State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

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	08/01/2023	07/31/2024	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 (07/01/25 - 06/30/26)
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 07/01/2025 - 06/30/2026** — $ 19,909,371
   (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 07/01/2025 - 06/30/2026**
   (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 Services07/01/2025 - 06/30/2026** — $ 19,909,371

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	CFO/ADMIN OFFICER Title	11/14/2025 Date
BRIAN CHURCH Hospital CEO or CFO Printed Name	229-312-4068 Hospital CEO or CFO Telephone Number	BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	REBECCA KENDALL
Title	SYSTEM REIMBURSEMENT DIRECTOR
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 9.02 4/22/2025

D. General Cost Report Year Information 8/1/2023 - 7/31/2024

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		
	8/1/2023 through 7/31/2024		
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):	5 - Amended		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/5/2025		

	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	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	Yes	
11. Rural Referral Center (Yes or No)	Yes	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.
12. State Name & Number	FLORIDA	913855200
13. State Name & Number	ALABAMA	PH0007N
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2023 - 07/31/2024)

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)	$ 251,260	$ 971,898	$1,223,158
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,956,730	$ 9,486,136	$11,442,866
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)	$2,207,990	$10,458,034	$12,666,024
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.38%	9.29%	9.66%

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 (08/01/2023 - 07/31/2024)

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)	112,579 **(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	1,026
3.	Outpatient Hospital Subsidies	103,570
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 104,596
7.	Inpatient Hospital Charity Care Charges	80,154,002
8.	Outpatient Hospital Charity Care Charges	71,442,192
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 151,596,194

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	$171,103,403.00			$ 118,187,653	$ -	$ -	$ 52,915,750
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	$670,079,908.00	$1,214,840,959.00		$ 462,849,775	$ 839,137,032	$ -	$ 582,934,060
20.	Outpatient Services		$151,094,566.00			$ 104,366,785	$ -	$ 46,727,781
21.	Home Health Agency			$6,066,148.00			$ 4,190,120	
22.	Ambulance			$ 556,375			$ 384,309	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$6,343,451.00			$ 4,381,664	
26.	Other	$31,054,273.00	$57,494,775.00	$0.00	$ 21,450,372	$ 39,713,836	$ -	$ 27,384,840
27.	Total	$ 872,237,584	$ 1,423,430,300	$ 12,965,974	$ 602,487,800	$ 983,217,653	$ 8,956,093	$ 709,962,430
28.	Total Hospital and Non Hospital		Total from Above	$ 2,308,633,858		Total from Above	$ 1,594,661,547	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,308,633,858	Total Contractual Adj. (G-3 Line 2)	1,594,661,547
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				1,594,661,547
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2023-07/31/2024) 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	$ 116,817,027	$ -	$ -	$0.00	$ 116,817,027	90,763	$101,510,729.00		$ 1,287.06
2	03100 INTENSIVE CARE UNIT	$ 33,747,872	$ 150,838	$ -		$ 33,898,710	13,414	$37,290,063.00		$ 2,527.11
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	$ 11,501,656	$ -	$ -		$ 11,501,656	5,540	$18,372,162.00		$ 2,076.11
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-			$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-			$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 10,784,276	$ -	$ -		$ 10,784,276	10,863	$17,957,041.00		$ 992.75
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 172,850,831	$ 150,838	$ -	$ -	$ 173,001,669	120,580	$ 175,129,995		
19	Weighted Average									$ 1,434.75

		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
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	8,001	-	-	$ 10,297,767	$3,821,178.00	$10,109,271.00	$ 13,930,449	0.739227

		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	$52,752,333.00	$ 220,304	$ -		$ 52,972,637	$107,088,597.00	$197,206,361.00	$ 304,294,958	0.174083
22	5100 RECOVERY ROOM	$12,758,154.00	$ -	$ -		$ 12,758,154	$18,712,254.00	$37,320,204.00	$ 56,032,458	0.227692
23	5200 DELIVERY ROOM & LABOR ROOM	$11,846,783.00	$ 337,402	$ -		$ 12,184,185	$8,578,823.00	$1,636,624.00	$ 10,215,447	1.192722
24	5300 ANESTHESIOLOGY	$521,330.00	$ -	$ -		$ 521,330	$26,759,394.00	$46,108,132.00	$ 72,867,526	0.007154
25	5400 RADIOLOGY-DIAGNOSTIC	$23,747,620.00	$ 130,991	$ -		$ 23,878,611	$62,663,111.00	$199,635,208.00	$ 262,298,319	0.091036
26	5500 RADIOLOGY-THERAPEUTIC	$20,052,839.00	$ -	$ -		$ 20,052,839	$2,784,783.00	$50,012,883.00	$ 52,797,666	0.379805
27	6000 LABORATORY	$26,813,608.00	$ -	$ -		$ 26,813,608	$108,775,703.00	$116,834,788.00	$ 225,610,491	0.118849
28	6500 RESPIRATORY THERAPY	$9,551,541.00	$ -	$ -		$ 9,551,541	$46,244,177.00	$7,942,937.00	$ 54,187,114	0.176270
29	6600 PHYSICAL THERAPY	$9,300,949.00	$ -	$ -		$ 9,300,949	$11,258,178.00	$6,298,944.00	$ 17,557,122	0.529754

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2023-07/31/2024) 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	$2,359,376.00	$ -	$ -		$ 2,359,376	$8,147,801.00	$1,524,633.00	$ 9,672,434	0.243928
31	6800	SPEECH PATHOLOGY	$1,351,545.00	$ -	$ -		$ 1,351,545	$4,915,460.00	$1,500,586.00	$ 6,416,046	0.210651
32	6900	ELECTROCARDIOLOGY	$4,691,390.00	$ -	$ -		$ 4,691,390	$6,140,213.00	$18,651,658.00	$ 24,791,871	0.189231
33	7000	ELECTROENCEPHALOGRAPHY	$2,131,292.00	$ 123,053	$ -		$ 2,254,345	$1,123,767.00	$5,967,456.00	$ 7,091,223	0.317906
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$12,680,146.00	$ -	$ -		$ 12,680,146	$44,069,562.00	$61,042,155.00	$ 105,111,717	0.120635
35	7300	DRUGS CHARGED TO PATIENTS	$70,298,976.00	$ -	$ -		$ 70,298,976	$146,502,854.00	$365,505,872.00	$ 512,008,726	0.137300
36	7400	RENAL DIALYSIS	$3,183,487.00	$ -	$ -		$ 3,183,487	$6,459,607.00	$621,577.00	$ 7,081,184	0.449570
37	7600	ENDOSCOPY	$11,662,042.00	$ 121,068	$ -		$ 11,783,110	$4,428,873.00	$32,234,448.00	$ 36,663,321	0.321387
38	7601	HEART CATH LAB	$19,954,171.00	$ -	$ -		$ 19,954,171	$55,426,751.00	$64,736,418.00	$ 120,163,169	0.166059
39	9000	CLINIC	$15,129,455.00	$ -	$ -		$ 15,129,455	$2,652,066.00	$17,718,079.00	$ 20,370,145	0.742727
40	9100	EMERGENCY	$24,215,787.00	$ 299,693			$ 24,515,480	$25,329,624.00	$105,394,797.00	$ 130,724,421	0.187536
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 (08/01/2023-07/31/2024) 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**	$ 335,002,824	$ 1,232,511	$ -		$ 336,235,335	$ 701,882,776	$ 1,348,003,031	$ 2,049,885,807	
127	**Weighted Average**									0.169050
128	**Sub Totals**	$ 507,853,655	$ 1,383,349	$ -		$ 509,237,004	$ 877,012,771	$ 1,348,003,031	$ 2,225,015,802	
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**					$ 509,237,004				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.27%				

* 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 (08/01/2023-07/31/2024) 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	$ 1,287.06		7,787		5,001		2,250		13,900		853		5,837		29,791		43.18%
2	03100 INTENSIVE CARE UNIT	$ 2,527.11		1,942		618		713		3,024		46		989		6,343		54.76%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ 2,076.11		887		2,844				1,357		2		22		5,090		92.27%
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 992.75		1,391		6,956				2,023		30		489		10,400		100.25%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	12,007		15,419		2,963		20,304		931		7,337		51,624		49.00%
19	Total Days per PS&R or Exhibit Detail			12,007		15,419		2,963		20,304		931		7,337				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 19,776,695		$ 28,518,073		$ 4,379,898		$ 32,353,019		$ 1,435,368		$ 10,399,390		$ 85,027,685		54.60%
21.01	Calculated Routine Charge Per Diem			$ 1,647.10		$ 1,849.54		$ 1,478.20		$ 1,593.43		$ 1,541.75		$ 1,417.39		$ 1,647.06		
	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)		0.739227	1,345,973	407,944	293,756	1,091,069	107,037	253,288	711,493	1,521,692	10,924	17,064	261,261	500,854	$ 2,458,259	$ 3,273,993	46.86%
23	5000 OPERATING ROOM		0.174083	8,111,312	6,491,880	8,046,159	12,902,644	2,895,455	5,754,615	16,682,170	25,808,603	216,493	418,941	9,389,671	6,891,095	$ 35,735,096	$ 50,957,742	34.06%
24	5100 RECOVERY ROOM		0.227692	972,995	1,593,734	1,987,574	4,823,523	320,561	721,425	2,386,738	4,236,972	37,749	43,824	1,047,251	1,780,590	$ 5,667,868	$ 11,375,654	35.63%
25	5200 DELIVERY ROOM & LABOR ROOM		1.192722	454,274	8,454	4,493,764	157,110	14,130	10,545	1,972,650	113,955	4,399	718	192,420	20,386	$ 6,934,818	$ 290,064	72.98%
26	5300 ANESTHESIOLOGY		0.007154	1,879,443	1,957,051	1,363,502	4,563,063	617,841	704,304	3,658,391	4,254,833	55,608	77,280	2,603,552	1,840,518	$ 7,519,177	$ 11,479,251	32.37%
27	5400 RADIOLOGY-DIAGNOSTIC		0.091036	10,530,334	6,971,201	3,890,814	11,388,085	3,640,249	3,580,076	16,813,393	17,573,283	292,562	318,131	9,066,498	17,253,439	$ 34,874,790	$ 39,512,645	38.70%
28	5500 RADIOLOGY-THERAPEUTIC		0.379805	399,792	2,853,811	287,885	1,141,070	35,379	882,383	501,499	4,312,510	33,672	103,667	127,099	1,774,727	$ 1,224,555	$ 9,189,774	23.59%
29	6000 LABORATORY		0.118849	14,721,684	5,354,917	11,512,456	8,188,339	5,303,476	2,338,633	25,685,531	10,543,976	505,702	189,956	9,637,067	7,884,160	$ 57,223,147	$ 26,425,865	45.26%
30	6500 RESPIRATORY THERAPY		0.176270	6,059,323	280,733	5,607,341	391,175	1,764,641	57,220	10,493,605	541,406	138,962	7,941	1,945,126	382,668	$ 23,924,910	$ 1,270,534	51.09%
31	6600 PHYSICAL THERAPY		0.529754	1,116,748	247,277	490,831	151,859	311,977	116,624	1,666,857	793,987	61,371	35,399	642,602	220,534	$ 3,586,413	$ 1,309,747	33.37%
32	6700 OCCUPATIONAL THERAPY		0.243928	631,868	18,732	115,504	66,740	210,390	42,965	1,052,836	198,617	45,036	4,867	465,480	86,498	$ 2,010,598	$ 327,054	30.39%
33	6800 SPEECH PATHOLOGY		0.210651	422,666	15,698	1,215,777	265,876	116,051	21,518	810,348	230,779	47,062	12,840	411,175	39,654	$ 2,564,842	$ 533,871	56.27%
34	6900 ELECTROCARDIOLOGY		0.189231	526,542	324,840	511,406	711,985	362,247	275,582	1,952,766	1,636,745	22,640	13,897	732,097	1,073,435	$ 3,352,961	$ 2,949,152	32.93%
35	7000 ELECTROENCEPHALOGRAPHY		0.317906	103,461	486,302	78,595	569,232	42,171	61,882	209,908	593,940	6,254	2,078	71,016	219,065	$ 434,135	$ 1,711,356	34.48%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.120635	2,867,625	882,051	493,923	1,764,009	955,368	1,445,387	5,457,440	6,792,540	37,155	174,447	3,056,590	1,771,004	$ 9,774,356	$ 10,883,987	24.46%
37	7300 DRUGS CHARGED TO PATIENTS		0.137300	20,085,238	18,390,983	10,732,005	10,910,448	5,305,516	8,663,793	29,010,795	37,995,240	764,281	780,332	12,661,003	13,323,018	$ 65,133,554	$ 75,960,464	32.96%
38	7400 RENAL DIALYSIS		0.449570	258,064		929,018	92,002	725,228	66,960	3,116,897	236,213	25,037	1,876	411,548	87,169	$ 5,029,207	$ 395,175	84.08%
39	7600 ENDOSCOPY		0.321387	328,929	844,561	103,179	762,531	206,040	483,419	821,132	3,026,775	14,270	28,273	405,893	1,106,502	$ 1,459,280	$ 5,117,286	22.19%
40	7601 HEART CATH LAB		0.166059	3,495,081	1,034,498	1,224,018	816,776	1,360,258	975,289	6,449,087	6,540,144	120,699	69,432	4,480,043	1,942,890	$ 12,528,444	$ 9,366,707	23.78%
41	9000 CLINIC		0.742727	22,999	828,179	96,512	761,312	49,869	428,973	275,476	2,196,695	11,344	61,151	197,015	681,848	$ 444,856	$ 4,215,159	27.63%
42	9100 EMERGENCY		0.187536	4,380,232	4,611,615	2,331,512	13,972,486	1,196,620	2,221,010	6,357,708	10,312,212	128,693	174,768	3,470,335	15,043,858	$ 14,266,072	$ 31,117,323	49.31%
43			-													$ -	$ -	
44			-													$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (08/01/2023-07/31/2024) 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				-													$ -	$ -
72				-													$ -	$ -
73				-													$ -	$ -
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					$ 78,714,583	$ 53,604,461	$ 55,805,531	$ 75,491,334	$ 25,540,504	$ 29,105,891	$ 136,086,720	$ 139,461,117	$ 2,579,913	$ 2,536,882	$ 61,274,742	$ 73,923,912		

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

Cost Report Year (08/01/2023-07/31/2024) 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)***	$ 98,491,278	$ 53,604,461	$ 84,323,604	$ 75,491,334	$ 29,920,402	$ 29,105,891	$ 168,439,739	$ 139,461,117	$ 4,015,281	$ 2,536,882	$ 71,674,132 (Agrees to Exhibit A)	$ 73,923,912 (Agrees to Exhibit A)	$ 381,175,023	$ 297,662,803	37.11%
129	Total Charges per PS&R or Exhibit Detail	$ 98,491,278	$ 53,604,461	$ 84,323,604	$ 75,491,334	$ 29,920,402	$ 29,105,891	$ 168,439,739	$ 139,461,117	$ 4,015,281	$ 2,536,882	$ 71,674,132	$ 73,923,912			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 30,976,047	$ 9,132,689	$ 34,430,683	$ 12,670,312	$ 8,707,629	$ 4,915,048	$ 53,855,038	$ 24,117,934	$ 1,669,613	$ 443,015	$ 19,884,516	$ 11,769,063	$ 127,969,397	$ 50,835,983	41.40%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 18,642,139	$ 9,474,595	$ -	$ 592	$ 87,679	$ 321,189	$ 4,540,003	$ 1,564,628					$ 23,269,821	$ 11,361,004	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 21,255,734	$ 12,388,421		$ 9	$ 622,542	$ 338,549					$ 21,878,276	$ 12,726,979	
134	Private Insurance (including primary and third party liability)			$ 400,515	$ 300,572	$ 539	$ 4,083	$ 15,126,454	$ 6,251,893					$ 15,527,508	$ 6,556,548	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 225,860	$ 31,710	$ 19	$ 2,645	$ 1,495	$ 1,244	$ 2,346	$ 4,840		$ 315			$ 229,720	$ 40,439	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 18,867,999	$ 9,506,305	$ 21,656,268	$ 12,692,230											
137	Medicaid Cost Settlement Payments (See Note B)		$ (472,728)											$ -	$ (472,728)	
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)	$ 237,973				$ 8,429,713	$ 3,413,515	$ 438,131	$ 204,227					$ 9,105,817	$ 3,617,742	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 240	$ -	$ 30,382,295	$ 16,538,935					$ 30,382,535	$ 16,538,935	
141	Medicare Cross-Over Bad Debt Payments					$ 268,943	$ 302,428							$ 268,943	$ 302,428	
142	Other Medicare Cross-Over Payments (See Note D)					$ 673,378	$ 212,270					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 673,378	$ 212,270	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 251,260	$ 971,898			
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)**	$ 11,870,075	$ 99,112	$ 12,774,415	$ (21,918)	$ (754,358)	$ 660,310	$ 2,743,267	$ (785,138)	$ 1,669,613	$ 442,700	$ 19,633,256	$ 10,797,165	$ 26,633,399	$ (47,634)	
146	**Calculated Payments as a Percentage of Cost**	62%	99%	63%	100%	109%	87%	95%	103%	0%	0%	1%	8%	79%	100%	
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)**					39,801										
148	**Percent of cross-over days to total Medicare days from the cost report**					8%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note 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 (08/01/2023-07/31/2024) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & 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	$ 1,287.06		69				23		20		112	
2	03100 INTENSIVE CARE UNIT	$ 2,527.11		4				9		1		14	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 2,076.11										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 992.75		1								1	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	74		-		32		21		127	
19	Total Days per PS&R or Exhibit Detail			74		-		32		21			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 110,338				$ 56,302		$ 26,473		$ 193,113	
21.01	Calculated Routine Charge Per Diem			$ 1,491.05		$ -		$ 1,759.44		$ 1,260.62		$ 1,520.57	
	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)		0.739227		5,748							$ -	$ 5,748
23	5000 OPERATING ROOM		0.174083	15,875				486		16,740		$ 33,101	$ -
24	5100 RECOVERY ROOM		0.227692	8,858				-		3,702		$ 12,560	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		1.192722	12,368				53		43		$ 12,464	$ -
26	5300 ANESTHESIOLOGY		0.007154	5,932				-		6,036	204	$ 11,968	$ 204
27	5400 RADIOLOGY-DIAGNOSTIC		0.091036	29,577	79,290			27,155	8,359	15,143	32,271	$ 71,875	$ 119,920
28	5500 RADIOLOGY-THERAPEUTIC		0.379805	-	-			-		-	-	$ -	$ -
29	6000 LABORATORY		0.118849	50,309	74,101			55,203	4,155	26,115	27,762	$ 131,627	$ 106,018
30	6500 RESPIRATORY THERAPY		0.176270	6,187	5,364			1,518		843	225	$ 8,548	$ 5,589
31	6600 PHYSICAL THERAPY		0.529754	890				-		1,218	-	$ 2,108	$ -
32	6700 OCCUPATIONAL THERAPY		0.243928	-				-		-	-	$ -	$ -
33	6800 SPEECH PATHOLOGY		0.210651	571				-		-	-	$ 571	$ -
34	6900 ELECTROCARDIOLOGY		0.189231	6,533	6,631			2,893	230	1,513	2,203	$ 10,939	$ 9,064
35	7000 ELECTROENCEPHALOGRAPHY		0.317906	-				1,039		-	-	$ 1,039	$ -
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.120635	11,828				-		-	-	$ 11,828	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.137300	59,433	29,520			34,509	3,877	19,821	7,064	$ 113,763	$ 40,461
38	7400 RENAL DIALYSIS		0.449570	1,656	1,827			165		359	-	$ 2,180	$ 1,827
39	7600 ENDOSCOPY		0.321387	3,216				110		89	-	$ 3,415	$ -
40	7601 HEART CATH LAB		0.166059	50,645	948			2,105	3,094	8,392	3,558	$ 61,142	$ 7,600
41	9000 CLINIC		0.742727	2,526	811			3,011	6,492	106	4,282	$ 5,643	$ 11,585
42	9100 EMERGENCY		0.187536	20,442	167,871			29,128		10,276	35,075	$ 59,846	$ 202,946
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2023-07/31/2024) 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			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
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104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2023-07/31/2024) 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			-									$ -	$ -
				$ 286,846	$ 372,111	$ -	$ -	$ 157,375	$ 26,207	$ 110,396	$ 112,644		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 397,184	$ 372,111	$ -	$ -	$ 213,677	$ 26,207	$ 136,869	$ 112,644	$ 747,730	$ 510,962
129	Total Charges per PS&R or Exhibit Detail	$ 397,184	$ 372,111	$ -	$ -	$ 213,677	$ 26,207	$ 136,869	$ 112,644		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 156,558	$ 59,591	$ -	$ -	$ 75,568	$ 7,166	$ 43,993	$ 18,014	$ 276,119	$ 84,771
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,678	$ 3,103				$ 2		$ 207	$ 2,678	$ 3,312
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)		$ 352					$ 27,657	$ 9,873	$ 27,657	$ 10,225
135	Self-Pay (including Co-Pay and Spend-Down)		$ 578							$ -	$ 578
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 2,678	$ 4,033	$ -	$ -						
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)					$ 71,809	$ 1,549		$ 214	$ 71,809	$ 1,763
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 32,504	$ 1,391	$ 32,504	$ 1,391
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)**	$ 153,880	$ 55,558	$ -	$ -	$ 3,759	$ 5,615	$ (16,168)	$ 6,329	$ 141,471	$ 67,502
144	**Calculated Payments as a Percentage of Cost**	2%	7%	0%	0%	95%	22%	137%	65%	49%	20%

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 (08/01/2023-07/31/2024) 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 Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From 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 (08/01/2023-07/31/2024) 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)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):														
11		Lung Acquisition	$ -	$ -	$ -	$ -	0								
12		Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13		Liver Acquisition	$ -	$ -	$ -	$ -	0								
14		Heart Acquisition	$ -	$ -	$ -	$ -	0								
15		Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16		Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17		Islet Acquisition	$ -	$ -	$ -	$ -	0								
18			$ -	$ -	$ -	$ -	0								
19		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20		**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (08/01/2023-07/31/2024) 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)*		$ 8,207,304		
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)		$ 8,207,304	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		$ 8,207,304		

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**	686,648,681
19	Uninsured Hospital	**Charges Sec. G**	145,598,044
20	Total Hospital	**Charges Sec. G**	2,225,015,802
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		30.86%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.54%
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**	312,679,972
27	Uninsured Hospital	**Charges Sec. G**	152,150,207
28	Total Hospital	**Charges Sec. G**	2,225,015,802
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		14.05%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.84%
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.*