EXAMINER ADJUSTED SURVEY

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

D. General Cost Report Year Information 7/1/2022 - 6/30/2023

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: HABERSHAM COUNTY MEDICAL CENTER

	7/1/2022 through 6/30/2023		
2. Select Cost Report Year Covered by this Survey:	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 5/9/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	HABERSHAM COUNTY MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000877A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110041	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2022 - 06/30/2023)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-	
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-	
8. **Out-of-State DSH Payments (See Note 2)**	$ -	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 37,818	$ 483,934	$521,752
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 281,580	$ 2,036,732	$2,318,312
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$319,398	$2,520,666	$2,840,064
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.84%	19.20%	18.37%

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

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ 1,292,238	***<--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.***
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	$1,292,238	

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 (07/01/2022 - 06/30/2023)

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)	3,727

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	59,165
8.	Outpatient Hospital Charity Care Charges	853,535
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 912,700

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			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 14,356,743	$ -	$ -	$ 9,705,573	$ -	$ -	$ 4,651,170
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ 6,770,847			$ 4,577,288	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 12,193,461	$ 69,988,966	$ -	$ 8,243,131	$ 47,314,560	$ -	$ 26,624,735
20.	Outpatient Services		$ 36,337,281	$ -		$ 24,565,050	$ -	$ 11,772,231
21.	Home Health Agency			$ 2,777,279			$ 1,877,521	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ 51,396	$ 1,195,865	$ -	$ 34,745	$ 808,439	$ 16,651
27.	Total	$ 26,550,204	$ 106,377,643	$ 10,743,991	$ 17,948,704	$ 71,914,356	$ 7,263,248	$ 43,064,787
28.	Total Hospital and Non Hospital		Total from Above	$ 143,671,838		Total from Above	$ 97,126,308	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 143,671,838	Total Contractual Adj. (G-3 Line 2)	$ 95,155,619
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)				+ $ 1,970,689
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				97,126,308
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) HABERSHAM COUNTY MEDICAL CENTER

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	$ 6,767,917	$ -	$ -	-	**$ 6,767,917**	5,918	$ 2,700,911		**$ 1,143.62**
2	03100 INTENSIVE CARE UNIT	$ 948,719	$ -	$ -		**$ 948,719**	386	$ 711,276		**$ 2,457.82**
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	$ 960,357	$ -	$ -		**$ 960,357**	835	$ 501,390		**$ 1,150.13**
18	Total Routine	$ 8,676,993	$ -	$ -	$ -	$ 8,676,993	7,139	$ 3,913,577		
19	Weighted Average									$ 1,215.44

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)	3,412	-	-	**$ 3,902,031**	564,238	2,962,311	$ 3,526,549	**1.106473**

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	$ 3,386,369	$ -	$ -		**$ 3,386,369**	$ 1,820,935	$ 4,469,346	$ 6,290,281	**0.538349**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 905,586	$ -	$ -		**$ 905,586**	$ 3,448,478	$ 217,037	$ 3,665,515	**0.247056**
23	5300 ANESTHESIOLOGY	$ 51,274	$ -	$ -		**$ 51,274**	$ 389,492	$ 1,271,114	$ 1,660,606	**0.030877**
24	5400 RADIOLOGY-DIAGNOSTIC	$ 3,392,076	$ -	$ -		**$ 3,392,076**	$ 997,082	$ 23,679,668	$ 24,676,750	**0.137460**
25	6000 LABORATORY	$ 3,900,095	$ -	$ -		**$ 3,900,095**	$ 2,735,042	$ 16,058,082	$ 18,793,124	**0.207528**
26	6500 RESPIRATORY THERAPY	$ 1,666,942	$ -	$ -		**$ 1,666,942**	$ 1,475,247	$ 1,284,031	$ 2,759,278	**0.604123**
27	6600 PHYSICAL THERAPY	$ 2,784,321	$ -	$ -		**$ 2,784,321**	$ 428,675	$ 5,225,611	$ 5,654,286	**0.492427**
28	6900 ELECTROCARDIOLOGY	$ 708,964	$ -	$ -		**$ 708,964**	$ 404,514	$ 5,896,482	$ 6,300,996	**0.112516**
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,042,942	$ -	$ -		**$ 1,042,942**	$ 899,279	$ 812,577	$ 1,711,856	**0.609246**
30	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 1,815,816	$ -	$ -		**$ 1,815,816**	$ 1,600,298	$ 7,839,436	$ 9,439,734	**0.192359**
31	7300 DRUGS CHARGED TO PATIENTS	$ 2,915,288	$ -	$ -		**$ 2,915,288**	$ 2,795,329	$ 7,251,224	$ 10,046,553	**0.290178**
32	7600 AUDIOLOGY	$ 901	$ -	$ -		**$ 901**	$ 127,894	$ 28,694	$ 156,588	**0.005754**
33	9001 MT YONAH CLINIC	$ 1,272	$ -	$ -		**$ 1,272**	$ -	$ 14,267	$ 14,267	**0.089157**
34	9002 SURGICAL PRACTICE CLINIC	$ 401,443	$ -	$ 59,755		**$ 461,198**	$ -	$ 169,317	$ 169,317	**2.723873**
35	9003 ORTHOPEDICS OF N. GA CLINIC	$ 2,816,611	$ -	$ -		**$ 2,816,611**	$ -	$ 4,229,994	$ 4,229,994	**0.665866**
36	9100 EMERGENCY	$ 5,339,889	$ -	$ -		**$ 5,339,889**	$ 2,259,466	$ 27,624,893	$ 29,884,359	**0.178685**
126	**Total Ancillary**	$ 31,129,789	$ -	$ 59,755		$ 31,189,544	$ 19,945,969	$ 109,034,084	$ 128,980,053	
127	**Weighted Average**									**0.272070**
128	**Sub Totals**	$ 39,806,782	$ -	$ 59,755		$ 39,866,537	$ 23,859,546	$ 109,034,084	$ 132,893,630	
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)					$ 57,328				
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**					**$ 39,809,209**				
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 (07/01/2022-06/30/2023) HABERSHAM COUNTY MEDICAL CENTER

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 (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) 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 (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) 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	$ 1,143.62		217		651		512		133		-		138		**1,513**		65.88%
2	03100 INTENSIVE CARE UNIT	$ 2,457.82		32		1		49		4		-		37		**86**		31.87%
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	$ 1,150.13		89		524		-		80		-		17		**692**		84.91%
18			**Total Days**	337		1,176		561		217		-		192		2,291		66.62%
19	Total Days per PS&R or Exhibit Detail			337		1,176		561		217		-		192				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 260,180		$ 826,632		$ 487,560		$ 166,042		$ -		$ 185,437		**$ 1,740,414**		49.21%
21.01	Calculated Routine Charge Per Diem			$ 772.05		$ 702.92		$ 869.09		$ 765.17		$ -		$ 965.82		$ 759.67		
	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)		1.106473	$ -	$ -	$ 79,845	$ 243,655	$ 76,104	$ 342,757	$ 8,152	$ 64,681	$ -	$ -	$ 32,581	$ 156,884	$ 164,101	$ 651,094	28.49%
23	5000 OPERATING ROOM		0.538349	$ 317,625	$ 404,801	$ 799,908	$ 346,975	$ 84,639	$ 246,110	$ 167,190	$ 97,009	$ -	$ -	$ 53,825	$ 151,808	$ 1,369,382	$ 1,094,895	42.44%
24	5200 DELIVERY ROOM & LABOR ROOM		0.247056	$ 176,315	$ 844	$ 2,171,027	$ 152,046	$ 2,883	$ 1,126	$ 479,122	$ 29,698	$ -	$ -	$ 56,778	$ 3,374	$ 2,829,347	$ 183,713	83.84%
25	5300 ANESTHESIOLOGY		0.030877	$ -	$ -	$ 134,258	$ 129,700	$ 33,312	$ 87,992	$ 28,489	$ 31,509	$ -	$ -	$ 15,517	$ 54,223	$ 196,059	$ 249,201	31.01%
26	5400 RADIOLOGY-DIAGNOSTIC		0.137460	$ 108,858	$ 681,237	$ 60,797	$ 2,406,210	$ 207,784	$ 1,605,969	$ 9,052	$ 379,211	$ -	$ -	$ 105,146	$ 2,593,252	$ 386,490	$ 5,072,626	33.06%
27	6000 LABORATORY		0.207528	$ 260,739	$ 613,680	$ 495,022	$ 2,391,987	$ 433,541	$ 1,038,721	$ 79,301	$ 243,968	$ -	$ -	$ 223,105	$ 2,293,867	$ 1,268,602	$ 4,288,356	42.96%
28	6500 RESPIRATORY THERAPY		0.604123	$ 100,237	$ 39,665	$ 57,552	$ 59,399	$ 320,157	$ 146,253	$ 4,207	$ 3,677	$ -	$ -	$ 48,180	$ 70,589	$ 482,153	$ 248,994	30.80%
29	6600 PHYSICAL THERAPY		0.492427	$ 16,338	$ 54,146	$ 1,792	$ 123,749	$ 99,380	$ 239,582	$ -	$ 39,911	$ -	$ -	$ 6,246	$ 5,255	$ 117,510	$ 457,389	10.37%
30	6900 ELECTROCARDIOLOGY		0.112516	$ 24,364	$ 66,756	$ 9,177	$ 190,196	$ 73,355	$ 360,647	$ 1,612	$ 31,513	$ -	$ -	$ 33,349	$ 349,141	$ 108,538	$ 649,112	18.09%
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.609246	$ 61,322	$ 230,598	$ 51,015	$ 22,965	$ 201,467	$ 129,387	$ 7,636	$ 6,073	$ -	$ -	$ 22,833	$ 24,294	$ 321,440	$ 389,024	44.26%
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.192359	$ -	$ -	$ 18,514	$ 196,907	$ 563,633	$ 658,208	$ -	$ 25,528	$ -	$ -	$ 37,499	$ 99,225	$ 582,147	$ 880,642	16.94%
33	7300 DRUGS CHARGED TO PATIENTS		0.290178	$ 165,156	$ 125,499	$ 692,577	$ 645,496	$ 350,863	$ 604,451	$ 132,397	$ 85,162	$ -	$ -	$ 139,803	$ 600,134	$ 1,340,992	$ 1,460,608	35.25%
34	7600 AUDIOLOGY		0.005754	$ -	$ -	$ 79,214	$ 10,946	$ -	$ -	$ 11,234	$ 576	$ -	$ -	$ 3,457	$ 576	$ 90,448	$ 11,522	67.70%
35	9001 MT YONAH CLINIC		0.089157	$ -	$ -	$ -	$ 2,242	$ -	$ 204	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,446	17.14%
36	9002 SURGICAL PRACTICE CLINIC		2.723873	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
37	9003 ORTHOPEDICS OF N. GA CLINIC		0.665866	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
38	9100 EMERGENCY		0.178685	$ 170,580	$ 954,959	$ 48,225	$ 5,452,496	$ 228,584	$ 1,591,035	$ 5,276	$ 534,151	$ -	$ -	$ 152,284	$ 4,586,757	$ 452,665	$ 8,532,642	45.92%
				1,401,564	3,172,186	4,698,923	12,374,970	2,675,700	7,052,441	933,667	1,572,667	-	-	930,601	10,989,380			
	Totals / Payments																	
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 1,661,744	$ 3,172,186	$ 5,525,555	$ 12,374,970	$ 3,163,260	$ 7,052,441	$ 1,099,709	$ 1,572,667	$ -	$ -	$ 1,116,038 (Agrees to Exhibit A)	$ 10,989,380 (Agrees to Exhibit A)	$ 11,450,268	$ 24,172,264	35.91%
129	Total Charges per PS&R or Exhibit Detail			$ 1,661,744	$ 3,172,186	$ 5,525,555	$ 12,374,970	$ 3,163,260	$ 7,052,441	$ 1,099,709	$ 1,572,667	$ -	$ -	$ 1,116,038	$ 10,989,380			
130	Unreconciled Charges (Explain Variance)			-		-		-		-		-		-				
131.01	**Sampling Cost Adjustment (if applicable)**															$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 898,765	$ 844,813	$ 2,801,567	$ 2,657,063	$ 1,580,438	$ 1,863,121	$ 536,722	$ 389,050	$ -	$ -	$ 533,455	$ 2,202,469	$ 5,817,492	$ 5,754,047	35.94%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 539,465	$ 656,984	$ -	$ -	$ 49,625	$ 127,168	$ 2,342	$ 8,023					$ 591,452	$ 792,175	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 1,913,370	$ 2,059,949	$ -	$ -	$ 76,264	$ 64,647					$ 1,989,634	$ 2,124,595	
134	Private Insurance (including primary and third party liability)			$ 7,695	$ 1,529	$ -	$ 986	$ -	$ 974	$ 424,227	$ 366,336					$ 431,922	$ 369,825	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ 1,019	$ -	$ -	$ -	$ 6,071	$ -	$ -			$ -	$ 7,090	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 547,180	$ 658,513	$ 1,913,370	$ 2,061,954											
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (89,368)	$ -	$ -									$ -	$ (89,368)	
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)			$ -		$ -		$ 982,453	$ 1,088,066	$ -	$ -	$ -		$ -		$ 982,453	$ 1,088,066	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -					$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ 151,295	$ 34,430	$ -	$ -					$ 151,295	$ 34,430	
142	Other Medicare Cross-Over Payments (See Note D)							$ 423,998	$ 223,997	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 423,998	$ 223,997	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													$ 37,818	$ 483,934			
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)**			$ 351,585	$ 275,668	$ 888,197	$ 595,109	$ (26,933)	$ 388,486	$ 33,889	$ (56,026)	$ -	$ -	$ 495,637	$ 1,718,535	$ 1,246,737	$ 1,203,237	
146	**Calculated Payments as a Percentage of Cost**			61%	67%	68%	78%	102%	79%	94%	114%	0%	0%	7%	22%	79%	79%	
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)**							2,165										
148	**Percent of cross-over days to total Medicare days from the cost report**							26%										

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 (07/01/2022-06/30/2023) | HABERSHAM COUNTY MEDICAL CENTER

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 Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 1,143.62		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ 2,457.82		-		-		-		-		-	
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	$ 1,150.13		-		-		-		-		-	
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)		1.106473	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.538349	-	-	-	-	-	-	-	-	$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.247056	-	-	-	-	-	-	-	-	$ -	$ -
25	5300 ANESTHESIOLOGY		0.030877	-	-	-	-	-	-	-	-	$ -	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.137460	-	-	-	-	-	-	-	-	$ -	$ -
27	6000 LABORATORY		0.207528	-	-	-	-	-	-	-	-	$ -	$ -
28	6500 RESPIRATORY THERAPY		0.604123	-	-	-	-	-	-	-	-	$ -	$ -
29	6600 PHYSICAL THERAPY		0.492427	-	-	-	-	-	-	-	-	$ -	$ -
30	6900 ELECTROCARDIOLOGY		0.112516	-	-	-	-	-	-	-	-	$ -	$ -
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.609246	-	-	-	-	-	-	-	-	$ -	$ -
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.192359	-	-	-	-	-	-	-	-	$ -	$ -
33	7300 DRUGS CHARGED TO PATIENTS		0.290178	-	-	-	-	-	-	-	-	$ -	$ -
34	7600 AUDIOLOGY		0.005754	-	-	-	-	-	-	-	-	$ -	$ -
35	9001 MT YONAH CLINIC		0.089157	-	-	-	-	-	-	-	-	$ -	$ -
36	9002 SURGICAL PRACTICE CLINIC		2.723873	-	-	-	-	-	-	-	-	$ -	$ -
37	9003 ORTHOPEDICS OF N. GA CLINIC		0.665866	-	-	-	-	-	-	-	-	$ -	$ -
38	9100 EMERGENCY		0.178685	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All 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			$ -		$ -		$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles							$ -	$ -	$ -	$ -	$ -	$ -
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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&F
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 surv
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 paymer
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 payme
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

Cost Report Year (07/01/2022-06/30/2023) HABERSHAM COUNTY MEDICAL CENTER

		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 (07/01/2022-06/30/2023) HABERSHAM COUNTY MEDICAL CENTER

		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**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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 (07/01/2022-06/30/2023) HABERSHAM COUNTY MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 434,056		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	01.9500.3270	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 434,056	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		$ 434,056		

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**	35,622,532
19	Uninsured Hospital	**Charges Sec. G**	12,105,418
20	Total Hospital	**Charges Sec. G**	132,893,630
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		26.81%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.11%
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**	22,734,455
27	Uninsured Hospital	**Charges Sec. G**	12,105,418
28	Total Hospital	**Charges Sec. G**	132,893,630
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		17.11%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.11%
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.*