

**A. General DSH Year Information**

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

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	08/01/2019	07/31/2020
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:**

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.)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #e6e6fa;"> <th style="text-align: center;">DSH Examination Year (07/01/19 - 06/30/20)</th> </tr> <tr> <td style="text-align: center;">Yes</td> </tr> </table>	DSH Examination Year (07/01/19 - 06/30/20)	Yes
DSH Examination Year (07/01/19 - 06/30/20)			
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?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">No</td> </tr> </table>	No	
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?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">No</td> </tr> </table>	No	
No			
3a. Was the hospital open as of December 22, 1987?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Yes</td> </tr> </table>	Yes	
Yes			
3b. What date did the hospital open?	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">8/1/1911</td> </tr> </table>	8/1/1911	
8/1/1911			

**C. Disclosure of Other Medicaid Payments Received:**

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** \$ 13,197,366  
 (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 07/01/2019 - 06/30/2020**    
 (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 Services 07/01/2019 - 06/30/2020** \$ 13,197,366

**Certification:**

1. Was your hospital allowed to retain 100% of the DSH payment It received for this DSH year?  
 Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments. Answer  
Yes

Explanation for "No" answers:

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

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

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

 _____ Hospital CEO or CFO Signature	CHIEF FINANCIAL & ADMINISTRATIVE OFFICER Title _____ 229-312-4068 Hospital CEO or CFO Telephone Number	10/25/2021 Date _____ BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail
BRIAN CHURCH Hospital CEO or CFO Printed Name		

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

<b>Hospital Contact:</b> 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	<b>Outside Preparer:</b> Name: _____ Title: _____ Firm Name: _____ Telephone Number: _____ E-Mail Address: _____
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**D. General Cost Report Year Information**

8/1/2019 - 7/31/2020

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:

PHOEBE PUTNEY MEMORIAL HOSPITAL

2. Select Cost Report Year Covered by this Survey (enter "X"):

8/1/2019 through 7/31/2020		
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:

1/15/2021

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
PHOEBE PUTNEY MEMORIAL HOSPITAL	Yes	
000001482A	No	PROVIDER NUMBER 000001482A & 000001416A
000001416A	No	1416A IS THE SECOND CAID NUMBER FOR PHOEBE . NOT SUBPROV
0	No	
110007	Yes	

5. Medicaid Provider Number:

000001482A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

000001416A

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110007

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

9. State Name & Number

State Name	Provider No.
FLORIDA	913855200
ALABAMA	PH0007N

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2019 - 07/31/2020)**

- Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)**
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**


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8. Out-of-State DSH Payments (See Note 2)

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- Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)
- Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
\$	1,416,285	\$ 1,030,350	\$2,446,635
\$	2,061,849	\$ 9,033,485	\$11,095,334
	\$3,478,134	\$10,063,835	\$13,541,969
	40.72%	10.24%	18.07%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

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.

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14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services

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15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services

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

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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 (08/01/2019 - 07/31/2020)**

**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) 109,500 (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	72,940
3. Outpatient Hospital Subsidies	147,967
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ 220,907
7. Inpatient Hospital Charity Care Charges	31,236,425
8. Outpatient Hospital Charity Care Charges	36,293,353
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 67,529,778

**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)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$138,371,477.00			\$ 97,538,146	\$ -	\$ -	\$ 40,833,331
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	\$627,510,352.00	\$993,838,536.00		\$ 442,332,464	\$ 700,557,444	\$ -	\$ 478,458,981
20. Outpatient Services		\$100,300,436.00			\$ 70,701,844	\$ -	\$ 29,598,592
21. Home Health Agency			\$4,173,268.00			\$ 2,941,739	
22. Ambulance			\$ 496,466			\$ 349,959	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$4,970,263.00			\$ 3,503,542	
26. Other	\$18,248,866.00	\$47,775,402.00	\$0.00	\$ 12,863,638	\$ 33,676,913	\$ -	\$ 19,483,718
27. Total	\$ 784,130,695	\$ 1,141,914,374	\$ 9,639,997	\$ 552,734,247	\$ 804,936,200	\$ 6,795,240	\$ 568,374,621
28. Total Hospital and Non Hospital		Total from Above	\$ 1,935,685,066		Total from Above	\$ 1,364,465,688	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	1,935,685,066		Total Contractual Adj. (G-3 Line 2)	1,360,688,469	
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)							
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						3,777,219	
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. Adjusted Contractual Adjustments						1,364,465,688	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (08/01/2019-07/31/2020) 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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.

**Routine Cost Centers (list below):**

1	03000 ADULTS & PEDIATRICS	\$ 92,633,756	\$ 1,317,089	\$ -	\$0.00	\$ 93,950,845	89,602	\$68,782,037.00	\$ 1,048.54
2	03100 INTENSIVE CARE UNIT	\$ 29,518,272	\$ 133,091	\$ -	\$ -	\$ 29,651,363	14,370	\$36,049,320.00	\$ 2,063.42
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ 11,988,304	\$ 119,264	\$ -	\$ -	\$ 12,107,568	8,583	\$21,238,824.00	\$ 1,410.65
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300 NURSERY	\$ 4,600,322	\$ -	\$ -	\$ -	\$ 4,600,322	8,382	\$7,031,879.00	\$ 548.83
11		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17		\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18	Total Routine	\$ 138,740,654	\$ 1,569,444	\$ -	\$ -	\$ 140,310,098	120,937	\$ 133,102,060	
19	Weighted Average								\$ 1,160.20

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
09200 Observation (Non-Distinct)	11,437	-	-	\$ 11,992,152	\$4,607,487.00	\$7,693,809.00	\$ 12,301,296	0.974869

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
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**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

5000 OPERATING ROOM	\$31,100,470.00	\$ 69,139	\$0.00	\$ 31,169,609	\$89,818,024.00	\$141,344,801.00	\$ 231,162,825	0.134838
5100 RECOVERY ROOM	\$9,644,405.00	\$ -	\$0.00	\$ 9,644,405	\$23,755,263.00	\$33,414,691.00	\$ 57,169,954	0.168697
5200 DELIVERY ROOM & LABOR ROOM	\$9,186,513.00	\$ 212,601	\$0.00	\$ 9,399,114	\$3,883,086.00	\$2,298,323.00	\$ 6,181,409	1.520546
5300 ANESTHESIOLOGY	\$303,933.00	\$ -	\$0.00	\$ 303,933	\$21,102,565.00	\$32,570,230.00	\$ 53,672,795	0.005663
5400 RADIOLOGY-DIAGNOSTIC	\$18,295,073.00	\$ 103,707	\$0.00	\$ 18,398,780	\$41,146,854.00	\$133,662,094.00	\$ 174,808,948	0.105251
5500 RADIOLOGY-THERAPEUTIC	\$21,428,242.00	\$ -	\$0.00	\$ 21,428,242	\$2,516,495.00	\$50,680,880.00	\$ 53,197,375	0.402806
6000 LABORATORY	\$20,931,854.00	\$ -	\$0.00	\$ 20,931,854	\$77,461,444.00	\$100,085,049.00	\$ 177,546,493	0.117895
6500 RESPIRATORY THERAPY	\$9,404,576.00	\$ -	\$0.00	\$ 9,404,576	\$25,242,143.00	\$5,461,833.00	\$ 30,703,976	0.306298
6600 PHYSICAL THERAPY	\$9,110,502.00	\$ -	\$0.00	\$ 9,110,502	\$10,769,122.00	\$5,452,741.00	\$ 16,221,863	0.561619
6700 OCCUPATIONAL THERAPY	\$2,088,774.00	\$ -	\$0.00	\$ 2,088,774	\$7,485,673.00	\$1,290,878.00	\$ 8,776,551	0.237995
6800 SPEECH PATHOLOGY	\$1,156,845.00	\$ -	\$0.00	\$ 1,156,845	\$3,561,583.00	\$1,320,354.00	\$ 4,881,937	0.236964

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (08/01/2019-07/31/2020) 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	\$3,248,740.00	\$ -	\$0.00	\$ 3,248,740	\$5,563,358.00	\$14,255,763.00	\$ 19,819,121	0.163919
33	7000 ELECTROENCEPHALOGRAPHY	\$1,801,633.00	\$ -	\$0.00	\$ 1,801,633	\$557,726.00	\$3,977,539.00	\$ 4,535,265	0.397250
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$36,698,112.00	\$ -	\$0.00	\$ 36,698,112	\$84,711,380.00	\$58,193,044.00	\$ 142,904,424	0.256802
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$18,142,060.00	\$ -	\$0.00	\$ 18,142,060	\$44,789,975.00	\$55,461,108.00	\$ 100,251,083	0.180966
36	7300 DRUGS CHARGED TO PATIENTS	\$67,612,136.00	\$ -	\$0.00	\$ 67,612,136	\$144,504,206.00	\$298,917,096.00	\$ 443,421,302	0.152478
37	7400 RENAL DIALYSIS	\$3,096,138.00	\$ -	\$0.00	\$ 3,096,138	\$5,723,100.00	\$977,251.00	\$ 6,700,351	0.462086
38	7600 ENDOSCOPY	\$6,129,328.00	\$ 93,337	\$0.00	\$ 6,222,665	\$2,295,483.00	\$17,441,073.00	\$ 19,736,556	0.315286
39	7601 HEART CATH LAB	\$4,515,701.00	\$ -	\$0.00	\$ 4,515,701	\$32,622,872.00	\$37,033,788.00	\$ 69,656,660	0.064828
40	9000 CLINIC	\$8,976,231.00	\$ -	\$0.00	\$ 8,976,231	\$1,629,199.00	\$16,733,999.00	\$ 18,363,198	0.488816
41	9100 EMERGENCY	\$24,052,203.00	\$ 292,110	\$3,702,592.00	\$ 28,046,905	\$13,194,129.00	\$68,743,109.00	\$ 81,937,238	0.342297
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	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (08/01/2019-07/31/2020) 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
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	<b>Total Ancillary</b>	\$ 306,923,469	\$ 770,894	\$ 3,702,592	\$ 311,396,955	\$ 646,941,167	\$ 1,087,009,453	\$ 1,733,950,620	
127	<b>Weighted Average</b>								0.186504
128	<b>Sub Totals</b>	\$ 445,664,123	\$ 2,340,338	\$ 3,702,592	\$ 451,707,053	\$ 780,043,227	\$ 1,087,009,453	\$ 1,867,052,680	
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	<b>Grand Total</b>				\$ 451,707,053				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.52%			

\* 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 (08/01/2019-07/31/2020) 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		% Survey								
63																							
64																							
65																							
66																							
67																							
68																							
69																							
70																							
71																							
72																							
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120																							
121																							
122																							
123																							
124																							
125																							
126																							
127																							
			\$	97,251,795	\$	61,999,484	\$	55,327,123	\$	64,582,111	\$	51,989,049	\$	54,433,636	\$	114,998,604	\$	78,507,303	\$	54,232,087	\$	72,061,043	

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

Cost Report Year (08/01/2019-07/31/2020) 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		% Survey
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 116,866,204	\$ 61,999,484	\$ 81,240,603	\$ 64,582,111	\$ 60,176,414	\$ 54,433,636	\$ 137,773,659	\$ 78,507,303	\$ 61,666,362	\$ 72,061,043	\$ 396,056,880	\$ 259,522,534	42.35%
129 Total Charges per PS&R or Exhibit Detail	\$ 116,866,204	\$ 61,999,484	\$ 81,240,603	\$ 64,582,111	\$ 60,176,414	\$ 54,433,636	\$ 137,773,659	\$ 78,507,303	(Agrees to Exhibit A)	(Agrees to Exhibit A)			
130 Unreconciled Charges (Explain Variance)													
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 37,690,425	\$ 11,812,314	\$ 33,790,905	\$ 12,960,706	\$ 18,459,929	\$ 9,830,637	\$ 44,296,964	\$ 15,040,260	\$ 17,253,600	\$ 14,422,727	\$ 134,238,223	\$ 49,643,917	47.83%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 24,935,275	\$ 10,031,118		\$ 653	\$ 159,136	\$ 1,011,993	\$ 8,996,278	\$ 2,742,917			\$ 34,090,689	\$ 13,786,681	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 24,056,674	\$ 10,742,975			\$ 212,873	\$ 125,689			\$ 24,269,547	\$ 10,868,664	
134 Private Insurance (including primary and third party liability)			\$ 294	\$ 19,019	\$ 1,359	\$ 294	\$ 10,509,521	\$ 4,534,194			\$ 10,511,174	\$ 4,553,507	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 287,611	\$ 24,563	\$ 128	\$ 4,585	\$ 87	\$ 5,420	\$ 13,206	\$ 14,859			\$ 301,032	\$ 49,427	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 25,222,896	\$ 10,055,681	\$ 24,057,096	\$ 10,767,232									
137 Medicaid Cost Settlement Payments (See Note B)		\$ 133,805										\$ 133,805	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 18,729,251	\$ 7,578,670	\$ 1,257,057	\$ 158,314			\$ 19,986,308	\$ 7,736,984	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 17,450,155	\$ 7,137,847			\$ 17,450,155	\$ 7,137,847	
141 Medicare Cross-Over Bad Debt Payments					\$ 687,993	\$ 578,140					\$ 687,993	\$ 578,140	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 547,753	\$ 123,525					\$ 547,753	\$ 123,525	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 1,416,285	\$ 1,030,350			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 12,467,539	\$ 1,622,828	\$ 9,733,809	\$ 2,193,474	\$ (1,665,650)	\$ 532,595	\$ 5,857,874	\$ 326,440	\$ 15,837,315	\$ 13,392,377	\$ 26,393,572	\$ 4,675,337	
146 <b>Calculated Payments as a Percentage of Cost</b>	67%	86%	71%	83%	109%	95%	87%	98%	8%	7%	80%	91%	
147 <b>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 &amp; 6)</b>					39,501								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					18%								

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.



**I. Out-of-State Medicaid Data:**

Cost Report Year (08/01/2019-07/31/2020) 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	
51													
52													
53													
54													
55													
56													
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59													
60													
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112													
113													

**I. Out-of-State Medicaid Data:**

Cost Report Year (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 595,649	\$ 102,778	\$ -	\$ -	\$ -	\$ 34,830	\$ 387,503	\$ 110,027	\$ -	\$ -

<b>Totals / Payments</b>											
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ 705,644	\$ 102,778	\$ -	\$ -	\$ -	\$ 34,830	\$ 507,028	\$ 110,027	\$ 1,212,672	\$ 247,635
129	Total Charges per PS&R or Exhibit Detail	\$ 705,644	\$ 102,778	\$ -	\$ -	\$ -	\$ 34,830	\$ 507,028	\$ 110,027		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ 241,562	\$ 27,648	\$ -	\$ -	\$ -	\$ 7,116	\$ 175,248	\$ 21,173	\$ 416,810	\$ 55,937
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,217	\$ 6,730				\$ 24	\$ 5,206	\$ 209	\$ 11,423	\$ 6,963
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)	\$ 10,244	\$ 82					\$ 196,363	\$ 1,040	\$ 206,607	\$ 1,122
135	Self-Pay (including Co-Pay and Spend-Down)						\$ 352	\$ -	\$ 106	\$ -	\$ 458
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 16,461	\$ 6,812	\$ -	\$ -						
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)						\$ 2,904	\$ 29,874	\$ 6,891	\$ 29,874	\$ 9,795
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 35,045	\$ 5,172	\$ 35,045	\$ 5,172
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 225,101	\$ 20,836	\$ -	\$ -	\$ -	\$ 3,836	\$ (91,240)	\$ 7,755	\$ 133,861	\$ 32,427
144	<b>Calculated Payments as a Percentage of Cost</b>	7%	25%	0%	0%	0%	46%	152%	63%	68%	42%

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 (08/01/2019-07/31/2020)

PHOEBE PUTNEY MEMORIAL HOSPITAL

	Total 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-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
	Organ Acquisition Cost	Additional Intern/Resident Cost	Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over &amp; uninsured). See Note C below.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>
<b>Organ Acquisition Cost Centers (list below):</b>															
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	<b>Totals</b>	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	<b>Total Cost</b>														

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 (08/01/2019-07/31/2020)

PHOEBE PUTNEY MEMORIAL HOSPITAL

	Total 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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
	Organ Acquisition Cost	Additional Intern/Resident Cost	Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over &amp; uninsured). See Note C below.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>
<b>Organ Acquisition Cost Centers (list below):</b>													
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	<b>Totals</b>	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	<b>Total Cost</b>												

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 (08/01/2019-07/31/2020) 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)*		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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	\$ -	

### DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>	
18 Medicaid Hospital Charges Sec. G	657,039,721
19 Uninsured Hospital Charges Sec. G	133,727,405
20 Total Hospital Charges Sec. G	1,867,052,680
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	35.19%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.16%
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.