

**A. General DSH Year Information**

1. DSH Year: 

Begin	End
07/01/2020	06/30/2021

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

**Identification of cost reports needed to cover the DSH Year:**

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2021	12/31/2021
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000000976A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110069

**B. DSH Qualifying Information**

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

**During the DSH Examination Year:**

<p>1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)</p> <p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p> <p>3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?</p> <p>3a. Was the hospital open as of December 22, 1987?</p> <p>3b. What date did the hospital open?</p>	<table border="1" style="margin-bottom: 10px;"> <tr><th>DSH Examination Year (07/01/20 - 06/30/21)</th></tr> <tr><td>Yes</td></tr> </table> <table border="1" style="margin-bottom: 10px;"> <tr><td>No</td></tr> </table> <table border="1" style="margin-bottom: 10px;"> <tr><td>No</td></tr> </table> <table border="1" style="margin-bottom: 10px;"> <tr><td>Yes</td></tr> </table> <table border="1"> <tr><td>7/2/1960</td></tr> </table>	DSH Examination Year (07/01/20 - 06/30/21)	Yes	No	No	Yes	7/2/1960
DSH Examination Year (07/01/20 - 06/30/21)							
Yes							
No							
No							
Yes							
7/2/1960							

**C. Disclosure of Other Medicaid Payments Received:**

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** \$ 6,083,963  
 (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 07/01/2020 - 06/30/2021**    
 (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 07/01/2020 - 06/30/2021** \$ 6,083,963

**Certification:**

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

**Answer**

Yes

**Explanation for "No" answers:**

Other protested item: "New Hampshire Hospital Association vs. Azar": We protest the inclusion of Commercial and Medicare payments for dual eligibles towards the hospital's specific limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Cost.

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

Sean Whilden  
 Hospital CEO or CFO Printed Name

CFO  
 Title

478-542-7959  
 Hospital CEO or CFO Telephone Number

  
 Date

swilden@hhc.org  
 Hospital CEO or CFO E-Mail

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

**Hospital Contact:**

Name	Darcie Winsper
Title	Director of Finance
Telephone Number	478-954-4191
E-Mail Address	dwinsper@hhc.org
Mailing Street Address	1601 Watson Blvd
Mailing City, State, Zip	Warner Robins, GA 31093

**Outside Preparer:**

Name	Dennis Willis
Title	Senior Manager
Firm Name	Southeast Reimbursement Group
Telephone Number	615-333-0655 ext 205
E-Mail Address	dennis.willis@srgllc.org