

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2024	06/30/2025

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

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	07/01/2022	06/30/2023
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	00000954A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111320

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:

<p>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.)</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <th style="text-align: center;">DSH Examination Year (07/01/24 - 06/30/25)</th> </tr> <tr> <td style="text-align: center;">No</td> </tr> </table>	DSH Examination Year (07/01/24 - 06/30/25)	No
DSH Examination Year (07/01/24 - 06/30/25)			
No			
<p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">No</td> </tr> </table>	No	
No			
<p>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?</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Yes</td> </tr> </table>	Yes	
Yes			
<p>3a. Was the hospital open as of December 22, 1987?</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">Yes</td> </tr> </table>	Yes	
Yes			
<p>3b. What date did the hospital open?</p>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="text-align: center;">1/3/1955</td> </tr> </table>	1/3/1955	
1/3/1955			

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025 \$ 190,833
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025 \$ -
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2024 - 06/30/2025 \$ 190,833

Certification:


Answer
Yes

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

Explanation for "No" answers:

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

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

	CFO	2/28/25
Hospital CEO or CFO Signature	Title	Date
Carol S. Crews	770-836-9745	ccrews@tanner.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	Carol S. Crews
Title	CFO
Telephone Number	770-836-9745
E-Mail Address	ccrews@tanner.org
Mailing Street Address	705 Dixie Street, Carrollton
Mailing City, State, Zip	Carrollton, GA 30117

Outside Preparer:	
Name	Wilson E. Joiner, III
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bjoiner@draffin-tucker.com

D. General Cost Report Year Information **7/1/2022 - 6/30/2023**

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

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

7/1/2022 through 6/30/2023		
----------------------------------	--	--

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

X		
---	--	--

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

3a. Date CMS processed the HCRIS file into the HCRIS database:

Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Yes	
5. Medicaid Provider Number:	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	Yes	
8. Medicare Provider Number:	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Yes	

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

State Name	Provider No.

9. State Name & Number
10. State Name & Number
11. State Name & Number
12. State Name & Number
13. State Name & Number
14. State Name & Number
15. State Name & Number
(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2022 - 06/30/2023)

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

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 1,762	\$ 417,337	\$419,099
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 24,475	\$ 1,915,594	\$1,940,069
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)	\$26,237	\$2,332,931	\$2,359,168
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.72%	17.89%	17.76%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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 (07/01/2022 - 06/30/2023)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 968 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	2,311,996
8. Outpatient Hospital Charity Care Charges	3,635,140
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 5,947,136

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$5,335,254.00			\$ 3,782,247	\$ -	\$ -	\$ 1,553,007
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$5,318,618.00			\$ 3,770,453	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$6,982,681.00	\$75,832,638.00		\$ 4,950,134	\$ 53,758,967	\$ -	\$ 24,106,218
20. Outpatient Services		\$27,568,610.00			\$ 19,543,827	\$ -	\$ 8,024,783
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	\$10,733,232.00	\$ -	\$ -	\$ 7,608,959	\$ -
27. Total	\$ 12,317,935	\$ 103,401,248	\$ 16,051,850	\$ 8,732,381	\$ 73,302,794	\$ 11,379,412	\$ 33,684,008
28. Total Hospital and Non Hospital		Total from Above	\$ 131,771,033	Total from Above	\$ 93,414,587		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	131,771,033	Total Contractual Adj. (G-3 Line 2)	90,530,098
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)				2,884,489
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				93,414,587
37. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 6,266,265	\$ -	\$ -	\$ 3,890,521.00	\$ 2,375,744	1,759	\$ 7,241,659.00	\$ 1,350.62
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	\$ 6,266,265	\$ -	\$ -	\$ 3,890,521	\$ 2,375,744	1,759	\$ 7,241,659	
19		Weighted Average								\$ 1,350.62

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
09200 Observation (Non-Distinct)	791	-	-	\$ 1,068,340	\$ 298,755.00	\$ 1,730,370.00	\$ 2,029,125	0.526503

	<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
--	---	---	--	-------------------	---	--	---	---

Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5000	OPERATING ROOM	\$ 4,644,170.00	\$ -	\$ -	\$ 4,644,170	\$ 23,566.00	\$ 16,212,791.00	\$ 16,236,357	0.286035
22	5400	RADIOLOGY-DIAGNOSTIC	\$ 2,705,858.00	\$ -	\$ -	\$ 2,705,858	\$ 849,703.00	\$ 34,347,243.00	\$ 35,196,946	0.076878
23	6000	LABORATORY	\$ 2,267,199.00	\$ -	\$ -	\$ 2,267,199	\$ 1,821,692.00	\$ 9,067,999.00	\$ 10,889,691	0.208197
24	6500	RESPIRATORY THERAPY	\$ 953,198.00	\$ -	\$ -	\$ 953,198	\$ 821,734.00	\$ 2,264,930.00	\$ 3,086,664	0.308812
25	6600	PHYSICAL THERAPY	\$ 1,362,171.00	\$ -	\$ -	\$ 1,362,171	\$ 1,467,793.00	\$ 986,801.00	\$ 2,454,594	0.554948
26	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 309,712.00	\$ -	\$ -	\$ 309,712	\$ 458,766.00	\$ 523,494.00	\$ 982,260	0.316306
27	7200	IMPL. DEV. CHARGED TO PATIENTS	\$ 428,584.00	\$ -	\$ -	\$ 428,584	\$ 0.00	\$ 1,113,381.00	\$ 1,113,381	0.384939
28	7300	DRUGS CHARGED TO PATIENTS	\$ 3,352,464.00	\$ -	\$ -	\$ 3,352,464	\$ 1,838,713.00	\$ 17,344,730.00	\$ 19,183,443	0.174758
29	9100	EMERGENCY	\$ 5,642,296.00	\$ -	\$ -	\$ 5,642,296	\$ 285,632.00	\$ 22,338,049.00	\$ 22,623,681	0.249398
30			\$ 0.00	\$ -	\$ -	\$ -	\$ 0.00	\$ 0.00	\$ -	-
31			\$ 0.00	\$ -	\$ -	\$ -	\$ 0.00	\$ 0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL 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		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL 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	\$ -	-
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	\$ 21,665,652	\$ -	\$ -	\$ 21,665,652	\$ 7,866,354	\$ 105,929,788	\$ 113,796,142	
127	Weighted Average								0.199778
128	Sub Totals	\$ 27,931,917	\$ -	\$ -	\$ 24,041,396	\$ 15,108,013	\$ 105,929,788	\$ 121,037,801	
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)				\$597,443.00				
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				\$ 23,443,953				
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 (07/01/2022-06/30/2023) HIGGINS GENERAL 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				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 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	From Hospital's Own Internal	
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,350.62		50		15		82		177				148		333		49.79%
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		\$ -																
19	Total Days per PS&R or Exhibit Detail			50		15		82		177				148		333		27.40%
20	Unreconciled Days (Explain Variance)																	
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21.01	Calculated Routine Charge Per Diem			\$ 113,456	\$ 29,088	\$ 151,893	\$ 312,551	\$ 1,765.82	\$ -	\$ 236,307	\$ 606,822	\$ 1,822.47						11.68%
22	Ancillary Cost Centers (from WIS C) (from Section G):			Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	05200 Observation (Non-District)	0.526503		333	40,109	1,488	15,793	2,046	66,934	16,217	193,242	875	339,999	20,084	316,078	35,63%		
23	5000 OPERATING ROOM	0.286035			331,106		744,280	2,677	206,563	5,238	706,976		3,362,943	7,915	1,988,024			
24	5400 RADIOLOGY-DIAGNOSTIC	0.076878		37,394	1,420,162	17,640	3,102,684	44,139	1,038,327	72,336	2,768,981	22,471	3,494,034	171,509	8,330,154			
25	6000 LABORATORY	0.208197		54,411	574,046	18,456	1,319,696	85,790	296,721	69,464	838,449	69,464	1,305,105	244,121	3,128,918			
26	6500 RESPIRATORY THERAPY	0.308812		24,179	121,011	11,517	179,804	22,737	65,653	34,300	246,139	27,452	253,063	92,733	611,537	8.30%		
27	6600 PHYSICAL THERAPY	0.554948		4,958	146,230	304	269,776	5,145	49,455	23,752	137,110	26,974	43,691	34,157	602,571	2.02%		
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.315306		11,001	13,063	1,995	8,664	18,330	12,167	10,138	38,777	18,620	73,916	41,464	72,671	1.96%		
29	7200 IMPL. DEV. CHARGED TO PATIENTS	0.394959			350		15,179		7,491		45,444		126,100		68,470	0.92%		
30	7300 DRUGS CHARGED TO PATIENTS	0.174758		68,947	546,768	32,303	1,165,654	70,698	381,463	92,197	1,237,756	33,731	1,881,306	284,144	3,331,670	290.80%		
31	9100 EMERGENCY	0.249398		17,052	1,239,307	6,863	5,407,802	20,087	520,374	26,943	1,661,359	19,245	3,816,319	70,945	8,828,842	1344.74%		
32																		0.00%
33																		0.00%
34																		0.00%
35																		
36																		
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																		

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

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL HOSPITAL

74				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report												
75																\$	\$												
76																\$	\$												
77																\$	\$												
78																\$	\$												
79																\$	\$												
80																\$	\$												
81																\$	\$												
82																\$	\$												
83																\$	\$												
84																\$	\$												
85																\$	\$												
86																\$	\$												
87																\$	\$												
88																\$	\$												
89																\$	\$												
90																\$	\$												
91																\$	\$												
92																\$	\$												
93																\$	\$												
94																\$	\$												
95																\$	\$												
96																\$	\$												
97																\$	\$												
98																\$	\$												
99																\$	\$												
100																\$	\$												
101																\$	\$												
102																\$	\$												
103																\$	\$												
104																\$	\$												
105																\$	\$												
106																\$	\$												
107																\$	\$												
108																\$	\$												
109																\$	\$												
110																\$	\$												
111																\$	\$												
112																\$	\$												
113																\$	\$												
114																\$	\$												
115																\$	\$												
116																\$	\$												
117																\$	\$												
118																\$	\$												
119																\$	\$												
120																\$	\$												
121																\$	\$												
122																\$	\$												
123																\$	\$												
124																\$	\$												
125																\$	\$												
126																\$	\$												
127																\$	\$												
				\$	218,273	\$	4,432,151	\$	90,566	\$	12,228,362	\$	251,648	\$	2,645,190	\$	386,585	\$	7,974,232	\$	-	\$	-	\$	218,818	\$	14,696,478	\$	

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

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL HOSPITAL

	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report							
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 331,723	\$ 4,432,151	\$ 119,554	\$ 12,228,362	\$ 403,541	\$ 2,645,190	\$ 699,136	\$ 7,974,232	\$ -	\$ -	\$ 455,125	\$ 14,696,478	\$ 1,553,954	\$ 27,279,935	37.51%
129 Total Charges per PS&R or Exhibit Detail	\$ 331,723	\$ 4,432,151	\$ 119,554	\$ 12,228,362	\$ 403,541	\$ 2,645,190	\$ 699,136	\$ 7,974,232	\$ -	\$ -	(Agrees to Exhibit A)	\$ 455,125	\$ 14,696,478		
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 124,052	\$ 871,925	\$ 37,952	\$ 2,500,401	\$ 162,705	\$ 486,822	\$ 326,416	\$ 1,524,685	\$ -	\$ -	\$ 256,551	\$ 3,136,061	\$ 651,125	\$ 5,383,833	41.40%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 89,541	\$ 857,588	\$ 21,315	\$ 1,951,490									\$ 89,541	\$ 857,588	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)													\$ 21,315	\$ 1,951,490	
134 Private Insurance (including primary and third party liability)	\$ 711	\$ 1,821					\$ 20,278	\$ 893,675					\$ 20,989	\$ 895,496	
135 Self-Pay (including Co-Pay and Spend-Down)				\$ 1,009		\$ 398		\$ 4,982					\$ -	\$ 6,389	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 90,252	\$ 859,409	\$ 21,315	\$ 1,952,499									\$ -	\$ -	
137 Medicaid Cost Settlement Payments (See Note B)		\$ (130,794)											\$ -	\$ (130,794)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)				\$ 182,142	\$ 443,978		\$ 4,568						\$ 182,142	\$ 448,546	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 459,728	\$ 1,196,220					\$ 459,728	\$ 1,196,220	
141 Medicare Cross-Over Bad Debt Payments				\$ -	\$ 6,546								\$ -	\$ 6,546	
142 Other Medicare Cross-Over Payments (See Note D)				\$ (21,178)	\$ 34,652			\$ 12,758					\$ (21,178)	\$ 47,410	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													\$ 1,762	\$ 417,337	
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)	\$ 33,800	\$ 143,310	\$ 16,637	\$ 547,902	\$ 1,741	\$ 1,248	\$ (153,590)	\$ (587,518)	\$ -	\$ -	\$ 254,789	\$ 2,718,724	\$ (101,412)	\$ 104,942	
146 Calculated Payments as a Percentage of Cost	73%	84%	56%	78%	99%	100%	147%	139%	0%	0%	1%	13%	116%	98%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)															
148 Percent of cross-over days to total Medicare days from the cost report															

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL HOSPITAL

Line #	Cost Center Description	Diem Cost for Routine Cost Centers From Section G	Charge Ratio for Ancillary Cost Centers From Section G	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	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				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 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	\$ 1,350.62											
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									
21.01				\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,450.00	\$ 2,450.00	\$ 2,450.00	\$ 2,450.00	\$ 2,450.00
22	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
22	09200 Observation (Non-Distinct)	0.526503			766			10,534		37,117	3,534	48,417	
23	5000 OPERATING ROOM	0.286035			31,976			9,484		33,825		75,285	
24	5400 RADIOLOGY-DIAGNOSTIC	0.076878			293,746			51,273	2,526	94,340	2,526	439,360	
25	6000 LABORATORY	0.208197			98,003			28,809	6,368	30,786	6,368	157,598	
26	6500 RESPIRATORY THERAPY	0.308812			20,394			11,044	835	5,696	835	37,134	
27	6600 PHYSICAL THERAPY	0.554948			1,092				943		943	1,092	
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.315306			1,508			1,325	2,166	1,314	2,166	4,147	
29	7200 IMPL. DEV. CHARGED TO PATIENTS	0.384939			604							604	
30	7300 DRUGS CHARGED TO PATIENTS	0.174758			87,105			23,350	13,274	33,029	13,274	143,484	
31	9100 EMERGENCY	0.249398			369,698			40,204	2,452	61,161	2,452	471,063	
32													
33													
34													
35													
36													
37													
38													
39													
40													
41													
42													
43													
44													
45													
46													
47													
48													
49													

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) HIGGINS GENERAL HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid		
112										\$ -	\$ -	
113										\$ -	\$ -	
114										\$ -	\$ -	
115										\$ -	\$ -	
116										\$ -	\$ -	
117										\$ -	\$ -	
118										\$ -	\$ -	
119										\$ -	\$ -	
120										\$ -	\$ -	
121										\$ -	\$ -	
122										\$ -	\$ -	
123										\$ -	\$ -	
124										\$ -	\$ -	
125										\$ -	\$ -	
126										\$ -	\$ -	
127										\$ -	\$ -	
		\$ -	\$ 904,892	\$ -	\$ -	\$ -	\$ 176,023	\$ 32,098	\$ 297,269	\$ -	\$ -	
Totals / Payments												
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 904,892	\$ -	\$ -	\$ -	\$ 176,023	\$ 34,548	\$ 297,269	\$ 34,548	\$ 1,378,184	
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 904,892	\$ -	\$ -	\$ -	\$ 176,023	\$ 34,548	\$ 297,269			
130	Unreconciled Charges (Explain Variance)											
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 167,572	\$ -	\$ -	\$ -	\$ 36,134	\$ 9,127	\$ 66,079	\$ 9,127	\$ 269,785	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 51,987							\$ -	\$ 51,987	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									\$ -	\$ -	
134	Private Insurance (including primary and third party liability)							\$ 33,389		\$ -	\$ 33,389	
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 178							\$ -	\$ 178	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 52,165	\$ -	\$ -							
137	Medicaid Cost Settlement Payments (See Note B)									\$ -	\$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					\$ 10,041				\$ -	\$ 10,041	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						\$ 2,051	\$ 45,926		\$ 2,051	\$ 45,926	
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)	\$ -	\$ 115,407	\$ -	\$ -	\$ -	\$ 26,093	\$ 7,076	\$ (13,236)	\$ 7,076	\$ 128,264	
144	Calculated Payments as a Percentage of Cost		0%	31%	0%	0%	0%	28%	22%	120%	22%	52%

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.

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 (07/01/2022-06/30/2023) HIGGINS GENERAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	30,246,621
19 Uninsured Hospital Charges Sec. G	15,151,604
20 Total Hospital Charges Sec. G	121,037,801
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	24.99%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	12.52%
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	18,016,682
27 Uninsured Hospital Charges Sec. G	15,151,604
28 Total Hospital Charges Sec. G	121,037,801
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	14.89%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	12.52%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

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

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

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