

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:

HIGGINS GENERAL HOSPITAL

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
000000954A
0
0
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:

- 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.)
- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?

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

3b. What date did the hospital open?

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

Yes

No

Yes

Yes

1/3/1955

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.)

\$ 132,055

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.

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

\$ 132,055

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

Yes

Explanation for "No" answers:

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

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


Hospital CEO or CFO Signature

CFO

Title

Carol S. Crews
Hospital CEO or CFO Printed Name

770-836-9745

Hospital CEO or CFO Telephone Number

11/30/2025
Date

ccrews@tanner.org

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, II
Title Partner
Firm Name Draffin & Tucker, LLP
Telephone Number 229-883-7876
E-Mail Address tjjoiner@draffin-tucker.com

4/22/2025

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.

HIGGINS GENERAL HOSPITAL

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

1 - As Submitted

12/4/2024

Data	Correct?	If Incorrect, Proper Information
HIGGINS GENERAL HOSPITAL	Yes	
0000000954A	Yes	
0	Yes	
0	Yes	
111320	Yes	
Non-State Govt.	Yes	
Pool 1	Yes	
No	Yes	

[illegible]

(List additional states on a separate attachment)

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Inpatient	Outpatient	Total
\$ -	\$ 100,601	\$100,601
\$ 12,308	\$ 1,230,307	\$1,242,615
\$12,308	\$1,330,908	\$1,343,216
0.00%	7.56%	7.49%

No

received by the hospital (not by the MCO), or other incentive payments.

\$-

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 (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)

727

(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
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

670,887
5,174,557
\$ 5,845,444

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	\$4,255,328.00			\$ 2,972,814	\$ -	\$ -	\$ 1,282,514
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$6,287,046.00			\$ 4,392,192	
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	\$8,571,166.00	\$80,359,073.00		\$ 5,987,901	\$ 56,139,639	\$ -	\$ 26,802,700
20. Outpatient Services		\$31,514,885.00			\$ 22,016,609	\$ -	\$ 9,498,276
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	\$11,127,464.00	\$ -	\$ -	\$ 7,773,756	\$ -
27. Total	\$ 12,826,494	\$ 111,873,958	\$ 17,414,510	\$ 8,960,715	\$ 78,156,247	\$ 12,165,948	\$ 37,583,490
28. Total Hospital and Non Hospital		Total from Above	\$ 142,114,962	Total from Above		\$ 99,282,910	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)			
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)	142,114,962			96,871,877			
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)				2,411,033			+
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				99,282,910			
37. Unreconciled Difference	Unreconciled Difference (Should be \$0)			Unreconciled Difference (Should be \$0)			
	\$ -			\$ -			

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
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.		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	\$ 6,065,581	\$ -	\$ -	\$ 4,483,316.00	\$ 1,582,265	1,327	\$ 7,826,513.00	\$ 1,192.36
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	\$ 6,065,581	\$ -	\$ -	\$ 4,483,316	\$ 1,582,265	1,327	\$ 7,826,513	
19	Weighted Average								\$ 1,192.36

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)	600	-	-	\$ 715,416	\$301,965.00	\$913,512.00	\$ 1,215,477	0.588589
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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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$4,651,627.00	\$ -	\$ -	\$ 4,651,627	\$26,776.00	\$13,581,487.00	\$ 13,608,263	0.341824
22	5400 RADIOLOGY-DIAGNOSTIC	\$2,818,361.00	\$ -	\$ -	\$ 2,818,361	\$1,162,218.00	\$38,938,506.00	\$ 40,100,724	0.070282
23	6000 LABORATORY	\$2,468,257.00	\$ -	\$ -	\$ 2,468,257	\$2,015,662.00	\$9,096,073.00	\$ 11,111,735	0.222131
24	6500 RESPIRATORY THERAPY	\$1,039,823.00	\$ -	\$ -	\$ 1,039,823	\$944,471.00	\$1,820,277.00	\$ 2,764,748	0.376100
25	6600 PHYSICAL THERAPY	\$1,025,795.00	\$ -	\$ -	\$ 1,025,795	\$1,273,145.00	\$924,357.00	\$ 2,197,502	0.466800
26	6700 OCCUPATIONAL THERAPY	\$430,564.00	\$ -	\$ -	\$ 430,564	\$951,808.00	\$0.00	\$ 951,808	0.452364
27	6800 SPEECH PATHOLOGY	\$10,727.00	\$ -	\$ -	\$ 10,727	\$24,666.00	\$3,835.00	\$ 28,501	0.376373
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$316,862.00	\$ -	\$ -	\$ 316,862	\$472,264.00	\$545,039.00	\$ 1,017,303	0.311473
29	7200 IMPL. DEV. CHARGED TO PATIENTS	\$459,274.00	\$ -	\$ -	\$ 459,274	\$21,772.00	\$1,134,944.00	\$ 1,156,716	0.397050

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
30	7300 DRUGS CHARGED TO PATIENTS	\$4,558,835.00	\$ -	\$ -	\$ 4,558,835	\$2,310,834.00	\$21,170,775.00	\$ 23,481,609	0.194145
31	9100 EMERGENCY	\$6,061,322.00	\$ -	\$ -	\$ 6,061,322	\$313,474.00	\$25,213,126.00	\$ 25,526,600	0.237451
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	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
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	\$ 23,841,447	\$ -	\$ -	\$ 23,841,447	\$ 9,819,055	\$ 113,341,931	\$ 123,160,986	
127	Weighted Average								0.199388
128	Sub Totals	\$ 29,907,028	\$ -	\$ -	\$ 25,423,712	\$ 17,645,568	\$ 113,341,931	\$ 130,987,499	
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)				\$711,905.00				
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				\$ 24,711,807				
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 (07/01/2023-06/30/2024) HIGGINS GENERAL HOSPITAL

		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-Over (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)
Line #	Cost Center Description			Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G															
Routine Cost Centers (from Section G):				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,192.36		41	6	47	150	134	25	378	57.22%							
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				41	6	47	150	134	25	378	31.35%							
Total Days per PS&R or Exhibit Detail				41	6	47	150	134	25									
Unreconciled Days (Explain Variance)				-	-	-	-	-	-	-	-	-	-	-	-	-	-	
Routine Charges		\$ 91,862	\$ 11,275	\$ 105,870	\$ 309,937	\$ 209,063	\$ 49,808	\$ 518,944	7.61%									
21.01	Calculated Routine Charge Per Diem	\$ 2,240.54	\$ 1,879.17	\$ 2,252.55	\$ 2,066.25	\$ 1,560.32	\$ 1,992.32	\$ 1,372.87										
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	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)	0.588589	21.334	7,951	3,069	12,591	26,130	32,881	41,513	104,803	6,696	5,766	81,826	\$ 92,046	\$ 158,226	\$ 30.25%		
23	5000 OPERATING ROOM	0.341824	-	495,909	-	501,062	925	248,199	-	885,502	-	87,585	2,425	1,512,862	\$ 925	\$ 2,130,672	27.99%	
24	5400 RADIOLOGY-DIAGNOSTIC	0.070282	43,520	1,461,122	12,208	2,997,070	47,473	817,441	117,307	2,583,803	18,228	223,425	34,126	3,961,783	\$ 220,308	\$ 7,859,437	32.13%	
25	6000 LABORATORY	0.222131	60,516	567,402	11,415	1,166,940	75,901	132,899	842,073	33,796	66,101	1,208,126	30,784	2,612,866	\$ 280,731	\$ 2,612,866	46.30%	
26	6500 RESPIRATORY THERAPY	0.376100	38,116	108,669	4,304	146,949	43,662	59,872	54,131	161,040	9,888	12,282	12,007	209,488	\$ 140,213	\$ 476,530	32.73%	
27	6600 PHYSICAL THERAPY	0.466800	3,508	135,025	-	222,387	7,211	27,134	24,877	89,957	64,844	17,490	1,436	57,939	\$ 35,596	\$ 474,503	28.74%	
28	6700 OCCUPATIONAL THERAPY	0.452364	-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	0.00%	
29	6800 SPEECH PATHOLOGY	0.376373	-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	0.00%	
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.311473	17,784	35,852	1,862	37,307	12,648	8,635	30,952	25,868	6,878	1,082	3,572	28,051	\$ 63,246	\$ 107,662	21.28%	
31	7200 IMPL. DEV. CHARGED TO PATIENTS	0.397050	-	21,616	-	32,331	-	8,781	-	33,615	-	3,920	-	110,218	\$ -	\$ 96,342	18.88%	
32	7300 DRUGS CHARGED TO PATIENTS	0.194145	65,706	606,477	38,504	1,212,026	129,317	397,185	210,768	1,130,222	48,342	135,201	34,292	1,994,216	\$ 444,295	\$ 3,347,909	26.64%	
33	9100 EMERGENCY	0.237451	24,035	1,492,243	5,431	4,927,729	24,656	436,885	46,919	1,504,578	6,725	201,739	20,554	4,321,150	\$ 101,041	\$ 8,321,435	53.31%	
34		-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
35		-	-	-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2023-06/30/2024) 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
																	\$	\$	\$	
71				-													\$	-	\$	-
72				-													\$	-	\$	-
73				-													\$	-	\$	-
74				-													\$	-	\$	-
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125				-													\$	-	\$	-
126				-													\$	-	\$	-
127				-													\$	-	\$	-
					\$ 274,319	\$ 4,894,266	\$ 76,793	\$ 11,256,392	\$ 367,923	\$ 2,273,458	\$ 659,367	\$ 7,161,467	\$ 188,701	\$ 755,521	\$ 153,964	\$ 13,505,659				

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

Cost Report Year (07/01/2023-06/30/2024) 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
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 366,181	\$ 4,894,266	\$ 88,068	\$ 11,256,392	\$ 473,793	\$ 2,273,458	\$ 969,304	\$ 7,161,467	\$ 397,784	\$ 755,521	\$ 203,772	\$ 13,505,659	\$ 1,897,345	\$ 25,585,582	32.86%
129 Total Charges per PS&R or Exhibit Detail	\$ 366,181	\$ 4,894,266	\$ 88,068	\$ 11,256,392	\$ 473,793	\$ 2,273,458	\$ 969,304	\$ 7,161,467	\$ 397,784	\$ 755,521	\$ 203,772	\$ 13,505,659			
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 117,907	\$ 989,541	\$ 23,318	\$ 2,237,477	\$ 146,621	\$ 436,377	\$ 334,728	\$ 1,389,246	\$ 215,677	\$ 153,095	\$ 63,105	\$ 2,685,066	\$ 622,572	\$ 5,052,641	35.58%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 75,355	\$ 908,569			\$ 18,837	\$ 196,024	\$ 13,478	\$ 110,837					\$ 107,670	\$ 1,215,430	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 21,680	\$ 1,724,156				\$ 9,484					\$ 21,680	\$ 1,733,640	
134 Private Insurance (including primary and third party liability)	\$ 1,105	\$ 1,445					\$ 11,230	\$ 878,089					\$ 12,335	\$ 879,534	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 663		\$ 1,054		\$ 5,704		\$ 832		\$ 361			\$ -	\$ 8,253	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 76,460	\$ 910,677	\$ 21,680	\$ 1,725,210									\$ -	\$ -	
137 Medicaid Cost Settlement Payments (See Note B)		\$ (72,632)											\$ -	\$ (72,632)	
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)					\$ 81,416	\$ 47,071		\$ 678					\$ 81,416	\$ 47,747	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 485,306	\$ 862,863					\$ 485,306	\$ 862,863	
141 Medicare Cross-Over Bad Debt Payments					\$ 2,319	\$ 4,531							\$ 2,319	\$ 4,531	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 41,289	\$ 174,431		\$ 343					\$ 41,289	\$ 174,774	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)															
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)	\$ 41,447	\$ 151,496	\$ 1,638	\$ 512,287	\$ 2,760	\$ 8,616	\$ (175,288)	\$ (473,878)	\$ 215,677	\$ 152,734	\$ 63,105	\$ 2,584,465	\$ (129,443)	\$ 198,501	
146 Calculated Payments as a Percentage of Cost	65%	85%	93%	77%	98%	98%	152%	134%	0%	0%	0%	4%	121%	96%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CIR, WIS S-3, Pl. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)						416									
148 Percent of cross-over days to total Medicare days from the cost report						12%									

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

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	
03000	ADULTS & PEDIATRICS	\$ 1,192.36		3				3		7		13	
03100	INTENSIVE CARE UNIT	\$ -										-	
03200	CORONARY CARE UNIT	\$ -										-	
03300	BURN INTENSIVE CARE UNIT	\$ -										-	
03400	SURGICAL INTENSIVE CARE UNIT	\$ -										-	
03500	OTHER SPECIAL CARE UNIT	\$ -										-	
04000	SUBPROVIDER I	\$ -										-	
04100	SUBPROVIDER II	\$ -										-	
04200	OTHER SUBPROVIDER	\$ -										-	
04300	NURSERY	\$ -										-	
		\$ -										-	
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Cost Report Year (07/01/2023-06/30/2024)	HIGGINS GENERAL HOSPITAL
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Cost Report Year (07/01/2023-06/30/2024)	HIGGINS GENERAL HOSPITAL
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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 (07/01/2023-06/30/2024) 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 ----->)	CAH	
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	30,492,109
19 Uninsured Hospital Charges Sec. G	13,709,431
20 Total Hospital Charges Sec. G	130,987,499
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	23.28%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.47%
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	17,741,174
27 Uninsured Hospital Charges Sec. G	14,862,736
28 Total Hospital Charges Sec. G	130,987,499
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	13.54%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	11.35%
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.