

**A. General DSH Year Information**

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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

**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	08/01/2020	07/31/2021
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:	00000019A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110044

**B. DSH 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.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
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?

DSH Examination Year (07/01/20 - 06/30/21)

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

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

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** \$ 1,902,184  
 (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 07/01/2020 - 06/30/2021** \$ -  
 (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 07/01/2020 - 06/30/2021** \$ 1,902,184

**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.

<u>Caryle Walton</u> Hospital CEO or CFO Signature	<u>CEO</u> Title	<u></u> Date
<u>CARLYLE WALTON</u> Hospital CEO or CFO Printed Name	<u>(229) 931-1280</u> Hospital CEO or CFO Telephone Number	<u>CWALTON@PHOEBEHEALTH.COM</u> Hospital CEO or CFO E-Mail

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

<p><b>Hospital Contact:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20%;">Name</td><td style="border: 1px solid black;">REBECCA KENDALL</td></tr> <tr><td>Title</td><td style="border: 1px solid black;">DIRECTOR OF REIMBURSEMENT</td></tr> <tr><td>Telephone Number</td><td style="border: 1px solid black;">(229) 312-6721</td></tr> <tr><td>E-Mail Address</td><td style="border: 1px solid black;">RKENDALL@PHOEBEHEALTH.COM</td></tr> <tr><td>Mailing Street Address</td><td style="border: 1px solid black;">810 13TH AVE STE 105</td></tr> <tr><td>Mailing City, State, Zip</td><td style="border: 1px solid black;">ALBANY, GA 31701</td></tr> </table>	Name	REBECCA KENDALL	Title	DIRECTOR OF REIMBURSEMENT	Telephone Number	(229) 312-6721	E-Mail Address	RKENDALL@PHOEBEHEALTH.COM	Mailing Street Address	810 13TH AVE STE 105	Mailing City, State, Zip	ALBANY, GA 31701	<p><b>Outside Preparer:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20%;">Name</td><td style="border: 1px solid black;"></td></tr> <tr><td>Title</td><td style="border: 1px solid black;"></td></tr> <tr><td>Firm Name</td><td style="border: 1px solid black;"></td></tr> <tr><td>Telephone Number</td><td style="border: 1px solid black;"></td></tr> <tr><td>E-Mail Address</td><td style="border: 1px solid black;"></td></tr> </table>	Name		Title		Firm Name		Telephone Number		E-Mail Address	
Name	REBECCA KENDALL																						
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E-Mail Address																							

**D. General Cost Report Year Information** **8/1/2020 - 7/31/2021**

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:

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

8/1/2020 through 7/31/2021		
X		

3. Status of Cost Report Used for this Survey (Should be audited if available):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	PHOEBE SUMTER MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000019A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110044	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

State Name	Provider No.
COLORADO	9000169560
IOWA	0131893
MICHIGAN	1609001312
TENNESSEE	0110044

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2020 - 07/31/2021)**

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)	\$ 202,562	\$ 453,795	\$656,357
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 396,744	\$ 2,229,430	\$2,626,174
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)	\$599,306	\$2,683,225	\$3,282,531
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	33.80%	16.91%	20.00%

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.*

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)

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 (08/01/2020 - 07/31/2021)**

**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) 13,483 (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	47,228
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 47,228
7. Inpatient Hospital Charity Care Charges	3,677,302
8. Outpatient Hospital Charity Care Charges	11,386,463
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 15,063,765

**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	\$20,539,213.00			\$ 14,984,273	\$ -	\$ -	\$ 5,554,940
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	\$69,631,071.00	\$194,067,240.00		\$ 50,798,975	\$ 141,580,716	\$ -	\$ 71,318,620
20. Outpatient Services		\$34,925,086.00			\$ 25,479,409	\$ -	\$ 9,445,677
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$1,223,608.00			\$ 892,677	
26. Other	\$0.00	\$0.00	\$592,822.00	\$ -	\$ -	\$ 432,490	\$ -
27. Total	\$ 90,170,284	\$ 228,992,326	\$ 1,816,430	\$ 65,783,248	\$ 167,060,125	\$ 1,325,167	\$ 86,319,237
28. Total Hospital and Non Hospital		Total from Above	\$ 320,979,040		Total from Above	\$ 234,168,540	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	320,979,040		Total Contractual Adj. (G-3 Line 2)	232,709,042	
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)						1,459,498	
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)							
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						234,168,540	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<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	\$ 17,209,671	\$ -	\$ -	\$ 0.00	\$ 17,209,671	12,013	\$8,374,294.00	\$ 1,432.59
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ 3,707,212	\$ -	\$ -	\$ -	\$ 3,707,212	1,850	\$3,866,707.00	\$ 2,003.90
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 1,414,672	\$ -	\$ -	\$ -	\$ 1,414,672	733	\$573,553.00	\$ 1,929.98
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 22,331,555	\$ -	\$ -	\$ -	\$ 22,331,555	14,596	\$ 12,814,554	
19		Weighted Average								\$ 1,529.98

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)	1,113	-	\$ 1,594,473	\$433,307.00	\$1,104,441.00	\$ 1,537,748	1.036888

Cost Center Description	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	Total Cost	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
	<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>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>

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

21	5000	OPERATING ROOM	\$7,162,572.00	\$ -	\$ -	\$ 7,162,572	\$9,021,558.00	\$20,748,102.00	\$ 29,769,660	0.240600
22	5100	RECOVERY ROOM	\$1,142,186.00	\$ -	\$ -	\$ 1,142,186	\$2,383,590.00	\$9,419,388.00	\$ 11,802,978	0.096771
23	5200	DELIVERY ROOM & LABOR ROOM	\$654,316.00	\$ -	\$ -	\$ 654,316	\$259,777.00	\$1,203,907.00	\$ 1,463,684	0.447034
24	5300	ANESTHESIOLOGY	\$183,245.00	\$ -	\$ -	\$ 183,245	\$3,058,257.00	\$6,368,952.00	\$ 9,427,209	0.019438
25	5400	RADIOLOGY-DIAGNOSTIC	\$6,279,504.00	\$ -	\$ -	\$ 6,279,504	\$13,513,995.00	\$29,784,154.00	\$ 43,298,149	0.145029
26	6000	LABORATORY	\$5,982,883.00	\$ -	\$ -	\$ 5,982,883	\$10,452,437.00	\$21,946,732.00	\$ 32,399,169	0.184662
27	6500	RESPIRATORY THERAPY	\$2,770,179.00	\$ -	\$ -	\$ 2,770,179	\$2,374,954.00	\$663,645.00	\$ 3,038,599	0.911663
28	6600	PHYSICAL THERAPY	\$2,440,971.00	\$ -	\$ -	\$ 2,440,971	\$2,344,649.00	\$3,126,415.00	\$ 5,471,064	0.446160
29	6900	ELECTROCARDIOLOGY	\$278,584.00	\$ -	\$ -	\$ 278,584	\$1,711,061.00	\$6,554,933.00	\$ 8,265,994	0.033702
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$3,806,680.00	\$ -	\$ -	\$ 3,806,680	\$11,049,999.00	\$9,908,382.00	\$ 20,958,381	0.181630

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	7200 IMPL. DEV. CHARGED TO PATIENTS	\$2,309,480.00	\$ -	\$ -	\$ 2,309,480	\$5,020,190.00	\$5,958,474.00	\$ 10,978,664	0.210361
32	7300 DRUGS CHARGED TO PATIENTS	\$11,402,812.00	\$ -	\$ -	\$ 11,402,812	\$21,665,974.00	\$72,314,864.00	\$ 93,980,838	0.121331
33	7400 RENAL DIALYSIS	\$325,586.00	\$ -	\$ -	\$ 325,586	\$1,042,986.00	\$15,747.00	\$ 1,058,733	0.307524
34	9000 CLINIC	\$580,895.00	\$ -	\$ -	\$ 580,895	\$23,756.00	\$738,123.00	\$ 761,879	0.762450
35	9100 EMERGENCY	\$7,679,052.00	\$ -	\$ 1,427,738	\$ 9,106,790	\$2,550,490.00	\$17,541,677.00	\$ 20,092,167	0.453251
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	<b>Total Ancillary</b>	\$ 52,998,945	\$ -	\$ 1,427,738	\$ 54,426,683	\$ 86,906,980	\$ 207,397,936	\$ 294,304,916	
127	<b>Weighted Average</b>								0.190351
128	<b>Sub Totals</b>	\$ 75,330,500	\$ -	\$ 1,427,738	\$ 76,758,238	\$ 99,721,534	\$ 207,397,936	\$ 307,119,470	
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>				\$ 76,758,238				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>					
1	03000 ADULTS & PEDIATRICS	\$ 1,432.59		1,447	858	813	2,369	675	5,487							56.71%	
2	03100 INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-								
3	03200 CORONARY CARE UNIT	\$ 2,003.90		326	28	138	464	92	956							56.65%	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-								
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-								
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-	-	-	-	-	-								
7	04000 SUBPROVIDER I	\$ -		-	-	-	-	-	-								
8	04100 SUBPROVIDER II	\$ -		-	-	-	-	-	-								
9	04200 OTHER SUBPROVIDER	\$ -		-	-	-	-	-	-								
10	04300 NURSERY	\$ 1,929.98		43	515	-	113	14	671							93.45%	
11		\$ -		-	-	-	-	-	-								
12		\$ -		-	-	-	-	-	-								
13		\$ -		-	-	-	-	-	-								
14		\$ -		-	-	-	-	-	-								
15		\$ -		-	-	-	-	-	-								
16		\$ -		-	-	-	-	-	-								
17		\$ -		-	-	-	-	-	-								
				<b>Total Days</b>	<b>1,816</b>	<b>1,401</b>	<b>951</b>	<b>2,946</b>	<b>781</b>	<b>7,114</b>						54.22%	
19	Total Days per PS&R or Exhibit Detail				<u>1,816</u>	<u>1,401</u>	<u>951</u>	<u>2,946</u>	<u>781</u>								
20	Unreconciled Days (Explain Variance)				-	-	-	-	-								
<b>Routine Charges</b>					<b>\$ 1,905,145</b>	<b>\$ 1,088,405</b>	<b>\$ 857,497</b>	<b>\$ 2,978,060</b>	<b>\$ 709,524</b>	<b>\$ 6,829,107</b>						58.98%	
21	Calculated Routine Charge Per Diem					\$ 776.88	\$ 901.68	\$ 1,010.88	\$ 908.48	\$ 959.95							
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>					<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>		
22	09200 Observation (Non-Distinct)		1.036888	184,297	87,142	143,799	119,331	26,160	105,553	73,803	125,420	32,549	111,458	\$ 428,059	\$ 437,446	65.65%	
23	5000 OPERATING ROOM		0.240600	1,058,136	1,064,460	1,826,068	2,319,086	252,536	687,001	1,697,481	1,996,765	384,421	1,026,031	\$ 4,834,221	\$ 6,067,312	41.37%	
24	5100 RECOVERY ROOM		0.096771	290,202	523,886	533,306	1,140,311	78,467	295,523	456,399	836,929	122,584	454,694	\$ 1,358,374	\$ 2,796,649	40.09%	
25	5200 DELIVERY ROOM & LABOR ROOM		0.447034	141,230	11,214	801,173	191,841	4,809	1,869	234,714	26,762	32,558	8,722	\$ 1,181,926	\$ 231,686	99.44%	
26	5300 ANESTHESIOLOGY		0.019438	352,118	359,280	572,411	789,615	84,847	190,652	549,992	582,779	128,770	375,440	\$ 1,559,368	\$ 1,922,326	42.89%	
27	5400 RADIOLOGY-DIAGNOSTIC		0.145029	1,110,124	2,233,565	349,620	2,919,270	576,981	1,438,556	1,788,470	3,421,151	898,060	4,410,940	\$ 3,825,195	\$ 10,012,542	43.85%	
28	6000 LABORATORY		0.184662	1,987,500	1,480,521	1,214,107	1,911,704	1,067,144	880,821	2,981,638	1,871,186	819,022	2,124,766	\$ 7,250,389	\$ 6,144,232	50.66%	
29	6500 RESPIRATORY THERAPY		0.911663	697,215	180,848	49,486	21,530	220,591	16,976	623,686	47,250	64,204	43,910	\$ 1,590,978	\$ 266,604	64.86%	
30	6600 PHYSICAL THERAPY		0.446160	341,795	210,625	172,962	181,739	144,238	161,038	581,645	335,526	66,585	178,845	\$ 1,240,640	\$ 888,928	43.66%	
31	6900 ELECTROCARDIOLOGY		0.033702	57,474	175,017	36,292	269,333	129,855	261,934	435,802	707,694	175,392	420,863	\$ 659,423	\$ 1,413,978	32.32%	
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.181630	1,417,177	759,023	1,130,380	1,166,904	596,088	413,419	2,428,174	1,000,113	350,210	850,704	\$ 5,571,819	\$ 3,339,459	48.33%	
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.210361	686,314	416,898	198,321	617,118	128,759	199,663	905,820	780,274	29,130	414,998	\$ 1,919,214	\$ 2,013,953	39.88%	
34	7300 DRUGS CHARGED TO PATIENTS		0.121331	3,413,120	6,015,230	2,275,384	4,419,112	1,471,993	2,653,887	5,164,490	7,038,501	1,374,873	3,427,079	\$ 12,324,987	\$ 20,126,730	38.24%	
35	7400 RENAL DIALYSIS		0.307524	-	-	45,454	-	203,447	-	255,145	-	9,602	-	\$ 504,046	\$ -	-	
36	9000 CLINIC		0.762450	320	43,327	890	42,579	-	21,311	240	72,193	182	2,831	\$ 1,450	\$ 179,410	24.13%	
37	9100 EMERGENCY		0.453251	499,741	916,804	140,259	2,093,094	341,248	863,714	769,803	1,635,132	348,601	3,231,206	\$ 1,751,051	\$ 5,508,744	54.18%	
38			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
39			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
40			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
41			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
42			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
43			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
44			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
45			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
46			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
47			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
48			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
49			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
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51			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
52			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
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54			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
55			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
56			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
57			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
58			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
59			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
60			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	



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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

			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		%	
61																
62																
63																
64																
65																
66																
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123																
124																
125																
126																
127																
			\$ 12,236,763	\$ 14,477,840	\$ 9,489,912	\$ 18,202,567	\$ 5,327,163	\$ 8,191,917	\$ 18,947,302	\$ 20,477,675	\$ 4,636,743	\$ 17,082,487				

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

	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		Total In-State Medicaid		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 14,141,908	\$ 14,477,840	\$ 10,578,317	\$ 18,202,567	\$ 6,184,660	\$ 8,191,917	\$ 21,925,362	\$ 20,477,675	\$ 5,346,267	\$ 17,082,487	\$ 52,830,247	\$ 61,349,999	44.55%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 14,141,908	\$ 14,477,840	\$ 10,578,317	\$ 18,202,567	\$ 6,184,660	\$ 8,191,917	\$ 21,925,362	\$ 20,477,675	\$ 5,346,267	\$ 17,082,487			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 5,713,682	\$ 2,675,202	\$ 4,288,298	\$ 3,638,449	\$ 2,622,273	\$ 1,622,135	\$ 8,524,937	\$ 3,769,025	\$ 2,077,817	\$ 3,708,046	\$ 21,149,190	\$ 11,704,811	50.44%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,097,676	\$ 2,405,210	\$ -	\$ 105	\$ 102,550	\$ 159,966	\$ 1,301,401	\$ 563,047			\$ 4,501,627	\$ 3,128,328	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 3,092,502	\$ 2,981,155	\$ -	\$ -	\$ 53,830	\$ 35,744			\$ 3,146,332	\$ 3,016,899	
134 Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ 29	\$ 139	\$ 643,248	\$ 1,188,794			\$ 643,277	\$ 1,188,933	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 39,290	\$ 750	\$ 13	\$ 1,719	\$ 56	\$ 401	\$ 1,347	\$ 2,759			\$ 40,706	\$ 5,629	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,136,966	\$ 2,405,960	\$ 3,092,515	\$ 2,982,979									
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ 187,584										\$ 187,584	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -										\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,547,064	\$ 1,013,662	\$ 113,810	\$ 86,784			\$ 1,660,874	\$ 1,100,446	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ 77	\$ 3,161,102	\$ 2,021,554			\$ 3,161,102	\$ 2,021,631	
141 Medicare Cross-Over Bad Debt Payments					\$ 90,217	\$ 48,079					\$ 90,217	\$ 48,079	
142 Other Medicare Cross-Over Payments (See Note D)					\$ (39,187)						\$ (39,187)	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 202,562	\$ 453,795			
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>	\$ 2,576,716	\$ 81,658	\$ 1,195,783	\$ 655,470	\$ 921,544	\$ 399,811	\$ 3,250,199	\$ (129,657)	\$ 1,875,255	\$ 3,254,251	\$ 7,944,242	\$ 1,007,282	
146 <b>Calculated Payments as a Percentage of Cost</b>	55%	97%	72%	82%	65%	75%	62%	103%	10%	12%	62%	91%	
147 <b>Total Medicare Days from WS S-3 of the Cost Report Excluding Swing-Bed (C/R, WS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 &amp; 6)</b>					6,891								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					14%								

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 (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days
1	03000 ADULTS & PEDIATRICS	\$ 1,432.59		-		19		-		-		19	
2	03100 INTENSIVE CARE UNIT	\$ -											
3	03200 CORONARY CARE UNIT	\$ 2,003.90											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ 1,929.98											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
				Total Days				19				19	
19	Total Days per PS&R or Exhibit Detail							19					
20	Unreconciled Days (Explain Variance)												
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21				\$ -		\$ -		\$ 19,997		\$ -		\$ 19,997	
21.01				Calculated Routine Charge Per Diem		\$ -		\$ 1,052.47		\$ -		\$ 1,052.47	
				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)	1.036888		-									
23	5000 OPERATING ROOM	0.240600		-				4,202				4,202	
24	5100 RECOVERY ROOM	0.096771		-									
25	5200 DELIVERY ROOM & LABOR ROOM	0.447034		-	623								623
26	5300 ANESTHESIOLOGY	0.019438		-									
27	5400 RADIOLOGY-DIAGNOSTIC	0.145029		-	26,185			5,417	57		7,553	5,417	33,795
28	6000 LABORATORY	0.184662		-	20,608			13,453	1,015		5,925	13,453	27,548
29	6500 RESPIRATORY THERAPY	0.911663		-	348			4,786				4,786	348
30	6600 PHYSICAL THERAPY	0.446160		-				1,948			709	1,948	709
31	6900 ELECTROCARDIOLOGY	0.033702		-	1,130			226			678	226	1,808
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.181630		-	2,821			12,945	583		1,083	12,945	4,487
33	7200 IMPL. DEV. CHARGED TO PATIENTS	0.210361		-				618				618	
34	7300 DRUGS CHARGED TO PATIENTS	0.121331		-	8,220			34,149	771		3,058	34,149	12,049
35	7400 RENAL DIALYSIS	0.307524		-				425				425	
36	9000 CLINIC	0.762450		-									
37	9100 EMERGENCY	0.453251		-	30,685			6,175	2,966		5,758	6,175	39,409
38													
39													
40													
41													
42													
43													
44													
45													
46													
47													
48													



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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid		
112										\$ -	\$ -	
113										\$ -	\$ -	
114										\$ -	\$ -	
115										\$ -	\$ -	
116										\$ -	\$ -	
117										\$ -	\$ -	
118										\$ -	\$ -	
119										\$ -	\$ -	
120										\$ -	\$ -	
121										\$ -	\$ -	
122										\$ -	\$ -	
123										\$ -	\$ -	
124										\$ -	\$ -	
125										\$ -	\$ -	
126										\$ -	\$ -	
127										\$ -	\$ -	
		\$ -	\$ 90,620	\$ -	\$ -	\$ 84,344	\$ 5,392	\$ -	\$ 24,764	\$ -	\$ -	
<b>Totals / Payments</b>												
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ -	\$ 90,620	\$ -	\$ -	\$ 104,341	\$ 5,392	\$ -	\$ 24,764	\$ 104,341	\$ 120,776	
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 90,620	\$ -	\$ -	\$ 104,341	\$ 5,392	\$ -	\$ 24,764			
130	Unreconciled Charges (Explain Variance)											
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ -	\$ 23,655	\$ -	\$ -	\$ 46,294	\$ 1,739	\$ -	\$ 5,706	\$ 46,294	\$ 31,100	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 3,056			\$ -	\$ 198	\$ -	\$ -	\$ -	\$ 3,254	
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)		\$ 153			\$ -	\$ -	\$ -	\$ 898	\$ -	\$ 1,051	
135	Self-Pay (including Co-Pay and Spend-Down)					\$ 396	\$ -			\$ 396	\$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 3,209	\$ -	\$ -							
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)					\$ 80,898	\$ 578			\$ 80,898	\$ 578	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 151	\$ -	\$ 151	
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>	\$ -	\$ 20,446	\$ -	\$ -	\$ (35,000)	\$ 963	\$ -	\$ 4,657	\$ (35,000)	\$ 26,066	
144	<b>Calculated Payments as a Percentage of Cost</b>		0%	14%	0%	0%	176%	45%	0%	18%	176%	16%

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 (08/01/2020-07/31/2021)

PHOEBE SUMTER MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						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
<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>	\$ -	\$ -	\$ -	\$ -	0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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 (08/01/2020-07/31/2021)

PHOEBE SUMTER MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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)
						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)
<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>	\$ -	\$ -	\$ -	\$ -	0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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 (08/01/2020-07/31/2021) PHOEBE SUMTER MEDICAL CENTER

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 945,102	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	02.700000.690057 & 02.700000.690055 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 945,102	5.00 (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	\$ 945,102	

**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	114,405,363
19 Uninsured Hospital Charges Sec. G	22,428,754
20 Total Hospital Charges Sec. G	307,119,470
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	37.25%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.30%
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.