GA DSH Payment Results for SFY 2026 - Pool 1

5/7/2026 15:46

DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

Provider Name	NORTHEAST GEORGIA MC LUMPKIN
Mcaid Provider Number	003229414A
Mcare Provider Number	110237

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) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	10/1/2023	-	9/30/2024	$ 4,220,413	$ -	$ 4,220,413

Less: 2024 Gross UPL Payments	$ 210,079
Less: 2026 Gross DPP Payments	$ 4,084,182
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ (36,550)
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ -
Hospital Specific DSH Limit (Total UCC)	$ (110,398)
2026 Eligibility	Not Eligible
DSH Year Low Income Utilization Ratio (LIUR):	25.05%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	20.45%

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 10/1/2023 - 9/30/2024

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: NORTHEAST GEORGIA MC LUMPKIN

	10/1/2023 through 9/30/2024		
2. Select Cost Report Year Covered by this Survey:	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/4/2025		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MC LUMPKIN	-	
5. Medicaid Provider Number:	003229414A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110237	-	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Private	-	
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)

	Amount
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)	$ 6,855	$ 234,731	$241,586
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 118,209	$ 1,997,544	$2,115,753
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$125,064	$2,232,275	$2,357,339
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.48%	10.52%	10.25%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

	Amount
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ 27,510
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	$27,510

<--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)

Line	Description	Amount
1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	2,259

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):

Line	Description	Amount
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	2,022,419
8.	Outpatient Hospital Charity Care Charges	9,245,770
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 11,268,189

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

Line		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 9,797,094	$ -	$ -	$ 7,962,986	$ -	$ -	$ 1,834,108
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 19,299,205	$ 96,856,606	$ -	$ 15,686,212	$ 78,724,136	$ -	$ 21,745,463
20.	Outpatient Services		$ 60,680,740	$ -		$ 49,320,734	$ -	$ 11,360,006
21.	Home Health Agency			$ -			$ -	
22.	Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	-
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 17,200	$ 108,950	$ -	$ 13,980	$ 88,554	$ -	$ 23,616
27.	Total	$ 29,113,499	$ 157,646,296	$ -	$ 23,663,178	$ 128,133,423	$ -	$ 34,963,194
28.	Total Hospital and Non Hospital		Total from Above	$ 186,759,795		Total from Above	$ 151,796,601	

Line	Description		Amount			Amount
29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 186,759,795	Total Contractual Adj. (G-3 Line 2)		$ 149,050,889
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)				+	$ 2,745,712
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					151,796,601
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 LUMPKIN

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 7,124,515	$ -	$ -	-	**$ 7,124,515**	3,983	$ 9,797,094		**$ 1,788.73**
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 7,124,515	$ -	$ -	$ -	$ 7,124,515	3,983	$ 9,797,094		
19	Weighted Average									$ 1,788.73

Line #	Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200 Observation (Non-Distinct)		1,724	-	-	**$ 3,083,771**	1,590,537	3,001,779	$ 4,592,316	**0.671507**

Line #	Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$ 3,133,185	$ -	$ -		**$ 3,133,185**	$ 28,088	$ 12,150,504	$ 12,178,592	**0.257270**
22	5300 ANESTHESIOLOGY	$ 202,119	$ -	$ -		**$ 202,119**	$ 5,746	$ 3,673,318	$ 3,679,064	**0.054938**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 2,355,581	$ -	$ -		**$ 2,355,581**	$ 3,900,070	$ 37,852,360	$ 41,752,430	**0.056418**
24	6000 LABORATORY	$ 2,983,952	$ -	$ -		**$ 2,983,952**	$ 3,592,010	$ 15,475,819	$ 19,067,829	**0.156491**
25	6500 RESPIRATORY THERAPY	$ 1,154,234	$ -	$ -		**$ 1,154,234**	$ 3,255,239	$ 3,668,616	$ 6,923,855	**0.166704**
26	6900 ELECTROCARDIOLOGY	$ 441,323	$ -	$ -		**$ 441,323**	$ 1,767,072	$ 6,227,597	$ 7,994,669	**0.055202**
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,346,573	$ -	$ -		**$ 1,346,573**	$ 63,056	$ 2,781,026	$ 2,844,082	**0.473465**
28	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 1,168,389	$ -	$ -		**$ 1,168,389**	$ -	$ 4,390,711	$ 4,390,711	**0.266105**
29	7300 DRUGS CHARGED TO PATIENTS	$ 3,845,579	$ -	$ -		**$ 3,845,579**	$ 6,687,924	$ 10,636,655	$ 17,324,579	**0.221972**
30	9100 EMERGENCY	$ 8,146,866	$ -	$ -		**$ 8,146,866**	$ 3,994,664	$ 52,093,760	$ 56,088,424	**0.145250**
126	**Total Ancillary**	$ 24,777,801	$ -	$ -		$ 24,777,801	$ 24,884,406	$ 151,952,145	$ 176,836,551	
127	**Weighted Average**									**0.157555**
128	**Sub Totals**	$ 31,902,316	$ -	$ -		$ 31,902,316	$ 34,681,500	$ 151,952,145	$ 186,633,645	

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				$ -				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				$ -				
131.01	Other Cost Adjustments (support must be submitted)				$ -				
132	**Grand Total**				**$ 31,902,316**				
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 LUMPKIN

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 – Inpatient	In-State Medicaid FFS Primary – Outpatient	In-State Medicaid Managed Care Primary – Inpatient	In-State Medicaid Managed Care Primary – Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) – Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) – Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) – Inpatient	In-State Other Medicaid Eligibles – Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) – Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered – Outpatient	Uninsured – Inpatient (See Exhibit A)	Uninsured – Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) – Inpatient	Total In-State Medicaid – Outpatient	% Survey to Cost Report Totals (Includes all payers)
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From 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		
1	03000	ADULTS & PEDIATRICS	$ 1,788.73		134		13		209		104		2		196		462		29.13%
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	$ -		-		-		-		-		-		-		-		
11		0	$ -		-		-		-		-		-		-		-		
12		0	$ -		-		-		-		-		-		-		-		
13		0	$ -		-		-		-		-		-		-		-		
14		0	$ -		-		-		-		-		-		-		-		
15		0	$ -		-		-		-		-		-		-		-		
16		0	$ -		-		-		-		-		-		-		-		
17		0	$ -		-		-		-		-		-		-		-		
18				Total Days	134		13		209		104		2		196		462		29.13%
19		Total Days per PS&R or Exhibit Detail			134		13		209		104		2		196				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 241,602		$ 23,439		$ 376,827		$ 187,512		$ 3,606		$ 353,496		**$ 829,380**		12.07%
21.01		Calculated Routine Charge Per Diem			$ 1,803.00		$ 1,803.00		$ 1,803.00		$ 1,803.00		$ 1,803.00		$ 1,803.55		$ 1,795.19		
		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	
22	09200	Observation (Non-Distinct)		0.671507	$ 70,263	$ 60,957	$ 22,311	$ 61,605	$ 123,543	$ 166,833	$ 150,849	$ 59,832	$ 6,882	$ -	$ 140,193	$ 230,769	$ 366,966	$ 349,227	24.14%
23	5000	OPERATING ROOM		0.257270	$ -	$ 272,731	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 272,731	2.24%
24	5300	ANESTHESIOLOGY		0.054938	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
25	5400	RADIOLOGY-DIAGNOSTIC		0.056418	$ 178,421	$ 1,216,385	$ 21,538	$ 1,765,214	$ 329,050	$ 2,628,418	$ 168,148	$ 906,444	$ 4,294	$ 96,967	$ 396,613	$ 4,243,158	$ 697,157	$ 6,516,461	28.91%
26	6000	LABORATORY		0.156491	$ 285,516	$ 759,639	$ 47,903	$ 1,253,419	$ 503,921	$ 1,294,921	$ 274,725	$ 510,859	$ 13,569	$ 72,322	$ 518,121	$ 2,543,850	$ 1,112,066	$ 3,818,838	42.68%
27	6500	RESPIRATORY THERAPY		0.166704	$ 50,062	$ 112,836	$ 5,944	$ 101,425	$ 66,206	$ 105,606	$ 162,610	$ 63,697	$ -	$ 3,715	$ 142,213	$ 121,262	$ 284,822	$ 383,564	13.51%
28	6900	ELECTROCARDIOLOGY		0.055202	$ 65,038	$ 143,512	$ 4,306	$ 516,727	$ 182,220	$ 476,954	$ 90,976	$ 153,272	$ 5,359	$ 43,352	$ 171,668	$ 907,537	$ 342,540	$ 1,290,465	34.67%
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.473465	$ 4,168	$ 78,271	$ -	$ 532,946	$ 882	$ 49,416	$ 828	$ 52,458	$ -	$ 35,992	$ 61,339	$ 557,118	$ 5,878	$ 713,091	48.29%
30	7200	IMPL. DEV. CHARGED TO PATIENTS		0.266105	$ -	$ 14,107	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 14,107	0.32%
31	7300	DRUGS CHARGED TO PATIENTS		0.221972	$ 388,723	$ 112,805	$ 73,771	$ 472,275	$ 581,924	$ 590,085	$ 299,923	$ 179,375	$ 17,254	$ 42,302	$ 608,290	$ 1,209,277	$ 1,344,341	$ 1,354,540	26.55%
32	9100	EMERGENCY		0.145250	$ 334,250	$ 1,867,399	$ 92,841	$ 5,384,020	$ 529,000	$ 3,244,136	$ 355,832	$ 1,221,606	$ 27,580	$ 300,544	$ 742,149	$ 8,146,926	$ 1,311,923	$ 11,717,161	40.02%
33				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
34				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
35				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
36				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
37				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
38				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
39				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
40				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
41				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
42				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

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

Line					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)	
71				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
72				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
73				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
74				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
75				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
76				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
77				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
78				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
79				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
80				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
81				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
82				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
83				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
84				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
85				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
86				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
87				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
88				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
89				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
90				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
91				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
92				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
93				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
94				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
95				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
96				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
97				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
98				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
99				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
100				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
101				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
102				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
103				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
104				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
105				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
106				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
107				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
108				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
109				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
110				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
111				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
112				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
113				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
114				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
115				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
116				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
117				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
118				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
119				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
120				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
121				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
122				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
123				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
124				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
125				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
126				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
127				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
					1,376,441	4,638,641	268,614	10,087,631	2,316,746	8,556,369	1,503,891	3,147,543	74,938	595,194	2,780,585	17,959,897		

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

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

Line	Totals / Payments	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 ...
128	**Total Charges *(includes organ acquisition from Section J)***	**$ 1,618,043**	**$ 4,638,641**	**$ 292,053**	**$ 10,087,631**	**$ 2,693,573**	**$ 8,556,369**	**$ 1,691,403**	**$ 3,147,543**	**$ 78,544**	**$ 595,194**	**$ 3,134,081**	**$ 17,959,897**	**$ 6,295,073**	**$ 26,430,185**	29.06%
												(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129	Total Charges per PS&R or Exhibit Detail	$ 1,618,043	$ 4,638,641	$ 292,053	$ 10,087,631	$ 2,693,573	$ 8,556,369	$ 1,691,403	$ 3,147,543	$ 78,544	$ 595,194	$ 3,134,081	$ 17,959,897			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 490,363**	**$ 662,425**	**$ 78,036**	**$ 1,521,731**	**$ 781,749**	**$ 1,132,487**	**$ 490,584**	**$ 432,433**	**$ 18,696**	**$ 89,886**	**$ 853,235**	**$ 2,578,298**	$ 1,840,732	$ 3,749,076	28.47%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 243,603	$ 504,687	$ -	$ -	$ 17,026	$ 87,386	$ -	$ 16,847					$ 260,629	$ 608,920	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 30,422	$ 1,083,624	$ -	$ -	$ -	$ 37,510					$ 30,422	$ 1,121,134	
134	Private Insurance (including primary and third party liability)	$ 10,770	$ 1,517	$ -	$ 180	$ -	$ 18	$ 8,986	$ 236,989					$ 19,756	$ 238,704	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ 120	$ -	$ 33	$ -	$ 108	$ -	$ 260	$ -	$ 1,762			$ -	$ 521	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 254,373	$ 506,324	$ 30,422	$ 1,083,837											
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (2,759)	$ -	$ -									$ -	$ (2,759)	
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)	$ -		$ -		$ 492,290	$ 642,256	$ 162,576	$ 3,828	$ -		$ -		$ 654,866	$ 646,084	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 81,351	$ 182,895					$ 81,351	$ 182,895	
141	Medicare Cross-Over Bad Debt Payments					$ 10,424	$ 4,226	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 10,424	$ 4,226	
142	Other Medicare Cross-Over Payments (See Note D)					$ 213,725	$ 51,873	$ -	$ -					$ 213,725	$ 51,873	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 6,855	$ 234,731			
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)**	$ 235,990	$ 158,860	$ 47,614	$ 437,894	$ 48,284	$ 346,620	$ 237,670	$ (45,896)	$ 18,696	$ 88,124	$ 846,380	$ 2,343,567	$ 569,559	$ 897,478	
146	**Calculated Payments as a Percentage of Cost**	52%	76%	39%	71%	94%	69%	52%	111%	0%	2%	1%	9%	69%	76%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					1,589										
148	**Percent of cross-over days to total Medicare days from the cost report**					13%										

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

NOTE: Inpatient 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 (10/01/2023-09/30/2024) NORTHEAST GEORGIA MC LUMPKIN

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 Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000	ADULTS & PEDIATRICS	$ 1,788.73		-		-		-		-		-	
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	$ -		-		-		-		-		-	
11			$ -		-		-		-		-		-	
12			$ -		-		-		-		-		-	
13			$ -		-		-		-		-		-	
14			$ -		-		-		-		-		-	
15			$ -		-		-		-		-		-	
16			$ -		-		-		-		-		-	
17			$ -		-		-		-		-		-	
18				Total Days	-		-		-		-		-	
19		Total Days per PS&R or Exhibit Detail			-		-		-		-			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21		Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
		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)		0.671507	-	5,439	-	-	9,213	-	-	-	$ 9,213	$ 5,439
23	5000	OPERATING ROOM		0.257270	-	-	-	-	-	-	-	-	$ -	$ -
24	5300	ANESTHESIOLOGY		0.054938	-	-	-	-	-	-	-	-	$ -	$ -
25	5400	RADIOLOGY-DIAGNOSTIC		0.056418	-	101,839	-	-	9,020	647	-	3,913	$ 9,020	$ 106,399
26	6000	LABORATORY		0.156491	-	45,224	-	-	9,875	1,650	-	3,152	$ 9,875	$ 50,026
27	6500	RESPIRATORY THERAPY		0.166704	-	-	-	-	-	-	-	-	$ -	$ -
28	6900	ELECTROCARDIOLOGY		0.055202	-	10,718	-	-	-	-	-	-	$ -	$ 10,718
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.473465	-	-	-	-	-	-	-	-	$ -	$ -
30	7200	IMPL. DEV. CHARGED TO PATIENTS		0.266105	-	-	-	-	-	-	-	-	$ -	$ -
31	7300	DRUGS CHARGED TO PATIENTS		0.221972	-	18,025	-	-	5,423	60	-	746	$ 5,423	$ 18,831
32	9100	EMERGENCY		0.145250	-	163,115	-	-	16,550	4,610	-	15,275	$ 16,550	$ 183,000
33				-	-	-	-	-	-	-	-	-	$ -	$ -
34				-	-	-	-	-	-	-	-	-	$ -	$ -
35				-	-	-	-	-	-	-	-	-	$ -	$ -
36				-	-	-	-	-	-	-	-	-	$ -	$ -
37				-	-	-	-	-	-	-	-	-	$ -	$ -
38				-	-	-	-	-	-	-	-	-	$ -	$ -
39				-	-	-	-	-	-	-	-	-	$ -	$ -
40				-	-	-	-	-	-	-	-	-	$ -	$ -
41				-	-	-	-	-	-	-	-	-	$ -	$ -
42				-	-	-	-	-	-	-	-	-	$ -	$ -
43				-	-	-	-	-	-	-	-	-	$ -	$ -
44				-	-	-	-	-	-	-	-	-	$ -	$ -
45				-	-	-	-	-	-	-	-	-	$ -	$ -
46				-	-	-	-	-	-	-	-	-	$ -	$ -
47				-	-	-	-	-	-	-	-	-	$ -	$ -
48				-	-	-	-	-	-	-	-	-	$ -	$ -
49				-	-	-	-	-	-	-	-	-	$ -	$ -
50				-	-	-	-	-	-	-	-	-	$ -	$ -
51				-	-	-	-	-	-	-	-	-	$ -	$ -
52				-	-	-	-	-	-	-	-	-	$ -	$ -
53				-	-	-	-	-	-	-	-	-	$ -	$ -
54				-	-	-	-	-	-	-	-	-	$ -	$ -
55				-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

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

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
56				-	-	-	-	-	-	-	-	-	$ -	$ -
57				-	-	-	-	-	-	-	-	-	$ -	$ -
58				-	-	-	-	-	-	-	-	-	$ -	$ -
59				-	-	-	-	-	-	-	-	-	$ -	$ -
60				-	-	-	-	-	-	-	-	-	$ -	$ -
61				-	-	-	-	-	-	-	-	-	$ -	$ -
62				-	-	-	-	-	-	-	-	-	$ -	$ -
63				-	-	-	-	-	-	-	-	-	$ -	$ -
64				-	-	-	-	-	-	-	-	-	$ -	$ -
65				-	-	-	-	-	-	-	-	-	$ -	$ -
66				-	-	-	-	-	-	-	-	-	$ -	$ -
67				-	-	-	-	-	-	-	-	-	$ -	$ -
68				-	-	-	-	-	-	-	-	-	$ -	$ -
69				-	-	-	-	-	-	-	-	-	$ -	$ -
70				-	-	-	-	-	-	-	-	-	$ -	$ -
71				-	-	-	-	-	-	-	-	-	$ -	$ -
72				-	-	-	-	-	-	-	-	-	$ -	$ -
73				-	-	-	-	-	-	-	-	-	$ -	$ -
74				-	-	-	-	-	-	-	-	-	$ -	$ -
75				-	-	-	-	-	-	-	-	-	$ -	$ -
76				-	-	-	-	-	-	-	-	-	$ -	$ -
77				-	-	-	-	-	-	-	-	-	$ -	$ -
78				-	-	-	-	-	-	-	-	-	$ -	$ -
79				-	-	-	-	-	-	-	-	-	$ -	$ -
80				-	-	-	-	-	-	-	-	-	$ -	$ -
81				-	-	-	-	-	-	-	-	-	$ -	$ -
82				-	-	-	-	-	-	-	-	-	$ -	$ -
83				-	-	-	-	-	-	-	-	-	$ -	$ -
84				-	-	-	-	-	-	-	-	-	$ -	$ -
85				-	-	-	-	-	-	-	-	-	$ -	$ -
86				-	-	-	-	-	-	-	-	-	$ -	$ -
87				-	-	-	-	-	-	-	-	-	$ -	$ -
88				-	-	-	-	-	-	-	-	-	$ -	$ -
89				-	-	-	-	-	-	-	-	-	$ -	$ -
90				-	-	-	-	-	-	-	-	-	$ -	$ -
91				-	-	-	-	-	-	-	-	-	$ -	$ -
92				-	-	-	-	-	-	-	-	-	$ -	$ -
93				-	-	-	-	-	-	-	-	-	$ -	$ -
94				-	-	-	-	-	-	-	-	-	$ -	$ -
95				-	-	-	-	-	-	-	-	-	$ -	$ -
96				-	-	-	-	-	-	-	-	-	$ -	$ -
97				-	-	-	-	-	-	-	-	-	$ -	$ -
98				-	-	-	-	-	-	-	-	-	$ -	$ -
99				-	-	-	-	-	-	-	-	-	$ -	$ -
100				-	-	-	-	-	-	-	-	-	$ -	$ -
101				-	-	-	-	-	-	-	-	-	$ -	$ -
102				-	-	-	-	-	-	-	-	-	$ -	$ -
103				-	-	-	-	-	-	-	-	-	$ -	$ -
104				-	-	-	-	-	-	-	-	-	$ -	$ -
105				-	-	-	-	-	-	-	-	-	$ -	$ -
106				-	-	-	-	-	-	-	-	-	$ -	$ -
107				-	-	-	-	-	-	-	-	-	$ -	$ -
108				-	-	-	-	-	-	-	-	-	$ -	$ -
109				-	-	-	-	-	-	-	-	-	$ -	$ -
110				-	-	-	-	-	-	-	-	-	$ -	$ -
111				-	-	-	-	-	-	-	-	-	$ -	$ -
112				-	-	-	-	-	-	-	-	-	$ -	$ -
113				-	-	-	-	-	-	-	-	-	$ -	$ -
114				-	-	-	-	-	-	-	-	-	$ -	$ -
115				-	-	-	-	-	-	-	-	-	$ -	$ -
116				-	-	-	-	-	-	-	-	-	$ -	$ -
117				-	-	-	-	-	-	-	-	-	$ -	$ -
118				-	-	-	-	-	-	-	-	-	$ -	$ -
119				-	-	-	-	-	-	-	-	-	$ -	$ -
120				-	-	-	-	-	-	-	-	-	$ -	$ -
121				-	-	-	-	-	-	-	-	-	$ -	$ -
122				-	-	-	-	-	-	-	-	-	$ -	$ -
123				-	-	-	-	-	-	-	-	-	$ -	$ -
124				-	-	-	-	-	-	-	-	-	$ -	$ -
125				-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

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

Line	Description		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
126		-	-	-	-	-	-	-	-	-	$ -	$ -
127		-	-	-	-	-	-	-	-	-	$ -	$ -
			-	344,360	-	-	50,081	6,967	-	23,086		
	Totals / Payments											
128	**Total Charges (includes organ acquisition from Section K)**		**$ -**	**$ 344,360**	**$ -**	**$ -**	**$ 50,081**	**$ 6,967**	**$ -**	**$ 23,086**	**$ 50,081**	**$ 374,413**
129	Total Charges per PS&R or Exhibit Detail		$ -	$ 344,360	$ -	$ -	$ 50,081	$ 6,967	$ -	$ 23,086		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)										$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**		**$ -**	**$ 44,760**	**$ -**	**$ -**	**$ 11,848**	**$ 978**	**$ -**	**$ 3,098**	**$ 11,848**	**$ 48,836**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ -	$ 1,376	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,376
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)		$ -	$ 97	$ -	$ -	$ -	$ -	$ -	$ 3,205	$ -	$ 3,302
135	Self-Pay (including Co-Pay and Spend-Down)		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ -	$ 1,473	$ -	$ -						
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)		$ -		$ -		$ 1,824	$ 421	$ -	$ -	$ 1,824	$ 421
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						$ -	$ -	$ -	$ 849	$ -	$ 849
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)**		$ -	$ 43,287	$ -	$ -	$ 10,024	$ 557	$ -	$ (956)	$ 10,024	$ 42,888
144	**Calculated Payments as a Percentage of Cost**		0%	3%	0%	0%	15%	43%	0%	131%	15%	12%

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 LUMPKIN

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-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**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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 LUMPKIN

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not 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**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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 LUMPKIN

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 313,936		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	358001-69000	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 313,936	5.01	*(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		$ 313,936		

DSH UCC Provider Tax Assessment Adjustment:

Line	Description		Amount
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**	33,823,489
19	Uninsured Hospital	**Charges Sec. G**	21,093,979
20	Total Hospital	**Charges Sec. G**	186,633,645
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		18.12%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.30%
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**	16,980,728
27	Uninsured Hospital	**Charges Sec. G**	21,767,717
28	Total Hospital	**Charges Sec. G**	186,633,645
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		9.10%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.66%
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 LUMPKIN**
Hospital Medicaid Number	**003229414A**
Cost Report Period	From **10/1/2023** To **9/30/2024**

		Source	As-Reported	Adjustments	As-Adjusted
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 2,032,438	$ -	$ 2,032,438
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 2,032,438	$ -	$ 2,032,438
4	Net Hospital Patient Revenue	Survey F-3	$ 34,963,194	$ -	$ 34,963,194
5	Medicaid Fraction		5.81%	0.00%	5.81%
6	Inpatient Charity Care Charges	Survey F-2	$ 2,022,419	$ -	$ 2,022,419
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 2,022,419	$ -	$ 2,022,419
10	Inpatient Hospital Charges	Survey F-3	$ 29,113,499	$ -	$ 29,113,499
11	Inpatient Charity Fraction		6.95%	0.00%	6.95%
12	LIUR		12.76%	0.00%	12.76%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	462	-	462
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		462	-	462
16	Total Hospital Days (excludes swing-bed)	Survey F-1	2,259	-	2,259
17	MIUR		20.45%	0.00%	20.45%

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 LUMPKIN
Hospital Medicaid Number: 003229414A
Cost Report Period From 10/1/2023 To 9/30/2024

As-Reported:

Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	490,363	243,603	-	10,770	-	-	-	-	-	-	-			254,373	235,990	51.87%
2 Medicaid Fee for Service	Outpatient	662,425	504,687	-	1,517	120	(2,759)	-	-	-	-	-			503,565	158,860	76.02%
3 Medicaid Managed Care	Inpatient	78,036	-	30,422	-	-	-	-	-						30,422	47,614	38.98%
4 Medicaid Managed Care	Outpatient	1,521,721	-	1,083,624	180	33	-	-							1,083,837	437,894	71.22%
5 Medicare Cross-over (FFS)	Inpatient	781,749	17,026	-	-	-		-	492,290	-	10,424	213,725			733,465	48,284	93.82%
6 Medicare Cross-over (FFS)	Outpatient	1,132,487	87,386	-	18	108		-	642,256	-	4,226	51,873			785,867	346,620	69.39%
7 Other Medicaid Eligibles	Inpatient	490,584	-	-	8,986	-			162,576	81,351	-	-			252,914	237,670	51.55%
8 Other Medicaid Eligibles	Outpatient	432,433	16,847	37,510	236,989	260			3,828	182,895	-	-			478,329	(45,896)	110.61%
9 Uninsured	Inpatient	871,931	-	-	-	-	-	-	-	-	-	-	6,855	-	6,855	865,076	0.79%
10 Uninsured	Outpatient	2,668,184	-	-	-	1,762	-	-	-	-	-	-	234,731	-	236,493	2,431,691	8.86%
11 In-State Sub-total	Inpatient	2,712,663	260,629	30,422	19,756	-	-	-	654,866	81,351	10,424	213,725	6,855	-	1,278,028	1,434,635	47.11%
12 In-State Sub-total	Outpatient	6,417,260	608,920	1,121,134	238,704	2,283	(2,759)	-	646,084	182,895	4,226	51,873	234,731	-	3,088,091	3,329,169	48.12%
13 Out-of-State Medicaid	Inpatient	11,848	-	-	-	-	-	-	1,824	-	-	-			1,824	10,024	15.40%
14 Out-of-State Medicaid	Outpatient	48,836	1,376	-	3,302	-	-	-	421	849	-	-			5,948	42,888	12.18%
15 Sub-Total	I/P and O/P	9,190,607	870,924	1,151,555	261,761	2,283	(2,759)	-	1,303,196	265,095	14,650	265,598	241,586	-	4,373,891	4,816,716	47.59%

Adjustments:

Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
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 LUMPKIN
Hospital Medicaid Number: 003229414A
Cost Report Period From 10/1/2023 To 9/30/2024

As-Adjusted:

	Service Type		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
			Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	490,363	243,603	-	10,770	-	-	-	-	-	-	-			254,373	235,990	51.87%
2	Medicaid Fee for Service	Outpatient	662,425	504,687	-	1,517	120	(2,759)	-	-	-	-	-			503,565	158,860	76.02%
3	Medicaid Managed Care	Inpatient	78,036	-	30,422	-	-	-	-	-						30,422	47,614	38.98%
4	Medicaid Managed Care	Outpatient	1,521,731	-	1,083,624	180	33	-	-							1,083,837	437,894	71.22%
5	Medicare Cross-over (FFS)	Inpatient	781,749	17,026	-	-	-		-	492,290	-	10,424	213,725			733,465	48,284	93.82%
6	Medicare Cross-over (FFS)	Outpatient	1,132,487	87,386	-	18	108		-	642,256	-	4,226	51,873			785,867	346,620	69.39%
7	Other Medicaid Eligibles	Inpatient	490,584	-	-	8,986	-			162,576	81,351	-	-			252,914	237,670	51.55%
8	Other Medicaid Eligibles	Outpatient	432,433	16,847	37,510	236,989	260			3,828	182,895	-	-			478,329	(45,896)	110.61%
9	Uninsured	Inpatient	871,931	-	-	-	-	-	-	-	-	-	-	6,855	-	6,855	865,076	0.79%
10	Uninsured	Outpatient	2,668,184	-	-	-	1,762	-	-	-	-	-	-	234,731	-	236,493	2,431,691	8.86%
11	In-State Sub-total	Inpatient	2,712,663	260,629	30,422	19,756	-	-	-	654,866	81,351	10,424	213,725	6,855	-	1,278,028	1,434,635	47.11%
12	In-State Sub-total	Outpatient	6,417,260	608,920	1,121,134	238,704	2,283	(2,759)	-	646,084	182,895	4,226	51,873	234,731	-	3,088,091	3,329,169	48.12%
13	Out-of-State Medicaid	Inpatient	11,848	-	-	-	-	-	-	1,824	-	-	-			1,824	10,024	15.40%
14	Out-of-State Medicaid	Outpatient	48,836	1,376	-	3,302	-	-	-	421	849	-	-			5,948	42,888	12.18%
15	Cost Report Year Sub-Total	I/P and O/P	9,190,607	870,924	1,151,555	261,761	2,283	(2,759)	-	1,303,196	265,095	14,650	265,598	241,586	-	4,373,891	4,816,716	47.59%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments	4,816,716
18	Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments	596,303
19	Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments	4,220,413

Medicaid DSH Survey Adjustments

PROVIDER: NORTHEAST GEORGIA MC LUMPKIN
Mcaid Number: 003229414A
FROM: 10/1/2023 TO: 9/30/2024
Mcare Number: 110237

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.

Medicaid DSH Report Notes

PROVIDER: NORTHEAST GEORGIA MC LUMPKIN
Mcaid Number: 003229414A
FROM: 10/1/2023 TO: 9/30/2024
Mcare Number: 110237

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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