State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2022

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2021	06/30/2022

2. Select Your Facility from the Drop-Down Menu Provided: PHOEBE PUTNEY MEMORIAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	08/01/2021	07/31/2022	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000001482A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001416A
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110007

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/21 - 06/30/22)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	8/1/1911

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022** $ 12,678,378
   (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 07/01/2021 - 06/30/2022** $ 8,033,765
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06/30/2022** $ 20,712,143

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.

Also note: provider id for Phoebe Putney Memorial Hosptial is 000001482A & 000001416A. Format will not let the change be updated on line 7. 000001416A is not a subprovider.

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

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

Hospital CEO or CFO Signature	CHIEF FINANCIAL & ADMINISTRATIVE OFFICER Title	10/9/2023 Date
BRIAN CHURCH Hospital CEO or CFO Printed Name	229-312-4068 Hospital CEO or CFO Telephone Number	BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	REBECCA KENDALL
Title	DIRECTOR OF REIMBURSEMENT
Telephone Number	229-312-6711
E-Mail Address	RKENDALL@PHOEBEHEALTH.COM
Mailing Street Address	810 13th AVENUE STE 105
Mailing City, State, Zip	ALBANY GA 31701

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH Version 8.11 2/10/2023

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: PHOEBE PUTNEY MEMORIAL HOSPITAL

	8/1/2021 through 7/31/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	5/12/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	PHOEBE PUTNEY MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000001482A	No	PROVIDER NUMBER 000001482A & 000001416A
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001416A	No	1416A IS THE SECOND CAID NUMBER FOR PHOEBE . NOT SUBPROVID
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	No	REHAB UNIT IS 11-T007
8. Medicare Provider Number:	110007	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	FLORIDA	913855200
10. State Name & Number	ALABAMA	PH0007N
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2021 - 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)	$ 302,828	$ 1,019,370	$1,322,198
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,207,485	$ 10,018,118	$12,225,603
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$2,510,313	$11,037,488	$13,547,801
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.06%	9.24%	9.76%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 4,610,028
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	$4,610,028

<--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.

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)	121,618	**(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	73,251
3.	Outpatient Hospital Subsidies	143,802
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 217,053
7.	Inpatient Hospital Charity Care Charges	73,340,340
8.	Outpatient Hospital Charity Care Charges	74,995,435
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 148,335,775

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$178,522,931.00			$ 124,377,782	$ -	$ -	$ 54,145,149
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	$637,135,723.00	$994,912,043.00		$ 443,895,513	$ 693,159,990	$ -	$ 494,992,263
20.	Outpatient Services		$111,000,346.00			$ 77,334,473	$ -	$ 33,665,873
21.	Home Health Agency			$3,865,534.00			$ 2,693,136	
22.	Ambulance			$ 603,245			$ 420,284	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,603,898.00			$ 3,904,263	
26.	Other	$27,870,052.00	$47,304,392.00	$0.00	$ 19,417,199	$ 32,957,197	$ -	$ 22,800,048
27.	Total	$ 843,528,706	$ 1,153,216,781	$ 10,072,677	$ 587,690,493	$ 803,451,660	$ 7,017,682	$ 605,603,333
28.	Total Hospital and Non Hospital		Total from Above	$ 2,006,818,164		Total from Above	$ 1,398,159,836	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,006,818,164	Total Contractual Adj. (G-3 Line 2)		1,393,418,680
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	4,741,156
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					1,398,159,836
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 PUTNEY MEMORIAL HOSPITAL

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 154,589,006	$ -	$ -	$0.00	$ 154,589,006	95,930	$109,142,416.00		$ 1,611.48
2	03100	INTENSIVE CARE UNIT	$ 55,299,068	$ 160,415	$ -		$ 55,459,483	13,762	$46,014,149.00		$ 4,029.90
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ 10,207,794	$ -	$ -		$ 10,207,794	5,227	$16,639,090.00		$ 1,952.90
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 9,756,915	$ -	$ -		$ 9,756,915	10,928	$16,026,322.00		$ 892.84
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 229,852,783	$ 160,415	$ -	$ -	$ 230,013,198	125,847	$ 187,821,977		
19		Weighted Average									$ 1,827.72

Line #		Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	4,229	-	-	$ 6,814,949	$2,742,631.00	$4,309,194.00	$ 7,051,825	0.966409

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$40,964,031.00	$ 154,946	$ -		$ 41,118,977	$94,885,020.00	$154,452,189.00	$ 249,337,209	0.164913
22	5100	RECOVERY ROOM	$11,067,368.00	$ -	$ -		$ 11,067,368	$14,688,155.00	$31,710,171.00	$ 46,398,326	0.238529
23	5200	DELIVERY ROOM & LABOR ROOM	$12,328,393.00	$ 198,696	$ -		$ 12,527,089	$3,692,879.00	$8,835,794.00	$ 12,528,673	0.999874
24	5300	ANESTHESIOLOGY	$521,958.00	$ -	$ -		$ 521,958	$22,087,309.00	$39,068,191.00	$ 61,155,500	0.008535
25	5400	RADIOLOGY-DIAGNOSTIC	$19,121,042.00	$ 83,854	$ -		$ 19,204,896	$55,056,528.00	$151,642,464.00	$ 206,698,992	0.092912
26	5500	RADIOLOGY-THERAPEUTIC	$18,032,538.00	$ 14,583	$ -		$ 18,047,121	$2,064,963.00	$49,068,679.00	$ 51,133,642	0.352940
27	6000	LABORATORY	$25,033,903.00	$ -	$ -		$ 25,033,903	$106,748,999.00	$99,801,924.00	$ 206,550,923	0.121200
28	6500	RESPIRATORY THERAPY	$11,143,145.00	$ -	$ -		$ 11,143,145	$48,159,455.00	$6,422,471.00	$ 54,581,926	0.204154
29	6600	PHYSICAL THERAPY	$8,969,850.00	$ -	$ -		$ 8,969,850	$11,135,777.00	$5,710,654.00	$ 16,846,431	0.532448
30	6700	OCCUPATIONAL THERAPY	$2,019,932.00	$ -	$ -		$ 2,019,932	$7,795,880.00	$1,219,911.00	$ 9,015,791	0.224044

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6800	SPEECH PATHOLOGY	$1,040,513.00	$ -	$ -		$ 1,040,513	$3,990,871.00	$1,096,037.00	$ 5,086,908	0.204547
32	6900	ELECTROCARDIOLOGY	$5,842,490.00	$ -	$ -		$ 5,842,490	$7,063,325.00	$15,053,837.00	$ 22,117,162	0.264161
33	7000	ELECTROENCEPHALOGRAPHY	$1,922,850.00	$ 100,259	$ -		$ 2,023,109	$959,162.00	$4,388,763.00	$ 5,347,925	0.378298
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$20,021,430.00	$ -	$ -		$ 20,021,430	$40,501,516.00	$53,606,994.00	$ 94,108,510	0.212748
35	7300	DRUGS CHARGED TO PATIENTS	$68,476,311.00	$ -	$ -		$ 68,476,311	$166,720,428.00	$306,059,094.00	$ 472,779,522	0.144838
36	7400	RENAL DIALYSIS	$2,646,042.00	$ -	$ -		$ 2,646,042	$7,466,569.00	$425,536.00	$ 7,892,105	0.335277
37	7600	ENDOSCOPY	$9,471,001.00	$ 125,780	$ -		$ 9,596,781	$3,144,748.00	$31,694,606.00	$ 34,839,354	0.275458
38	7601	HEART CATH LAB	$12,825,112.00	$ -	$ -		$ 12,825,112	$40,437,751.00	$34,791,225.00	$ 75,228,976	0.170481
39	9000	CLINIC	$12,425,828.00	$ -	$ -		$ 12,425,828	$869,861.00	$15,023,530.00	$ 15,893,391	0.781824
40	9100	EMERGENCY	$28,226,114.00	$ 340,882	$ 3,583,989		$ 32,150,985	$22,604,429.00	$72,538,708.00	$ 95,143,137	0.337922
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 (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	**Total Ancillary**	$ 312,099,851	$ 1,019,000	$ 3,583,989		$ 316,702,840	$ 662,816,256	$ 1,086,919,972	$ 1,749,736,228	
127	**Weighted Average**									0.184895
128	**Sub Totals**	$ 541,952,634	$ 1,179,415	$ 3,583,989		$ 546,716,038	$ 850,638,233	$ 1,086,919,972	$ 1,937,558,205	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 546,716,038				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.22%				

* 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 PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,611.48		11,646		6,212		4,399		17,283		7,554		39,540		51.36%
2	03100 INTENSIVE CARE UNIT	$ 4,029.90		2,248		487		1,042		3,135		1,073		6,912		58.02%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,952.90		540		3,747				705		96		4,992		97.34%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 892.84		1,209		7,003				1,494		204		9,706		90.68%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	15,643		17,449		5,441		22,617		8,927		61,150		55.69%
19	Total Days per PS&R or Exhibit Detail			15,643		17,449		5,441		22,617		8,927				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 23,636,619		$ 30,004,102		$ 8,203,514		$ 32,895,385		$ 12,464,775		$ 94,739,620		57.08%
21.01	Calculated Routine Charge Per Diem			$ 1,511.00		$ 1,719.53		$ 1,507.72		$ 1,454.45		$ 1,396.30		$ 1,549.30		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.966409	2,481,039	420,471	411,417	761,270	124,735	159,690	373,766	605,161	211,810	434,815	$ 3,390,957	$ 1,946,592	84.88%
23	5000 OPERATING ROOM		0.164913	7,441,500	5,504,872	8,842,337	11,768,920	4,129,845	8,489,223	14,799,975	19,800,743	8,208,937	6,527,213	$ 35,213,657	$ 45,563,758	38.31%
24	5100 RECOVERY ROOM		0.238529	827,759	1,520,998	2,153,875	4,438,495	383,887	841,260	1,885,109	3,070,040	888,716	1,626,701	$ 5,250,630	$ 9,870,793	38.01%
25	5200 DELIVERY ROOM & LABOR ROOM		0.999874	346,403	31,816	4,030,612	162,244	13,440	2,510	1,260,686	46,853	74,003	41,554	$ 5,651,141	$ 243,423	47.98%
26	5300 ANESTHESIOLOGY		0.008535	1,742,528	2,033,455	1,482,428	4,353,820	855,066	811,177	3,261,697	3,214,339	2,255,139	2,441,197	$ 7,341,719	$ 10,412,791	36.71%
27	5400 RADIOLOGY-DIAGNOSTIC		0.092912	10,064,420	6,049,980	4,153,501	10,265,684	4,209,728	3,536,633	15,428,362	10,826,764	8,867,639	14,736,517	$ 33,856,011	$ 30,679,061	42.64%
28	5500 RADIOLOGY-THERAPEUTIC		0.352940	485,665	2,789,756	341,090	1,839,585	138,742	1,385,152	591,979	4,466,206	87,535	1,565,656	$ 1,557,476	$ 10,480,699	26.78%
29	6000 LABORATORY		0.121200	15,905,678	5,307,658	12,908,617	7,761,359	7,184,306	2,623,770	24,179,760	6,976,484	9,874,931	7,006,080	$ 60,178,361	$ 22,669,271	48.29%
30	6500 RESPIRATORY THERAPY		0.204154	6,617,468	177,882	5,364,244	269,705	2,809,726	89,894	9,441,922	750,436	2,588,243	183,499	$ 24,233,360	$ 1,287,917	51.84%
31	6600 PHYSICAL THERAPY		0.532448	1,063,023	237,449	395,098	238,453	445,361	140,273	1,785,707	573,583	526,591	245,533	$ 3,689,189	$ 1,189,758	33.54%
32	6700 OCCUPATIONAL THERAPY		0.224044	652,830	54,796	49,426	62,056	243,529	19,736	1,140,826	199,038	322,103	85,383	$ 2,086,611	$ 335,626	31.39%
33	6800 SPEECH PATHOLOGY		0.204547	393,269	47,737	1,222,898	147,608	80,082	32,563	546,725	190,415	149,488	27,547	$ 2,242,974	$ 418,323	55.80%
34	6900 ELECTROCARDIOLOGY		0.264161	468,644	319,475	501,303	722,471	595,960	305,771	2,086,241	1,087,200	983,010	1,112,943	$ 3,652,148	$ 2,434,917	37.00%
35	7000 ELECTROENCEPHALOGRAPHY		0.378298	141,634	403,102	73,670	530,309	39,425	105,310	221,323	394,134	76,307	160,153	$ 476,052	$ 1,432,855	40.12%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.212748	2,809,749	2,995,717	728,590	2,127,915	1,473,632	1,837,911	5,501,903	6,686,818	2,788,784	1,798,948	$ 10,513,874	$ 13,648,361	30.55%
37	7300 DRUGS CHARGED TO PATIENTS		0.144838	25,106,216	20,546,916	12,794,757	11,750,717	8,632,410	11,813,957	34,869,470	31,259,907	15,685,999	15,428,981	$ 81,402,853	$ 75,371,497	39.74%
38	7400 RENAL DIALYSIS		0.335277	181,094	50,358	1,028,489	96,188	1,257,064	39,243	3,280,678	127,592	567,834	92,490	$ 5,747,325	$ 313,381	85.16%
39	7600 ENDOSCOPY		0.275458	248,847	1,246,583	88,844	883,814	156,347	698,654	440,778	2,507,877	250,531	1,275,708	$ 934,816	$ 5,336,928	22.40%
40	7601 HEART CATH LAB		0.170481	2,355,484	763,053	1,294,626	751,736	1,132,883	685,174	5,198,026	3,546,458	4,142,786	1,064,359	$ 9,981,019	$ 5,746,421	27.83%
41	9000 CLINIC		0.781824	27,271	989,128	80,320	821,338	55,517	567,860	129,998	1,830,742	182,670	625,982	$ 293,106	$ 4,209,068	33.43%
42	9100 EMERGENCY		0.337922	3,996,491	3,613,366	2,708,724	12,377,435	1,782,688	1,866,576	5,717,211	5,289,776	3,381,252	12,999,044	$ 14,205,114	$ 23,147,153	56.50%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61			-											$ -	$ -	-
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
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125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 83,357,012	$ 55,104,568	$ 60,654,866	$ 72,131,122	$ 35,744,373	$ 36,052,337	$ 132,142,142	$ 103,450,566	$ 62,114,307	$ 69,480,300			

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

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

		In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	Total In-State Medicaid	%
	Totals / Payments							
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 106,993,631 / $ 55,104,568	$ 90,658,968 / $ 72,131,122	$ 43,947,887 / $ 36,052,337	$ 165,037,527 / $ 103,450,566	$ 74,579,082 (Agrees to Exhibit A) / $ 69,480,300 (Agrees to Exhibit A)	$ 406,638,013 / $ 266,738,593	42.19%
129	Total Charges per PS&R or Exhibit Detail	$ 106,993,631 / $ 55,104,568	$ 90,658,968 / $ 72,131,122	$ 43,947,887 / $ 36,052,337	$ 165,037,527 / $ 103,450,566	$ 74,579,082 / $ 69,480,300		
130	Unreconciled Charges (Explain Variance)	- / -	- / -	- / -	- / -	- / -		
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 45,636,204 / $ 10,435,851	$ 39,329,626 / $ 14,479,238	$ 17,434,139 / $ 6,623,875	$ 66,551,305 / $ 19,570,319	$ 27,098,523 / $ 13,328,853	$ 168,951,274 / $ 51,109,283	47.65%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 21,466,674 / $ 8,988,586		$ 381,507 / $ 723,182	$ 8,060,671 / $ 2,421,422		$ 29,908,852 / $ 12,133,190	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ 25,750,042 / $ 12,179,466		$ 323,735 / $ 141,302		$ 26,073,777 / $ 12,320,768	
134	Private Insurance (including primary and third party liability)		$ 250 / $ 31,164	$ 353 / $ 963	$ 8,900,938 / $ 5,099,032		$ 8,901,541 / $ 5,131,159	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 194,843 / $ 819	$ 22 / $ 4,122	$ 212 / $ 1,363	$ 899 / $ 7,820		$ 195,976 / $ 14,124	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 21,661,517 / $ 8,989,405	$ 25,750,314 / $ 12,214,752					
137	Medicaid Cost Settlement Payments (See Note B)	/ $ 185,972					$ - / $ 185,972	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						$ - / $ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)			$ 11,730,948 / $ 5,683,237	$ 789,572 / $ 506,691		$ 12,520,520 / $ 6,189,928	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)				$ 24,568,154 / $ 12,823,399		$ 24,568,154 / $ 12,823,399	
141	Medicare Cross-Over Bad Debt Payments			$ 416,580 / $ 235,023			$ 416,580 / $ 235,023	
142	Other Medicare Cross-Over Payments (See Note D)			$ 462,503 / $ 265,514		(Agrees to Exhibit B and B-1)	$ 462,503 / $ 265,514	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)					$ 302,828 / (Agrees to Exhibit B and B-1) $ 1,019,370		
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)					$ - / $ -		
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 23,974,687 / $ 1,260,474	$ 13,579,312 / $ 2,264,486	$ 4,442,036 / $ (285,407)	$ 23,907,336 / $ (1,429,347)	$ 26,795,695 / $ 12,309,483	$ 65,903,371 / $ 1,810,206	
146	**Calculated Payments as a Percentage of Cost**	47% / 88%	65% / 84%	75% / 104%	64% / 107%	1% / 8%	61% / 96%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**			45,231				
148	**Percent of cross-over days to total Medicare days from the cost report**			12%				

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 PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,611.48								2		2	
2	03100 INTENSIVE CARE UNIT	$ 4,029.90										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,952.90										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 892.84										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		2		2	
19	Total Days per PS&R or Exhibit Detail			-		-		-		2			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 1,991		$ 1,991	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 995.50		$ 995.50	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.966409		1,276							$ -	$ 1,276
23	5000 OPERATING ROOM		0.164913									$ -	$ -
24	5100 RECOVERY ROOM		0.238529							780		$ 780	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.999874		829							$ -	$ 829
26	5300 ANESTHESIOLOGY		0.008535		-					653		$ 653	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.092912		4,296					1,369	378	$ 1,369	$ 4,674
28	5500 RADIOLOGY-THERAPEUTIC		0.352940		-					-		$ -	$ -
29	6000 LABORATORY		0.121200		9,519				1,100	4,511	302	$ 4,511	$ 10,921
30	6500 RESPIRATORY THERAPY		0.204154							-		$ -	$ -
31	6600 PHYSICAL THERAPY		0.532448							-		$ -	$ -
32	6700 OCCUPATIONAL THERAPY		0.224044							-		$ -	$ -
33	6800 SPEECH PATHOLOGY		0.204547							-		$ -	$ -
34	6900 ELECTROCARDIOLOGY		0.264161		1,045					209		$ 209	$ 1,045
35	7000 ELECTROENCEPHALOGRAPHY		0.378298									$ -	$ -
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.212748									$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.144838		5,255				391	1,345		$ 1,345	$ 5,646
38	7400 RENAL DIALYSIS		0.335277									$ -	$ -
39	7600 ENDOSCOPY		0.275458							4,687		$ 4,687	$ -
40	7601 HEART CATH LAB		0.170481									$ -	$ -
41	9000 CLINIC		0.781824						1,591			$ -	$ 1,591
42	9100 EMERGENCY		0.337922		19,009					1,617		$ 1,617	$ 19,009
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
83				-									$ -	$ -
84				-									$ -	$ -
85				-									$ -	$ -
86				-									$ -	$ -
87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
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101				-									$ -	$ -
102				-									$ -	$ -
103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 41,229	$ -	$ -	$ -	$ 3,082	$ 15,171	$ 680		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ 41,229	$ -	$ -	$ -	$ 3,082	$ 17,162	$ 680	$ 17,162	$ 44,991
129	Total Charges per PS&R or Exhibit Detail			$ -	$ 41,229	$ -	$ -	$ -	$ 3,082	$ 17,162	$ 680		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ 11,076	$ -	$ -	$ -	$ 1,434	$ 6,176	$ 72	$ 6,176	$ 12,582
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ 121							$ -	$ 121
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)										$ 302	$ -	$ 302
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 121	$ -	$ -						
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)								$ 235			$ -	$ 235
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 4,350	$ 28	$ 4,350	$ 28
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ 10,955	$ -	$ -	$ -	$ 1,199	$ 1,826	$ (258)	$ 1,826	$ 11,896
144	**Calculated Payments as a Percentage of Cost**			0%	1%	0%	0%	0%	16%	70%	458%	70%	5%

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 PUTNEY MEMORIAL HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (08/01/2021-07/31/2022) PHOEBE PUTNEY MEMORIAL HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is 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 PUTNEY MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 7,576,782		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	80.700000.690057	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 7,576,782	Line 5.03 Shared A&G	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 7,576,782		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	673,438,759
19	Uninsured Hospital	**Charges Sec. G**	144,059,382
20	Total Hospital	**Charges Sec. G**	1,937,558,205
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		34.76%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.44%
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.*