State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: MITCHELL COUNTY HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	10/01/2016	09/30/2017	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000001339A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111331

B. DSH OB 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:

	DSH Examination Year (07/01/16 - 06/30/17)
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.)	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

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Lauren Fraser, M.D.
Stephen A. Rubendall, Jr., M.D.

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is 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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 139,553

Certification:

	Answer
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.**	**Yes**

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.

	Senior Vice President and CFO	11/6/2018
Hospital CEO or CFO Signature	Title	Date
Greg Hembree	(229) 228-2880	gshembree@archbold.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:	
Name	Patricia L. Barrett
Title	Director of Reimbursement/MCH
Telephone Number	(229) 228-8857
E-Mail Address	pbarrett@archbold.org
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	

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:	MITCHELL COUNTY HOSPITAL		
	10/1/2016 through 9/30/2017		
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:	3/19/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	MITCHELL COUNTY HOSPITAL	Yes	
5. Medicaid Provider Number:	000001339A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	111331	Yes	
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):	Small Rural	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	Florida	020989100
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

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)	$ -	$ 144,544	$144,544
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,736	$ 619,220	$627,956
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)	$8,736	$763,764	$772,500
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	18.93%	18.71%

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)	277	**(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	249,996
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 249,996
7.	Inpatient Hospital Charity Care Charges	78,838
8.	Outpatient Hospital Charity Care Charges	2,615,702
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 2,694,540

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$213,949.00			$ 104,712	$ -	$ -	$ 109,237
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$1,875,992.00			$ 918,161	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$10,462,509.00			$ 5,120,631	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$11,592,930.00	$19,298,095.00		$ 5,673,889	$ 9,445,003	$ -	$ 15,772,133
20.	Outpatient Services		$6,605,360.00			$ 3,232,839	$ -	$ 3,372,521
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$4,628,506.00	$ -	$ -	$ 2,265,314	$ -
27.	Total	$ 11,806,879	$ 25,903,455	$ 16,967,007	$ 5,778,602	$ 12,677,842	$ 8,304,106	$ 19,253,890
28.	Total Hospital and Non Hospital		Total from Above	$ 54,677,341		Total from Above	$ 26,760,550	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	54,677,341	Total Contractual Adj. (G-3 Line 2)	26,760,550
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				26,760,550

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) | MITCHELL COUNTY HOSPITAL

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.

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
		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	$ 2,560,772	$ -	$ -	$2,290,449.00	$ 270,323	346	$2,053,567.00		$ 781.28
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	$ 2,560,772	$ -	$ -	$ 2,290,449	$ 270,323	346	$ 2,053,567		
19	Weighted Average									$ 781.28

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)	69	-	-	$ 53,908	$0.00	$113,511.00	$ 113,511	0.474914

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	5400	RADIOLOGY-DIAGNOSTIC	$819,696.00	$ -	$0.00		$ 819,696	$146,029.00	$2,520,215.00	$ 2,666,244	0.307435
22	5700	CT SCAN	$219,110.00	$ -	$0.00		$ 219,110	$158,077.00	$5,002,952.00	$ 5,161,029	0.042455
23	5800	MRI	$77,506.00	$ -	$0.00		$ 77,506	$30,616.00	$435,375.00	$ 465,991	0.166325
24	6000	LABORATORY	$1,175,575.00	$ -	$0.00		$ 1,175,575	$1,291,203.00	$5,853,495.00	$ 7,144,698	0.164538
25	6500	RESPIRATORY THERAPY	$511,002.00	$ -	$0.00		$ 511,002	$540,736.00	$288,396.00	$ 829,132	0.616310
26	6600	PHYSICAL THERAPY	$981,664.00	$ -	$0.00		$ 981,664	$3,022,989.00	$1,707,296.00	$ 4,730,285	0.207527
27	6601	PHYSICAL THERAPY - SNF	$244,552.00	$ -	$0.00		$ 244,552	$392,844.00	$0.00	$ 392,844	0.622517
28	6700	OCCUPATIONAL THERAPY	$564,477.00	$ -	$0.00		$ 564,477	$2,782,953.00	$344,727.00	$ 3,127,680	0.180478
29	6701	OCCUPATIONAL THERAPY - SNF	$145,067.00	$ -	$0.00		$ 145,067	$259,217.00	$0.00	$ 259,217	0.559635
30	6800	SPEECH PATHOLOGY	$104,399.00	$ -	$0.00		$ 104,399	$229,506.00	$99,542.00	$ 329,048	0.317276
31	6801	SPEECH PATHOLOGY - SNF	$86,300.00	$ -	$0.00		$ 86,300	$152,103.00	$0.00	$ 152,103	0.567379

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
32	6900	ELECTROCARDIOLOGY	$37,361.00	$ -	$0.00		$ 37,361	$39,704.00	$653,700.00	$ 693,404	0.053881
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$137,015.00	$ -	$0.00		$ 137,015	$364,120.00	$286,874.00	$ 650,994	0.210470
34	7300	DRUGS CHARGED TO PATIENTS	$814,403.00	$ -	$0.00		$ 814,403	$2,392,925.00	$797,181.00	$ 3,190,106	0.255290
35	9100	EMERGENCY	$2,113,243.00	$ -	$0.00		$ 2,113,243	$26,066.00	$6,284,221.00	$ 6,310,287	0.334889
36			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 8,031,370	$ -	$ -		$ 8,031,370	$ 11,829,088	$ 24,387,485	$ 36,216,573	
127		**Weighted Average**									0.223248
128		**Sub Totals**	$ 10,592,142	$ -	$ -		$ 8,301,693	$ 13,882,655	$ 24,387,485	$ 38,270,140	
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)*					$1,000,433.00				
131		NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 7,301,260				
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) MITCHELL COUNTY HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 781.28		7		19		48		27		47		101		53.43%
2	03100 INTENSIVE CARE UNIT	$ -												-		
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	7		19		48		27		47		101		42.77%
19	Total Days per PS&R or Exhibit Detail			7		19		48		27		47				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 4,299		$ 12,030		$ 31,584		$ 17,059		$ 29,924		$ 64,972		4.62%
21.01	Calculated Routine Charge Per Diem			$ 614.14		$ 633.16		$ 658.00		$ 631.81		$ 636.68		$ 643.29		
	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)		0.474914	-	3,045	-	7,626	-	33,576	-	14,057	-	-	$ -	$ 58,304	51.36%
23	5400 RADIOLOGY-DIAGNOSTIC		0.307435	591	186,203	2,166	432,960	6,445	213,007	4,386	171,493	3,306	381,703	$ 13,588	$ 1,003,663	52.67%
24	5700 CT SCAN		0.042455	4,120	222,875	5,607	470,199	13,614	505,619	8,969	310,428	7,996	1,116,302	$ 32,310	$ 1,509,121	51.72%
25	5800 MRI		0.166325		9,612		20,237	2,060	33,738	2,060	35,287	1,540	52,608	$ 4,120	$ 98,874	33.72%
26	6000 LABORATORY		0.164538	8,521	462,093	9,470	726,988	53,916	590,469	33,709	439,682	46,633	1,090,986	$ 105,616	$ 2,219,232	48.52%
27	6500 RESPIRATORY THERAPY		0.616310	522	17,201	10,307	43,673	24,414	49,691	19,146	20,908	10,842	60,937	$ 54,389	$ 131,473	31.16%
28	6600 PHYSICAL THERAPY		0.207527	-	46,443	-	40,778	473	116,598	473	200,498	1,182	52,118	$ 946	$ 404,317	9.70%
29	6601 PHYSICAL THERAPY - SNF		0.622517	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
30	6700 OCCUPATIONAL THERAPY		0.180478	-	4,636	-	3,182	-	33,956	-	38,895	-	17,479	$ -	$ 80,669	3.14%
31	6701 OCCUPATIONAL THERAPY - SNF		0.559635	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
32	6800 SPEECH PATHOLOGY		0.317276	-	-	-	29,963	1,189	3,616	-	4,007	-	392	$ 1,189	$ 37,586	11.90%
33	6801 SPEECH PATHOLOGY - SNF		0.567379	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
34	6900 ELECTROCARDIOLOGY		0.053881	531	30,533	177	36,840	6,267	78,501	4,178	50,513	354	70,061	$ 11,153	$ 196,387	40.14%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.210470	563	19,636	1,674	40,214	8,644	36,360	4,088	18,738	3,837	66,265	$ 14,969	$ 114,948	30.79%
36	7300 DRUGS CHARGED TO PATIENTS		0.255290	3,796	327,942	8,554	112,043	44,691	100,805	17,829	66,380	41,416	227,674	$ 74,870	$ 607,170	29.85%
37	9100 EMERGENCY		0.334889	3,465	379,553	3,458	1,266,210	5,088	545,814	5,348	363,606	1,277	1,663,704	$ 17,359	$ 2,555,183	67.28%
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
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80			-											$ -	$ -	
81			-											$ -	$ -	

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

Cost Report Year (10/01/2016-09/30/2017) 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)		Uninsured		Total In-State Medicaid		% Survey
82			-											$ -	$ -	
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
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101			-											$ -	$ -	
102			-											$ -	$ -	
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104			-											$ -	$ -	
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109			-											$ -	$ -	
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120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 22,109	$ 1,709,772	$ 41,413	$ 3,230,913	$ 166,801	$ 2,341,750	$ 100,186	$ 1,734,492	$ 118,383	$ 4,800,229			

Totals / Payments

128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 26,408	$ 1,709,772	$ 53,443	$ 3,230,913	$ 198,385	$ 2,341,750	$ 117,245	$ 1,734,492	$ 148,307 (Agrees to Exhibit A)	$ 4,800,229 (Agrees to Exhibit A)	$ 395,481	$ 9,016,927	37.58%
129	Total Charges per PS&R or Exhibit Detail	$ 26,408	$ 1,709,772	$ 53,443	$ 3,230,913	$ 198,385	$ 2,341,750	$ 117,245	$ 1,734,492	$ 148,307	$ 4,800,229			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,826	$ 383,467	$ 27,362	$ 788,226	$ 80,067	$ 488,166	$ 48,039	$ 358,956	$ 64,760	$ 1,037,652	$ 165,294	$ 2,018,815	45.08%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 16,817	$ 344,347	$ -	$ -	$ 22,188	$ 161,519	$ 35,433	$ 364,327			$ 74,438	$ 870,193	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 25,147	$ 838,439	$ -	$ -	$ 2,155	$ 65,768			$ 27,302	$ 904,207	
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)	$ 16,817	$ 344,347	$ 25,147	$ 838,439									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 3,404	$ -	$ -							$ -	$ 3,404	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 40,559	$ 321,307	$ -	$ -			$ 40,559	$ 321,307	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 1,316	$ 15,440	$ -	$ -			$ 1,316	$ 15,440	
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)									$ -	$ 144,544			
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)**	$ (6,991)	$ 35,716	$ 2,215	$ (50,213)	$ 16,004	$ (10,100)	$ 10,451	$ (71,139)	$ 64,760	$ 893,108	$ 21,679	$ (95,736)	
146	**Calculated Payments as a Percentage of Cost**	171%	91%	92%	106%	80%	102%	78%	120%	0%	14%	87%	105%	

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)**	165
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: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) MITCHELL COUNTY HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 781.28										-	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
						$ -						$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.474914			-	-			-	-	$ -	$ -
23	5400 RADIOLOGY-DIAGNOSTIC		0.307435			-	1,353			-	677	$ -	$ 2,030
24	5700 CT SCAN		0.042455			-	3,704			-	-	$ -	$ 3,704
25	5800 MRI		0.166325			-	-			-	-	$ -	$ -
26	6000 LABORATORY		0.164538			-	3,734			-	483	$ -	$ 4,217
27	6500 RESPIRATORY THERAPY		0.616310			-	362			-	361	$ -	$ 723
28	6600 PHYSICAL THERAPY		0.207527			-	151			-	-	$ -	$ 151
29	6601 PHYSICAL THERAPY - SNF		0.622517			-	-			-	-	$ -	$ -
30	6700 OCCUPATIONAL THERAPY		0.180478			-	-			-	-	$ -	$ -
31	6701 OCCUPATIONAL THERAPY - SNF		0.559635			-	-			-	-	$ -	$ -
32	6800 SPEECH PATHOLOGY		0.317276			-	-			-	-	$ -	$ -
33	6801 SPEECH PATHOLOGY - SNF		0.567379			-	-			-	-	$ -	$ -
34	6900 ELECTROCARDIOLOGY		0.053881			-	354			-	-	$ -	$ 354
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.210470			-	128			-	286	$ -	$ 414
36	7300 DRUGS CHARGED TO PATIENTS		0.255290			-	1,087			-	154	$ -	$ 1,241
37	9100 EMERGENCY		0.334889			-	6,309			-	1,804	$ -	$ 8,113
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
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64			-									$ -	$ -
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67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) 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)		Total Out-Of-State Medicaid	
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			-									$ -	$ -
				$ -	$ -	$ -	$ 17,182	$ -	$ -	$ -	$ 3,765		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ 17,182	$ -	$ -	$ -	$ 3,765	$ -	$ 20,947
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ 17,182	$ -	$ -	$ -	$ 3,765		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ 3,878	$ -	$ -	$ -	$ 1,214	$ -	$ 5,092
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)			$ -	$ 2,651			$ -	$ 1,080	$ -	$ 3,731
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)	$ -	$ -	$ -	$ 2,651						
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)									$ -	$ -
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)**	$ -	$ -	$ -	$ 1,227	$ -	$ -	$ -	$ 134	$ -	$ 1,361
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	68%	0%	0%	0%	89%	0%	73%

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) 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)		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*
	Organ Acquisition Cost Centers (list below):																
1		Lung Acquisition	$0.00	$ -	$ -		0										
2		Kidney Acquisition	$0.00	$ -	$ -		0										
3		Liver Acquisition	$0.00	$ -	$ -		0										
4		Heart Acquisition	$0.00	$ -	$ -		0										
5		Pancreas Acquisition	$0.00	$ -	$ -		0										
6		Intestinal Acquisition	$0.00	$ -	$ -		0										
7		Islet Acquisition	$0.00	$ -	$ -		0										
8			$0.00	$ -	$ -		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 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 (10/01/2016-09/30/2017) 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)	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):														
11		Lung Acquisition	$ -	$ -	$ -	$ -	0								
12		Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13		Liver Acquisition	$ -	$ -	$ -	$ -	0								
14		Heart Acquisition	$ -	$ -	$ -	$ -	0								
15		Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16		Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17		Islet Acquisition	$ -	$ -	$ -	$ -	0								
18			$ -	$ -	$ -	$ -	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 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 (10/01/2016-09/30/2017) 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	$ -	

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