

A. General DSH Year Information

1. DSH Year:

Begin

07/01/2024

End

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:

3. Cost Report Year 1

Cost Report
Begin Date(s)

10/01/2022

Cost Report
End Date(s)

09/30/2023

4. Cost Report Year 2 (if applicable)

5. Cost Report Year 3 (if applicable)

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

Data

000001339A

6. Medicaid Provider Number:

0

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.

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to 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.)

DSH Examination
Year (07/01/24 -
06/30/25)

Yes

2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

No

3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

No

3a. Was the hospital open as of December 22, 1987?

Yes

3b. What date did the hospital open?

9/11/1949

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025

\$

299,401

(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025

\$

-

(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025

\$

299,401

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?

Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature Greg Hembree Hospital CEO or CFO Printed Name	Senior Vice President/Chief Financial Officer Title (229) 228-2880 Hospital CEO or CFO Telephone Number	11/21/2024 Date Hospital CEO or CFO E-Mail
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Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:

Name	Patricia L. Barrett
Title	Director of Reimbursement
Telephone Number	
E-Mail Address	
Mailing Street Address	920 Cairo Rd
Mailing City, State, Zip	Thomasville, GA 31792-4255

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

D. General Cost Report Year Information 10/1/2022 - 9/30/2023

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

1. Select Your Facility from the Drop-Down Menu Provided:

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

4. Hospital Name:

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

8. Medicare Provider Number:

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

MITCHELL COUNTY HOSPITAL

000001339A

0

0

111331

Non-State Govt.

Correct?

Yes

Yes

Yes

Yes

Yes

Yes

If Incorrect, Proper Information

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

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)

State Name

Provider No.

FL

020989100

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2022 - 09/30/2023)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)

2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

4. Total Section 1011 Payments Related to Hospital Services (See Note 1)

5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)

6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)

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

\$

-

\$

-

\$

-

\$-

\$

-

\$

-

\$-

\$

-

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

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)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

Inpatient

Outpatient

Total

\$

-

\$

43,364

\$43,364

\$

9,909

\$

425,123

\$435,032

\$9,909

\$468,487

\$478,396

0.00%

9.26%

9.06%

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

15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services

16. Total Medicaid managed care non-claims payments (see question 13 above) received

No

\$

-

\$

-

\$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 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

-
-
250,000
\$ 250,000

7. Inpatient Hospital Charity Care Charges
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

889,151
8,811,895
-
\$ 9,701,046

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)			Net Hospital Revenue
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
\$238,503.00			\$ 119,718	\$ -	\$ -	\$ 118,785
\$0.00			\$ -	\$ -	\$ -	\$ -
\$0.00			\$ -	\$ -	\$ -	\$ -
		\$3,092,125.00			\$ 1,552,105	
		\$0.00			\$ -	
		\$12,923,826.00			\$ 6,487,169	
		\$0.00			\$ -	
		\$0.00			\$ -	
\$9,139,999.00	\$30,596,064.00		\$ 4,587,861	\$ 15,357,822	\$ -	\$ 19,790,380
	\$12,492,308.00			\$ 6,270,566	\$ -	\$ 6,221,742
		\$0.00			\$ -	
		\$ -			\$ -	
		\$0.00	\$ -	\$ -	\$ -	\$ -
\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
		\$0.00			\$ -	
\$0.00	\$0.00	\$7,058,898.00	\$ -	\$ -	\$ 3,543,243	\$ -
\$ 9,378,502	\$ 43,088,372	\$ 23,074,849	\$ 4,707,578	\$ 21,628,389	\$ 11,582,517	\$ 26,130,907
	Total from Above	\$ 75,541,723		Total from Above	\$ 37,918,484	

29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) 75,541,723
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)	37,918,484
+	
+	
+	
+	
-	
-	
	37,918,484
Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

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

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
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.		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 3,788,758	\$ -	\$ -	\$3,216,824.00	\$ 571,934	559	\$3,313,068.00	\$ 1,023.14
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$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

Observation Data (Non-Distinct)

20	09200	Observation (Non-Distinct)		328	-	-	\$ 335,590	\$0.00	\$445,367.00	\$ 445,367	0.753513
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		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>		<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5400	RADIOLOGY-DIAGNOSTIC	\$836,577.00	\$ -	\$ -	\$ 836,577	\$125,092.00	\$3,149,783.00	\$ 3,274,875	0.255453
22	5700	CT SCAN	\$228,154.00	\$ -	\$ -	\$ 228,154	\$409,367.00	\$8,673,889.00	\$ 9,083,256	0.025118
23	5800	MRI	\$88,748.00	\$ -	\$ -	\$ 88,748	\$49,414.00	\$1,032,556.00	\$ 1,081,970	0.082024
24	6000	LABORATORY	\$2,133,735.00	\$ -	\$ -	\$ 2,133,735	\$1,463,243.00	\$10,546,414.00	\$ 12,009,657	0.177668
25	6500	RESPIRATORY THERAPY	\$1,003,856.00	\$ -	\$ -	\$ 1,003,856	\$439,018.00	\$209,244.00	\$ 648,262	1.548534
26	6600	PHYSICAL THERAPY	\$841,306.00	\$ -	\$ -	\$ 841,306	\$1,839,600.00	\$788,959.00	\$ 2,628,559	0.320064
27	6601	PHYSICAL THERAPY - SNF	\$389,769.00	\$ -	\$ -	\$ 389,769	\$369,617.00	\$0.00	\$ 369,617	1.054521
28	6700	OCCUPATIONAL THERAPY	\$575,484.00	\$ -	\$ -	\$ 575,484	\$1,731,005.00	\$197,933.00	\$ 1,928,938	0.298342
29	6701	OCCUPATIONAL THERAPY - SNF	\$173,245.00	\$ -	\$ -	\$ 173,245	\$144,765.00	\$0.00	\$ 144,765	1.196733

G. Cost Report - Cost / Days / Charges

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

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
30	6800 SPEECH PATHOLOGY	\$239,989.00	\$ -	\$ -	\$ 239,989	\$62,376.00	\$236,741.00	\$ 299,117	0.802325
31	6801 SPEECH PATHOLOGY - SNF	\$75,079.00	\$ -	\$ -	\$ 75,079	\$143,847.00	\$0.00	\$ 143,847	0.521937
32	6900 ELECTROCARDIOLOGY	\$116,473.00	\$ -	\$ -	\$ 116,473	\$99,371.00	\$1,080,244.00	\$ 1,179,615	0.098738
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$191,774.00	\$ -	\$ -	\$ 191,774	\$326,830.00	\$378,304.00	\$ 705,134	0.271968
34	7300 DRUGS CHARGED TO PATIENTS	\$934,854.00	\$ -	\$ -	\$ 934,854	\$2,086,301.00	\$1,858,694.00	\$ 3,944,995	0.236972
35	9100 EMERGENCY	\$2,698,884.00	\$ -	\$ -	\$ 2,698,884	\$314,635.00	\$12,040,260.00	\$ 12,354,895	0.218447
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

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

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
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$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	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 10,527,927	\$ -	\$ -	\$ 10,527,927	\$ 9,604,481	\$ 40,638,388	\$ 50,242,869	
127	Weighted Average								0.216220
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 (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)				\$729,206.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 10,370,655				
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.

Cost Report Year (10/01/2022-09/30/2023)	MITCHELL COUNTY HOSPITAL
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Printed 6/23/2026

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

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

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to										
71				-													\$	-	\$	-								
72				-													\$	-	\$	-								
73				-													\$	-	\$	-								
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127				-													\$	-	\$	-								
				\$	97,927	\$	2,428,304	\$	32,529	\$	7,373,610	\$	154,012	\$	1,587,948	\$	180,039	\$	2,692,162	\$	-	\$	-	\$	47,693	\$	5,366,581	

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

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

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to			
Totals / Payments																			
128	Total Charges (includes organ acquisition from Section J)	\$ 113,534	\$ 2,428,304	\$ 41,052	\$ 7,373,610	\$ 193,197	\$ 1,587,948	\$ 215,272	\$ 2,692,162	\$ -	\$ -	\$ 57,384	\$ 5,366,581	\$ 563,055	\$ 14,082,024	37.47%			
		(Agrees to Exhibit A) (Agrees to Exhibit A)																	
129	Total Charges per PS&R or Exhibit Detail	\$ 113,534	\$ 2,428,304	\$ 41,052	\$ 7,373,610	\$ 193,197	\$ 1,587,948	\$ 215,272	\$ 2,692,162	\$ -	\$ -	\$ 57,384	\$ 5,366,581						
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-						
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 39,945	\$ 451,635	\$ 13,564	\$ 1,538,602	\$ 88,048	\$ 275,684	\$ 105,904	\$ 510,764	\$ -	\$ -	\$ 20,230	\$ 911,578	\$ 247,461	\$ 2,776,685	38.15%			
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 42,788	\$ 425,790	\$ -	\$ -	\$ 13,973	\$ 104,693	\$ 4,845	\$ 26,958						\$ 61,606	\$ 557,441			
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 8,309	\$ 2,087,144	\$ -	\$ -	\$ -	\$ -						\$ 8,309	\$ 2,087,144			
134	Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,348						\$ -	\$ 1,348			
135	Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,063	\$ -	\$ -				\$ -	\$ 1,063			
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 42,788	\$ 425,790	\$ 8,309	\$ 2,087,144														
137	Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (31,240)	\$ -	\$ -												\$ -	\$ (31,240)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -												\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	\$ -		\$ -	\$ -	\$ 51,644	\$ 182,785	\$ -	\$ -	\$ -		\$ -				\$ 51,644	\$ 182,785		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 45,148	\$ 457,880								\$ 45,148	\$ 457,880	
141	Medicare Cross-Over Bad Debt Payments					\$ 2,051	\$ 22,656	\$ -	\$ -								\$ 2,051	\$ 22,656	
142	Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -								\$ -	\$ -	
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)											\$ -		\$ 43,364					
												\$ -		\$ -					
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ (2,843)	\$ 57,085	\$ 5,255	\$ (548,542)	\$ 20,380	\$ (34,450)	\$ 55,911	\$ 23,515	\$ -	\$ -	\$ 20,230	\$ 868,214	\$ 78,703	\$ (502,392)				
146	Calculated Payments as a Percentage of Cost	107%	87%	61%	136%	77%	112%	47%	95%	0%	0%	0%	5%	68%	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, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)																142		
148	Percent of cross-over days to total Medicare days from the cost report																29%		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

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

I. Out-of-State Medicaid Data:

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

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid							
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine 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)	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						
03000	ADULTS & PEDIATRICS	\$ 1,023.14										-						
03100	INTENSIVE CARE UNIT	\$ -																
03200	CORONARY CARE UNIT	\$ -																
03300	BURN INTENSIVE CARE UNIT	\$ -																
03400	SURGICAL INTENSIVE CARE UNIT	\$ -																
03500	OTHER SPECIAL CARE UNIT	\$ -																
04000	SUBPROVIDER I	\$ -																
04100	SUBPROVIDER II	\$ -																
04200	OTHER SUBPROVIDER	\$ -																
04300	NURSERY	\$ -																
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I. Out-of-State Medicaid Data:

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

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
48			-									\$ -	\$ -
49			-									\$ -	\$ -
50			-									\$ -	\$ -
51			-									\$ -	\$ -
52			-									\$ -	\$ -
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I. Out-of-State Medicaid Data:

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

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
110			-									\$ -	\$ -
111			-									\$ -	\$ -
112			-									\$ -	\$ -
113			-									\$ -	\$ -
114			-									\$ -	\$ -
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127			-									\$ -	\$ -
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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)											\$ -	\$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											\$ -	\$ -
134	Private Insurance (including primary and third party liability)											\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)											\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$ -	\$ -								
137	Medicaid Cost Settlement Payments (See Note B)											\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)											\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments											\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)											\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
144	Calculated Payments as a Percentage of Cost	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	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.

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 Organ Acquisition Cost			Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
		Charges	Useable Organs (Count)	Charges					Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)			
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From 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):																				
	Lung Acquisition	\$0.00	\$	-	\$	-		0												
	Kidney Acquisition	\$0.00	\$	-	\$	-		0												
	Liver Acquisition	\$0.00	\$	-	\$	-		0												
	Heart Acquisition	\$0.00	\$	-	\$	-		0												
	Pancreas Acquisition	\$0.00	\$	-	\$	-		0												
	Intestinal Acquisition	\$0.00	\$	-	\$	-		0												
	Islet Acquisition	\$0.00	\$	-	\$	-		0												
		\$0.00	\$	-	\$	-		0												
Totals		\$	-	\$	-	\$	-		-	\$	-		-	\$	-		-	\$	-	
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 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 Organ Acquisition Cost		Additional Add-In Intern/Resident Cost		Total Adjusted Organ Acquisition Cost		Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold		Total Useable Organs (Count)		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)									
												Charges		Useable Organs (Count)		Charges		Useable Organs (Count)		Charges		Useable Organs (Count)		Charges		Useable Organs (Count)	
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61		Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost		Sum of Cost Report Organ Acquisition Cost and the Add-On Cost		Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.		Cost Report Worksheet D-4, Pt. III, Line 62		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)		From Paid Claims Data or Provider Logs (Note A)	
Organ Acquisition Cost Centers (list below):																											
	Lung Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Kidney Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Liver Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Heart Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Pancreas Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Intestinal Acquisition	\$	-	\$	-	\$	-	\$	-		0																
	Islet Acquisition	\$	-	\$	-	\$	-	\$	-		0																
		\$	-	\$	-	\$	-	\$	-		0																
Totals		\$	-	\$	-	\$	-	\$	-		-	\$	-		-	\$	-		-	\$	-		-		-		
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.

L. Provider Tax Assessment Reconciliation / Adjustment

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

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

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	14,645,079
19 Uninsured Hospital Charges Sec. G	5,423,965
20 Total Hospital Charges Sec. G	53,555,937
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	27.35%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.13%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	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 include in DSH Uninsured UCC	10.13%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

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

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

***For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.