

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02

2/10/2023

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2025	06/30/2026

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

CHI MEMORIAL HOSPITAL - GEORGIA

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2023	06/30/2024

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

6. Medicaid Provider Number:

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

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

9. Medicare Provider Number:

Data
003180661A
0
0
110236

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

DSH Examination
Year (07/01/25 -
06/30/26)

No

No

No

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

No

3b. What date did the hospital open?

12/29/2017

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026

(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 219,486

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026

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

NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

6.02

Property of Myers and Stauffer LC

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State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2025 - 06/30/2026

\$ 219,486

Certification:

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

Answer

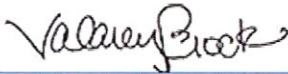
No

Explanation for "No" answers:

Received no DSH payment.

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

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



Hospital CEO or CFO Signature

Sr. Reimbursement Analyst

Title

11/14/2025

Date

Valarey A. Brock

Hospital CEO or CFO Printed Name

(423)495-5885

Hospital CEO or CFO Telephone Number

valarey.brock@commonspirit.org

Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Vanessa Bennett
Title	Reimbursement Analyst II
Telephone Number	(423)702-6084
E-Mail Address	vanessa.bennett@commonspirit.org
Mailing Street Address	2525 deSales Avenue
Mailing City, State, Zip	Chattanooga, TN 37404

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

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D. General Cost Report Year Information 7/1/2023 - 6/30/2024

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:

CHI MEMORIAL HOSPITAL - GEORGIA

2. Select Cost Report Year Covered by this Survey (enter "X"):

7/1/2023 through 6/30/2024
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:

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
CHI MEMORIAL HOSPITAL - GEORGIA	Yes	
Medicaid Provider Number:	Yes	
003180661A	Yes	
Medicaid Subprovider Number 1 (Psychiatric or Rehab):	Yes	
0	Yes	
Medicaid Subprovider Number 2 (Psychiatric or Rehab):	Yes	
0	Yes	
Medicare Provider Number:	Yes	
110236	Yes	
Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Yes	
Private	Yes	
PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others):	Yes	
Pool 2	Yes	
Rural Referral Center (Yes or No):	Yes	
No	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.
12. State Name & Number	
13. State Name & Number	
14. State Name & Number	
15. State Name & Number	
16. State Name & Number	
17. State Name & Number	
18. State Name & Number	

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2023 - 06/30/2024)

- Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)

\$-
\$-
\$-
\$-
\$-
\$-
\$-

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

\$ 714,304

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

Inpatient	Outpatient	Total
\$ 50	\$ 138,178	\$138,228
\$ 81,689	\$ 1,456,521	\$1,538,210
\$81,739	\$1,594,699	\$1,676,438
0.06%	8.66%	8.25%

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

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

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

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

No

Should include all non-claims specific payments such as lump sum payments for full Medicaid pricing, supplemental, 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 (07/01/2023 - 06/30/2024)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (CIR, WIS S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 19.00-19.03, 30, 31 less lines 5 & 6)

1.710

(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 (LUR) Calculation)

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified IP and OP Hospital Subsidies
5. Non-Hospital Subsidies
6. Total Hospital Subsidies
7. Inpatient Hospital Charity Care Charges
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

\$	-

\$	-

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

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

Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenues
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
\$ 4,233,444			\$ 3,676,918	\$ -	\$ -	\$ 556,526
\$ -			\$ -	\$ -	\$ -	\$ -
\$ -			\$ -	\$ -	\$ -	\$ -
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
\$ 8,774,704	\$ 116,531,915		\$ 7,621,190	\$ 101,212,737	\$ -	\$ 16,472,693
	\$ 38,745,159			\$ 33,651,756	\$ -	\$ 5,093,403
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
		\$ -			\$ -	\$ -
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
\$ 13,008,148	\$ 155,277,074	\$ -	\$ 11,298,109	\$ 134,864,493	\$ -	\$ 22,122,602
	Total from Above	\$ 168,265,222		Total from Above	\$ 145,162,602	

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

Total Contractual Adj (G-3 Line 2)	
	149,152,602
+	
+	
+	
+	
-	
-	149,152,602
Reconciled Difference (Should be \$0)	
\$	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) CHI MEMORIAL HOSPITAL - GEORGIA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	IP Days and IP Ancillary Charges	IP Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6000 PHYSICAL THERAPY	\$ 72,019	\$ -	\$ -	\$ 72,019	\$ 191,844	\$ 53,483	\$ 245,332	0.293557
32	7000 ELECTROENCEPHALOGRAPHY	\$ 107,737	\$ -	\$ -	\$ 107,737	\$ -	\$ -	\$ -	-
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 107,972	\$ -	\$ -	\$ 107,972	\$ 4,926	\$ 302,335	\$ 307,261	0.351402
34	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 1,030	\$ -	\$ -	\$ 1,030	\$ -	\$ 7,467	\$ 7,467	0.131940
35	7300 DRUGS CHARGED TO PATIENTS	\$ 749,057	\$ -	\$ -	\$ 749,057	\$ 952,649	\$ 2,178,133	\$ 3,130,782	0.239256
36	9100 EMERGENCY	\$ 5,835,043	\$ -	\$ -	\$ 5,835,043	\$ 1,831,148	\$ 36,571,673	\$ 38,402,821	0.151943
37		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
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		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
63		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
64		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
65		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
66		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
67		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
68		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
69		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
70		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
71		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
72		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
73		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
74		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
75		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
76		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
77		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
78		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
79		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
80		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
81		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
82		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
83		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
84		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
85		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
86		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
87		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
88		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
89		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
90		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) CHI MEMORIAL HOSPITAL - GEORGIA

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	IP Days and IP Ancillary Charges	IP Routine Charges and OIP Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	Total Ancillary	\$ 20,995,665	\$ -	\$ -	\$ 20,995,665	\$ 12,426,762	\$ 153,425,489	\$ 165,852,251	
127	Weighted Average								0.133298
128	Sub Totals	\$ 24,619,847	\$ -	\$ -	\$ 24,619,847	\$ 14,859,735	\$ 153,425,489	\$ 168,285,224	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)	\$ -			\$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)	\$ -			\$ -				
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	\$ 24,619,847			\$ 24,619,847				
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

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

Cost Report Year: 07/01/2016-06/30/2017

OH MEMORIAL HOSPITAL - GEORGIA

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Care	Medicaid Cost to Charge Ratio for Routine Care	In-State Medicaid PPS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid PPS Cross-Over with Medicaid Secondary		In-State Medicaid Managed Care Cross-Over with Medicaid Secondary		Medicaid PPS & NCC (Inpatient and Outpatient Covered Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Data reflect Medicaid PPS & NCC Covered and Non-Covered)		% Survey to Cost Report Totals (Includes all Lines)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line A)	From PPSR Summary (Line 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		Days		
1	0200 INPATIENT BEDS	\$ 1,408.11		137		27		208		8				137		582		0.0%
2	0200 INPATIENT CARE UNIT	\$ -																
3	0200 CORONARY CARE UNIT	\$ -																
4	0200 BURN INTENSIVE CARE UNIT	\$ -																
5	0200 SURGICAL INTENSIVE CARE UNIT	\$ -																
6	0200 CRITICAL CARE UNIT	\$ -																
7	0200 ISOLATOR	\$ -																
8	0200 SURFACER	\$ -																
9	0200 SURFACER	\$ -																
10	0200 SURFACER	\$ -																
11	0200 SURFACER	\$ -																
12	0200 SURFACER	\$ -																
13	0200 SURFACER	\$ -																
14	0200 SURFACER	\$ -																
15	0200 SURFACER	\$ -																
16	0200 SURFACER	\$ -																
17	0200 SURFACER	\$ -																
18	0200 SURFACER	\$ -																
19	Total Days per PPSR in Exhibit Detail			137		27		208		8				137		582		0.0%
20	Estimated Days (Explain Variance)																	
21	Exhibit Charges			Days		Days		Days		Days		Days		Days		Days		
21.01	Calculated Routine Charge Per Day			1,408.11		1,408.11		1,408.11		1,408.11		1,408.11		1,408.11		1,408.11		0.0%
22	Auxiliary Cost Centers from Section G:			Days		Days		Days		Days		Days		Days		Days		
23	0300 LABORATORY	\$ 3,000.00																
24	0300 RECOVERY ROOM	\$ 1,000.00																
25	0300 INTENSIVE CARE	\$ 1,000.00																
26	0300 RADIOLOGY	\$ 1,000.00																
27	0300 RADIOLOGY	\$ 1,000.00																
28	0300 RADIOLOGY	\$ 1,000.00																
29	0300 RADIOLOGY	\$ 1,000.00																
30	0300 RADIOLOGY	\$ 1,000.00																
31	0300 RADIOLOGY	\$ 1,000.00																
32	0300 RADIOLOGY	\$ 1,000.00																
33	0300 RADIOLOGY	\$ 1,000.00																
34	0300 RADIOLOGY	\$ 1,000.00																
35	0300 RADIOLOGY	\$ 1,000.00																
36	0300 RADIOLOGY	\$ 1,000.00																
37	0300 RADIOLOGY	\$ 1,000.00																
38	0300 RADIOLOGY	\$ 1,000.00																
39	0300 RADIOLOGY	\$ 1,000.00																
40	0300 RADIOLOGY	\$ 1,000.00																
41	0300 RADIOLOGY	\$ 1,000.00																
42	0300 RADIOLOGY	\$ 1,000.00																
43	0300 RADIOLOGY	\$ 1,000.00																
44	0300 RADIOLOGY	\$ 1,000.00																
45	0300 RADIOLOGY	\$ 1,000.00																
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67	0300 RADIOLOGY	\$ 1,000.00																
68	0300 RADIOLOGY	\$ 1,000.00																
69	0300 RADIOLOGY	\$ 1,000.00																
70	0300 RADIOLOGY	\$ 1,000.00																
71	0300 RADIOLOGY	\$ 1,000.00																

Case Report Year 2017/2018/2019/2020/2021 CHI MEMORIAL HOSPITAL - GEORGIA

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Call Request Your 127.010202-00702024 CHI MEMORIAL HOSPITAL - GEORGIA

[illegible]

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) CH MEMORIAL HOSPITAL - GEORGIA

		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 & with Medicaid Secondary)		Total Out-of-State Medicaid	
Line #	Cost Center Description			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	\$ 1,405.81				5		2		9			15
2	03100 INTENSIVE CARE UNIT	\$ -											-
3	03200 CORONARY CARE UNIT	\$ -											-
4	03300 SURG 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		\$ -											-
19	Total Days			-		5		2		9		-	15
20	Total Days per PS&R or Exhibit Detail			-		5		2		9			
	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Dem			\$ -		\$ 1,615.00		\$ 1,300.00		\$ 1,360.00		\$ 1,439.69	
Ancillary Cost Centers (from WIS C) (List below)				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
22	05000 Observation (Non-Discharge)		0.376330	3,744		3,744		2,025		12,012		15,258	
23	5000 OPERATING ROOM		0.844799										
24	5100 RECOVERY ROOM		15.753378										
25	5300 ANESTHESIOLOGY		-										
26	5400 RADIOLOGY-DIAGNOSTIC		0.128289	45,353		2,794		3,505		15,965		98,023	
27	5500 RADIOLOGY-THERAPEUTIC		0.091001										
28	5600 RADIOISOTOPE		0.128557										
29	6000 LABORATORY		0.131255	45,814		13,099		4,227		22,923		81,609	
30	6200 URINE BLOOD & PACKED RED BLOOD CELL		0.383259										
31	6400 INTRAVENOUS THERAPY		0.063395	284		1,082		1,349		14,687		18,253	
32	6500 RESPIRATORY THERAPY		0.104626	12,427		8,863		743		24,524		30,533	
33	6600 PHYSICAL THERAPY		0.209567							1,017		1,017	
34	7000 ELECTROENCEPHALOGRAPHY		-										
35	7200 MEDICAL SUPPLIES CHARGED TO PATIENT		0.351402	35				137		159		159	
36	7300 MPL DEV. CHARGED TO PATIENTS		0.137940										
37	7500 DRUGS CHARGED TO PATIENTS		0.230256	5,042		3,455		968		4,290		9,547	
38	9100 EMERGENCY		0.151943	111,648		5,678		532,142		2,185		109,048	
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L. Out-of-State Medicaid Data:

Cont Report Year (07/01/2023-06/30/2024) CH MEMORIAL HOSPITAL - GEORGIA

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
49												\$ -	\$ -
50												\$ -	\$ -
51												\$ -	\$ -
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111												\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (8/01/2023-06/30/2024) CH MEMORIAL HOSPITAL - GEORGIA

			Out-of-State Medicaid FFS Primary	Out-of-State Medicaid Managed Care Primary	Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)	Out-of-State Other Medicaid Eligible (not Included Elsewhere & with Medicaid Secondary)	Total Out-Of-State Medicaid					
112								\$ -	\$ -			
113								\$ -	\$ -			
114								\$ -	\$ -			
115								\$ -	\$ -			
116								\$ -	\$ -			
117								\$ -	\$ -			
118								\$ -	\$ -			
119								\$ -	\$ -			
120								\$ -	\$ -			
121								\$ -	\$ -			
122								\$ -	\$ -			
123								\$ -	\$ -			
124								\$ -	\$ -			
125								\$ -	\$ -			
126								\$ -	\$ -			
127								\$ -	\$ -			
			\$ -	\$ 224,357	\$ 35,715	\$ 1,179,515	\$ 14,970	\$ 283,038	\$ 97,507	\$ 462,376		
Totals / Payments												
128	Total Charges (includes organ acquisition from Section K)		\$ -	\$ 224,357	\$ 43,790	\$ 1,179,515	\$ 17,690	\$ 283,038	\$ 109,747	\$ 462,376	\$ 171,227	\$ 2,149,287
129	Total Charges per PS&R or Exhibit Detail		\$ -	\$ 224,357	\$ 43,790	\$ 1,179,515	\$ 17,690	\$ 283,038	\$ 109,747	\$ 462,376		
130	Unreconciled Charges (Explain Variance)											
131	Total Calculated Cost (includes organ acquisition from Section K)		\$ -	\$ 32,739	\$ 12,797	\$ 171,658	\$ 5,296	\$ 38,939	\$ 28,278	\$ 67,159	\$ 48,371	\$ 310,555
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ 1,430				\$ 100		\$ 224	\$ -	\$ 1,754
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 15,447	\$ 12,915	\$ 103,838			\$ 4,129	\$ 12,915	\$ 123,414	
134	Private Insurance (including primary and third party liability)								\$ 6,444	\$ 61,327	\$ 6,444	\$ 61,327
135	Self-Pay (including Co-Pay and Spend-Down)					\$ 343		\$ 123		\$ 92	\$ -	\$ 558
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$ -	\$ 16,877	\$ 12,915	\$ 104,181						
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 (includes coinsurance/deductibles) (See Note F)						\$ 5,332	\$ 7,807	\$ 5,287	\$ 5,332	\$ 5,332	\$ 13,094
140	Medicare Managed Care (HMO) Paid Amount (includes coinsurance/deductibles)						\$ 16,969	\$ 12,561	\$ 25,881	\$ 12,561	\$ 12,561	\$ 42,600
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)		\$ -	\$ 15,862	\$ (115)	\$ 67,507	\$ (35)	\$ 13,910	\$ 9,273	\$ (29,751)	\$ 9,119	\$ 67,528
144	Calculated Payments as a Percentage of Cost		0%	52%	101%	61%	101%	64%	67%	144%	80%	78%

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 Out-of-State 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: 12/31/2020-06/30/2021 CH MEMORIAL HOSPITAL - GEORGIA

	Total Organ Acquisition Cost	Additional Add-in Items/Passive Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid Cross-Over / Uninsured Organs Sold	Total Usable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid FFS Cross-Over with Medicaid Secondary		In-State Other Medicaid Organs that Subsidized Donations & with Medicaid Secondary - Uninsured Medicaid Cross-Over with Medicaid Secondary		Medicaid FFS & MCO Excluded and Non-Covered that not Subsidized Donations		Uninsured	
						Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)
	Cost Report Worksheet O-4, Pt. B, Col. 1, Line 81	Add-On Cost Factor on Section 6, Line 133 + 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-5, D-4 Pt. B, Col. 1, Line 81. Justifiable in Medicaid with Medicaid Cross-Over & Uninsured. See Note C below.	Cost Report Worksheet O-4, Pt. B, Line 82	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
1	Heart Acquisition	\$ -	\$ -	\$ -	\$ -												
2	Liver Acquisition	\$ -	\$ -	\$ -	\$ -												
3	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -												
4	Lung Acquisition	\$ -	\$ -	\$ -	\$ -												
5	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -												
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -												
7	Other Acquisition	\$ -	\$ -	\$ -	\$ -												
8		\$ -	\$ -	\$ -	\$ -												
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 K 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 able for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisition, the amount entered must also include an amount representing the acquisition cost of the organs implanted into such patients.

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

Cost Report Year: 12/31/2020-06/30/2021 CH MEMORIAL HOSPITAL - GEORGIA

	Total Organ Acquisition Cost	Additional Add-in Items/Passive Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid Cross-Over / Uninsured Organs Sold	Total Usable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicaid FFS Cross-Over with Medicaid Secondary		Out-of-State Other Medicaid Organs that Subsidized Donations & with Medicaid Secondary	
						Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)	Charges	Usable Organs (Count)
	Cost Report Worksheet O-4, Pt. B, Col. 1, Line 81	Add-On Cost Factor on Section 6, Line 133 + 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-5, D-4 Pt. B, Col. 1, Line 81. Justifiable in Medicaid with Medicaid Cross-Over & Uninsured. See Note C below.	Cost Report Worksheet O-4, Pt. B, Line 82	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
11	Heart Acquisition	\$ -	\$ -	\$ -	\$ -								
12	Liver Acquisition	\$ -	\$ -	\$ -	\$ -								
13	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -								
14	Lung Acquisition	\$ -	\$ -	\$ -	\$ -								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -								
17	Other Acquisition	\$ -	\$ -	\$ -	\$ -								
18		\$ -	\$ -	\$ -	\$ -								
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 L 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 survey.

Cost Report Year: 07/01/2020 - 06/30/2024 CH MEMORIAL HOSPITAL - GEORGIA

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	WIS A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	225,495	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	760092 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (WIS A, Col. 2)	225,495	5.00 (Where is the cost included on wty A?)
3 Difference (Explain Here -----)		
Provider Tax Assessment Reclassifications (from wty A-4 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 wty 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 wty 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	225,495	
DSH UCC Provider Tax Assessment Adjustment:		
17 Gross Allowable Assessment Not Included in the Cost Report		
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18 Medicaid Eligible*** Charges Sec. G	20,699,539	
19 Uninsured Hospital Charges Sec. G	15,435,644	
20 Total Hospital Charges Sec. G	168,285,224	
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	17.65%	
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.77%	
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -	
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -	
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ -	
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26 Medicaid Primary*** Charges Sec. G	14,609,021	
27 Uninsured Hospital Charges Sec. G	15,435,644	
28 Total Hospital Charges Sec. G	168,285,224	
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	8.65%	
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.77%	
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -	
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -	
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -	

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

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

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