

**D. General Cost Report Year Information** 8/1/2021 - 7/31/2022

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"):  

8/1/2021 through 7/31/2022
X

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- 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	No	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	No	
8. Medicare Provider Number:	110044	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

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

	State Name	Provider No.
9. State Name & Number	COLORADO	9000169560
10. State Name & Number	IOWA	0131893
11. State Name & Number	MICHIGAN	1609001312
12. State Name & Number	TENNESSEE	0110044
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: (08/01/2021 - 07/31/2022)**

- 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)	\$ 51,959	\$ 407,831	\$459,790
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 419,995	\$ 3,508,305	\$3,928,300
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)	\$471,954	\$3,916,136	\$4,388,090
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.01%	10.41%	10.48%

- 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  **<-These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.**
- 15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services
- 16. Total Medicaid managed care non-claims payments (see question 13 above) received

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

**F. MIUR / LIUR Qualifying Data from the Cost Report (08/01/2021 - 07/31/2022)**

**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) 16,330 (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	50,810
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 50,810
7. Inpatient Hospital Charity Care Charges	4,948,848
8. Outpatient Hospital Charity Care Charges	12,065,515
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 17,014,363

**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	\$30,050,564.00			\$ 21,781,809	\$ -	\$ -	\$ 8,268,755
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	\$77,785,426.00	\$191,752,343.00		\$ 56,381,880	\$ 138,989,502	\$ -	\$ 74,166,388
20. Outpatient Services		\$39,209,808.00			\$ 28,420,783	\$ -	\$ 10,789,025
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$1,087,872.00			\$ 788,532	
26. Other	\$0.00	\$76,214.00	\$491,263.00	\$ -	\$ 55,243	\$ 356,086	\$ 20,971
27. Total	\$ 107,835,990	\$ 231,038,365	\$ 1,579,135	\$ 78,163,689	\$ 167,465,527	\$ 1,144,618	\$ 93,245,139
28. Total Hospital and Non Hospital		Total from Above	\$ 340,453,490		Total from Above	\$ 246,773,834	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	340,453,490		Total Contractual Adj. (G-3 Line 2)	243,567,780	
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)						3,206,054	
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. Adjusted Contractual Adjustments						246,773,834	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

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

Cost Report Year (08/01/2021-07/31/2022) 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	\$ 21,205,844	\$ -	\$ -	\$0.00	\$ 21,205,844	14,914	\$15,848,793.00	\$ 1,421.88
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ 4,723,140	\$ -	\$ -		\$ 4,723,140	1,989	\$6,629,082.00	\$ 2,374.63
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	\$ 1,296,239	\$ -	\$ -		\$ 1,296,239	742	\$652,589.00	\$ 1,746.95
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 27,225,223	\$ -	\$ -	\$ -	\$ 27,225,223	17,645	\$ 23,130,464	
19		Weighted Average								\$ 1,542.95

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)	1,315	-	\$ 1,869,772	\$529,548.00	\$ 1,616,200.00	\$ 2,145,748	0.871385

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):**

21	5000	OPERATING ROOM	\$8,467,772.00	\$ -	\$ -	\$ 8,467,772	\$12,265,695.00	\$23,946,949.00	\$ 36,212,644	0.233835
22	5100	RECOVERY ROOM	\$1,044,222.00	\$ -	\$ -	\$ 1,044,222	\$1,980,570.00	\$8,118,479.00	\$ 10,099,049	0.103398
23	5200	DELIVERY ROOM & LABOR ROOM	\$927,661.00	\$ -	\$ -	\$ 927,661	\$376,846.00	\$1,303,059.00	\$ 1,679,905	0.552210
24	5300	ANESTHESIOLOGY	\$173,185.00	\$ -	\$ -	\$ 173,185	\$2,936,041.00	\$6,762,010.00	\$ 9,698,051	0.017858
25	5400	RADIOLOGY-DIAGNOSTIC	\$6,329,097.00	\$ -	\$ -	\$ 6,329,097	\$4,595,088.00	\$38,885,834.00	\$ 43,480,922	0.145560
26	6000	LABORATORY	\$6,252,590.00	\$ -	\$ 139,879	\$ 6,392,469	\$13,662,695.00	\$24,545,020.00	\$ 38,207,715	0.167308
27	6500	RESPIRATORY THERAPY	\$4,503,985.00	\$ -	\$ -	\$ 4,503,985	\$4,182,123.00	\$963,754.00	\$ 5,145,877	0.875261
28	6600	PHYSICAL THERAPY	\$2,323,350.00	\$ -	\$ -	\$ 2,323,350	\$3,207,299.00	\$2,923,579.00	\$ 6,130,878	0.378959
29	6900	ELECTROCARDIOLOGY	\$335,842.00	\$ -	\$ -	\$ 335,842	\$2,394,188.00	\$6,259,575.00	\$ 8,653,763	0.038809

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

Cost Report Year (08/01/2021-07/31/2022) 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
30	7200 IMPL. DEV. CHARGED TO PATIENTS	\$2,200,146.00	\$ -	\$ -	\$ 2,200,146	\$3,849,944.00	\$5,805,612.00	\$ 9,655,556	0.227863
31	7300 DRUGS CHARGED TO PATIENTS	\$12,694,949.00	\$ -	\$ -	\$ 12,694,949	\$28,043,155.00	\$72,998,701.00	\$ 101,041,856	0.125640
32	7400 RENAL DIALYSIS	\$359,777.00	\$ -	\$ -	\$ 359,777	\$1,888,311.00	\$21,270.00	\$ 1,909,581	0.188406
33	9000 CLINIC	\$516,333.00	\$ -	\$ -	\$ 516,333	\$2,409.00	\$498,543.00	\$ 500,952	1.030704
34	9100 EMERGENCY	\$8,810,425.00	\$ -	\$ 1,362,839	\$ 10,173,264	\$4,027,041.00	\$22,508,922.00	\$ 26,535,963	0.383376
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-

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

Cost Report Year (08/01/2021-07/31/2022) 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
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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>	\$ 54,939,334	\$ -	\$ 1,502,718	\$ 56,442,052	\$ 83,940,953	\$ 217,157,507	\$ 301,098,460	
127	<b>Weighted Average</b>								0.193663
128	<b>Sub Totals</b>	\$ 82,164,557	\$ -	\$ 1,502,718	\$ 83,667,275	\$ 107,071,417	\$ 217,157,507	\$ 324,228,924	
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>				\$ 83,667,275				
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 (08/01/2021-07/31/2022) 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-Over (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>		<b>Days</b>			
1	03000 ADULTS & PEDIATRICS	\$ 1,421.88		1,699		817		988		2,571		804		6,075		50.60%	
2	03100 INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-			
3	03200 CORONARY CARE UNIT	\$ 2,374.63		311		36		162		355		136		864		50.28%	
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	\$ 1,746.95		98		494		-		126		7		718		97.71%	
11		\$ -		-		-		-		-		-		-			
12		\$ -		-		-		-		-		-		-			
13		\$ -		-		-		-		-		-		-			
14		\$ -		-		-		-		-		-		-			
15		\$ -		-		-		-		-		-		-			
16		\$ -		-		-		-		-		-		-			
17		\$ -		-		-		-		-		-		-			
18		\$ -		-		-		-		-		-		-			
19																	
20	Total Days per PS&R or Exhibit Detail			2,108		1,347		1,150		3,052		947		7,657		48.77%	
21	Unreconciled Days (Explain Variance)			-		-		-		-		-		-			
21.01	Routine Charges			\$ 3,173,605		\$ 1,408,166		\$ 1,683,080		\$ 4,266,235		\$ 1,195,691		\$ 10,531,086		50.71%	
	Calculated Routine Charge Per Diem			\$ 1,505.51		\$ 1,045.41		\$ 1,463.55		\$ 1,397.85		\$ 1,262.61		\$ 1,375.35			
22	<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>		
23	09200 Observation (Non-Distinct)		0.871385	391,295	105,466	156,270	134,727	24,278	83,203	82,142	210,798	13,704	119,787	\$ 653,985	\$ 534,194	61.94%	
24	5000 OPERATING ROOM		0.233835	1,145,481	1,221,121	2,309,345	2,649,606	618,311	718,493	1,820,310	2,562,067	689,109	1,158,967	\$ 5,893,447	\$ 7,151,287	41.13%	
25	5100 RECOVERY ROOM		0.103398	211,491	480,452	451,414	978,706	94,875	239,559	319,385	862,899	118,229	329,625	\$ 1,077,165	\$ 2,561,616	40.47%	
26	5200 DELIVERY ROOM & LABOR ROOM		0.552210	144,195	17,628	895,899	186,967	650	2,599	252,813	33,150	8,957	18,003	\$ 1,293,357	\$ 240,344	92.90%	
27	5300 ANESTHESIOLOGY		0.017858	281,160	412,309	547,133	816,013	149,995	189,953	448,626	689,026	183,833	337,963	\$ 1,426,914	\$ 2,107,301	41.62%	
28	5400 RADIOLOGY-DIAGNOSTIC		0.145560	1,302,779	1,964,898	335,561	3,126,805	753,937	1,221,256	1,865,715	3,445,757	881,642	3,997,377	\$ 4,257,992	\$ 9,758,716	43.60%	
29	6000 LABORATORY		0.167308	2,690,576	1,456,274	1,368,590	2,705,846	1,374,216	732,313	3,326,812	1,896,677	1,174,807	1,940,901	\$ 8,760,194	\$ 6,791,110	48.96%	
30	6500 RESPIRATORY THERAPY		0.875261	1,162,459	164,495	127,425	52,759	353,254	24,580	816,565	79,816	208,394	39,210	\$ 2,459,703	\$ 321,650	58.96%	
31	6600 PHYSICAL THERAPY		0.378959	368,442	158,465	173,989	133,007	190,432	143,242	646,640	332,848	136,842	155,055	\$ 1,379,503	\$ 767,562	39.80%	
32	6900 ELECTROCARDIOLOGY		0.038809	71,604	95,836	80,208	279,699	179,776	241,344	510,431	638,273	257,118	301,848	\$ 842,019	\$ 1,255,152	30.79%	
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.227863	697,294	620,626	90,592	536,668	232,302	259,248	736,415	617,584	106,227	219,660	\$ 1,756,603	\$ 2,034,126	42.63%	
34	7300 DRUGS CHARGED TO PATIENTS		0.125840	4,868,935	6,058,323	2,179,726	3,654,952	1,961,640	2,509,827	5,005,369	7,524,929	1,879,258	2,478,216	\$ 13,815,670	\$ 19,748,031	37.56%	
35	7400 RENEWAL DIALYSIS		0.188406	-	-	51,455	4,504	-	189,300	508,935	34,996	-	-	\$ 751,818	\$ 4,504	41.64%	
36	9000 CLINIC		0.1030704	277	50,049	320	19,557	-	589	281	6,884	272	1,108	\$ 878	\$ 77,079	15.84%	
37	9100 EMERGENCY		0.383376	778,378	1,078,783	255,766	3,266,319	449,250	765,859	985,873	1,993,573	505,460	3,433,674	\$ 2,469,267	\$ 7,104,534	51.15%	
38			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
39			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
40			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
41			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
42			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
43			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
44			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
45			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
46			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
47			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
48			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
49			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
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51			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
52			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
53			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
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55			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
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58			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
59			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		
60			-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -		

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

Cost Report Year (08/01/2021-07/31/2022) 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																							
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126																							
127																							
			\$	13,916,494	\$	13,884,725	\$	9,023,693	\$	18,546,135	\$	6,572,216	\$	7,132,065	\$	17,326,112	\$	20,894,281	\$	6,198,848	\$	14,531,394	

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

Cost Report Year (08/01/2021-07/31/2022) 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		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 17,090,099	\$ 13,884,725	\$ 10,431,859	\$ 18,546,135	\$ 8,255,296	\$ 7,132,065	\$ 21,592,347	\$ 20,894,281	\$ 7,394,539	\$ 14,531,394	\$ 57,369,601	\$ 60,457,206	43.17%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 17,090,099	\$ 13,884,725	\$ 10,431,859	\$ 18,546,135	\$ 8,255,296	\$ 7,132,065	\$ 21,592,347	\$ 20,894,281	\$ 7,394,539	\$ 14,531,394			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 6,885,058	\$ 2,549,372	\$ 4,198,483	\$ 3,825,997	\$ 3,203,376	\$ 1,324,186	\$ 8,475,078	\$ 3,799,820	\$ 2,701,995	\$ 3,115,772	\$ 22,761,995	\$ 11,499,375	47.97%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,593,397	\$ 2,294,638	\$ -	\$ 23	\$ 184,922	\$ 145,078	\$ 991,777	\$ 466,476			\$ 4,770,096	\$ 2,906,215	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 3,106,319	\$ 3,000,329	\$ -	\$ -	\$ 33,580	\$ 39,646			\$ 3,139,879	\$ 3,039,975	
134 Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 72	\$ 777,757			\$ 798,704	\$ 777,829	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 49,248	\$ 94	\$ 46	\$ 371	\$ -	\$ 109	\$ 25	\$ 1,710			\$ 49,319	\$ 2,284	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,642,645	\$ 2,294,732	\$ 3,106,365	\$ 3,000,723									
137 Medicaid Cost Settlement Payments (See Note B)		\$ 79,306									\$ -	\$ 79,306	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,939,395	\$ 883,365	\$ 179,054	\$ 36,782			\$ 2,118,449	\$ 920,147	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 3,620,567	\$ 2,120,125			\$ 3,620,567	\$ 2,120,125	
141 Medicare Cross-Over Bad Debt Payments					\$ 93,382	\$ 45,950					\$ 93,382	\$ 45,950	
142 Other Medicare Cross-Over Payments (See Note D)					\$ (46,809)						\$ (46,809)	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 51,959	\$ 407,831	
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>	\$ 3,242,413	\$ 175,334	\$ 1,092,118	\$ 825,274	\$ 1,032,486	\$ 249,612	\$ 2,851,391	\$ 357,324	\$ 2,650,036	\$ 2,707,941	\$ 8,218,408	\$ 1,607,544	
146 <b>Calculated Payments as a Percentage of Cost</b>	53%	93%	74%	78%	68%	81%	66%	91%	2%	13%	64%	86%	
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>					8,606								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					13%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).  
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).  
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.  
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).  
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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





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

Cost Report Year (08/01/2021-07/31/2022) 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	
49												
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**I. Out-of-State Medicaid Data:**

Cost Report Year (08/01/2021-07/31/2022) 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										\$ -	\$ -
		\$ 36,725	\$ 142,937	\$ -	\$ -	\$ -	\$ 17,010	\$ -	\$ 20,997	\$ -	\$ -
<b>Totals / Payments</b>											
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ 38,715	\$ 142,937	\$ -	\$ -	\$ -	\$ 17,010	\$ -	\$ 20,997	\$ 38,715	\$ 180,944
129	Total Charges per PS&R or Exhibit Detail	\$ 38,715	\$ 142,937	\$ -	\$ -	\$ -	\$ 17,010	\$ -	\$ 20,997		
130	Unreconciled Charges (Explain Variance)										
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ 9,893	\$ 38,897	\$ -	\$ -	\$ -	\$ 3,999	\$ -	\$ 4,706	\$ 9,893	\$ 47,602
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 5,538	\$ 3,497			\$ -	\$ 173	\$ -	\$ 958	\$ 5,538	\$ 4,628
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)					\$ -	\$ -	\$ -	\$ 1,052	\$ -	\$ 1,052
135	Self-Pay (including Co-Pay and Spend-Down)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 5,538	\$ 3,497	\$ -	\$ -						
137	Medicaid Cost Settlement Payments (See Note B)										
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)										
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ 1,529	\$ -	\$ -	\$ -	\$ 1,529
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ -	\$ 337	\$ -	\$ 337
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>	\$ 4,355	\$ 35,400	\$ -	\$ -	\$ -	\$ 2,297	\$ -	\$ 2,359	\$ 4,355	\$ 40,056
144	<b>Calculated Payments as a Percentage of Cost</b>	56%	9%	0%	0%	0%	43%	0%	50%	56%	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 (08/01/2021-07/31/2022)

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	\$ -	\$ -											
2	Kidney Acquisition	\$0.00	\$ -	\$ -											
3	Liver Acquisition	\$0.00	\$ -	\$ -											
4	Heart Acquisition	\$0.00	\$ -	\$ -											
5	Pancreas Acquisition	\$0.00	\$ -	\$ -											
6	Intestinal Acquisition	\$0.00	\$ -	\$ -											
7	Islet Acquisition	\$0.00	\$ -	\$ -											
8		\$0.00	\$ -	\$ -											
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 (08/01/2021-07/31/2022)

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	\$ -	\$ -	\$ -									
12	Kidney Acquisition	\$ -	\$ -	\$ -									
13	Liver Acquisition	\$ -	\$ -	\$ -									
14	Heart Acquisition	\$ -	\$ -	\$ -									
15	Pancreas Acquisition	\$ -	\$ -	\$ -									
16	Intestinal Acquisition	\$ -	\$ -	\$ -									
17	Islet Acquisition	\$ -	\$ -	\$ -									
18		\$ -	\$ -	\$ -									
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 (08/01/2021-07/31/2022) 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)*	\$ 1,247,329	
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)	\$ 1,247,329	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	\$ 1,247,329	

**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	118,046,466
19 Uninsured Hospital Charges Sec. G	21,925,933
20 Total Hospital Charges Sec. G	324,228,924
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	36.41%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.76%
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.