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

Version 7.25

1. State: Georgia

2. In-State: Set 3 - Other

Select the Column Headings You Want for Section H of the Survey (This will depend on data received from state for crossovers and managed care)

	Instructions Tab will Say This:	UCC Summary Tab Will Say This:
1 In-State Medicaid FFS Primary	Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)	Medicaid Fee for Service
2 In-State Medicaid Managed Care Primary	Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)	Medicaid Managed Care
3 In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary	Medicare Cross-over (FFS)
4 In-State Other Medicaid Eligibles (Not Included Elsewhere)	In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCH	Other Medicaid Eligibles
5 Uninsured	Uninsured	Uninsured

3. Out-of-State: Set 3 - Other

Select the Column Headings You Want for Section I of the Survey (This will depend on data received from state for crossovers and managed care)

	Instructions Tab will Say This:	UCC Summary Tab Will Say This:
1 Out-of-State Medicaid FFS Primary	Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)	Out-of-State Medicaid
2 Out-of-State Medicaid Managed Care Primary	Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)	
3 Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary	
4 Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)	

4. Tax Options: Display Provider Tax Form? YES | Tax Methodology? Charges Sec. G | Tax will be allocated based on charges in the survey in Section L (back-end). Total hospital cost report charges will be pulled from Section G.

NOTE: Review the certification and instructions in the DSH Survey Part I to ensure that section L is properly excluded or included from the certification and instructions. (See set-up tab of DSH Survey Part I.)

5. State/Local-Only Indigent Care Program Options: Display State/Local-Only Indigent Care Program Column? NO

NOTE: This column is intended to collect Exhibit C data for State/Local-Only Indigent Care Program claims for such programs where a private Managed Care Organization (MCO) is delivering the services to the indigent patients and is paying the hospital for the services provided. Per CMS FAQ published April 7, 2014 (#12), these payments from the MCO must be netted against cost in the UCC calculation. Payments should be reported on accrual basis, and thus cannot be picked up in Exhibit B. Before generating surveys, lock down and black out any payment cells in these columns that you do not want providers to utilize to report payments to ensure accurate reporting. (This column should NOT include any state/local government indigent care program claims where the patient is also enrolled in Medicaid, Medicare, or private insurance.)

Note F - Only include claims in this column that are NOT Medicaid eligible, but are co

6. Is Ambulance considered a hospital service? NO

8. REQUIRED MACRO:
After entering 1-6, above, click on "Run page setup" below to set-up the headers and footers with the state name (in all sheets). This is a slow process so be patient! This also sets up the Provider Tax forms and certain Indiana-only columns based on your answers, above.

9. Update LIUR calculation
If your state has a broader LIUR calculation than the federal LIUR, and you want to update the LIUR reconciliation lines in Section F-3 of the DSH survey, change the descriptions and the +/- values below to match your state's LIUR calculation **(the +/- indicates whether you are increasing or decreasing worksheet G-3, Line 2)**. The default descriptions and +/- included below are based on the FEDERAL LIUR. The federal LIUR defaults are available in the drop-down selections on lines 28-32 below.

Note: If you are not using all available lines, you should:
1. Update the reconciliation **Line Numbers** on the **as-filed Section F-3**. All other tabs are linked to this tab, so it is only necessary to update the line numbers on **"Sec. D, E, F CR Data"** tab.
2. **Hide** any un-used reconciliation **Lines** on ***BOTH*** the as-filed Section F-3 and ADJ Section F-3 ***BEFORE*** you generate the surveys.

Note: Line 36 is an optional line that can be blank, or can account for a state-specific difference in the definition of charity care, for example. Line 36 is NOT part of the reconciliation intended to calculate the LIUR following the federal definition.

Line 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)	**INCREASE**
Line 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)	**INCREASE**
Line 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)	**INCREASE**
Line 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)	**INCREASE**
Line 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)	**DECREASE**
Line 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)"**	**DECREASE**

7. Contact Info:
Myers and Stauffer LC
Attention: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, MO 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
e-mail:

NOTE: DO NOT DELETE LINES IN THE SURVEY! THIS WILL CAUSE REFERENCE ERRORS THROUGHOUT! HIDE ANY UNUSED LINES AND UPDATE THE LINE NUMBERS.

9. HCRIS Survey Macro: Output Directory: ata\Georgia\Georgia DSH Project\2019 DSH Project

***Notes* - This requires SQL drivers to be installed.**

***NOTE: Medicare number should not contain anything but numbers**

List All Hospital Data Below:

	1	2	3	4	5	6	7	8	9	10	11		
	Hospital Name	Medicaid Provider ID	Medicaid SubProvider1 ID	Medicaid SubProvider2 ID	Medicare Provider ID	Report Period From	Reporting Period To	Report Period From	Reporting Period To	Report Period From	Reporting Period To	Owner Type	DSH Pool
	SELECT HOSPITAL NAME	M'Caid #	M'Caid Sub 1 #	M'Caid Sub 2 #	M'Care #								
1	HAMILTON MEDICAL CENTER	000000899A			110001	10/1/16	9/30/17					Private	Urban
2	UPSON REGIONAL MEDICAL CENTER	000001988A			110002	1/1/17	12/31/17					Non-State Govt.	Non-Small Rural
3	MEMORIAL SATILLA HEALTH	000001229A			110003	1/1/17	4/30/17	5/1/17	12/31/17			Private	Non-Small Rural
4	NORTHSIDE HOSPITAL-FORSYTH	000000767A			110005	10/1/16	9/30/17					Non-State Govt.	Urban

5	SAINT MARY'S HOSPITAL	000001823A		110006	7/1/16	6/30/17		Private	Urban
6	PHOEBE PUTNEY MEMORIAL HOSPITAL	000001482A	000001416A	110007	8/1/16	7/31/17		Non-State Govt.	Urban
7	NORTHSIDE HOSPITAL-CHEROKEE	000001108A		110008	10/1/16	9/30/17		Non-State Govt.	Urban
8	EMORY UNIVERSITY HOSPITAL	000000712A	000000712B	110010	9/1/16	8/31/17		Private	Urban
9	TANNER MEDICAL CENTER-CARROLLTON	000001867A		110011	7/1/16	6/30/17		Non-State Govt.	Urban
10	TANNER MEDICAL CENTER-VILLA RICA	000002032A		110015	7/1/16	6/30/17		Non-State Govt.	Urban
11	WELLSTAR WEST GEORGIA HOSPITAL	000002065A		110016	7/1/16	6/30/17		Non-State Govt.	Non-Small Rural
12	PIEDMONT NEWTON HOSPITAL	000001394A		110018	7/1/16	6/30/17		Non-State Govt.	Urban
13	GORDON HOSPITAL	000000833A		110023	1/1/17	12/31/17		Private	Small Rural
14	CANDLER HOSPITAL	000000327A		110024	7/1/16	6/30/17		Private	Urban
15	SOUTHEAST GEORGIA MEDICAL CENTER	000000822A		110025	5/1/16	4/30/17		Non-State Govt.	Urban
16	ELBERT MEMORIAL HOSPITAL	000000668A		110026	7/1/16	6/30/17		Non-State Govt.	Small Rural
17	ST. MARYS SACRED HEART HOSPITAL	000000437A		110027	7/1/16	6/30/17		Private	Small Rural
18	UNIVERSITY HOSPITAL	000001977A		110028	1/1/17	12/31/17		Non-State Govt.	Urban
19	NORTHEAST GEORGIA MEDICAL CENTER	000000888A	000000888S	110029	10/1/16	9/30/17		Non-State Govt.	Urban
20	CARTERSVILLE MEDICAL CENTER	000001625A		110030	10/1/16	9/30/17		Private	Urban
21	WELLSTAR SPALDING REGIONAL HOSPITAL	000000866A		110031	7/1/16	6/30/17		Private	Urban
22	STEPHENS COUNTY HOSPITAL	000001834A		110032	10/1/16	9/30/17		Non-State Govt.	Small Rural
23	MEDICAL COLLEGE OF GA HOSP & CLINICS	000000723A		110034	7/1/16	6/30/17		State Govt.	Urban
24	WELLSTAR KENNESTONE HOSPITAL	000001119A		110035	7/1/16	6/30/17		Non-State Govt.	Urban
25	MEMORIAL HEALTH UNIV MEDICAL CENTER	000001273A		110036	1/1/17	1/31/18		Private	Urban
26	JOHN D. ARCHBOLD MEMORIAL HOSPITAL	000000063A		110038	10/1/16	9/30/17		Private	Non-Small Rural
27	TRINITY HOSPITAL OF AUGUSTA	000001779A		110039	10/1/16	6/30/17		Private	Urban
28	NORTHRIDGE MEDICAL CENTER	000000151A		110040	1/1/17	12/31/17		Private	Small Rural
29	HABERSHAM COUNTY MEDICAL CENTER	000000877A		110041	7/1/16	6/30/17		Non-State Govt.	Small Rural
30	WELLSTAR PAULDING HOSPITAL	000001438A		110042	7/1/16	6/30/17		Non-State Govt.	Urban
31	ST. JOSEPH HOSPITAL SAVANNAH	000001801A		110043	7/1/16	6/30/17		Private	Urban
32	PHOEBE SUMTER MEDICAL CENTER	000000019A		110044	8/1/16	7/31/17		Non-State Govt.	Non-Small Rural
33	BARROW REGIONAL MEDICAL CENTER	000002098A		110045	1/1/17	9/30/17		Private	Urban
34	PIEDMONT WALTON	000020677A		110046	10/1/16	9/30/17		Private	Urban
35	MURRAY MEDICAL CENTER	000001383A		110050	1/1/17	12/31/17		Non-State Govt.	Urban
36	UNION GENERAL HOSPITAL	000001966A		110051	5/1/16	4/30/17		Non-State Govt.	Small Rural
37	FLOYD MEDICAL CENTER	000000756A		110054	7/1/16	6/30/17		Non-State Govt.	Urban
38	MIDTOWN MEDICAL CENTER	000001196A	000148233A	110064	7/1/16	6/30/17		Non-State Govt.	Urban
39	HOUSTON MEDICAL CENTER	000000976A		110069	1/1/17	12/31/17		Non-State Govt.	Urban
40	APPLING HOSPITAL	000000052A		110071	9/1/16	8/31/17		Non-State Govt.	Small Rural
41	DORMINY MEDICAL CENTER	000000613A		110073	8/1/16	7/31/17		Non-State Govt.	Small Rural
42	PIEDMONT ATHENS REGIONAL MED CTR	000000074A		110074	10/1/16	6/30/17		Non-State Govt.	Urban
43	EAST GEORGIA MEDICAL CENTER	000000272A		110075	10/1/16	9/30/17		Private	Non-Small Rural
44	DEKALB MEDICAL CENTER	000000536A		110076	7/1/16	6/30/17		Non-State Govt.	Urban
45	EMORY UNIVERSITY HOSPITAL MIDTOWN	000000503A		110078	9/1/16	8/31/17		Private	Urban
46	CHILDREN'S HLTHCRE-HUGHES SPALDING	000679808A		110079	1/1/17	12/31/17		Non-State Govt.	Urban
47	GRADY MEMORIAL HOSPITAL	000000855A		110079	1/1/17	12/31/17		Non-State Govt.	Urban
48	ST. JOSEPH HOSPITAL-ATLANTA	000001812A		110082	9/1/16	8/31/17			Urban
49	PIEDMONT HOSPITAL	000001504A		110083	7/1/16	6/30/17		Private	Urban
50	WASHINGTON COUNTY REGIONAL MED CTR	000001218A		110086	9/1/16	8/31/17		Non-State Govt.	Small Rural
51	GWINNETT MEDICAL CENTER-DULUTH	000001064A		110087	7/1/16	6/30/17		Non-State Govt.	Urban
52	GWINNETT MEDICAL CTR LAWRENCEVILLE	000000294A		110087	7/1/16	6/30/17		Non-State Govt.	Urban
53	COFFEE REGIONAL MEDICAL CENTER	000000448A		110089	1/1/17	12/31/17		Non-State Govt.	Small Rural
54	ROCKDALE MEDICAL CENTER	000001603A		110091	10/1/16	9/30/17		Private	Urban
55	DODGE COUNTY HOSPITAL	000000591A		110092	10/1/16	9/30/17		Non-State Govt.	Small Rural
56	TIFT REGIONAL MEDICAL CENTER	000001922A		110095	10/1/16	9/30/17		Non-State Govt.	Non-Small Rural
57	JEFFERSON HOSPITAL	000001031A		110100	1/1/17	12/31/17		Non-State Govt.	Small Rural
58	COOK MEDICAL CENTER	000001251A		110101	7/1/16	6/30/17		Non-State Govt.	Small Rural
59	CRISP REGIONAL HOSPITAL	000000514A		110104	7/1/16	6/30/17		Non-State Govt.	Small Rural
60	COLQUITT REGIONAL MEDICAL CENTER	000002021A		110105	10/1/16	9/30/17		Non-State Govt.	Small Rural
61	MEDICAL CENTER OF CENTRAL GEORGIA	000001207A		110107	10/1/16	9/30/17		Non-State Govt.	Urban
62	EMANUEL MEDICAL CENTER	000000701A		110109	7/1/16	6/30/17		Non-State Govt.	Small Rural
63	UNIVERSITY HOSPITAL MCDUFFIE	000001185A		110111	1/1/17	12/31/17		Non-State Govt.	Small Rural
64	BURKE MEDICAL CENTER	000000283A		110113	6/1/16	5/31/17		Non-State Govt.	Small Rural
65	WELLSTAR ATLANTA MEDICAL CENTER	000000789A	000001713A	110115	7/1/16	6/30/17		Private	Urban
66	GRADY GENERAL HOSPITAL	000000844A		110121	10/1/16	9/30/17		Non-State Govt.	Small Rural
67	SOUTH GEORGIA MEDICAL CENTER	000001724A	000001724G	110122	10/1/16	9/30/17		Non-State Govt.	Urban
68	WAYNE MEMORIAL HOSPITAL	000002054A		110124	7/1/16	6/30/17		Non-State Govt.	Small Rural
69	FAIRVIEW PARK HOSPITAL	000001141A		110125	5/1/16	4/30/17		Private	Non-Small Rural
70	MEADOWS REGIONAL MEDICAL CENTER	000001086A		110128	7/1/16	6/30/17		Non-State Govt.	Small Rural
71	SAINT FRANCIS HOSPITAL	000001768A		110129	1/1/17	12/31/17		Private	Urban
72	IRWIN COUNTY HOSPITAL	000000987A		110130	12/1/16	11/30/17		Non-State Govt.	Small Rural
73	MEMORIAL HOSPITAL & MANOR-BAINBRIDGE	000001262A		110132	4/1/16	3/31/17		Non-State Govt.	Small Rural
74	TAYLOR REGIONAL HOSPITAL	000001548A		110135	4/1/16	3/31/17		Private	Small Rural
75	EVANS MEMORIAL HOSPITAL	000000734A		110142	10/1/16	9/30/17		Non-State Govt.	Small Rural
76	WELLSTAR COBB HOSPITAL	000000426A		110143	7/1/16	6/30/17		Non-State Govt.	Urban
77	SOUTHEAST GA HLTH SYS-CAMDEN CAMPUS	000000811A		110146	5/1/16	4/30/17		Non-State Govt.	Small Rural
78	OCONEE REGIONAL MEDICAL CENTER	000000129A		110150	10/1/16	9/30/17		Private	Non-Small Rural
79	PERRY HOSPITAL	000001471A		110153	1/1/17	12/31/17			
80	NORTHSIDE HOSPITAL	000001405A		110161	10/1/16	9/30/17		Non-State Govt.	Urban
81	COLISEUM MEDICAL CENTER	000000459A		110164	7/1/16	6/30/17		Private	Urban
82	SOUTHERN REGIONAL MEDICAL CENTER	000000404A		110165	1/1/17	12/31/17		Private	Urban
83	REDMOND REGIONAL MEDICAL CENTER	000001581A		110168	7/1/16	6/30/17		Private	Urban
84	DOCTORS HOSPITAL-AUGUSTA	000000558A		110177	4/1/16	3/31/17		Private	Urban
85	WELLSTAR DOUGLAS HOSPITAL	000000624A		110184	7/1/16	6/30/17		Non-State Govt.	Urban
86	FANNIN REGIONAL HOSPITAL	000134406A		110189	1/1/17	12/31/17		Private	Small Rural
87	FLINT RIVER HOSPITAL	000149487A		110190	1/1/17	12/31/17		Private	Small Rural
88	PIEDMONT HENRY HOSPITAL	000182388A		110191	7/1/16	6/30/17		Non-State Govt.	Urban
89	EMORY EASTSIDE MEDICAL CENTER	000190088A		110192	9/1/16	8/31/17		Private	Urban
90	DONALSONVILLE HOSPITAL	000206181A		110194	7/1/16	6/30/17		Private	Small Rural
91	WELLSTAR NORTH FULTON REGIONAL HOSP	000275976A		110198	7/1/16	6/30/17		Private	Urban
92	NORTHSIDE MEDICAL CENTER	000315642A		110200	7/1/16	6/30/17		Non-State Govt.	Urban
93	COLISEUM NORTHSIDE	000295358A		110201	7/1/16	6/30/17		Private	Urban
94	PIEDMONT FAYETTE HOSPITAL	000755323A		110215	7/1/16	6/30/17		Private	Urban
95	PIEDMONT MOUNTAINSIDE HOSPITAL	000001493A		110225	7/1/16	6/30/17		Private	Small Rural

96	DEKALB MEDICAL CENTER-HILLENDALE	000000536U		110226	7/1/16	6/30/17				Non-State Govt.	Urban
97	PIEDMONT NEWNAN HOSPITAL	000000492A		110229	7/1/16	6/30/17				Private	Urban
98	EMORY JOHNS CREEK	344886600A		110230	9/1/16	8/31/17				Private	Urban
99	SOUTH GEORGIA MED CTR - BERRIEN	000000173A		110234	10/1/16	9/30/17				Non-State Govt.	Small Rural
100	CORNERSTONE MEDICAL CENTER	003180661A		110236	1/1/17	12/29/17				Private	Urban
101	SOUTHWEST GEORGIA REGIONAL MEDICAL C	000001427A		111300	8/1/16	7/31/17				Non-State Govt.	Small Rural
102	BLECKLEY MEMORIAL HOSPITAL	000000195A		111302	4/1/16	3/31/17				Non-State Govt.	Small Rural
103	JASPER MEMORIAL HOSPITAL	000000998A		111303	10/1/16	9/30/17				Non-State Govt.	Small Rural
104	MORGAN MEMORIAL HOSPITAL	000694229A		111304	7/1/16	6/30/17				Non-State Govt.	Small Rural
105	MILLER COUNTY HOSPITAL	000001317A		111305	7/1/16	6/30/17				Non-State Govt.	Small Rural
106	EFFINGHAM HOSPITAL	000000657A		111306	7/1/16	10/31/16	11/1/16	6/30/17		Non-State Govt.	Urban
107	CLINCH MEMORIAL HOSPITAL	000000415A		111308	42,552	42,916				Non-State Govt.	Small Rural
108	MEDICAL CENTER OF PEACH COUNTY	000001449A		111310	10/1/16	9/30/17				Non-State Govt.	Small Rural
109	OPTIM MEDICAL CENTER - JENKINS	000001042A		111311	1/1/17	6/15/17				Private	Small Rural
110	OPTIM MEDICAL CENTER - SCREVEN	000001647A		111312	1/1/17	12/31/17				Private	Small Rural
111	PUTNAM GENERAL HOSPITAL	000001537A		111313	10/1/16	9/30/17				Non-State Govt.	Small Rural
112	PIONEER HLTH SERV OF EARLY COUNTY	000000635A		111314	10/1/16	10/31/17				Non-State Govt.	Small Rural
113	WARM SPRINGS MEDICAL CENTER	000001284A		111316	1/1/17	12/31/17				Non-State Govt.	Small Rural
114	MONROE COUNTY HOSPITAL	000001361A		111318	10/1/16	9/30/17				Non-State Govt.	Small Rural
115	WELLSTAR SYLVAN GROVE HOSPITAL	000001856A		111319	7/1/16	6/30/17				Non-State Govt.	Small Rural
116	HIGGINS GENERAL HOSPITAL	000000954A		111320	7/1/16	6/30/17				Non-State Govt.	Small Rural
117	OPTIM MEDICAL CENTER - TATTNALL	000001878A		111323	1/1/17	12/31/17				Private	Small Rural
118	CHATUGE REGIONAL HOSPITAL	000001933A		111324	5/1/16	4/30/17				Non-State Govt.	Small Rural
119	WILLS MEMORIAL HOSPITAL	000002087A		111325	5/1/16	4/30/17				Non-State Govt.	Small Rural
120	SOUTH GEORGIA MED CTR - LANIER	000001163A		111326	10/1/16	9/30/17				Non-State Govt.	Small Rural
121	BACON COUNTY HOSPITAL	000000118A		111327	7/1/16	6/30/17				Non-State Govt.	Small Rural
122	PHOEBE WORTH MEDICAL CENTER	000002109A		111328	8/1/16	7/31/17				Private	Small Rural
123	ST. MARYS GOOD SAMARITAN	000001328A		111329	7/1/16	6/30/17				Private	Small Rural
124	POLK MEDICAL CENTER	000001526A		111330	7/1/16	6/30/17				Non-State Govt.	Small Rural
125	MITCHELL COUNTY HOSPITAL	000001339A		111331	10/1/16	9/30/17				Non-State Govt.	Small Rural
126	BROOKS COUNTY HOSPITAL	000000239A		111332	10/1/16	9/30/17				Non-State Govt.	Small Rural
127	JEFF DAVIS HOSPITAL	000001009A		111333	10/1/16	9/30/17				Non-State Govt.	Small Rural
128	CANDLER COUNTY HOSPITAL	000000316A		111334	1/1/17	12/31/17				Non-State Govt.	Small Rural
129	LIBERTY REGIONAL MEDICAL CENTER	000001152A		111335	12/1/16	11/30/17				Non-State Govt.	Small Rural
130	MOUNTAIN LAKES MEDICAL CENTER	000001559A		111336	1/1/17	12/31/17				Private	Small Rural
131	SHEPHERD CENTER	000248069A		112003	4/1/16	3/31/17				Private	Urban
132	DEKALB MEDICAL CENTER AT DECATUR	000000525A		112006	7/1/16	6/30/17				Non-State Govt.	Urban
133	WELLSTAR WINDY HILL HOSPITAL	000001999A		112007	7/1/16	6/30/17				Non-State Govt.	Urban
134	KINDRED HOSPITAL ROME	000886179A		112010	9/1/16	8/31/17					Urban
135	HEALTHSOUTH WALTON REHAB HOSPITAL	000368387A		113030	4/1/16	3/31/17					Urban
136	ROOSEVELT WARM SPRGS LTAC HOSPITAL	000000778A		113028	7/1/16	6/30/17				State Govt.	Small Rural
137	CHILDREN'S HOSPITAL ATL AT EGLESTON	000000943A		113300	1/1/17	12/31/17				Private	Urban
138	CHILDREN'S HEALTHCARE-SCOTTISH RITE	000001636A		113301	1/1/17	12/31/17				Private	Urban
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If more providers are needed, insert rows above this line. DO NOT delete this line and continue the list.

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

Set 1 - State Provided Data Instructions	Set 1 - State Provided Data UCC Summary Titles	Set 2 - Hospital Provided Data	Set 2 - Hospital Provided Data Instructions
Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP) Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP) Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary Medicare Managed Care Primary with Traditional Medicaid or Managed Care Medicaid Secondary (should exclude Uninsured	Medicaid Fee for Service Medicaid Managed Care Medicare Cross-over (FFS) Medicare Cross-over (Mg. Care) Uninsured	In-State Medicaid FFS Primary In-State Medicaid Managed Care Primary In-State Medicare FFS Cross-Overs (with Medicaid Secondary) In-State Medicare Managed Care Cross-Overs (with Medicaid Secondary) Uninsured	Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP) Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP) Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary Medicare Managed Care Primary with Traditional Medicaid or Managed Care Medicaid Secondary Uninsured
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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)*			
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)*			
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)*			
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)*			
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)*			
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)"			

Set 2 - Hospital Provided Data UCC Summary Titles	Set 3 - Other
Medicaid Fee for Service	In-State Medicaid FFS Primary
Medicaid Managed Care	In-State Medicaid Managed Care Primary
Medicare Cross-over (FFS)	In-State Medicare FFS Cross-Overs (with Medicaid
Medicare Cross-over (Mg. Care)	In-State Other Medicaid Eligibles (Not Included Elsew
Uninsured	Uninsured
Out-of-State Medicaid	Out-of-State Medicaid FFS Primary
	Out-of-State Medicaid Managed Care Primary
	Out-of-State Medicare FFS Cross-Overs (with
	Out-of-State Other Medicaid Eligibles (Not Included El
	Uninsured

General Instructions and Identification of Cost Reports that Cover the DSH Year:

Macro Settings for Microsoft Excel 2007 Software

1. Please make sure Macros are enabled under the Excel options. If Macros are disabled, the DSH survey will not have full functionality. Macros can be enabled for Microsoft Excel 2007 software by first selecting "Excel Options" under the Microsoft Office File Menu Button (upper left hand corner of the screen). Then under the Excel Options dialog box select the "Trust Center" option. Under the Trust Center Dialog box select the "Trust Center Settings" button. Then select "Macro Settings" and click the "Enable all macros" button. Then press the OK button. After the Macro settings have been enabled it will be necessary to save changes and close the Excel program and re-open the DSH Survey Part II Excel workbook so the setting changes can take place.

   OR

   Select the Developer tab on the Excel Ribbon Menu. If the Developer tab is not displayed, click the Microsoft Office File Menu Button (upper left hand corner of the screen), then select the "Excel Options" button. Under Excel Options, Select the "Popular" category, then under "Top Options for working with Excel" select the "Show Developer Tab in The Ribbon" option. Once the Developer tab is available select the "Macro Security" option under the Code Group. Under Macro Security settings select the "Enable All Macros" option or the option that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message). Then close and re-open the Excel workbook so the settings changes can take place.

Macro Settings for Older Versions of Microsoft Excel Software

For older versions of Microsoft Excel software (before Microsoft Excel 2007) select the "Tools" menu. Under the Tools Menu select "Macro" - "Security". Then select "Low" or "Medium" security. Then close and re-open the Excel workbook for the settings changes to take place.

2. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.

3. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 -Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.

4. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

NOTE: For the 2014 DSH Survey, if your hospital completed the DSH survey for 2013, the first cost report year should follow the last cost report year reported on the 2013 DSH survey. The last cost report year on the 2014 survey must end on or after the end of the 2014 DSH year. If your hospital did not complete the 2013 survey, you must report data for each cost report year that covers the 2014 DSH year.

5. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Exhibit A - Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.

2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).

3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.

4. The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 128 of the DSH survey.

Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

   Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments received from patients during the cost report year regardless of dates of service and insurance status.

3. Only the payments received from uninsured patients should be included on Section H of the DSH survey, line 143. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 143 should reconcile to Section E, line 9.

Section D - General Cost Report Year Information

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.

2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E - Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.

2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.

3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.

4. Line 13 is a drop-down menu. Please answer 'Yes' or 'No' to the question.

5. Lines 14 and 15 should be completed if you answered 'Yes' to line 13. Please provide the amount of lump sum (non-claims-based) payments received from Medicaid Managed Care plans. Please also provide supporting documentation for the amounts reported in the form of cancelled checks, general ledger records, or some other financial records.

Section F - MIUR / LIUR Qualifying Data from the Cost Report

Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

2. For Lines 2 through 6 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate cell. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified cell. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.

3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

4. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.

5. For Lines 7 through 10 report the applicable charity care charges. Charity care charges are used in the calculation of the low-income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. Any charity care charges related to non-hospital services should be reported on the non-hospital charity care charges line. Total charity care charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.

7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State.

2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.

3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.

4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.

2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.

3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

In-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state version generated from the MMIS. Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
Same requirements as above, except payments received from the Medicaid Managed Care entity should be reported on the line titled "Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)". If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). NOTE: 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.

In-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

In-State Other Medicaid Eligibles (Not Included Elsewhere)

In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number. This would include Medicare Part C cross-overs not reported elsewhere on the survey.

N/A

N/A

N/A

N/A

N/A

N/A

N/A
N/A

Uninsured
Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance) or third party liability for the specific service provided. See "Uninsured Definitions" tab for additional details.

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I - Calculation of Out-of-State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

Out-of-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section H.**

2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.**

2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

3. The following columns will **NOT** need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Section L. Provider Tax Assessment Reconciliation / Adjustment

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**

   The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.

2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

   It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.

3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.

4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).

5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.

6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangments outside of the state's assessed tax).

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.

9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH UCC.

10. The amount on Line 25 may NOT be the final amount added into your DSH UCC. The examination will review the various adjustments and reconciliations and make a final determination.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit To:

Myers and Stauffer LC
Attention: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, MO 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
e-mail:

General Instructions and Identification of Cost Reports that Cover the DSH Year:

Macro Settings for Microsoft Excel 2007 Software

1. Please make sure Macros are enabled under the Excel options. If Macros are disabled, the DSH survey will not have full functionality. Macros can be enabled for Microsoft Excel 2007 software by first selecting "Excel Options" under the Microsoft Office File Menu Button (upper left hand corner of the screen). Then under the Excel Options dialog box select the "Trust Center" option. Under the Trust Center Dialog box select the "Trust Center Settings" button. Then select "Macro Settings" and click the "Enable all macros" button. Then press the OK button. After the Macro settings have been enabled it will be necessary to save changes and close the Excel program and re-open the DSH Survey Part II Excel workbook so the setting changes can take place.

   OR
   Select the Developer tab on the Excel Ribbon Menu. If the Developer tab is not displayed, click the Microsoft Office File Menu Button (upper left hand corner of the screen), then select the "Excel Options" button. Under Excel Options, Select the "Popular" category, then under "Top Options for working with Excel" select the "Show Developer Tab in The Ribbon" option. Once the Developer tab is available select the "Macro Security" option under the Code Group. Under Macro Security settings select the "Enable All Macros" option or the option that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message). Then close and re-open the Excel workbook so the settings changes can take place.

Macro Settings for Older Versions of Microsoft Excel Software

For older versions of Microsoft Excel software (before Microsoft Excel 2007) select the "**Tools**" menu. Under the Tools Menu select **"Macro" - "Security**". Then select **"Low"** or **"Medium"** security. Then close and re-open the Excel workbook for the settings changes to take place.

2. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.

3. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 -Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.

4. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

   NOTE: For the 2012 DSH Survey, if your hospital completed the DSH survey for 2011, the first cost report year should follow the last cost report year reported on the 2011 DSH survey. The last cost report year on the 2012 survey must end on or after the end of the 2012 DSH year. If your hospital did not complete the 2011 survey, you must report data for each cost report year that covers the 2012 DSH year.

5. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Section D - General Cost Report Year Information

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.

2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E - Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.

2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.

3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.

Section F - MIUR / LIUR Qualifying Data from the Cost Report

Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

2a. For Lines 2 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate box. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified column.

2b. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

2c. Answer Line 3a question. If there is cash subsidy amount not included in w/s G-3, Line 3 (survey Section F-3 Column P, line 25), list the amount in Line 3b, which will be added back to Total Hospital Revenues to calculate LIUR.

2d. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.

3a. Report the applicable charity care charges in lines 4. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. These charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

3b. Amount reported in Line 5 should be traced back to Exhibit A.

3c. Charity care charges are used in the calculation of the low-income utilization rate.

Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.

7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State.

2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.

3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will **NOT** need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.

4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.

2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.

3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

i) **In-State Paid Claims - from M&S paid claims reports**

In-State Medicaid FFS Primary

Traditional Medicaid Primary

In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to the **Included Medicaid Paid Claims** data. Record in the box labeled "Total Allowed Amount from Medicaid Paid Claim Data (Payments)" the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the Included Medicaid Paid Claims data total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary

Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).

In-State Medicaid FFS Cross-Overs (with Medicare Primary)

Traditional Medicare or Managed Care Medicare Primary with Traditional Medicaid Secondary

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments. Reconcile your responses on the survey with the Included Medicaid Paid Claims data total for cross-overs at the bottom of each column. Provide an explanation for any unreconciled amounts.

HIP claims

Same requirements as i) above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient).

*If you have supplemental HIP claims that not included in the Included Medicaid Paid Claims data, put those claims in column "In-State Medicaid-Eligible Not on Medicaid Paid Claims Data - MCO and HIP", with supporting detail claims submitted in Exhibit C.

ii) **Validated Paid Claims – Not Duplicates/Overlaps**

*Using the criteria listed below, we identified several sets of Medicaid claims that may pertain to the same service- which may indicate a possible duplicate claim for which no adjustment was made by Indiana AIM; and some sets of Medicaid claims that the FDOS and LDOS overlapped (within the same provider and across the providers) - which may indicate a possible overlap claim. Accordingly, we have removed these claims from the Included paid claims report, and put them in a separate report entitled "**Possible Duplicate and Overlap Claims Report**" and mailed to you.*

Criteria for including **inpatient claims** in Possible Duplicate/Overlap Claims Report: Claims, including managed care and crossovers, were identified as ***possible duplicate records*** if they that had different ICNs, but identical recipient ID, provider ID, FDOS and LDOS; were identified as ***possible overlap records*** if the FDOS/LODS of the claims overlap each other.

Please review these claims against your records and make decision which claims should be included in the survey.

1) Send the "Possible Duplicates and Overlaps-provider number-FYE" back with a column added to indicate that among the duplicates/overlaps, which claim(s) should be included in the survey, and which should be excluded. Please note: You can NOT include both/all of a duplicate/overlap set.

2) For valid claims that are for separate services and are not duplicates/overlaps of other reported services, please include in the Section H "Validated Paid Claims – Not Duplicates/Overlaps" columns. Please provide an explanation as to why these claims do not represent duplicate/overlap claims. Supporting documentation for these explanations to verify that they are separate services, and are not duplicate/overlap claims, should be prepared and retained in your records, and made available upon request by OMPP.

3) For claims you identify as a duplicate/overlap reporting of a service already included in the survey, do not include in your survey response.

iii) Report services provided to all Indiana **Medicaid-eligible** patients that were **not included in the Medicaid Paid Claims reports**, regardless of payment status or if covered under other insurance.

In-State Medicaid-Eligible Not on Medicaid Paid Claims Data - FFS
In these two columns, record your in-state Medicaid fee-for-service days, charges and payments for services not included on the Medicaid Paid Claims Data. Exhibit C needed as supporting documentation.

In-State Medicaid-Eligible Not on Medicaid Paid Claims Data - MC and HIP

Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). Exhibit C needed as supporting documentation.

In-State Medicaid-Eligible Not on Medicaid Paid Claims Data - FFS Cross-over

Same requirements as above. If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). Exhibit C needed as supporting documentation.

vi) **Uninsured claims**

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in an auditable analysis. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. **Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance). If the patient had health insurance, even if the third party insurer did not pay, those services are insured and cannot be reported as uninsured on the survey.**

Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in an auditable format and made available upon request.

Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

4. **The Lines 19 and 129 "Total Days / Charges per Paid Claims Reports or other Exhibits" MUST be filled, and any outstanding reconciled amount in Lines below need to be explained.**

   The totals need to be traceable to the "Included Claims-provider number-FYE" we mailed to you, the "Possible Duplicates and Overlaps-provider number-FYE" you sent back, and the other supplemental claims supported by the Exhibit A, B and C submitted by you.

Section I - Calculation of Out-of-State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and other services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule (details in Exhibit D) should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

   Out-of-State Medicaid FFS Primary

   Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

   Out-of-State Medicaid Managed Care Primary

   Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

   Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)

   Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

   Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)

   Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

2. **The Lines 19 and 129 "Total Days / Charges per Paid Claims Reports or other Exhibits" MUST be filled, and any outstanding reconciled amount in Lines below need to be explained.**
   The totals need to be traceable to the Out-Of-State claims supported by the Exhibit D submitted by you.

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only.** Information is collected in a format similar to Section H.

2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only.** Information is collected in a format similar to Section I.

2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

3. The following columns will **NOT** need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Section L - Tax Assessment

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**

   The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.

2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

   It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.

3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.

4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).

5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.

6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangements outside of the state's assessed tax).

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.

9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH UCC.

   The amount on Line 25 may NOT be the final amount added into your DSH UCC. The examination will review the various adjustments and reconciliations and make a final determination.

Exhibit A - Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.

2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).

3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.

4. The total inpatient and outpatient hospital charges (Column N - excluding professional fees, and other non-hospital items) from Exhibit A should tie to **Section H, Uninsured columns, line 129** of the survey.

5. The total inpatient and outpatient hospital charges (Column N) from Exhibit A, with Column R indicating "the charges NOT included in charity care charges" should tie to **Section F-2, line 5** of the survey.

Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

   Note: If insurance status cannot be determined on older service dates, report the older service date payments received during the cost report period on Exhibit B-1, as noted below.

   Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments **received** from patients **during the cost report year *regardless of dates of service and insurance status***.
3. Only the payments received from *uninsured* patients should be included on **Section H of the survey, line 140**. Payments from both the uninsured and insured patients should be reported on **Section E of the survey, lines 9 and 10, respectively**. **The total payments from Section H, line 140 should reconcile to Section E, line 9.**

Exhibit C - Support of In-State Medicaid-Eligible Not on Included Medicaid Paid Claims report data

1. See Exhibit C for an example format of the information that needs to be available to support the data reported in Section H of the survey related to services for In-State Medicaid-Eligible Not on Medicaid Paid Claims Data provided for each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit C for each cost reporting period included in the survey.

Exhibit D - Support of Out-Of-State claims data:

1. See Exhibit D for an example format of the information that needs to be available to support the data reported in Section I of the survey related to services provided for Out-Of-State Medicaid-Eligible claims for each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit D for each cost reporting period included in the survey.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit To:

Myers and Stauffer LC
Attention: DSH Audits
9266 Counselors Row, Suite 200
Indianapolis, Indiana 46241
Phone: 800-877-6928

Fax: (317) 571-8482
claimsrequest@mslc.com

Medicaid Paid Claims Reports Sum

Medicaid Paid Claims reports have been provided to assist you in completing this survey. The accuracy an responsible for the accuracy and completeness of the information reported on the survey you submit.

Several paid claims reports accompany this survey on the CD sent to your facility. Below is a description of the rep submitted by your facility, the CD may not include all of these reports.

As noted above, the accuracy and completeness of this information has not been verified. There may be inaccurac

File Name

Included Claims-provider number-FYE

Description

Header Level Information for included paid claims - FFS, MC, HIP, Crossover

Purpose

The survey allows you to report services provided to Medicaid-eligible patients that are not included on the paid clai which services have not been included.

File Name

Included Claims-provider number-FYE-Paid and Denied Detail

Description

Paid/Denied Detail Level Information for included paid claims - FFS, MC, HIP, Crossover

Purpose

A revenue code summary has been provided to assist with completing Survey Section H (Medicaid costs). Even th provided to Medicaid-eligible patients are permitted.

File Name

Included Claims-provider number-FYE-Disallowed Detail

Description

Disallowed Detail Level Information for included paid claims - FFS, MC, HIP, Crossover

Purpose

Costs for these detail lines are for services not permitted by federal rule to be included in the DSH calculation. Thes your survey response. If your paid claims include charges for these services, do not include an apportionment of he

File Name

Possible Duplicates and Overlaps-provider number-FYE

Description

Possible Duplicates/Overlaps - Header Level Information for paid claims - FFS, MC, HIP, Crossover

Purpose

Our review of paid claims data indicated several claims that could be duplicates or overlaps. Please review and det be included in the DSH calculation.

File Name

Possible Duplicates and Overlaps-provider number-FYE-Paid and Denied Detail

Description

Possible Duplicates/Overlaps - Paid/Denied Detail Level Information for paid claims - FFS, MC, HIP, Crossover

Purpose

A revenue code summary has been provided to assist with completing Survey Section H (Medicaid costs). Even th provided to Medicaid-eligible patients are permitted in the DSH calculation. These are possible duplicate/overlap cl overlaps, and are eligible to be included in the DSH calculation.

File Name

Possible Duplicates and Overlaps-provider number-FYE-Disallowed Detail

Description

Possible Duplicates/Overlaps - Disallowed Detail Level Information for paid claims - FFS, MC, HIP, Crossover

Purpose

Costs for these detail lines are for services not permitted by federal rule to be included in the DSH calculation. Thes
your survey response. If your paid claims include charges for these services, do not include an apportionment of he

File Name

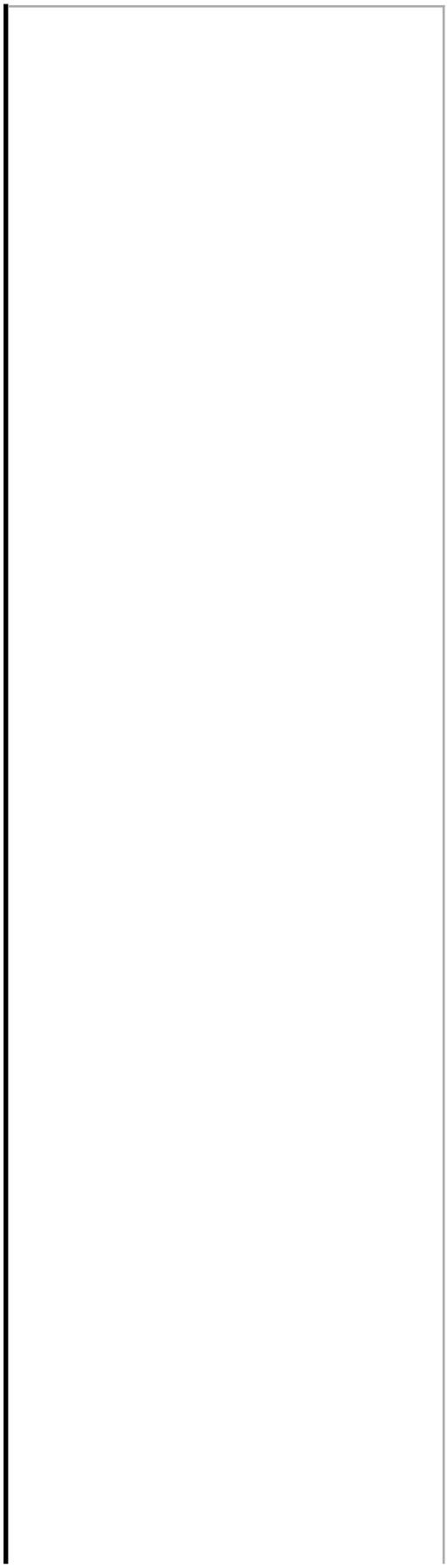
Excluded Claims-provider number-FYE

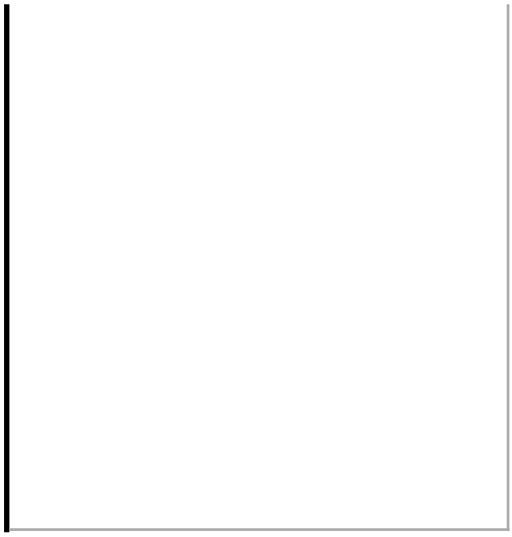
Description

Claims excluded from DSH calculation

Purpose

The claims in this report were excluded from the claims to be utilized in completing the Hospital Specific Limit surve
to Residents to County Homes (ARCH), category 9 with no credible insurance or TPL (CHIP1), SCHIP (category 1(
response. They are provided to serve as identification of these claims for that exclusion.





Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who have no source of third party coverage for a specific inpatient hospital or outpatient hospital service (reported based on date of service). (*42 CFR 447.295 (b)*)

- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments provided for hospital patients that met the uninsured definition for the specific inpatient or outpatient hospital service provided. The payments must be reported on a cash basis (report in the year provided, regardless of the year of service). (73 FR dated 12/19/08, pages 77913 & 77927)

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

Do NOT Include In Hospital Uninsured Charges:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage for the specific inpatient or outpatient hospital service provided. Exclude charges for all non-hospital services. (42 CFR 447.295 (b))

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage for the specific inpatient or outpatient hospital service provided. (42 CFR 447.299 (15) and 42 CFR 447.295 (b))
- Exclude claims denied by an active health insurance carrier unless the entire claim was denied due to exhaustion of benefits or due to the benefit package not covering the specific inpatient or outpatient hospital service provided. *(73 FR dated 12/19/08, pages 77910-77911, 77913 and 42 CFR 447.295 (b))*
- Exclude uninsured charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)*
- Exclude charges for services to prisoners (wards of the state). *(73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)*
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)*
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured). *(45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)*
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured). (*42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)*
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). *(73 FR dated 12/19/08, page 77916)*
- Exclude charges related to accounts with unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). *(42 CFR 447.299 (15))*
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)*
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude non-Title XIX charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

Do NOT Include In Hospital Uninsured Payments:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. *(42 CFR 447.299 (12))*
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). *(42 CFR 447.299 (15))*
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

December 3, 2014 Final Rule Highlights:

- **Medicaid Eligible Individuals:**

  • If an individual is Medicaid eligible for any day during a single inpatient stay for a particular service, states must classify the individual as Medicaid eligible.

  • If an individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, states cannot include any costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

  • If an individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, states should classify the individual as uninsured and include all costs and revenues associated with the particular service when calculating the hospital-specific DSH limit.

- **Uninsured and Underinsured:**

  • Individuals who have exhausted benefits before obtaining services will be considered uninsured.

  • Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for the particular service. If the individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, the costs and revenues of the service cannot be included in the hospital-specific DSH limit.

  • Individuals with high deductible or catastrophic plans are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims cannot be included in the hospital-specific DSH limit.

  • The costs and revenues, including the payments from private insurance for Medicaid eligible individuals, should be included in the calculation of the hospital-specific DSH limit.

- **Scope of Inpatient and Outpatient Hospital Services:**

  • To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, the service must meet the federal and state definitions of inpatient or outpatient hospital services and must be included in the state's definition of an inpatient or outpatient hospital service under the approved state plan.

  • FQHC services are not inpatient or outpatient hospital services and cannot be included in the hospital-specific DSH limit.

  • Example: If transplant services are not covered under the approved state plan, costs associated with transplants cannot be included in calculating the hospital-specific DSH limit.

  • Example: NF, HHA, employed physicians or other licensed practitioners are not recognized as inpatient or outpatient hospital services and are not covered under the inpatient or outpatient hospital Medicaid benefit service categories and cannot be included in the hospital-specific DSH limit.

  • Administratively necessary days (days awaiting placement) are recognized as inpatient hospital services and should be included in the hospital-specific DSH limit.

- **Timing of Service Specific Determination:**

  • The determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire claim's services.

• When benefits have been exhausted for individuals with a source of third party coverage, only costs associated with separate services provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific limit. These services must be a separate service based on the definition of a service for Medicaid (e.g., separate inpatient stay or separate outpatient billing period).

• Uncompensated care costs incurred by hospitals due to unpaid co-pays, co-insurance, or deductibles associated with a non-Medicaid eligible individual cannot be included in the calculation of the hospital-specific DSH limit.

- **Physician Services:**

• Services that are not inpatient or outpatient hospital services, including physician services, must be excluded when calculating the hospital-specific DSH limit.

• Exception: Costs where insurance pays an all inclusive rate are allowable.

• Physician costs under Section 1115 waivers are still excluded from the DSH limit calculation.

- **Prisoners:**

• Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage.

- **Indian Health Services:**

• For Medicaid DSH purposes, American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs (direct health care services) and for services specifically authorized under CHS.

• Determining factor in deciding whether an American Indian or Alaska Native has health insurance for I/P or O/P hospital service is if the providing entity is an IHS facility or tribal health program.

• Contract Services (Non-IHS provider): if the service is specifically authorized via a purchase order or equivalent document, it is considered to be insured. If it does not have an authorization, it is considered an uninsured service.

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

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/60	999-99-999	Female	Doe, Jane	3/1/10	3/11/10	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/85	999-99-999	Male	Jones, James	6/15/10	6/15/10	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/85	999-99-999	Male	Jones, James	6/15/10	6/15/10	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/00	999-99-999	Male	Smith, Mike	8/10/10	8/10/10	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

State of Georgia
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Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S) **	Insurance Status When Services Were Provided (Insured or Uninsured) (T) *	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0) *****
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/25	999-99-999	Male	Jones, Anthony	7/12/95	7/14/95	1/1/10	$ 50	No	Inpatient	$ 10,000	$ 900	$ - 0	Insured		$ - 0
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/25	999-99-999	Male	Jones, Anthony	7/12/95	7/14/95	2/1/10	$ 50	No	Inpatient	$ 10,000	$ 900	$ - 0	Insured		$ - 0
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/25	999-99-999	Male	Jones, Anthony	7/12/95	7/14/95	3/1/10	$ 50	No	Inpatient	$ 10,000	$ 900	$ - 0	Insured		$ - 0
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/25	999-99-999	Male	Jones, Anthony	7/12/95	7/14/95	4/1/10	$ 50	No	Inpatient	$ 10,000	$ 900	$ - 0	Insured		$ - 0
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/79	999-99-999	Male	Smith, John	9/21/00	9/21/00	9/30/09	$ 150	No	Outpatient	$ 2,000	$ - 0	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/79	999-99-999	Male	Smith, John	9/21/00	9/21/00	10/31/09	$ 150	No	Outpatient	$ 2,000	$ - 0	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/79	999-99-999	Male	Smith, John	9/21/00	9/21/00	11/30/09	$ 150	No	Outpatient	$ 2,000	$ - 0	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/00	999-99-999	Male	Cliff, Heath	12/31/09	1/1/10	5/15/10	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ - 0	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/00	999-99-999	Male	Cliff, Heath	12/31/09	1/1/10	5/31/10	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ - 0	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/60	999-99-999	Male	Johnson, Joe	9/1/05	9/3/05	11/12/10	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

Notes for Completing Exhibit B:

* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B-1

Summary of Self Pay Cash Collections During the Cost Report Year (Unknown Insurance Status)

NOTE: This is NOT intended for DOS prior to the cost report period. It is intended to be used for claims that are too old to determine the patient's true insurance status. Claims with DOS prior to the cost report period should be included in Exhibit B unless the patient's insurance status cannot be determined.

Patient Identifier Code (PCN) (A)	Name (B)	Admit Date (C)	Discharge Date (D)	Date of Cash Collection (E)	Amount of Cash Collections (F)	Indicate if Collection is a 1011 Payment (G) ***	Total Hospital Charges for Services Provided (H) *	Total Physician Charges for Services Provided (I)	Total Other Non-Hospital Charges for Services Provided (J) **	Calculated Uninsured Percentage (K) ****	Calculated Hospital Uninsured Collections (= (H)/((H)+(I)+(J))*(F)*(K))
8888888	Johnson, Joe	5/12/99	5/25/99	5/1/10	$ 500	No	$ 55,000	$ 1,100	$ -	7%	$ 33
8888888	Johnson, Joe	5/12/99	5/25/99	3/1/10	$ 250	Yes	$ 55,000	$ 1,100	$ -	7%	$ 16
8888888	Johnson, Joe	5/12/99	5/25/99	5/15/10	$ 100	No	$ 55,000	$ 1,100	$ -	7%	$ 7
8888888	Johnson, Joe	5/12/99	5/25/99	6/15/10	$ 300	No	$ 55,000	$ 1,100	$ -	7%	$ 20
5555555	Smith, Scott	7/1/04	7/15/04	2/18/10	$ 800	No	$ 35,000	$ 550	$ 330	7%	$ 52
5555555	Smith, Scott	7/1/04	7/15/04	3/25/10	$ 500	No	$ 35,000	$ 550	$ 330	7%	$ 33
5555555	Smith, Scott	7/1/04	7/15/04	4/28/10	$ 200	No	$ 35,000	$ 550	$ 330	7%	$ 13
5555555	Smith, Scott	7/1/04	7/15/04	6/15/10	$ 100	No	$ 35,000	$ 550	$ 330	7%	$ 7

Notes for Completing Exhibit B-1:

* Charges will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** The uninsured percentage should be calculated based on the total uninsured payments as a percentage of the self pay payments shown on Exhibit B. This percentage will be the same for all of the older service date collections since documentation is not available to support the insurance status.

Please submit the above data in an electronic file with this survey document. The electronic file must be submitted in Excel (.xls, .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key).

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

Example of Exhibit C (Other Medicaid Eligible example)

Claim Type (A) **	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	120	$ 1,200	3	$ - 0	$ - 0	$ 50	$ - 0	$ 1,500	$ - 0	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	206	$ 1,500	1	$ - 0	$ - 0	$ 50	$ - 0	$ 1,500	$ - 0	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	250	$ 100	-	$ - 0	$ - 0	$ 50	$ - 0	$ 1,500	$ - 0	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	300	$ 375	-	$ - 0	$ - 0	$ 50	$ - 0	$ 1,500	$ - 0	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	450	$ 1,500	-	$ - 0	$ - 0	$ 50	$ - 0	$ 1,500	$ - 0	$ 1,550
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	250	$ 100	-	$ - 0	$ - 0	$ - 0	$ - 0	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	300	$ 375	-	$ - 0	$ - 0	$ - 0	$ - 0	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	450	$ 1,500	-	$ - 0	$ - 0	$ - 0	$ - 0	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/00	999-99-999	Female	Jeffery, Susan	2/28/10	2/28/10	Outpatient	300	$ 375	-	$ - 0	$ - 0	$ 100	$ - 0	$ 1,000	$ - 0	$ 1,100
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/00	999-99-999	Female	Jeffery, Susan	2/28/10	2/28/10	Outpatient	450	$ 1,500	-	$ - 0	$ - 0	$ 100	$ - 0	$ 1,000	$ - 0	$ 1,100

Notes for Completing Exhibit C:

* All charges for non-hospital services should be excluded.

** **A separate Exhibit C file should be submitted for each claim type reported (e.g. Medicaid Managed Care, Other Medicaid Eligibles, Out-of-State Medicaid, etc.). The format above should be used for each Exhibit C.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

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

Example of Exhibit D (Out-of-State Medicaid example)

Claim Type (A) **	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	120	$ 1,200	3	$ - 0	$ - 0	$ 1,500	$ - 0	$ 50	$ - 0	$ 1,550
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	206	$ 1,500	1	$ - 0	$ - 0	$ 1,500	$ - 0	$ 50	$ - 0	$ 1,550
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	250	$ 100	-	$ - 0	$ - 0	$ 1,500	$ - 0	$ 50	$ - 0	$ 1,550
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	300	$ 375	-	$ - 0	$ - 0	$ 1,500	$ - 0	$ 50	$ - 0	$ 1,550
Out-of-State Medicaid	Arkansas Medicaid		12345	888888	123456789	1/1/60	999-99-999	Male	James, Samuel	9/1/09	9/4/09	Inpatient	450	$ 1,500	-	$ - 0	$ - 0	$ 1,500	$ - 0	$ 50	$ - 0	$ 1,550
Out-of-State Medicaid	Texas Medicaid		12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	250	$ 100	-	$ - 0	$ - 0	$ 900	$ - 0	$ - 0	$ 75	$ 975
Out-of-State Medicaid	Texas Medicaid		12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	300	$ 375	-	$ - 0	$ - 0	$ 900	$ - 0	$ - 0	$ 75	$ 975
Out-of-State Medicaid	Texas Medicaid		12345	666666	978654321	7/12/85	999-99-999	Female	Johnson, Sandy	6/30/10	6/30/10	Outpatient	450	$ 1,500	-	$ - 0	$ - 0	$ 900	$ - 0	$ - 0	$ 75	$ 975
Out-of-State Medicaid	Texas Medicaid		12345	555555	654321978	3/5/00	999-99-999	Female	Jeffery, Susan	2/28/10	2/28/10	Outpatient	300	$ 375	-	$ - 0	$ - 0	$ 1,000	$ - 0	$ 100	$ - 0	$ 1,100
Out-of-State Medicaid	Texas Medicaid		12345	555555	654321978	3/5/00	999-99-999	Female	Jeffery, Susan	2/28/10	2/28/10	Outpatient	450	$ 1,500	-	$ - 0	$ - 0	$ 1,000	$ - 0	$ 100	$ - 0	$ 1,100

Notes for Completing Exhibit D:

* All charges for non-hospital services should be excluded.

** **A separate Exhibit D file should be submitted for each claim type reported (e.g. OOS FFS, OOS Medicaid Managed Care, OOS Other Medicaid Eligibles, etc.). The format above should be used for each Exhibit D.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

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

DSH Version 7.25 5/3/18

D. General Cost Report Year Information -

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: APPLING HOSPITAL

2. Select Cost Report Year Covered by this Survey (enter "X"): 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: 2/26/18

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:		Yes	
5. Medicaid Provider Number:		Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):		Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):		Yes	
8. Medicare Provider Number:		Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):		Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):		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: (09/01/2016 - 08/31/2017)

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)**	$ - 0
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)**	$ - 0
8. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 7,083	$ 201,944	$ 209,027
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 79,899	$ 610,485	$ 690,384
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$ 86,982	$ 812,429	$ 899,411
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.14%	24.86%	23.24%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

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	$ 475,089
15.	Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ 799,808
16.	Total Medicaid managed care non-claims payments (see question 13 above) received	$ 1,274,897

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 (09/01/2016 - 08/31/2017)

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)	12,063 **(See Note in Section F-3, below)**

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	- 0
3.	Outpatient Hospital Subsidies	- 0
4.	Unspecified I/P and O/P Hospital Subsidies	- 0
5.	Non-Hospital Subsidies	- 0
6.	Total Hospital Subsidies	$ - 0
7.	Inpatient Hospital Charity Care Charges	
8.	Outpatient Hospital Charity Care Charges	
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ - 0

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments *(formulas below can be overwritten if amounts are known)*			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$2,102,152.00						
12.	Subprovider I (Psych or Rehab)	$5,157,392.00						
13.	Subprovider II (Psych or Rehab)	$0.00						
14.	Swing Bed - SNF			$0.00				
15.	Swing Bed - NF			$0.00				
16.	Skilled Nursing Facility			$7,570,604.00				
17.	Nursing Facility			$0.00				
18.	Other Long-Term Care			$0.00				
19.	Ancillary Services	$15,287,742.00	$23,482,972.00					
20.	Outpatient Services		$3,888,597.00					
21.	Home Health Agency			$0.00				
22.	Ambulance	0	0	$ 908,197				
23.	Outpatient Rehab Providers			$0.00				
24.	ASC	$0.00	$0.00					
25.	Hospice			$0.00				
26.	Other	$1,695,227.00	$2,554,689.00	$4,147,259.00				
27.	Total	$ 24,242,513	$ 29,926,258	$ 12,626,060				
28.	Total Hospital and Non Hospital		Total from Above	$ 66,794,831		Total from Above		

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	66,794,831	Total Contractual Adj. (G-3 Line 2)	36,444,953

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)		+
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)"		-
35.	Adjusted Contractual Adjustments		-

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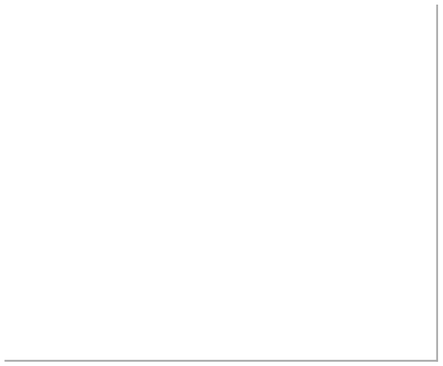

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2016-08/31/2017)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Routine Cost Centers (list below):

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Total 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	Title XIX: I/P Days and I/P Ancillary Charges	Title XIX: I/P Routine Charges and O/P Ancillary Charges	Title XVIII: I/P Days and I/P Ancillary Charges	Title XVIII: I/P Routine Charges and O/P Ancillary Charges
		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*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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*	*Days - Cost Report W/S S-3, Pt. I, Column 7*	*Inpatient Routine Charges - Cost Report W/S D-3, Col. 2 (Informational only)*	*Days - Cost Report W/S S-3, Pt. I, Column 6*	*Inpatient Routine Charges - Cost Report W/S D-3, Col. 2 (Informational only)*
1	03000 ADULTS & PEDIATRICS	$ 6,515,495	$ - 0	$ -	$79,769.00	$ - 0	$ 6,435,726	12,390	$1,263,120.00		$ 519.43	303	$612,240.00	982	$489,036.00
2	03100 INTENSIVE CARE UNIT	$ 856,674	$ - 0	$ -		$ - 0	$ 856,674	764	$839,032.00		$ 1,121.30	57	$65,241.00	430	$476,822.00
3	03200 CORONARY CARE UNIT	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
7	04000 SUBPROVIDER I	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$5,157,392.00		$ -	927	$0.00	7,816	$4,430,947.00
8	04100 SUBPROVIDER II	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
9	04200 OTHER SUBPROVIDER	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
10	04300 NURSERY	$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
11		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
12		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
13		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
14		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
15		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
16		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
17		$ -	$ - 0	$ -		$ - 0	$ - 0	- 0	$0.00		$ -	- 0	$0.00	- 0	$0.00
18	Total Routine	$ 7,372,169	$ - 0	$ - 0	$ 79,769	$ - 0	$ 7,292,400	13,154	$ 7,259,544			1,287	$ 677,481	9,228	$ 5,396,805
19	Weighted Average										$ 554.39				

Observation Data (Non-Distinct)

Line #		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	Inpatient Charges - Cost Report W/S D-3, Col. 2	Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4	Inpatient Charges - Cost Report W/S D-3, Col. 2	Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4
20	09200 Observation (Non-Distinct)	1,091	- 0	- 0		$ 566,698	$304,733.00	$447,695.00	$ 752,428	0.753159	$7,707.00	$47,431.00	$51,455.00	$135,648.00

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

Line #		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		Allocation of Provider Tax from Section L of the Survey Based on Total Cost	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	Inpatient Charges - Cost Report W/S D-3, Col. 2	Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4	Inpatient Charges - Cost Report W/S D-3, Col. 2	Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4
21	5000 OPERATING ROOM	$484,780.00	$ - 0	$0.00		$ - 0	$ 484,780	$370,491.00	$1,916,693.00	$ 2,287,184	0.211955	$55,850.00	$88,269.00	$155,328.00	$770,709.00
22	5300 ANESTHESIOLOGY	$12,673.00	$ - 0	$0.00		$ - 0	$ 12,673	$72,812.00	$447,109.00	$ 519,921	0.024375	$16,659.00	$32,132.00	$56,153.00	$115,660.00
23	5400 RADIOLOGY-DIAGNOSTIC	$1,158,123.00	$ - 0	$0.00		$ - 0	$ 1,158,123	$1,182,994.00	$8,004,663.00	$ 9,187,657	0.126052	$95,883.00	$411,612.00	$908,071.00	$1,901,485.00
24	6000 LABORATORY	$1,607,839.00	$ - 0	$0.00		$ - 0	$ 1,607,839	$3,798,807.00	$7,110,771.00	$ 10,909,578	0.147379	$456,707.00	$25,956.00	$2,754,287.00	$861,124.00
25	6500 RESPIRATORY THERAPY	$727,415.00	$ - 0	$0.00		$ - 0	$ 727,415	$917,067.00	$829,888.00	$ 1,746,955	0.416390	$94,681.00	$62,835.00	$610,665.00	$199,037.00
26	6600 PHYSICAL THERAPY	$660,020.00	$ - 0	$0.00		$ - 0	$ 660,020	$648,704.00	$1,254,432.00	$ 1,903,136	0.346807	$20,685.00	$2,199.00	$157,237.00	$4,109.00
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$727,087.00	$ - 0	$0.00		$ - 0	$ 727,087	$561,042.00	$802,703.00	$ 1,363,745	0.533155	$53,105.00	$60,996.00	$410,525.00	$152,448.00
28	7200 IMPL. DEV. CHARGED TO PATIENTS	$18,894.00	$ - 0	$0.00		$ - 0	$ 18,894	$44,086.00	$63,076.00	$ 107,162	0.176312	$4,726.00	$750.00	$22,556.00	$34,135.00
29	7300 DRUGS CHARGED TO PATIENTS	$1,979,364.00	$ - 0	$0.00		$ - 0	$ 1,979,364	$7,666,941.00	$3,053,637.00	$ 10,720,578	0.184632	$656,547.00	$171,686.00	$5,066,646.00	$1,005,453.00
30	7400 RENAL DIALYSIS	$160,956.00	$ - 0	$0.00		$ - 0	$ 160,956	$24,798.00	$0.00	$ 24,798	6.490685	$0.00	$0.00	$14,520.00	$4,228.00
31	9100 EMERGENCY	$2,414,405.00	$ - 0	$125,634.00		$ - 0	$ 2,540,039	$321,333.00	$2,814,836.00	$ 3,136,169	0.809918	$32,751.00	$202,396.00	$148,373.00	$433,718.00
32		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
33		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
34		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
35		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
36		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
37		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
38		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
39		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
40		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
41		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
42		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
43		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
44		$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00

45			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
46			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
47			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
48			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
49			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
50			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
51			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
52			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
53			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
54			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
55			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
56			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
57			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
58			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
59			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
60			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
61			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
62			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
63			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
64			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
65			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
66			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
67			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
68			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
69			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
70			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
71			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
72			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
73			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
74			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
75			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
76			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
77			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
78			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
79			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
80			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
81			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
82			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
83			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
84			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
85			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
86			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
87			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
88			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
89			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
90			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
91			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
92			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
93			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
94			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
95			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
96			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
97			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
98			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
99			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
100			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
101			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
102			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
103			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
104			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
105			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
106			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
107			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
108			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
109			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
110			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
111			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
112			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
113			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
114			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
115			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
116			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
117			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
118			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
119			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
120			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
121			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
122			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
123			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
124			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
125			$0.00	$ - 0	$0.00		$ - 0	$ - 0	$0.00	$0.00	$ - 0	-	$0.00	$0.00	$0.00	$0.00
126		**Total Ancillary**	$ 9,951,556	$ - 0	$ 125,634		$ - 0	$ 10,077,190	$ 15,913,808	$ 26,745,503	$ 42,659,311		$ 1,495,301	$ 1,106,262	$ 10,355,816	$ 5,617,754
127		**Weighted Average**										0.249509				

128	**Sub Totals**	$ 17,323,725	$ - 0	$ 125,634	[redacted]	$ - 0	$ 17,369,590	$ 23,173,352	$ 26,745,503	$ 49,918,855	[redacted]	$ 2,172,782	$ 1,106,262	$ 15,752,621	$ 5,617,754			
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)*						$0.00											
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)*						$119,468.00											
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*																	
131.01	Other Cost Adjustments (support must be submitted)																	
132	**Grand Total**						$ 17,250,122											
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.

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Disproportionate Share Hospital (DSH) Examination Survey Part II

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

Cost Report Year (09/01/2016-08/31/2017)

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)								State/Local-Only Indigent Care Program		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
			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		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 519.43		1,257		79		521		74										291		1,931		19.67%
2	03100 INTENSIVE CARE UNIT	$ 1,121.30		57		15		89		6										95		167		34.29%
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**		1,314		94		610		80		-		-		-		-		386		2,098		18.88%
19	Total Days per PS&R or Exhibit Detail			1,314		94		610		80										386				
20	Unreconciled Days (Explain Variance)			- 0		- 0		- 0		- 0		- 0		- 0		- 0		- 0		- 0				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 690,927		$ 57,216		$ 373,298		$ 42,396		$ -		$ -		$ -		$ -		$ 252,773		$ 1,163,837		19.51%
21.01	Calculated Routine Charge Per Diem			$ 525.82		$ 608.68		$ 611.96		$ 529.95		$ -		$ -		$ -		$ -		$ 654.85		$ 554.74		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.753159	7,707	47,350	1,911	100,564	10,273	27,059	1,320	14,563									13,100	93,245	$ 21,211	$ 189,536	42.14%
23	5000 OPERATING ROOM		0.211955	57,965	103,744	24,557	113,515	34,057	184,467	1,984	95,969									78,238	92,051	$ 118,563	$ 497,695	34.39%
24	5300 ANESTHESIOLOGY		0.024375	16,659	31,557	8,811	34,068	12,256	35,631	505	13,569									27,662	29,106	$ 38,231	$ 114,825	40.36%
25	5400 RADIOLOGY-DIAGNOSTIC		0.126052	101,658	428,656	25,929	806,074	156,198	513,826	45,322	224,321									183,761	1,187,440	$ 329,107	$ 1,972,877	39.98%
26	6000 LABORATORY		0.147379	463,426	481,608	54,688	850,861	381,074	218,063	75,387	171,493									364,201	977,042	$ 974,575	$ 1,722,025	37.01%
27	6500 RESPIRATORY THERAPY		0.416390	94,424	63,915	26,069	90,126	117,798	44,960	18,851	19,330									89,101	86,043	$ 257,142	$ 218,331	37.24%
28	6600 PHYSICAL THERAPY		0.346807	20,685	2,199	-	49,989	26,209	47,203	4,415	4,566									15,091	6,845	$ 51,309	$ 103,957	9.31%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.533155	52,259	61,222	22,465	83,201	76,252	46,878	8,464	10,416									80,853	95,006	$ 159,440	$ 201,717	39.38%
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.176312	4,545	750	198	1,325	3,535	7,785	837	5,309									1,864	-	$ 9,116	$ 15,169	24.40%
31	7300 DRUGS CHARGED TO PATIENTS		0.184632	660,586	223,861	74,348	427,094	357,422	273,180	71,762	71,276									357,418	551,204	$ 1,164,117	$ 995,411	28.62%
32	7400 RENAL DIALYSIS		6.490685	-	-	-	-	1,210	-	-	-									3,630	-	$ 1,210	$ - 0	19.52%
33	9100 EMERGENCY		0.809918	33,556	234,794	11,887	609,010	41,079	209,255	7,426	61,989									41,887	1,273,663	$ 93,948	$ 1,115,048	80.50%
34			-																			$ - 0	$ - 0	
35			-																			$ - 0	$ - 0	
36			-																			$ - 0	$ - 0	
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116			-																			$ - 0	$ - 0	
117			-																			$ - 0	$ - 0	

State of Georgia
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Version 7.25

118	[redacted]		-																				$ - 0	$ - 0	
119	[redacted]		-																				$ - 0	$ - 0	
120	[redacted]		-																				$ - 0	$ - 0	
121	[redacted]		-																				$ - 0	$ - 0	
122	[redacted]		-																				$ - 0	$ - 0	
123	[redacted]		-																				$ - 0	$ - 0	
124	[redacted]		-																				$ - 0	$ - 0	
125	[redacted]		-																				$ - 0	$ - 0	
126	[redacted]		-																				$ - 0	$ - 0	
127	[redacted]		-																				$ - 0	$ - 0	
				$ 1,513,470	$ 1,679,656	$ 250,863	$ 3,165,827	$ 1,217,363	$ 1,608,307	$ 236,272	$ 692,801	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,256,806	$ 4,391,646			
	Totals / Payments																								
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 2,204,397	$ 1,679,656	$ 308,079	$ 3,165,827	$ 1,590,661	$ 1,608,307	$ 278,668	$ 692,801	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,509,579 (Agrees to Exhibit A)	$ 4,391,646 (Agrees to Exhibit A)	$ 4,381,805	$ 7,146,591	34.92%
129	Total Charges per PS&R or Exhibit Detail			$ 2,204,397	$ 1,679,656	$ 308,079	$ 3,165,827	$ 1,590,661	$ 1,608,307	$ 278,668	$ 692,801											$ 1,509,579	$ 4,391,646			
130	Unreconciled Charges (Explain Variance)			- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 1,040,745	$ 475,077	$ 122,263	$ 999,198	$ 668,057	$ 438,628	$ 96,720	$ 164,678	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 570,888	$ 1,606,310	$ 1,927,785	$ 2,077,581	35.84%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,090,713	$ 402,046			$ 205,703	$ 67,069	$ 20,010	$ 35,496								[redacted]	[redacted]				$ 1,316,426	$ 504,611	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)						$ 725,585																	$ - 0	$ 725,585	
134	Private Insurance (including primary and third party liability)									$ 122,581	$ 94,495													$ 122,581	$ 94,495	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 11,969	$ 1,626		$ 472	$ 2	$ 125	$ 3	$ 1,700													$ 11,974	$ 3,923	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,102,682	$ 403,672	$ -	$ 726,057					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -					
137	Medicaid Cost Settlement Payments (See Note B)				$ 19,605														[redacted]	[redacted]				$ - 0	$ 19,605	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)																							$ - 0	$ - 0	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 558,547	$ 294,971		$ 485													$ 558,547	$ 295,456	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																							$ - 0	$ - 0	
141	Medicare Cross-Over Bad Debt Payments																							$ - 0	$ - 0	
142	Other Medicare Cross-Over Payments (See Note D)																					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ - 0	$ - 0	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																					$ 7,083	$ 201,944			
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)**			$ (61,937)	$ 51,800	$ 122,263	$ 273,141	$ (96,195)	$ 76,463	$ (45,874)	$ 32,502	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 563,805	$ 1,404,366	$ (81,743)	$ 433,906	
146	**Calculated Payments as a Percentage of Cost**			106%	89%	0%	73%	114%	83%	147%	80%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	13%	104%	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)**							9,695																		
148	**Percent of cross-over days to total Medicare days from the cost report**							6%																		

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.

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

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2016-08/31/2017)

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)		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	$ 519.43										-	
2	03100 INTENSIVE CARE UNIT	$ 1,121.30										-	
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)			**- 0**		**- 0**		**- 0**		**- 0**			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ - 0	
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)		0.753159									$ - 0	$ - 0
23	5000 OPERATING ROOM		0.211955									$ - 0	$ - 0
24	5300 ANESTHESIOLOGY		0.024375									$ - 0	$ - 0
25	5400 RADIOLOGY-DIAGNOSTIC		0.126052									$ - 0	$ - 0
26	6000 LABORATORY		0.147379									$ - 0	$ - 0
27	6500 RESPIRATORY THERAPY		0.416390									$ - 0	$ - 0
28	6600 PHYSICAL THERAPY		0.346807									$ - 0	$ - 0
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.533155									$ - 0	$ - 0
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.176312									$ - 0	$ - 0
31	7300 DRUGS CHARGED TO PATIENTS		0.184632									$ - 0	$ - 0
32	7400 RENAL DIALYSIS		6.490685									$ - 0	$ - 0
33	9100 EMERGENCY		0.809918									$ - 0	$ - 0
34			-									$ - 0	$ - 0
35			-									$ - 0	$ - 0
36			-									$ - 0	$ - 0
37			-									$ - 0	$ - 0
38			-									$ - 0	$ - 0
39			-									$ - 0	$ - 0
40			-									$ - 0	$ - 0
41			-									$ - 0	$ - 0
42			-									$ - 0	$ - 0
43			-									$ - 0	$ - 0
44			-									$ - 0	$ - 0
45			-									$ - 0	$ - 0
46			-									$ - 0	$ - 0
47			-									$ - 0	$ - 0
48			-									$ - 0	$ - 0
49			-									$ - 0	$ - 0
50			-									$ - 0	$ - 0
51			-									$ - 0	$ - 0
52			-									$ - 0	$ - 0
53			-									$ - 0	$ - 0
54			-									$ - 0	$ - 0
55			-									$ - 0	$ - 0
56			-									$ - 0	$ - 0
57			-									$ - 0	$ - 0
58			-									$ - 0	$ - 0

59				-										$ - 0	$ - 0
60				-										$ - 0	$ - 0
61				-										$ - 0	$ - 0
62				-										$ - 0	$ - 0
63				-										$ - 0	$ - 0
64				-										$ - 0	$ - 0
65				-										$ - 0	$ - 0
66				-										$ - 0	$ - 0
67				-										$ - 0	$ - 0
68				-										$ - 0	$ - 0
69				-										$ - 0	$ - 0
70				-										$ - 0	$ - 0
71				-										$ - 0	$ - 0
72				-										$ - 0	$ - 0
73				-										$ - 0	$ - 0
74				-										$ - 0	$ - 0
75				-										$ - 0	$ - 0
76				-										$ - 0	$ - 0
77				-										$ - 0	$ - 0
78				-										$ - 0	$ - 0
79				-										$ - 0	$ - 0
80				-										$ - 0	$ - 0
81				-										$ - 0	$ - 0
82				-										$ - 0	$ - 0
83				-										$ - 0	$ - 0
84				-										$ - 0	$ - 0
85				-										$ - 0	$ - 0
86				-										$ - 0	$ - 0
87				-										$ - 0	$ - 0
88				-										$ - 0	$ - 0
89				-										$ - 0	$ - 0
90				-										$ - 0	$ - 0
91				-										$ - 0	$ - 0
92				-										$ - 0	$ - 0
93				-										$ - 0	$ - 0
94				-										$ - 0	$ - 0
95				-										$ - 0	$ - 0
96				-										$ - 0	$ - 0
97				-										$ - 0	$ - 0
98				-										$ - 0	$ - 0
99				-										$ - 0	$ - 0
100				-										$ - 0	$ - 0
101				-										$ - 0	$ - 0
102				-										$ - 0	$ - 0
103				-										$ - 0	$ - 0
104				-										$ - 0	$ - 0
105				-										$ - 0	$ - 0
106				-										$ - 0	$ - 0
107				-										$ - 0	$ - 0
108				-										$ - 0	$ - 0
109				-										$ - 0	$ - 0
110				-										$ - 0	$ - 0
111				-										$ - 0	$ - 0
112				-										$ - 0	$ - 0
113				-										$ - 0	$ - 0
114				-										$ - 0	$ - 0
115				-										$ - 0	$ - 0
116				-										$ - 0	$ - 0
117				-										$ - 0	$ - 0
118				-										$ - 0	$ - 0
119				-										$ - 0	$ - 0
120				-										$ - 0	$ - 0
121				-										$ - 0	$ - 0
122				-										$ - 0	$ - 0
123				-										$ - 0	$ - 0
124				-										$ - 0	$ - 0
125				-										$ - 0	$ - 0
126				-										$ - 0	$ - 0
127				-										$ - 0	$ - 0
					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			

Totals / Payments

128	**Total Charges** ***(includes organ acquisition from Section K)***	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ - 0	$ - 0
129	Total Charges per PS&R or Exhibit Detail	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0		
130	Unreconciled Charges (Explain Variance)	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ - 0	$ - 0
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ - 0	$ - 0
134	Private Insurance (including primary and third party liability)									$ - 0	$ - 0
135	Self-Pay (including Co-Pay and Spend-Down)									$ - 0	$ - 0
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ - 0	$ - 0
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ - 0	$ - 0
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ - 0	$ - 0
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ - 0	$ - 0
141	Medicare Cross-Over Bad Debt Payments									$ - 0	$ - 0
142	Other Medicare Cross-Over Payments (See Note D)									$ - 0	$ - 0
141											
143	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
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&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.

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

Cost Report Year (09/01/2016-08/31/2017)

		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)		State/Local-Only Indigent Care Program						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)	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 Acquistion 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 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	$0.00	$ - 0	$ - 0		0																
2	Kidney Acquisition	$0.00	$ - 0	$ - 0		0																
3	Liver Acquisition	$0.00	$ - 0	$ - 0		0																
4	Heart Acquisition	$0.00	$ - 0	$ - 0		0																
5	Pancreas Acquisition	$0.00	$ - 0	$ - 0		0																
6	Intestinal Acquisition	$0.00	$ - 0	$ - 0		0																
7	Islet Acquisition	$0.00	$ - 0	$ - 0		0																
8		$0.00	$ - 0	$ - 0		0																
9	**Totals**	$ - 0	$ - 0	$ - 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0
10	**Total Cost**							- 0		- 0		- 0		- 0		- 0		- 0		- 0		- 0		- 0

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 H 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 (09/01/2016-08/31/2017)

		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)	
							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 Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
12	Kidney Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
13	Liver Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
14	Heart Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
15	Pancreas Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
16	Intestinal Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
17	Islet Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0								
18		$ - 0	$ - 0	$ - 0	$ - 0	0								
19	**Totals**	$ - 0	$ - 0	$ - 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0
20	**Total Cost**							- 0		- 0		- 0		- 0

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 I as part of your Out-of-State Medicaid total payments.

Total
0
0
0
0
0
0
0
0
0

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 (09/01/2016-08/31/2017)

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 227,905		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*	Expense	8210.79	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	$ 227,905		*(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*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*

DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)

8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*

DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)

12	*Reason for adjustment*			
13	*Reason for adjustment*			
14	*Reason for adjustment*			
15	*Reason for adjustment*			

16	Total Net Provider Tax Assessment Expense Included in the Cost Report	$ 227,905

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ - 0

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

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

EXAMINER ADJUSTED SURVEY

Workpaper #:			**Reviewer:**
Examiner:			
Date:			
DSH Version	**7.25**	**5/3/18**	

D. General Cost Report Year Information -

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: **APPLING HOSPITAL**

2. Select Cost Report Year Covered by this Survey:	X		
3. Status of Cost Report Used for this Survey (Should be audited if availab	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	2/26/18		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:		Yes	
5. Medicaid Provider Number:		Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):		Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):		Yes	
8. Medicare Provider Number:		Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):		Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):		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		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (09/01/2016 - 08/31/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ - 0
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ - 0
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ - 0
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$ - 0
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ - 0
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ - 0
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$ - 0
8. **Out-of-State DSH Payments (See Note 2)**	$ - 0

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 7,083	$ 201,944	$ 209,027
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 79,899	$ 610,485	$ 690,384
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$ 86,982	$ 812,429	$ 899,411
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.14%	24.86%	23.24%

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

14.	Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ 475,089
15.	Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ 799,808
16.	Total Medicaid managed care non-claims payments (see question 13 above) received	$ 1,274,897

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 (09/01/2016 - 08/31/2017)

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)	12,063

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	- 0
3.	Outpatient Hospital Subsidies	- 0
4.	Unspecified I/P and O/P Hospital Subsidies	- 0
5.	Non-Hospital Subsidies	**- 0**
6.	Total Hospital Subsidies	$ - 0
7.	Inpatient Hospital Charity Care Charges	- 0
8.	Outpatient Hospital Charity Care Charges	- 0
9.	Non-Hospital Charity Care Charges	- 0
10.	Total Charity Care Charges	$ - 0

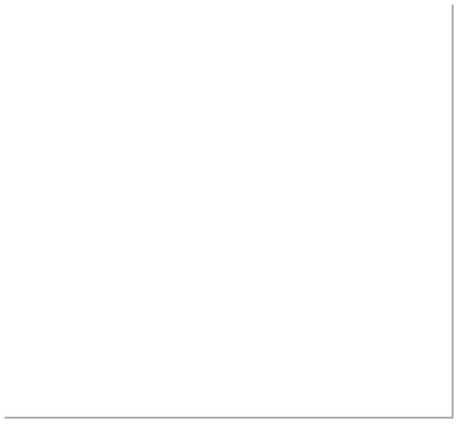
F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 2,102,152	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 2,102,152
12.	Psych Subprovider	$ 5,157,392	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 5,157,392
13.	Rehab. Subprovider	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
14.	Swing Bed - SNF			$ - 0			$ - 0	
15.	Swing Bed - NF			$ - 0			$ - 0	
16.	Skilled Nursing Facility			$ 7,570,604			$ - 0	
17.	Nursing Facility			$ - 0			$ - 0	
18.	Other Long-Term Care			$ - 0			$ - 0	
19.	Ancillary Services	$ 15,287,742	$ 23,482,972	$ - 0	$ - 0	$ - 0	$ - 0	$ 38,770,714
20.	Outpatient Services		$ 3,888,597	$ - 0		$ - 0	$ - 0	$ 3,888,597
21.	Home Health Agency			$ - 0			$ - 0	
22.	Ambulance			$ 908,197			$ - 0	
23.	Outpatient Rehab Providers	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
24.	ASC	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
25.	Hospice			$ - 0			$ - 0	
26.	Other	$ 1,695,227	$ 2,554,689	$ 4,147,259	$ - 0	$ - 0	$ - 0	$ 4,249,916
27.	Total	$ 24,242,513	$ 29,926,258	$ 12,626,060	$ - 0	$ - 0	$ - 0	$ 54,168,771
28.	Total Hospital and Non Hospital		Total from Above	$ 66,794,831		Total from Above	$ - 0	

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

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 66,794,831	Total Contractual Adj. (G-3 Line 2)		$ 36,444,953
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)				+	$ - 0
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)				+	$ - 0
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)				-	$ - 0
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)"				-	$ - 0
35.	Adjusted Contractual Adjustments					
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ - 0	Unreconciled Difference (Should be $0)		

OKLAHOMA



G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2016-08/31/2017)

Note: Values below are only used for spreading and analytical purposes.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	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	W/S S-3 DAYS (EXCLUDES OBSERVATION DAYS)	Title XIX: I/P Days and I/P Ancillary Charges	Title XIX: I/P Routine Charges and O/P Ancillary Charges	Title XVIII: I/P Days and I/P Ancillary Charges	Title XVIII: I/P Routine Charges and O/P Ancillary Charges
		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*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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*		*Days - Cost Report W/S S-3, Pt. I, Column 7*	*Inpatient Routine Charges - Cost Report W/S D-3, Col. 2 (Informational only)*	*Days - Cost Report W/S S-3, Pt. I, Column 6*	*Inpatient Routine Charges - Cost Report W/S D-3, Col. 2 (Informational only)*
	Routine Cost Centers (list below):															
1	03000 ADULTS & PEDIATRICS	$ 6,515,495	$ - 0	$ - 0	$ 79,769	$ - 0	$ 6,435,726	12,390	$ 1,263,120		$ 519.43	11,299	303	$ 612,240	982	$ 489,036
2	03100 INTENSIVE CARE UNIT	$ 856,674	$ - 0	$ - 0		$ - 0	$ 856,674	764	$ 839,032		$ 1,121.30	764	57	$ 65,241	430	$ 476,822
3	03200 CORONARY CARE UNIT	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
4	03300 BURN INTENSIVE CARE UNIT	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
5	03400 SURGICAL INTENSIVE CARE UNIT	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
6	03500 OTHER SPECIAL CARE UNIT	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
7	04000 SUBPROVIDER I	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ 5,157,392		$ -	- 0	927	$ - 0	7,816	$ 4,430,947
8	04100 SUBPROVIDER II	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
9	04200 OTHER SUBPROVIDER	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
10	04300 NURSERY	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
11	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
12	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
13	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
14	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
15	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
16	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
17	0	$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	- 0	$ - 0		$ -	- 0	- 0	$ - 0	- 0	$ - 0
18	Total Routine	$ 7,372,169	$ - 0	$ - 0	$ 79,769	$ - 0	$ 7,292,400	13,154	$ 7,259,544				1,287	$ 677,481	9,228	$ 5,396,805
19	Weighted Average										$ 554.39	12,063				

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*		*Inpatient Charges - Cost Report W/S D-3, Col. 2*	*Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4*	*Inpatient Charges - Cost Report W/S D-3, Col. 2*	*Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4*
20	09200 Observation (Non-Distinct)	1,091	- 0	- 0		$ 566,698	$ 304,733	$ 447,695	$ 752,428	0.753159	1,091	$ 7,707	$ 47,431	$ 51,455	$ 135,648

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	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	W/S S-3 DAYS (EXCLUDES OBSERVATION DAYS)	Title XIX: I/P Days and I/P Ancillary Charges	Title XIX: I/P Routine Charges and O/P Ancillary Charges	Title XVIII: I/P Days and I/P Ancillary Charges	Title XVIII: I/P Routine Charges and O/P Ancillary Charges
		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*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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*		*Inpatient Charges - Cost Report W/S D-3, Col. 2*	*Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4*	*Inpatient Charges - Cost Report W/S D-3, Col. 2*	*Outpatient Charges - Cost Report W/S D, Pt. V, Col. 2-4*
21	5000 OPERATING ROOM	$ 484,780	$ - 0	$ - 0		$ - 0	$ 484,780	$ 370,491	$ 1,916,693	$ 2,287,184	0.211955		$ 55,850	$ 88,269	$ 155,328	$ 770,709
22	5300 ANESTHESIOLOGY	$ 12,673	$ - 0	$ - 0		$ - 0	$ 12,673	$ 72,812	$ 447,109	$ 519,921	0.024375		$ 16,659	$ 32,132	$ 56,153	$ 115,660
23	5400 RADIOLOGY-DIAGNOSTIC	$ 1,158,123	$ - 0	$ - 0		$ - 0	$ 1,158,123	$ 1,182,994	$ 8,004,663	$ 9,187,657	0.126052		$ 95,883	$ 411,612	$ 908,071	$ 1,901,485
24	6000 LABORATORY	$ 1,607,839	$ - 0	$ - 0		$ - 0	$ 1,607,839	$ 3,798,807	$ 7,110,771	$ 10,909,578	0.147379		$ 456,707	$ 25,956	$ 2,754,287	$ 861,124
25	6500 RESPIRATORY THERAPY	$ 727,415	$ - 0	$ - 0		$ - 0	$ 727,415	$ 917,067	$ 829,888	$ 1,746,955	0.416390		$ 94,681	$ 62,835	$ 610,665	$ 199,037
26	6600 PHYSICAL THERAPY	$ 660,020	$ - 0	$ - 0		$ - 0	$ 660,020	$ 648,704	$ 1,254,432	$ 1,903,136	0.346807		$ 20,685	$ 2,199	$ 157,237	$ 4,109
27	7100 MEDICAL SUPPLIES CHARGED TO PATIEN	$ 727,087	$ - 0	$ - 0		$ - 0	$ 727,087	$ 561,042	$ 802,703	$ 1,363,745	0.533155		$ 53,105	$ 60,996	$ 410,525	$ 152,448
28	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 18,894	$ - 0	$ - 0		$ - 0	$ 18,894	$ 44,086	$ 63,076	$ 107,162	0.176312		$ 4,726	$ 750	$ 22,556	$ 34,135
29	7300 DRUGS CHARGED TO PATIENTS	$ 1,979,364	$ - 0	$ - 0		$ - 0	$ 1,979,364	$ 7,666,941	$ 3,053,637	$ 10,720,578	0.184632		$ 656,547	$ 171,686	$ 5,066,646	$ 1,005,453
30	7400 RENAL DIALYSIS	$ 160,956	$ - 0	$ - 0		$ - 0	$ 160,956	$ 24,798	$ - 0	$ 24,798	6.490685		$ - 0	$ - 0	$ 14,520	$ 4,228
31	9100 EMERGENCY	$ 2,414,405	$ - 0	$ 125,634		$ - 0	$ 2,540,039	$ 321,333	$ 2,814,836	$ 3,136,169	0.809918		$ 32,751	$ 202,396	$ 148,373	$ 433,718
32		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
33		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
34		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
35		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
36		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
37		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
38		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
39		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
40		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
41		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
42		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
43		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
44		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
45		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
46		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
47		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
48		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
49		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
50		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
51		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
52		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
53		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
54		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
55		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
56		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-		$ - 0	$ - 0	$ - 0	$ - 0
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58		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
59		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
60		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
61		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
62		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
63		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
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65		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
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68		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
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70		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
71		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
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74		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
75		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
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77		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
78		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
79		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
80		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
81		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
82		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
83		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
84		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
85		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
86		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
87		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
88		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
89		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
90		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
91		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
92		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
93		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
94		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
95		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
96		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
97		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
98		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
99		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
100		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
101		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
102		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
103		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
104		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
105		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
106		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
107		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
108		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
109		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
110		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
111		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
112		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
113		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
114		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
115		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
116		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
117		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
118		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
119		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
120		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
121		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
122		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
123		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
124		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
125		$ - 0	$ - 0	$ - 0		$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	-	$ - 0	$ - 0	$ - 0	$ - 0
126	**Total Ancillary**	$ 9,951,556	$ - 0	$ 125,634		$ - 0	$ 10,077,190	$ 15,913,808	$ 26,745,503	$ 42,659,311		$ 1,495,301	$ 1,106,262	$ 10,355,816	$ 5,617,754
127	**Weighted Average**										0.249509				
128	**Sub Totals**	$ 17,323,725	$ - 0	$ 125,634		$ - 0	$ 17,369,590	$ 23,173,352	$ 26,745,503	$ 49,918,855		$ 2,172,782	$ 1,106,262	$ 15,752,621	$ 5,617,754
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)						$ - 0								
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)						$ 119,468								
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)						$ - 0								
131.01	Other Cost Adjustments (support must be submitted)						$ - 0								
132	**Grand Total**						**$ 17,250,122**								
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 (09/01/2016-08/31/2017)

Line #	Code	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) – Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) – 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 (from Section G):			Days		Days		Days		Days	
1	03000	ADULTS & PEDIATRICS	$ 519.43		1,257		79		521		74	
2	03100	INTENSIVE CARE UNIT	$ 1,121.30		57		15		89		6	
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	1,314		94		610		80	
19		Total Days per PS&R or Exhibit Detail			1,314		94		610		80	
20		Unreconciled Days (Explain Variance)			- 0		- 0		- 0		- 0	
					Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21		Routine Charges			$ 690,927		$ 57,216		$ 373,298		$ 42,396	
21.01		Calculated Routine Charge Per Diem			$ 525.82		$ 608.68		$ 611.96		$ 529.95	
		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
22	09200	Observation (Non-Distinct)		0.753159	$ 7,707	$ 47,350	$ 1,911	$ 100,564	$ 10,273	$ 27,059	$ 1,320	$ 14,563
23	5000	OPERATING ROOM		0.211955	$ 57,965	$ 103,744	$ 24,557	$ 113,515	$ 34,057	$ 184,467	$ 1,984	$ 95,969
24	5300	ANESTHESIOLOGY		0.024375	$ 16,659	$ 31,557	$ 8,811	$ 34,068	$ 12,256	$ 35,631	$ 505	$ 13,569
25	5400	RADIOLOGY-DIAGNOSTIC		0.126052	$ 101,658	$ 428,656	$ 25,929	$ 806,074	$ 156,198	$ 513,826	$ 45,322	$ 224,321
26	6000	LABORATORY		0.147379	$ 463,426	$ 481,608	$ 54,688	$ 850,861	$ 381,074	$ 218,063	$ 75,387	$ 171,493
27	6500	RESPIRATORY THERAPY		0.416390	$ 94,424	$ 63,915	$ 26,069	$ 90,126	$ 117,798	$ 44,960	$ 18,851	$ 19,330
28	6600	PHYSICAL THERAPY		0.346807	$ 20,685	$ 2,199	$ - 0	$ 49,989	$ 26,209	$ 47,203	$ 4,415	$ 4,566
29	7100	MEDICAL SUPPLIES CHARGED TO PATIEN		0.533155	$ 52,259	$ 61,222	$ 22,465	$ 83,201	$ 76,252	$ 46,878	$ 8,464	$ 10,416
30	7200	IMPL. DEV. CHARGED TO PATIENTS		0.176312	$ 4,545	$ 750	$ 198	$ 1,325	$ 3,535	$ 7,785	$ 837	$ 5,309
31	7300	DRUGS CHARGED TO PATIENTS		0.184632	$ 660,586	$ 223,861	$ 74,348	$ 427,094	$ 357,422	$ 273,180	$ 71,762	$ 71,276
32	7400	RENAL DIALYSIS		6.490685	$ - 0	$ - 0	$ - 0	$ - 0	$ 1,210	$ - 0	$ - 0	$ - 0
33	9100	EMERGENCY		0.809918	$ 33,556	$ 234,794	$ 11,887	$ 609,010	$ 41,079	$ 209,255	$ 7,426	$ 61,989
34				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
35				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
36				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
37				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
38				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
39				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
40				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
41				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
42				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
43				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
44				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
45				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
46				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
47				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
48				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
49				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
50				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
51				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
52				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
53				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
54				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
55				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
56				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
57				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
58				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
59				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
60				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
61				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
62				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
63				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
64				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
65				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
66				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
67				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
68				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
69				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
70				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
71				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
72				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
73				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
74				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
75				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
76				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
77				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
78				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
79				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
80				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
81				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
82				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
83				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
84				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
85				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
86				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
87				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
88				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
89				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
90				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
91				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
92				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
93				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
94				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
95				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
96				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
97				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
98				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
99				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
100				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
101				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
102				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
103				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
104				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
105				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
106				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
107				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
108				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
109				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
110				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
111				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
112				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
113				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
114				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
115				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
116				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
117				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
118				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
119				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
120				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
121				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
122				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
123				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
124				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
125				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
126				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
127				-	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
					1,513,470	1,679,656	250,863	3,165,827	1,217,363	1,608,307	236,272	692,801
		Totals / Payments										
128		**Total Charges** *(includes organ acquisition from Section J)*			$ 2,204,397	$ 1,679,656	$ 308,079	$ 3,165,827	$ 1,590,661	$ 1,608,307	$ 278,668	$ 692,801
129		Total Charges per PS&R or Exhibit Detail			$ 2,204,397	$ 1,679,656	$ 308,079	$ 3,165,827	$ 1,590,661	$ 1,608,307	$ 278,668	$ 692,801
130		Unreconciled Charges (Explain Variance)			- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0
131.01		**Sampling Cost Adjustment (if applicable)**										
131.02		**Total Calculated Cost (includes organ acquisition from Section J)**			$ 1,040,745	$ 475,077	$ 122,263	$ 999,198	$ 668,057	$ 438,628	$ 96,720	$ 164,678

Line #	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	State/Local-Only Indigent Care Program – Inpatient	Outpatient	Inpatient	Outpatient	Uninsured – Inpatient (See Exhibit A)	Uninsured – Outpatient (See Exhibit A)	Total In-State Medicaid – Inpatient	Total In-State Medicaid – Outpatient	% Survey to Cost Report Totals
									From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Days		Days		Days		Days		Days		Days		Days		
1	-		-		-		-		-		291		1,931		19.67%
2	-		-		-		-		-		95		167		34.29%
3	-		-		-		-		-		-		-		
4	-		-		-		-		-		-		-		
5	-		-		-		-		-		-		-		
6	-		-		-		-		-		-		-		
7	-		-		-		-		-		-		-		
8	-		-		-		-		-		-		-		
9	-		-		-		-		-		-		-		
10	-		-		-		-		-		-		-		
11	-		-		-		-		-		-		-		
12	-		-		-		-		-		-		-		
13	-		-		-		-		-		-		-		
14	-		-		-		-		-		-		-		
15	-		-		-		-		-		-		-		
16	-		-		-		-		-		-		-		
17	-		-		-		-		-		-		-		
18	-		-		-		-		-		386		2,098		20.59%
19	-		-		-		-		-		386				
20	- 0		- 0		- 0		- 0		- 0		- 0				
	Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	$ - 0		$ - 0		$ - 0		$ - 0		$ - 0		$ 252,773		$ 1,163,837		19.51%
21.01	$ -		$ -		$ -		$ -		$ -		$ 654.85		$ 554.74		
	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	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 13,100	$ 93,245	$ 21,211	$ 189,536	42.14%
23	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 78,238	$ 92,051	$ 118,563	$ 497,695	34.39%
24	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 27,662	$ 29,106	$ 38,231	$ 114,825	40.36%
25	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 183,761	$ 1,187,440	$ 329,107	$ 1,972,877	39.98%
26	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 364,201	$ 977,042	$ 974,575	$ 1,722,025	37.01%
27	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 89,101	$ 86,043	$ 257,142	$ 218,331	37.24%
28	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 15,091	$ 6,845	$ 51,309	$ 103,957	9.31%
29	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 80,853	$ 95,006	$ 159,440	$ 201,717	39.38%
30	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 1,864	$ - 0	$ 9,116	$ 15,169	24.40%
31	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 357,418	$ 551,204	$ 1,164,117	$ 995,411	28.62%
32	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 3,630	$ - 0	$ 1,210	$ - 0	19.52%
33	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 41,887	$ 1,273,663	$ 93,948	$ 1,115,048	80.50%
34	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
35	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
36	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
37	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
38	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
39	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
40	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
41	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
42	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
43	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
44	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
45	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
46	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
47	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
48	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
49	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
50	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
51	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
52	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
53	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
54	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
55	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
56	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
57	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
58	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
59	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
60	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
61	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
62	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
63	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
64	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
65	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
66	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
67	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
68	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
69	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
70	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
71	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
72	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
73	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
74	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
75	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
76	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
77	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
78	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
79	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
80	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
81	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
82	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
83	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
84	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
85	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
86	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
87	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
88	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
89	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
90	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
91	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
92	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
93	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
94	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
95	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
96	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
97	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
98	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
99	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
100	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
101	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
102	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
103	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
104	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
105	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
106	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
107	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
108	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
109	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
110	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
111	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
112	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
113	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
114	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
115	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
116	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
117	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
118	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
119	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
120	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
121	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
122	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
123	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
124	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
125	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
126	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
127	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	
	-	-	-	-	-	-	-	-	-	-	1,256,806	4,391,646			
128	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,509,579 (Agrees to Exhibit A)	$ 4,391,646 (Agrees to Exhibit A)	$ 4,381,805	$ 7,146,591	34.92%
129	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 1,509,579	$ 4,391,646			
130	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			
131.01													$ - 0	$ - 0	
131.02	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 570,888	$ 1,606,310	$ 1,927,785	$ 2,077,581	35.84%

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

132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,090,713	$ 402,046	$ - 0	$ - 0	$ 205,703	$ 67,069	$ 20,010	$ 35,496	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	[redacted]	[redacted]			$ 1,316,426	$ 504,611
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ - 0	$ - 0	$ - 0	$ 725,585	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0			$ - 0	$ 725,585
134	Private Insurance (including primary and third party liability)	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ 122,581	$ 94,495	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	[redacted]	[redacted]			$ 122,581	$ 94,495
135	Self-Pay (including Co-Pay and Spend-Down)	$ 11,969	$ 1,626	$ - 0	$ 472	$ 2	$ 125	$ 3	$ 1,700	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0			$ 11,974	$ 3,923
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,102,682	$ 403,672	$ -	$ 726,057					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			[redacted]	[redacted]
137	Medicaid Cost Settlement Payments (See Note B)	$ - 0	$ 19,605	$ - 0	$ - 0							$ - 0	$ - 0						[redacted]	[redacted]			$ - 0	$ 19,605
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ - 0	$ - 0	$ - 0	$ - 0					$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	[redacted]				$ - 0	$ - 0
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 558,547	$ 294,971	$ - 0	$ 485			$ - 0	$ - 0										$ 558,547	$ 295,456
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ - 0	$ - 0	$ - 0	$ - 0			$ - 0	$ - 0										$ - 0	$ - 0
141	Medicare Cross-Over Bad Debt Payments					$ - 0	$ - 0	$ - 0	$ - 0			$ - 0	$ - 0										$ - 0	$ - 0
142	Other Medicare Cross-Over Payments (See Note D)					$ - 0	$ - 0	$ - 0	$ - 0			$ - 0	$ - 0										$ - 0	$ - 0
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																				(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)		
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)																				$ 7,083	$ 201,944		
																					$ -	$ -		
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ (61,937)	$ 51,800	$ 122,263	$ 273,141	$ (96,195)	$ 76,463	$ (45,874)	$ 32,502	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 563,805	$ 1,404,366	$ (81,743)	$ 433,906
146	**Calculated Payments as a Percentage of Cost**	106%	89%	0%	73%	114%	83%	147%	80%	0%	0%	0%	0%	0%	0%	**0%**	0%	0%	0%	0%	1%	13%	104%	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)**					9,695																		
148	**Percent of cross-over days to total Medicare days from the cost report**					6%																		

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.

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

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2016-08/31/2017)

0

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)		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	$ 519.43		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ 1,121.30		-		-		-		-		-	
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)			**- 0**		**- 0**		**- 0**		**- 0**			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ - 0		$ - 0		$ - 0		$ - 0		$ - 0	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	

Line #	Ancillary Cost Centers (from W/S C) (list below):	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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)	0.753159	-	-	-	-	-	-	-	-	$ - 0	$ - 0
23	5000 OPERATING ROOM	0.211955	-	-	-	-	-	-	-	-	$ - 0	$ - 0
24	5300 ANESTHESIOLOGY	0.024375	-	-	-	-	-	-	-	-	$ - 0	$ - 0
25	5400 RADIOLOGY-DIAGNOSTIC	0.126052	-	-	-	-	-	-	-	-	$ - 0	$ - 0
26	6000 LABORATORY	0.147379	-	-	-	-	-	-	-	-	$ - 0	$ - 0
27	6500 RESPIRATORY THERAPY	0.416390	-	-	-	-	-	-	-	-	$ - 0	$ - 0
28	6600 PHYSICAL THERAPY	0.346807	-	-	-	-	-	-	-	-	$ - 0	$ - 0
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.533155	-	-	-	-	-	-	-	-	$ - 0	$ - 0
30	7200 IMPL. DEV. CHARGED TO PATIENTS	0.176312	-	-	-	-	-	-	-	-	$ - 0	$ - 0
31	7300 DRUGS CHARGED TO PATIENTS	0.184632	-	-	-	-	-	-	-	-	$ - 0	$ - 0
32	7400 RENAL DIALYSIS	6.490685	-	-	-	-	-	-	-	-	$ - 0	$ - 0
33	9100 EMERGENCY	0.809918	-	-	-	-	-	-	-	-	$ - 0	$ - 0
34		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
35		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
36		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
37		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
38		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
39		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
40		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
41		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
42		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
43		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
44		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
45		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
46		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
47		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
48		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
49		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
50		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
51		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
52		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
53		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
54		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
55		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
56		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
57		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
58		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0
59		-	-	-	-	-	-	-	-	-	$ - 0	$ - 0

60			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
61			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
62			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
63			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
64			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
65			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
66			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
67			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
68			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
69			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
70			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
71			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
72			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
73			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
74			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
75			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
76			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
77			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
78			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
79			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
80			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
81			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
82			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
83			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
84			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
85			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
86			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
87			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
88			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
89			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
90			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
91			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
92			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
93			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
94			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
95			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
96			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
97			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
98			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
99			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
100			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
101			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
102			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
103			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
104			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
105			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
106			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
107			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
108			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
109			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
110			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
111			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
112			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
113			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
114			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
115			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
116			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
117			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
118			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
119			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
120			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
121			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
122			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
123			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
124			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
125			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
126			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
127			-	-	-	-	-	-	-	-	-	$ -	0	$ -	0
				-	-	-	-	-	-	-	-				

Totals / Payments

128	**Total Charges** ***(includes organ acquisition from Section K)***	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0	$ -	0
129	Total Charges per PS&R or Exhibit Detail	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0				
130	Unreconciled Charges (Explain Variance)	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0				
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)	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ -	0	$ -	0

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133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
134	Private Insurance (including primary and third party liability)	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
135	Self-Pay (including Co-Pay and Spend-Down)	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)	$ - 0	$ - 0							$ - 0	$ - 0
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ - 0	$ - 0	$ - 0	$ - 0					$ - 0	$ - 0
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
141	Medicare Cross-Over Bad Debt Payments					$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
142	Other Medicare Cross-Over Payments (See Note D)					$ - 0	$ - 0	$ - 0	$ - 0	$ - 0	$ - 0
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
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&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.

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Disproportionate Share Hospital (DSH) Examination Survey Part II

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

Cost Report Year (09/01/2016-08/31/2017)

		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)						State/Local-Only Indigent Care Program						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)	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 Acquistion 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 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	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
2	Kidney Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
3	Liver Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
4	Heart Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
5	Pancreas Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
6	Intestinal Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
7	Islet Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
8		$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0
9	**Totals**	$ - 0	$ - 0	$ - 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0
10	**Total 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, 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 (09/01/2016-08/31/2017)

		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)		Total
							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 Acquistion 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	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
12	Kidney Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
13	Liver Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
14	Heart Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
15	Pancreas Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
16	Intestinal Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
17	Islet Acquisition	$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
18		$ - 0	$ - 0	$ - 0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	$ - 0	0	0
19	**Totals**	$ - 0	$ - 0	$ - 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	$ - 0	- 0	
20	**Total Cost**							**- 0**		**- 0**		**- 0**		**- 0**	

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 (09/01/2016-08/31/2017)

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 227,905		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	8210.79	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 227,905	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ - 0		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ - 0	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ - 0	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ - 0	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ - 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	$ - 0	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ - 0	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ - 0	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ - 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	$ - 0	-	
13	*Reason for adjustment*	0	$ - 0	-	
14	*Reason for adjustment*	0	$ - 0	-	
15	*Reason for adjustment*	0	$ - 0	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 227,905		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ - 0

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

DSH Examination Eligibility Summary

Hospital Name
Hospital Medicaid Number
Cost Report Period From To

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 2,580,294	$ - 0	$ 2,580,294
2	Hospital Cash Subsidies	Survey F-2	$ - 0	$ - 0	$ - 0
3	Total		$ 2,580,294	$ - 0	$ 2,580,294
4	Net Hospital Patient Revenue	Survey F-3			$ 54,168,771
5	Medicaid Fraction				4.76%
6	Inpatient Charity Care Charges	Survey F-2	$ - 0	$ - 0	$ - 0
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ - 0	$ - 0	$ - 0
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ - 0	$ - 0	$ - 0
9	Adjusted Inpatient Charity Care		$ - 0	$ - 0	$ - 0
10	Inpatient Hospital Charges	Survey F-3	$ 24,242,513	$ - 0	$ 24,242,513
11	Inpatient Charity Fraction		0.00%	0.00%	0.00%
12	LIUR				4.76%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	2,098	- 0	2,098
14	Out-of-State Medicaid Eligible Days	Survey I	- 0	- 0	- 0
15	Total Medicaid Eligible Days		2,098	- 0	2,098
16	Total Hospital Days (excludes swing-bed)	Survey F-1	12,063	- 0	12,063
17	MIUR		17.39%	0.00%	17.39%

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.

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name
Hospital Medicaid Number
Cost Report Period — From ____ To ____

As-Reported:

Service Type		Total Costs (Survey H & I)	Medicaid Basic Rate Payments (Survey H & I)	Medicaid Managed Care Payments (Survey H & I)	Private Insurance Payments (Survey H & I)	Self-Pay Payments (Includes Co-Pay and Spenddown) (Survey H & I)	Medicaid Cost Settlement Payments (Survey H & I)	Other Medicaid Payments (Outliers, etc..) ** (Survey H & I)	Medicare Traditional (non-HMO) Payments (Survey H & I)	Medicare Managed Care (HMO) Payments (Survey H & I)	Medicare Cross-over Bad Debt (Survey H & I)	Other Medicare Cross-over Payments (GME, etc..) (Survey H & I)	Uninsured Payments (Survey H & I)	Uninsured Payments Not On Exhibit B (1011 Payments) (Survey E)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	1,040,745	1,090,713	- 0	- 0	11,969	- 0	- 0	- 0	- 0	- 0	- 0			1,102,682	(61,937)	105.95%
2 Medicaid Fee for Service	Outpatient	475,077	402,046	- 0	- 0	1,626	19,605	- 0	- 0	- 0	- 0	- 0			423,277	51,800	89.10%
3 Medicaid Managed Care	Inpatient	122,263	- 0	- 0	- 0	- 0	- 0	- 0							- 0	122,263	0.00%
4 Medicaid Managed Care	Outpatient	999,198	- 0	725,585	- 0	472	- 0	- 0							726,057	273,141	72.66%
5 Medicare Cross-over (FFS)	Inpatient	668,057	205,703	- 0	- 0	2		- 0	558,547	- 0	- 0	- 0			764,252	(96,195)	114.40%
6 Medicare Cross-over (FFS)	Outpatient	438,628	67,069	- 0	- 0	125		- 0	294,971	- 0	- 0	- 0			362,165	76,463	82.57%
7 Other Medicaid Eligibles	Inpatient	96,720	20,010	- 0	122,581	3			- 0	- 0	- 0	- 0			142,594	(45,874)	147.43%
8 Other Medicaid Eligibles	Outpatient	164,678	35,496	- 0	94,495	1,700			485	- 0	- 0	- 0			132,176	32,502	80.26%
9 Uninsured	Inpatient	570,888	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	7,083	- 0	7,083	563,805	1.24%
10 Uninsured	Outpatient	1,606,310	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	201,944	- 0	201,944	1,404,366	12.57%
11 In-State Sub-total	Inpatient	2,498,673	1,316,426	- 0	122,581	11,974	- 0	- 0	558,547	- 0	- 0	- 0	7,083	- 0	2,016,611	482,062	80.71%
12 In-State Sub-total	Outpatient	3,683,891	504,611	725,585	94,495	3,923	19,605	- 0	295,456	- 0	- 0	- 0	201,944	- 0	1,845,619	1,838,272	50.10%
13 Out-of-State Medicaid	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	n/a
14 Out-of-State Medicaid	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	n/a
15 Sub-Total	I/P and O/P	6,182,564	1,821,037	725,585	217,076	15,897	19,605	- 0	854,003	- 0	- 0	- 0	209,027	- 0	3,862,230	2,320,334	62.47%

Adjustments:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
2 Medicaid Fee for Service	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
3 Medicaid Managed Care	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0							- 0	- 0	0.00%
4 Medicaid Managed Care	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0							- 0	- 0	0.00%
5 Medicare Cross-over (FFS)	Inpatient	- 0	- 0	- 0	- 0	- 0		- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
6 Medicare Cross-over (FFS)	Outpatient	- 0	- 0	- 0	- 0	- 0		- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
7 Other Medicaid Eligibles	Inpatient	- 0	- 0	- 0	- 0	- 0			- 0	- 0	- 0	- 0			- 0	- 0	0.00%
8 Other Medicaid Eligibles	Outpatient	- 0	- 0	- 0	- 0	- 0			- 0	- 0	- 0	- 0			- 0	- 0	0.00%
9 Uninsured	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	0.00%
10 Uninsured	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	0.00%
11 In-State Sub-total	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	0.00%
12 In-State Sub-total	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	0.00%
13 Out-of-State Medicaid	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
14 Out-of-State Medicaid	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	0.00%
15 Sub-Total	I/P and O/P	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	0.00%

As-Adjusted:

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

	Service Type		Total Costs Survey H & I	Medicaid Basic Rate Payments Survey H & I	Medicaid Managed Care Payments Survey H & I	Private Insurance Payments Survey H & I	Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	Medicaid Cost Settlement Payments Survey H & I	Other Medicaid Payments (Outliers, etc..) ** Survey H & I	Medicare Traditional (non-HMO) Payments Survey H & I	Medicare Managed Care (HMO) Payments Survey H & I	Medicare Cross-over Bad Debt Survey H & I	Other Medicare Cross-over Payments (GME, etc..) Survey H & I	Uninsured Payments Survey H & I	Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1	Medicaid Fee for Service	Inpatient	1,040,745	1,090,713	- 0	- 0	11,969	- 0	- 0	- 0	- 0	- 0	- 0			1,102,682	(61,937)	105.95%
2	Medicaid Fee for Service	Outpatient	475,077	402,046	- 0	- 0	1,626	19,605	- 0	- 0	- 0	- 0	- 0			423,277	51,800	89.10%
3	Medicaid Managed Care	Inpatient	122,263	- 0	- 0	- 0	- 0	- 0	- 0							- 0	122,263	0.00%
4	Medicaid Managed Care	Outpatient	999,198	- 0	725,585	- 0	472	- 0	- 0							726,057	273,141	72.66%
5	Medicare Cross-over (FFS)	Inpatient	668,057	205,703	- 0	- 0	2		- 0	558,547	- 0	- 0	- 0			764,252	(96,195)	114.40%
6	Medicare Cross-over (FFS)	Outpatient	438,628	67,069	- 0	- 0	125		- 0	294,971	- 0	- 0	- 0			362,165	76,463	82.57%
7	Other Medicaid Eligibles	Inpatient	96,720	20,010	- 0	122,581	3			- 0	- 0	- 0	- 0			142,594	(45,874)	147.43%
8	Other Medicaid Eligibles	Outpatient	164,678	35,496	- 0	94,495	1,700			485	- 0	- 0	- 0			132,176	32,502	80.26%
9	Uninsured	Inpatient	570,888	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	7,083	- 0	7,083	563,805	1.24%
10	Uninsured	Outpatient	1,606,310	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	201,944	- 0	201,944	1,404,366	12.57%
11	In-State Sub-total	Inpatient	2,498,673	1,316,426	- 0	122,581	11,974	- 0	- 0	558,547	- 0	- 0	- 0	7,083	- 0	2,016,611	482,062	80.71%
12	In-State Sub-total	Outpatient	3,683,891	504,611	725,585	94,495	3,923	19,605	- 0	295,456	- 0	- 0	- 0	201,944	- 0	1,845,619	1,838,272	50.10%
13	Out-of-State Medicaid	Inpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	n/a
14	Out-of-State Medicaid	Outpatient	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0	- 0			- 0	- 0	n/a
15	Cost Report Year Sub-Total	I/P and O/P	6,182,564	1,821,037	725,585	217,076	15,897	19,605	- 0	854,003	- 0	- 0	- 0	209,027	- 0	3,862,230	2,320,334	62.47%
16																		
17																		

Less: Out of State DSH Payments from Adjusted Survey	- 0
Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	2,320,334

Medicaid DSH Survey Adjustments

PROVIDER: Mcaid Number:

FROM: TO: Mcare Number:

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: Mcaid Numb
FROM: TO: Mcare Numb

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
1		
2		
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Standard Notes

No 1011 undocumented alien payment verification.
Uninsured payment data reported on an accrual basis.
Uninsured payment scope limitation (not a full year of cash based payments).
Uninsured payment scope limitation (estimated payments).
Uninsured Charge scope limitation (not a full year, estimated, or understated UCC for some reason).
Uninsured Charge scope limitation (no patient level detail, uninsured data removed).
No signed attestation statement.
Provider did not submit a survey.
Scope Limitation - provider filed too late for field work or expanded testing.
Hospital closed.
Provider may not have included all Medicaid eligible claims.
OB requirement not met.

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

DSH Cost & Payment Summary — Georgia

Hospital Name
Hospital Medicaid Number
Cost Report Period — From ____ To ____

A	B	C	D	E	F	G	H	I	J	K	L	M	N	K
Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Total Medicaid IP/OP Payments (A+B) [1]	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Net Cost (D-C)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Cost (H-G-F)	Total Cost Report Period UCC* (E+I)	Total Cumulative Trend (See Table Below)	Trended Total Estimated Net Cost (J*K)	Trended Estimated Medicaid Net Cost (E*K)	Trended Estimated Uninsured Uncompensated Care Cost (UCC) (I*K)	Out of State (OOS) DSH Payment
$ 2,927,146	$ 726,057	$ 3,653,203	$ 4,005,366	$ 352,163	$ 209,027	$ - 0	$ 2,177,198	$ 1,968,171	$ 2,320,334	0.00%	$ - 0	$ - 0	$ - 0	$ - 0

* Note 1: Total Medicaid payments do not include other Medicaid payments paid during the state DSH year (i.e., supplemental payments, GME, UPL, etc.) which must be included in the final uncompensated care cost calculation in determining the DSH UCC.

Total Cumulative Trend

Based on Facility Fiscal Year End (FYE) and Adjusted to a Common Fiscal Year End of June 30

Hospital FYE	SFY 2016 Trend 1.50%	SFY 2017 Trend 1.50%	SFY 2018 Trend 1.50%	SFY 2019 Trend 1.50%	Total Cumulative Trend
Required State DSH Survey Trends					
6/30/15	**1.50%**	**1.50%**	**1.50%**	**1.50%**	**106.14%**
7/31/15	1.38%	1.50%	1.50%	1.50%	**106.01%**
8/31/15	1.25%	1.50%	1.50%	1.50%	**105.87%**
9/30/15	1.13%	1.50%	1.50%	1.50%	**105.75%**
10/31/15	1.00%	1.50%	1.50%	1.50%	**105.61%**
11/30/15	0.88%	1.50%	1.50%	1.50%	**105.49%**
12/31/15	0.75%	1.50%	1.50%	1.50%	**105.35%**
1/31/15	0.63%	1.50%	1.50%	1.50%	**105.23%**
2/28/15	0.50%	1.50%	1.50%	1.50%	**105.09%**
3/31/15	0.38%	1.50%	1.50%	1.50%	**104.97%**
4/30/15	0.25%	1.50%	1.50%	1.50%	**104.83%**
5/31/15	0.13%	1.50%	1.50%	1.50%	**104.70%**
Alternate State DSH Survey Trends					
6/30/16		**1.50%**	**1.50%**	**1.50%**	**104.57%**
7/31/16		1.38%	1.50%	1.50%	**104.44%**
8/31/16		1.25%	1.50%	1.50%	**104.31%**
9/30/16		1.13%	1.50%	1.50%	**104.19%**
10/31/16		1.00%	1.50%	1.50%	**104.05%**
11/30/16		0.88%	1.50%	1.50%	**103.93%**
12/31/16		0.75%	1.50%	1.50%	**103.80%**
1/31/16		0.63%	1.50%	1.50%	**103.67%**
2/28/16		0.50%	1.50%	1.50%	**103.54%**
3/31/16		0.38%	1.50%	1.50%	**103.41%**
4/30/16		0.25%	1.50%	1.50%	**103.28%**
5/31/16		0.13%	1.50%	1.50%	**103.16%**
6/30/17			**1.50%**	**1.50%**	**103.02%**
7/31/17			1.38%	1.50%	**102.90%**
8/31/17			1.25%	1.50%	**102.77%**
9/30/17			1.13%	1.50%	**102.65%**
10/31/17			1.00%	1.50%	**102.52%**
11/30/17			0.88%	1.50%	**102.39%**
12/31/17			0.75%	1.50%	**102.26%**

1/31/17	0.63%	1.50%	**102.14%**
2/28/17	0.50%	1.50%	**102.01%**
3/31/17	0.38%	1.50%	**101.89%**
4/30/17	0.25%	1.50%	**101.75%**
5/31/17	0.13%	1.50%	**101.63%**
6/30/18		**1.50%**	**101.50%**
7/31/18		1.38%	**101.38%**
8/31/18		1.25%	**101.25%**
9/30/18		1.13%	**101.13%**
10/31/18		1.00%	**101.00%**
11/30/18		0.88%	**100.88%**
12/31/18		0.75%	**100.75%**

Note:

If the FYE is prior to the 15th of the month, the prior month's trend will be used (i.e., if FYE is 8/14/15, or before, the 7/31/15 trend of 106.01% will be applied)

If the FYE is after the 15th of the month, that month's trend will be used (i.e., if FYE is 8/15/15, or after, the 8/31/15 trend of 105.87% will be applied).