DSH Version 9.02 4/22/2025

D. General Cost Report Year Information 10/1/2023 - 9/30/2024

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: STEPHENS COUNTY HOSPITAL

	10/1/2023 through 9/30/2024		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 3/4/2025

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	STEPHENS COUNTY HOSPITAL	Yes	
5. Medicaid Provider Number:	000001834A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110032	Yes	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 1	Yes	
11. Rural Referral Center (Yes or No)	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: (10/01/2023 - 09/30/2024)

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)	$ 20,902	$ 271,409	$292,311
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 123,749	$ 1,172,057	$1,295,806
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)	$144,651	$1,443,466	$1,588,117
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.45%	18.80%	18.41%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 322,814
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	$322,814

<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2023 - 09/30/2024)

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)	3,327

(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	823,535
8.	Outpatient Hospital Charity Care Charges	3,682,596
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 4,506,131

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$4,788,369.00			$ 2,906,477	$ -	$ -	$ 1,881,892
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$397,100.00			$ 241,034	
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	$14,349,313.00	$47,499,350.00		$ 8,709,843	$ 28,831,478	$ -	$ 24,307,342
20.	Outpatient Services		$41,577,954.00			$ 25,237,269	$ -	$ 16,340,685
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 8,008,508			$ 4,861,059	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$294,962.00	$16,240,277.00	$0.00	$ 179,038	$ 9,857,634	$ -	$ 6,498,567
27.	Total	$ 19,432,644	$ 105,317,581	$ 8,405,608	$ 11,795,358	$ 63,926,380	$ 5,102,093	$ 49,028,487
28.	Total Hospital and Non Hospital		Total from Above	$ 133,155,833		Total from Above	$ 80,823,831	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	133,155,833	Total Contractual Adj. (G-3 Line 2)	80,823,831
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				80,823,831
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 6,955,729	$ -	$ -	$197,502.00	$ 6,758,227	3,337	$4,278,975.00		$ 2,025.24
2	03100 INTENSIVE CARE UNIT	$ 2,095,908	$ -	$ -		$ 2,095,908	349	$1,283,971.00		$ 6,005.47
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	$ 9,051,637	$ -	$ -	$ 197,502	$ 8,854,135	3,686	$ 5,562,946		
19	Weighted Average									$ 2,402.10

			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*
	Observation Data (Non-Distinct)									
20	09200 Observation (Non-Distinct)		359	-	-	$ 727,061	$130,000.00	$2,855,430.00	$ 2,985,430	0.243536

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$4,683,348.00	$ -	$ -		$ 4,683,348	$3,820,766.00	$23,399,736.00	$ 27,220,502	0.172052
22	5100 RECOVERY ROOM	$387,914.00	$ -	$ -		$ 387,914	$411,289.00	$2,863,928.00	$ 3,275,217	0.118439
23	5300 ANESTHESIOLOGY	$606,888.00	$ -	$ -		$ 606,888	$496,643.00	$1,973,392.00	$ 2,470,035	0.245700
24	5400 RADIOLOGY-DIAGNOSTIC	$2,114,569.00	$ -	$ -		$ 2,114,569	$341,408.00	$6,049,562.00	$ 6,390,970	0.330868
25	5600 RADIOISOTOPE	$197,547.00	$ -	$ -		$ 197,547	$38,317.00	$623,709.00	$ 662,026	0.298398
26	5700 CT SCAN	$388,524.00	$ -	$ -		$ 388,524	$650,771.00	$12,176,869.00	$ 12,827,640	0.030288
27	5800 MRI	$329,439.00	$ -	$ -		$ 329,439	$82,781.00	$1,284,145.00	$ 1,366,926	0.241007
28	6000 LABORATORY	$3,129,569.00	$ -	$ -		$ 3,129,569	$996,256.00	$6,419,092.00	$ 7,415,348	0.422039
29	6500 RESPIRATORY THERAPY	$959,674.00	$ -	$ -		$ 959,674	$2,622,229.00	$1,085,304.00	$ 3,707,533	0.258844
30	6600 PHYSICAL THERAPY	$1,061,434.00	$ -	$ -		$ 1,061,434	$1,105,320.00	$1,337,016.00	$ 2,442,336	0.434598

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6900	ELECTROCARDIOLOGY	$258,059.00	$ -	$ -	$ 258,059	$221,370.00	$1,028,578.00	$ 1,249,948	0.206456
32	6901	CARDIAC REHAB	$395,349.00	$ -	$ -	$ 395,349	$17,000.00	$337,504.00	$ 354,504	1.115217
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$1,854,723.00	$ -	$ -	$ 1,854,723	$1,609,677.00	$1,546,705.00	$ 3,156,382	0.587610
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$992,684.00	$ -	$ -	$ 992,684	$943,218.00	$2,101,936.00	$ 3,045,154	0.325988
35	7300	DRUGS CHARGED TO PATIENTS	$2,936,486.00	$ -	$ -	$ 2,936,486	$2,376,159.00	$5,184,518.00	$ 7,560,677	0.388389
36	9001	WOUND CARE CENTER	$1,539,747.00	$ -	$ -	$ 1,539,747	$1,081.00	$6,435,216.00	$ 6,436,297	0.239229
37	9100	EMERGENCY	$5,717,583.00	$ -	$ -	$ 5,717,583	$577,701.00	$14,471,169.00	$ 15,048,870	0.379934
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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**	$ 27,553,537	$ -	$ -	$ 27,553,537	$ 16,441,986	$ 91,173,809	$ 107,615,795	
127		**Weighted Average**								0.262792
128		**Sub Totals**	$ 36,605,174	$ -	$ -	$ 36,407,672	$ 22,004,932	$ 91,173,809	$ 113,178,741	

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)*	$155,457.00
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**	$ 36,252,215
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Inpatient	In-State Other Medicaid Eligibles Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals (Includes all payers)
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 2,025.24		124		20		319		268				243		731		32.71%
2	03100 INTENSIVE CARE UNIT	$ 6,005.47		14		6		36		34				38		90		36.68%
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**	138		26		355		302		-		281		821		29.90%
19	Total Days per PS&R or Exhibit Detail			138		26		355		302		-		281				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 335,206		$ 34,370		$ 357,130		$ 355,490				$ 333,540		$ 1,082,196		25.45%
21.01	Calculated Routine Charge Per Diem			$ 2,429.03		$ 1,321.92		$ 1,006.00		$ 1,177.12		$ -		$ 1,186.98		$ 1,318.14		
	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)		0.243536	9,378	317,624	-	51,518	1,644	338,286	-	406,876	-	33,555	2,276	184,983	$ 11,022	$ 1,114,304	45.26%
23	5000 OPERATING ROOM		0.172052	40,875	252,577	54,350	587,010	153,598	1,160,526	54,350	1,379,483	13,500	49,071	300,406	529,960	$ 303,173	$ 3,379,597	16.89%
24	5100 RECOVERY ROOM		0.118439	18,555	51,708	9,218	112,231	28,168	151,950	9,218	195,878	-	-	46,561	74,511	$ 65,158	$ 511,766	21.38%
25	5300 ANESTHESIOLOGY		0.245700	20,459	32,195	10,167	86,453	30,710	97,774	10,167	132,887	-	-	54,571	57,808	$ 71,504	$ 349,308	21.69%
26	5400 RADIOLOGY-DIAGNOSTIC		0.330868	14,748	142,940	7,313	382,301	87,263	469,382	7,313	442,105	279	58,977	66,243	417,993	$ 116,636	$ 1,436,728	33.03%
27	5600 RADIOISOTOPE		0.298398	-	-	-	19,406	5,199	111,623	-	123,620	-	-	7,278	51,832	$ 5,199	$ 254,648	48.18%
28	5700 CT SCAN		0.030288	52,522	330,600	13,400	722,335	155,035	660,139	13,400	951,151	-	101,941	152,172	1,590,372	$ 234,357	$ 2,664,225	37.27%
29	5800 MRI		0.241007	2,309	32,922	-	49,359	8,005	133,181	-	130,799	-	9,678	14,115	56,134	$ 10,314	$ 346,260	32.04%
30	6000 LABORATORY		0.422039	91,638	457,736	16,305	639,623	174,948	392,415	16,305	534,647	2,364	35,022	177,909	763,599	$ 299,195	$ 2,024,421	44.86%
31	6500 RESPIRATORY THERAPY		0.258844	62,511	34,827	14,356	45,349	187,507	75,845	14,356	101,071	-	15,872	78,421	85,120	$ 278,730	$ 257,092	19.36%
32	6600 PHYSICAL THERAPY		0.434598	31,043	11,130	2,203	25,035	89,614	107,379	2,203	115,821	570	20,537	52,445	18,917	$ 125,063	$ 259,365	19.56%
33	6900 ELECTROCARDIOLOGY		0.206456	7,859	39,133	2,666	56,526	22,712	94,580	2,666	88,893	-	22,881	24,159	154,801	$ 35,903	$ 279,132	41.51%
34	6901 CARDIAC REHAB		1.115217	10,120	15,127	-	-	375	12,500	-	11,453	-	7,911	1,100	2,380	$ 10,495	$ 39,080	17.20%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.587610	133,212	186,895	56,887	485,445	349,301	503,186	56,887	588,479	2,038	25,450	272,990	467,541	$ 596,287	$ 1,744,005	99.19%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.325988	59,893	29,038	-	20,765	54,351	226,821	-	238,205	-	7,765	66,395	77,612	$ 114,244	$ 514,829	25.66%
37	7300 DRUGS CHARGED TO PATIENTS		0.388389	76,458	113,698	30,272	524,014	281,441	557,174	30,272	554,388	8,041	59,297	276,503	1,060,167	$ 418,442	$ 1,749,274	47.57%
38	9001 WOUND CARE CENTER		0.239229	-	15,095	-	7,065	-	17,364	-	17,581	-	2,632	-	13,959	$ -	$ 57,105	1.15%
39	9100 EMERGENCY		0.379934	53,850	729,614	14,283	2,387,687	163,917	1,406,792	14,283	1,534,527	850	21,325	176,755	2,980,065	$ 246,333	$ 6,058,619	63.66%
40			-													$ -	$ -	
41			-													$ -	$ -	
42			-													$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & 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			-													$ -	$ -	
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125			-													$ -	$ -	
126			-													$ -	$ -	
127			-													$ -	$ -	
				$ 685,430	$ 2,772,859	$ 231,419	$ 6,202,121	$ 1,793,787	$ 6,516,916	$ 231,419	$ 7,547,863	$ 27,642	$ 471,914	$ 1,770,300	$ 8,587,754			

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

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

	Totals / Payments	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
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 1,020,636	$ 2,772,859	$ 265,789	$ 6,202,121	$ 2,150,917	$ 6,516,916	$ 586,909	$ 7,547,863	$ 27,642	$ 471,914	$ 2,103,840 (Agrees to Exhibit A)	$ 8,587,754 (Agrees to Exhibit A)	$ 4,024,252	$ 23,039,759	33.59%
129	Total Charges per PS&R or Exhibit Detail	$ 1,020,636	$ 2,772,859	$ 265,789	$ 6,202,121	$ 2,150,917	$ 6,516,916	$ 586,909	$ 7,547,863	$ 27,642	$ 471,914	$ 2,103,840	$ 8,587,754			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 587,985	$ 864,580	$ 155,020	$ 2,022,763	$ 1,497,986	$ 1,954,819	$ 825,433	$ 2,195,035	$ 8,304	$ 132,157	$ 1,304,596	$ 2,609,218	$ 3,066,424	$ 7,037,197	38.90%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 268,283	$ 827,373			$ 39,972	$ 191,142	$ 30,130	$ 103,320					$ 338,385	$ 1,121,835	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 77,820	$ 1,488,003			$ 15,186	$ 78,664					$ 93,006	$ 1,566,667	
134	Private Insurance (including primary and third party liability)					$ 170		$ 52,473	$ 443,687					$ 52,643	$ 443,687	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 4,008	$ 5,045	$ 12	$ 1,533		$ 639	$ 113	$ 2,424					$ 4,133	$ 9,641	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 272,291	$ 832,418	$ 77,832	$ 1,489,536											
137	Medicaid Cost Settlement Payments (See Note B)		$ (169,098)											$ -	$ (169,098)	
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)					$ 798,877	$ 1,059,371							$ 798,877	$ 1,059,371	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 525,683	$ 949,996					$ 525,683	$ 949,996	
141	Medicare Cross-Over Bad Debt Payments													$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 20,902	$ 271,409			
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)**	$ 315,694	$ 201,260	$ 77,188	$ 533,227	$ 658,967	$ 703,667	$ 201,848	$ 616,944	$ 8,304	$ 132,157	$ 1,283,694	$ 2,337,809	$ 1,253,697	$ 2,055,098	
146	**Calculated Payments as a Percentage of Cost**	46%	77%	50%	74%	56%	64%	76%	72%	0%	0%	2%	10%	59%	71%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					1,901										
148	**Percent of cross-over days to total Medicare days from the cost report**					19%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note 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 (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 2,025.24										-	
2	03100 INTENSIVE CARE UNIT	$ 6,005.47										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.243536		5,142							$ -	$ 5,142
23	5000 OPERATING ROOM		0.172052		20,850							$ -	$ 20,850
24	5100 RECOVERY ROOM		0.118439		2,227							$ -	$ 2,227
25	5300 ANESTHESIOLOGY		0.245700		2,620							$ -	$ 2,620
26	5400 RADIOLOGY-DIAGNOSTIC		0.330868		14,361							$ -	$ 14,361
27	5600 RADIOISOTOPE		0.298398		-							$ -	$ -
28	5700 CT SCAN		0.030288		37,201							$ -	$ 37,201
29	5800 MRI		0.241007		1,480							$ -	$ 1,480
30	6000 LABORATORY		0.422039		24,161							$ -	$ 24,161
31	6500 RESPIRATORY THERAPY		0.258844		2,378							$ -	$ 2,378
32	6600 PHYSICAL THERAPY		0.434598		721							$ -	$ 721
33	6900 ELECTROCARDIOLOGY		0.206456		1,918							$ -	$ 1,918
34	6901 CARDIAC REHAB		1.115217		-							$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.587610		22,512							$ -	$ 22,512
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.325988		495							$ -	$ 495
37	7300 DRUGS CHARGED TO PATIENTS		0.388389		24,954							$ -	$ 24,954
38	9001 WOUND CARE CENTER		0.239229		-							$ -	$ -
39	9100 EMERGENCY		0.379934		96,163							$ -	$ 96,163
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
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			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 257,183	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ 257,183	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 257,183
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 257,183	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ 83,121	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 83,121
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 13,704							$ -	$ 13,704
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)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 13,704	$ -	$ -						
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)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ 69,417	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 69,417
144	**Calculated Payments as a Percentage of Cost**	0%	16%	0%	0%	0%	0%	0%	0%	0%	16%

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 (10/01/2023-09/30/2024) STEPHENS COUNTY HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	27,820,750
19	Uninsured Hospital	**Charges Sec. G**	10,691,594
20	Total Hospital	**Charges Sec. G**	113,178,741
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		24.58%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.45%
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**	10,518,589
27	Uninsured Hospital	**Charges Sec. G**	11,191,150
28	Total Hospital	**Charges Sec. G**	113,178,741
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		9.29%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.89%
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.*