State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

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	08/01/2022	07/31/2023	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 (07/01/24 - 06/30/25)
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 07/01/2024 - 06/30/2025** — $ 17,988,686
   (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 07/01/2024 - 06/30/2025** — $ -
   (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 Services07/01/2024 - 06/30/2025** — $ 17,988,686

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	Title	Date
	CFO/ADMINISTRATIVE OFFICER	11/22/2024

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
BRIAN CHURCH	229-312-4068	BCHURCH@PHOEBEHEALTH.COM

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	2000 PALYMRA ROAD 1ST FLOOR REIMBURSEMENT
Mailing City, State, Zip	ALBANY GA 31701

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

DSH Version 9.00 9/11/2024

D. General Cost Report Year Information 8/1/2022 - 7/31/2023

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		
	8/1/2022 through 7/31/2023		
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:	5/9/2024		

	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	SUBPROVIDER. PSYCH UNIT IS 11-S007
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: (08/01/2022 - 07/31/2023)

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)	$ 424,752	$ 973,817	$1,398,569
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,113,256	$ 8,949,592	$11,062,848
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)	$2,538,008	$9,923,409	$12,461,417
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	16.74%	9.81%	11.22%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received 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 (08/01/2022 - 07/31/2023)

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)	113,609 (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	42,938
3.	Outpatient Hospital Subsidies	85,321
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 128,259
7.	Inpatient Hospital Charity Care Charges	77,825,447
8.	Outpatient Hospital Charity Care Charges	75,814,815
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 153,640,262

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	$162,712,589.00			$ 112,563,973	$ -	$ -	$ 50,148,616
12.	Subprovider I (Psych or Rehab)				$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)				$ -	$ -	$ -	$ -
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	$628,526,469.00	$1,159,046,847.00		$ 434,812,307	$ 801,824,359	$ -	$ 550,936,650
20.	Outpatient Services		$120,456,956.00			$ 83,331,681	$ -	$ 37,125,275
21.	Home Health Agency			$5,619,843.00			$ 3,887,787	
22.	Ambulance	-	-	$ 576,309	-	-	$ 398,688	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,603,044.00			$ 3,876,165	
26.	Other	$27,401,783.00	$49,447,419.00	$0.00	$ 18,956,453	$ 34,207,543	$ -	$ 23,685,206
27.	Total	$ 818,640,841	$ 1,328,951,222	$ 11,799,196	$ 566,332,732	$ 919,363,583	$ 8,162,641	$ 661,895,748
28.	Total Hospital and Non Hospital		Total from Above	$ 2,159,391,259		Total from Above	$ 1,493,858,956	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,159,391,259	Total Contractual Adj. (G-3 Line 2)	1,493,858,956
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36.	Adjusted Contractual Adjustments				1,493,858,956
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2022-07/31/2023) 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	$ 123,903,249	$ -	$ -	$0.00	$ 123,903,249	92,264	$99,701,068.00		$ 1,342.92
2	03100 INTENSIVE CARE UNIT	$ 31,188,512	$ 156,296	$ -		$ 31,344,808	12,399	$34,098,738.00		$ 2,528.01
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	$ 10,732,568	$ -	$ -		$ 10,732,568	5,253	$17,502,663.00		$ 2,043.13
7	04000 SUBPROVIDER I		$ -	$ -		$ -				$ -
8	04100 SUBPROVIDER II		$ -	$ -		$ -				$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 10,258,446	$ -	$ -		$ 10,258,446	10,834	$16,648,472.00		$ 946.88
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 176,082,775	$ 156,296	$ -	$ -	$ 176,239,071	120,750	$ 167,950,941		
19	Weighted Average									$ 1,459.54

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)	7,141	-	-	$ 9,589,792	$2,921,116.00	$8,489,004.00	$ 11,410,120	0.840464

Line #		*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*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$50,974,804.00	$ 189,394	$ -		$ 51,164,198	$98,395,189.00	$182,616,553.00	$ 281,011,742	0.182071
22	5100 RECOVERY ROOM	$13,188,021.00	$ -	$ -		$ 13,188,021	$17,361,431.00	$36,665,112.00	$ 54,026,543	0.244103
23	5200 DELIVERY ROOM & LABOR ROOM	$12,370,363.00	$ 296,042	$ -		$ 12,666,405	$7,306,539.00	$2,325,905.00	$ 9,632,444	1.314973
24	5300 ANESTHESIOLOGY	$491,760.00	$ -	$ -		$ 491,760	$24,671,341.00	$46,441,000.00	$ 71,112,341	0.006915
25	5400 RADIOLOGY-DIAGNOSTIC	$21,338,111.00	$ 49,647	$ -		$ 21,387,758	$54,820,171.00	$174,601,480.00	$ 229,421,651	0.093225
26	5500 RADIOLOGY-THERAPEUTIC	$19,336,907.00	$ -	$ -		$ 19,336,907	$1,314,603.00	$51,200,154.00	$ 52,514,757	0.368219
27	6000 LABORATORY	$26,767,421.00	$ -	$ -		$ 26,767,421	$100,941,330.00	$114,644,431.00	$ 215,585,761	0.124161
28	6500 RESPIRATORY THERAPY	$9,764,769.00	$ -	$ -		$ 9,764,769	$43,960,400.00	$6,660,492.00	$ 50,620,892	0.192900
29	6600 PHYSICAL THERAPY	$9,379,559.00	$ -	$ -		$ 9,379,559	$11,588,467.00	$6,505,420.00	$ 18,093,887	0.518383

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2022-07/31/2023) 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
30	6700	OCCUPATIONAL THERAPY	$2,442,199.00	$ -	$ -		$ 2,442,199	$7,881,735.00	$1,590,557.00	$ 9,472,292	0.257826
31	6800	SPEECH PATHOLOGY	$1,042,016.00	$ -	$ -		$ 1,042,016	$4,258,084.00	$926,509.00	$ 5,184,593	0.200983
32	6900	ELECTROCARDIOLOGY	$4,548,508.00	$ -	$ -		$ 4,548,508	$5,897,556.00	$16,705,519.00	$ 22,603,075	0.201234
33	7000	ELECTROENCEPHALOGRAPHY	$2,052,458.00	$ 126,876	$ -		$ 2,179,334	$888,502.00	$5,934,192.00	$ 6,822,694	0.319424
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$17,162,821.00	$ -	$ -		$ 17,162,821	$45,199,244.00	$67,337,484.00	$ 112,536,728	0.152509
35	7300	DRUGS CHARGED TO PATIENTS	$67,827,532.00	$ -	$ -		$ 67,827,532	$145,909,598.00	$345,297,506.00	$ 491,207,104	0.138083
36	7400	RENAL DIALYSIS	$2,787,732.00	$ -	$ -		$ 2,787,732	$5,615,740.00	$656,038.00	$ 6,271,778	0.444488
37	7600	ENDOSCOPY	$12,565,115.00	$ 99,294	$ -		$ 12,664,409	$3,466,792.00	$34,228,791.00	$ 37,695,583	0.335965
38	7601	HEART CATH LAB	$21,009,185.00	$ -	$ -		$ 21,009,185	$49,049,522.00	$64,610,321.00	$ 113,659,843	0.184843
39	9000	CLINIC	$13,613,027.00	$ -	$ -		$ 13,613,027	$712,206.00	$15,501,205.00	$ 16,213,411	0.839615
40	9100	EMERGENCY	$23,966,218.00	$ 294,203	$ 4,364,303		$ 28,624,724	$21,960,063.00	$82,283,482.00	$ 104,243,545	0.274595
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 (08/01/2022-07/31/2023) 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
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		**Total Ancillary**	$ 332,628,526	$ 1,055,456	$ 4,364,303		$ 338,048,285	$ 654,119,629	$ 1,265,221,155	$ 1,919,340,784	
127		**Weighted Average**									0.181124
128		**Sub Totals**	$ 508,711,301	$ 1,211,752	$ 4,364,303		$ 514,287,356	$ 822,070,570	$ 1,265,221,155	$ 2,087,291,725	
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**					$ 514,287,356				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.24%				

* 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 (08/01/2022-07/31/2023) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From 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**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,342.92		9,507		6,338		3,500		14,641		86		6,619		34,072		47.86%
2	03100 INTENSIVE CARE UNIT	$ 2,528.01		1,721		193		708		2,665		5		1,056		5,292		51.26%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ 2,043.13		456		3,648				799				94		4,903		95.24%
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 946.88		1,041		7,216				1,628		8		248		9,893		93.86%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	12,725		17,395		4,208		19,733		99		8,017		54,160		51.57%
19	Total Days per PS&R or Exhibit Detail			12,725		17,395		4,208		19,733		99		8,017				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 18,578,769		$ 30,100,871		$ 5,958,732		$ 28,697,305		$ 113,723		$ 11,559,058		$ 83,335,677		56.58%
21.01	Calculated Routine Charge Per Diem			$ 1,460.02		$ 1,730.43		$ 1,416.05		$ 1,454.28		$ 1,148.72		$ 1,441.82		$ 1,538.69		
	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**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.840464	1,320,930	440,108	454,779	970,037	147,310	321,147	523,133	1,482,652	2,041	6,368	225,732	553,552	$ 2,446,152	$ 3,213,944	56.57%
23	5000 OPERATING ROOM		0.182071	7,808,645	6,087,413	9,363,221	14,776,782	2,767,576	6,318,848	15,053,943	25,643,493	102,691	409,863	8,755,181	6,949,441	$ 34,993,386	$ 52,826,536	37.03%
24	5100 RECOVERY ROOM		0.244103	949,918	1,570,811	2,247,282	5,715,464	372,658	932,846	2,113,710	4,315,196	16,502	79,912	1,006,191	1,736,447	$ 5,683,568	$ 12,534,317	38.98%
25	5200 DELIVERY ROOM & LABOR ROOM		1.314973	451,775	8,818	4,689,278	174,921	16,771	-	1,342,341	77,617	6,704	-	45,641	7,032	$ 6,500,165	$ 261,356	70.81%
26	5300 ANESTHESIOLOGY		0.006915	1,816,837	2,449,084	1,695,239	5,656,760	696,538	911,376	3,428,267	4,703,007	17,737	74,828	2,467,391	2,011,673	$ 7,636,881	$ 13,720,227	36.46%
27	5400 RADIOLOGY-DIAGNOSTIC		0.093225	10,247,279	6,589,511	4,420,313	12,535,453	4,184,710	3,733,385	15,556,898	15,883,862	87,088	189,389	8,923,199	16,000,376	$ 34,409,200	$ 38,542,210	42.84%
28	5500 RADIOLOGY-THERAPEUTIC		0.368219	343,548	1,383,550	262,582	935,994	58,794	1,090,794	669,084	5,728,078	199	116,195	158,282	1,986,329	$ 1,334,008	$ 9,138,416	24.25%
29	6000 LABORATORY		0.124161	14,227,173	5,839,782	12,770,321	9,506,369	5,692,483	2,951,879	22,701,311	10,077,483	99,658	200,931	9,949,451	7,885,331	$ 55,391,288	$ 28,375,514	47.34%
30	6500 RESPIRATORY THERAPY		0.192900	5,687,297	123,210	6,161,859	355,511	1,758,295	68,641	9,301,243	580,121	32,656	5,548	2,474,560	244,223	$ 22,908,694	$ 1,127,483	52.99%
31	6600 PHYSICAL THERAPY		0.518383	1,105,672	184,689	403,975	214,428	545,539	131,319	2,016,499	849,764	9,604	54,792	631,953	237,886	$ 4,071,685	$ 1,380,200	35.32%
32	6700 OCCUPATIONAL THERAPY		0.257826	642,269	26,099	86,307	78,989	342,786	36,102	1,254,607	265,764	7,612	19,049	430,659	119,304	$ 2,325,969	$ 406,954	34.99%
33	6800 SPEECH PATHOLOGY		0.200983	431,714	12,642	1,247,455	120,035	144,433	24,018	674,216	162,828	4,010	7,550	211,131	19,840	$ 2,497,818	$ 319,523	59.08%
34	6900 ELECTROCARDIOLOGY		0.201234	516,176	317,599	512,678	809,765	428,722	319,602	1,775,511	1,468,095	16,216	11,689	875,628	1,163,772	$ 3,233,087	$ 2,915,061	36.39%
35	7000 ELECTROENCEPHALOGRAPHY		0.319424	105,102	543,713	67,555	687,379	47,367	152,216	137,472	579,140	3,836	16,092	87,433	167,928	$ 357,496	$ 1,962,448	38.07%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.152509	2,951,447	2,456,607	1,140,109	2,420,569	1,007,924	1,361,200	6,149,910	8,170,281	20,662	141,985	3,804,566	2,756,640	$ 11,249,390	$ 14,408,657	28.78%
37	7300 DRUGS CHARGED TO PATIENTS		0.138083	19,567,264	20,120,217	11,349,886	10,659,296	6,960,605	13,711,311	30,387,327	37,782,402	135,617	686,057	15,245,516	13,904,302	$ 68,265,083	$ 82,273,225	36.78%
38	7400 RENAL DIALYSIS		0.444488	174,498	-	1,040,311	113,584	1,027,560	78,554	2,651,723	240,436	7,728	808	505,588	92,738	$ 4,894,092	$ 432,574	94.65%
39	7600 ENDOSCOPY		0.335965	317,315	1,077,410	61,617	1,082,664	137,147	660,879	545,362	2,987,758	-	66,945	287,329	1,193,267	$ 1,061,441	$ 5,808,711	22.33%
40	7601 HEART CATH LAB		0.184843	3,632,301	769,639	2,017,212	992,745	1,663,166	1,584,294	7,368,760	7,725,073	74,126	57,706	4,626,606	3,284,974	$ 14,681,440	$ 11,071,751	29.79%
41	9000 CLINIC		0.839615	12,212	804,883	68,279	707,061	35,343	473,886	122,431	1,985,770	631	141,156	168,276	558,227	$ 238,265	$ 3,971,600	31.34%
42	9100 EMERGENCY		0.274595	4,303,805	4,101,848	2,846,650	14,312,897	1,647,853	2,223,413	5,878,344	7,524,031	45,264	55,248	3,539,227	13,149,101	$ 14,676,652	$ 28,162,189	57.29%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (08/01/2022-07/31/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													$ -	$ -	
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					$ 76,613,180	$ 54,907,634	$ 62,906,908	$ 82,826,702	$ 29,683,580	$ 37,085,709	$ 129,652,093	$ 138,032,851	$ 690,582	$ 2,342,111	$ 64,419,539	$ 74,032,382			

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

Cost Report Year (08/01/2022-07/31/2023) PHOEBE PUTNEY MEMORIAL HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
128	**Total Charges *(includes organ acquisition from Section J)***	$ 95,191,949	$ 54,907,634	$ 93,007,779	$ 82,826,702	$ 35,642,312	$ 37,085,709	$ 158,349,398	$ 138,032,851	$ 804,305	$ 2,342,111	$ 75,978,597 (Agrees to Exhibit A)	$ 74,032,382 (Agrees to Exhibit A)	$ 382,191,437	$ 312,852,896	40.52%
129	Total Charges per PS&R or Exhibit Detail	$ 95,191,949	$ 54,907,634	$ 93,007,779	$ 82,826,702	$ 35,642,312	$ 37,085,709	$ 158,349,398	$ 138,032,851	$ 804,305	$ 2,342,111	$ 75,978,597	$ 74,032,382			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 32,513,620	$ 9,564,689	$ 39,425,100	$ 15,432,991	$ 11,602,194	$ 6,638,102	$ 52,847,975	$ 25,794,683	$ 260,159	$ 512,375	$ 22,354,719	$ 13,342,952	$ 136,388,889	$ 57,430,465	44.67%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 18,818,300	$ 9,487,727		$ 246	$ 91,584	$ 701,564	$ 4,420,183	$ 2,251,338					$ 23,330,066	$ 12,440,875	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 26,961,105	$ 13,901,739			$ 249,497	$ 152,803					$ 27,210,601	$ 14,054,542	
134	Private Insurance (including primary and third party liability)			$ 29,371	$ 31,996	$ 4,626	$ 854	$ 10,269,680	$ 7,490,829					$ 10,303,677	$ 7,523,680	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 210,837	$ 5,739		$ 2,203	$ 14	$ 1,018	$ 7,169	$ 6,574					$ 218,020	$ 15,533	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 19,029,137	$ 9,493,466	$ 26,990,476	$ 13,936,184											
137	Medicaid Cost Settlement Payments (See Note B)		$ (278,639)											$ -	$ (278,639)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ 177,090				$ 9,763,515	$ 5,484,493	$ 614,813	$ 617,424					$ 10,555,418	$ 6,101,917	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 28,084,484	$ 16,668,884					$ 28,084,484	$ 16,668,884	
141	Medicare Cross-Over Bad Debt Payments					$ 348,531	$ 240,009							$ 348,531	$ 240,009	
142	Other Medicare Cross-Over Payments (See Note D)					$ 683,898	$ 286,436					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 683,898	$ 286,436	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 424,752	$ 973,817			
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)**	$ 13,307,393	$ 349,862	$ 12,434,624	$ 1,496,807	$ 710,027	$ (76,271)	$ 9,202,150	$ (1,393,170)	$ 260,159	$ 512,375	$ 21,929,967	$ 12,369,135	$ 35,654,194	$ 377,227	
146	**Calculated Payments as a Percentage of Cost**	59%	96%	68%	90%	94%	101%	83%	105%	0%	0%	2%	7%	74%	99%	
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)**					47,552										
148	**Percent of cross-over days to total Medicare days from the cost report**					9%										

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 surve
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 payment
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 payment
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) 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 Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 1,342.92		41						7		48	
2	03100 INTENSIVE CARE UNIT	$ 2,528.01		8								8	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 2,043.13		6								6	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 946.88		28								28	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	83		-		-		7		90	
19	Total Days per PS&R or Exhibit Detail			83		-		-		7			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 131,674						$ 7,245		$ 138,919	
21.01	Calculated Routine Charge Per Diem			$ 1,586.43		$ -		$ -		$ 1,035.00		$ 1,543.54	
	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)		0.840464		5,398						1,790	$ -	$ 7,188
23	5000 OPERATING ROOM		0.182071	9,022	-				1,817	-	-	$ 9,022	$ 1,817
24	5100 RECOVERY ROOM		0.244103	2,687	-				-	-	-	$ 2,687	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		1.314973	-	-				-	-	-	$ -	$ -
26	5300 ANESTHESIOLOGY		0.006915	1,978	194				-	-	-	$ 1,978	$ 194
27	5400 RADIOLOGY-DIAGNOSTIC		0.093225	72,645	52,091				690	11,806	5,961	$ 84,451	$ 58,742
28	5500 RADIOLOGY-THERAPEUTIC		0.368219	995	-				-	-	-	$ 995	$ -
29	6000 LABORATORY		0.124161	82,200	31,529				6,824	15,802	4,591	$ 98,002	$ 42,944
30	6500 RESPIRATORY THERAPY		0.192900	25,762	-				-	3,375	-	$ 29,137	$ -
31	6600 PHYSICAL THERAPY		0.518383	3,584	-				-	562	276	$ 4,146	$ 276
32	6700 OCCUPATIONAL THERAPY		0.257826	3,704	-				-	633	-	$ 4,337	$ -
33	6800 SPEECH PATHOLOGY		0.200983	3,151	-				-	-	-	$ 3,151	$ -
34	6900 ELECTROCARDIOLOGY		0.201234	7,728	1,254				-	-	209	$ 7,728	$ 1,463
35	7000 ELECTROENCEPHALOGRAPHY		0.319424	944	-				-	-	944	$ 944	$ 944
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.152509	1,306	-					-	-	$ 1,306	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.138083	112,407	22,040				630	9,653	5,958	$ 122,060	$ 28,628
38	7400 RENAL DIALYSIS		0.444488	2,588	359				-	-	-	$ 2,588	$ 359
39	7600 ENDOSCOPY		0.335965	-	-				-	-	-	$ -	$ -
40	7601 HEART CATH LAB		0.184843	56,426	-				4,155	1,764	-	$ 58,190	$ 4,155
41	9000 CLINIC		0.839615	-	397				2,833	-	-	$ -	$ 3,230
42	9100 EMERGENCY		0.274595	18,214	67,164					3,154	4,935	$ 21,368	$ 72,099
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
48				-									$ -	$ -
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
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74				-									$ -	$ -
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105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 405,341	$ 180,426	$ -	$ -	$ -	$ 16,949	$ 46,749	$ 24,664		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 537,015	$ 180,426	$ -	$ -	$ -	$ 16,949	$ 53,994	$ 24,664	$ 591,009	$ 222,039
129	Total Charges per PS&R or Exhibit Detail	$ 537,015	$ 180,426	$ -	$ -	$ -	$ 16,949	$ 53,994	$ 24,664		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 176,287	$ 35,540	$ -	$ -	$ -	$ 4,476	$ 16,094	$ 5,295	$ 192,381	$ 45,311
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 2,394				$ 101	$ 125		$ 125	$ 2,494
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)		$ 64						$ 150	$ -	$ 213
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 2,457	$ -	$ -						
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) (See Note F)						$ 2,471	$ 12,493		$ 12,493	$ 2,471
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 2,716	$ -	$ 2,716
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)**	$ 176,287	$ 33,083	$ -	$ -	$ -	$ 1,904	$ 3,476	$ 2,429	$ 179,763	$ 37,416
144	**Calculated Payments as a Percentage of Cost**	0%	7%	0%	0%	0%	57%	78%	54%	7%	17%

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 (08/01/2022-07/31/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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 (08/01/2022-07/31/2023) 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 & with Medicaid Secondary)	
							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)*							
	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 (08/01/2022-07/31/2023) 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)*		$ 7,815,799		
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)		$ 7,815,799	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		$ 7,815,799		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	699,003,796
19	Uninsured Hospital	**Charges Sec. G**	150,010,980
20	Total Hospital	**Charges Sec. G**	2,087,291,725
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		33.49%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.19%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ -**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	326,651,504
27	Uninsured Hospital	**Charges Sec. G**	153,157,396
28	Total Hospital	**Charges Sec. G**	2,087,291,725
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		15.65%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.34%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary 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.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*