#### State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2025

2/10/2023 DSH Version 6.02 A. General DSH Year Information 1. DSH Year: 07/01/2024 06/30/2025 2. Select Your Facility from the Drop-Down Menu Provided: MITCHELL COUNTY HOSPITAL Identification of cost reports needed to cover the DSH Year: Cost Report Cost Report Begin Date(s) End Date(s) 3. Cost Report Year 1 09/30/2023 10/01/2022 Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES 4. Cost Report Year 2 (if applicable) 5. Cost Report Year 3 (if applicable) Data 6. Medicaid Provider Number: 000001339A 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0 9. Medicare Provider Number: 111331 B. DSH Qualifying Information Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act. DSH Examination Year (07/01/24 -**During the DSH Examination Year:** 06/30/25) 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to Yes provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's No inpatients are predominantly under 18 years of age? 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-No emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987? 3a. Was the hospital open as of December 22, 1987? Yes

3b. What date did the hospital open?

9/11/1949

# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2025

Disclosure of Other Medicaid Payments Received:		
Medicaid Supplemental Payments for Hospital Services DSH Year     (Should include UPL and non-claim specific payments paid based on	ar 07/01/2024 - 06/30/2025 the state fiscal year. However, DSH payments should NOT be included	\$ 299,401
2. Medicaid Managed Care Supplemental Payments for hospital se	rvices for DSH Year 07/01/2024 - 06/30/2025	\$ -
(Should include all non-claim specific payments for hospital services payments, capitation payments received by the hospital (not by the N	such as lump sum payments for full Medicaid pricing (FMP), supplemer ICO), or other incentive payments.	tals, quality payments, bonus
NOTE: Hospital portion of supplemental payments reported on DSH	Survey Part II, Section E, Question 14 should be reported here if paid o	n a SFY basis.
3. Total Medicaid and Medicaid Managed Care Non-Claims Paymer	nts for Hospital Services07/01/2024 - 06/30/2025	\$ 299,401
rtification:		
Was your hospital allowed to retain 100% of the DSH payment it Matching the federal share with an IGT/CPE is not a basis for an hospital was not allowed to retain 100% of its DSH payments, pl present that prevented the hospital from retaining its payments.  Explanation for "No" answers:	swering this question <sup>"</sup> no". If your ease explain what circumstances were	Answer Yes
The following certification is to be completed by the hospital's C	EEO or CFO:	
records of the hospital. All Medicaid eligible patients, including those payment on the claim. I understand that this information will be used	, I, J, K and L of the DSH Survey files are true and accurate to the best who have private insurance coverage, have been reported on the DSH to determine the Medicaid program's compliance with federal Dispropor vey. These records will be retained for a period of not less than 5 years	survey regardless of whether the hospital received tionate Share Hospital (DSH) eligibility and payments
H * 1050 . 050 0	Senior Vice President/Chief Financial Office	ter 11/21/2024 Date
Hospital CEO or CFO Signature	Title	Date
Greg Hembree Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Contact Information for individuals authorized to respond to inq	uiries related to this survey:	
Hospital Contact:		Outside Preparer:
Name	Patricia L. Barrett	Name
	Director of Reimbursement	Title
Telephone Number		Firm Name
E-Mail Address		Telephone Number
Mailing Street Address		E-Mail Address
Mailing City State 7in	Thomasville GA 31792-4255	

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

DSH Version 9.00

9/11/2024

). General Cost Report Year Information	10/1/2022 - 9/30/2023		
he following information is provided based on the information we received fron f the information. If you disagree with one of these items, please provide the c			
The information. If you disagree with one of these items, please provide the c	briect information along with supporting documentation	on when you submit your sur-	76y.
Select Your Facility from the Drop-Down Menu Provided:	MITCHELL COUNTY HOSPITAL		
	10/1/2022		
	through		
	9/30/2023		
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:	2/27/2024		
·			
	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	MITCHELL COUNTY HOSPITAL	Yes	
5. Medicaid Provider Number:	000001339A	Yes	
Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
Medicaid Subprovider Number 1 (1 sychiatric or Rehab):     Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	111331	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
	2000 0010		1-1
Out-of-State Medicaid Provider Number. List all states where you ha	ad a Medicaid provider agreement during the cost	report year:	
Cat of State Medicald Florider Humber. List an states where you in	State Name	Provider No.	
9. State Name & Number	FL	020989100	
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)			
,			
. Disclosure of Medicaid / Uninsured Payments Received: (1	0/01/2022 - 09/30/2023)		
. Disclosure of medicala / Offinsured Fayments Received. (1	70 172022 - 03/00/2023)		
1. Section 1011 Payment Related to Hospital Services Included in Exhibits			\$ -
<ol> <li>Section 1011 Payment Related to Inpatient Hospital Services NOT Included.</li> <li>Section 1011 Payment Related to Outpatient Hospital Services NOT Included.</li> </ol>			\$ -
4. Total Section 1011 Payments Related to Hospital Services (See Not	te 1)		\$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exh			-
<ol> <li>Section 1011 Payment Related to Non-Hospital Services NOT Included in</li> <li>Total Section 1011 Payments Related to Non-Hospital Services (See</li> </ol>			<u> </u>
	,		•
8. Out-of-State DSH Payments (See Note 2)			\$ -
			Inpatient Outpatient Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			\$ - \$ 43,364 \$43,364
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B	•		\$ 9,909 \ \$ 425,123 \ \$435,032
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column		nts)	\$9,909 \$468,487 \$478,396
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash	Basis Patient Payments:		0.00% 9.26% 9.06%
<ol> <li>Did your hospital receive any Medicaid managed care payments not Should include all non-claim-specific payments such as lump sum payments for fu</li> </ol>		navments canitation navments	No
Should include all non-claim-specific payments such as lump sum payments for it	iii wedicala pricing, supplementals, quality payments, bonus	раутына, сарпаноп раутеть	received by the <u>mosphal</u> (flot by the MCO), of other incentive payments.
14. Total Medicaid managed care non-claims payments (see question 13 about			\$ -
15. Total Medicaid managed care non-claims payments (see question 13 about	ove) received applicable to non-hospital services		\$ -
16. Total Medicaid managed care non-claims payments (see question 13 about	ove) received		<b>\$-</b>

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.

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

\$3,092,125.00 \$0.00 \$12,923,826.00 \$0.00 \$0.00

\$0.00

\$0.00

\$0.00

\$7,058,898.00

23,074,849

75,541,723

75,541,723

250,000

250,000

889,151

8.811.895

9.701.046

4,707,578

\$

Total from Above

21,628,389

#### F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 09/30/2023)

#### F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 231 (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
- 3. Outpatient Hospital Subsidies
- 4. Unspecified I/P and O/P Hospital Subsidies
- 5. Non-Hospital Subsidies
- 6. Total Hospital Subsidies
- 7. Inpatient Hospital Charity Care Charges
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

#### 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

arready 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 (Charg	es)
Inpatient Hospital	Outpatient Hospital	Non-Hospital
\$238,503.00	Outpatient Hospital	Non-Hospital

\$30,596,064.00

\$12,492,308,00

\$0.00

\$0.00

\$

43,088,372

Total from Above

			KIIOWII)			
Inpatient Hos	spital	Outpat	tient Hospital	Non-Hospital	Net Ho	ospital Revenue
\$ 1	19,718	\$	-	\$ -	\$	118,785
\$	-	\$	-	\$ -	\$	-
\$	-	\$	-	\$ -	\$	-
				\$ 1,552,105		
				\$ -		
				\$ 6,487,169		
				\$ -		
				\$ -		
\$ 4,5	87,861	\$	15,357,822	\$ -	\$	19,790,380
		\$	6,270,566	\$ -	\$	6,221,742

Contractual Adjustments (formulas below can be overwritten if amounts are

15. Swing Bed - NF
16. Skilled Nursing Facility
17. Nursing Facility
18. Other Long-Term Care
19. Ancillary Services
20. Outpatient Services
21. Home Health Agency
22. Ambulance

12. Subprovider I (Psych or Rehab)

13. Subprovider II (Psych or Rehab)

23. Outpatient Rehab Providers

24. ASC

25. Hospice 26. Other

11. Hospital

14. Swing Bed - SNF

27. Tot	tal		
28. Tot	tal Hospital and	Non	Hospital

	Total Patient Revenues (G-3 Lin	ie 1)
		/

\$

\$0.00

\$0.00

\$0.00

\$0.00

9,378,502

\$9,139,999,00

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3,	Line 2 (impact is a decrease in net patient
	revenue)	

- 31. Increase worksheet G-3. Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3. Line 2 (impact is a decrease in net patient revenue)
- 32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)
- 35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"
- 36. Adjusted Contractual Adjustments
- 37. Unreconciled Difference

Unreconciled Difference (Should be \$0)	\$ -

Total Contractual Adj. (G-3 Line 2)	Į	37,918,484
	+	
	+	
	Ť	
	+	
	+	
	-	
	_	
Unreconciled Difference (Should be \$0)	-	37,918,484 \$ -

\$

3,543,243

11,582,517

37.918.484

\$

26.130.907

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

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

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		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
hospit com hospit data she	tal. If da pleted i al has a ould be	lata in this section must be verified by the ata is already present in this section, it was using CMS HCRIS cost report data. If the a more recent version of the cost report, the updated to the hospital's version of the cost las can be overwritten as needed with actual data.	Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)		Calculated Per Diem
	Routin	ne Cost Centers (list below):									
1	03000	ADULTS & PEDIATRICS	\$ 3,788,758	\$ -	\$ -	\$3,216,824.00	\$ 571,934	559	\$3,313,068.00		\$ 1,023.14
2		INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
3		CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
4		BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
5 6		SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE UNIT	\$ - \$ -	\$ - \$ -	\$ - \$ -		\$ - \$ -	-	\$0.00 \$0.00		\$ - \$ -
о 7		SUBPROVIDER I	\$ - \$ -	•	\$ - \$ -		\$ -	-	\$0.00		\$ - \$ -
8		SUBPROVIDER I	\$ -		\$ -		\$ -	-	\$0.00		\$ -
9		OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -		\$0.00		\$ -
10		NURSERY	\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
11	- 1000		\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00		\$ -
16			\$ -	•	\$ -		\$ -	-	\$0.00		\$ -
17			\$ -	·	\$ -		\$ -	-	\$0.00		\$ -
18		Total Routine	\$ 3,788,758	\$ -	\$ -	\$ 3,216,824	\$ 571,934	559	\$ 3,313,068		
19		Weighted Average									\$ 1,023.14
	Observ	vation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20		Observation (Non-Distinct)		328			\$ 335,590	\$0.00	\$445,367.00	\$ 445,367	0.753513
	00200	observation (From Blottinety		020			Ψ 000,000	\$0.00	<b>\$110,001100</b>	Ψ 110,007	0.7000.0
			Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
		ary Cost Centers (from W/S C excluding Obser									
21		RADIOLOGY-DIAGNOSTIC	\$836,577.00		\$ -		\$ 836,577	\$125,092.00	\$3,149,783.00		0.255453
22		CT SCAN	\$228,154.00		\$ -		\$ 228,154	\$409,367.00	\$8,673,889.00	\$ 9,083,256	0.025118
23	5800		\$88,748.00	\$ -	\$ -		\$ 88,748	\$49,414.00	\$1,032,556.00	\$ 1,081,970	0.082024
24 25		LABORATORY RESPIRATORY THERAPY	\$2,133,735.00	\$ -	\$ -		\$ 2,133,735 \$ 1,003,856	\$1,463,243.00	\$10,546,414.00 \$209,244.00	\$ 12,009,657 \$ 648,262	0.177668 1.548534
25 26		PHYSICAL THERAPY	\$1,003,856.00 \$841,306.00	φ -	\$ - \$ -		\$ 1,003,856	\$439,018.00 \$1,839,600.00	\$209,244.00 \$788,959.00	\$ 648,262 \$ 2,628,559	0.320064
26 27		PHYSICAL THERAPY PHYSICAL THERAPY - SNF	\$389,769.00	\$ -	\$ -		\$ 389,769	\$369,617.00	\$768,959.00	\$ 2,028,559	1.054521
28		OCCUPATIONAL THERAPY	\$575,484.00		\$ -		\$ 575,484	\$1,731,005.00	\$197,933.00	\$ 1,928,938	0.298342
29		OCCUPATIONAL THERAPY - SNF	\$173,245.00				\$ 173,245	\$144,765.00	\$0.00	\$ 1,920,930	1.196733
-			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 -				,,	+1.00	, . 00	

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

Line		Total Allowable	Intern & Resident Costs Removed	Add-Back (If		I/P Days and I/P	I/P Routine Charges and O/P		Medicaid Per Diem /
#	Cost Center Description	Cost	on Cost Report *	Applicable	Total Cost		Ancillary Charges	Total Charges	Cost or Other Ratios
	SPEECH PATHOLOGY	\$239,989.00		\$ -	\$ 239,989	\$62,376.00		\$ 299,117	0.802325
	SPEECH PATHOLOGY - SNF	\$75,079.00		\$ -	\$ 75,079	\$143,847.00		\$ 143,847	0.521937
	ELECTROCARDIOLOGY	\$116,473.00		\$ -	\$ 116,473	\$99,371.00		\$ 1,179,615	0.098738
	MEDICAL SUPPLIES CHARGED TO PATIENT	\$191,774.00		\$ - \$ -	\$ 191,774	\$326,830.00		\$ 705,134 \$ 3,944,995	0.271968
	DRUGS CHARGED TO PATIENTS EMERGENCY	\$934,854.00 \$2,698,884.00		\$ - \$ -	\$ 934,854 2,698,884	\$2,086,301.00 \$314,635.00		\$ 3,944,995 \$ 12,354,895	0.236972 0.218447
91001	IMERGENCT	\$2,098,084.00		\$ -	\$ 2,090,004	\$314,635.00	\$12,040,260.00		U.210447 -
		\$0.00		\$ -	\$ 	\$0.00		\$ -	-
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		\$0.00		\$ -	\$ -	\$0.00		\$ -	-
		\$0.00		\$ -	\$ -	\$0.00		\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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		\$0.00		\$ -	\$ -	\$0.00		\$ -	-
		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

# ${\bf State\ of\ Georgia}$ Disproportionate Share Hospital (DSH) Examination Survey Part II

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

	Line		Total Allowable	Intern & Resident Costs Removed	RCE and Therapy Add-Back (If			I/P Days and I/P	I/P Routine Charges and O/P		Medicaid Per Diem /
	#	Cost Center Description	Cost	on Cost Report *	Applicable		Total Cost	•	Ancillary Charges	Total Charges	Cost or Other Ratios
90		·	\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$ -	-
91			\$0.00		\$ -	\$	-	\$0.00		\$ -	-
92			\$0.00	\$ -	\$ -	\$	-	\$0.00		\$ -	-
93			\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$ -	-
94			\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$ -	-
95			\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$ -	-
96			\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$ -	-
97			\$0.00		\$ -	\$	-	\$0.00		\$ -	-
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126		Total Ancillary	\$ 10,527,927		\$ -	\$	10,527,927			•	!
127		Weighted Average	Ψ 10,021,021	Ψ	•	Ψ	10,021,021	φ 0,004,401	Ψ 40,000,000	Ψ 00,242,000	0.216220
127		Weighted Average									0.210220
128		Sub Totals	\$ 14,316,685		\$ -	\$	11,099,861	\$ 12,917,549	\$ 40,638,388	\$ 53,555,937	
129		NF, SNF, and Swing Bed Cost for Medicaid (S		Report Worksheet D-3	, Title 19, Column 3,	Line 200 and	\$0.00				
		Worksheet D, Part V, Title 19, Column 5-7, Lin									
130		NF, SNF, and Swing Bed Cost for Medicare (S		Report Worksheet D-3	3, Title 18, Column 3,	Line 200 and	\$729,206.00				
		Worksheet D, Part V, Title 18, Column 5-7, Lin	e 200)								
131		NF, SNF, and Swing Bed Cost for Other Payer	s (Hospital must calcula	ate. Submit support fo	r calculation of cost.)	)					
131.01		Other Cost Adjustments (support must be subr		• •	,						
132		Grand Total	/			\$	10,370,655				
			an Allawahla Caat			Φ					
133		Total Intern/Resident Cost as a Percent of Other	er Allowable Cost				0.00%				

<sup>\*</sup> 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:

Diem Cost for Charge Ratio for Routine Cost Ancillary Cost (Inpatient Outpatient (Included Cost Ancillary Cost (Inpatient Outpatient Outpatient (Included Cost Outpatient Outpatient Outpatient Outpatient (Included Cost Outpatient Ou		Medicaid Per	Medicaid Cost to	In-State Medic	aid FFS Primary	In-State Medicaid I	Managed Care Primary		FS Cross-Overs (with Secondary)	Included Elsewh Secondary - Exclud	edicaid Eligibles (Not ere & with Medicaid le Medicaid Exhausted n-Covered)		O Exhausted and Non- Included Elsewhere)	Unir	sured	Medicaid FFS & MCC	dicaid (Days Include D Exhausted and Nor ered)	n- % Surve
Pan Basic   Pan	ne# Cost Center Description	Routine Cost	Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	Total (Include payer
County   February   County		From Section G	From Section G											Own Internal	Own Internal			
Control Charges   Routine Charges   Routine Charges   Routine Charges   Routine Charges   Routine Charges   Routine Charges   S   5,697   S   5,653   S   5,967	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT 00 EURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT 00 OTHER SPECIAL CARE UNIT 00 OTHER SPECIAL CARE UNIT 01 SUBPROVIDER II 00 SUBPROVIDER 10 OTHER SUBPROVIDER	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Total Days	16		Days 9		41		37		Days			The grade of the g	103		
Second collect No.	Unreconciled Days	(Explain Variance)		Routine Charges			1	Routine Charges		Routine Charges	-	- Routine Charges				Routine Charges \$ 98,548		3.27%
	cillary Cost Centers (from WiS C) (from Section Cost Centers (from WiS C) (from Section Cost Cost Cost Cost Cost Cost Cost Cost		0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.0954521 0.288342 1.196733 0.802325 0.521937 0.098738 0.271938 0.27368 0.27368 0.27368	Ancillary Charges  2.468 17.199 5.185 25.556 4.953 3.844	11,088 165,285 423,685 56,764 688,733 13,940 60,734 2,259 1,023 1,03 1,03 1,03 1,03 1,03 1,03 1,03 1,0	Ancillary Charges	59,077 574,004 1,074,294 54,280 1,833,984 45,112 79,634 53,685	Ancillary Charges  5.181 11,641 48,766 10,844 6,153 - 5,541 - 1,174 - 7,456 5,569 49,885	41,193 142,658 412,233 107,093 298,382 7,584 30,499 16,265 1,566 80,396 17,438 67,569	Ancillary Charges 3, 503 4, 703 5, 630 47, 711 20, 850 6, 674 - 2, 233 300 - 6, 766 8, 493 69, 933	72,013 232,175 556,133 89,257 846,028 25,096 54,658 - 8,846 - 870 118,705 32,284 111,988	Ancillary Charges	Ancillary Charges	Ancillary Charges  186 2,282 1,962 15,371 264 408 230 1,241	1002 291,466 1,297,201 38,276 1,215,351 24,467 27,833 15,500 2,246 94,781 56,284 237,818	Ancillary Charges \$ 3.503 \$ 12.352 \$ 45.985 \$ 5,155 \$ 131.857 \$ 36.786 \$ 16.671 \$ 12.379 \$ 1.967 \$ 1.967 \$ 25,406 \$ 17,929 \$ 138.586	\$ 183,371 \$ 1,114,102 \$ 2,466,345 \$ 3,667,127 \$ 91,732 \$ 225,525 \$ 81,055 \$ 158,063 \$ 298,711 \$ 133,178 \$ 777,080	1 41.98% 2 43.30% 5 41.97% 4 32.61% 7 41.88% 2 23.64% 5 10.29% - 0.00% 5 5.65% - 0.00% 3 54.25% - 0.00% 3 54.25% - 0.00% 3 59.59% 0 29.89%
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#### H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

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

Cost Report Year (10/01/2022-09/30/2023) MITCHELL COUNTY HOSPITAL

		li	n-State Medic	aid FFS Primary	In-St	ate Medicaid Ma	anaged Care Prima		In-State Medicare Fl Medicaid S			In-State Other Included Elsev Secondary - Excl and N	vhere & w	vith Medicaid caid Exhausted		ICO Exhausted and Non- be Included Elsewhere)		Jninsured		I In-State Medicaio d FFS & MCO Ext Covered	hausted and Non-	% Survey to
	Totals / Payments																					
128	Total Charges (includes organ acquisition from Section J)	\$	113,534	\$ 2,428,304	\$	41,052	\$ 7,373,6	10 \$	193,197	\$	1,587,948	\$ 215,27	2 \$	2,692,162	\$ -	\$ -	\$ 57,3 (Agrees to Exhibit		\$	563,055 \$	14,082,024	37.47%
129 130	Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance)	\$	113,534	\$ 2,428,304	S	41,052	\$ 7,373,6	10 \$	193,197	\$	1,587,948	\$ 215,27	2 \$	2,692,162	\$	- s -	\$ 57,3	\$ 5,366,581	] =			
131	Total Calculated Cost (includes organ acquisition from Section J)	\$	39,945	\$ 451,635	\$	13,564	\$ 1,538,6	)2 \$	88,048	\$	275,684	\$ 105,90	4 \$	510,764	\$ -	\$ -	\$ 20,2	911,578	\$	247,461 \$	2,776,685	38.15%
132 133 134	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) Private Insurance (including nimary and third party liability)	S S	42,788	\$ 425,790 \$ - \$ -	\$ \$ \$	8,309 -	\$ 2,087,14 \$	- \$	13,973	s s	104,693	\$ 4,84 \$ \$	5 \$ - \$	26,958					\$ \$ \$	61,606 \$ 8,309 \$	557,441 2,087,144 1,348	
135	Self-Pay (including Co-Pay and Spend-Down)	\$	-	\$ -	\$	-	\$	- \$	-	\$	-	\$	- \$	1,063	\$	- \$ -			\$	- \$	1,063	
136 137	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments) Medicaid Cost Settlement Payments (See Note B)	\$	42,788	\$ 425,790 \$ (31,240)	S	8,309	\$ 2,087,14	-											\$	- \$	(31,240)	
138 139	Other Medicaid Payments Reported on Cost Report Year (See Note C)  Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	\$	-	S -	\$	-	\$	- \$	51,644	\$	182,785	\$	- \$	-	\$	-	\$	-	\$	- \$ 51,644 \$	182,785	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)  Medicare Cross-Over Bad Debt Payments							\$	2.051	\$	22,656	\$ 45,14	8 \$	457,880					\$	45,148 \$ 2,051 \$	457,880 22,656	
142	Other Medicare Cross-Over Payments (See Note D)							\$	-	\$	-	\$	- \$	-			(Agrees to Exhibit B : B-1)	B-1)	\$	- \$	-	
143 144	Payment from Hospital Uninsured During Cost Report Year (Cash Basis) Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from	Section E)															\$ \$	- \$ 43,364 \$ -	_			
145 146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$	(2,843) 107%	\$ 57,085 87%	\$	5,255 61%	\$ (548,5a	12) \$ 3%	20,380 77%	\$	(34,450) 112%	\$ 55,91 47		23,515 95%	\$ -	s - % 0%	\$ 20,2	80 S 868,214 5%		78,703 \$ 68%	(502,392) 118%	
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. Sur	m of Lns. 2. 3	. 4. 14. 16. 17. 18 less	lines 5 &	6)			142													

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)
148 Percent of cross-over days to total Medicare days from the cost report

Note A - These amounts must agree to your inpatient and outpatient Nediciard paid claims summany. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with surve Note B - Mediciard cost settlement payments refer to payments made by Mediciard dynners should Not Post Note C - Other Mediciard Payments Note Note Note Institute (payments Should Not Post Post Institute (payments Should Not Post Post Institute (payments Should Note Payments Post Institute (payments Payments not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

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

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

21.01

Cost Report Y	Year (10/01/2022-09/30/2023)												
				Out-of-State Med	dicaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs id Secondary)	Included Elsewhe	Medicaid Eligibles (Not ere & with Medicaid ndary)	Total Out-Of-	State Medicaid
Line#	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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)							
Routine Cost	st Centers (list below):			Days		Days		Days		Days		Days	
	LTS & PEDIATRICS	\$ 1,023.14		,-									
	NSIVE CARE UNIT	\$ -										-	
03200 CORO	ONARY CARE UNIT	\$ -										-	
	N INTENSIVE CARE UNIT	\$ -										-	
	GICAL INTENSIVE CARE UNIT	\$ -										-	
	ER SPECIAL CARE UNIT	\$ -										-	
	PROVIDER I	\$ -										-	
	PROVIDER II	\$ -										-	
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Total Days pe	er PS&R or Exhibit Detail	\$ -	Total Days	-		-		-		-		-	
Total Days pe	er PS&R or Exhibit Detail Unreconciled Days	\$ -	Total Days			- Routine Charges							
Routir		\$ -	Total Days	-				-		-		-	
Routir Calcu	Unreconciled Days ine Charges ulated Routine Charge Per Diem ost Centers (from W/S C) (list below)	\$ - (Explain Variance)		-	Ancillary Charges		Ancillary Charges	- Routine Charges	Ancillary Charges	-	Ancillary Charges	- Routine Charges	Ancillary Charge
Routir Calcu Ancillary Cos	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  ervation (Non-Distinct)	\$ - (Explain Variance)	0.753513	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$ - \$ - Ancillary Charges \$ -	\$
Routir Calcu Ancillary Cos 19200 Obser 5400 RADIO	Unreconciled Days  ine Charges ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below) evation (Non-Distinct) IOLOGY-DIAGNOSTIC	\$ - (Explain Variance)	0.753513 0.255453	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ - Ancillary Charges \$ - \$ -	\$
Routir Calcu Ancillary Cos 9200 Obser 5400 RADIO 5700 CT SO	Unreconciled Days ine Charges ulated Routine Charge Per Diem bot Centers (from W/S C) (list below) ervation (Non-Distinct) IOLOGY-DIAGNOSTIC ICAN	\$ - (Explain Variance)	0.753513 0.255453 0.025118	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$
Routin Calcu Ancillary Cos 9200 Obser 5400 RADIO 5700 CT SC 5800 MRI	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  ervation (Non-Distinct)  IOLOGY-DIAGNOSTIC  ICAN	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$ - \$ - Ancillary Charges  \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$	\$ \$ \$
Routin Calcu Ancillary Cos 9200 Obser 5400 RADIO 5700 CT SC 5800 MRI 6000 LABO	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  revation (Non-Distinct)  UL OGY-DIAGNOSTIC  CAN  DRATORY	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ - Anciliary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$
Routin Calcu Ancillary Cos 99200 Obser 5400 RADIO 5700 CT SC 5800 MRI 6000 LABO 6500 RESP	Unreconciled Days ine Charges ulated Routine Charge Per Diem bot Centers (from W/S C) (list below) ervation (Non-Distinct) IOLOGY-DIAGNOSTIC ICAN DRATORY PIRATORY THERAPY	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$
Routir Calcu 9200 Obser 5400 RADI 5700 CT S0 5800 MRI 6000 LABO 6500 RESP 6600 PHYS	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  ervation (Non-Distinct)  IOL OGY-DIAGNOSTIC  CAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$
Routir Calcu Macillary Cos 19200 Obser 5400 RADIG 5700 CT SO 5800 MRI 6000 LABO 6500 RESP 6600 PHYS	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  evation (Non-Distinct)  IOLOGY-DIAGNOSTIC  CAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY - SNF	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688 1.548534 0.320064 1.054521	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$
Routin Calcu Ancillary Cos 99200 Obser 5400 RADIO 55700 CT SG 5800 MRI 6000 LABO 6500 RESP 6600 PHYS 6700 OCCU	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  ervation (Non-Distinct)  IOL OGY-DIAGNOSTIC  CAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$
Routir Calcu Ancillary Cos 99200 Obset 5400 RADId 5700 CT SC 5800 MRI 6000 LABO 6600 RESP 6600 PHYS 6601 PHYS 6700 OCCL 6701 OCCL	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  set Centers (from W/S C) (list below)  revation (Non-Distinct)  IOLOGY-DIAGNOSTIC  CAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY  SICAL THERAPY  UPATIONAL THERAPY  UPATIONAL THERAPY	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calcu	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (from W/S C)  ost Centers (from W	\$ - (Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.32004 1.054521 0.298342 1.196733	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calcu  Ca	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  evation (Non-Distinct)  IOLOGY-DIAGNOSTIC  CAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY  SICAL THERAPY - SNF  UPATIONAL THERAPY - SNF  ECH PATHOLOGY  ECH PATHOLOGY  ECH PATHOLOGY  ETROCARBIOLOGY	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routir Calcu   Routing Co.   R	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  bot Centers (from W/S C) (list below)  ervation (Non-Distinct)  IOLOGY-DIAGNOSTIC  CCAN  DRATORY  PIRATORY THERAPY  SICAL THERAPY  SICAL THERAPY - SNF  UPATIONAL THERAPY - SNF  ECH PATHOLOGY  ECH PATHOLOGY  ECH PATHOLOGY  ECH PATHOLOGY  ECH PATHOLOGY  ECH CARGED TO PATIEN  CALL SUPPLIES CHARGED TO PATIEN  CALL SUPPLIES CHARGED TO PATIEN  CALL SUPPLIES CHARGED TO PATIEN	(Explain Variance)	0.753513 0.255453 0.025148 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$ - \$ -  Anciliary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.28972	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025118 0.082024 0.177688 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 99200 Obsession RADII 5400 RA	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025148 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.236972 0.218477 -	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routillary Co: 20200 Obset 5400 RADII 5400 RADII 5400 RADII 6500 RES 6600 PHYS 6700 OCCL 6701 OCCL 6701 OCCL 6800 SPEE 6801 SPEE 6801 SPEE 6801 SPEE 6801 SPEE	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025148 0.082024 0.177688 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.271968 0.236972 0.218447	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$  Ancillary Charges  \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routing Color Colo	Unreconciled Days  ine Charges  ulated Routine Charge Per Diem  ost Centers (from W/S C) (list below)  ost Centers (list b	(Explain Variance)	0.753513 0.255453 0.025148 0.082024 0.177668 1.548534 0.320064 1.054521 0.298342 1.196733 0.802325 0.521937 0.098738 0.236972 0.218477 -	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges  \$  Ancillary Charges  \$	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5

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

Control   Cont	Cost Report Yea	ear (10/01/2022-09/30/2023) MITCHELL COUNTY H	OSPITAL									
				Out-of-State Medicaid FFS Prim	Out-of-S	State Medicaid Managed Care Primary	Out-of-State Medic	care FFS Cross-Overs aid Secondary)	Included Elsewhe	ere & with Medicaid	To	tal Out-Of-State Medicaid
	48		- 1								\$	- \$ -
1	49		-								\$	
Color												
											7	
1	52										7	
Second   S												
	55										7	
Second	56		-								\$	
99	57										\$	
Column			-								-	
Column												
Color	60											
Color		-										
Color	63										-	
Column	64										7	
	65										\$	- \$ -
S												
Color												
70	68										7	
1												
Total		<u> </u>									-	
Table   Tabl	72											
74												
Total	74		-								\$	- \$ -
Total   Tota			-								7	
Total   Tota											-	
0												
1	80											- 3 -
Company   Comp												
S	82											
S												
86	84										Ÿ	
S												
88												
89											7	
90												
91												
93	91		-									- \$ -
94	92											
95	93											
96	94											
97	90										7	
98		<del> </del>										
99											-	
100												
102	100											- \$ -
103			-									
104												
105	103										7	
106												
107 108												
108	107										Ÿ	
											7	
109											\$	

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

	Cost Report Year (10/01/2022-09/30/2023) MITCHELL COUNTY HOSPITAL										
		Out-of-State Med	licaid FFS Primary	Out-of-State Medi	caid Managed Care nary		are FFS Cross-Overs aid Secondary)	Included Elsewhe	Medicaid Eligibles (Not ere & with Medicaid ndary)	Total Out-Of-S	State Medicaid
110	-									\$ -	\$ -
111	-									\$ -	\$ -
112	-									\$ -	\$ -
113	•									\$ -	\$ -
114	-									\$ -	\$ -
115	-									\$ -	\$ -
116	-									\$ -	\$ -
117	-									\$ -	\$ -
118	-									\$ -	\$ -
119 120	-									\$ -	\$ -
121										\$ -	\$ -
122	-									\$ -	\$ -
123	-									\$ -	\$ -
124										s -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		9 -	s -	\$ -	\$ -	\$ -	s -	s -	s -		
		•	*	•	*	*	•	•	•		
	Totals / Payments										
	· · · · · · · · · · · · · · · · · · ·										
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)		-		-	-	-				
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									e	e
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									\$ -	\$ -
134	Private Insurance (including primary and third party liability)									•	•
135	Self-Pay (including Co-Pay and Spend-Down)									9	e -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	¢	¢	¢	¢					- پ	9 -
137	Medicaid Cost Settlement Payments (See Note B)	- پ	- پ	Ψ -	٠ -					¢	e
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									÷ -	φ - ¢
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)									÷ -	φ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)									\$ -	\$ -
										÷ -	ş -
141	Medicare Cross-Over Bad Debt Payments									\$ -	<b>5</b> -
142	Other Medicare Cross-Over Payments (See Note D)									<b>a</b> -	<b>a</b> -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

- 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).

Calculated Payments as a Percentage of Cost

- 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.

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

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

Cost Report Year (10/01/2022-09/30/2023) MITCHELL COUNTY HOSPITAL

	Total			Revenue for	Total	In-State Medic	aid FFS Primary	In-State Medicaid M	lanaged Care Primary	In-State Medicare F Medicaid	FS Cross-Overs (with Secondary)			Medicaid FFS & MC0 Covered (Not to be	O Exhausted and Non- Included Elsewhere)	Unir	nsured
	Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Orga (Count)								
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add- On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicaire with Medicair(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 Hospital's Own Internal Analysis	From Hospital' Own Internal Analysis									
an Acquisition Cost Centers (list below):																	
Lung Acquisition	\$0.00	\$ -	\$ -		0												
Kidney Acquisition	\$0.00	\$ -	\$ -		0												
Liver Acquisition	\$0.00	\$ -	\$ -		0												.
Heart Acquisition	\$0.00	\$ -	\$ -		0												
Pancreas Acquisition	\$0.00	s -	s -		0												
Intestinal Acquisition	\$0.00	\$ -	\$ -		0												
Islet Acquisition	\$0.00	\$ -	s -		0												
	\$0.00	\$ -	\$ -		0												
Totals	s -	\$ -	\$ -	\$ -	_	\$ -	-	\$ -	-	\$ -	_	\$ -	-	\$ -	-	\$ -	
Total Cost	7							1									

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 (10/01/2022-09/30/2023) MITCHELL COUNTY HOSPITAL

		Total			Revenue for	Total	Out-of-State Med	dicaid FFS Primary		caid Managed Care mary		are FFS Cross-Overs	Included Elsewhe	Medicaid Eligibles (Not are & with Medicaid ndary)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)						
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost		Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute 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)							
Org	an Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	s -	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	s -	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0								
18		s -	\$ -	\$ -	\$ -	0								
		1	1											
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
		-												
20	Total Cost							-		-		-		

Total Cost

Total Cost

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments

### ${\bf State\ of\ Georgia}$ Disproportionate Share Hospital (DSH) Examination Survey Part II

#### L. Provider Tax Assessment Reconciliation / Adjustment

Cost Report Year (10/01/2022-09/30/2023) MITCHELL COUNTY HOSPITAL

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 to not the Medicaire 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 Medicaire 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.

I Hospital Cross-Provider Tax Assessment Reconciliation:  1 Hospital Cross-Provider Tax Assessment (from general edgary* 18 Working Trial Basince Account Type and Account # Brit Includes Ones Provider Tax Assessment (budden in Equation (Wish A. Col. 2) 3 Difference (Explain Here ———) Provider Tax Assessment Reclassifications (from wish A.4 of the Medicare cost report) 4 Reclassification Code R				
Hospital Gross Provider Tax Assessment (from general ledger)*   18 Working Taid Balance Account Type and Account of Balanchious's Gross Provider Tax Assessment   19 Working Taid Balance Account Type and Account of Balanchious's Gross Provider Tax Assessment   19 Working Taid Balance Account Type and Account of Balanchious's Gross Provider Tax Assessment Included in Experience on the Cost Report)   2	orksheet A Pi	rovider Tax Assessment Reconciliation:		
1 Hospital Gross Provider Tax Assessment (mg pareal ledger) 2 Hospital Gross Provider Tax Assessment Adjustments (from wis A.9 of the Medicare cost report) 3 Difference (Explain Here				
In Vision Trail Balance Account 1 pps and Account 8 pps involves Tax Assessment   In Vision 1   In			Dollar Amount Line	
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (WS A, Col. 2)  3 Difference (Expital Here				
Provider Tax Assessment Reclassifications (from whs A.8 of the Medicare cost report)  ### Reclassification Code ### Reclas				
Provider Tax Assessment Raclassifications (from wis A-6 of the Medicare cost report)  4 Reclassification Code 5 Reclassification Code 6 Reclassification Code 7 Reclassification Code 8 Reclassification Code 9 Reclassification Code 9 Reclassification Code 9 Reclassification Code 1 Reclassification Code 9 Reclassification Code 1 Reclassificati	2 Hospi	ital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	(Where is the cost included on w/s	A?)
4 Reclassification Code 5 Reclassification Code 6 Reclassification Code 7 Reclassification Code 9 Reposit to Provider Tax Assessment Adjustments (from wis A-8 of the Medicare cost report) 9 Reason for adjustment 9 Reason for adjustment 16 Total Net Provider Tax Assessment Expense Included in the Cost Report 17 Gross Allowable Assessment Expense Included in the Cost Report 18 Report Tax Assessment Adjustment to All Medicaid Eligible & Uninsured: 19 Reason for Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured: 10 Total Inclination Code 10 Total Inclina	3 Differe	ence (Explain Here>)	s -	
Section   Reclassification Code	Provi	der Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
Geolassification Code	4	Reclassification Code	(Reclassified to / (from))	
DSHUCC ALLOWABLE - Provider Tax Assessment Adjustments (from wis A-3 of the Medicare cost report)  8 Reason for adjustment   (Adjusted to / (from))  10 Reason for adjustment   (Adjusted to / (from))  11 Reason for adjustment   (Adjusted to / (from))  12 Reason for adjustment   (Adjusted to / (from))  13 Reason for adjustment   (Adjusted to / (from))  14 Reason for adjustment   (Adjusted to / (from))  15 Reason for adjustment   (Adjusted to / (from))  16 Reason for adjustment   (Adjusted to / (from))  17 Reason for adjustment   (International Control of the Adjustment of (from wis A-3 of the Medicare cost report)  18 Reason for adjustment   (International Control of the Adjustment of (from wis A-3 of the Medicare Cost report)  19 Corson Allowable Assessment Expense Included in the Cost Report   (International Control of the Adjustment of (Internat	5	Reclassification Code	(Reclassified to / (from))	
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from wis A-8 of the Medicare cost report)  8	6	Reclassification Code	(Reclassified to / (from))	
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Reason for adjustment to All Medicaid Eligible & Uninsured Reason for adjustment of Provider Tax Assessment Adjustment to Include in DSH Medicaid UCC** Reason for adjustment Reason Reaso	Deut	LICC ALLOWARIE - Provider Toy Accessment Adjustments (from w/s A 9 of the Medicare cost report)		
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Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:  26 Medicaid Primary*** Charges Sec. G  27 Uninsured Hospital Charges Sec. G  28 Total Hospital Charges Sec. G  29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***  30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC  31 Medicaid Primary Provider Tax Assessment Adjustment to Include in DSH UCC***  32 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  33 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  34 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  35  36 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  36  37 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  38  39 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  39  310 Uninsured Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  30  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***  31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		·		
26         Medicaid Primary***         Charges Sec. G         9,956,500           27         Uninsured Hospital         Charges Sec. G         5,423,965           28         Total Hospital         Charges Sec. G         53,555,937           29         Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***         18.59%           30         Percentage of Provider Tax Assessment Adjustment to DSH Uninsured UCC         10.13%           31         Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***         \$           32         Uninsured Provider Tax Assessment Adjustment to DSH UCC         \$		,	•	
27 Uninsured Hospital Charges Sec. G 28 Total Hospital Charges Sec. G 29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC*** 30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC 31 Uninsured Provider Tax Assessment Adjustment to Include in DSH Uninsured UCC 40 10.13% 31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC*** 32 Uninsured Provider Tax Assessment Adjustment to DSH UCC** \$			9 956 500	
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33 Medicard Primary Lax Assessment Adjustment to DSH UCC***  [\$ -]				
	33 Medio	caid Primary Tax Assessment Adjustment to DSH UCC****	\$ -	

<sup>\*</sup> Assessment must exclude any non-hospital assessment such as Nursing Facility.

<sup>\*\*</sup> The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.

<sup>\*\*\*</sup>For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligible population.