# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part 7 For State DSH Year 2017

		DSH Version	5.20 11/1/2017
A. General DSH Year Information			
1. DSH Year.	Begin   End		
2. Select Your Facility from the Drop-Down Menu Provided:	PHOEBE WORTH MEDICAL CENTER		
dentification of cost reports needed to cover the DSH Year:	Cost Report Cost Report		
3. Cost Report Year 1 4. Cost Report Year 2 (if applicable) 5. Cost Report Year 3 (if applicable)	Begin Date(s)   End Date(s)	Must also complete a separate survey fee for each conf	repaid period Euleo - SEE OSM SURVEY PART (I FILES
× **	Data		
6. Modicaid Provider Number:	000002109A		
<ol> <li>Medicaid Subprovider Number 1 (Psychiatric or Rehab):</li> </ol>	D		
Medicaid Subprovider Number 2 (Psychiatric or Rehab).	0		
9. Medicare Provider Number:	111328		
During the DSH Examination Year:  1. Did the hospital have at least two obstetricians who had staff privileg provide obstetric services to Medicaid-eligible individuals during the located in a rural area, the term "obstetric procedures.)  2. Was the hospital exampt from the requirement listed under #1 abov inpatients are predominantly under 18 years of age?  3. Was the hospital exampt from the requirement listed under #1 abov emergency obstetric services to the general population when federal were enacted on December 22, 1987?  3a. Was the hospital open as of December 22, 1987?  3b. What date did the hospital open?	es at the hospital that agreed to DSH year? (In the case of a hospital with staff privileges at the because the hospital's because it did not offer non-	DSH Examination Year (07/01/16 - 06/30/17)  Yes  No  No  Yes	
Questions 4-6, below, should be answered in the accordance wi	th Sec. 1923(d) of the Social Security Act.		
During the Interim DSH Payment Year:  4. Does the hospital have at least two obstetricians who have staff priviprovide obstetric services to Medicald-elligible individuals during the located in a rural area, the term "obstetrician" includes any physician hospital to perform nonemergency obstetric procedures.)	eges at the hospital who have agreed to ISH year? (In the case of a hospital	OSH Paymont Year (07/01/18 - 05/30/19) Yes	
List the Names of the two Obstatricians (or case of rural hospital, Phy DR, JOHNATHAN GASKINS DR, DARREN WOOTEN	sicians) who have agreed to perform OB services		
5. Is the hospital exempt from the requirement listed under #1 above be	cause the hospital's	No	
inpatients are predominantly under 18 years of age?	annua it did not offer year	No.	
6 Is the hospital exempt from the requirement listed under #1 above be emergency obstetric services to the general population when federal		No	

were enacted on December 22, 1987?

# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part 1 For State DSH Year 2017

C. Disclosure of Other Medicaid Payments Received:		
Medicald Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017     (Should Include UPL and Non-Claim Specific payments paid based on the state)	fiscal year. However, DSH payments should NOT be included.)	\$ 82.715
Certification:		Answer
1. Was your hospital allowed to retain 100% of the DSH payment it received for Matching the federal share with an IGT/CPE is not a basis for answering this hospital was not allowed to retain 100% of its DSH payments, please explain present that prevented the hospital from retaining its payments.	s question "no". If your	Yes
Explanation for "No" answers:		
Other Protested Item: "New Hampshire Hospital Association v. Azar". We prote-	st the inclusion of Commercial and Medicare	
payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH a	and the payment calculation reduction of Uncompensated Care Co	ost
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 records of the hospital. All Medicaid eligible patients, including those who have pi payment on the claim. I understand that this information will be used to determine provisions. Detailed support exists for all amounts reported in the survey. These available for inspection when requested.  Hospital CEO or CFO Signature  CANDACE GUARNIERI	of the DSH Survey files are true and accurate to the best of our a fivate insurance coverage, have been reported on the DSH surver the Medicaid program's compliance with federal Disproportionate	y regardless of whether the hospital received e Share Hospital (DSH) eligibility and payments
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Contact information for individuals authorized to respond to inquiries related  Hospital Contact: Name REBECCA K The SE REMAIN	I to this survey:	Outside Preparer: Norme

Hospital Comact:	
Name	REBECCA KENDALL
Title	SR REIMBURSEMENT SPECIALIST
Telephone Number	229-312-6711
	RKENDALL@PHOEBEHEALTH.COM
Mailing Street Address	417 W THIRD AVENUE
Mailing City, State, Zip	ALBANY, GA 31701

5/3/2018

DSH Version 7.25

D. General Cost Report Year Information	8/1/2016 - 7/31/2017			
The following information is provided based on the information we received from accuracy of the information. If you disagree with one of these items, please pro-	m the state. Please review this information for items 4 to ovide the correct information along with supporting docu-	through 8 and select "Ye umentation when you sub	s" or "No" to either agree or disagree with the bmit your survey.	
			-	
1, Select Your Facility from the Drop-Down Menu Provided:	PHOEBE WORTH MEDICAL CENTER		1	
	8/1/2016 through 7/31/2017			
2_ Select Cost Report Year Covered by this Survey (enter "X"):	X X		i i	
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:	1/18/2018			
	TO MARKE TO STATE OF THE STATE	IN NELE, IV		5 V.C 150
	Data	Correct?	If Incorrect, Proper Information	
4. Hospital Name:  5. Medicaid Provider Number:	PHOEBE WORTH MEDICAL CENTER 000002109A	Yes		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes Yes		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes		
8 Medicare Provider Number:	111328	Yes		
8a Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Private	Yes		
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes		
Out-of-State Medicaid Provider Number. List all states where you h				
9. State Name & Number	State Name	Provider No.	4	
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)		1	J	
E. Disclosure of Medicaid / Uninsured Payments Received: (0	8/01/2016 - 07/31/2017)			
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 Include	led in Exhibits B & B-1 (See Note 1)		T	
<ol> <li>Section 1011 Payment Related to Outpatient Hospital Services NOT Included Total Section 1011 Payments Related to Hospital Services (See Not</li> </ol>			S-	
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhi				
<ol> <li>Section 1011 Payment Related to Non-Hospital Services NOT Included in T<sub>a</sub> Total Section 1011 Payments Related to Non-Hospital Services (See</li> </ol>			\$-	
8. Out-of-State DSH Payments (See Note 2)	,			
			Inpatient Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			\$ 1,202 \$ 60,967	\$62,169
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)			\$ 10,740 \$ 319,410	\$330,150
11, Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column		en(s)	\$11,942 \$380,377	\$392,319
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash f	pasis Palient Payments:		10.07% 16.03%	15,85%
Did your hospital receive any Medicald <u>managed care</u> payments not Should include all non-cleim-specific payments such as lump sum payments for fu	paid at the claim level? Il Medicaid pricing, supplementals, quality payments, bonus pa	ayments, capitation paymen	No  No entire received by the thospital (not by the MCO), or other incentive payments received by the thospital (not by the MCO), or other incentive payments	ments
14. Total Medicaid managed care non-claims payments (see question 13 abo 15. Total Medicaid managed care non-claims payments (see question 13 abo				

16, Total Medicaid managed care non-claims payments (see question 13 above) received

# State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part II

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 (08/01/2016 - 07/31/2017)

F-1. Total Hospital Days Used in Medicald Inpatient Utilization Rati	o (MIUR)
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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)

518 (See Note In Section F-3, below)

## F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation);

- 2. Inpatient Hospital Subsidies
- 3. Outpatient Hospital Subsidies
- 4. Unspecified I/P and O/P Hospital Subsidies
- 5 Non-Hospital Subsidies
- 6. Total Hospital Subsidies
- 7. Inpatient Hospital Charity Care Charges
- 8. Outpatient Hospital Charity Care Charges
- 9 Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

# \$ 250,170 4,682,731 \$ 4,932,901

## 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.

F	ormulas can be overwritten as needed with actual data.
	11. Hospital
	12. Subprovider I (Psych or Rehab)
	13. Subprovider II (Psych or Rehab)
	14. Swing Bed - SNF
	15. Swing Bed - NF
	16. Skilled Nursing Facility
	17. Nursing Facility
	18 Other Long-Term Care
	19. Ancillary Services
	20. Oulpatient Services
	21. Home Health Agency
	22 Ambulance
	23. Outpatient Rehab Providers
	24 ASC
	25, Hospice
	26 Other

27. Total	
28 Total Hospital and Non Hospital	
20 Total Per Cort Peport	

t , Tola	l Patient Revenues (Charg	as)	Contractual Adjustme			
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
\$552,799.00 \$0.00 \$0.00			\$ 355,720 \$ - \$ -	\$ .	\$ . \$ .	\$ 197,079 \$
		\$1,754,792.00 \$0.00 \$0,00 \$0,00			\$ 1,129,190 \$ - \$ - \$ -	
\$6,566,510.00	\$13,269,563.00 \$13,853,426.00	\$0.00	\$ 4,225,481	\$ 8,538,826 \$ 8,914,536	\$ - \$ - \$ -	\$ 7,071,766 \$ 4,938,890
\$0.00	\$0.00	\$ 0.00 \$0.00 \$2,424,452.00	\$ -	\$ - \$ -	\$ - \$ - \$ 1,560,110	\$ - \$ -
\$ 7,119,309	\$ 27,122,989 Total from Above	\$ 4,179,244 \$ 38,421,542	<b>\$</b> 4,581,202	\$ 17,453,362 Total from Above	\$ 2,689,300 \$ 24,723,864	\$ 12,207,734
Total Patien rksheet G-3, Line 2 (impact is	·	38,421,542	Total Cont	ractual Adj. (G-3 Line 2)	23,457,802	

	Total Per Cost Report Total Patient Revenues (G-3 Line Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patier 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 not 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)
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)"

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	23,457,802
-	
+	1,266,062
-	
-	24,723,864

35. Adjusted Contractual Adjustments

# G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) PHOEBE WORTH MEDICAL CENTER

Line	Cost Conter 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	Medicald Per Diem / Cost or Other Ratios
pital. If da pleted usi pital has a should b	ta In this section must be verified by the tal is already present in this section, it was ing CMS HCRIS cost report data. If the inmore recent version of the cost report, the e updated to the hospital's version of the cost ilas can be overwritten as needed with actual	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			Calculated Per Diem
Routi	ine Cost Centers (list below):									
	ADULTS & PEDIATRICS	\$ 3,457,119	\$ -	\$ -	\$2,924,197.00	\$ 532,922	641	\$2,032,404.00	A STATE OF THE PARTY OF	\$ 831,39
	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	AV I S P. DI	\$
03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -		\$0.00	Design of the second	\$
03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -		\$0.00		\$ -
	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$		\$0.00		\$
	OTHER SPECIAL CARE UNIT	\$ -		\$ -	1500	\$		\$0.00	Marine and all	\$ -
	SUBPROVIDER I	\$ -		\$ -		\$ -		\$0,00		\$ -
	SUBPROVIDER II	\$ -	The state of the s	\$ -		\$ -		\$0.00		\$ -
	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	*	\$0.00		\$ .
04300	NURSERY	\$ -	\$ -	\$ -		\$ -		\$0.00		\$ -
		\$ -		\$ -		\$ -	*	\$0,00		\$ -
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		\$ -	WHI -	\$ -		\$ -	*	\$0.00		\$ -
		s -		s -		\$ -		\$0.00		\$ -
			THE REAL PROPERTY AND ADDRESS OF THE PERTY	s -		\$ -	*	\$0,00		\$ -
		s -		\$ -		\$ -		\$0,00		\$ -
		\$ -	the same of the sa	\$ -		\$ -		\$0.00	MENTAL VIOLE MI	\$ -
	Total Routine	\$ 3,457,119	\$	\$	\$ 2,924,197	\$ 532,922	641	\$ 2,032,404		
	Weighted Average									\$ 831.39
Obser	rvation Data (Non-Distinct)		Cost Report W/S S-	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)	Inpalient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheel C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200	Observation (Non-Distinct)		123		-	\$ 102,261	\$17,150.00	\$100,628.00	\$ 117,778	0.868252
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Parl I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpalient 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 Ralio
	ary Cost Centers (from W/S C excluding Obser	vation) (list below):		-					V	
Ancill	RADIOLOGY-DIAGNOSTIC	\$1,009,698.00	\$ -	\$0.00	Ferencia R. B. Com	\$ 1,009,698	\$125,453.00	\$5,865,508.00	\$ 5,990,961	0.168537
		\$1,370,469.00		\$0.00		\$ 1,370,469	\$584,148.00		\$ 5,242,182	0.261431
5400 6000	LABORATORY		\$	\$0.00		\$ 346,782	\$31,861.00		\$ 802,417	0.432172
5400 6000 6500	RESPIRATORY THERAPY	\$346,782.00				\$ 999,361	\$1,670,719.00		\$ 1,927,588	0.518452
5400 6000 6500 6600	RESPIRATORY THERAPY PHYSICAL THERAPY	\$999,361.00	\$ -	\$0.00			W11010111000	#250,005,00	U 1,021,000	0.010402
5400 6000 6500 6600 7100	RESPIRATORY THERAPY PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO PATIENT	\$999,361.00 \$561,266.00	\$ - \$ -	\$0.00		\$ 561,266	\$825,077.00	\$354,233.00	\$ 1,179,310	0.475927
5400 6000 6500 6600 7100 7300	RESPIRATORY THERAPY PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	\$999,361.00 \$561,266.00 \$1,014,600.00	\$ - \$ - \$					\$354,233.00 \$1,699,351.00	\$ 1,179,310 \$ 5,348,047	
5400 6000 6500 6600 7100 7300	RESPIRATORY THERAPY PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO PATIENT	\$999,361,00 \$561,266,00 \$1,014,600,00 \$3,691,961,00	\$ - \$ - \$ - \$ -	\$0.00 \$0.00 \$0.00		\$ 561,266 \$ 1,014,600 \$ 3,691,961	\$825,077.00	\$354,233.00 \$1,699,351.00 \$7,187,647.00	\$ 1,179,310 \$ 5,348,047 \$ 7,210,648	0.475927
5400 6000 6500 6600 7100 7300	RESPIRATORY THERAPY PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	\$999,361.00 \$561,266.00 \$1,014,600.00 \$3,691,961.00 \$0.00	\$ - \$ - \$ - \$ - \$ -	\$0.00 \$0.00 \$0.00 \$0.00		\$ 561,266 \$ 1,014,600 \$ 3,691,961 \$	\$825,077.00 \$3,648,696.00 \$23,001.00 \$0,00	\$354,233.00 \$1,699,351.00 \$7,187,647.00 \$0.00	\$ 1,179,310 \$ 5,348,047 \$ 7,210,648 \$	0.475927 0.189714 0.512015
5400 6000 6500 6600 7100 7300	RESPIRATORY THERAPY PHYSICAL THERAPY MEDICAL SUPPLIES CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	\$999,361,00 \$561,266,00 \$1,014,600,00 \$3,691,961,00	\$ - \$ - \$ - \$ - \$ - \$ -	\$0.00 \$0.00 \$0.00		\$ 561,266 \$ 1,014,600 \$ 3,691,961	\$825,077.00 \$3,648,696.00 \$23,001.00	\$354,233.00 \$1,699,351.00 \$7,187,647.00 \$0.00	\$ 1,179,310 \$ 5,348,047 \$ 7,210,648 \$	0.475927 0.189714 0.512015

# G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016:07/31/2017) PHOEBE WORTH MEDICAL CENTER

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	Medicald Per Diem / Cost or Other Ratios
		\$0.00		\$0.00	\$		\$0.00	\$0.00	\$ -	
		\$0.00		\$0.00	\$		\$0.00	\$0.00		
		\$0.00		\$0.00	\$		\$0.00	\$0.00		
		\$0.00		\$0.00	\$		\$0.00	\$0.00		
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		\$0.00		\$0.00	3		\$0,00	\$0,00		
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		\$0.00	\$ -	\$0.00	\$		\$0.00	\$0.00	\$ -	593
		\$0.00		\$0,00	Same Same S		\$0,00		\$ -	
		\$0.00	\$ -	\$0.00	\$ S	-	\$0,00		\$ -	
		\$0,00		\$0.00	\$	-	\$0,00		\$ -	28.5
		\$0.00 \$0.00		\$0.00 \$0.00	\$		\$0.00	\$0,00		3.
		\$0.00		\$0.00	\$		\$0.00 \$0.00	2.0	\$ :-	128
		\$0.00		\$0.00	\$		\$0.00		\$ -	(3)
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		\$0.00	\$ -	\$0.00	\$		\$0.00	\$0.00	\$ -	9.1
		4000	\$ -	\$0.00	\$		\$0.00	\$0.00	\$ -	
		\$0.00	\$ -	\$0.00	\$		\$0.00		\$ -	
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		\$0.00	\$ -	\$0.00	\$		\$0.00		\$ -	-
		\$0.00	\$ -	\$0.00	\$		\$0.00		\$ -	-
			\$ -	\$0,00	\$	*	\$0.00		\$ -	*
		\$0.00	\$ -	\$0.00	\$		\$0.00	\$0.00	\$ -	- 3
			5 -	\$0.00	\$		\$0.00		\$ -	*
			5 -	\$0.00	\$		\$0.00	\$0.00		8
			s -	\$0.00	\$	*	\$0.00	\$0.00		*
			\$ -	\$0.00	\$	£.	\$0.00	\$0.00		8
_			\$ -  \$ -	\$0.00 \$0.00	\$	*	\$0.00 \$0.00	\$0.00   1 \$0.00   1		
			\$ -	\$0.00	\$		\$0.00	\$0.00		
			\$ -	\$0.00	\$		\$0.00	\$0.00		
			S -	\$0.00	ELECTRIC SERVICE S	-	\$0.00	\$0.00		
			\$ .	\$0.00	\$	18:	\$0.00	\$0.00		*
		\$0.00	\$ -	\$0.00	\$	( e.	\$0.00	\$0.00		
			\$ -	\$0.00	\$		\$0.00	\$0.00	-	€
			\$ -	\$0,00	\$	35	\$0.00	\$0.00		
			\$ -	\$0.00	\$	E	\$0.00	\$0.00		
		\$0.00		\$0.00	\$	95	\$0.00	\$0.00		*
_		\$0.00		\$0.00 \$0.00	\$ 6	(*)	\$0.00	\$0.00		*
-			\$ -  \$ -	\$0.00	\$ \$		\$0.00 \$0.00	\$0.00 \$		-
		\$0.00		\$0.00	s = 1 s		\$0.00	\$0.00   \$		
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			\$ -	\$0.00	\$	-	\$0.00	\$0.00		
		\$0.00		\$0.00	\$		\$0.00	\$0.00		-
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		\$0.00	\$ -	\$0.00	s	- 3	\$0.00	\$0.00 \$		567

# G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017)	PHOEBE WORTH MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intem & 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	Medicald Per Diem / Cost or Other Ratios
		\$0.00		\$0,00	\$	\$0.00	\$0.00		
		\$0.00	\$	\$0.00	\$ -	\$0.00	\$0.00	\$ -	
		\$0,00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00		
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	
		\$0,00		\$0,00	\$ -	\$0.00	\$0.00	\$ -	25.0
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	(*)
		\$0.00		\$0,00	\$ -	\$0.00	\$0.00	\$ -	
		\$0.00		\$0.00	- 5	\$0.00	\$0,00	\$ -	
		\$0.00		\$0.00	\$ -	\$0,00	\$0,00	\$	
		\$0,00		\$0.00	\$	\$0,00	\$0,00	\$ -	5.00
		\$0.00		\$0.00	S -	\$0,00	\$0,00	\$ -	- 23
		\$0.00		\$0.00	\$ -	\$0.00	441	\$ -	- 20
		\$0.00		\$0.00	\$ -	\$0,00	\$0,00	\$ -	- 9
		\$0.00	\$ -	\$0,00	\$ -	\$0,00		\$	
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		\$0.00	\$ -	\$0.00	- 3	\$0,00	\$0.00		
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			\$ -	\$0.00	\$ ·	\$0.00	\$0.00		
_		\$0.00		\$0.00	\$ -	\$0.00	7.41	\$ -	
_				\$0.00	\$	\$0.00	9.412.	\$ -	
_		\$0.00		\$0.00	\$ =	\$0.00		\$ -	*
				\$0.00	\$ -	\$0.00	\$0.00		8
	Total Ancillary	\$ 8,994,137	\$	-	\$ 8,994,137	\$ 6,926,105	\$ 20,892,826	\$ 27,818,931	
	Weighted Average								0.326986
	0.1.7.4.1.	A 40 454 050	•	Tanada da					PURE NAME OF THE PARTY.
	Sub Totals  SNF, and Swing Bed Cost for Medicaid ( rksheet D, Part V, Title 19, Column 5-7, Li				\$ 9,527,059 \$0.00	\$ 8,958,509	\$ 20,892,826	\$ 29,851,335	18 01 NOT 1991
	SNF, and Swing Bed Cost for Medicare ( rksheet D, Part V, Title 18, Column 5-7, Li		eport Worksheet D-3,	Fille 18, Column 3, Line 200 and	\$908,435 00				
NF.	SNF, and Swing Bed Cost for Other Payo	ors (Hospital must calculat	e Submit support for c	alculation of cost.)					
	er Cost Adjustments (support must be sub								
Ollie		Jilimed)							
	Grand Total				\$ 8,618,624				
	al Intern/Resident Cost as a Percent of Ot	thor Allowoble Cost			0.00%				

<sup>\*</sup> Note A - Final cost-to-charge ratios should include leaching 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 Medicald and All Uninsured Inpatient and Outpatient Hospital Data:

Gest Hilbert Year (05/01/2016-07/31/2017) PHOEBE WORTH MEDICAL CENTER

Cest Habert Year (05/01/2016-07/31/2017)	PHOEBE WORTH N	MEDICAL CENTER												
(A-20) - 12, 11 (a) - 12, 11	Medicald Per Diem Cost for	Medicald Cost to Charge Ratio for	to Plate Alesia	ald FFS Premary	in State Moderat N	Annaged Care Primary	In-Blate Modeans i Moderard	FS Ones Overs (with Secondary)	in-State Office Me- inchided	ricoud Eligibles (foor Classifiero)		ntured	Total in St	th Made and
Line # Cost Center Description	Routine Cost Centers	Ancillary Cost Conters	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Impatient	Outpatient	Inpatient (Bee Exhibit A)	Outpatient (See Eshibit A)	Inpatient	Cutpatient T
	From Section G	Fram Section G	From PS&R Summery (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summery (Note A)	From PS&R Summery (Note A)	From PS&R Summery (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospitat's Own Internal Analysis	From Hospital's Own Internal Analysis		
Routine Gost Centers (from Section G):  (00000 ADULTS & PEDIATRICS  (00100 INTENSIVE CARE UNIT  (00000 COROMARY CARE UNIT  (00000 BURN INTENSIVE CARE UNIT  (0000 SURGICAL INTENSIVE CARE UNIT  (0000 SURGICAL INTENSIVE CARE UNIT  (0000 SUBPROVIDER I  (00100 SUBPROVI	\$ 831.29 \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ .		50.		Dava 49		Days 32		Days 6.3		Days 79		Days 192	
Total Days per PS&R or Exhibit Detail		Total Days	58		49		32		53		79		192	
Unreconciled Days (Expl	olain Variance)										7.6		essential composition	
Reutine Charges Calculated Rootine Charge Per Diem	E.	n in	Routine Charges  \$ 31,217 \$ 538 22	, I went	# 28,328   \$ 578 12		Routine Charges    \$ 18,534   \$ 579 19		Foutine Charges  \$ 31,095 \$ 586,19	Event Little	Routine Charges	S. WINE	Routine Charges \$ 109,147 \$ 568,47	100
Ancillary Cost Centers (from W/S C) (from Section G): [62500] Observation (Nan-Cishard) 5400 (RADIOLOGY OMGNOSTIC 6400 (RADIOLOGY OMGNOSTIC 6500 (RESPIRATORY THERAPY 6500 (RESPIRATORY THERAPY 7100 MEDICAL SUPPLES CHARGED TO PATIENT 7200 ORUGE CHARGED TO PATIENTS 1100 EMERGENCY		0.668252 0.168537 0.751431 0.432172 0.518452 0.475027 0.189714 0.512015	Ancillary Charges  6,50a  29,187  4,499  926  10,134  50,031  9,893	Ancillary Charges 4,637, 341,621 371,687, 40,540, 91,44 28,907, 122,617, 552,083	Ancillary Charges, 2,600 19,751 23,353 654 12,947 44,232 12,447	Ancillary Charges 77,076 700,676 631,251 75,442 8,700 58,113 200,722 1,528,307	Ancillary Charges 652 652 652 652 652 652 652 652 652 652	Ancillary Charges 5,949 255,099 297,156 51,030 16,722 57,463 16,722 57,140 256,891	Ancillary Charges 1,543 1,543 1,543 1,540	Ancillary Charges 3.345.24 307.742 50.016 15.750 22.865 72.921 337.107	Ancillary Charges 256 256 35.876 45.984 3.351 873 24.567 77.7079 34.100	Ancillary Charges 15, 550 1, 692, 761 143, 670 16, 173 90, 652 472, 916 2, 903, 177	\$	Anothray Charges
	,	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1											\$ .	5
	114	-											\$	

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

Gost Report Year (0%01/2016-07/11/2017) PHOEBE WORTH MEDICAL CENTER In Blate Medicara FFS Cross-Overs (wi 116,184 3,305,966 89,740 972.966 144,931 1.132,500 Totals / Payments Total Charges (includes organ acquisition from Section J) 152,385 1,463,000 \$ 144,512 \$ 3,305,956 128 108,274 \$ 273,004 5 5,000,740 5 (Agrees to Exhibit A) 972,966 \$ 175,999 \$ 1,132,502 \$ 581,170 \$ 6,874,443 42.70% 129 130 Total Charges per PS&R or Exhibit Detail 152,385 \$ 1,463,009 \$ 144,512 3,305,966 \$ 109,274 5 972,968 \$ 175,999 \$ 1,132,502 \$ 273,004 5,006,740 Unreconciled Charges (Explain Variance) Total Galculated Cost (includes organ acquisition from Section J) 498,452 74,361 1,206,659 367,763 53,982 313,425 69.174 | 5 130,623 \$ 1,695,375 \$ 300,400 \$ 2,354,312 52 38% 132 Total Medicald Paid Amount (excludes TPL, Co-Pay and Spend-Down) 99,325 418.499 543,670 Total Medicald Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) 133 70,207 824.916 5,245 70.207 630,161 Private Insurance (Including primary and third party Hability) 134 106,000 105,000 135 Self-Pay (Including Co-Pay and Spend-Down) 747 420 747 860 Total Allowed Amount from Medicald PS&R or RA Detail (All Payments) 416,919 136 97,072 70.207 624,934 137 Medicaid Cost Settlement Payments (See Note B) 16:433 18,433 138 Other Medicaid Payments Reported on Cost Report Year (See Note C) 139 Medicare Traditional (non-HMO) Pald Amount (excludes coinsurance/deductibles) 165,014 31,170 109,845 140 Medicare Managed Care (HMO) Pald Amount (excludes colnaurance/deductibles) 56,535 220,977 141 Medicare Cross-Over Bad Debl Payments 23,377 (Agrees to Exhibit B and (Agrees to Exhibit B and Other Medicare Cross-Over Payments (See Note D) Payment from Hospital Uninsured During Cost Report Year (Cash Basis) 1,207 60,967 144 Section 1011 Payment Related to Inpatient Hospital Services NOT included in Exhibite B & B-1 (from Section E)

Note A - These amounts must agree to your inpatient and outpatient Medicald 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).

61,110 5

4,104 5

581,725

0,587 \$

128

23,590 \$

(10,963) \$

129,621 \$

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

147 Total Medicare Days from W/S S-3 of the Coal Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 2, 3, 4, 14, 18, 17, 18 less lines 5 & 6)

Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)

Calculated Payments as a Percentage of Cost

Percent of cross-over days to total Medicare days from the cost report

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

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

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

1,634,408 \$

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

# I. Out-of-State Medicaid Data:

			Dut-of-State Mad	towl FFS Primary	Out-of-State Medicals	Managed Care Primary	Out-of-State Medicare	FFS Cross-Overs (with Secondary)		dedicard Eligibles (Not Eliminations)	Total Old Old	State Medicaid
Line# Cost Center Description	Medicald Per Diem Cost for Routine Cost Conters	Medicald Cort to Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inputient	Outpatient	Impatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatien
	From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summery (Note A)	From PS&R Summary (Note A)	From PS&R Summery (Note A)	From PS&R Summery (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): 13000   ADULTS & PEDIATRICS	5 831.39	K IIV	Days		Days		Days		Days		Days	900
33100 INTERISIVE CARE UNIT 33200 CORONARY CARE UNIT 33200 USER CORONARY CARE UNIT 33200 USER UNIT USER CARE UNIT 33200 USER UNIT USER CARE UNIT 33200 SURGEAL WITERISIVE CARE UNIT 33200 OTHER SPECIAL CARE UNIT 33200 OTHER SPECIAL CARE UNIT 33200 OTHER SPECIAL CARE UNIT 33200 OTHER SUBPROVIDER 33200 UNITSERV	\$		107.00						11:11		3	
	5 .	Total Days		34 50							•	(A) =
otal Days per PS&R or Exhibit Detail Unreconciled Days (Ex	oplain Varlance)		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
Routine Charges Calculated Routine Charge Per Dison	Į.	Service Confess	\$ .	NAME OF TAXABLE	\$ .	CONTRACTOR	s .	18 t 5 2	s .		\$ .	
ncillary Cost Centers (from W/8 C) (list below): 9200   Observation (Non-Distinct)	Jan Sanddon	0.868252	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Chi					
5400 RADIOLOGY-DIAGNOBTIC 6000 LABORATORY 6500 RESPIRATORY THERAPY 6000 PHYSICAL THERAPY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1	0.168537 0.261431 0.432172 0.518452 0.475927		4,030 1,219 235 397							\$ . \$ . \$ .	\$ 4 5 1 5 5 5 5
7300 DRUGS CHARGED TO PATIENTS 9100 EMERGENCY		0.189714 0.512015		1,423 4,171						367	5	5 1 5 4
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## I. Out-of-State Medicald Data;

Cost Report Year (08/01/2010-07/31/2017) PHOEBE WORTH MEDICAL CENTER										
	Out of State Medicald F	FS Primary	Out-of-State Medicald t	fanaged Care Primary	Out of State Medicard Medicard	s FFS Cross Overs (with Statendary)	Out-of-State Officer	Medicaxi Eligibies (Not Elizabers)	Total Cut-C	or-Style Medicald
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	3 - 3	11,475	\$	\$	3	\$	1 .	\$ 367	I have	d to
Cotals / Payments					2					
Total Charges (includes organ acquisition from Section K)	5 5	11,475	5			5	5 - ]			\$ 11.8
Fotal Charges per PS&R or Exhibit Defail Unreconciled Charges (Explain Variance)	5 - 5	11,475	1 .	•	5	š -	[\$ -	3 367		
Total Calculated Cost (includes organ acquisition from Section K)	\$	3,694	5 -	6 0 1	s	5	5 .	\$ 189	s .	\$ 3,8
otal Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	[ 5	4,300								3 4.30
otal Medicaid Managed Care Pald Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									5 .	15
Private Insurance (including primary and third party liability) Self-Pay (including Co-Pay and Spend-Down)		58						\$ 20	5	5
otal Allowed Amount from Medicald PS&R or RA Detait (All Payments)	3 . 3	4,358	\$ .							
fledicald Cost Settlement Paymente (See Note B) Other Medicald Payments Reported on Cost Report Year (See Note C)									\$ -	3
nner medicaid Payments Reported on Cost Report Year (See Note C)  [edicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									5	5
fedicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									3 -	5
fledicare Cross-Over Bad Debt Payments Other Medicare Cross-Over Payments (See Note D)									5	5
the medicale procedure regiments (pee note of				1					19	5

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 peyments 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 Outleen and Non-Claim Specific payments. DSH payments included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicaid recrease-over payments in included in the paid claims data resported above. This included payments paid based on the Medicaider costs-over cost reports element (e.g., Medicare Graduate Medicai Education payments).

Note E - Medicaid Managed Care payments included all Medicaid Medicaid

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

Cost Recon Vear (04/01/2016 07/11/2017) PHOEBE WORTH MEDICAL CENTER

	Your			Revenue for	Total	In Visite Meet	Lord F.F.S Framery	In-State Medicavi I	danaged Care Primary		FFS Cross-Overs (with Secondary)		sid Eligibles (Not Included Where)	Um	neward
	Organ Acquisition C	Additional		Medicaid/ Cross- Over / Uninsured Organs Sold	Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheel D Pt III, Col. 1, 61	our section or,	Cost and the Add-	Smiller to instructions from Coal Report W/S D4 Ft III, Cat 1, Ln 66 (substitute Medicare with Medicard Cross-Over 4 uninsured). See Note C below.	Cost Report Worksheet D- 4, Pt III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Peid Claims Data or Provider Logs (Nate A)	From Paid Clalms Dala or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospilel's Own Internal Analysis	From HospilaFs Own Internal Analysis				
Organ Acquisition Cost Cente	rs (list below):														
1 Lung Acquistion	\$0	00 \$	. 5		0					Marie and the second			1		
2 Kidney Acquisition	\$0	00 \$	. 5		0										
3 Liver Acquisition	\$0	00 \$	. 5		0										

Total Cost Note A - These amounts must agree to your inpatient and outpatient Medicald 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 Medicald total payments.

\$0.00 \$

\$0.00 \$

\$0.00 \$

\$0.00 5 \$0.00 \$

Note C: Enter Organ requismon regiments in section in regiments in section in regiments in section in regiments in the Medical and Uninsured organ counts above). Such revenues must be determined under the Note C: Enter the total revenue applicable to organ programs turnished into on-Medical and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting, if organs are transplanted into non-Medicaldinon-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

		Total		i i	Revenue for	Total	Out-of-State Med	dead FFS Frimary	Ote-of-State Medicald	Managed Care Primary		FFS Cross-Overs (with Secondary)		Aedicaid Eligibles (No Elsewhere)
		Organ Acquirition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicald/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Gount)	Charges	Useable Organa (Count)	Charges	Useable Organs (Count)	Charges	Useable Organi (Count)
		Cost Report Worksheet D-4, Ff. W. Col. 1, Ln	Add-On Cost Factor on Section G. Line 133 x Total Cost Report Organ	Sum of Cost Report Organ Acquisition Cost and the Add- On Cost	Similar to Instructions from Cost Report W/S D-4 Pt W/ Col. 1, Ln 66 (substitute Medicare with Medicard Cross-Over	Cost Report Worksheet D- 4: Pt. III, Line 62	From Paid Claims Date or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Loge (Note A)	From Paid Claims Date or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Date or Provider Logs (Note A)	From Paid Claims Data or Provider Logn (Note A)	From Paid Claims Data or Provider Logs (Note A)
2200		61	Acquistion Cost	Un Coar	& unmsured). See Note C helow.	V-175								
Orga	in Acquisition Cost Centers (list below):	61	Acquistion Cost	S -	& uninsured). See	0	<u> </u>							
	in Acquisition Cost Centers (list below): Lung Acquisition Kitney Acquisition	5 . s	Acquission Cost	\$ \$	& uninsured). See	0 0								
	Lung Acquisition	5 . 5 .	Acquission Cost	5 +	& uninsured). See	0 0								
	Lung Acquisition Kidney Acquisition	\$	Acquistion Cost	5 - 5 - 5 -	& uninsured). See	0 0								
	Lung Acquisition Kidney Acquisition Liver Acquisition	\$	Acquisition Cost	5 - S - S - S - S - S - S - S - S - S -	& uninsured). See	0 0 0 0								
	Lung Acquisition Kidney Acquisition Liver Acquisition Heart Acquisition	\$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ . \$ .	Acquisition Cost	5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 - 5 -	& uninsured). See	0 0 0 0 0								
1	Lung Acquisition Kidney Acquisition Liver Acquisition Harit Acquisition Pameress Acquisition	\$	S - S - S - S - S - S - S - S - S - S -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$	& uninsured). See	0 0 0 0 0								
Orga 1 2 3 4 5 5	Lung Acquisition Kitiney Acquisition Liver Acquisition Heart Acquisition Pancress Acquisition Intestinal Acquisition	5 - S - S - S - S - S - S - S - S - S -	Acquisition Cont	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	& uninsured). See	0 0 0 0 0 0								

Note A - These amounts must agree to your impatient and outpatient Medicald 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 Medicald total payments.

Heart Acquisition

latet Acquisition

Pancreas Acquisition

Intestinal Acquisition

Totals

# L. Provider Tax Assessment Reconciliation / Adjustment

Cost Report Year (08/01/2016-07/31/2017) PHOERE WORTH MEDICAL CENTER

An adjustment is necessary to properly reflect 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 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.

heet A P	rovider Tax Assessment Reconciliation:				
1a Worki	tal Gross Provider Tax Assessment (from general le ng Trial Balance Account Type and Account # that ii tal Gross Provider Tax Assessment Included in Expe	ocludes Gross Provider Tax Assessment	Dollar Amount	W/S A Cost Center Line	(WTB Account # ) (Where is the cost included on w/s A?
3 Differe	ence (Explain Here>)		\$		
Provi	der Tax Assessment Reclassifications (from w/s	A-6 of the Medicare cost report)			
4 5 6 7 <b>DSH</b> I		justments (from w/s A-8 of the Medicare cost report)			(Reclassified to / (from)) (Reclassified to / (from)) (Reclassified to / (from)) (Reclassified to / (from))
9	Reason for adjustment Reason for adjustment		-		(Adjusted to / (from))
10	Reason for adjustment				(Adjusted to / (from))
11	Reason for adjustment				(Adjusted to / (from)) (Adjusted to / (from))
DSHI	ICC NON-ALLOWARI F Provider Tax Assessmen	t Adjustments (from w/s A-8 of the Medicare cost repo			
12	Reason for adjustment	The state of the s	4		Ì
13	Reason for adjustment				
14	Reason for adjustment				
15	Reason for adjustment				
16 Total N	Net Provider Tax Assessment Expense Included in the	e Cost Report	\$ -		
CC Provi	der Tax Assessment Adjustment:		-,		
	Allowable Assessment Not Included in the Cost Rep				

<sup>\*</sup> Assessment must exclude any non-hospital assessment such as Nursing Facility.