399	0.099467
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 949,669	\$ -	\$ -	\$ -	\$ 949,669	\$ 1,248,431	\$ 3,916,803	\$ 5,165,234	0.183858
32	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 1,844,723	\$ -	\$ -	\$ -	\$ 1,844,723	\$ 725,013	\$ 6,408,805	\$ 7,133,818	0.258588
33	7300 DRUGS CHARGED TO PATIENTS	\$ 4,279,196	\$ -	\$ -	\$ -	\$ 4,279,196	\$ 10,023,178	\$ 17,507,906	\$ 27,531,084	0.155431
34	9100 EMERGENCY	\$ 10,456,179	\$ -	\$ -	\$ -	\$ 10,456,179	\$ 5,420,776	\$ 81,470,341	\$ 86,891,117	0.120337

G. Cost Report - Cost / Days / Charges

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

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
126	Total Ancillary	\$ 41,873,004	\$ -	\$ -	\$ 41,873,004	\$ 54,078,544	\$ 289,826,932	\$ 343,905,476	
127	Weighted Average								0.136149
128	Sub Totals	\$ 54,075,199	\$ -	\$ -	\$ 54,075,199	\$ 75,162,226	\$ 289,826,932	\$ 364,989,158	
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)				\$ 151,733				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				\$ -				
131.01	Other Cost Adjustments (support must be submitted)				\$ -				
132	Grand Total				\$ 53,923,466				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost								0.00%

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

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

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	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days			
03000	ADULTS & PEDIATRICS	\$ 1,383.26		245		348		356		289		130		180		1,368		33.03%	
03100	INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-			
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-		-		-			
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-			
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		-			
03500	OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-		-		-			
04000	SUBPROVIDER I	\$ -		-		-		-		-		-		-		-			
04100	SUBPROVIDER II	\$ -		-		-		-		-		-		-		-			
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-		-		-			
04300	NURSERY	\$ 931.40		114		298		37		135		11		582				74.55%	
Total Days				359	644	358	326	265	191	1,350								39.03%	
Total Days per PS&R or Exhibit Detail				359	644	356	326	265	191										
Unreconciled Days (Explain Variance)				-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Routine Charges				\$ 872,025	\$ 1,280,414	\$ 642,732	\$ 1,805.43	\$ 637,113	\$ 1,954.33	\$ 515,900	\$ 1,946.79	\$ 1,817.58	\$ 1,657.58						17.04%
Calculated Routine Charge Per Diem				1,871.94	1,988.22	1,805.43	1,805.43	1,954.33	1,954.33	1,946.79	1,946.79	1,817.58	1,657.58						
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
09200	Observation (Non-Distinct)	0.519307	\$ 154,879	\$ 106,976	\$ 48,507	\$ 106,459	\$ 193,029	\$ 390,720	\$ 128,205	\$ 265,646	\$ 9,990	\$ 47,397	\$ 157,620	\$ 321,456	\$ 524,620	\$ 869,801	\$ 20,36%		
5000	OPERATING ROOM	0.146952	\$ 384,552	\$ 379,383	\$ 974,512	\$ 519,790	\$ 71,946	\$ 1,057,653	\$ 242,413	\$ 348,173	\$ 266,103	\$ 264,402	\$ 90,811	\$ 1,252,303	\$ 1,673,423	\$ 2,304,999	\$ 20,42%		
5200	DELIVERY ROOM & LABOR ROOM	0.425830	\$ 440,445	\$ 11,322	\$ 1,599,722	\$ 326,687	\$ -	\$ 13,035	\$ 508,747	\$ 77,941	\$ 683,373	\$ 146,542	\$ 95,089	\$ 24,782	\$ 2,547,914	\$ 428,985	\$ 33,77%		
5300	ANESTHESIOLOGY	0.097529	\$ 194,884	\$ 103,220	\$ 851,017	\$ 147,837	\$ 19,461	\$ 282,162	\$ 194,199	\$ 81,972	\$ 69,958	\$ 33,111	\$ 353,418	\$ 1,059,581	\$ 558,191	\$ 24,07%			
5400	RADIOLOGY-DIAGNOSTIC	0.098095	\$ 53,302	\$ 726,146	\$ 24,549	\$ 1,368,854	\$ 72,303	\$ 1,091,069	\$ 59,298	\$ 702,382	\$ 8,828	\$ 363,490	\$ 81,256	\$ 1,897,988	\$ 208,452	\$ 3,888,451	\$ 25,08%		
5700	CT SCAN	0.022075	\$ 226,353	\$ 1,207,759	\$ 52,503	\$ 1,840,457	\$ 240,629	\$ 2,580,580	\$ 184,461	\$ 1,535,837	\$ 10,301	\$ 416,310	\$ 267,012	\$ 5,487,124	\$ 703,846	\$ 7,164,633	\$ 26,83%		
5800	MRI	0.043934	\$ 9,183	\$ 103,194	\$ 4,731	\$ 50,343	\$ 13,079	\$ 277,232	\$ 15,528	\$ 106,564	\$ -	\$ 7,349	\$ 27,409	\$ 150,609	\$ 42,521	\$ 537,333	\$ 18,83%		
6000	LABORATORY	0.121893	\$ 588,904	\$ 1,674,524	\$ 889,288	\$ 2,289,734	\$ 611,125	\$ 1,912,571	\$ 502,147	\$ 1,641,987	\$ 252,911	\$ 731,861	\$ 544,091	\$ 4,035,799	\$ 2,401,464	\$ 7,513,717	\$ 43,55%		
6500	RESPIRATORY THERAPY	0.174242	\$ 64,752	\$ 63,698	\$ 41,314	\$ 92,984	\$ 223,006	\$ 428,346	\$ 300,189	\$ 459,971	\$ 25,077	\$ 103,279	\$ 219,719	\$ 706,357	\$ 628,282	\$ 1,075,000	\$ 22,29%		
8600	PHYSICAL THERAPY	0.386727	\$ 22,785	\$ 39,177	\$ 1,323	\$ 18,783	\$ 64,383	\$ 257,287	\$ 41,862	\$ 41,905	\$ 273	\$ 61,089	\$ 13,463	\$ 285,707	\$ 130,353	\$ 357,152	\$ 9,75%		
6900	ELECTROCARDIOLOGY	0.099467	\$ 160,275	\$ 432,195	\$ 20,226	\$ 270,940	\$ 199,441	\$ 887,272	\$ 104,680	\$ 519,024	\$ 1,251	\$ 106,729	\$ 138,091	\$ 1,094,745	\$ 484,622	\$ 2,109,431	\$ 20,30%		
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.183858	\$ 113,311	\$ 66,267	\$ 345,597	\$ 143,615	\$ 30,311	\$ 163,594	\$ 101,459	\$ 44,351	\$ 79,799	\$ 88,314	\$ 29,578	\$ 162,780	\$ 580,668	\$ 417,826	\$ 26,50%		
7200	INPL. DEV. CHARGED TO PATIENTS	0.259588	\$ 30,999	\$ -	\$ 4,561	\$ 54,100	\$ 37,069	\$ 409,879	\$ 8,319	\$ 53,183	\$ 370	\$ -	\$ 212,598	\$ 80,947	\$ 508,161	\$ 11,24%			
7300	DRUGS CHARGED TO PATIENTS	0.155431	\$ 689,177	\$ 216,553	\$ 859,888	\$ 773,586	\$ 702,434	\$ 938,610	\$ 548,119	\$ 646,919	\$ 310,772	\$ 299,309	\$ 507,305	\$ 1,782,837	\$ 2,799,618	\$ 2,575,668	\$ 30,29%		
9100	EMERGENCY	0.120337	\$ 525,751	\$ 3,644,392	\$ 332,347	\$ 9,660,180	\$ 684,084	\$ 4,183,617	\$ 401,961	\$ 3,097,090	\$ 92,982	\$ 2,392,167	\$ 712,681	\$ 11,848,661	\$ 1,944,143	\$ 20,585,279	\$ 43,54%		
TOTAL				\$ 3,660,553	\$ 8,804,806	\$ 5,649,075	\$ 17,662,349	\$ 3,162,301	\$ 14,844,627	\$ 3,341,586	\$ 9,622,845	\$ 1,987,920	\$ 5,098,196	\$ 2,917,235	\$ 29,617,244				

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

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

	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)								
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 4,341,578	\$ 8,804,806	\$ 6,929,489	\$ 17,662,349	\$ 3,805,033	\$ 14,844,627	\$ 3,978,699	\$ 9,622,845	\$ 2,503,820	\$ 5,098,196	\$ 3,264,393	\$ 29,617,244	\$ 19,054,799	\$ 50,934,627	28.36%
129 Total Charges per PS&R or Exhibit Detail	\$ 4,341,578	\$ 8,804,806	\$ 6,929,489	\$ 17,662,349	\$ 3,805,033	\$ 14,844,627	\$ 3,978,699	\$ 9,622,845	\$ 2,503,820	\$ 5,098,196	\$ 3,264,393	\$ 29,617,244	\$ 19,054,799	\$ 50,934,627	
130 Unreconciled Charges (Explain Variance)															
131.01 Sampling Cost Adjustment (if applicable)															
131.02 Total Calculated Cost (includes organ acquisition from Section J)	\$ 1,107,483	\$ 991,596	\$ 2,005,624	\$ 2,114,750	\$ 982,876	\$ 1,844,214	\$ 1,077,061	\$ 1,181,051	\$ 775,618	\$ 669,933	\$ 706,819	\$ 3,332,162	\$ 5,173,044	\$ 6,131,611	28.61%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 772,691	\$ 1,562,234	\$ -	\$ -	\$ 30,628	\$ 204,391	\$ 27,477	\$ 42,705					\$ 830,797	\$ 1,809,331	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 1,193,111	\$ 1,897,149	\$ -	\$ -	\$ 17,410	\$ 29,568					\$ 1,210,521	\$ 1,926,817	
134 Private Insurance (including primary and third party liability)	\$ 11,101	\$ 12,472	\$ -	\$ 4,329	\$ -	\$ 5,330	\$ 412,927	\$ 655,408					\$ 424,028	\$ 677,537	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ 789	\$ -	\$ 1,918	\$ -	\$ 1,158	\$ -	\$ -					\$ -	\$ 5,057	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 783,792	\$ 1,575,496	\$ 1,193,111	\$ 1,903,396	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (730,993)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ (730,993)	
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)	\$ -	\$ -	\$ -	\$ -	\$ 728,053	\$ 1,157,907	\$ 226,427	\$ 49,383	\$ -	\$ -	\$ -	\$ -	\$ 954,480	\$ 1,207,290	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 378,430	\$ 599,596	\$ -	\$ -	\$ -	\$ -	\$ 378,430	\$ 599,596	
141 Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ 6,193	\$ 458	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,193	\$ 458	
142 Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ 233,205	\$ 143,677	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 233,205	\$ 143,677	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 76,012	\$ 616,831	\$ -	\$ -	
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 323,691	\$ 147,093	\$ 812,513	\$ 211,354	\$ (15,203)	\$ 331,293	\$ 14,390	\$ (196,899)	\$ 775,618	\$ 669,933	\$ 830,807	\$ 2,715,331	\$ 1,135,391	\$ 492,841	
146 Calculated Payments as a Percentage of Cost	71%	85%	59%	90%	102%	82%	99%	117%	0%	0%	11%	19%	78%	92%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)							1,528								23%
148 Percent of cross-over days to total Medicare days from the cost report															

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 HABERSHAM

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)
		From Section G	From Section G										
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,383.26		6		-		1		-		7	
2	03100 INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	\$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
10	04300 NURSERY	\$ 931.40		-		-		-		-		-	
18			Total Days	6		-		1		-		7	
19	Total Days per PS&R or Exhibit Detail			6		-		1		-		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem	\$ 1,803.00		\$ -		\$ -		\$ 1,803.00		\$ -		\$ 1,803.00	
				\$ 10,818		\$ -		\$ 1,803		\$ -		\$ 12,621	
				\$ 1,803.00		\$ -		\$ 1,803.00		\$ -		\$ 1,803.00	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)	0.519307		4,662	2,886	-	-	1,887	-	-	-	6,549	2,886
23	5000 OPERATING ROOM	0.146952		-	-	-	-	-	19,895	-	-	-	19,895
24	5200 DELIVERY ROOM & LABOR ROOM	0.425930		-	676	-	-	-	-	-	-	-	676
25	5300 ANESTHESIOLOGY	0.089529		-	-	-	-	-	3,455	-	-	-	3,455
26	5400 RADIOLOGY-DIAGNOSTIC	0.089095		1,339	21,139	-	-	2,064	1,906	-	1,487	3,403	24,532
27	5700 CT SCAN	0.022075		11,161	68,179	-	-	1,946	12,338	-	-	13,107	80,517
28	5800 MRI	0.043934		3,061	-	-	-	7,713	-	-	-	10,774	-
29	6000 LABORATORY	0.121893		11,383	62,511	-	-	7,404	9,325	-	3,684	18,787	75,520
30	6500 RESPIRATORY THERAPY	0.174242		20,731	7,636	-	-	1,343	1,171	-	219	22,074	9,026
31	6600 PHYSICAL THERAPY	0.386727		1,643	-	-	-	273	-	-	-	1,916	-
32	6900 ELECTROCARDIOLOGY	0.099467		5,140	9,071	-	-	417	2,085	-	417	5,557	11,573
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.183858		-	-	-	-	-	-	-	-	-	-
34	7200 IMPL. DEV. CHARGED TO PATIENTS	0.258588		-	-	-	-	-	-	-	-	-	-
35	7300 DRUGS CHARGED TO PATIENTS	0.155431		12,242	21,114	-	-	1,747	27,685	-	169	13,989	48,968
36	9100 EMERGENCY	0.120337		14,451	204,563	-	-	4,962	25,938	-	7,826	19,413	238,327
				85,813	397,775	-	-	29,756	103,798	-	13,802	-	-
	Totals / Payments												
128	Total Charges (includes organ acquisition from Section K)	\$ 96,631	\$ 397,775	\$ -	\$ -	\$ 31,559	\$ 103,798	\$ -	\$ 13,802	\$ 128,190	\$ 515,375		
129	Total Charges per PS&R or Exhibit Detail	\$ 96,631	\$ 397,775	\$ -	\$ -	\$ 31,559	\$ 103,798	\$ -	\$ 13,802				
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-
131.01	Sampling Cost Adjustment (if applicable)	-	-	-	-	-	-	-	-	-	-	-	-
131.02	Total Calculated Cost (includes organ acquisition from Section K)	\$ 21,021	\$ 43,116	\$ -	\$ -	\$ 5,100	\$ 12,692	\$ -	\$ 1,643	\$ 26,121	\$ 57,451		
132	Total Medicaid Paid Amount (excludes TPL Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,753	\$ -	\$ -	\$ -	\$ 1,753		
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)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,727	\$ -	\$ 3,727	
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)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 8,911	\$ -	\$ -	\$ -	\$ 8,911		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	\$ -	\$ -	\$ -	\$ -	\$ 8,989	\$ 474	\$ -	\$ -	\$ -	\$ 9,463	\$ 474	
141	Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
142	Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 21,021	\$ 43,116	\$ -	\$ -	\$ (3,889)	\$ 1,554	\$ -	\$ (2,084)	\$ 17,132	\$ 42,586		
144	Calculated Payments as a Percentage of Cost	0%	0%	0%	0%	176%	88%	0%	227%	34%	26%		

I. Out-of-State Medicaid Data:

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

NORTHEAST GEORGIA MC HABERSHAM

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
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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 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 HABERSHAM

	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
Organ Acquisition Cost Centers (list below):																	
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	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
10	Total Cost																

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.

Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

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

NORTHEAST GEORGIA MC HABERSHAM

	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)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18		\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B - Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

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

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	WS A Cost Center Line	
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 1,160,666		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	408001-69000	(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 1,160,666	5.00	(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 0		
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)			
4 Reclassification Code	\$ 0		(Reclassified to / (from))
5 Reclassification Code	\$ 0		(Reclassified to / (from))
6 Reclassification Code	\$ 0		(Reclassified to / (from))
7 Reclassification Code	\$ 0		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
8 Reason for adjustment	\$ 0		(Adjusted to / (from))
9 Reason for adjustment	\$ 0		(Adjusted to / (from))
10 Reason for adjustment	\$ 0		(Adjusted to / (from))
11 Reason for adjustment	\$ 0		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
12 Reason for adjustment	\$ 0		
13 Reason for adjustment	\$ 0		
14 Reason for adjustment	\$ 0		
15 Reason for adjustment	\$ 0		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 1,160,666		

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	78,235,008
19 Uninsured Hospital Charges Sec. G	32,881,637
20 Total Hospital Charges Sec. G	364,989,158
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	21.43%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.01%
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***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	38,232,628
27 Uninsured Hospital Charges Sec. G	40,483,654
28 Total Hospital Charges Sec. G	364,989,158
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	10.48%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	11.09%
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	NORTHEAST GEORGIA MC HABERSHAM		
Hospital Medicaid Number	000000877A		
Cost Report Period	From	10/1/2023	To
			9/30/2024

		As-Reported	Adjustments	As-Adjusted	
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 5,078,834	\$ -	\$ 5,078,834
2	Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
3	Total		\$ 5,078,834	\$ -	\$ 5,078,834
4	Net Hospital Patient Revenue	Survey F-3	\$ 5,791,581	\$ 59,741,144	\$ 65,532,725
5	Medicaid Fraction		87.69%	-79.94%	7.75%
6	Inpatient Charity Care Charges	Survey F-2	\$ 1,923,214	\$ -	\$ 1,923,214
7	Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9	Adjusted Inpatient Charity Care		\$ 1,923,214	\$ -	\$ 1,923,214
10	Inpatient Hospital Charges	Survey F-3	\$ 12,368,769	\$ 54,677,144	\$ 67,045,913
11	Inpatient Charity Fraction		15.55%	-12.68%	2.87%
12	LIUR		103.24%	-92.62%	10.62%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	1,950	-	1,950
14	Out-of-State Medicaid Eligible Days	Survey I	7	-	7
15	Total Medicaid Eligible Days		1,957	-	1,957
16	Total Hospital Days (excludes swing-bed)	Survey F-1	741	4,762	5,503
17	MIUR		264.10%	-228.54%	35.56%

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 HABERSHAM**
 Hospital Medicaid Number: **00000877A**
 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	Survey H & I	Survey H & I	Survey H & I
1 Medicaid Fee for Service	Inpatient	1,107,483	772,691	-	11,101	-	-	-	-	-	-	-	-	-	783,792	323,691	70.77%
2 Medicaid Fee for Service	Outpatient	991,596	1,562,234	-	12,472	789	(730,993)	-	-	-	-	-	-	-	844,503	147,093	85.17%
3 Medicaid Managed Care	Inpatient	2,005,624	-	1,193,111	-	-	-	-	-	-	-	-	-	-	1,193,111	812,513	59.49%
4 Medicaid Managed Care	Outpatient	2,114,750	-	1,897,149	4,329	1,918	-	-	-	-	-	-	-	-	1,903,396	211,354	90.01%
5 Medicare Cross-over (FFS)	Inpatient	982,876	30,628	-	-	-	-	-	728,053	-	6,193	233,205	-	-	998,079	(15,203)	101.55%
6 Medicare Cross-over (FFS)	Outpatient	1,844,214	204,391	-	5,330	1,158	-	-	1,157,907	-	458	143,677	-	-	1,512,921	331,293	82.04%
7 Other Medicaid Eligibles	Inpatient	1,077,061	27,477	17,410	412,927	-	-	-	226,427	378,430	-	-	-	-	1,082,671	14,390	98.66%
8 Other Medicaid Eligibles	Outpatient	1,181,051	42,705	29,668	655,406	1,192	-	-	49,383	599,596	-	-	-	-	1,377,950	(196,899)	116.67%
9 Uninsured	Inpatient	1,482,437	-	-	-	-	-	-	-	-	-	-	76,012	-	76,012	1,406,425	5.13%
10 Uninsured	Outpatient	4,002,095	-	-	-	-	-	-	-	-	-	-	616,831	-	616,831	3,385,264	15.41%
11 In-State Sub-total	Inpatient	6,655,481	830,797	1,210,521	424,028	-	-	-	954,480	378,430	6,193	233,205	76,012	-	4,113,665	2,541,816	61.81%
12 In-State Sub-total	Outpatient	10,133,706	1,809,331	1,926,817	677,537	5,057	(730,993)	-	1,207,290	599,596	458	143,677	616,831	-	6,255,601	3,878,105	61.73%
13 Out-of-State Medicaid	Inpatient	26,121	-	-	-	-	-	-	-	8,989	-	-	-	-	8,989	17,132	34.41%
14 Out-of-State Medicaid	Outpatient	57,451	1,753	-	3,727	-	-	-	8,911	474	-	-	-	-	14,865	42,586	25.87%
15 Sub-Total	I/P and O/P	16,872,759	2,641,881	3,137,337	1,105,292	5,057	(730,993)	-	2,170,681	987,489	6,651	376,882	692,843	-	10,393,120	6,479,639	61.60%

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	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name: **NORTHEAST GEORGIA MC HABERSHAM**
 Hospital Medicaid Number: **000000877A**
 Cost Report Period: From **10/1/2023** To **9/30/2024**

As-Adjusted:	Service Type														Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)	
		A	B	C	D	E	F	G	H	I	J	K	L	M				
		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)				
		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	1,107,483	772,691	-	11,101	-	-	-	-	-	-	-	-	-	783,792	323,691	70.77%
2	Medicaid Fee for Service	Outpatient	991,596	1,562,234	-	12,472	789	(730,993)	-	-	-	-	-	-	-	844,503	147,093	85.17%
3	Medicaid Managed Care	Inpatient	2,005,624	-	1,193,111	-	-	-	-	-	-	-	-	-	-	1,193,111	812,513	59.49%
4	Medicaid Managed Care	Outpatient	2,114,750	-	1,897,149	4,329	1,918	-	-	-	-	-	-	-	-	1,903,396	211,354	90.01%
5	Medicare Cross-over (FFS)	Inpatient	982,876	30,628	-	-	-	-	728,053	-	6,193	233,205	-	-	-	998,079	(15,203)	101.55%
6	Medicare Cross-over (FFS)	Outpatient	1,844,214	204,391	-	5,330	1,158	-	1,157,907	-	458	143,677	-	-	-	1,512,921	331,293	82.04%
7	Other Medicaid Eligibles	Inpatient	1,077,061	27,477	17,410	412,927	-	-	226,427	378,430	-	-	-	-	-	1,082,671	14,390	98.66%
8	Other Medicaid Eligibles	Outpatient	1,181,051	42,705	29,668	655,406	1,192	-	49,383	599,596	-	-	-	-	-	1,377,950	(196,899)	116.67%
9	Uninsured	Inpatient	1,482,437	-	-	-	-	-	-	-	-	-	76,012	-	76,012	1,406,425	5.13%	
10	Uninsured	Outpatient	4,002,095	-	-	-	-	-	-	-	-	-	616,831	-	616,831	3,385,264	15.41%	
11	In-State Sub-total	Inpatient	6,655,481	830,797	1,210,521	424,028	-	-	954,480	378,430	6,193	233,205	76,012	-	4,113,665	2,541,816	61.81%	
12	In-State Sub-total	Outpatient	10,133,706	1,809,331	1,926,817	677,537	5,057	(730,993)	1,207,290	599,596	458	143,677	616,831	-	6,255,601	3,878,105	61.73%	
13	Out-of-State Medicaid	Inpatient	26,121	-	-	-	-	-	-	8,989	-	-	-	-	8,989	17,132	34.41%	
14	Out-of-State Medicaid	Outpatient	57,451	1,753	-	3,727	-	-	8,911	474	-	-	-	-	14,865	42,586	25.87%	
15	Cost Report Year Sub-Total	I/P and O/P	16,872,759	2,641,881	3,137,337	1,105,292	5,057	(730,993)	2,170,681	987,489	6,651	376,882	692,843	-	10,393,120	6,479,639	61.60%	
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
																		6,479,639
18																		Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments
19																		Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments
																		129,161
																		6,350,477

Medicaid DSH Survey Adjustments

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

TO: 9/30/2024

Mcaid Number: 00000877A
Mcare Number: 110041

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.
1	F - MIUR/LIUR Data	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)	1.00	Amount	Adjust to cost report.	741	4,762	5,503	2002
1	F - MIUR/LIUR Data	11	Hospital	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 3,687,846	\$ 16,241,086	\$ 19,928,932	2002
1	F - MIUR/LIUR Data	19	Ancillary Services	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 8,410,673	\$ 37,527,058	\$ 45,937,731	2002
1	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.	\$ 270,250	\$ 909,000	\$ 1,179,250	2002
1	F - MIUR/LIUR Data	19	Ancillary Services	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 40,526,646	\$ 161,019,389	\$ 201,546,035	2002
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 112,700	\$ (112,700)	\$ -	2002
1	F - MIUR/LIUR Data	20	Outpatient Services	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 19,079,762	\$ 77,341,948	\$ 96,421,710	2002
1	F - MIUR/LIUR Data	16	Skilled Nursing Facility	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ 1,608,885	\$ 4,367,188	\$ 5,976,073	2002
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	\$ -	\$ 216,550	\$ 216,550	2002
1	F - MIUR/LIUR Data	11	Hospital	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 3,391,562	\$ 12,959,429	\$ 16,350,991	2002
1	F - MIUR/LIUR Data	19	Ancillary Services	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 7,734,955	\$ 29,955,346	\$ 37,690,301	2002
1	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 248,538	\$ 718,995	\$ 967,533	2002
1	F - MIUR/LIUR Data	19	Ancillary Services	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 37,270,712	\$ 128,090,756	\$ 165,361,469	2002
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 103,646	\$ (103,646)	\$ -	2002
1	F - MIUR/LIUR Data	20	Outpatient Services	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 17,546,883	\$ 61,563,756	\$ 79,110,639	2002
1	F - MIUR/LIUR Data	16	Skilled Nursing Facility	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ 1,479,626	\$ 3,423,533	\$ 4,903,159	2002
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	\$ -	\$ 177,672	\$ 177,672	2002

Medicaid DSH Report Notes

PROVIDER: NORTHEAST GEORGIA MC HABERSHAM

Mcaid Number: 00000877A

FROM: 10/1/2023 TO: 9/30/2024

Mcare Number: 110041

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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