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 SUMTER MEDICAL CENTER

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:	000000019A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110044

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?	1/1/1908

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:

KENNETH HEALEY, MD
MOHAN PAPUDESU, MD

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.)

$ 747,822

Certification:

Answer
Yes

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.**

Explanation for "No" answers:

Other Protested Item: "New Hampshire Hospital Association v. Azar" We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Cost.

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

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

Hospital CEO or CFO Signature	CEO Title	11/16/18 Date
BRANDI LUNNEBORG Hospital CEO or CFO Printed Name	229-931-1288 Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	REBECCA KENDALL
Title	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 SUMTER MEDICAL CENTER

	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 SUMTER MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000019A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110044	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):	Non-Small Rural	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	ALABAMA	135519
10. State Name & Number	FLORIDA	004529400
11. State Name & Number	SOUTH CAROLINA	11138B
12. State Name & Number	NORTH CAROLINA	1100044
13. State Name & Number	TENNESSEE	0110044
14. State Name & Number	MISSISSIPPI	00098332
15. State Name & Number	CALIFORNIA	1609001312

(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)	$ 24,914	$ 267,907	$292,821
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 374,426	$ 2,374,836	$2,749,262
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)	$399,340	$2,642,743	$3,042,083
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.24%	10.14%	9.63%

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)	11,582 **(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	2,736,319
8.	Outpatient Hospital Charity Care Charges	13,066,808
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 15,803,127

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	$13,334,706.00			$ 9,597,169	$ -	$ -	$ 3,737,537
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
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	$55,024,650.00	$140,021,962.00		$ 39,601,989	$ 100,775,710	$ -	$ 54,668,913
20.	Outpatient Services		$38,864,495.00			$ 27,971,306	$ -	$ 10,893,189
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,167,982.00			$ 1,560,326	
26.	Other	$0.00	$62,089.00	$542,390.00	$ -	$ 44,686	$ 390,365	$ 17,403
27.	Total	$ 68,359,356	$ 178,948,546	$ 2,710,372	$ 49,199,158	$ 128,791,702	$ 1,950,692	$ 69,317,042
28.	Total Hospital and Non Hospital		Total from Above	$ 250,018,274		Total from Above	$ 179,941,552	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	250,018,274	Total Contractual Adj. (G-3 Line 2)	177,867,742
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)			+	2,073,810
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				179,941,552

G. Cost Report - Cost / Days / Charges

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

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	$ 9,139,888	$ -	$ -	$0.00	$ 9,139,888	10,836	$5,736,807.00		$ 843.47
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ 2,433,117	$ -	$ -		$ 2,433,117	1,135	$1,542,356.00		$ 2,143.72
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,224,045	$ -	$ -		$ 1,224,045	967	$552,893.00		$ 1,265.82
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 12,797,050	$ -	$ -	$ -	$ 12,797,050	12,938	$ 7,832,056		
19	Weighted Average									$ 989.10

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)	1,356	-	-	$ 1,143,745	$357,396.00	$1,267,175.00	$ 1,624,571	0.704029

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	$6,069,044.00	$ -	$0.00		$ 6,069,044	$6,810,882.00	$15,094,835.00	$ 21,905,717	0.277053
22	5100 RECOVERY ROOM	$884,410.00	$ -	$0.00		$ 884,410	$1,971,459.00	$6,911,551.00	$ 8,883,010	0.099562
23	5200 DELIVERY ROOM & LABOR ROOM	$715,933.00	$ -	$0.00		$ 715,933	$506,269.00	$750,654.00	$ 1,256,923	0.569592
24	5300 ANESTHESIOLOGY	$134,459.00	$ -	$0.00		$ 134,459	$2,210,382.00	$4,242,181.00	$ 6,452,563	0.020838
25	5400 RADIOLOGY-DIAGNOSTIC	$5,715,805.00	$ -	$0.00		$ 5,715,805	$3,280,805.00	$37,418,209.00	$ 40,699,014	0.140441
26	6000 LABORATORY	$4,886,773.00	$ -	$0.00		$ 4,886,773	$7,955,134.00	$11,632,238.00	$ 19,587,372	0.249486
27	6500 RESPIRATORY THERAPY	$1,613,021.00	$ -	$0.00		$ 1,613,021	$2,011,828.00	$571,310.00	$ 2,583,138	0.624442
28	6600 PHYSICAL THERAPY	$1,778,997.00	$ -	$0.00		$ 1,778,997	$1,806,801.00	$1,242,900.00	$ 3,049,701	0.583335
29	6900 ELECTROCARDIOLOGY	$39,753.00	$ -	$0.00		$ 39,753	$1,800,136.00	$4,579,719.00	$ 6,379,855	0.006231
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$3,078,206.00	$ -	$0.00		$ 3,078,206	$6,541,872.00	$5,840,633.00	$ 12,382,505	0.248593

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2016-07/31/2017) PHOEBE SUMTER 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	Medicaid Per Diem / Cost or Other Ratios
31	7200	IMPL. DEV. CHARGED TO PATIENTS	$2,681,192.00	$ -	$0.00		$ 2,681,192	$6,410,338.00	$3,084,830.00	$ 9,495,168	0.282374
32	7300	DRUGS CHARGED TO PATIENTS	$9,273,481.00	$ -	$0.00		$ 9,273,481	$15,756,581.00	$51,621,388.00	$ 67,377,969	0.137634
33	7400	RENAL DIALYSIS	$215,717.00	$ -	$0.00		$ 215,717	$1,000,927.00	$0.00	$ 1,000,927	0.215517
34	9000	CLINIC	$43,870.00	$ -	$0.00		$ 43,870	$21,096.00	$410,018.00	$ 431,114	0.101760
35	9100	EMERGENCY	$6,888,322.00	$ -	$838,436.00		$ 7,726,758	$2,121,672.00	$19,038,951.00	$ 21,160,623	0.365148
36			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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 SUMTER 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	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**	$ 44,018,983	$ -	$ 838,436		$ 44,857,419	$ 60,563,578	$ 163,706,592	$ 224,270,170	
127		**Weighted Average**									0.205115
128		**Sub Totals**	$ 56,816,033	$ -	$ 838,436		$ 57,654,469	$ 68,395,634	$ 163,706,592	$ 232,102,226	
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**					$ 57,654,469				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

* 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 (06/01/2016-05/31/2017) PHOEBE SUMTER MEDICAL CENTER

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 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	$ 843.47		1,278		879		1,138		1,407		557		4,700		55.47%
2	03100 INTENSIVE CARE UNIT	$ -												-		
3	03200 CORONARY CARE UNIT	$ 2,143.72		175		30		169		187		118		561		58.82%
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,265.82		116		714				130		7		960		100.00%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	1,569		1,623		1,305		1,724		682		6,221		53.37%
19	Total Days per PS&R or Exhibit Detail			1,569		1,623		1,305		1,724		682				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,026,567		$ 956,575		$ 927,440		$ 1,175,300		$ 501,776		$ 4,085,882		58.59%
21.01	Calculated Routine Charge Per Diem			$ 654.28		$ 589.39		$ 710.68		$ 681.73		$ 735.74		$ 656.79		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.704029	99,907	140,353	99,592	151,627	31,260	107,095	49,182	121,096	7,917	125,289	$ 276,941	$ 520,171	57.49%
23	5000 OPERATING ROOM		0.277053	811,930	805,675	1,369,418	1,602,036	527,821	822,774	834,453	870,179	298,150	746,801	$ 3,543,622	$ 4,150,664	39.89%
24	5100 RECOVERY ROOM		0.099562	221,076	440,934	475,066	808,624	321,591	347,539	349,491	358,760	124,437	360,867	$ 1,367,224	$ 1,955,877	42.87%
25	5200 DELIVERY ROOM & LABOR ROOM		0.569593	83,802	14,070	668,314	204,424	5,640	3,752	140,368	39,396	14,688	10,318	$ 896,124	$ 261,642	94.28%
26	5300 ANESTHESIOLOGY		0.020838	261,348	266,951	440,111	530,441	153,014	186,074	260,940	293,754	89,919	269,876	$ 1,115,413	$ 1,187,220	41.14%
27	5400 RADIOLOGY-DIAGNOSTIC		0.140441	788,499	2,161,334	164,282	3,051,581	789,168	2,108,523	687,354	2,202,069	551,038	3,221,960	$ 2,609,303	$ 9,523,507	39.14%
28	6000 LABORATORY		0.249486	1,179,334	799,959	629,577	1,397,653	1,121,028	758,217	1,292,258	812,288	576,284	1,090,077	$ 4,422,197	$ 3,758,697	50.33%
29	6500 RESPIRATORY THERAPY		0.624442	528,116	124,264	39,905	30,422	410,996	70,683	469,771	43,892	161,501	54,091	$ 1,448,788	$ 269,261	74.92%
30	6600 PHYSICAL THERAPY		0.583335	203,510	43,367	167,303	68,234	216,827	79,765	286,652	93,811	75,161	70,849	$ 876,092	$ 285,177	42.87%
31	6900 ELECTROCARDIOLOGY		0.006231	41,968	151,974	15,055	132,400	202,296	225,414	222,391	293,872	98,397	220,586	$ 481,710	$ 803,660	25.20%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.248593	622,015	469,602	713,730	722,674	748,914	314,916	685,826	301,165	309,552	508,293	$ 3,170,485	$ 1,808,379	46.83%
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.282374	1,123,225	202,086	243,490	276,832	496,779	178,553	681,678	224,329	92,260	136,820	$ 2,545,172	$ 891,800	38.50%
34	7300 DRUGS CHARGED TO PATIENTS		0.137634	2,530,536	4,831,893	1,655,070	3,137,177	2,323,655	3,775,997	2,473,768	3,241,209	1,092,140	3,419,752	$ 8,983,029	$ 14,986,276	42.27%
35	7400 RENAL DIALYSIS		0.215517			5,184	2,496	192	1,152	1,344	1,152		1,891	$ 6,720	$ 4,800	1.34%
36	9000 CLINIC		0.101760		26,580		15,497	945	30,449		40,722		14,766	$ 945	$ 113,248	29.91%
37	9100 EMERGENCY		0.365148	462,307	1,599,272	74,327	2,979,430	473,872	1,072,802	449,009	1,101,231	299,970	3,599,966	$ 1,459,515	$ 6,749,735	57.35%
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
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46			-											$ -	$ -	
47			-											$ -	$ -	
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74			-											$ -	$ -	
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81			-											$ -	$ -	
82			-											$ -	$ -	

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

Cost Report Year (06/01/2016-05/31/2017) PHOEBE SUMTER MEDICAL CENTER

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
83		-											$ -	$ -	
84		-											$ -	$ -	
85		-											$ -	$ -	
86		-											$ -	$ -	
87		-											$ -	$ -	
88		-											$ -	$ -	
89		-											$ -	$ -	
90		-											$ -	$ -	
91		-											$ -	$ -	
92		-											$ -	$ -	
93		-											$ -	$ -	
94		-											$ -	$ -	
95		-											$ -	$ -	
96		-											$ -	$ -	
97		-											$ -	$ -	
98		-											$ -	$ -	
99		-											$ -	$ -	
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101		-											$ -	$ -	
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121		-											$ -	$ -	
122		-											$ -	$ -	
123		-											$ -	$ -	
124		-											$ -	$ -	
125		-											$ -	$ -	
126		-											$ -	$ -	
127		-											$ -	$ -	
			$ 9,136,573	$ 12,115,314	$ 6,960,424	$ 15,111,548	$ 7,825,708	$ 10,083,707	$ 9,284,485	$ 9,948,945	$ 3,783,744	$ 13,840,202			

Totals / Payments

128	Total Charges *(Includes organ acquisition from Section J)*	$ 10,163,140	$ 12,115,314	$ 7,916,999	$ 15,111,548	$ 8,753,238	$ 10,083,707	$ 10,459,785	$ 9,948,945	$ 4,265,526 (Agrees to Exhibit A)	$ 13,840,202 (Agrees to Exhibit A)	$ 37,293,162	$ 47,259,514	44.28%
129	Total Charges per PS&R or Exhibit Detail	$ 10,163,140	$ 12,115,314	$ 7,916,999	$ 15,111,548	$ 8,753,238	$ 10,083,707	$ 10,459,785	$ 9,948,945	$ 4,265,526	$ 13,840,202			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (Includes organ acquisition from Section J)**	$ 3,859,236	$ 2,422,237	$ 3,451,051	$ 3,375,137	$ 3,122,518	$ 1,984,814	$ 3,954,577	$ 1,975,442	$ 1,571,061	$ 3,094,288	$ 14,397,382	$ 9,737,630	49.99%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,319,218	$ 2,626,214		$ 200	$ 259,753	$ 167,282	$ 1,101,563	$ 315,001			$ 4,680,534	$ 3,108,697	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,523,287	$ 3,105,951			$ 39,935	$ 35,736			$ 2,563,202	$ 3,141,687	
134	Private Insurance (including primary and third party liability)				$ 10,588	$ 4,455	$ 22	$ 651,013	$ 559,692			$ 655,468	$ 570,502	
135	Self-Pay (Including Co-Pay and Spend-Down)	$ 35,167	$ 6,547	$ 123	$ 282	$ 13	$ 6	$ 13	$ 3,393			$ 35,316	$ 10,228	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,354,385	$ 2,632,761	$ 2,523,390	$ 3,117,021									
137	Medicaid Cost Settlement Payments (See Note B)		$ (530,375)									$ -	$ (530,375)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 2,102,575	$ 1,299,854	$ 164,371	$ 25,038			$ 2,326,946	$ 1,324,892	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,361,571	$ 866,361			$ 1,361,571	$ 866,361	
141	Medicare Cross-Over Bad Debt Payments					$ 15,390	$ 99,048					$ 15,390	$ 99,048	
142	Other Medicare Cross-Over Payments (See Note D)					$ (78,925)				(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (78,925)	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 24,914	$ 267,907			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 504,651	$ 319,851	$ 927,661	$ 258,116	$ 759,257	$ 398,602	$ 648,111	$ 170,021	$ 1,546,147	$ 2,826,381	$ 2,837,880	$ 1,146,590	
146	**Calculated Payments as a Percentage of Cost**	87%	87%	73%	92%	76%	80%	84%	91%	2%	9%	80%	88%	
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. 8, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 8)**					3,626								
148	**Percent of cross-over days to total Medicare days from the cost report**					36%								

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 (BM01/2016-07/31/2017) PHOEBE SUMTER MEDICAL CENTER

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 Eligible (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	$ 643.47								2		2	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ 2,143.72										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,265.82										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		-		-		2		2	
19	Total Days per PS&R or Exhibit Detail			-		-		-		2			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ -		$ -		$ -		$ 1,194		$ 1,194	
21.01	Calculated Routine Charge Per Diem									$ 597.00		$ 597.00	
	Ancillary Cost Centers (from WIS C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	01200 Observation (Non-Distinct)		0.704029		-				1,688			$ -	$ 1,688
23	5000 OPERATING ROOM		0.277053									$ -	$ -
24	5100 RECOVERY ROOM		0.099562							62		$ 62	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.569592									$ -	$ -
26	5300 ANESTHESIOLOGY		0.020838								1,163	$ -	$ 1,163
27	5400 RADIOLOGY-DIAGNOSTIC		0.140441		14,436				9,088	308		$ 308	$ 23,524
28	6000 LABORATORY		0.249466		2,901				4,146	1,942	167	$ 1,942	$ 7,214
29	6500 RESPIRATORY THERAPY		0.624442							1,687		$ 1,687	$ -
30	6600 PHYSICAL THERAPY		0.583335								206	$ -	$ 206
31	6900 ELECTROCARDIOLOGY		0.006231		618				2,822	206		$ 206	$ 3,440
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.248593		834				371	1,073	108	$ 1,073	$ 1,313
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.282374									$ -	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.137634		5,702				3,479	3,034	621	$ 3,034	$ 9,802
35	7400 RENAL DIALYSIS		0.215517									$ -	$ -
36	9000 CLINIC		0.101760									$ -	$ -
37	9100 EMERGENCY		0.365148		21,932				2,858	1,835	2,518	$ 1,835	$ 27,348
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
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56			-									$ -	$ -
57			-									$ -	$ -
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76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

			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											$ -	$ -
82											$ -	$ -
83											$ -	$ -
84											$ -	$ -
85											$ -	$ -
86											$ -	$ -
87											$ -	$ -
88											$ -	$ -
89											$ -	$ -
90											$ -	$ -
91											$ -	$ -
92											$ -	$ -
93											$ -	$ -
94											$ -	$ -
95											$ -	$ -
96											$ -	$ -
97											$ -	$ -
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99											$ -	$ -
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104											$ -	$ -
105											$ -	$ -
106											$ -	$ -
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115											$ -	$ -
116											$ -	$ -
117											$ -	$ -
118											$ -	$ -
119											$ -	$ -
120											$ -	$ -
121											$ -	$ -
122											$ -	$ -
123											$ -	$ -
124											$ -	$ -
125											$ -	$ -
126											$ -	$ -
127											$ -	$ -
	Totals / Payments		$ -	$ 46,423	$ -	$ -	$ -	$ 24,492	$ 10,147	$ 4,783		
128	**Total Charges (Includes organ acquisition from Section K)**		$ -	$ 46,423	$ -	$ -	$ -	$ 24,492	$ 11,341	$ 4,783	$ 11,341	$ 75,698
129	Total Charges per PS&R or Exhibit Detail		$ -	$ 46,423	$ -	$ -	$ -	$ 24,492	$ 11,341	$ 4,783		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (Includes organ acquisition from Section K)**		$ -	$ 11,756	$ -	$ -	$ -	$ 5,146	$ 4,630	$ 1,218	$ 4,630	$ 18,120
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)							$ 140			$ -	$ 140
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)								$ 5,026	$ 1,589	$ 5,026	$ 1,589
135	Self-Pay (including Co-Pay and Spend-Down)										$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)										$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)										$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 2,259			$ -	$ 2,259
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
141	Medicare Cross-Over Bad Debt Payments										$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)										$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**		$ -	$ 11,756	$ -	$ -	$ -	$ 2,747	$ (398)	$ (371)	$ (398)	$ 14,132
144	**Calculated Payments as a Percentage of Cost**		0%	0%	0%	0%	0%	47%	109%	130%	109%	22%

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 (06/01/2016-07/31/2017) PHOEBE SUMTER MEDICAL CENTER

		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 (06/01/2016-07/31/2017) PHOEBE SUMTER MEDICAL CENTER

		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 SUMTER MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 720,601		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*	Expense	02 700000 690057 & 02 700000 690058	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	$ 720,601	5.00	*(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	$ 720,601		

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.*