State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

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	08/01/2018	07/31/2019
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 (07/01/18 - 06/30/19)
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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** $ 12,856,787
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2018 - 06/30/2019** $ 12,856,787

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 inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Cost.

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

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

Hospital CEO or CFO Signature	SR VP/CFO Title	10/26/2019 Date
BRIAN CHURCH Hospital CEO or CFO Printed Name	229-312-4068 Hospital CEO or CFO Telephone Number	BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail

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

Hospital Contact:

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

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

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	08/01/2018	07/31/2019
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 (07/01/18 - 06/30/19)
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

DSH Version 8.00 3/31/2020

D. General Cost Report Year Information 8/1/2018 - 7/31/2019

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 c 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		
	8/1/2018 through 7/31/2019		
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:	5/13/2020		

	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	1416A IS THE SECOND CAID NUMBER FOR PHOEBE . NOT SUBPROVI
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	No	
8. Medicare Provider Number:	110007	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report yea

	State Name	Provider No.
9. State Name & Number	FLORIDA	913855200
10. State Name & Number	ALABAMA	PH0007N
11. State Name & Number		
12. 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: (08/01/2018 - 07/31/2019)

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)	$ 226,088	$ 958,871	$1,184,959
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,996,541	$ 8,701,896	$10,698,437
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)	$2,222,629	$9,660,767	$11,883,396
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	10.17%	9.93%	9.97%

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 thes 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 (08/01/2018 - 07/31/2019)

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)	111,125	**(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	177,059
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 177,059
7.	Inpatient Hospital Charity Care Charges	30,963,146
8.	Outpatient Hospital Charity Care Charges	43,271,422
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 74,234,568

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)			
11.	Hospital	$122,832,662.00			$ 87,734,356	$ -	$ -	$ 35,098,306
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	$621,617,488.00	$1,019,941,070.00		$ 443,995,995	$ 728,502,269	$ -	$ 469,060,293
20.	Outpatient Services		$96,771,157.00			$ 69,119,687	$ -	$ 27,651,470
21.	Home Health Agency			$6,068,204.00			$ 4,334,270	
22.	Ambulance	-	-	$ 519,119	-	-	$ 370,786	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$6,080,939.00			$ 4,343,366	
26.	Other	$6,898,947.00	$0.00	$55,991,347.00	$ 4,927,636	$ -	$ 39,992,333	$ 1,971,311
27.	Total	$ 751,349,097	$ 1,116,712,227	$ 68,659,609	$ 536,657,988	$ 797,621,956	$ 49,040,756	$ 533,781,380

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,936,720,933	Total Contractual Adj. (G-3 Line 2)	1,378,591,457
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)			+	4,729,243
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				1,383,320,700
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2018-07/31/2019) 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	$ 90,692,878	$ 1,328,929	$ -	$0.00	$ 92,021,807	92,988	$67,595,326.00		$ 989.61
2	03100 INTENSIVE CARE UNIT	$ 18,404,888	$ 117,873	$ -		$ 18,522,761	11,412	$21,904,939.00		$ 1,623.10
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	$ 12,804,554	$ 87,455	$ -		$ 12,892,009	8,310	$20,626,735.00		$ 1,551.38
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,922,481	$ -	$ -		$ 4,922,481	8,696	$6,898,947.00		$ 566.06
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 126,824,801	$ 1,534,257	$ -	$ -	$ 128,359,058	121,406	$ 117,025,947		
19	Weighted Average									$ 1,057.27

Line #	Observation Data (Non-Distinct)	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
20	09200 Observation (Non-Distinct)	10,281	-	-	$ 10,174,180	$6,158,687.00	$6,546,975.00	$ 12,705,662	0.800760

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below)	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
21	5000 OPERATING ROOM	$24,746,501.00	$ 74,146	$0.00		$ 24,820,647	$90,641,205.00	$135,253,189.00	$ 225,894,394	0.109877
22	5100 RECOVERY ROOM	$8,557,707.00	$ -	$0.00		$ 8,557,707	$20,556,268.00	$42,525,192.00	$ 63,081,460	0.135661
23	5200 DELIVERY ROOM & LABOR ROOM	$9,598,127.00	$ 218,636	$0.00		$ 9,816,763	$2,990,384.00	$2,402,202.00	$ 5,392,586	1.820418
24	5300 ANESTHESIOLOGY	$531,650.00	$ -	$0.00		$ 531,650	$20,898,924.00	$32,737,052.00	$ 53,635,976	0.009912
25	5400 RADIOLOGY-DIAGNOSTIC	$16,895,092.00	$ 87,455	$0.00		$ 16,982,547	$41,484,883.00	$143,312,499.00	$ 184,797,382	0.091898
26	5500 RADIOLOGY-THERAPEUTIC	$25,072,043.00	$ -	$0.00		$ 25,072,043	$2,487,988.00	$60,585,055.00	$ 63,073,043	0.397508
27	6000 LABORATORY	$20,951,343.00	$ -	$0.00		$ 20,951,343	$73,791,902.00	$85,345,324.00	$ 159,137,226	0.131656
28	6500 RESPIRATORY THERAPY	$9,158,058.00	$ -	$0.00		$ 9,158,058	$25,291,249.00	$6,089,080.00	$ 31,380,329	0.291841
29	6600 PHYSICAL THERAPY	$9,669,085.00	$ -	$0.00		$ 9,669,085	$10,680,412.00	$6,238,425.00	$ 16,918,837	0.571498
30	6700 OCCUPATIONAL THERAPY	$2,372,676.00	$ -	$0.00		$ 2,372,676	$7,332,685.00	$1,438,085.00	$ 8,770,770	0.270521
31	6800 SPEECH PATHOLOGY	$1,047,206.00	$ -	$0.00		$ 1,047,206	$2,925,315.00	$949,505.00	$ 3,874,820	0.270259

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2018-07/31/2019) PHOEBE PUTNEY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	6900	ELECTROCARDIOLOGY	$2,992,355.00	$ -	$0.00		$ 2,992,355	$5,797,306.00	$14,040,318.00	$ 19,837,624	0.150842
33	7000	ELECTROENCEPHALOGRAPHY	$1,891,977.00	$ -	$0.00		$ 1,891,977	$463,515.00	$5,635,834.00	$ 6,099,349	0.310193
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$40,817,922.00	$ -	$0.00		$ 40,817,922	$85,308,864.00	$64,170,114.00	$ 149,478,978	0.273068
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$19,765,443.00	$ -	$0.00		$ 19,765,443	$49,043,182.00	$56,813,972.00	$ 105,857,154	0.186718
36	7300	DRUGS CHARGED TO PATIENTS	$62,853,726.00	$ -	$0.00		$ 62,853,726	$137,289,449.00	$293,764,775.00	$ 431,054,224	0.145814
37	7400	RENAL DIALYSIS	$2,751,225.00	$ -	$0.00		$ 2,751,225	$5,994,987.00	$580,649.00	$ 6,575,636	0.418397
38	7600	ENDOSCOPY	$6,238,971.00	$ 115,972	$0.00		$ 6,354,943	$2,543,780.00	$20,084,137.00	$ 22,627,917	0.280845
39	7601	HEART CATH LAB	$2,606,771.00	$ -	$0.00		$ 2,606,771	$36,095,190.00	$47,975,663.00	$ 84,070,853	0.031007
40	9000	CLINIC	$8,443,813.00	$ -	$0.00		$ 8,443,813	$1,179,798.00	$11,702,203.00	$ 12,882,001	0.655474
41	9100	EMERGENCY	$20,915,513.00	$ 249,055	$3,809,477.00		$ 24,974,045	$14,634,283.00	$69,254,873.00	$ 83,889,156	0.297703
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2018-07/31/2019) PHOEBE PUTNEY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 297,877,204	$ 745,264	$ 3,809,477		$ 302,431,945	$ 643,590,256	$ 1,107,445,121	$ 1,751,035,377	
127		**Weighted Average**									0.178526
128		**Sub Totals**	$ 424,702,005	$ 2,279,521	$ 3,809,477		$ 430,791,003	$ 760,616,203	$ 1,107,445,121	$ 1,868,061,324	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 430,791,003				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.53%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using

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

Cost Report Year (08/01/2018-07/31/2019) 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	$ 989.61		11,604		6,568		6,858		12,794		6,485		37,824		53.71%
2	03100 INTENSIVE CARE UNIT	$ 1,623.10		1,643		163		1,118		1,833		920		4,757		49.96%
3	03200 CORONARY CARE UNIT	$ -				-								-		
4	03300 BURN INTENSIVE CARE UNIT	$ -				-								-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,551.38		1,236		6,136				912		26		8,284		100.00%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 566.06		1,008		6,762				734		103		8,504		99.00%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	15,491		19,629		7,976		16,273		7,534		59,369		55.22%
19	Total Days per PS&R or Exhibit Detail			15,491		19,629		7,976		16,273		7,534				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 14,824,587		$ 25,739,150		$ 7,678,880		$ 16,452,110		$ 7,159,250		$ 64,694,727		61.51%
21.01	Calculated Routine Charge Per Dien			$ 956.98		$ 1,311.28		$ 962.75		$ 1,011.01		$ 950.26		$ 1,089.71		
	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		0.800760	1,499,579	874,444	360,374	1,129,496	424,156	533,096	587,513	942,451	109,192	1,029,464	$ 2,871,622	$ 3,479,487	59.07%
23	5000 OPERATING ROOM		0.109877	9,463,187	5,518,707	7,603,963	10,524,966	6,717,128	15,489,655	11,806,014	9,681,616	7,128,366	5,515,113	$ 35,590,292	$ 41,214,944	39.63%
24	5100 RECOVERY ROOM		0.135661	1,596,423	1,967,043	3,490,043	5,881,622	2,808,180	2,118,986	3,786,427	2,782,512	1,538,596	1,946,457	$ 11,681,073	$ 12,750,163	44.30%
25	5200 DELIVERY ROOM & LABOR ROOM		1.820418	277,066	23,830	2,735,620	219,090	26,947		973,064	67,474	22,478	5,128	$ 4,012,697	$ 310,394	80.72%
26	5300 ANESTHESIOLOGY		0.009912	1,977,776	1,488,315	1,335,768	3,798,479	1,307,430	1,367,803	2,510,907	1,982,273	1,766,971	1,613,348	$ 7,131,881	$ 8,636,870	35.73%
27	5400 RADIOLOGY-DIAGNOSTIC		0.091898	8,030,158	6,033,211	2,762,886	8,545,981	5,837,129	5,553,591	9,119,568	9,027,576	6,879,221	16,472,592	$ 25,749,741	$ 29,160,359	42.44%
28	5500 RADIOLOGY-THERAPEUTIC		0.397508	612,467	3,839,048	45,594	1,585,553	239,712	2,916,242	797,922	5,152,760	215,312	3,452,347	$ 1,695,695	$ 13,493,603	29.90%
29	6000 LABORATORY		0.131656	11,564,666	4,839,597	8,755,169	5,801,994	7,716,565	4,005,507	13,343,185	6,223,834	6,926,807	7,297,728	$ 41,379,585	$ 20,870,932	48.17%
30	6500 RESPIRATORY THERAPY		0.291841	4,669,140	390,135	3,382,214	330,931	2,554,485	102,423	4,746,800	432,374	1,716,432	215,977	$ 15,352,639	$ 1,255,863	59.22%
31	6600 PHYSICAL THERAPY		0.571498	1,596,163	256,995	512,431	274,570	992,672	303,001	1,955,304	513,673	476,233	185,836	$ 5,056,570	$ 1,348,239	41.82%
32	6700 OCCUPATIONAL THERAPY		0.270521	705,709	27,120	96,597	69,338	498,691	41,607	1,066,905	197,243	353,654	51,934	$ 2,367,902	$ 335,308	35.53%
33	6800 SPEECH PATHOLOGY		0.270259	308,556	25,231	942,354	148,434	122,417	50,768	434,877	117,079	113,234	25,043	$ 1,808,204	$ 341,512	59.11%
34	6900 ELECTROCARDIOLOGY		0.150842	442,011	326,846	549,582	670,551	757,835	490,517	1,417,272	804,431	799,950	1,324,408	$ 3,166,700	$ 2,292,345	38.35%
35	7000 ELECTROENCEPHALOGRAPHY		0.310193	72,188	410,950	39,501	574,251	50,956	250,834	79,639	359,387	37,884	206,581	$ 242,284	$ 1,595,422	34.15%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.273068	9,355,312	2,944,730	9,433,834	3,831,430	6,342,578	3,860,426	12,049,137	4,675,653	5,874,203	4,042,755	$ 37,180,861	$ 15,312,239	41.82%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.186718	4,267,656	2,729,752	793,640	1,496,531	2,975,285	4,585,346	6,093,399	5,412,610	3,386,968	1,635,753	$ 14,129,980	$ 14,224,239	31.54%
38	7300 DRUGS CHARGED TO PATIENTS		0.145814	21,635,103	20,075,477	11,109,819	11,345,982	13,360,354	14,421,559	23,764,402	26,962,213	13,241,418	13,984,365	$ 69,869,678	$ 72,805,231	39.52%
39	7400 RENAL DIALYSIS		0.418397	102,864	-			47,146		122,151	-	25,716		$ 272,161	$ -	4.53%
40	7600 ENDOSCOPY		0.280845	347,445	806,744	41,710	530,300	272,809	836,255	423,056	1,306,403	245,630	1,094,033	$ 1,085,020	$ 3,479,702	26.12%
41	7601 HEART CATH LAB		0.031007	2,554,212	1,100,834	1,156,704	890,909	2,389,436	1,811,574	4,018,944	3,509,985	4,612,334	2,229,080	$ 10,119,296	$ 7,313,302	28.91%
42	9000 CLINIC		0.655474	222	514,884	271,397	640,758	97,373	1,038,846	159,411	1,428,377	184,999	769,555	$ 528,403	$ 3,622,865	39.70%
43	9100 EMERGENCY		0.297703	3,129,345	4,646,451	1,542,290	10,888,928	2,229,668	2,829,857	3,339,968	4,607,162	2,875,760	14,130,564	$ 10,241,271	$ 22,972,398	60.04%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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61			-											$ -	$ -	

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

Cost Report Year (08/01/2018-07/31/2019 | 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	%
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
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124				-											$ -	$ -
125				-											$ -	$ -
126				-											$ -	$ -
127				-											$ -	$ -
					$ 84,207,248	$ 58,840,344	$ 56,961,490	$ 69,180,094	$ 57,768,952	$ 62,607,893	$ 102,595,865	$ 86,187,086	$ 58,531,358	$ 77,228,061		

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

Cost Report Year (08/01/2018-07/31/2019 | PHOEBE PUTNEY MEMORIAL HOSPITAL

	Totals / Payments	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		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 99,031,835	$ 58,840,344	$ 82,700,640	$ 69,180,094	$ 65,447,832	$ 62,607,893	$ 119,047,975	$ 86,187,086	$ 65,690,608 (Agrees to Exhibit A)	$ 77,228,061 (Agrees to Exhibit A)	$ 366,228,282	$ 276,815,417	42.15%
129	Total Charges per PS&R or Exhibit Detail	$ 99,031,835	$ 58,840,344	$ 82,700,640	$ 69,180,094	$ 65,447,832	$ 62,607,893	$ 119,047,975	$ 86,187,086	$ 65,690,608	$ 77,228,061			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 32,419,374	$ 11,023,448	$ 34,811,472	$ 12,884,736	$ 18,514,272	$ 10,834,246	$ 36,890,037	$ 15,775,707	$ 17,176,258	$ 14,556,549	$ 122,635,155	$ 50,518,137	47.65%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 24,663,556	$ 9,980,488		$ 123	$ 522,816	$ 1,132,219	$ 8,632,923	$ 2,782,074			$ 33,819,295	$ 13,894,904	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 26,541,694	$ 11,457,094			$ 411,223	$ 166,872			$ 26,952,917	$ 11,623,966	
134	Private Insurance (including primary and third party liability)			$ 97,021	$ 23,334	$ 114	$ 2,084	$ 6,062,353	$ 3,813,696			$ 6,159,488	$ 3,839,114	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 222,343	$ 87,012	$ 677	$ 3,857	$ 48	$ 3,244	$ 1,271	$ 8,860			$ 224,339	$ 102,973	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 24,885,899	$ 10,067,500	$ 26,639,392	$ 11,484,408									
137	Medicaid Cost Settlement Payments (See Note B)		$ 73,547									$ -	$ 73,547	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 19,453,503	$ 8,527,593	$ 1,301,140	$ 562,088			$ 20,754,643	$ 9,089,681	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 15,538,963	$ 8,757,743			$ 15,538,963	$ 8,757,743	
141	Medicare Cross-Over Bad Debt Payments					$ 401,583	$ 480,762					$ 401,583	$ 480,762	
142	Other Medicare Cross-Over Payments (See Note D)					$ (93,422)	$ 96,283			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (93,422)	$ 96,283	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 226,088	$ 958,871			
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)**	$ 7,533,475	$ 882,401	$ 8,172,080	$ 1,400,328	$ (1,770,370)	$ 592,061	$ 4,942,164	$ (315,626)	$ 16,950,170	$ 13,597,678	$ 18,877,349	$ 2,559,164	
146	**Calculated Payments as a Percentage of Cost**	77%	92%	77%	89%	110%	95%	87%	102%	1%	7%	85%	95%	
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)**					42,048								
148	**Percent of cross-over days to total Medicare days from the cost report**					19%								

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 s
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 pay
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 payn

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

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2018-07/31/2019) 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	$ 989.61		52				28		33		113	
2	03100 INTENSIVE CARE UNIT	$ 1,623.10		11				7		6		24	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,551.38										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 566.06		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	65		-		35		39		139	
19	Total Days per PS&R or Exhibit Detail			65		-		35		39			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 61,900				$ 34,650		$ 37,725		$ 134,275	
21.01	Calculated Routine Charge Per Dierr			$ 952.31		$ -		$ 990.00		$ 967.31		$ 966.01	
	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)		0.800760		5,270			1,748	3,682	3,106	2,286	$ 4,854	$ 11,238
23	5000 OPERATING ROOM		0.109877	43,754				16,875	2,027	14,548		$ 75,177	$ 2,027
24	5100 RECOVERY ROOM		0.135661	17,618	421			6,855	258	5,731		$ 30,204	$ 679
25	5200 DELIVERY ROOM & LABOR ROOM		1.820418		641			1,367				$ 1,367	$ 641
26	5300 ANESTHESIOLOGY		0.009912	4,473	144			2,094	664	8,130		$ 14,697	$ 808
27	5400 RADIOLOGY-DIAGNOSTIC		0.091898	52,136	25,587			20,726	12,390	39,888	11,654	$ 112,750	$ 49,631
28	5500 RADIOLOGY-THERAPEUTIC		0.397508									$ -	$ -
29	6000 LABORATORY		0.131656	60,983	20,064			24,523	31,079	38,364	10,514	$ 123,870	$ 61,657
30	6500 RESPIRATORY THERAPY		0.291841	19,017	337			6,785	345	14,794	1,380	$ 40,596	$ 2,062
31	6600 PHYSICAL THERAPY		0.571498	1,620				2,379		4,838		$ 8,837	$ -
32	6700 OCCUPATIONAL THERAPY		0.270521	1,975				917		4,363		$ 7,255	$ -
33	6800 SPEECH PATHOLOGY		0.270259	914						1,595		$ 2,509	$ -
34	6900 ELECTROCARDIOLOGY		0.150842	9,062	1,881			4,609	1,563	5,546	836	$ 19,217	$ 4,280
35	7000 ELECTROENCEPHALOGRAPHY		0.310193	941								$ 941	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.273068	45,721	5,737			19,845	5,025	20,882	1,695	$ 86,448	$ 12,457
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.186718	893				1,261	215	2,668	117	$ 4,822	$ 332
38	7300 DRUGS CHARGED TO PATIENTS		0.145814	173,085	22,813			130,964	8,035	95,445	7,793	$ 399,494	$ 38,641
39	7400 RENAL DIALYSIS		0.418397	-								$ -	$ -
40	7600 ENDOSCOPY		0.280845	1,806						3,531		$ 5,337	$ -
41	7601 HEART CATH LAB		0.031007	9,679				2,602	18,573	2,602		$ 14,883	$ 18,573
42	9000 CLINIC		0.655474	344				273	7,730	56	374	$ 673	$ 8,104
43	9100 EMERGENCY		0.297703	28,852	64,660			15,353	16,650	8,199	16,787	$ 52,404	$ 98,097
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2018-07/31/2019) PHOEBE PUTNEY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
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106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2018-07/31/2019) PHOEBE PUTNEY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 472,873	$ 147,555	$ -	$ -	$ 259,176	$ 108,236	$ 274,286	$ 53,436		

Totals / Payments

		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	
128	**Total Charges (includes organ acquisition from Section K)**	$ 534,773	$ 147,555	$ -	$ -	$ 293,826	$ 108,236	$ 312,011	$ 53,436	$ 1,140,610	$ 309,227
129	Total Charges per PS&R or Exhibit Detail	$ 534,773	$ 147,555	$ -	$ -	$ 293,826	$ 108,236	$ 312,011	$ 53,436		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 146,936	$ 34,963	$ -	$ -	$ 84,761	$ 21,963	$ 89,254	$ 11,678	$ 320,951	$ 68,604
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 9,283	$ 446			$ 1,477	$ 165		$ 597	$ 10,760	$ 1,208
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)	$ 11,532	$ 667					$ 21,058	$ 2,494	$ 32,590	$ 3,161
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 20,815	$ 1,113	$ -	$ -						
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)					$ 82,115	$ 9,410			$ 82,115	$ 9,410
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 19,794	$ 1,449	$ 19,794	$ 1,449
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 126,121	$ 33,850	$ -	$ -	$ 1,169	$ 12,388	$ 48,402	$ 7,138	$ 175,692	$ 53,376
144	**Calculated Payments as a Percentage of Cost**	14%	3%	0%	0%	99%	44%	46%	39%	45%	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 (08/01/2018-07/31/2019) 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 Include 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 (08/01/2018-07/31/2019) 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 a 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 (08/01/2018-07/31/2019) 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)*		$ 6,460,363		
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)		$ 6,460,363	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		$ 6,460,363		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	644,493,536
19	Uninsured Hospital	**Charges Sec. G**	142,918,669
20	Total Hospital	**Charges Sec. G**	1,868,061,324
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		34.50%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.65%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*