

A. General DSH Year Information

1. DSH Year:

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

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

Identification of cost reports needed to cover the DSH Year:

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

Cost Report Begin Date(s)	Cost Report End Date(s)
10/01/2022	09/30/2023

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

6. Medicaid Provider Number:
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number:

Data
000001361A
0
0
111318

B. DSH Qualifying Information

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

During the DSH Examination Year:

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

DSH Examination
Year (07/01/24 -
06/30/25)

No

No

Yes

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

Yes

3b. What date did the hospital open?

6/15/1957

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025

\$ 89,771

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

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025

\$ -

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

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

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

\$ 89,771

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?

Answer

Yes

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature

Chief Administrator/Interim CEO
Title

Date

Kerry Trapnell

Hospital CEO or CFO Printed Name

Hospital CEO or CFO Telephone Number

Kerry.Trapnell@monroehospital.org

Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Kim Ralls
Title	Director of Financial Services
Telephone Number	478-394-6293
E-Mail Address	kralls@monroehospital.org
Mailing Street Address	88 Martin Luther King Jr. Drive
Mailing City, State, Zip	Forsyth, GA 31029

Outside Preparer:

Name	Jennifer Johnson
Title	Senior Manager
Firm Name	Southeast Reimbursement Group
Telephone Number	(770) 928-3352 ext 106
E-Mail Address	Jennifer.johnson@srgllc.org

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

Cost Report Year (10/01/2022-09/30/2023) MONROE COUNTY HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):			Days	Days	Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 993.03	53	34	26		28		28		-		55		141		20.10%
2	03100 INTENSIVE CARE UNIT	\$ -															
3	03200 CORONARY CARE UNIT	\$ -															
4	03300 BURN INTENSIVE CARE UNIT	\$ -															
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -															
6	03500 OTHER SPECIAL CARE UNIT	\$ -															
7	04000 SUBPROVIDER I	\$ -															
8	04100 SUBPROVIDER II	\$ -															
9	04200 OTHER SUBPROVIDER	\$ -															
10	04300 NURSERY	\$ -															
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17		\$ -															
18			Total Days	53	34	26		28		-		55		141		14.98%	
19	Total Days per PS&R or Exhibit Detail		53	34	26		28		-		-		55				
20	Unreconciled Days (Explain Variance)		-	-	-		-		-		-		-				
Routine Charges			\$ 26,860	\$ 17,582	\$ 12,090		\$ 14,349		\$ -		\$ -		\$ 27,790		\$ 70,881		3.91%
21.01	Calculated Routine Charge Per Diem		\$ 506.79	\$ 517.12	\$ 465.00		\$ 512.46		\$ -		\$ -		\$ 505.27		\$ 502.70		
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)	2.108425	-	5.000	-	1.210	989	39,806	5,243	39,806	5,243	39,806	10,832	-	47,005	36.88%	
23	5400 RADIOLOGY-DIAGNOSTIC	0.163820	18,216	137,644	19,669	562,584	6,010	139,367	5,243	139,367	5,243	139,367	31,786	1,343,221	1,708,153	33.33%	
24	6000 LABORATORY	0.336900	32,790	167,130	30,042	619,862	9,230	77,716	13,028	77,716	13,028	77,716	45,135	85,090	1,191,130	42.38%	
25	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.203977	-	-	9,592	4,548	3,032	4,548	4,919	6,482	-	-	5,104	15,765	17,543	19.10%	
26	6500 RESPIRATORY THERAPY	0.704422	20,249	16,231	11,488	44,217	8,931	7,051	10,277	70,478	-	871	16,982	77,478	50,945	137,976	23.69%
27	6600 PHYSICAL THERAPY	0.596919	1,384	-	-	-	1,037	2,178	7,965	-	-	-	1,139	-	4,600	7,965	0.98%
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.260948	5,866	11,019	3,372	18,222	2,769	6,614	2,592	26,615	-	278	4,569	33,672	14,599	62,470	25.16%
29	7300 DRUGS CHARGED TO PATIENTS	0.392325	30,642	17,888	19,917	85,493	9,192	14,263	10,396	107,965	-	1,535	27,995	153,821	70,146	225,209	22.39%
30	9100 EMERGENCY	0.357186	27,817	443,912	28,039	1,529,746	1,326	168,536	2,292	894,477	-	21,484	43,314	2,044,452	59,474	3,036,671	51.21%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2022-09/30/2023) MONROE 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
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				\$ 136,964	\$ 798,824	\$ 122,120	\$ 2,765,883	\$ 41,527	\$ 414,537	\$ 50,925	\$ 2,448,365	\$ -	\$ 49,272	\$ 176,025	\$ 4,406,770			

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

Cost Report Year (10/01/2022-09/30/2023) MONROE COUNTY HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to	
Totals / Payments																
128	Total Charges (includes organ acquisition from Section J)															35.16%
	\$ 163,824	\$ 798,824	\$ 139,702	\$ 2,765,883	\$ 53,617	\$ 414,537	\$ 65,274	\$ 2,448,365	\$ -	\$ 49,272	\$ 203,815	\$ 4,406,770	\$ 422,416	\$ 6,427,609		
129	Total Charges per PS&R or Exhibit Detail															
130	Unreconciled Charges (Explain Variance)															
	\$ 163,824	\$ 798,824	\$ 139,702	\$ 2,765,883	\$ 53,617	\$ 414,537	\$ 65,274	\$ 2,448,365	\$ -	\$ 49,272	\$ 203,815	\$ 4,406,770				
131	Total Calculated Cost (includes organ acquisition from Section J)															37.51%
	\$ 105,240	\$ 269,283	\$ 75,864	\$ 886,630	\$ 42,244	\$ 123,586	\$ 48,169	\$ 794,239	\$ -	\$ 14,315	\$ 116,360	\$ 1,345,174	\$ 271,517	\$ 2,073,738		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)															
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)															
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	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)															
	\$ 84,143	\$ 200,124	\$ -	\$ -									\$ 84,143	\$ 200,124		
	\$ -	\$ -	\$ 56,179	\$ 573,495				\$ -					\$ 56,179	\$ 573,495		
	\$ -	\$ 335	\$ -	\$ -			\$ 19,798	\$ 640,930					\$ 19,798	\$ 641,265		
	\$ -	\$ -	\$ -	\$ 1,101			\$ -	\$ 7,964					\$ -	\$ 9,065		
	\$ 84,143	\$ 200,459	\$ 56,179	\$ 574,596									\$ -	\$ -		
	\$ -	\$ 6,218											\$ -	\$ 6,218		
	\$ -	\$ -											\$ -	\$ -		
	\$ -				\$ 35,086	\$ 103,577	\$ -						\$ 35,086	\$ 103,577		
					\$ 2,789	\$ 15,161							\$ -	\$ -		
					\$ 3,938	\$ 3,587							\$ 3,938	\$ 3,587		
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Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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).