State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2018

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2017	06/30/2018

2. Select Your Facility from the Drop-Down Menu Provided: PHOEBE PUTNEY MEMORIAL HOSPITAL

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	08/01/2017	07/31/2018
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:	000001482A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001416A
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110007

B. DSH OB 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:

	DSH Examination Year (07/01/17 - 06/30/18)
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.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
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?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	8/1/1911

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/19 - 06/30/20)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

MICHAEL BOWMAN
DAVIS SULLIVAN

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is 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?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 11,481,024

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 v. Azar" We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals 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	SR VP/CFO Title	11/16/2018 Date
BRIAN CHURCH Hospital CEO or CFO Printed Name	229-312-4068 Hospital CEO or CFO Telephone Number	BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	REBECCA KENDALL
Title	DIRECTOR OF REIMBURSEMENT
Telephone Number	229-312-6711
E-Mail Address	RKENDALL@PHOEBEHEALTH.COM
Mailing Street Address	417 W THIRD AVENUE ALBANY GA 31701

Outside Preparer:

Name	
Title:	
Firm Name:	
Telephone Number	
E-Mail Address	

DSH Version 7.30 3/26/2019

D. General Cost Report Year Information 8/1/2017 - 7/31/2018

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: PHOEBE PUTNEY MEMORIAL HOSPITAL

	8/1/2017 through 7/31/2018		
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: 1/28/2019

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	PHOEBE PUTNEY MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000001482A	No	PROVIDER NUMBER 000001482A & 000001416A
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001416A	No	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	No	
8. Medicare Provider Number:	110007	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	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.
9. State Name & Number	FLORIDA	913855200
10. State Name & Number	ALABAMA	PH0007N
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: (08/01/2017 - 07/31/2018)

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)	$ 210,996	$ 761,411	$972,407
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,816,821	$ 7,071,915	$8,888,736
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)	$2,027,817	$7,833,326	$9,861,143
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	10.41%	9.72%	9.86%

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 (08/01/2017 - 07/31/2018)

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)	103,854	**(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	116
3.	Outpatient Hospital Subsidies	181,005
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 181,121
7.	Inpatient Hospital Charity Care Charges	27,918,709
8.	Outpatient Hospital Charity Care Charges	31,778,035
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 59,696,744

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	$97,127,741.00			$ 67,744,464	$ -	$ -	$ 29,383,277
12.	Subprovider I (Psych or Rehab)	$3,566,744.00			$ 2,487,726	$ -	$ -	$ 1,079,018
13.	Subprovider II (Psych or Rehab)			$ 6,010,351	$ -	$ -	$ 4,192,088	$ -
14.	Swing Bed - SNF			$0.00			$ -	
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	$558,738,146.00	$851,313,113.00		$ 389,707,572	$ 593,772,178	$ -	$ 426,571,509
20.	Outpatient Services		$88,106,159.00			$ 61,452,109	$ -	$ 26,654,050
21.	Home Health Agency			$9,800,951.00			$ 6,835,948	
22.	Ambulance			$ 408,106			$ 284,645	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,530,309.00			$ 3,857,269	
26.	Other	$11,114,155.00	$31,274,339.00	$0.00	$ 7,751,879	$ 21,813,164	$ -	$ 12,823,451
27.	Total	$ 670,546,786	$ 970,693,611	$ 21,749,717	$ 467,691,640	$ 677,037,451	$ 15,169,949	$ 496,511,306
28.	Total Hospital and Non Hospital		Total from Above	$ 1,662,990,114		Total from Above	$ 1,159,899,040	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,662,990,114	Total Contractual Adj. (G-3 Line 2)	1,153,001,139
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)			+	6,897,901
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)"			-	
35.	Adjusted Contractual Adjustments				1,159,899,040

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2017-07/31/2018) | PHOEBE PUTNEY MEMORIAL 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	$ 81,211,184	$ -	$ -	$0.00	$ 81,211,184	88,350	$60,831,288.00		$ 919.20
2	03100 INTENSIVE CARE UNIT	$ 16,708,589	$ 98,354	$ -		$ 16,806,943	10,039	$17,752,463.00		$ 1,674.17
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	$ 11,483,135	$ 69,212	$ -		$ 11,552,347	7,901	$16,018,996.00		$ 1,462.14
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 3,983,817	$ -	$ -		$ 3,983,817	7,181	$4,378,850.00		$ 554.77
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 113,386,725	$ 167,566	$ -	$ -	$ 113,554,291	113,471	$ 98,981,597		
19	Weighted Average									$ 1,000.74

		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)	9,617	-	-	$ 8,839,946	$6,784,550.00	$5,317,539.00	$ 12,102,089	0.730448

		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	$23,041,351.00	$ 98,354	$0.00	$ 23,139,705	$83,918,020.00	$114,870,815.00	$ 198,788,835	0.116403
22	5100 RECOVERY ROOM	$7,785,812.00	$ -	$0.00	$ 7,785,812	$20,522,592.00	$36,420,806.00	$ 56,943,398	0.136729
23	5200 DELIVERY ROOM & LABOR ROOM	$7,794,109.00	$ 196,709	$0.00	$ 7,990,818	$2,690,255.00	$3,745,635.00	$ 6,435,890	1.241603
24	5300 ANESTHESIOLOGY	$282,930.00	$ 27,321	$0.00	$ 310,251	$19,483,295.00	$27,536,977.00	$ 47,020,272	0.006598
25	5400 RADIOLOGY-DIAGNOSTIC	$16,655,738.00	$ 60,105	$0.00	$ 16,715,843	$34,088,600.00	$138,162,210.00	$ 172,250,810	0.097044
26	5500 RADIOLOGY-THERAPEUTIC	$25,456,384.00	$ -	$0.00	$ 25,456,384	$1,969,263.00	$45,946,593.00	$ 47,915,856	0.531273
27	6000 LABORATORY	$20,104,228.00	$ -	$0.00	$ 20,104,228	$68,830,754.00	$64,055,563.00	$ 132,886,317	0.151289
28	6500 RESPIRATORY THERAPY	$8,719,768.00	$ -	$0.00	$ 8,719,768	$22,563,853.00	$5,623,742.00	$ 28,187,595	0.309348
29	6600 PHYSICAL THERAPY	$9,299,820.00	$ -	$0.00	$ 9,299,820	$9,514,907.00	$5,795,816.00	$ 15,310,723	0.607406
30	6700 OCCUPATIONAL THERAPY	$2,535,695.00	$ -	$0.00	$ 2,535,695	$7,114,355.00	$1,219,090.00	$ 8,333,445	0.304279
31	6800 SPEECH PATHOLOGY	$1,182,937.00	$ -	$0.00	$ 1,182,937	$2,911,207.00	$888,607.00	$ 3,799,814	0.311314

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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
32	6900	ELECTROCARDIOLOGY	$2,438,015.00	$ -	$0.00		$ 2,438,015	$4,583,042.00	$12,173,810.00	$ 16,756,852	0.145494
33	7000	ELECTROENCEPHALOGRAPHY	$1,865,548.00	$ -	$0.00		$ 1,865,548	$427,913.00	$6,131,227.00	$ 6,559,140	0.284420
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$37,021,882.00	$ -	$0.00		$ 37,021,882	$68,045,375.00	$41,879,656.00	$ 109,925,031	0.336792
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,534,350.00	$ -	$0.00		$ 16,534,350	$52,256,476.00	$44,886,810.00	$ 97,143,286	0.170206
36	7300	DRUGS CHARGED TO PATIENTS	$56,337,149.00	$ -	$0.00		$ 56,337,149	$121,972,926.00	$239,150,452.00	$ 361,123,378	0.156005
37	7400	RENAL DIALYSIS	$2,356,285.00	$ -	$0.00		$ 2,356,285	$4,389,434.00	$0.00	$ 4,389,434	0.536808
38	7600	ENDOSCOPY	$4,252,152.00	$ 98,354	$0.00		$ 4,350,506	$2,402,283.00	$19,448,281.00	$ 21,850,564	0.199103
39	7601	HEART CATH LAB	$5,690,944.00	$ -	$0.00		$ 5,690,944	$31,647,701.00	$36,813,321.00	$ 68,461,022	0.083127
40	9000	CLINIC	$7,763,812.00	$ -	$0.00		$ 7,763,812	$773,431.00	$10,434,720.00	$ 11,208,151	0.692693
41	9100	EMERGENCY	$20,141,590.00	$ 280,493	$5,409,937.00		$ 25,832,020	$13,846,917.00	$69,020,688.00	$ 82,867,605	0.311726
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 277,260,499	$ 761,336	$ 5,409,937		$ 283,431,772	$ 580,737,149	$ 929,522,358	$ 1,510,259,507	
127		**Weighted Average**									0.193524
128		**Sub Totals**	$ 390,647,224	$ 928,902	$ 5,409,937		$ 396,986,063	$ 679,718,746	$ 929,522,358	$ 1,609,241,104	
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)*					$0.00				
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**					$ 396,986,063				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.23%				

* 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 (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 919.20		10,168		5,963		7,445		9,933		6,091		33,509		50.36%
2	03100 INTENSIVE CARE UNIT	$ 1,674.17		1,167		204		1,280		1,146		803		3,797		45.88%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,462.14		669		5,638				871		14		7,178		91.08%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 554.77		636		5,710				697		81		7,043		99.25%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	12,640		17,515		8,725		12,647		6,989		51,527		51.63%
19	Total Days per PS&R or Exhibit Detail			12,640		17,515		8,725		12,647		6,989				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 10,643,244		$ 20,344,220		$ 7,815,637		$ 11,310,200		$ 5,937,029		$ 50,113,301		56.69%
21.01	Calculated Routine Charge Per Diem			$ 842.03		$ 1,161.53		$ 895.78		$ 894.30		$ 849.48		$ 972.56		
	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**	
22	09200 Observation (Non-Distinct)		0.730448	1,316,510	1,010,110	537,479	905,971	440,842	511,307	510,878	629,313	161,024	867,443	$ 2,805,709	$ 3,056,701	57.14%
23	5000 OPERATING ROOM		0.116403	6,749,387	4,766,350	6,495,727	9,514,318	7,724,678	13,906,456	9,175,230	7,504,399	6,055,260	4,041,753	$ 30,145,022	$ 35,691,523	38.24%
24	5100 RECOVERY ROOM		0.136729	1,199,830	1,685,121	2,914,050	5,112,375	2,526,288	1,799,658	2,641,448	2,095,085	1,272,056	1,428,653	$ 9,281,616	$ 10,992,239	39.85%
25	5200 DELIVERY ROOM & LABOR ROOM		1.241603	272,236	37,632	2,920,846	869,142	25,177	6,468	888,910	180,006	58,958	45,864	$ 4,107,169	$ 1,093,248	82.50%
26	5300 ANESTHESIOLOGY		0.006598	1,523,564	1,295,439	1,213,491	3,465,357	1,545,823	1,208,749	1,938,219	1,443,399	1,497,208	1,155,289	$ 6,221,097	$ 7,412,944	34.67%
27	5400 RADIOLOGY-DIAGNOSTIC		0.097044	5,465,685	6,219,974	2,232,990	8,036,458	5,197,538	6,791,624	5,670,194	7,769,556	5,024,393	13,796,650	$ 18,566,407	$ 28,817,612	38.51%
28	5500 RADIOLOGY-THERAPEUTIC		0.531273	474,140	1,771,214	102,377	1,278,198	251,646	711,643	438,921	5,895,576	114,121	1,599,008	$ 1,267,084	$ 9,656,631	26.37%
29	6000 LABORATORY		0.151289	8,092,638	3,243,918	7,244,455	4,344,309	7,197,425	2,558,723	8,633,921	5,727,253	5,515,363	4,985,634	$ 31,368,439	$ 15,874,203	43.52%
30	6500 RESPIRATORY THERAPY		0.309348	3,298,686	178,924	2,530,732	307,600	2,810,948	108,140	3,385,589	415,000	1,461,282	259,610	$ 12,025,955	$ 1,009,664	52.38%
31	6600 PHYSICAL THERAPY		0.607406	1,160,721	154,781	409,652	247,927	788,104	250,825	1,030,028	534,105	426,670	123,895	$ 3,388,505	$ 1,187,638	33.54%
32	6700 OCCUPATIONAL THERAPY		0.304279	648,043	43,401	60,981	45,592	435,765	70,180	753,995	180,536	325,900	32,703	$ 1,898,784	$ 339,709	31.19%
33	6800 SPEECH PATHOLOGY		0.311314	289,529	36,051	936,073	134,296	127,776	40,960	346,619	117,037	116,340	17,893	$ 1,699,997	$ 328,344	56.97%
34	6900 ELECTROCARDIOLOGY		0.145494	386,996	290,365	413,926	499,736	805,550	524,687	962,001	580,322	595,076	1,046,041	$ 2,568,473	$ 1,895,110	36.49%
35	7000 ELECTROENCEPHALOGRAPHY		0.284420	47,196	478,762	56,421	612,447	52,611	290,029	61,244	423,527	29,749	173,900	$ 217,472	$ 1,804,765	33.94%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.336792	6,630,106	2,334,504	7,156,150	3,147,936	6,087,831	2,022,829	7,995,332	2,623,741	4,419,974	2,975,850	$ 27,869,419	$ 10,129,010	41.35%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.170206	3,771,583	2,454,836	689,701	978,931	3,989,732	4,458,840	4,918,324	3,692,412	3,160,202	1,522,562	$ 13,369,340	$ 11,585,019	30.62%
38	7300 DRUGS CHARGED TO PATIENTS		0.156005	15,516,867	15,574,170	9,351,847	10,477,892	12,570,908	4,944,962	16,424,602	25,050,005	11,974,472	9,970,346	$ 53,864,224	$ 56,047,029	36.55%
39	7400 RENAL DIALYSIS		0.536808				-			4,286				$ 4,286	$ -	0.10%
40	7600 ENDOSCOPY		0.199103	205,912	686,059	30,633	563,996	271,211	888,792	245,814	1,030,651	270,268	756,112	$ 753,570	$ 3,169,498	22.67%
41	7601 HEART CATH LAB		0.083127	2,602,792	1,090,983	870,565	954,298	2,521,642	1,735,547	3,054,118	1,871,232	2,910,757	1,595,874	$ 9,049,117	$ 5,652,060	28.06%
42	9000 CLINIC		0.692693	137	267,896	228,220	631,642	93,247	321,868	97,346	1,698,810	145,889	698,301	$ 418,950	$ 2,920,216	37.38%
43	9100 EMERGENCY		0.311726	2,633,376	4,940,902	669,984	9,929,356	2,356,928	3,046,832	2,253,136	3,412,291	2,614,377	14,903,818	$ 7,913,424	$ 21,329,381	56.58%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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83			-											$ -	$ -	

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

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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)		Uninsured		Total In-State Medicaid		%
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
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125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 62,285,934	$ 48,561,392	$ 47,066,300	$ 62,057,777	$ 57,821,670	$ 46,199,119	$ 71,630,155	$ 72,874,256	$ 48,149,339	$ 61,997,199			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 72,929,178	$ 48,561,392	$ 67,410,520	$ 62,057,777	$ 65,637,307	$ 46,199,119	$ 82,940,355	$ 72,874,256	$ 54,086,368 (Agrees to Exhibit A)	$ 61,997,199 (Agrees to Exhibit A)	$ 288,917,360	$ 229,692,544	39.50%
129	Total Charges per PS&R or Exhibit Detail			$ 72,929,178	$ 48,561,392	$ 67,410,520	$ 62,057,777	$ 65,637,307	$ 46,199,119	$ 82,940,355	$ 72,874,256	$ 54,086,368	$ 61,997,199			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 25,353,717	$ 9,552,697	$ 29,632,598	$ 12,820,618	$ 19,727,675	$ 7,762,915	$ 27,082,763	$ 15,375,633	$ 15,518,725	$ 12,909,038	$ 101,796,753	$ 45,511,863	44.33%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 21,831,225	$ 9,960,934			$ 1,656,550	$ 797,747	$ 6,120,786	$ 1,932,399			$ 29,608,561	$ 12,691,080	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)					$ 22,328,666	$ 11,610,108			$ 267,194	$ 139,191			$ 22,595,860	$ 11,749,299	
134	Private Insurance (including primary and third party liability)					$ 3,781	$ 19,533	$ 1,314	$ 900	$ 6,661,388	$ 4,118,469			$ 6,666,483	$ 4,138,902	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 227,612	$ 46,095	$ 1,558	$ 3,488	$ 1,508	$ 1,781	$ 4,101	$ 8,009			$ 234,779	$ 59,373	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 22,058,837	$ 10,007,029	$ 22,334,005	$ 11,633,129									
137	Medicaid Cost Settlement Payments (See Note B)				$ (373,442)									$ -	$ (373,442)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 16,069,068	$ 6,703,480	$ 1,127,329	$ 2,111,474			$ 17,196,397	$ 8,814,954	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ 34	$ 11,029,081	$ 6,451,717			$ 11,029,081	$ 6,451,751	
141	Medicare Cross-Over Bad Debt Payments							$ 288,436	$ 485,181			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 288,436	$ 485,181	
142	Other Medicare Cross-Over Payments (See Note D)							$ 201,861	$ 66,334					$ 201,861	$ 66,334	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 210,996	$ 761,411			
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)**			$ 3,294,880	$ (80,890)	$ 7,298,593	$ 1,187,489	$ 1,508,938	$ (292,542)	$ 1,872,884	$ 614,374	$ 15,307,729	$ 12,147,627	$ 13,975,295	$ 1,428,431	
146	**Calculated Payments as a Percentage of Cost**			87%	101%	75%	91%	92%	104%	93%	96%	1%	6%	86%	97%	
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)**							43,500								
148	**Percent of cross-over days to total Medicare days from the cost report**							20%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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		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)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 919.20		24				18		11		53	
2	03100 INTENSIVE CARE UNIT	$ 1,674.17		2				3		1		6	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,462.14		4								4	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 554.77		3								3	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	33		-		21		12		66	
19	Total Days per PS&R or Exhibit Detail			33		-		21		12			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 35,540				$ 17,721		$ 9,492		$ 62,753	
21.01	Calculated Routine Charge Per Diem			$ 1,076.97		$ -		$ 843.86		$ 791.00		$ 950.80	
	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)		0.730448	924	13,581				7,416		2,099	$ 924	$ 23,096
23	5000 OPERATING ROOM		0.116403	99	16,107			6,728	2,172	63,824	4,155	$ 70,651	$ 22,434
24	5100 RECOVERY ROOM		0.136729	1,465	3,233			3,779	567	5,152	3,872	$ 10,396	$ 7,672
25	5200 DELIVERY ROOM & LABOR ROOM		1.241603	2,309	1,764					-		$ 2,309	$ 1,764
26	5300 ANESTHESIOLOGY		0.006598	-	3,881			2,816		7,437	1,594	$ 10,253	$ 5,475
27	5400 RADIOLOGY-DIAGNOSTIC		0.097044	23,388	37,484			14,533	33,764	8,571	15,529	$ 46,492	$ 86,777
28	5500 RADIOLOGY-THERAPEUTIC		0.531273									$ -	$ -
29	6000 LABORATORY		0.151289	24,059	17,628			12,649	20,481	7,293	7,709	$ 44,001	$ 45,818
30	6500 RESPIRATORY THERAPY		0.309348	52	5,510			3,343	103			$ 3,395	$ 5,613
31	6600 PHYSICAL THERAPY		0.607406	502				1,468	1,003	5,467		$ 7,437	$ 1,003
32	6700 OCCUPATIONAL THERAPY		0.304279					1,126		819		$ 1,945	$ -
33	6800 SPEECH PATHOLOGY		0.311314	457				1,624				$ 2,081	$ -
34	6900 ELECTROCARDIOLOGY		0.145494	1,624	1,219			1,686	2,699	1,214	1,624	$ 4,524	$ 5,542
35	7000 ELECTROENCEPHALOGRAPHY		0.284420									$ -	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.336792	5,109	11,597			10,701	3,481	28,689	3,058	$ 44,499	$ 18,136
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.170206		3,847					102,157		$ 102,157	$ 3,847
38	7300 DRUGS CHARGED TO PATIENTS		0.156005	21,978	36,054			28,834	10,880	25,973	4,475	$ 76,785	$ 51,409
39	7400 RENAL DIALYSIS		0.536808									$ -	$ -
40	7600 ENDOSCOPY		0.199103		1,806						1,806	$ -	$ 3,612
41	7601 HEART CATH LAB		0.083127	3,328								$ 3,328	$ -
42	9000 CLINIC		0.692693	3,255	490				2,341	112		$ 3,367	$ 2,831
43	9100 EMERGENCY		0.311726	9,950	63,323			6,763	25,511	2,534	17,056	$ 19,247	$ 105,890
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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)		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			-									$ -	$ -
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106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL 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)		Total Out-Of-State Medicaid	
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 98,499	$ 217,524	$ -	$ -	$ 96,050	$ 110,418	$ 259,242	$ 62,977		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ 134,039	$ 217,524	$ -	$ -	$ 113,771	$ 110,418	$ 268,734	$ 62,977	$ 516,544	$ 390,919
129	Total Charges per PS&R or Exhibit Detail			$ 134,039	$ 217,524	$ -	$ -	$ 113,771	$ 110,418	$ 268,734	$ 62,977		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 54,067	$ 53,263	$ -	$ -	$ 39,440	$ 25,600	$ 57,619	$ 12,871	$ 151,126	$ 91,734
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 13,130	$ 3,367			$ 1,331	$ 159	$ 4,390	$ -	$ 18,851	$ 3,526
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 593							$ -	$ 593
134	Private Insurance (including primary and third party liability)				$ 79						$ 3,628	$ -	$ 3,707
135	Self-Pay (including Co-Pay and Spend-Down)								$ 18			$ -	$ 18
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 13,130	$ 4,039	$ -	$ -						
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)							$ 13,381	$ 11,222		$ 605	$ 13,381	$ 11,827
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 40,947	$ 4,174	$ 40,947	$ 4,174
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)**			$ 40,937	$ 49,224	$ -	$ -	$ 24,728	$ 14,201	$ 12,282	$ 4,464	$ 77,947	$ 67,889
144	**Calculated Payments as a Percentage of Cost**			24%	8%	0%	0%	37%	45%	79%	65%	48%	26%

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.

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

Cost Report Year (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL HOSPITAL

			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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*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*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																
1		Lung Acquisition	$0.00	$ -	$ -		0										
2		Kidney Acquisition	$0.00	$ -	$ -		0										
3		Liver Acquisition	$0.00	$ -	$ -		0										
4		Heart Acquisition	$0.00	$ -	$ -		0										
5		Pancreas Acquisition	$0.00	$ -	$ -		0										
6		Intestinal Acquisition	$0.00	$ -	$ -		0										
7		Islet Acquisition	$0.00	$ -	$ -		0										
8			$0.00	$ -	$ -		0										
9		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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 H 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 (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL HOSPITAL

			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-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*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)*
	Organ Acquisition Cost Centers (list below):														
11		Lung Acquisition	$ -	$ -	$ -	$ -	0								
12		Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13		Liver Acquisition	$ -	$ -	$ -	$ -	0								
14		Heart Acquisition	$ -	$ -	$ -	$ -	0								
15		Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16		Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17		Islet Acquisition	$ -	$ -	$ -	$ -	0								
18			$ -	$ -	$ -	$ -	0								
19		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
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 I 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 (08/01/2017-07/31/2018) PHOEBE PUTNEY MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 6,374,920		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	80.700000.690057	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 6,374,920	Line 5.03 Shared A&G	*(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		$ 6,374,920		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	519,517,367
19	Uninsured Hospital	**Charges Sec. G**	116,083,567
20	Total Hospital	**Charges Sec. G**	1,609,241,104
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		32.28%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.21%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider 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.*