DSH Version 8.11 2/10/2023

D. General Cost Report Year Information 10/1/2021 - 9/30/2022

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		
	10/1/2021 through 9/30/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	2/24/2023		

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	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	FL	020989100
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2021 - 09/30/2022)

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)	$ -	$ 63,102	$63,102
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 12,921	$ 438,824	$451,745
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$12,921	$501,926	$514,847
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	12.57%	12.26%

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 (10/01/2021 - 09/30/2022)

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)	294 (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	250,000
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 250,000
7.	Inpatient Hospital Charity Care Charges	1,295,001
8.	Outpatient Hospital Charity Care Charges	5,268,210
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 6,563,211

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	$288,890.00			$ 145,874	$ -	$ -	$ 143,016
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$3,289,972.00			$ 1,661,261	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$10,168,996.00			$ 5,134,804	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$11,463,284.00	$27,343,603.00		$ 5,788,351	$ 13,807,070	$ -	$ 19,211,467
20.	Outpatient Services		$12,136,172.00			$ 6,128,123	$ -	$ 6,008,049
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	$5,762,072.00	$ -	$ -	$ 2,909,541	$ -
27.	Total	$ 11,752,174	$ 39,479,775	$ 19,221,040	$ 5,934,225	$ 19,935,193	$ 9,705,606	$ 25,362,531
28.	Total Hospital and Non Hospital		Total from Above	$ 70,452,989		Total from Above	$ 35,575,024	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	70,452,989	Total Contractual Adj. (G-3 Line 2)	35,575,024
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				35,575,024
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$ 4,401,314	$ -	$ -	$3,727,517.00	$ 673,797	666	$3,557,211.00		$ 1,011.71
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	$ 4,401,314	$ -	$ -	$ 3,727,517	$ 673,797	666	$ 3,557,211		
19	Weighted Average									$ 1,011.71

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)	372	-	-	$ 376,356	$0.00	$457,722.00	$ 457,722	0.822237

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5400	RADIOLOGY-DIAGNOSTIC	$783,986.00	$ -	$ -		$ 783,986	$154,001.00	$2,778,870.00	$ 2,932,871	0.267310
22	5700	CT SCAN	$212,401.00	$ -	$ -		$ 212,401	$505,321.00	$7,563,876.00	$ 8,069,197	0.026322
23	5800	MRI	$92,482.00	$ -	$ -		$ 92,482	$69,172.00	$651,484.00	$ 720,656	0.128330
24	6000	LABORATORY	$1,787,883.00	$ -	$ -		$ 1,787,883	$1,819,185.00	$9,249,105.00	$ 11,068,290	0.161532
25	6500	RESPIRATORY THERAPY	$922,635.00	$ -	$ -		$ 922,635	$727,539.00	$288,181.00	$ 1,015,720	0.908356
26	6600	PHYSICAL THERAPY	$875,372.00	$ -	$ -		$ 875,372	$1,905,287.00	$891,462.00	$ 2,796,749	0.312996
27	6601	PHYSICAL THERAPY - SNF	$353,283.00	$ -	$ -		$ 353,283	$373,709.00	$0.00	$ 373,709	0.945342
28	6700	OCCUPATIONAL THERAPY	$545,597.00	$ -	$ -		$ 545,597	$1,810,144.00	$176,957.00	$ 1,987,101	0.274569
29	6701	OCCUPATIONAL THERAPY - SNF	$161,830.00	$ -	$ -		$ 161,830	$150,197.00	$0.00	$ 150,197	1.077452

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) MITCHELL COUNTY HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	6800 SPEECH PATHOLOGY	$223,167.00	$ -	$ -		$ 223,167	$52,531.00	$194,331.00	$ 246,862	0.904015
31	6801 SPEECH PATHOLOGY - SNF	$25,125.00	$ -	$ -		$ 25,125	$31,251.00	$0.00	$ 31,251	0.803974
32	6900 ELECTROCARDIOLOGY	$25,489.00	$ -	$ -		$ 25,489	$82,738.00	$1,027,851.00	$ 1,110,589	0.022951
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$203,921.00	$ -	$ -		$ 203,921	$512,100.00	$379,381.00	$ 891,481	0.228744
34	7300 DRUGS CHARGED TO PATIENTS	$986,721.00	$ -	$ -		$ 986,721	$3,438,126.00	$2,036,280.00	$ 5,474,406	0.180243
35	9100 EMERGENCY	$2,806,571.00	$ -	$ -		$ 2,806,571	$401,039.00	$11,426,212.00	$ 11,827,251	0.237297
36		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
37		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
38		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
40		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) MITCHELL COUNTY HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 10,006,463	$ -	$ -		$ 10,006,463	$ 12,032,340	$ 37,121,712	$ 49,154,052	
127		**Weighted Average**									0.211230
128		**Sub Totals**	$ 14,407,777	$ -	$ -		$ 10,680,260	$ 15,589,551	$ 37,121,712	$ 52,711,263	
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)*					$824,319.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 9,855,941				
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 (10/01/2021-09/30/2022) MITCHELL COUNTY HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		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	$ 1,011.71		3		15		53		7		34		78		38.10%
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**	3		15		53		7		34		78		16.82%
19	Total Days per PS&R or Exhibit Detail			3		15		53		7		34				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 2,772		$ 13,806		$ 47,760		$ 6,342		$ 31,290		$ 70,680		2.87%
21.01	Calculated Routine Charge Per Diem			$ 924.00		$ 920.40		$ 901.13		$ 906.00		$ 920.29		$ 906.15		
	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)		0.822237	-	21,330	-	58,471	-	102,854	-	90,122	-	2,882	$ -	$ 272,777	60.75%
23	5400 RADIOLOGY-DIAGNOSTIC		0.267310	600	141,948	805	491,047	4,201	208,425	-	177,338	3,563	323,765	$ 5,606	$ 1,018,758	46.19%
24	5700 CT SCAN		0.026322	3,911	304,554	11,370	869,799	9,635	765,580	-	320,626	1,813	1,366,652	$ 24,916	$ 2,260,559	45.68%
25	5800 MRI		0.128330	-	22,315	-	31,205	8,009	112,047	-	49,767	-	49,945	$ 8,009	$ 215,334	38.20%
26	6000 LABORATORY		0.161532	5,766	580,704	24,693	1,513,202	45,794	591,654	9,543	736,650	45,587	1,231,367	$ 85,796	$ 3,422,210	43.39%
27	6500 RESPIRATORY THERAPY		0.908356	6,983	14,543	8,480	59,096	23,246	26,979	1,716	23,644	1,909	41,537	$ 40,425	$ 124,262	20.56%
28	6600 PHYSICAL THERAPY		0.312996	-	55,219	-	66,459	2,100	56,081	-	84,243	811	22,817	$ 2,100	$ 262,002	10.41%
29	6601 PHYSICAL THERAPY - SNF		0.945342	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
30	6700 OCCUPATIONAL THERAPY		0.274569	-	3,086	-	42,610	2,072	10,395	-	10,562	319	4,661	$ 2,072	$ 66,653	3.71%
31	6701 OCCUPATIONAL THERAPY - SNF		1.077452	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
32	6800 SPEECH PATHOLOGY		0.904015	-	903	-	119,669	390	4,233	-	975	-	620	$ 390	$ 125,780	51.36%
33	6801 SPEECH PATHOLOGY - SNF		0.803974	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
34	6900 ELECTROCARDIOLOGY		0.022951	230	27,534	690	56,532	4,912	163,115	-	76,580	5,224	117,849	$ 5,832	$ 323,761	40.86%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.228744	1,371	17,364	4,824	64,143	15,125	40,339	959	23,104	3,926	67,373	$ 22,279	$ 144,950	26.95%
36	7300 DRUGS CHARGED TO PATIENTS		0.180243	1,993	345,333	33,632	185,413	85,148	213,055	7,355	114,081	70,588	301,534	$ 128,128	$ 857,882	24.87%
37	9100 EMERGENCY		0.237297	1,751	499,462	10,818	2,915,580	1,262	729,626	-	392,552	-	2,314,886	$ 13,831	$ 4,537,220	58.35%
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2021-09/30/2022) 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		%
61				-											$ -	$ -	
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
69				-											$ -	$ -	
70				-											$ -	$ -	
71				-											$ -	$ -	
72				-											$ -	$ -	
73				-											$ -	$ -	
74				-											$ -	$ -	
75				-											$ -	$ -	
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124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 22,605	$ 2,034,295	$ 95,312	$ 6,473,226	$ 201,894	$ 3,024,383	$ 19,573	$ 2,100,244	$ 133,740	$ 5,845,888			

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

Cost Report Year (10/01/2021-09/30/2022) 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		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 25,377	$ 2,034,295	$ 109,118	$ 6,473,226	$ 249,654	$ 3,024,383	$ 25,915	$ 2,100,244	$ 165,030 (Agrees to Exhibit A)	$ 5,845,888 (Agrees to Exhibit A)	$ 410,064	$ 13,632,148	38.24%
129	Total Charges per PS&R or Exhibit Detail	$ 25,377	$ 2,034,295	$ 109,118	$ 6,473,226	$ 249,654	$ 3,024,383	$ 25,915	$ 2,100,244	$ 165,030	$ 5,845,888			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 11,667	$ 377,691	$ 37,130	$ 1,386,280	$ 105,336	$ 543,637	$ 11,727	$ 427,707	$ 58,578	$ 998,696	$ 165,860	$ 2,735,315	40.35%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,588	$ 385,889	$ -	$ -	$ 16,317	$ 193,446	$ 1,400	$ 21,410			$ 24,305	$ 600,745	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 40,851	$ 1,918,579	$ -	$ -	$ -	$ 4,837			$ 40,851	$ 1,923,416	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -				$ -	$ -	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 504			$ -	$ 504	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 6,588	$ 385,889	$ 40,851	$ 1,918,579									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (52,526)	$ -	$ -							$ -	$ (52,526)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 67,159	$ 372,128	$ -				$ 67,159	$ 372,128	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 12,543	$ 385,985			$ 12,543	$ 385,985	
141	Medicare Cross-Over Bad Debt Payments					$ 965	$ 30,209	$ -		(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 965	$ 30,209	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -				$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ -	$ 63,102			
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)**	$ 5,079	$ 44,328	$ (3,721)	$ (532,299)	$ 20,895	$ (52,146)	$ (2,216)	$ 14,971	$ 58,578	$ 935,594	$ 20,037	$ (525,146)	
146	**Calculated Payments as a Percentage of Cost**	56%	88%	110%	138%	80%	110%	119%	96%	0%	6%	88%	119%	
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**					32%								

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 (10/01/2021-09/30/2022) MITCHELL COUNTY HOSPITAL

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	$ 1,011.71		-		-						-	
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)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	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)		0.822237	-	2,395	-	-					$ -	$ 2,395
23	5400 RADIOLOGY-DIAGNOSTIC		0.267310	-	2,140	-	1,002					$ -	$ 3,142
24	5700 CT SCAN		0.026322	-	28,225	-	4,084					$ -	$ 32,309
25	5800 MRI		0.128330	-	2,004	-	-					$ -	$ 2,004
26	6000 LABORATORY		0.161532	-	14,561	-	3,118					$ -	$ 17,679
27	6500 RESPIRATORY THERAPY		0.908356	-	484	-	240					$ -	$ 724
28	6600 PHYSICAL THERAPY		0.312996	-	2,550	-	995					$ -	$ 3,545
29	6601 PHYSICAL THERAPY - SNF		0.945342	-	-	-	-					$ -	$ -
30	6700 OCCUPATIONAL THERAPY		0.274569	-	-	-	-					$ -	$ -
31	6701 OCCUPATIONAL THERAPY - SNF		1.077452	-	-	-	-					$ -	$ -
32	6800 SPEECH PATHOLOGY		0.904015	-	-	-	-					$ -	$ -
33	6801 SPEECH PATHOLOGY - SNF		0.803974	-	-	-	-					$ -	$ -
34	6900 ELECTROCARDIOLOGY		0.022951	-	1,150	-	-					$ -	$ 1,150
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.228744	-	1,668	-	84					$ -	$ 1,752
36	7300 DRUGS CHARGED TO PATIENTS		0.180243	-	2,849	-	388					$ -	$ 3,237
37	9100 EMERGENCY		0.237297	-	27,333	-	8,235					$ -	$ 35,568
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
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88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 85,359	$ -	$ 18,146	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ 85,359	$ -	$ 18,146	$ -	$ -	$ -	$ -	$ -	$ 103,505		
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 85,359	$ -	$ 18,146	$ -	$ -	$ -	$ -				
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-				
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ 14,539	$ -	$ 3,452	$ -	$ -	$ -	$ -	$ -	$ 17,991		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ 3,948	$ -	$ -					$ -	$ 3,948		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ 1,815					$ -	$ 1,815		
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)	$ -	$ 3,948	$ -	$ 1,815								
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) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ 10,591	$ -	$ 1,637	$ -	$ -	$ -	$ -	$ -	$ 12,228		
144	**Calculated Payments as a Percentage of Cost**	0%	27%	0%	53%	0%	0%	0%	0%	0%	32%		

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 (10/01/2021-09/30/2022) | 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From 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 (10/01/2021-09/30/2022) | 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
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 (10/01/2021-09/30/2022) MITCHELL COUNTY HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	14,145,717
19	Uninsured Hospital	**Charges Sec. G**	6,010,918
20	Total Hospital	**Charges Sec. G**	52,711,263
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		26.84%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.40%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

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

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