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 SUMTER MEDICAL CENTER

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:	000000019A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110044

B. DSH Qualifying Information

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

During the DSH Examination Year:

	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?	1/1/1908

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** $ 1,755,911
   (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** $ 1,755,911

Certification:

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

Explanation for "No" answers:

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

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

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

Hospital CEO or CFO Signature	CEO Title	11/22/2024 Date
CARLYE WALTON Hospital CEO or CFO Printed Name	229-931-1280 Hospital CEO or CFO Telephone Number	CWALTON@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	REBECCA KENDALL	Name	
Title	DIRECTOR OF REIMBURSEMENT	Title	
Telephone Number	(229) 312-6721	Firm Name	
E-Mail Address	RKENDALL@PHOEBEHEALTH.COM	Telephone Number	
Mailing Street Address	2000 PALMYRA ROAD FIRST FLOOR REIMBURSEMENT	E-Mail Address	
Mailing City, State, Zip	ALBANY, GA 31701		

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 SUMTER MEDICAL CENTER		
	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 SUMTER MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000019A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110044	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

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

	State Name	Provider No.
9. State Name & Number	COLORADO	9000169560
10. State Name & Number	IOWA	0131893
11. State Name & Number	MICHIGAN	1609001312
12. State Name & Number	TENNESSEE	0110044
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2022 - 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)	$ 83,532	$ 399,611	$483,143
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 472,397	$ 2,078,192	$2,550,589
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)	$555,929	$2,477,803	$3,033,732
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	15.03%	16.13%	15.93%

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)	16,916	(See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	43,924
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 43,924
7.	Inpatient Hospital Charity Care Charges	5,116,668
8.	Outpatient Hospital Charity Care Charges	14,095,398
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 19,212,066

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	$27,572,637.00			$ 20,200,872	$ -	$ -	$ 7,371,765
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	$76,393,388.00	$212,325,228.00		$ 55,969,004	$ 155,558,378	$ -	$ 77,191,235
20.	Outpatient Services		$44,632,958.00			$ 32,699,979	$ -	$ 11,932,979
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$1,417,802.00			$ 1,038,741	
26.	Other	$0.00	$80,125.00	$461,548.00	$ -	$ 58,703	$ 338,149	$ 21,422
27.	Total	$ 103,966,025	$ 257,038,311	$ 1,879,350	$ 76,169,875	$ 188,317,060	$ 1,376,891	$ 96,517,401
28.	Total Hospital and Non Hospital		Total from Above	$ 362,883,686		Total from Above	$ 265,863,826	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	362,883,686	Total Contractual Adj. (G-3 Line 2)	261,925,746
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	3,938,080
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				265,863,826
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 SUMTER MEDICAL CENTER

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	$ 17,918,804	$ -	$ -	$0.00	$ 17,918,804	16,334	$15,669,201.00		$ 1,097.02
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ 4,498,199	$ -	$ -		$ 4,498,199	1,511	$3,545,691.00		$ 2,976.97
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,466,277	$ -	$ -		$ 1,466,277	871	$825,852.00		$ 1,683.44
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 23,883,280	$ -	$ -	$ -	$ 23,883,280	18,716	$ 20,040,744		
19	Weighted Average									$ 1,276.08

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)	1,800	-	-	$ 1,974,636	$626,365.00	$2,418,565.00	$ 3,044,930	0.648500

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	$9,876,557.00	$ -	$ -		$ 9,876,557	$13,062,476.00	$27,136,950.00	$ 40,199,426	0.245689
22	5100 RECOVERY ROOM	$1,105,329.00	$ -	$ -		$ 1,105,329	$2,193,315.00	$8,729,385.00	$ 10,922,700	0.101196
23	5200 DELIVERY ROOM & LABOR ROOM	$1,234,750.00	$ -	$ -		$ 1,234,750	$334,358.00	$2,076,762.00	$ 2,411,120	0.512106
24	5300 ANESTHESIOLOGY	$150,068.00	$ -	$ -		$ 150,068	$3,295,878.00	$7,826,663.00	$ 11,122,541	0.013492
25	5400 RADIOLOGY-DIAGNOSTIC	$7,192,513.00	$ -	$ -		$ 7,192,513	$27,546,359.00	$49,823,990.00	$ 77,370,349	0.092962
26	6000 LABORATORY	$6,352,063.00	$ -	$ -		$ 6,352,063	$13,010,610.00	$28,569,948.00	$ 41,580,558	0.152765
27	6500 RESPIRATORY THERAPY	$3,788,566.00	$ -	$ -		$ 3,788,566	$5,346,052.00	$1,099,232.00	$ 6,445,284	0.587804
28	6600 PHYSICAL THERAPY	$2,602,739.00	$ -	$ -		$ 2,602,739	$4,112,517.00	$3,399,436.00	$ 7,511,953	0.346480
29	6900 ELECTROCARDIOLOGY	$357,571.00	$ -	$ -		$ 357,571	$2,262,256.00	$5,902,470.00	$ 8,164,726	0.043795

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	7200	IMPL. DEV. CHARGED TO PATIENTS	$2,742,975.00	$ -	$ -	$ 2,742,975	$4,210,922.00	$8,540,288.00	$ 12,751,210	0.215115
31	7300	DRUGS CHARGED TO PATIENTS	$11,793,726.00	$ -	$ -	$ 11,793,726	$23,370,575.00	$49,142,298.00	$ 72,512,873	0.162643
32	7400	RENAL DIALYSIS	$317,192.00	$ -	$ -	$ 317,192	$1,431,105.00	$14,889.00	$ 1,445,994	0.219359
33	9000	CLINIC	$398,126.00	$ -	$ -	$ 398,126	$31,322.00	$953,531.00	$ 984,853	0.404249
34	9100	EMERGENCY	$9,140,077.00	$ -	$ 1,045,205	$ 10,185,282	$4,867,046.00	$26,334,778.00	$ 31,201,824	0.326432
35			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
36			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 57,052,252	$ -	$ 1,045,205		$ 58,097,457	$ 105,701,156	$ 221,969,185	$ 327,670,341	
127		**Weighted Average**									0.183331
128		**Sub Totals**	$ 80,935,532	$ -	$ 1,045,205		$ 81,980,737	$ 125,741,900	$ 221,969,185	$ 347,711,085	

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**	$ 81,980,737
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

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

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

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & 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	$ 1,097.02		2,162		876		532		2,865				824		6,435		49.96%
2	03100 INTENSIVE CARE UNIT	$ -														-		
3	03200 CORONARY CARE UNIT	$ 2,976.97		210		42		82		262				124		596		47.65%
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 1,683.44		97		622				128		2		10		849		98.62%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	2,469		1,540		614		3,255		2		958		7,880		47.23%
19	Total Days per PS&R or Exhibit Detail			2,469		1,540		614		3,255		2		958				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 3,524,601		$ 1,621,609		$ 780,860		$ 3,818,869		$ 1,598		$ 1,173,986		$ 9,745,939		54.50%
21.01	Calculated Routine Charge Per Diem			$ 1,427.54		$ 1,052.99		$ 1,271.76		$ 1,173.23		$ 799.00		$ 1,225.46		$ 1,236.79		
	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)		0.648500	320,884	126,474	206,917	184,585	3,768	66,116	68,274	428,656	-	14,813	17,868	167,541	$ 599,843	$ 805,831	52.91%
23	5000 OPERATING ROOM		0.245689	1,200,394	1,166,366	2,742,402	3,126,930	262,902	544,604	1,925,077	3,146,236	-	81,585	631,201	1,482,023	$ 6,130,775	$ 7,984,136	40.57%
24	5100 RECOVERY ROOM		0.101196	208,007	412,220	561,713	1,060,230	50,182	168,610	343,467	895,115	-	9,180	108,875	377,179	$ 1,163,369	$ 2,536,175	38.41%
25	5200 DELIVERY ROOM & LABOR ROOM		0.512106	187,361	13,762	1,325,349	274,318	9,244	4,128	396,150	50,912	-	-	33,618	22,016	$ 1,918,104	$ 343,120	96.28%
26	5300 ANESTHESIOLOGY		0.013492	300,702	383,324	684,512	933,784	77,140	143,752	490,933	840,846	-	20,670	167,426	414,411	$ 1,553,287	$ 2,301,706	40.08%
27	5400 RADIOLOGY-DIAGNOSTIC		0.092962	1,548,826	1,828,995	432,894	3,934,089	423,111	975,101	2,161,188	3,643,993	-	54,032	1,108,093	4,744,859	$ 4,566,019	$ 10,382,178	26.99%
28	6000 LABORATORY		0.152765	2,945,698	1,524,623	1,451,522	2,881,580	767,245	636,171	3,526,884	2,600,045	1,367	25,775	1,293,590	2,277,785	$ 8,691,349	$ 7,642,418	47.97%
29	6500 RESPIRATORY THERAPY		0.587804	1,053,176	105,408	108,075	96,972	331,526	30,108	1,352,520	109,358	131	859	263,489	49,858	$ 2,845,297	$ 341,846	54.33%
30	6600 PHYSICAL THERAPY		0.346480	488,125	122,953	224,580	97,073	117,066	156,446	797,425	441,455	480	16,720	166,198	140,585	$ 1,627,196	$ 817,927	36.89%
31	6900 ELECTROCARDIOLOGY		0.043795	102,340	91,057	56,972	252,222	75,786	156,237	491,406	707,581	-	10,778	221,097	286,934	$ 726,504	$ 1,207,097	30.05%
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.215115	622,428	582,013	144,127	663,623	136,911	310,518	778,668	1,362,062	-	19,512	77,686	461,760	$ 1,682,134	$ 2,918,217	40.46%
33	7300 DRUGS CHARGED TO PATIENTS		0.162643	4,104,914	4,797,829	2,268,312	4,424,869	854,314	2,630,937	4,839,218	6,730,575	381	31,047	1,670,301	2,339,371	$ 12,066,757	$ 18,584,210	47.87%
34	7400 RENAL DIALYSIS		0.219359	21,616	-	93,343	-	96,669	-	388,793	-	-	-	22,472	328	$ 600,421	$ -	43.10%
35	9000 CLINIC		0.404249	1,014	47,141	2,017	55,152	1,159	28,622	3,920	105,664	-	3,369	2,084	25,147	$ 8,110	$ 236,579	27.95%
36	9100 EMERGENCY		0.326432	1,098,315	1,426,421	241,669	4,182,248	275,783	679,728	1,233,855	2,533,977	-	26,069	597,318	4,326,804	$ 2,849,622	$ 8,822,374	53.34%
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38			-													$ -	$ -	
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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 SUMTER MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & 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				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
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					$ 14,203,802	$ 12,628,586	$ 10,544,404	$ 22,167,676	$ 3,482,806	$ 6,531,079	$ 18,797,778	$ 23,596,474	$ 2,359	$ 314,408	$ 6,381,316	$ 17,116,601			

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

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

	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)***	$ 17,728,403	$ 12,628,586	$ 12,166,013	$ 22,167,676	$ 4,263,666	$ 6,531,079	$ 22,616,647	$ 23,596,474	$ 3,957	$ 314,408	$ 7,555,302 (Agrees to Exhibit A)	$ 17,116,601 (Agrees to Exhibit A)	$ 56,774,729	$ 64,923,815	42.12%
129	Total Charges per PS&R or Exhibit Detail	$ 17,728,403	$ 12,628,586	$ 12,166,013	$ 22,167,676	$ 4,263,666	$ 6,531,079	$ 22,616,647	$ 23,596,474	$ 3,957	$ 314,408	$ 7,555,302	$ 17,116,601			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 6,336,143	$ 2,324,219	$ 4,591,811	$ 4,305,875	$ 1,581,006	$ 1,192,529	$ 8,176,637	$ 4,420,718	$ 3,881	$ 65,708	$ 2,498,985	$ 3,309,901	$ 20,685,597	$ 12,243,341	47.28%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,829,352	$ 2,069,525	$ 3,560,481	$ 3,505,976	$ 23,043	$ 127,968	$ 548,125	$ 364,391					$ 7,961,001	$ 6,067,860	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 198			$ 117,712	$ 67,406					$ 117,712	$ 67,604	
134	Private Insurance (including primary and third party liability)				$ 9,812	$ 1,547	$ 653	$ 1,319,299	$ 1,225,325					$ 1,320,846	$ 1,235,790	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 25	$ 1,291	$ -	$ 447		$ 2,339					$ 25	$ 4,078	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,829,352	$ 2,069,525	$ 3,560,506	$ 3,517,278											
137	Medicaid Cost Settlement Payments (See Note B)		$ 60,051											$ -	$ 60,051	
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)	$ 44,766				$ 1,229,186	$ 822,806	$ 126,672	$ 47,531					$ 1,400,624	$ 870,337	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 4,367,994	$ 2,547,866					$ 4,367,994	$ 2,547,866	
141	Medicare Cross-Over Bad Debt Payments					$ 71,498	$ 46,053							$ 71,498	$ 46,053	
142	Other Medicare Cross-Over Payments (See Note D)					$ (24,739)						(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (24,739)	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 83,532	$ 399,611			
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)**	$ 2,462,024	$ 194,643	$ 1,031,305	$ 788,597	$ 280,472	$ 194,602	$ 1,696,836	$ 165,860	$ 3,881	$ 65,708	$ 2,415,453	$ 2,910,290	$ 5,470,637	$ 1,343,702	
146	**Calculated Payments as a Percentage of Cost**	61%	92%	78%	82%	82%	84%	79%	96%	0%	0%	3%	12%	74%	89%	
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)**					8,971										
148	**Percent of cross-over days to total Medicare days from the cost report**					7%										

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).

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		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	$ 1,097.02		2								2	
2	03100 INTENSIVE CARE UNIT	$ -										-	
3	03200 CORONARY CARE UNIT	$ 2,976.97										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,683.44										-	
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			$ 2,070								$ 2,070	
21.01	Calculated Routine Charge Per Diem			$ 1,035.00		$ -		$ -		$ -		$ 1,035.00	
	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)		0.648500		1,907				3,375			$ -	$ 5,282
23	5000 OPERATING ROOM		0.245689	-	-				-		-	$ -	$ -
24	5100 RECOVERY ROOM		0.101196	601	-				-		-	$ 601	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.512106	4,622	-				-		-	$ 4,622	$ -
26	5300 ANESTHESIOLOGY		0.013492	-	141				-		-	$ -	$ 141
27	5400 RADIOLOGY-DIAGNOSTIC		0.092962	-	14,444				2,706		6,257	$ -	$ 23,407
28	6000 LABORATORY		0.152765	2,117	9,011				3,208		866	$ 2,117	$ 13,085
29	6500 RESPIRATORY THERAPY		0.587804	-	-				-		-	$ -	$ -
30	6600 PHYSICAL THERAPY		0.346480	-	646				1,482		-	$ -	$ 2,128
31	6900 ELECTROCARDIOLOGY		0.043795	-	1,208				-		-	$ -	$ 1,208
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.215115	-	298				-		-	$ -	$ 298
33	7300 DRUGS CHARGED TO PATIENTS		0.162643	506	13,255				2,409		1,670	$ 506	$ 17,333
34	7400 RENAL DIALYSIS		0.219359	-	-				-		-	$ -	$ -
35	9000 CLINIC		0.404249	-	-				-		-	$ -	$ -
36	9100 EMERGENCY		0.326432	-	14,126				2,948		2,957	$ -	$ 20,031
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & 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				-									$ -	$ -
73				-									$ -	$ -
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103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2022-07/31/2023) PHOEBE SUMTER MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & 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			-									$ -	$ -
				$ 7,846	$ 55,037	$ -	$ -	$ -	$ 16,128	$ -	$ 11,750		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 9,916	$ 55,037	$ -	$ -	$ -	$ 16,128	$ -	$ 11,750	$ 9,916	$ 82,914
129	Total Charges per PS&R or Exhibit Detail	$ 9,916	$ 55,037	$ -	$ -	$ -	$ 16,128	$ -	$ 11,750		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 5,028	$ 11,066	$ -	$ -	$ -	$ 4,798	$ -	$ 1,951	$ 5,028	$ 17,815
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,966	$ 2,438				$ 1,703			$ 3,966	$ 4,141
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)		$ 110						$ 47	$ -	$ 158
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,966	$ 2,548	$ -	$ -						
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)								$ 564	$ -	$ 564
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
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)**	$ 1,062	$ 8,518	$ -	$ -	$ -	$ 3,095	$ -	$ 1,340	$ 1,062	$ 12,953
144	**Calculated Payments as a Percentage of Cost**	79%	23%	0%	0%	0%	35%	0%	31%	79%	27%

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 SUMTER MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-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 SUMTER MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-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 SUMTER MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,102,552		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	02.700000.690057 & 02.700000.690055	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,102,552		*(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		$ 1,102,552		

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**	122,109,739
19	Uninsured Hospital	**Charges Sec. G**	24,671,903
20	Total Hospital	**Charges Sec. G**	347,711,085
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		35.12%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.10%
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**	64,755,631
27	Uninsured Hospital	**Charges Sec. G**	24,990,268
28	Total Hospital	**Charges Sec. G**	347,711,085
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		18.62%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.19%
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.*