EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 10/1/2016 - 9/30/2017

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

1. Select Your Facility from the Drop-Down Menu Provided: NORTHEAST GEORGIA MEDICAL CENTER

	10/1/2016 through 9/30/2017		
2. Select Cost Report Year Covered by this Survey:	X		

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 5/29/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	NORTHEAST GEORGIA MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000888A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000000888S	No	Remote Campus provider number (not Subprovider)
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110029	Yes	Both campuses - same Medicare provider number
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 693,560	$ 2,245,284	$2,938,844
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,406,282	$ 31,049,980	$39,456,262
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$9,099,842	$33,295,264	$42,395,106
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.62%	6.74%	6.93%

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

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

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

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 (10/01/2016 - 09/30/2017)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	188,783

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	90,886,697
8. Outpatient Hospital Charity Care Charges	85,282,465
9. Non-Hospital Charity Care Charges	804,984
10. Total Charity Care Charges	$ 176,974,146

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

	Total Patient Revenues (Charges)			Contractual Adjustments			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$ 200,845,660	$ -	$ -	$ 145,796,050	$ -	$ -	$ 55,049,610
12. Psych Subprovider	$ 19,842,893	$ -	$ -	$ 14,404,172	$ -	$ -	$ 5,438,721
13. Rehab. Subprovider	$ 4,161,419	$ -	$ -	$ 3,020,819	$ -	$ -	$ 1,140,600
14. Swing Bed - SNF			$ -			$ -	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ 19,132,860			$ 13,888,751	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 1,592,805,329	$ 1,628,848,560	$ -	$ 1,156,234,722	$ 1,182,398,895	$ -	$ 883,020,272
20. Outpatient Services		$ 207,194,561	$ -		$ 150,404,787	$ -	$ 56,789,774
21. Home Health Agency			$ -			$ -	
22. Ambulance			$ -			$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ 12,347,988			$ 8,963,539	
26. Other	$ 44,548,086	$ 452,760,872	$ -	$ 32,337,940	$ 328,664,044	$ -	$ 136,306,973
27. Total	$ 1,862,203,387	$ 2,288,803,993	$ 31,480,848	$ 1,351,793,704	$ 1,661,467,726	$ 22,852,290	$ 1,137,745,950
28. Total Hospital and Non Hospital		Total from Above	$ 4,182,488,228		Total from Above	$ 3,036,113,720	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 4,182,488,228	Total Contractual Adj. (G-3 Line 2)	$ 3,029,767,166
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)			+	$ -
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)			+	$ 6,346,554
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	$ -
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
35. Adjusted Contractual Adjustments				3,036,113,720
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 158,796,537	$ -	$ -	$ -	**$ 158,796,537**	156,590	$ 172,071,339		**$ 1,014.09**
2	03100	INTENSIVE CARE UNIT	$ 28,005,493	$ -	$ -		**$ 28,005,493**	14,563	$ 30,942,181		**$ 1,923.06**
3	03200	CORONARY CARE UNIT	$ 21,657,174	$ -	$ -		**$ 21,657,174**	11,491	$ 21,836,452		**$ 1,884.71**
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000	SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100	SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300	NURSERY	$ 21,297,282	$ -	$ -		**$ 21,297,282**	16,799	$ 19,571,978		**$ 1,267.77**
11		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18		Total Routine	$ 229,756,486	$ -	$ -	$ -	$ 229,756,486	199,443	$ 244,421,950		
19		Weighted Average									$ 1,151.99

Line #		Observation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200	Observation (Non-Distinct)		10,660	-	-	**$ 10,810,199**	$ 4,345,947	$ 16,179,281	$ 20,525,228	**0.526679**

Line #		Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$ 70,919,068	$ -	$ -		**$ 70,919,068**	$ 225,812,846	$ 245,231,163	$ 471,044,009	**0.150557**
22	5200	DELIVERY ROOM & LABOR ROOM	$ 15,059,803	$ -	$ -		**$ 15,059,803**	$ 52,709,178	$ 3,208,219	$ 55,917,397	**0.269322**
23	5300	ANESTHESIOLOGY	$ 4,410,349	$ -	$ -		**$ 4,410,349**	$ 66,140,876	$ 59,484,685	$ 125,625,561	**0.035107**
24	5400	RADIOLOGY-DIAGNOSTIC	$ 35,939,212	$ -	$ -		**$ 35,939,212**	$ 36,500,081	$ 164,091,270	$ 200,591,351	**0.179166**
25	5401	VASCULAR LAB	$ 2,540,190	$ -	$ -		**$ 2,540,190**	$ 6,195,015	$ 11,326,465	$ 17,521,480	**0.144976**
26	5500	RADIOLOGY-THERAPEUTIC	$ 16,432,018	$ -	$ -		**$ 16,432,018**	$ 2,647,505	$ 80,181,908	$ 82,829,413	**0.198384**
27	5700	CT SCAN	$ 12,305,496	$ -	$ -		**$ 12,305,496**	$ 99,055,397	$ 221,259,595	$ 320,314,992	**0.038417**
28	5800	MRI	$ 5,492,822	$ -	$ -		**$ 5,492,822**	$ 19,283,190	$ 60,393,542	$ 79,676,732	**0.068939**
29	6000	LABORATORY	$ 39,138,876	$ -	$ -		**$ 39,138,876**	$ 176,677,326	$ 206,606,828	$ 383,284,154	**0.102115**
30	6500	RESPIRATORY THERAPY	$ 14,200,326	$ -	$ -		**$ 14,200,326**	$ 108,374,364	$ 13,583,255	$ 121,957,619	**0.116437**
31	6600	PHYSICAL THERAPY	$ 18,966,629	$ -	$ -		**$ 18,966,629**	$ 20,559,705	$ 21,898,060	$ 42,457,765	**0.446718**
32	6900	ELECTROCARDIOLOGY	$ 32,643,771	$ -	$ -		**$ 32,643,771**	$ 96,961,492	$ 156,040,928	$ 253,002,420	**0.129026**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33	7000	ELECTROENCEPHALOGRAPHY	$ 3,302,242	$ -	$ -	**$ 3,302,242**	$ 2,334,700	$ 11,806,736	$ 14,141,436	**0.233515**
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 78,067,686	$ -	$ -	**$ 78,067,686**	$ 162,966,228	$ 88,180,044	$ 251,146,272	**0.310845**
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 70,275,946	$ -	$ -	**$ 70,275,946**	$ 170,378,273	$ 78,834,598	$ 249,212,871	**0.281992**
36	7300	DRUGS CHARGED TO PATIENTS	$ 69,468,132	$ -	$ -	**$ 69,468,132**	$ 332,627,589	$ 195,678,625	$ 528,306,214	**0.131492**
37	7400	RENAL DIALYSIS	$ 3,031,262	$ -	$ -	**$ 3,031,262**	$ 13,325,740	$ 1,669,189	$ 14,994,929	**0.202152**
38	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	$ 87,961	$ -	$ -	**$ 87,961**	$ 114,882	$ -	$ 114,882	**0.765664**
39	7601	WOUND CARE CLINIC	$ 2,592,695	$ -	$ -	**$ 2,592,695**	$ 139,943	$ 9,160,125	$ 9,300,068	**0.278782**
40	7602	DIABETIC EDUCATION	$ 949,913	$ -	$ -	**$ 949,913**	$ 1,000	$ 213,325	$ 214,325	**4.432115**
41	9100	EMERGENCY	$ 43,451,812	$ -	$ -	**$ 43,451,812**	$ 38,999,191	$ 147,670,142	$ 186,669,333	**0.232774**
42			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
43			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
44			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
45			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
46			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
47			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
48			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
49			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
50			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
51			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
52			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
53			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
54			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
55			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
56			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
57			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
58			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
59			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
60			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
61			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
62			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
63			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
64			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
65			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
66			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
67			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
68			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
69			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
70			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
71			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
72			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
73			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
74			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
75			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
76			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
77			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
78			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
79			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
80			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
81			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
82			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
83			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
84			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
85			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
86			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
87			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
88			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
89			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
90			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
91			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
92			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**
93			$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	**-**

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
94			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 539,276,209	$ -	$ -		$ 539,276,209	$ 1,636,150,468	$ 1,792,697,983	$ 3,428,848,451	
127		**Weighted Average**									0.160429
128		**Sub Totals**	$ 769,032,695	$ -	$ -		$ 769,032,695	$ 1,880,572,418	$ 1,792,697,983	$ 3,673,270,401	

Line	Description	Amount
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)	$ -
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)	$ 389,108
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)	$ -
131.01	Other Cost Adjustments (support must be submitted)	$ -
132	**Grand Total**	**$ 768,643,587**
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line #	Code	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
		Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000	ADULTS & PEDIATRICS	$ 1,014.09		12,929		8,120		9,065		8,716		8,763		**38,830**		32.68%
2	03100	INTENSIVE CARE UNIT	$ 1,923.06		2,332		284		1,485		1,377		1,399		**5,478**		47.29%
3	03200	CORONARY CARE UNIT	$ 1,884.71		377		61		399		196		425		**1,033**		12.70%
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
6	03500	OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		-		
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-		-		
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-		-		
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300	NURSERY	$ 1,267.77		2,911		8,372		-		1,319		355		**12,602**		77.13%
11		0	$ -		-		-		-		-		-		-		
12		0	$ -		-		-		-		-		-		-		
13		0	$ -		-		-		-		-		-		-		
14		0	$ -		-		-		-		-		-		-		
15		0	$ -		-		-		-		-		-		-		
16		0	$ -		-		-		-		-		-		-		
17		0	$ -		-		-		-		-		-		-		
18				Total Days	18,549		16,837		10,949		11,608		10,942		57,943		36.55%
19		Total Days per PS&R or Exhibit Detail			18,549		16,837		10,949		11,608		10,942				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 22,086,698		$ 20,424,349		$ 16,026,173		$ 14,861,269		$ 13,008,651		$ 73,398,489		35.41%
21.01		Calculated Routine Charge Per Dier			$ 1,190.72		$ 1,213.06		$ 1,463.71		$ 1,280.26		$ 1,188.87		$ 1,266.74		
		Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200	Observation (Non-Distinct		0.526679	$ 446,790	$ 1,271,892	$ 269,167	$ 1,347,344	$ 403,890	$ 2,217,288	$ 180,502	$ 442,637	$ 467,133	$ 2,288,292	$ 1,300,349	$ 5,279,161	45.52%
23	5000	OPERATING ROOM		0.150557	$ 14,398,708	$ 6,521,937	$ 11,564,371	$ 12,784,669	$ 14,789,980	$ 12,984,747	$ 9,937,816	$ 3,207,114	$ 10,873,660	$ 10,838,942	$ 50,690,875	$ 35,498,467	22.95%
24	5200	DELIVERY ROOM & LABOR ROOM		0.269322	$ 2,085,558	$ 84,172	$ 7,176,594	$ 1,405,230	$ 6,048	$ 10,618	$ 2,715,318	$ 347,440	$ 144,552	$ 180,838	$ 11,983,518	$ 1,847,460	25.32%
25	5300	ANESTHESIOLOGY		0.035107	$ 3,976,837	$ 1,550,347	$ 5,397,960	$ 3,836,323	$ 3,799,955	$ 2,709,566	$ 3,302,222	$ 720,563	$ 2,907,551	$ 2,654,855	$ 16,476,974	$ 8,816,799	24.61%
26	5400	RADIOLOGY-DIAGNOSTIC		0.179166	$ 3,149,099	$ 7,156,244	$ 1,024,785	$ 6,702,614	$ 2,939,973	$ 8,334,526	$ 1,330,850	$ 1,792,638	$ 2,633,948	$ 11,188,720	$ 8,444,707	$ 23,986,022	23.07%
27	5401	VASCULAR LAB		0.144976	$ 645,325	$ 650,009	$ 91,021	$ 278,561	$ 604,967	$ 1,288,197	$ 391,464	$ 166,560	$ 441,434	$ 825,773	$ 1,732,777	$ 2,383,327	30.75%
28	5500	RADIOLOGY-THERAPEUTIC		0.198384	$ -	$ -	$ 33,081	$ 1,303,939	$ 363,910	$ 5,989,286	$ 171,156	$ 1,435,922	$ 156,507	$ 1,610,412	$ 568,147	$ 8,729,147	13.36%
29	5700	CT SCAN		0.038417	$ 7,745,080	$ 8,340,331	$ 859,631	$ 9,775,349	$ 7,441,848	$ 11,978,373	$ 2,168,221	$ 2,106,924	$ 8,927,881	$ 31,431,647	$ 18,214,780	$ 32,200,977	28.35%
30	5800	MRI		0.068939	$ 1,607,180	$ 1,701,130	$ 221,897	$ 2,640,939	$ 1,566,290	$ 3,033,326	$ 557,122	$ 491,923	$ 1,545,084	$ 2,509,011	$ 3,952,489	$ 7,867,318	19.93%
31	6000	LABORATORY		0.102115	$ 18,579,571	$ 9,330,424	$ 6,843,361	$ 13,625,532	$ 15,933,345	$ 9,573,210	$ 8,499,987	$ 4,868,535	$ 14,514,998	$ 23,719,631	$ 49,856,264	$ 37,397,700	32.77%
32	6500	RESPIRATORY THERAPY		0.116437	$ 9,050,716	$ 246,671	$ 3,296,497	$ 399,495	$ 7,106,284	$ 418,007	$ 4,078,593	$ 60,385	$ 3,509,695	$ 533,125	$ 23,532,090	$ 1,124,558	23.56%
33	6600	PHYSICAL THERAPY		0.446718	$ 1,192,904	$ 220,342	$ 320,904	$ 2,899,540	$ 1,059,822	$ 607,264	$ 895,177	$ 856,037	$ 634,739	$ 1,014,992	$ 3,468,807	$ 4,583,183	22.86%
34	6900	ELECTROCARDIOLOGY		0.129026	$ 5,162,582	$ 2,463,533	$ 776,644	$ 1,660,313	$ 6,474,656	$ 7,676,208	$ 2,302,734	$ 1,071,702	$ 6,842,335	$ 7,315,468	$ 14,716,616	$ 12,871,756	16.53%
35	7000	ELECTROENCEPHALOGRAPHY		0.233515	$ 354,863	$ 730,625	$ 78,174	$ 553,327	$ 232,964	$ 642,938	$ 135,601	$ 103,126	$ 173,829	$ 266,211	$ 801,602	$ 2,030,016	23.15%
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.310845	$ 9,515,502	$ 1,612,780	$ 4,241,925	$ 3,464,067	$ 11,156,142	$ 4,449,765	$ 6,551,916	$ 930,594	$ 6,676,317	$ 3,838,061	$ 31,465,485	$ 10,457,206	20.91%
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.281992	$ 6,430,887	$ 186,461	$ 1,618,827	$ 1,107,256	$ 10,873,169	$ 6,085,110	$ 3,250,291	$ 547,310	$ 3,985,333	$ 1,585,777	$ 22,173,174	$ 7,926,137	14.34%
38	7300	DRUGS CHARGED TO PATIENTS		0.131492	$ 33,296,884	$ 8,819,852	$ 9,992,982	$ 8,270,529	$ 23,753,145	$ 14,617,867	$ 14,022,591	$ 2,117,069	$ 22,768,161	$ 18,982,864	$ 81,065,603	$ 33,825,317	29.68%
39	7400	RENAL DIALYSIS		0.202152	$ 850,176	$ -	$ 52,559	$ -	$ 1,303,148	$ 313,572	$ 1,421,867	$ 38,114	$ 320,522	$ 666,133	$ 3,627,750	$ 351,686	33.17%
40	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.765664	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
41	7601	WOUND CARE CLINIC		0.278782	$ 24,830	$ 622	$ 39,360	$ 2,710	$ -	$ 16,338	$ 5,904	$ 25,833	$ 492	$ 153,376	$ 70,094	$ 45,503	2.90%
42	7602	DIABETIC EDUCATION		4.432115	$ -	$ -	$ -	$ 8,890	$ -	$ 9,026	$ 240	$ 9,026	$ -	$ 17,580	$ 240	$ 26,942	20.89%
43	9100	EMERGENCY		0.232774	$ 3,324,082	$ 7,437,757	$ 1,331,121	$ 21,730,040	$ 3,082,729	$ 6,553,141	$ 1,900,080	$ 2,144,777	$ 3,509,866	$ 30,953,581	$ 9,638,012	$ 37,865,715	43.95%
44				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line	Description		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)		Uninsured		Total In-State Medicaid		%
85		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
86		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
87		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
88		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
89		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
90		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
91		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
92		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
93		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
94		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
95		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
96		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
97		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
98		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
99		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
100		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
101		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
102		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
103		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
104		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
105		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
106		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
107		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
108		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
109		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
110		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
111		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
112		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
113		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
114		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
115		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
116		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
117		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
118		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
119		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
120		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
121		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
122		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
123		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
124		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
125		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
126		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
			121,837,574	58,325,129	55,230,862	93,796,667	112,892,266	99,508,373	63,819,652	23,484,229	91,034,038	152,575,289			
	Totals / Payments														
128	**Total Charges** ***(includes organ acquisition from Section J)***		**$ 143,924,272**	**$ 58,325,129**	**$ 75,655,211**	**$ 93,796,667**	**$ 128,918,439**	**$ 99,508,373**	**$ 78,680,921**	**$ 23,484,229**	**$ 104,042,689** (Agrees to Exhibit A)	**$ 152,575,289** (Agrees to Exhibit A)	**$ 427,178,843**	**$ 275,114,398**	**26.14%**
129	Total Charges per PS&R or Exhibit Detail		$ 143,924,272	$ 58,325,129	$ 75,655,211	$ 93,796,667	$ 128,918,439	$ 99,508,373	$ 78,680,921	$ 23,484,229	$ 104,042,689	$ 152,575,289			
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**												$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**		**$ 40,502,392**	**$ 8,556,511**	**$ 28,531,150**	**$ 15,856,606**	**$ 30,911,522**	**$ 15,850,918**	**$ 24,018,830**	**$ 3,904,988**	**$ 26,041,229**	**$ 22,343,803**	$ 123,963,894	$ 44,169,023	28.20%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 32,421,703	$ 8,497,472	$ -	$ -	$ 2,126,551	$ 1,220,856	$ 842,829	$ 277,898			$ 35,391,083	$ 9,996,226	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ -	$ 14,784,289	$ 12,826,072	$ -	$ -	$ 36,542	$ 54,097			$ 14,820,831	$ 12,880,169	
134	Private Insurance (including primary and third party liability)		$ 168,481	$ 13,650	$ 2,335,317	$ 834,169	$ 10,020	$ 33,616	$ 15,856,005	$ 5,338,731			$ 18,369,823	$ 6,220,166	
135	Self-Pay (including Co-Pay and Spend-Down)		$ -	$ 19,677	$ 4,821	$ 14,090	$ -	$ -	$ 3,057	$ 9,072			$ 7,878	$ 42,839	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 32,590,184	$ 8,530,799	$ 17,124,427	$ 13,674,331									
137	Medicaid Cost Settlement Payments (See Note B)		$ -	$ (348,966)	$ -	$ -							$ -	$ (348,966)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						$ 23,452,718	$ 10,944,562	$ 8,791,798	$ 575,134			$ 32,244,516	$ 11,519,696	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						$ -	$ -	$ 162,059	$ 30,018			$ 162,059	$ 30,018	
141	Medicare Cross-Over Bad Debt Payments						$ -	$ -	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)						$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										$ 693,560	$ 2,245,284			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)										$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**		$ 7,912,208	$ 374,678	$ 11,406,723	$ 2,182,275	$ 5,322,233	$ 3,651,884	$ (1,673,460)	$ (2,379,962)	$ 25,347,669	$ 20,098,519	$ 22,967,704	$ 3,828,875	
146	**Calculated Payments as a Percentage of Cost**		80%	96%	60%	86%	83%	77%	107%	161%	3%	10%	81%	91%	
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 & (**						91,888								
148	**Percent of cross-over days to total Medicare days from the cost report**						12%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
			From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):				**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000	ADULTS & PEDIATRICS	$ 1,014.09		-		-		-		95		95	
2	03100	INTENSIVE CARE UNIT	$ 1,923.06		-		-		-		10		10	
3	03200	CORONARY CARE UNIT	$ 1,884.71		-		-		-		1		1	
4	03300	BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500	OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000	SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100	SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200	OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300	NURSERY	$ 1,267.77		-		-		-		-		-	
11			$ -		-		-		-		-		-	
12			$ -		-		-		-		-		-	
13			$ -		-		-		-		-		-	
14			$ -		-		-		-		-		-	
15			$ -		-		-		-		-		-	
16			$ -		-		-		-		-		-	
17			$ -		-		-		-		-		-	
18				**Total Days**	-		-		-		106		106	
19	Total Days per PS&R or Exhibit Detail				-		-		-		106			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ -		$ -		$ -		$ 133,670		$ 133,670	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 1,261.04		$ 1,261.04	
	Ancillary Cost Centers (from W/S C) (list below):				**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)		0.526679	-	-	-	-	-	-	-	8,712	$ -	$ 8,712
23	5000	OPERATING ROOM		0.150557	-	-	-	-	-	-	181,647	18,914	$ 181,647	$ 18,914
24	5200	DELIVERY ROOM & LABOR ROOM		0.269322	-	-	-	-	-	-	-	289	$ -	$ 289
25	5300	ANESTHESIOLOGY		0.035107	-	-	-	-	-	-	64,389	-	$ 64,389	$ -
26	5400	RADIOLOGY-DIAGNOSTIC		0.179166	-	-	-	-	-	-	8,417	21,882	$ 8,417	$ 21,882
27	5401	VASCULAR LAB		0.144976	-	-	-	-	-	-	4,941	-	$ 4,941	$ -
28	5500	RADIOLOGY-THERAPEUTIC		0.198384	-	-	-	-	-	-	-	-	$ -	$ -
29	5700	CT SCAN		0.038417	-	-	-	-	-	-	15,209	28,647	$ 15,209	$ 28,647
30	5800	MRI		0.068939	-	-	-	-	-	-	7,148	-	$ 7,148	$ -
31	6000	LABORATORY		0.102115	-	-	-	-	-	-	96,127	31,423	$ 96,127	$ 31,423
32	6500	RESPIRATORY THERAPY		0.116437	-	-	-	-	-	-	29,094	640	$ 29,094	$ 640
33	6600	PHYSICAL THERAPY		0.446718	-	-	-	-	-	-	3,615	(360)	$ 3,615	$ (360)
34	6900	ELECTROCARDIOLOGY		0.129026	-	-	-	-	-	-	56,265	18,147	$ 56,265	$ 18,147
35	7000	ELECTROENCEPHALOGRAPHY		0.233515	-	-	-	-	-	-	1,439	-	$ 1,439	$ -
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.310845	-	-	-	-	-	-	70,578	2,294	$ 70,578	$ 2,294
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.281992	-	-	-	-	-	-	39,587	23,102	$ 39,587	$ 23,102
38	7300	DRUGS CHARGED TO PATIENTS		0.131492	-	-	-	-	-	-	139,439	21,995	$ 139,439	$ 21,995
39	7400	RENAL DIALYSIS		0.202152	-	-	-	-	-	-	7,473	-	$ 7,473	$ -
40	7501	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0.765664	-	-	-	-	-	-	-	-	$ -	$ -
41	7601	WOUND CARE CLINIC		0.278782	-	-	-	-	-	-	-	-	$ -	$ -
42	7602	DIABETIC EDUCATION		4.432115	-	-	-	-	-	-	-	-	$ -	$ -
43	9100	EMERGENCY		0.232774	-	-	-	-	-	-	22,695	45,046	$ 22,695	$ 45,046
44				-	-	-	-	-	-	-	-	-	$ -	$ -
45				-	-	-	-	-	-	-	-	-	$ -	$ -
46				-	-	-	-	-	-	-	-	-	$ -	$ -
47				-	-	-	-	-	-	-	-	-	$ -	$ -
48				-	-	-	-	-	-	-	-	-	$ -	$ -
49				-	-	-	-	-	-	-	-	-	$ -	$ -
50				-	-	-	-	-	-	-	-	-	$ -	$ -
51				-	-	-	-	-	-	-	-	-	$ -	$ -
52				-	-	-	-	-	-	-	-	-	$ -	$ -
53				-	-	-	-	-	-	-	-	-	$ -	$ -
54				-	-	-	-	-	-	-	-	-	$ -	$ -
55				-	-	-	-	-	-	-	-	-	$ -	$ -
56				-	-	-	-	-	-	-	-	-	$ -	$ -
57				-	-	-	-	-	-	-	-	-	$ -	$ -
58				-	-	-	-	-	-	-	-	-	$ -	$ -
59				-	-	-	-	-	-	-	-	-	$ -	$ -
60				-	-	-	-	-	-	-	-	-	$ -	$ -
61				-	-	-	-	-	-	-	-	-	$ -	$ -
62				-	-	-	-	-	-	-	-	-	$ -	$ -
63				-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
73			-	-	-	-	-	-	-	-	-	$ -	$ -
74			-	-	-	-	-	-	-	-	-	$ -	$ -
75			-	-	-	-	-	-	-	-	-	$ -	$ -
76			-	-	-	-	-	-	-	-	-	$ -	$ -
77			-	-	-	-	-	-	-	-	-	$ -	$ -
78			-	-	-	-	-	-	-	-	-	$ -	$ -
79			-	-	-	-	-	-	-	-	-	$ -	$ -
80			-	-	-	-	-	-	-	-	-	$ -	$ -
81			-	-	-	-	-	-	-	-	-	$ -	$ -
82			-	-	-	-	-	-	-	-	-	$ -	$ -
83			-	-	-	-	-	-	-	-	-	$ -	$ -
84			-	-	-	-	-	-	-	-	-	$ -	$ -
85			-	-	-	-	-	-	-	-	-	$ -	$ -
86			-	-	-	-	-	-	-	-	-	$ -	$ -
87			-	-	-	-	-	-	-	-	-	$ -	$ -
88			-	-	-	-	-	-	-	-	-	$ -	$ -
89			-	-	-	-	-	-	-	-	-	$ -	$ -
90			-	-	-	-	-	-	-	-	-	$ -	$ -
91			-	-	-	-	-	-	-	-	-	$ -	$ -
92			-	-	-	-	-	-	-	-	-	$ -	$ -
93			-	-	-	-	-	-	-	-	-	$ -	$ -
94			-	-	-	-	-	-	-	-	-	$ -	$ -
95			-	-	-	-	-	-	-	-	-	$ -	$ -
96			-	-	-	-	-	-	-	-	-	$ -	$ -
97			-	-	-	-	-	-	-	-	-	$ -	$ -
98			-	-	-	-	-	-	-	-	-	$ -	$ -
99			-	-	-	-	-	-	-	-	-	$ -	$ -
100			-	-	-	-	-	-	-	-	-	$ -	$ -
101			-	-	-	-	-	-	-	-	-	$ -	$ -
102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
104			-	-	-	-	-	-	-	-	-	$ -	$ -
105			-	-	-	-	-	-	-	-	-	$ -	$ -
106			-	-	-	-	-	-	-	-	-	$ -	$ -
107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	748,063	220,731		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 881,733**	**$ 220,731**	**$ 881,733**	**$ 220,731**
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ 881,733	$ 220,731		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 231,009**	**$ 38,604**	**$ 231,009**	**$ 38,604**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ 1,315	$ 282	$ 1,315	$ 282
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)			$ -	$ -	$ -	$ -	$ -	$ -	$ 27,827	$ 47,164	$ 27,827	$ 47,164
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ (2,445)	$ -	$ (2,445)
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Line	Description	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
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)					$ -	$ -	$ 123,095	$ 19,299	$ 123,095	$ 19,299
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 62,659	$ -	$ 62,659	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 16,113	$ (25,696)	$ 16,113	$ (25,696)
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	93%	167%	93%	167%

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 (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Organ Acquisition Cost Centers (list below):	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)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

	Organ Acquisition Cost Centers (list below):	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2016-09/30/2017) NORTHEAST GEORGIA MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

#	Description	Explanation	Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 9,179,607		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	208001/258001-69760	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 9,179,607	5.05	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 9,179,607		

DSH UCC Provider Tax Assessment Adjustment:

#	Description	Dollar Amount
17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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

DSH Examination Eligibility Summary

Hospital Name	**NORTHEAST GEORGIA MEDICAL CENTER**
Hospital Medicaid Number	**000000888A**
Cost Report Period	From **10/1/2016** To **9/30/2017**

		Source	As-Reported	Adjustments	As-Adjusted
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 76,131,145	$ -	$ 76,131,145
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 76,131,145	$ -	$ 76,131,145
4	Net Hospital Patient Revenue	Survey F-3	$ 1,137,745,950	$ -	$ 1,137,745,950
5	Medicaid Fraction		6.69%	0.00%	6.69%
6	Inpatient Charity Care Charges	Survey F-2	$ 90,886,697	$ -	$ 90,886,697
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 90,886,697	$ -	$ 90,886,697
10	Inpatient Hospital Charges	Survey F-3	$ 1,862,203,387	$ -	$ 1,862,203,387
11	Inpatient Charity Fraction		4.88%	0.00%	4.88%
12	LIUR		11.57%	0.00%	11.57%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	57,943	-	57,943
14	Out-of-State Medicaid Eligible Days	Survey I	106	-	106
15	Total Medicaid Eligible Days		58,049	-	58,049
16	Total Hospital Days (excludes swing-bed)	Survey F-1	188,783	-	188,783
17	MIUR		30.75%	0.00%	30.75%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	NORTHEAST GEORGIA MEDICAL CENTER
Hospital Medicaid Number	000000888A
Cost Report Period	From 10/1/2016 To 9/30/2017

As-Reported:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	40,502,392	32,421,703	-	168,481	-	-	-	-	-	-	-			32,590,184	7,912,208	80.46%
2 Medicaid Fee for Service	Outpatient	8,556,511	8,497,472	-	13,650	19,677	(348,966)	-	-	-	-	-			8,181,833	374,678	95.62%
3 Medicaid Managed Care	Inpatient	28,531,150	-	14,784,289	2,335,317	4,821	-	-							17,124,427	11,406,723	60.02%
4 Medicaid Managed Care	Outpatient	15,856,606	-	12,826,072	834,169	14,090	-	-							13,674,331	2,182,275	86.24%
5 Medicare Cross-over (FFS)	Inpatient	30,911,522	2,126,551	-	10,020	-		-	23,452,718	-	-	-			25,589,289	5,322,233	82.78%
6 Medicare Cross-over (FFS)	Outpatient	15,850,918	1,220,856	-	33,616	-		-	10,944,562	-	-	-			12,199,034	3,651,884	76.96%
7 Other Medicaid Eligibles	Inpatient	24,018,830	842,829	36,542	15,856,005	3,057			8,791,798	162,059	-	-			25,692,290	(1,673,460)	106.97%
8 Other Medicaid Eligibles	Outpatient	3,904,988	277,898	54,097	5,338,731	9,072			575,134	30,018	-	-			6,284,950	(2,379,962)	160.95%
9 Uninsured	Inpatient	26,041,229	-	-	-	-	-	-	-	-	-	-	693,560	-	693,560	25,347,669	2.66%
10 Uninsured	Outpatient	22,343,803	-	-	-	-	-	-	-	-	-	-	2,245,284	-	2,245,284	20,098,519	10.05%
11 In-State Sub-total	Inpatient	150,005,123	35,391,083	14,820,831	18,369,823	7,878	-	-	32,244,516	162,059	-	-	693,560	-	101,689,750	48,315,373	67.79%
12 In-State Sub-total	Outpatient	66,512,826	9,996,226	12,880,169	6,220,166	42,839	(348,966)	-	11,519,696	30,018	-	-	2,245,284	-	42,585,432	23,927,394	64.03%
13 Out-of-State Medicaid	Inpatient	231,009	1,315	-	27,827	-	-	-	123,095	62,659	-	-			214,896	16,113	93.02%
14 Out-of-State Medicaid	Outpatient	38,604	282	-	47,164	(2,445)	-	-	19,299	-	-	-			64,300	(25,696)	166.56%
15 Sub-Total	I/P and O/P	216,787,562	45,388,906	27,701,000	24,664,980	48,272	(348,966)	-	43,906,606	254,736	-	-	2,938,844	-	144,554,378	72,233,184	66.68%

Adjustments:

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

DSH Examination UCC Cost & Payment Summary

Georgia

Hospital Name	NORTHEAST GEORGIA MEDICAL CENTER
Hospital Medicaid Number	000000888A
Cost Report Period	From 10/1/2016 To 9/30/2017

As-Adjusted:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	40,502,392	32,421,703	-	168,481	-	-	-	-	-	-	-			32,590,184	7,912,208	80.46%
2 Medicaid Fee for Service	Outpatient	8,556,511	8,497,472	-	13,650	19,677	(348,966)	-	-	-	-	-			8,181,833	374,678	95.62%
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5 Medicare Cross-over (FFS)	Inpatient	30,911,522	2,126,551	-	10,020	-		-	23,452,718	-	-	-			25,589,289	5,322,233	82.78%
6 Medicare Cross-over (FFS)	Outpatient	15,850,918	1,220,856	-	33,616	-		-	10,944,562	-	-	-			12,199,034	3,651,884	76.96%
7 Other Medicaid Eligibles	Inpatient	24,018,830	842,829	36,542	15,856,005	3,057			8,791,798	162,059	-	-			25,692,290	(1,673,460)	106.97%
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10 Uninsured	Outpatient	22,343,803	-	-	-	-	-	-	-	-	-	-	2,245,284	-	2,245,284	20,098,519	10.05%
11 In-State Sub-total	Inpatient	150,005,123	35,391,083	14,820,831	18,369,823	7,878	-	-	32,244,516	162,059	-	-	693,560	-	101,689,750	48,315,373	67.79%
12 In-State Sub-total	Outpatient	66,512,826	9,996,226	12,880,169	6,220,166	42,839	(348,966)	-	11,519,696	30,018	-	-	2,245,284	-	42,585,432	23,927,394	64.03%
13 Out-of-State Medicaid	Inpatient	231,009	1,315	-	27,827	-	-	-	123,095	62,659	-	-			214,896	16,113	93.02%
14 Out-of-State Medicaid	Outpatient	38,604	282	-	47,164	(2,445)	-	-	19,299	-	-	-			64,300	(25,696)	166.56%
15 Cost Report Year Sub-Total	I/P and O/P	216,787,562	45,388,906	27,701,000	24,664,980	48,272	(348,966)	-	43,906,606	254,736	-	-	2,938,844	-	144,554,378	72,233,184	66.68%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	72,233,184

Medicaid DSH Survey Adjustments

PROVIDER: NORTHEAST GEORGIA MEDICAL CENTER
FROM: 10/1/2016 TO: 9/30/2017

Mcaid Number: 000000888A
Mcare Number: Both campuses - same Medicare provider number

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.

Medicaid DSH Report Notes

PROVIDER: NORTHEAST GEORGIA MEDICAL CENTER

Mcaid Number: 000000888A

FROM: 10/1/2016 TO: 9/30/2017

Mcare Number: Both campuses - same Medicare provider number

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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