

**EXAMINER ADJUSTED SURVEY**

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	9.00	9/11/2024

**D. General Cost Report Year Information** 1/1/2023 - 12/31/2023

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: ATRIUM HEALTH NAVICENT BALDWIN
- 2. Select Cost Report Year Covered by this Survey: 

1/1/2023 through 12/31/2023		
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- 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: 6/18/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ATRIUM HEALTH NAVICENT BALDWIN	-	
5. Medicaid Provider Number:	000000129A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110150	-	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	-	

**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: (01/01/2023 - 12/31/2023)**

- 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)                              | \$ 12,315  | \$ 238,274   | \$250,589   |
| 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)                    | \$ 373,211 | \$ 2,308,203 | \$2,681,414 |
| 11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B) | \$385,526  | \$2,546,477  | \$2,932,003 |
| 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: | 3.19%      | 9.36%        | 8.55%       |
- 13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No  
*Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.*
  - 14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services \$ -
  - 15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services \$ -
  - 16. Total Medicaid managed care non-claims payments (see question 13 above) received \$-

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

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

**F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2023 - 12/31/2023)**

**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) 10,577

**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	500,000
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 500,000
7. Inpatient Hospital Charity Care Charges	4,075,803
8. Outpatient Hospital Charity Care Charges	7,342,514
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 11,418,317

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

	Total Patient Revenues (Charges)			Contractual Adjustments			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 17,156,633	\$ -	\$ -	\$ 12,523,671	\$ -	\$ -	\$ 4,632,962
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15. Swing Bed - NF	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16. Skilled Nursing Facility	\$ -	\$ -	\$ 3,805,445	\$ -	\$ -	\$ 2,777,826	\$ -
17. Nursing Facility	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18. Other Long-Term Care	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19. Ancillary Services	\$ 48,952,522	\$ 111,346,754	\$ -	\$ 35,733,425	\$ 81,278,772	\$ -	\$ 43,287,079
20. Outpatient Services	\$ -	\$ 40,396,263	\$ -	\$ -	\$ 29,487,691	\$ -	\$ 10,908,572
21. Home Health Agency	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22. Ambulance	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
26. Other	\$ 1,465,641	\$ -	\$ -	\$ 1,069,861	\$ -	\$ -	\$ 395,780
27. Total	\$ 67,574,796	\$ 151,743,017	\$ 3,805,445	\$ 49,326,956	\$ 110,766,463	\$ 2,777,826	\$ 59,224,394
28. Total Hospital and Non Hospital		Total from Above	\$ 223,123,258		Total from Above	\$ 162,871,245	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 223,123,258		Total Contractual Adj. (G-3 Line 2)	\$ 162,871,245	
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						162,871,245	
37. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net 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 &amp; 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. I, Line 2 for Adults &amp; 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>																																																																																																																																																																																																																																																														
<b>Routine Cost Centers (list below):</b>																																																																																																																																																																																																																																																																							
1	03000 ADULTS & PEDIATRICS	\$ 8,462,304	\$ -	\$ -	\$ -	\$ 8,462,304	8,792	\$ 11,535,049	\$ 962.50																																																																																																																																																																																																																																																														
2	03100 INTENSIVE CARE UNIT	\$ 4,491,514	\$ -	\$ -	\$ -	\$ 4,491,514	2,021	\$ 5,621,584	\$ 2,222.42																																																																																																																																																																																																																																																														
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	\$ 1,189,269	\$ -	\$ -	\$ -	\$ 1,189,269	933	\$ 1,465,641	\$ 1,274.67																																																																																																																																																																																																																																																														
18	Total Routine	\$ 14,143,087	\$ -	\$ -	\$ -	\$ 14,143,087	11,746	\$ 18,622,274	\$ -																																																																																																																																																																																																																																																														
19	Weighted Average								\$ 1,204.08																																																																																																																																																																																																																																																														
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I, Col. 8</th> <th>Medicaid Calculated Cost-to-Charge Ratio</th> </tr> </thead> <tbody> <tr> <td colspan="10"><b>Ancillary Cost Centers (from W/S C excluding Observation) (list below):</b></td> </tr> <tr> <td>21</td> <td>5000 OPERATING ROOM</td> <td>\$ 10,253,509</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 10,253,509</td> <td>\$ 5,000,854</td> <td>\$ 20,023,642</td> <td>\$ 25,024,496</td> <td>0.409739</td> </tr> <tr> <td>22</td> <td>5200 DELIVERY ROOM &amp; LABOR ROOM</td> <td>\$ 2,560,822</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 2,560,822</td> <td>\$ 2,818,979</td> <td>\$ 205,812</td> <td>\$ 3,024,791</td> <td>0.846611</td> </tr> <tr> <td>23</td> <td>5400 RADIOLOGY-DIAGNOSTIC</td> <td>\$ 6,778,777</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 6,778,777</td> <td>\$ 1,638,308</td> <td>\$ 27,089,803</td> <td>\$ 28,728,111</td> <td>0.235963</td> </tr> <tr> <td>24</td> <td>5700 CT SCAN</td> <td>\$ 1,406,514</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 1,406,514</td> <td>\$ 5,672,420</td> <td>\$ 20,173,806</td> <td>\$ 25,846,226</td> <td>0.054419</td> </tr> <tr> <td>25</td> <td>5800 MRI</td> <td>\$ 258,741</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 258,741</td> <td>\$ 404,044</td> <td>\$ 2,555,937</td> <td>\$ 2,959,981</td> <td>0.087413</td> </tr> <tr> <td>26</td> <td>6000 LABORATORY</td> <td>\$ 6,089,132</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 6,089,132</td> <td>\$ 9,646,509</td> <td>\$ 16,068,093</td> <td>\$ 25,714,602</td> <td>0.236797</td> </tr> <tr> <td>27</td> <td>6500 RESPIRATORY THERAPY</td> <td>\$ 2,319,682</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 2,319,682</td> <td>\$ 5,306,484</td> <td>\$ 1,094,743</td> <td>\$ 6,401,227</td> <td>0.362381</td> </tr> <tr> <td>28</td> <td>6600 PHYSICAL THERAPY</td> <td>\$ 1,178,866</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 1,178,866</td> <td>\$ 1,818,411</td> <td>\$ 1,931,384</td> <td>\$ 3,749,795</td> <td>0.314381</td> </tr> <tr> <td>29</td> <td>6900 ELECTROCARDIOLOGY</td> <td>\$ 848,128</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 848,128</td> <td>\$ 2,166,589</td> <td>\$ 1,965,904</td> <td>\$ 4,132,493</td> <td>0.205234</td> </tr> <tr> <td>30</td> <td>7100 MEDICAL SUPPLIES CHARGED TO PATIENT</td> <td>\$ 1,318,967</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 1,318,967</td> <td>\$ 1,337,209</td> <td>\$ 5,685,309</td> <td>\$ 7,022,518</td> <td>0.187820</td> </tr> <tr> <td>31</td> <td>7200 IMPL. DEV. CHARGED TO PATIENTS</td> <td>\$ 1,717,562</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 1,717,562</td> <td>\$ 1,478,827</td> <td>\$ 6,235,114</td> <td>\$ 7,713,941</td> <td>0.222657</td> </tr> <tr> <td>32</td> <td>7300 DRUGS CHARGED TO PATIENTS</td> <td>\$ 4,204,983</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 4,204,983</td> <td>\$ 11,663,888</td> <td>\$ 8,317,208</td> <td>\$ 19,981,096</td> <td>0.210448</td> </tr> <tr> <td>33</td> <td>9100 EMERGENCY</td> <td>\$ 8,993,040</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 8,993,040</td> <td>\$ 7,454,981</td> <td>\$ 31,088,483</td> <td>\$ 38,543,464</td> <td>0.233322</td> </tr> <tr> <td>126</td> <td>Total Ancillary</td> <td>\$ 47,928,723</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 47,928,723</td> <td>\$ 57,216,804</td> <td>\$ 143,478,736</td> <td>\$ 200,695,540</td> <td></td> </tr> <tr> <td>127</td> <td>Weighted Average</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0.244419</td> </tr> <tr> <td>128</td> <td><b>Sub Totals</b></td> <td>\$ 62,071,810</td> <td>\$ -</td> <td>\$ -</td> <td>\$ -</td> <td>\$ 62,071,810</td> <td>\$ 75,839,078</td> <td>\$ 143,478,736</td> <td>\$ 219,317,814</td> <td></td> </tr> <tr> <td>129</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>\$ -</td> <td></td> <td></td> <td></td> </tr> <tr> <td>130</td> <td>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)</td> <td></td> <td></td> <td></td> <td></td> <td>\$ 254,378</td> <td></td> <td></td> <td></td> </tr> <tr> <td>131</td> <td>NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)</td> <td></td> <td></td> <td></td> <td></td> <td>\$ -</td> <td></td> <td></td> <td></td> </tr> <tr> <td>131.01</td> <td>Other Cost Adjustments (support must be submitted)</td> <td></td> <td></td> <td></td> <td></td> <td>\$ -</td> <td></td> <td></td> <td></td> </tr> <tr> <td>132</td> <td><b>Grand Total</b></td> <td></td> <td></td> <td></td> <td></td> <td>\$ 61,817,432</td> <td></td> <td></td> <td></td> </tr> <tr> <td>133</td> <td>Total Intern/Resident Cost as a Percent of Other Allowable Cost</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0.00%</td> </tr> </tbody> </table>											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	<b>Ancillary Cost Centers (from W/S C excluding Observation) (list below):</b>										21	5000 OPERATING ROOM	\$ 10,253,509	\$ -	\$ -	\$ -	\$ 10,253,509	\$ 5,000,854	\$ 20,023,642	\$ 25,024,496	0.409739	22	5200 DELIVERY ROOM & LABOR ROOM	\$ 2,560,822	\$ -	\$ -	\$ -	\$ 2,560,822	\$ 2,818,979	\$ 205,812	\$ 3,024,791	0.846611	23	5400 RADIOLOGY-DIAGNOSTIC	\$ 6,778,777	\$ -	\$ -	\$ -	\$ 6,778,777	\$ 1,638,308	\$ 27,089,803	\$ 28,728,111	0.235963	24	5700 CT SCAN	\$ 1,406,514	\$ -	\$ -	\$ -	\$ 1,406,514	\$ 5,672,420	\$ 20,173,806	\$ 25,846,226	0.054419	25	5800 MRI	\$ 258,741	\$ -	\$ -	\$ -	\$ 258,741	\$ 404,044	\$ 2,555,937	\$ 2,959,981	0.087413	26	6000 LABORATORY	\$ 6,089,132	\$ -	\$ -	\$ -	\$ 6,089,132	\$ 9,646,509	\$ 16,068,093	\$ 25,714,602	0.236797	27	6500 RESPIRATORY THERAPY	\$ 2,319,682	\$ -	\$ -	\$ -	\$ 2,319,682	\$ 5,306,484	\$ 1,094,743	\$ 6,401,227	0.362381	28	6600 PHYSICAL THERAPY	\$ 1,178,866	\$ -	\$ -	\$ -	\$ 1,178,866	\$ 1,818,411	\$ 1,931,384	\$ 3,749,795	0.314381	29	6900 ELECTROCARDIOLOGY	\$ 848,128	\$ -	\$ -	\$ -	\$ 848,128	\$ 2,166,589	\$ 1,965,904	\$ 4,132,493	0.205234	30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 1,318,967	\$ -	\$ -	\$ -	\$ 1,318,967	\$ 1,337,209	\$ 5,685,309	\$ 7,022,518	0.187820	31	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 1,717,562	\$ -	\$ -	\$ -	\$ 1,717,562	\$ 1,478,827	\$ 6,235,114	\$ 7,713,941	0.222657	32	7300 DRUGS CHARGED TO PATIENTS	\$ 4,204,983	\$ -	\$ -	\$ -	\$ 4,204,983	\$ 11,663,888	\$ 8,317,208	\$ 19,981,096	0.210448	33	9100 EMERGENCY	\$ 8,993,040	\$ -	\$ -	\$ -	\$ 8,993,040	\$ 7,454,981	\$ 31,088,483	\$ 38,543,464	0.233322	126	Total Ancillary	\$ 47,928,723	\$ -	\$ -	\$ -	\$ 47,928,723	\$ 57,216,804	\$ 143,478,736	\$ 200,695,540		127	Weighted Average								0.244419	128	<b>Sub Totals</b>	\$ 62,071,810	\$ -	\$ -	\$ -	\$ 62,071,810	\$ 75,839,078	\$ 143,478,736	\$ 219,317,814		129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					\$ -				130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					\$ 254,378				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	<b>Grand Total</b>					\$ 61,817,432				133	Total Intern/Resident Cost as a Percent of Other Allowable Cost								0.00%
	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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\* 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 (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		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 Analysis	From Hospital's Own Internal Analysis	
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		
1	03000 ADULTS & PEDIATRICS	\$ 962.50		225	909	19	392	80	1,486	-	-	-	-	507	-	3,500	62.8%	
2	03100 INTENSIVE CARE UNIT	\$ 2,222.42		725	19	338	80	1,384	-	-	-	-	-	1,384	-	1,384	75.5%	
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	\$ 1,274.67		97	662	-	-	4	4	-	-	-	-	36	-	763	87.3%	
18	<b>Total Days</b>			1,047	1,590	-	-	1,182	1,828	-	-	-	-	681	-	5,647	60.3%	
19	Total Days per PS&R or Exhibit Detail			1,047	1,590	-	-	1,182	1,828	-	-	-	-	681	-	5,647		
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-	-	-	-	-	-	-		
21	Routine Charges			\$ 1,775,720	\$ 1,758,172	\$ 2,200,916	\$ 3,022,291	\$ 1,653,333	\$ 1,653,333	\$ -	\$ -	\$ -	\$ -	\$ 1,650,688	\$ -	\$ 6,782,992	53.6%	
21.01	Calculated Routine Charge Per Diem			\$ 1,686.01	\$ 1,108.91	\$ 1,878.95	\$ 1,878.95	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,650.68	\$ -	\$ 1,650.68		
<b>Ancillary Cost Centers (from Section C):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		
22	02020 Observation (Non-District)	\$ 607,277		\$ 72,069	\$ 80,779	\$ 45,320	\$ 113,690	\$ 65,480	\$ 79,822	\$ 220,512	\$ 216,723	\$ 37,178	\$ 114,834	\$ 317,401	\$ 114,834	\$ 432,235	51.8%	
23	5000 OPERATING ROOM	\$ 4,097.38		\$ 494,055	\$ 569,821	\$ 1,743,761	\$ 1,424,896	\$ 351,392	\$ 706,829	\$ 444,845	\$ 1,866,065	\$ -	\$ -	\$ 226,922	\$ 454,352	\$ 3,034,063	93.2%	
24	5200 DELIVERY ROOM & LABOR ROOM	\$ 5,666.11		\$ 125,671	\$ -	\$ 1,892,922	\$ 1,043	\$ -	\$ -	\$ 19,494	\$ -	\$ -	\$ -	\$ 23,540	\$ -	\$ 2,038,064	48.4%	
25	5400 RADIOLOGY-DIAGNOSTIC	\$ 125,447		\$ 526,184	\$ 68,858	\$ 1,593,423	\$ 214,128	\$ 1,191,401	\$ 282,508	\$ 2,966,254	\$ -	\$ -	\$ 99,268	\$ 1,174,390	\$ 671,371	\$ 6,277,262	28.7%	
26	5700 CT SCAN	\$ 473,430		\$ 898,629	\$ 133,505	\$ 1,216,379	\$ 669,881	\$ 849,590	\$ 857,225	\$ 1,831,545	\$ -	\$ -	\$ 342,699	\$ 1,424,356	\$ 2,134,047	\$ 4,796,347	24.1%	
27	5800 MRI	\$ 59,747		\$ 15,793	\$ 6,950	\$ 76,081	\$ 18,861	\$ 36,054	\$ 54,694	\$ 129,213	\$ -	\$ -	\$ 29,468	\$ 86,244	\$ 19,244	\$ 333,165	18.4%	
28	6000 LABORATORY	\$ 236,797		\$ 851,824	\$ 585,820	\$ 3,456,365	\$ 1,140,242	\$ 585,797	\$ 585,797	\$ 1,482,096	\$ 1,581,577	\$ -	\$ -	\$ 548,161	\$ 1,559,451	\$ 4,092,531	49.8%	
29	6060 RESPIRATORY THERAPY	\$ 362,381		\$ 402,273	\$ 22,199	\$ 138,901	\$ 78,598	\$ 74,016	\$ 24,597	\$ 918,315	\$ 81,118	\$ -	\$ -	\$ 210,963	\$ 43,552	\$ 2,202,187	42.8%	
30	6600 PHYSICAL THERAPY	\$ 314,381		\$ 62,188	\$ 75,212	\$ 25,474	\$ 399,996	\$ 97,552	\$ 69,040	\$ 212,339	\$ 225,573	\$ -	\$ -	\$ 59,393	\$ 99,770	\$ 397,553	34.8%	
31	6900 ELECTROCARDIOLOGY	\$ 209,881		\$ 91,018	\$ 26,516	\$ 117,777	\$ 310,541	\$ 213,898	\$ 386,533	\$ 213,898	\$ -	\$ -	\$ -	\$ 100,814	\$ 67,339	\$ 633,491	43.8%	
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 18,820		\$ 104,281	\$ 113,305	\$ 221,480	\$ 557,951	\$ 100,548	\$ 187,713	\$ 112,390	\$ 499,683	\$ -	\$ -	\$ 65,455	\$ 154,275	\$ 539,513	38.3%	
33	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 22,257		\$ 109,833	\$ 178,861	\$ 20,861	\$ 344,505	\$ 163,348	\$ 170,283	\$ 167,818	\$ 718,891	\$ -	\$ -	\$ 80,564	\$ 100,204	\$ 462,364	28.6%	
34	7300 DRUGS CHARGED TO PATIENTS	\$ 210,448		\$ 928,987	\$ 228,029	\$ 815,705	\$ 736,378	\$ 1,395,683	\$ 270,679	\$ 1,785,458	\$ 826,517	\$ -	\$ -	\$ 649,339	\$ 861,369	\$ 4,925,830	41.3%	
35	9100 EMERGENCY	\$ 2,333.22		\$ 1,745,369	\$ 282,483	\$ 6,759,880	\$ 747,392	\$ 1,095,338	\$ 1,134,293	\$ 2,756,201	\$ -	\$ -	\$ -	\$ 470,823	\$ 4,543,137	\$ 2,560,938	52.0%	
				4,485,100	5,449,237	5,989,629	16,907,365	6,017,000	5,401,992	7,938,720	13,964,322	-	-	3,008,554	10,393,606	-		
<b>Totals / Payments</b>																		
128	Total Charges (includes organ acquisition from Section J)			\$ 6,260,620	\$ 5,449,237	\$ 7,782,801	\$ 16,907,365	\$ 6,237,919	\$ 5,401,992	\$ 10,961,001	\$ 13,964,322	\$ -	\$ -	\$ 4,132,666	\$ 10,393,606	\$ 33,212,541	\$ 41,722,916	41.8%
129	Total Charges per PS&R or Exhibit Detail			\$ 6,260,619	\$ 5,449,238	\$ 7,782,802	\$ 16,907,365	\$ 6,237,917	\$ 5,401,994	\$ 10,961,000	\$ 13,964,323	\$ -	\$ -	\$ 4,132,665	\$ 10,393,604	\$ 33,212,541	\$ 41,722,916	
130	Unreconciled Charges (Explain Variance)			2	(1)	(1)	2	(2)	1	(1)	(1)	-	-	2	-	-	-	
131.01	Sampling Cost Adjustment (if applicable)			-	-	-	-	-	-	-	-	-	-	-	-	-	-	
131.02	Total Calculated Cost (includes organ acquisition from Section J)			\$ 3,129,439	\$ 1,229,695	\$ 4,611,697	\$ 4,020,164	\$ 2,947,042	\$ 1,244,985	\$ 4,099,390	\$ 3,307,293	\$ -	\$ -	\$ 1,668,231	\$ 2,276,542	\$ 14,787,568	\$ 9,802,049	46.2%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ 1,821,364	\$ 1,090,804	\$ 5,200	\$ -	\$ 82,527	\$ 74,133	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,909,177	\$ 1,164,937	\$ -	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ -	\$ -	\$ 1,930,127	\$ 2,182,480	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,939,127	\$ 2,182,480	\$ -	
134	Private Insurance (including primary and third party liability)			\$ 30,590	\$ 4,582	\$ 384,778	\$ 618,540	\$ -	\$ 107	\$ 63,434	\$ 112,592	\$ -	\$ -	\$ -	\$ 458,802	\$ 735,821	\$ -	
135	Self-Pay (including Co-Pay and Spend-Down)			\$ -	\$ -	\$ -	\$ 13	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,678	\$ 20,343	\$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ 1,851,974	\$ 1,095,386	\$ 2,309,184	\$ 2,802,065	\$ -	\$ -	\$ 2,565	\$ 19,307	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
137	Medicaid Cost Settlement Payments (See Note B)			\$ -	\$ -	\$ -	\$ 1,492	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,490	
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)			\$ -	\$ -	\$ -	\$ -	\$ 2,289,838	\$ 873,422	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,289,838	\$ 873,422	\$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,662,696	\$ 2,217,400	\$ -	\$ -	\$ -	\$ -	\$ 2,662,696	\$ 2,217,400	\$ -	
141	Medicare Cross-Over Bad Debt Payments			\$ -	\$ -	\$ -	\$ -	\$ 20,157	\$ 25,804	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 20,157	\$ 25,804	\$ -	
142	Other Medicare Cross-Over Payments (See Note D)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
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)			\$ 1,277,465	\$ 134,309	\$ 2,302,513	\$ 1,216,639	\$ 554,522	\$ 271,518	\$ 1,370,495	\$ 903,897	\$ -	\$ -	\$ 1,555,910	\$ 2,038,288	\$ 5,504,995	\$ 2,528,364	
146	Calculated Payments as a Percentage of Cost			59%	89%	50%	70%	78%	67%	73%	0%	0%	1%	10%	63%	74%		
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt L Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)							5,341										
148	Percent of cross-over days to total Medicare days from the cost report							21%										

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

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payer 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).

**I. Out-of-State Medicaid Data:**

Cost Report Year (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers From Section G	Medicaid Cost to 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-Overs (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)
<b>Routine Cost Centers (list below):</b>													
				<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>
1	03000 ADULTS & PEDIATRICS	\$ 962.50		28	-	-	-	2	2	-	-	32	-
2	03100 INTENSIVE CARE UNIT	\$ 2,222.42		5	-	-	-	-	-	-	-	5	-
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	\$ 1,274.67		16	-	-	-	-	-	-	-	16	-
17		\$ -		-	-	-	-	-	-	-	-	-	-
18			<b>Total Days</b>	49	-	-	-	2	2	-	-	53	-
19	Total Days per PS&R or Exhibit Detail												
20	Unreconciled Days (Explain Variance)												
21				<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>	<b>Routine Charges</b>
21.01				\$ 76,614	\$ -	\$ 3,308	\$ 1,654.00	\$ 2,609	\$ 1,304.50	\$ -	\$ -	\$ 82,531	\$ 1,557.19
				\$ 1,563.55	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Ancillary Cost Centers (from W/S C) (list below):</b>													
22	09200 Observation (Non-Distinct)	0.607277		14	3,662	-	-	2	1,309	1	289	17	5,460
23	5000 OPERATING ROOM	0.409739		25,647	379	-	-	3	31	19	123	25,669	533
24	5200 DELIVERY ROOM & LABOR ROOM	0.846611		5,172	-	-	-	-	-	-	-	5,172	-
25	5400 RADIOLOGY-DIAGNOSTIC	0.235963		7,658	14,115	-	-	143	2,276	286	6,859	8,087	23,250
26	5700 CT SCAN	0.054419		20,845	26,259	-	-	-	2,395	5,934	9,336	26,779	37,990
27	5800 MRI	0.087413		-	-	-	-	-	-	2,219	-	2,219	-
28	6000 LABORATORY	0.236797		30,149	52,448	-	-	4,236	1,900	3,106	8,013	37,491	62,361
29	6500 RESPIRATORY THERAPY	0.362381		11,798	1,717	-	-	1,881	18	588	62	14,267	1,797
30	6600 PHYSICAL THERAPY	0.314381		1,556	-	-	-	147	-	538	-	2,241	-
31	6900 ELECTROCARDIOLOGY	0.209234		4,170	329	-	-	12	2,173	2,071	522	6,253	3,024
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.187820		14,842	161	-	-	-	-	-	28	14,842	188
33	7200 IMPL. DEV. CHARGED TO PATIENTS	0.222657		1,955	-	-	-	-	-	-	-	1,955	-
34	7300 DRUGS CHARGED TO PATIENTS	0.210448		47,371	7,848	-	-	2,449	1,085	1,748	1,812	51,568	10,745
35	9100 EMERGENCY	0.233322		20,959	114,909	-	-	3,157	5,243	4,376	22,051	28,492	142,203
				191,936	221,827	-	-	12,030	16,630	20,886	49,095		
<b>Totals / Payments</b>													
128	<b>Total Charges (includes organ acquisition from Section K)</b>			\$ 268,550	\$ 221,827	\$ -	\$ -	\$ 15,338	\$ 16,630	\$ 23,495	\$ 49,095	\$ 307,383	\$ 287,552
129	Total Charges per PS&R or Exhibit Detail			\$ 268,549	\$ 221,827	\$ -	\$ -	\$ 15,336	\$ 16,631	\$ 23,496	\$ 49,096	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)			1	-	-	-	2	(1)	(1)	(1)	-	-
131.01	Sampling Cost Adjustment (if applicable)			-	-	-	-	-	-	-	-	-	-
131.02	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>			\$ 107,098	\$ 48,741	\$ -	\$ -	\$ 4,947	\$ 3,951	\$ 5,449	\$ 9,911	\$ 117,494	\$ 62,603
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			\$ 17,364	\$ 13,860	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 17,364	\$ 13,860
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)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,714	\$ 12,802	\$ 2,714	\$ 12,802
135	Self-Pay (including Co-Pay and Spend-Down)			\$ 75	\$ 2,023	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 75	\$ 2,593
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			\$ 17,439	\$ 15,883	\$ -	\$ -	\$ -	\$ 17	\$ -	\$ 553	\$ -	\$ -
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)			\$ -	\$ -	\$ -	\$ -	\$ 12,645	\$ 2,394	\$ -	\$ -	\$ 12,645	\$ 2,394
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,832	\$ 2,083	\$ 1,832	\$ 2,083
141	Medicare Cross-Over Bad Debt Payments			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143	<b>Calculated Payment Shortfall (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>			\$ 89,659	\$ 32,858	\$ -	\$ -	\$ (7,698)	\$ 1,540	\$ 903	\$ (5,527)	\$ 82,864	\$ 28,871
144	<b>Calculated Payments as a Percentage of Cost</b>			16%	33%	0%	0%	256%	61%	83%	156%	29%	54%

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 reported 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).

**J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured**

Cost Report Year (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Medicare FFS Cross-Over (with Medicaid Secondary) - Excluded Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured			
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
					From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis
<b>Organ Acquisition Cost Centers (list below):</b>																		
1 Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
2 Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
3 Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
4 Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
5 Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
6 Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
7 Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
8	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
9 Totals	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	
10 Total Cost																		

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Included Elsewhere & with Medicaid Secondary		
					Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	
					From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	
<b>Organ Acquisition Cost Centers (list below):</b>													
11 Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12 Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13 Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14 Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15 Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16 Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17 Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19 Totals	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
20 Total Cost													

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments

**L. Provider Tax Assessment Reconciliation / Adjustment**

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2023-12/31/2023) ATRIUM HEALTH NAVICENT BALDWIN

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 748,188	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	1203-10533-40814-667091 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 748,188	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 0	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code	\$ 0	- (Reclassified to / (from))
5 Reclassification Code	\$ 0	- (Reclassified to / (from))
6 Reclassification Code	\$ 0	- (Reclassified to / (from))
7 Reclassification Code	\$ 0	- (Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
8 Reason for adjustment	\$ (748,188)	5.00 (Adjusted to / (from))
9 Reason for adjustment	\$ 0	- (Adjusted to / (from))
10 Reason for adjustment	\$ 0	- (Adjusted to / (from))
11 Reason for adjustment	\$ 0	- (Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
12 Reason for adjustment	\$ 0	-
13 Reason for adjustment	\$ 0	-
14 Reason for adjustment	\$ 0	-
15 Reason for adjustment	\$ 0	-
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	\$ 748,188
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	75,530,392
19 Uninsured Hospital Charges Sec. G	14,526,271
20 Total Hospital Charges Sec. G	219,317,814
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	34.44%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.62%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 257,667
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 49,555
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ 307,222
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	36,860,600
27 Uninsured Hospital Charges Sec. G	14,526,271
28 Total Hospital Charges Sec. G	219,317,814
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	16.81%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.62%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 125,747
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 49,555
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 175,302

\* 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.

**DSH Examination Eligibility Summary**

Hospital Name	<b>ATRIUM HEALTH NAVICENT BALDWIN</b>		
Hospital Medicaid Number	<b>000000129A</b>		
Cost Report Period	From	<b>1/1/2023</b>	To <b>12/31/2023</b>

		As-Reported	Adjustments	As-Adjusted	
<b>LIUR</b>					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 8,250,051	\$ -	\$ 8,250,051
2	Hospital Cash Subsidies	Survey F-2	\$ 500,000	\$ -	\$ 500,000
3	Total		\$ 8,750,051	\$ -	\$ 8,750,051
4	Net Hospital Patient Revenue	Survey F-3	\$ 59,224,394	\$ -	\$ 59,224,394
5	Medicaid Fraction		14.65%	0.00%	14.65%
6	Inpatient Charity Care Charges	Survey F-2	\$ 4,075,803	\$ -	\$ 4,075,803
7	Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	\$ 500,000	\$ -	\$ 500,000
9	Adjusted Inpatient Charity Care		\$ 3,921,746	\$ -	\$ 3,921,746
10	Inpatient Hospital Charges	Survey F-3	\$ 67,574,796	\$ -	\$ 67,574,796
11	Inpatient Charity Fraction		5.80%	0.00%	5.80%
12	LIUR		20.45%	0.00%	20.45%
<b>MIUR</b>					
13	In-State Medicaid Eligible Days	Survey H	5,647	-	5,647
14	Out-of-State Medicaid Eligible Days	Survey I	53	-	53
15	Total Medicaid Eligible Days		5,700	-	5,700
16	Total Hospital Days (excludes swing-bed)	Survey F-1	10,577	-	10,577
17	MIUR		53.89%	0.00%	53.89%

*NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.*

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name **ATRIUM HEALTH NAVICENT BALDWIN**  
 Hospital Medicaid Number **000000129A**  
 Cost Report Period From **1/1/2023** To **12/31/2023**

As-Reported:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E		
1 Medicaid Fee for Service	Inpatient	3,129,439	1,821,384	-	30,590	-	-	-	-	-	-	-	-	-	1,851,974	1,277,465	59.18%
2 Medicaid Fee for Service	Outpatient	1,229,695	1,090,804	-	4,582	-	-	-	-	-	-	-	-	-	1,095,386	134,309	89.08%
3 Medicaid Managed Care	Inpatient	4,611,697	5,266	1,939,127	364,778	13	-	-	-	-	-	-	-	-	2,309,184	2,302,513	50.07%
4 Medicaid Managed Care	Outpatient	4,020,164	-	2,182,489	618,540	1,036	1,460	-	-	-	-	-	-	-	2,803,525	1,216,639	69.74%
5 Medicare Cross-over (FFS)	Inpatient	2,947,042	82,527	-	-	-	-	-	2,289,836	-	20,157	-	-	-	2,392,520	554,522	81.18%
6 Medicare Cross-over (FFS)	Outpatient	1,244,985	74,133	-	107	-	-	-	873,422	-	25,804	-	-	-	973,466	271,519	78.19%
7 Other Medicaid Eligibles	Inpatient	4,099,390	-	-	63,434	2,565	-	-	-	2,662,896	-	-	-	-	2,728,895	1,370,495	66.57%
8 Other Medicaid Eligibles	Outpatient	3,307,205	-	-	112,592	19,307	-	-	-	2,271,409	-	-	-	-	2,403,308	903,897	72.67%
9 Uninsured	Inpatient	1,568,231	-	-	-	-	-	-	-	-	-	-	12,315	-	12,315	1,555,916	0.79%
10 Uninsured	Outpatient	2,276,542	-	-	-	-	-	-	-	-	-	-	238,274	-	238,274	2,038,268	10.47%
11 In-State Sub-total	Inpatient	16,355,799	1,909,177	1,939,127	458,802	2,578	-	-	2,289,836	2,662,896	20,157	-	12,315	-	9,294,888	7,060,911	56.83%
12 In-State Sub-total	Outpatient	12,078,591	1,164,937	2,182,489	735,821	20,343	1,460	-	873,422	2,271,409	25,804	-	238,274	-	7,513,959	4,564,632	62.21%
13 Out-of-State Medicaid	Inpatient	117,494	17,364	-	2,714	75	-	-	12,645	1,832	-	-	-	-	34,630	82,864	29.47%
14 Out-of-State Medicaid	Outpatient	62,603	13,860	-	12,802	2,593	-	-	2,394	2,083	-	-	-	-	33,732	28,871	53.88%
15 Sub-Total	I/P and O/P	28,614,487	3,105,338	4,121,616	1,210,139	25,589	1,460	-	3,178,297	4,938,220	45,961	-	250,589	-	16,877,209	11,737,278	58.98%
15.01 Provider Tax Assessment Adjustment to UCC																307,222	

Adjustments:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01 Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name **ATRIUM HEALTH NAVICENT BALDWIN**  
 Hospital Medicaid Number **000000129A**  
 Cost Report Period From **1/1/2023** To **12/31/2023**

Service Type		A		B		C		D	E	F	G	H	I	J	K	L	M	N	O	P
		Total Costs Survey H & I	Medicaid Basic Rate Payments Survey H & I	Medicaid Managed Care Payments Survey H & I	Private Insurance Payments Survey H & I	Self-Pay Payments (Includes Co- Pay and Spendedown) Survey H & I	Medicaid Cost Settlement Payments Survey H & I	Other Medicaid Payments (Outliers, etc.) ** Survey H & I	Medicare Traditional (non-HMO) Payments Survey H & I	Medicare Managed Care (HMO) Payments Survey H & I	Medicare Cross-over Bad Debt Survey H & I	Other Medicare Cross-over Payments (GME, etc.) Survey H & I	Uninsured Payments Survey H & I	Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)			
1 Medicaid Fee for Service	Inpatient	3,129,439	1,821,384	-	30,590	-	-	-	-	-	-	-	-	-	-	-	-	1,851,974	1,277,465	59.18%
2 Medicaid Fee for Service	Outpatient	1,229,695	1,090,804	-	4,582	-	-	-	-	-	-	-	-	-	-	-	-	1,095,366	134,309	89.08%
3 Medicaid Managed Care	Inpatient	4,611,697	5,266	1,939,127	364,778	13	-	-	-	-	-	-	-	-	-	-	-	2,309,184	2,302,513	50.07%
4 Medicaid Managed Care	Outpatient	4,020,164	-	2,182,489	618,540	1,036	-	1,460	-	-	-	-	-	-	-	-	-	2,803,525	1,216,639	69.74%
5 Medicare Cross-over (FFS)	Inpatient	2,947,042	82,527	-	-	-	-	-	2,289,836	-	-	-	-	20,157	-	-	-	2,392,520	554,522	81.18%
6 Medicare Cross-over (FFS)	Outpatient	1,244,985	74,133	-	107	-	-	-	873,422	-	-	-	25,804	-	-	-	-	973,466	271,519	78.19%
7 Other Medicaid Eligibles	Inpatient	4,099,390	-	-	63,434	2,565	-	-	-	-	-	-	2,662,896	-	-	-	-	2,728,895	1,370,495	66.57%
8 Other Medicaid Eligibles	Outpatient	3,307,205	-	-	112,592	19,307	-	-	-	-	-	-	2,271,409	-	-	-	-	2,403,308	903,897	72.67%
9 Uninsured	Inpatient	1,568,231	-	-	-	-	-	-	-	-	-	-	-	-	-	12,315	-	12,315	1,555,916	0.79%
10 Uninsured	Outpatient	2,276,542	-	-	-	-	-	-	-	-	-	-	-	-	-	238,274	-	238,274	2,038,268	10.47%
11 In-State Sub-total	Inpatient	16,355,799	1,909,177	1,939,127	458,802	2,578	-	-	2,289,836	-	-	-	2,662,896	20,157	-	-	-	9,294,888	7,060,911	56.83%
12 In-State Sub-total	Outpatient	12,078,591	1,164,937	2,182,489	735,821	20,343	-	1,460	873,422	-	-	-	2,271,409	25,804	-	238,274	-	7,513,959	4,564,632	62.21%
13 Out-of-State Medicaid	Inpatient	117,494	17,364	-	2,714	75	-	-	12,645	-	-	-	1,832	-	-	-	-	34,630	82,864	29.47%
14 Out-of-State Medicaid	Outpatient	62,603	13,860	-	12,802	2,593	-	-	2,394	-	-	-	2,083	-	-	-	-	33,732	28,871	53.88%
15 Cost Report Year Sub-Total	I/P and O/P	28,614,487	3,105,338	4,121,616	1,210,139	25,589	-	1,460	3,178,297	-	-	-	4,938,220	45,961	-	250,589	-	16,877,209	11,737,278	58.98%
15.01																			307,222	
16																			-	
17																			12,044,500	
18																			131,920	
19																			3,089,651	
20																			8,822,929	

Medicaid DSH Survey Adjustments

PROVIDER: ATRIUM HEALTH NAVICENT BALDWIN  
 FROM: 1/1/2023

TO: 12/31/2023

Mcaid Number: 000000129A  
 Mcare Number: 110150

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
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**Medicaid DSH Report Notes**

PROVIDER: ATRIUM HEALTH NAVICENT BALDWIN

Mcaid Number: 000000129A

FROM: 1/1/2023 TO: 12/31/2023

Mcare Number: 110150

**Myers and Stauffer DSH Report Notes**

Note #	Note for Report	Amounts
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