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

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

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	08/01/2016	07/31/2017
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 (07/01/16 - 06/30/17)
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 (07/01/18 - 06/30/19)
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:

MIKE EDWARDS
NANCY HENDRIX

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 07/01/2016 - 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.)

$ 9,000,002

Certification:

	Answer
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.	Yes

Explanation for "No" answers:

Other Protested Item: "New Hampshire Hospital Association v. Azar" (We protest the reduction of Community and Medicare payments for Dual Eligibles towards the Hospitals Specific limit for Medicaid DSH and the Garment calculated 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	Title	Date
BRIAN CHURCH	SR VP/CFO	[illegible]
Hospital CEO or CFO Printed Name	**Hospital CEO or CFO Telephone Number**	**Hospital CEO or CFO E-Mail**
	229-312-4368	BCHURCH@PHOEBEHEALTH.COM

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

Hospital Contact:

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

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 8/1/2016 - 7/31/2017

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			
	8/1/2016 through 7/31/2017			
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:	1/18/2018			

	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	THIS IS NOT A SUBPROVIDER
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110007	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. 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: (08/01/2016 - 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 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)	$ 237,184	$ 1,023,529	$1,260,713
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,309,912	$ 10,484,402	$12,794,314
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)	$2,547,096	$11,507,931	$14,055,027
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.31%	8.89%	8.97%

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

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) — 105,594 **(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	24,043,762
8.	Outpatient Hospital Charity Care Charges	34,202,052
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 58,245,814

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	$92,250,968.00			$ 62,981,612	$ -	$ -	$ 29,269,356
12.	Subprovider I (Psych or Rehab)	$2,126,900.00			$ 1,452,078	$ -	$ -	$ 674,822
13.	Subprovider II (Psych or Rehab)	$5,794,761.00			$ 3,956,201	$ -	$ -	$ 1,838,560
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	$551,570,038.00	$759,280,926.00		$ 376,568,084	$ 518,376,533	$ -	$ 415,906,349
20.	Outpatient Services		$94,219,228.00			$ 64,325,383	$ -	$ 29,893,845
21.	Home Health Agency			$9,653,318.00			$ 6,590,517	
22.	Ambulance			$ 710,697			$ 485,207	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,331,795.00			$ 3,640,125	
26.	Other	$12,347,837.00	$26,867,220.00	$0.00	$ 8,430,119	$ 18,342,798	$ -	$ 12,442,140
27.	Total	$ 664,090,504	$ 880,367,376	$ 15,695,810	$ 453,388,095	$ 601,044,714	$ 10,715,849	$ 490,025,071
28.	Total Hospital and Non Hospital		Total from Above	$ 1,560,153,690		Total from Above	$ 1,065,148,658	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,560,153,690	Total Contractual Adj. (G-3 Line 2)	1,060,188,939
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)			+	4,959,719
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				1,065,148,658

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) 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	$ 76,270,688	$ 1,077,670	$ -	$0.00	$ 77,348,358	88,068	$57,337,440.00		$ 878.28
2	03100 INTENSIVE CARE UNIT	$ 18,487,058	$ 109,425	$ -		$ 18,596,483	11,238	$19,698,429.00		$ 1,654.79
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	$ 9,025,947	$ -	$ -		$ 9,025,947	6,535	$13,257,183.00		$ 1,381.17
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,488,518	$ -	$ -		$ 4,488,518	9,047	$5,671,301.00		$ 496.13
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 108,272,211	$ 1,187,095	$ -	$ -	$ 109,459,306	114,888	$ 95,964,353		
19	Weighted Average									$ 952.75

Line #			*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)	9,294	-	-	$ 8,162,734	$3,552,729.00	$6,326,848.00	$ 9,879,577	0.826223

Line #			*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	$20,242,381.00	$ 92,845	$0.00		$ 20,335,226	$75,700,701.00	$91,178,354.00	$ 166,879,055	0.121856
22	5100	RECOVERY ROOM	$7,833,747.00	$ -	$0.00		$ 7,833,747	$18,111,036.00	$32,169,774.00	$ 50,280,810	0.155800
23	5200	DELIVERY ROOM & LABOR ROOM	$7,190,451.00	$ 165,795	$0.00		$ 7,356,246	$2,560,356.00	$3,040,617.00	$ 5,600,973	1.313387
24	5300	ANESTHESIOLOGY	$199,532.00	$ 3,316	$0.00		$ 202,848	$18,893,432.00	$26,460,501.00	$ 45,353,933	0.004473
25	5400	RADIOLOGY-DIAGNOSTIC	$16,495,922.00	$ 92,845	$0.00		$ 16,588,767	$29,643,573.00	$133,171,301.00	$ 162,814,874	0.101887
26	5500	RADIOLOGY-THERAPEUTIC	$21,546,659.00	$ -	$0.00		$ 21,546,659	$1,768,744.00	$39,343,917.00	$ 41,112,661	0.524088
27	6000	LABORATORY	$19,665,592.00	$ -	$0.00		$ 19,665,592	$66,141,948.00	$48,432,267.00	$ 114,574,215	0.171641
28	6500	RESPIRATORY THERAPY	$8,337,129.00	$ -	$0.00		$ 8,337,129	$21,217,049.00	$4,667,692.00	$ 25,884,741	0.322087
29	6600	PHYSICAL THERAPY	$9,445,375.00	$ -	$0.00		$ 9,445,375	$8,393,895.00	$5,033,439.00	$ 13,427,334	0.703444
30	6700	OCCUPATIONAL THERAPY	$2,585,712.00	$ -	$0.00		$ 2,585,712	$6,054,128.00	$1,114,006.00	$ 7,168,134	0.360723

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) 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
31	6800	SPEECH PATHOLOGY	$1,050,700.00	$ -	$0.00	$ 1,050,700	$2,210,007.00	$843,406.00	$ 3,053,413	0.344107
32	6900	ELECTROCARDIOLOGY	$2,568,518.00	$ -	$0.00	$ 2,568,518	$4,683,341.00	$11,876,423.00	$ 16,559,764	0.155106
33	7000	ELECTROENCEPHALOGRAPHY	$1,602,034.00	$ -	$0.00	$ 1,602,034	$478,312.00	$5,337,250.00	$ 5,815,562	0.275474
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$34,336,827.00	$ -	$0.00	$ 34,336,827	$67,810,652.00	$40,601,191.00	$ 108,411,843	0.316726
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$18,317,151.00	$ -	$0.00	$ 18,317,151	$50,035,505.00	$36,766,019.00	$ 86,801,524	0.211023
36	7300	DRUGS CHARGED TO PATIENTS	$53,542,026.00	$ -	$0.00	$ 53,542,026	$142,447,557.00	$222,505,799.00	$ 364,953,356	0.146709
37	7400	RENAL DIALYSIS	$2,206,473.00	$ -	$0.00	$ 2,206,473	$3,548,355.00	$0.00	$ 3,548,355	0.621830
38	7600	ENDOSCOPY	$5,661,694.00	$ 51,397	$0.00	$ 5,713,091	$2,558,622.00	$20,734,391.00	$ 23,293,013	0.245271
39	7601	HEART CATH LAB	$5,304,968.00	$ -	$0.00	$ 5,304,968	$29,312,825.00	$36,004,581.00	$ 65,317,406	0.081218
40	9000	CLINIC	$7,478,469.00	$ -	$0.00	$ 7,478,469	$228,399.00	$12,257,185.00	$ 12,485,584	0.598968
41	9100	EMERGENCY	$18,225,009.00	$ 165,795	$4,946,551.00	$ 23,337,355	$12,438,388.00	$69,295,256.00	$ 81,733,644	0.285529
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) 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
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	$ -	-
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**	$ 263,836,369	$ 571,993	$ 4,946,551		$ 269,354,913	$ 567,789,554	$ 847,160,217	$ 1,414,949,771	
127		**Weighted Average**									0.196132
128		**Sub Totals**	$ 372,108,580	$ 1,759,088	$ 4,946,551		$ 378,814,219	$ 663,753,907	$ 847,160,217	$ 1,510,914,124	
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 Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 378,814,219				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.47%				

* 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 (05/01/2016-03/31/2017) | 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	$ 878.28		10,312		6,739		8,190		10,256		5,366		35,497		51.93%
2	03100 INTENSIVE CARE UNIT	$ 1,654.79		1,787		195		1,451		1,563		821		4,996		51.77%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,381.17		812		4,339				1,204		17		6,365		59.53%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 496.13		862		7,304				240		19		8,405		93.12%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	13,773		18,577		9,641		13,263		6,223		55,254		53.61%
19	Total Days per PS&R or Exhibit Detail			13,773		18,577		9,641		13,263		6,223				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 12,236,718		$ 19,066,827		$ 8,697,731		$ 12,309,478		$ 5,368,390		$ 52,301,754		60.25%
21.01	Calculated Routine Charge Per Diem			$ 888.46		$ 1,026.37		$ 902.16		$ 927.43		$ 862.67		$ 946.57		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.826223	1,311,137	540,705	371,626	862,797	331,068	427,973	367,991	490,066	242,997	677,736	$ 2,352,020	$ 2,261,541	56.38%
23	5000 OPERATING ROOM		0.121656	6,590,983	4,256,104	6,397,062	8,281,703	5,935,726	8,658,620	8,024,912	5,367,037	4,949,857	4,150,857	$ 26,948,683	$ 26,763,464	37.65%
24	5100 RECOVERY ROOM		0.155800	1,163,350	1,851,474	2,919,638	4,530,969	2,308,053	1,752,845	2,522,711	1,842,963	1,237,487	1,508,032	$ 8,913,752	$ 9,978,271	43.06%
25	5200 DELIVERY ROOM & LABOR ROOM		1.313387	212,840	41,440	2,775,724	812,847	14,406	10,052	719,750	143,381	49,822	27,001	$ 3,722,720	$ 1,007,720	86.00%
26	5300 ANESTHESIOLOGY		0.004473	1,610,134	1,387,434	1,155,341	2,925,670	1,425,367	1,250,813	1,828,040	1,278,586	1,352,036	1,319,068	$ 6,016,882	$ 6,840,503	34.28%
27	5400 RADIOLOGY-DIAGNOSTIC		0.101687	4,681,863	6,594,047	2,076,822	7,893,804	4,920,798	6,935,417	4,895,284	6,577,556	4,216,835	13,720,662	$ 16,874,767	$ 28,000,824	38.62%
28	5500 RADIOLOGY-THERAPEUTIC		0.524088	532,903	2,660,216	75,736	1,243,291	184,539	2,539,177	365,716	3,277,225	67,965	1,455,492	$ 1,158,894	$ 9,709,819	30.19%
29	6000 LABORATORY		0.171641	8,321,276	3,140,757	8,522,856	4,057,912	7,581,107	3,035,056	8,919,663	2,989,011	5,174,999	4,671,401	$ 33,344,902	$ 13,232,736	49.30%
30	6500 RESPIRATORY THERAPY		0.322087	3,809,065	247,135	2,576,319	232,396	2,662,326	122,827	3,576,678	229,347	1,101,507	216,441	$ 12,626,388	$ 830,905	57.14%
31	6600 PHYSICAL THERAPY		0.703444	1,041,957	103,891	383,774	246,388	903,397	159,508	1,013,640	448,671	334,575	276,319	$ 3,342,768	$ 996,458	36.90%
32	6700 OCCUPATIONAL THERAPY		0.360723	671,936	23,693	64,398	59,413	548,001	21,489	769,923	132,142	206,945	100,860	$ 2,052,260	$ 236,937	36.25%
33	6800 SPEECH PATHOLOGY		0.344107	235,452	17,291	821,152	159,892	136,474	40,716	261,676	81,978	43,035	21,456	$ 1,454,754	$ 299,875	59.66%
34	6900 ELECTROCARDIOLOGY		0.155106	317,822	342,419	56,078	257,570	381,694	337,897	342,692	287,023	278,079	723,736	$ 1,100,486	$ 1,224,909	20.10%
35	7000 ELECTROENCEPHALOGRAPHY		0.275474	57,441	383,018	52,559	843,982	67,405	192,793	57,619	335,035	21,362	206,559	$ 235,024	$ 1,754,828	38.14%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.316726	7,546,343	2,507,014	6,839,499	3,357,349	6,463,000	2,439,814	7,871,467	2,387,720	4,216,631	2,955,762	$ 26,722,305	$ 10,691,897	43.02%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.211023	3,790,672	2,201,270	491,739	996,286	3,732,572	3,564,219	4,492,066	2,751,000	2,065,979	1,662,597	$ 12,507,049	$ 9,512,775	29.66%
38	7300 DRUGS CHARGED TO PATIENTS		0.146709	21,090,543	16,720,631	11,320,035	7,842,233	15,779,041	11,618,211	22,313,495	12,785,303	11,386,821	11,216,169	$ 70,503,114	$ 48,965,378	38.95%
39	7400 RENAL DIALYSIS		0.621830											$ -	$ -	0.00%
40	7600 ENDOSCOPY		0.245271	287,620	892,922	41,977	504,488	313,409	1,052,315	296,863	1,037,161	218,991	339,074	$ 941,689	$ 3,486,888	21.41%
41	7601 HEART CATH LAB		0.081218	2,007,444	1,146,240	884,092	700,274	2,716,569	2,353,721	2,283,039	2,108,433	2,747,656	1,588,965	$ 7,891,134	$ 6,398,668	28.53%
42	9000 CLINIC		0.596968	616	738,882	16,939	337,255	32,350	824,484	838,101	30,025	22,643	611,297	$ 72,548	$ 2,738,722	27.66%
43	9100 EMERGENCY		0.285529	2,353,172	5,467,955	696,377	10,613,021	2,445,654	3,554,516	1,970,810	2,905,264	2,324,406	15,681,914	$ 7,465,913	$ 22,540,756	59.06%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
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82			-											$ -	$ -	

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

Cost Report Year (06/01/2016-07/31/2017) 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		%
83												$ -	$ -	
84												$ -	$ -	
85												$ -	$ -	
86												$ -	$ -	
87												$ -	$ -	
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125												$ -	$ -	
126												$ -	$ -	
127												$ -	$ -	
	Totals / Payments	$ 67,936,571	$ 51,264,736	$ 48,543,929	$ 56,799,470	$ 58,881,054	$ 51,121,663	$ 72,918,678	$ 48,289,001	$ 42,297,193	$ 63,312,022			
128	Total Charges *(includes organ acquisition from Section J)*	$ 80,173,289	$ 51,264,736	$ 67,610,756	$ 56,799,470	$ 67,578,785	$ 51,121,663	$ 85,219,156	$ 48,289,001	$ 47,665,592 (Agrees to Exhibit A)	$ 63,312,022 (Agrees to Exhibit A)	$ 309,581,996	$ 207,474,672	41.01%
129	Total Charges per PS&R or Exhibit Detail	$ 80,173,289	$ 51,264,736	$ 67,610,756	$ 56,799,470	$ 67,578,785	$ 51,121,663	$ 85,219,156	$ 48,289,001	$ 47,665,592	$ 63,312,022			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	Total Calculated Cost (Includes organ acquisition from Section J)	$ 27,671,724	$ 10,273,008	$ 28,418,120	$ 12,054,550	$ 20,654,704	$ 9,772,380	$ 28,077,411	$ 10,011,249	$ 13,665,302	$ 12,922,379	$ 105,019,959	$ 42,111,187	45.89%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 23,854,382	$ 10,144,008	$ 3,927	$ 854	$ 1,466,816	$ 985,168	$ 7,254,604	$ 1,597,856					
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 35,029,281	$ 10,498,642			$ 392,773	$ 101,338			$ 32,599,731	$ 12,727,896	
134	Private Insurance (including primary and third party liability)			$ 12,316	$ 20,963	$ 5,208	$ 3,468	$ 5,180,271	$ 2,382,074			$ 25,422,034	$ 10,599,980	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 160,095	$ 43,185	$ 1,924	$ 7,783	$ 1,799	$ 7,207	$ 6,544	$ 9,425			$ 5,197,795	$ 2,406,505	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 24,014,477	$ 10,187,193	$ 35,047,428	$ 10,528,252							$ 170,362	$ 67,800	
137	Medicaid Cost Settlement Payments (See Note B)		$ (229,473)											
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ (229,473)	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 18,434,107	$ 7,676,707	$ 688,108	$ 253,485			$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 9,631,090	$ 4,958,395			$ 17,122,215	$ 7,930,192	
141	Medicare Cross-Over Bad Debt Payments					$ 351,762	$ 567,710					$ 9,631,090	$ 4,958,395	
142	Other Medicare Cross-Over Payments (See Note D)					$ 188,829	$ 81,009					$ 351,762	$ 567,710	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 188,829	$ 81,009	
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ 237,184	$ 1,023,529			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 3,657,247	$ 315,285	$ 3,368,692	$ 1,525,235	$ 2,366,181	$ 451,111	$ 4,924,021	$ 709,676	$ 13,428,118	$ 11,798,850	$ 14,336,141	$ 3,001,373	
146	**Calculated Payments as a Percentage of Cost**	87%	97%	88%	87%	89%	95%	82%	93%	2%	8%	86%	93%	
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)**					42,716								
148	**Percent of cross-over days to total Medicare days from the cost report**					23%								

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 (03/01/2016-02/31/2017) | 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	$ 878.28		32						16		48	
2	03100 INTENSIVE CARE UNIT	$ 1,654.79		1								1	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,381.17		67								67	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 496.13										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	100		-		-		16		116	
19	Total Days per PS&R or Exhibit Detail			100		-		-		16			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges $ 142,241		Routine Charges $ -		Routine Charges $ -		Routine Charges $ 10,480		Routine Charges $ 152,721	
21.01	Calculated Routine Charge Per Diem			$ 1,422.41		$ -		$ -		$ 655.00		$ 1,316.56	
	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)		0.826223		3,150						3,060	$ -	$ 6,210
23	5000 OPERATING ROOM		0.121856	10,622	3,812				1,479		-	$ 10,622	$ 5,291
24	5100 RECOVERY ROOM		0.155800	7,038	7,310					860	-	$ 7,898	$ 7,310
25	5200 DELIVERY ROOM & LABOR ROOM		1.313387	6,879	1,575						525	$ 6,879	$ 2,100
26	5300 ANESTHESIOLOGY		0.004473	3,978	2,107						-	$ 3,978	$ 2,107
27	5400 RADIOLOGY-DIAGNOSTIC		0.101887	9,640	32,991					12,731	10,180	$ 22,371	$ 43,171
28	5500 RADIOLOGY-THERAPEUTIC		0.524088									$ -	$ -
29	6000 LABORATORY		0.171641	33,048	13,248				1,719	5,542	2,182	$ 38,590	$ 17,149
30	6500 RESPIRATORY THERAPY		0.322087	8,892	1,133				213	5,050		$ 13,952	$ 1,346
31	6600 PHYSICAL THERAPY		0.703444	3,628						949	450	$ 4,577	$ 450
32	6700 OCCUPATIONAL THERAPY		0.360723	653						843		$ 1,496	$ -
33	6800 SPEECH PATHOLOGY		0.344107	2,324						166		$ 2,490	$ -
34	6900 ELECTROCARDIOLOGY		0.155106	190	570				570	570	186	$ 760	$ 1,326
35	7000 ELECTROENCEPHALOGRAPHY		0.275474									$ -	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.316726	40,273	6,347				548	5,910	920	$ 46,183	$ 7,815
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.211023	530								$ 530	$ -
38	7300 DRUGS CHARGED TO PATIENTS		0.146709	39,396	15,978				782	13,110	7,954	$ 52,506	$ 24,714
39	7400 RENAL DIALYSIS		0.621830									$ -	$ -
40	7600 ENDOSCOPY		0.245271									$ -	$ -
41	7601 HEART CATH LAB		0.091218	6,672								$ 6,672	$ -
42	9000 CLINIC		0.599968	-					771			$ -	$ 771
43	9100 EMERGENCY		0.285529	8,152	60,966				3,906	3,771	2,930	$ 11,923	$ 67,802
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
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61			-									$ -	$ -
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66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2016-07/31/2017) 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	
81-127											
	Totals / Payments	$ 182,115	$ 149,187	$ -	$ -	$ -	$ 9,988	$ 49,512	$ 28,387		
128	Total Charges (Includes organ acquisition from Section K)	$ 324,356	$ 149,187	$ -	$ -	$ -	$ 9,988	$ 59,992	$ 28,387	$ 384,348	$ 187,562
129	Total Charges per PS&R or Exhibit Detail	$ 324,356	$ 149,187	$ -	$ -	$ -	$ 9,988	$ 59,992	$ 28,387		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (Includes organ acquisition from Section K)	$ 168,418	$ 34,135	$ -	$ -	$ -	$ 2,498	$ 24,054	$ 7,270	$ 192,472	$ 43,903
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 1,762				$ 59			$ -	$ 1,821
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)	$ 72,411								$ 72,411	$ -
135	Self-Pay (including Co-Pay and Spend-Down)		$ 783							$ -	$ 783
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 72,411	$ 2,545	$ -	$ -						
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)						$ 1,573	$ 6,502		$ 6,502	$ 1,573
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,208	$ 423	$ 5,208	$ 423
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	Calculated Payment Shortfall / (Longfall)	$ 96,007	$ 31,590	$ -	$ -	$ -	$ 866	$ 12,344	$ 6,847	$ 108,351	$ 39,303
144	Calculated Payments as a Percentage of Cost	43%	7%	0%	0%	0%	65%	49%	6%	44%	10%

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 (08/01/2016-07/31/2017) 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 (08/01/2016-07/31/2017) 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 (08/01/2016-07/31/2017) 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)*	$ 6,250,678		
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)	$ 6,250,678	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	$ 6,250,678		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*