State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2020

DSH Version 6.00 2/17/2021 A. General DSH Year Information 1. DSH Year: 07/01/2019 06/30/2020 PHOEBE PUTNEY MEMORIAL HOSPITAL 2. Select Your Facility from the Drop-Down Menu Provided: 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 08/01/2019 07/31/2020 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): 110007 9. Medicare Provider Number: **B. DSH OB Qualifying Information** Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act. **DSH Examination** Year (07/01/19 -06/30/20) During the DSH Examination Year: 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to Yes 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.) 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's No inpatients are predominantly under 18 years of age? 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-No emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3b. What date did the hospital open?

3a. Was the hospital open as of December 22, 1987?

Yes

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2020

Disclosure of Other Medicaid Payments Received:		
Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/20 (Should include UPL and non-claim specific payments paid based on the state fi		\$ 13,197,366
2. Medicaid Managed Care Supplemental Payments for hospital services for l	DSH Year 07/01/2019 - 06/30/2020	
(Should include all non-claim specific payments for hospital services such as lun payments, capitation payments received by the hospital (not by the MCO), or other contents are contents as a service of the contents are contents.		lity payments, bonus
NOTE: Hospital portion of supplemental payments reported on DSH Survey Par	t 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 Hos	pital Services07/01/2019 - 06/30/2020	\$ 13,197,366
rtification:		
 Was your hospital allowed to retain 100% of the DSH payment it received f Matching the federal share with an IGT/CPE is not a basis for answering th hospital was not allowed to retain 100% of its DSH payments, please expla present that prevented the hospital from retaining its payments. 	nis question "no". If your	Yes
Explanation for "No" answers:		
Other Protested Item: "New Hampshire Hospital Association v. Azar" We prot	test the inclusion of Commercial and Medicare	
payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH	H and the payment calculation reduction of Uncompensated Care Co	st.
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 records of the hospital. All Medicaid eligible patients, including those who have payment on the claim. I understand that this information will be used to determin provisions. Detailed support exists for all amounts reported in the survey. These available for inspection when equested. Hospital CEO or CFO Signature	I L of the DSH Survey files are true and accurate to the best of our all private insurance coverage, have been reported on the DSH survey the the Medicaid program's compliance with federal Disproportionate	regardless of whether the hospital received Share Hospital (DSH) eligibility and payments g the due date of the survey, and will be made
BRIAN CHURCH Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	BCHURCH@PHOEBEHEALTH.COM Hospital CEO or CFO E-Mail
	·	
Telephone Number 229-312-6	A KENDALL DR OF REIMBURSEMENT 6711 LL@PHOEBEHEALTH.COM	Outside Preparer: Name Title Firm Name Telephone Number E-Mail Address

6,00 Property of Myers and Stauffer LC Page 2

DSH Version 8.00 1/28/2021 D. General Cost Report Year Information 8/1/2019 7/31/2020 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 8/1/2019 through 7/31/2020 2. Select Cost Report Year Covered by this Survey (enter "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: 1/15/2021 Correct? Data If Incorrect, Proper Information PHOEBE PUTNEY MEMORIAL HOSPITAL Yes 4. Hospital Name: 000001482A PROVIDER NUMBER 000001482A & 000001416A 5. Medicaid Provider Number: No 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 000001416A No 416A IS THE SECOND CAID NUMBER FOR PHOEBE, NOT SUBPROV 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): No 110007 Yes 8. Medicare Provider Number: Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year: State Name Provider No. 9. State Name & Number **FLORIDA** 913855200 10. State Name & Number ALABAMA PH0007N 11. State Name & Number 12 State Name & Number 13 State Name & Number 14. State Name & Number 15. State Name & Number (List additional states on a separate attachment) E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2019 - 07/31/2020) 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) Outpatient Total Inpatient 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 1.416.285 \$2,446,635 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 2.061.849 9.033.485 \$11.095.334 \$3,478,134 \$10,063,835 \$13,541,969 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) 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 40.72% 10.24% 18.07% 13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments. 14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services 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 (08/01/2019 - 07/31/2020)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

109.500 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) (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 4. Unspecified I/P and O/P Hospital Subsidies
- 5. Non-Hospital Subsidies
- 6. Total Hospital Subsidies
- 7. Inpatient Hospital Charity Care Charges
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

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.

11	. F	los	pita	al
11	. г	105	DILG	il.

- 12. Subprovider I (Psych or Rehab)
- 13. Subprovider II (Psych or Rehab)
- 14. Swing Bed SNF
- 15. Swing Bed NF
- 16. Skilled Nursing Facility 17. Nursing Facility
- 18. Other Long-Term Care
- 19. Ancillary Services
- 20. Outpatient Services
- 21. Home Health Agency
- 22. Ambulance
- 23. Outpatient Rehab Providers
- 24. ASC
- 25. Hospice
- 26. Other 27. Total
- 28. Total Hospital and Non Hospital

29. Total Per Cost Report			Total	Patient Rever	nues (G-3	Line

- 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on work revenue)
- 31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLU 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. Adjusted Contractual Adjustments
- 36. Unreconciled Difference

is it	Total	Patient Revenues (Charge	es)	Contractual Adjustme	nts (formulas below can be are known)	e overwritten if amounts	
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
	\$138,371,477.00 \$0.00 \$0.00 \$0.00 \$627,510,352.00 \$0.00 \$18,248,866.00	\$993,838,536.00 \$100,300,436.00 \$0.00 \$47,775,402.00	\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$4,173,268.00 \$496,466 \$0.00 \$4,970,263.00 \$0.00	\$ 97,538,146 \$ - \$ - \$ 442,332,464 \$ - \$ - \$ 12,863,638	\$ - \$ - \$ - \$ - \$ 700,557,444 \$ 70,701,844 \$ - \$ - \$ - \$ 33,676,913	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 40,833,331 \$ - \$ - \$ - \$ 478,458,981 \$ 29,598,592 \$ - \$ - \$ - \$ 19,483,718
\$	784,130,695	\$ 1,141,914,374 Total from Above	\$ 9,639,997 \$ 1,935,685,066	\$ 552,734,247	\$ 804,936,200 Total from Above	\$ 6,795,240 \$ 1,364,465,688	\$ 568,374,621
	Total Patient et G-3, Line 2 (impact is a	•	1,935,685,066	Total Con	tractual Adj. (G-3 Line 2)	1,360,688,469	

Unreconciled Difference (Should be \$0)

3,777,219

1.364.465.688

147,967

220,907

31,236,425

36,293,353

67.529.778

Unreconciled Difference (Should be \$0)

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL

NOTE: All state in this section must be warfied by the heapstal. First six stated by search is the section. It was completed using CES PORTS over inport data. If the section is section in the section of the section		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
1	hospi con hospi data sh	tal. If d apleted tal has a ould be	ata is already present in this section, it was using CMS HCRIS cost report data. If the a more recent version of the cost report, the updated to the hospital's version of the cost las can be overwritten as needed with actual	Worksheet B,	Worksheet B, Part I, Col. 25 (Intern & Resident	Worksheet C, Part I, Col.2 and	Out - Cost Report Worksheet D-1,	Calculated	W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for	Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges		Calculated Per Diem
2 0000 INTENSIVE CARE UNIT		Routin	ne Cost Centers (list below):									
State Stat	1			\$ 92,633,756	\$ 1,317,089	\$ -	\$0.00	\$ 93,950,845	89,602	\$68,782,037.00		\$ 1,048.54
	2			\$ 29,518,272	\$ 133,091	\$ -		\$ 29,651,363	14,370	\$36,049,320.00		
Source S	3			\$ -	T				-	\$0.00		
6				<u>'</u>					-			
				T					-	* * * * * * * * * * * * * * * * * * * *		
Subprovider				+ 11,000,001					8,583	4 ,,		
9 04000 OTHER SUBPROVIDER \$ - \$ - \$ \$ - \$ \$ - \$ \$ \$ \$	-			T		•			-			
10 5400 NURSERY				<u>'</u>		<u>'</u>			-			
12												
12		04300			*	*			8,382			
13				•	7				-	* * * * * * * * * * * * * * * * * * * *		
S				•		•			-	* * * * * * * * * * * * * * * * * * * *		
S				•	T	•			-			
10				•		•			-	* * * * * * * * * * * * * * * * * * * *		
Total Routine \$ 138,740,654 \$ 1,569,444 \$ - \$ \$ 140,310,098 120,937 \$ 133,102,080 \$ 1,160,20 \$ \$ \$ 1,160,20 \$ \$ \$ \$ \$ \$ \$ \$ \$									-	* * * * * * * * * * * * * * * * * * * *		
Total Routine S 138,740,654 S 1,569,444 S S S 140,310,098 120,937 S 133,102,060									-			
Hospital Diservation Days Cost Report Wis S Cost Report Wi		\square		T	7	*	•	т.	400.007			Φ -
Hospital Observation Days - Cost Report WS - Cost Report Worksheet B, Part I, Col. 25 United MR Resident Offset ONL!)* Ancillary Cost Centers (from WS C excluding Observation) (list below):				\$ 138,740,654	\$ 1,569,444	5 -	\$ -	\$ 140,310,098	120,937	\$ 133,102,060		
Observation Days Cost Report Wis S Cost Report Wis Report Wis S Cost Report Wis	19		Weighted Average									\$ 1,160.20
Cost Report Worksheet B, Part I, Col. 26 Cost Report Worksheet C, Part I, Col. 26 Cost Report Worksheet C, Part I, Col. 20 Cost Report Worksheet C, Part I, Col. 20 Cost Report Worksheet C, Pt. I, Col. 6 Cost Report Worksheet C, Pt. I, Col. 7 Col. 7 Col. 8 Cost Report Worksheet C, Pt. I, Col. 8 Cost Report Cost Report Worksheet C, Pt. I, Col. 8 Cost Report Cost Repor		Observ	vation Data (Non-Distinct)		Observation Days - Cost Report W/S S- 3, Pt. I, Line 28,	Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01,	Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.02,	Diems Above	Cost Report Worksheet C, Pt. I,	- Cost Report Worksheet C, Pt. I,	Cost Report Worksheet C, Pt. I,	
Cost Report Worksheet B, Part I, Col. 26 Part I, Col. 27 Part I, Col. 26 Part I, Col. 26 Part I, Col. 27 Part I, Col. 28 Part I, Col. 29 P	20	09200	Observation (Non-Distinct)		11,437	-	-	\$ 11,992,152	\$4,607,487.00	\$7,693,809.00	\$ 12,301,296	0.974869
Morksheet B, Part I, Col. 26 Part I, Col. 24 Part I, Col. 24 Part I, Col. 2 and Col. 4 Part I, Col. 2 and Col. 4 Part I, Col. 26 Part I, Col. 2 and Col. 4 Part I, Col. 4 Part I, Col. 2 and Col. 4 Part I, Col. 4 Part I, Col. 2 and Col. 4 Part I, Col. 4 Part I, Col. 2 and Col. 4 Part I, Col. 2 and Col. 4 Part I, Col. 4 Part I, Col. 2 and Col. 4 Part I, Col.					Worksheet B,							Medicaid Calculated
21 5000 OPERATING ROOM \$31,100,470.00 \$ 69,139 \$0.00 \$31,169,609 \$89,818,024.00 \$141,344,801.00 \$ 231,162,825 0.134838 22 5100 RECOVERY ROOM \$9,644,405.00 \$ - \$0.00 \$ 9,644,405 \$23,755,263.00 \$33,414,691.00 \$ 57,169,954 0.168697 23 5200 DELIVERY ROOM \$9,186,513.00 \$ 212,601 \$0.00 \$ 9,399,114 \$3,883,086.00 \$2,298,323.00 \$ 6,181,409 1.520546 24 5300 ANESTHESIOLOGY \$303,933.00 \$ - \$0.00 \$ 303,933.00 \$ 0 \$0.00 \$ 303,933 \$21,102,565.00 \$32,570,230.00 \$ 53,672,795 0.005663 25 5400 RADIOLOGY-DIAGNOSTIC \$18,295,073.00 \$ 103,707 \$0.00 \$ 18,398,780 \$41,146,854.00 \$133,662,094.00 \$ 174,808,948 0.105251 26 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 \$ 21,428,242 \$2,516,495.00 \$50,680,880.00 \$ 53,197,375 \$0.402806 27 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$ 20,931,854.00 \$ 177,546,493 \$0.117895 28 6500 RESPIRATORY THERAPY \$9,404,5760 \$ - \$0.00 \$ 9,404,576 \$25,241,43.00 \$5,461,833.00 \$ 30,703,767 \$0.306298 29 6600 PHYSICAL THERAPY \$9,404,5760 \$ - \$0.00 \$ 9,404,576 \$25,241,43.00 \$5,462,741.00 \$ 16,221,863 \$0.561619 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$1,290,878.00 \$ 8,776,551 \$0.237995 \$0.027995 \$0.00 \$ 2,088,774 \$7,485,673.00 \$1,290,878.00 \$ 8,776,551 \$0.237995 \$0.00 \$ 2,088,774 \$7,485,673.00 \$1,290,878.00 \$ 8,776,551 \$0.237995 \$0.00		Ancilla	ary Cost Centers (from W/S C excluding Observ	Part I, Col. 26	(Intern & Resident Offset ONLY)*	Part I, Col.2 and		Calculated	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Worksheet C, Pt. I,	
22 5100 RECOVERY ROOM \$9,644,405.00 \$ - \$0.00 \$ 9,186,513.00 \$ 212,601 \$0.00 \$ 9,399,114 \$3,883,086.00 \$2,299,323.00 \$ 6,181,409 \$1.520546 \$ 5400 RADIOLOGY-DIAGNOSTIC \$18,295,073.00 \$ 103,707 \$0.00 \$ 18,398,780 \$41,146,854.00 \$133,662,094.00 \$174,808,948 \$0.105251 \$ 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 \$13,938,780 \$41,146,854.00 \$133,662,094.00 \$174,808,948 \$0.105251 \$ 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$12,931,854.00 \$12,293,1854.00 \$12	21					\$0.00		\$ 31,169,609	\$89.818.024.00	\$141,344,801.00	\$ 231,162,825	0.134838
23 5200 DELIVERY ROOM & LABOR ROOM \$9,186,513.00 \$ 212,601 \$0.00 24 5300 ANESTHESIOLOGY \$303,933.00 \$ - \$0.00 \$ 303,933 \$21,102,565.00 \$32,570,230.00 \$ 53,672,795 0.005663 25 5400 RADIOLOGY-DIAGNOSTIC \$18,295,073.00 \$ 103,707 \$0.00 \$ 18,398,780 \$41,146,854.00 \$133,662,094.00 \$ 174,808,948 0.105251 26 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 \$ 21,428,242 \$2,516,495.00 \$50,680,880.00 \$ 53,197,375 0.402806 27 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$ 20,931,854 \$77,644.40.00 \$100,085,049.00 \$ 177,546,973 0.317895 28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,461,833.00 \$ 30,703,976 0.306298 29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,404,576 \$25,422,741.00 \$ 16,221,863						* * * * * * * * * * * * * * * * * * * *						
24 5300 ANESTHESIOLOGY \$303,933.00 \$ - \$0.00 \$ 303,933 \$21,102,565.00 \$32,570,230.00 \$ 53,672,795 0.005663 25 5400 RADIOLOGY-DIAGNOSTIC \$18,295,073.00 \$ 103,707 \$0.00 \$ 18,398,780 \$41,146,854.00 \$133,662,094.00 \$ 174,808,948 0.105251 26 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 \$ 21,428,242 \$2,516,495.00 \$50,680,880.00 \$ 53,197,375 0.402806 27 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$ 20,931,854 \$77,461,444.00 \$100,085,049.00 \$ 177,546,493 0.117895 28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,461,833.00 \$ 30,703,976 0.306298 29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,462,741.00 \$ 16,221,863 0.561619 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$ 8,776,551 0.237995						****						
25 5400 RADIOLOGY-DIAGNOSTIC \$18,295,073.00 \$ 103,707 \$0.00 26 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 \$ 21,428,242 \$2,516,495.00 \$50,680,880.00 \$ 53,197,375 0.402806 27 5000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$ 20,931,854 \$77,461,444.00 \$100,085,049.00 \$ 177,546,493 0.117895 28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,461,833.00 \$ 30,703,976 0.3026298 29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,110,502 \$10,769,122.00 \$5,462,741.00 \$ 16,221,863 0.561619 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$ 1,290,878.00 \$ 8,776,551 0.237995												
26 5500 RADIOLOGY-THERAPEUTIC \$21,428,242.00 \$ - \$0.00 27 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 29 6600 PHYSICAL THERAPY \$9,404,576.00 \$ - \$0.00 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$0.237995						\$0.00						
27 6000 LABORATORY \$20,931,854.00 \$ - \$0.00 \$20,931,854 \$77,461,444.00 \$100,085,049.00 \$ 177,546,493 0.117895 28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,461,833.00 \$ 30,703,976 0.306298 29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,110,502 \$10,769,122.00 \$5,452,741.00 \$ 16,221,863 0.561619 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$ 1,290,878.00 \$ 8,776,551 0.237995						\$0.00			* / -/	*/ /		
28 6500 RESPIRATORY THERAPY \$9,404,576.00 \$ - \$0.00 \$ 9,404,576 \$25,242,143.00 \$5,461,833.00 \$ 30,703,976 0.306298 29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,110,502 \$10,769,122.00 \$5,452,741.00 \$ 16,221,863 0.561619 30 6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$1,290,878.00 \$ 8,776,551 0.237995						\$0.00				\$100,085,049.00		
29 6600 PHYSICAL THERAPY \$9,110,502.00 \$ - \$0.00 \$ 9,110,502 \$10,769,122.00 \$5,452,741.00 \$ 16,221,863 0.561619 \$ 0.6700 OCCUPATIONAL THERAPY \$2,088,774.00 \$ - \$0.00 \$ 2,088,774 \$7,485,673.00 \$1,290,878.00 \$ 8,776,551 0.237995						\$0.00						
The state of the s	29	6600	PHYSICAL THERAPY	\$9,110,502.00	\$ -	\$0.00		\$ 9,110,502	\$10,769,122.00	\$5,452,741.00	\$ 16,221,863	0.561619
31 6800 SPEECH PATHOLOGY \$1,156,845.00 \$ - \$0.00 \$ 1,156,845 \$3,561,583.00 \$1,320,354.00 \$ 4,881,937 0.236964		6700	OCCUPATIONAL THERAPY	\$2,088,774.00	\$ -					\$1,290,878.00	\$ 8,776,551	0.237995
	31	6800	SPEECH PATHOLOGY	\$1,156,845.00	\$ -	\$0.00		\$ 1,156,845	\$3,561,583.00	\$1,320,354.00	\$ 4,881,937	0.236964

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2019-07/31/2020)

PHOEBE PUTNEY MEMORIAL HOSPITAL

Line		Total Allowable	Intern & Resident Costs Removed on				I/P Days and I/P	I/P Routine Charges and O/P		Medicaid Per Diem /
#	Cost Center Description	Cost	Cost Report *	Applicable)		Total Cost	Ancillary Charges	Ancillary Charges	Total Charges	Cost or Other Ratios
	ELECTROCARDIOLOGY	\$3,248,740.00	\$ -	\$0.00	\$	3,248,740	\$5,563,358.00	\$14,255,763.00	\$ 19,819,121	0.163919
	ELECTROENCEPHALOGRAPHY	\$1,801,633.00		\$0.00	\$	1,801,633	\$557,726.00		\$ 4,535,265	0.397250
	MEDICAL SUPPLIES CHARGED TO PATIENT	\$36,698,112.00		\$0.00	\$	36,698,112	\$84,711,380.00		\$ 142,904,424	0.256802
	IMPL. DEV. CHARGED TO PATIENTS	\$18,142,060.00		\$0.00	\$	18,142,060	\$44,789,975.00		\$ 100,251,083	0.180966
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	\$67,612,136.00 \$3,096,138.00		\$0.00 \$0.00	\$	67,612,136 3,096,138	\$144,504,206.00 \$5,723,100.00		\$ 443,421,302 \$ 6,700,351	0.152478 0.462086
	ENDOSCOPY	\$6,129,328.00		\$0.00	\$	6,222,665	\$2,295,483.00		\$ 19,736,556	0.462086
	HEART CATH LAB	\$4,515,701.00		\$0.00	\$	4,515,701	\$32,622,872.00		\$ 69,656,660	0.064828
	CLINIC	\$8,976,231.00		\$0.00	\$	8,976,231	\$1,629,199.00		\$ 18,363,198	0.488816
	EMERGENCY	\$24,052,203.00		\$3,702,592.00	\$	28,046,905	\$13,194,129.00		\$ 81,937,238	0.342297
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	*	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00 \$0.00		\$0.00 \$0.00	\$	-	\$0.00 \$0.00	·	\$ - \$ -	
		\$0.00	*	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$		\$0.00		\$ -	
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	•	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00	·	\$ -	-
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00	70.00	\$ -	-
		\$0.00 \$0.00		\$0.00 \$0.00	\$	-	\$0.00 \$0.00		\$ - \$ -	
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$		\$0.00	·	\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00	·	\$ -	_
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	\$ -	\$0.00	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	*	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00 \$0.00		\$0.00 \$0.00	<u>\$</u> \$	-	\$0.00 \$0.00		\$ - \$ -	-
		\$0.00	•	\$0.00	\$		\$0.00	*	\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	•	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00	•	\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$		\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		\$ -	-
		\$0.00		\$0.00	\$	-	\$0.00		<u>\$</u> -	-
		\$0.00		\$0.00 \$0.00	\$	-	\$0.00 \$0.00	·	\$ - \$ -	-
		\$0.00 \$0.00		\$0.00 \$0.00	\$	-	\$0.00 \$0.00		\$ - \$ -	-
		\$0.00	φ -	\$0.00	\$	-	\$0.00	\$0.00	φ -	-

G. Cost Report - Cost / Days / Charges

PHOEBE PUTNEY MEMORIAL HOSPITAL Cost Report Year (08/01/2019-07/31/2020)

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
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	*	\$0.00	\$ -	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	•	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	•	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	*	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	*	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	•	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00	*	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	•	-
		\$0.00	*	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	•	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
	Total Ancillary Weighted Average	\$ 306,923,469	\$ 770,894	\$ 3,702,592	\$ 311,396,955	\$ 646,941,167	\$ 1,087,009,453	\$ 1,733,950,620	0.186504
	Sub Totals	\$ 445,664,123	\$ 2.340.338	\$ 3.702.592	\$ 451,707,053	\$ 780 043 227	\$ 1,087,009,453	\$ 1.867.052.680	
Wo	, SNF, and Swing Bed Cost for Medicaid (Surksheet D, Part V, Title 19, Column 5-7, Line	ım of applicable Cost R e 200)	Report Worksheet D-3,	Title 19, Column 3, Line 200 and	\$0.00		• .,,,	• ',,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	, SNF, and Swing Bed Cost for Medicare (Sorksheet D, Part V, Title 18, Column 5-7, Line		Report Worksheet D-3,	Title 18, Column 3, Line 200 and	\$0.00				
NF,	, SNF, and Swing Bed Cost for Other Payers	(Hospital must calcula	ate. Submit support for	calculation of cost.)					
Oth	ner Cost Adjustments (support must be subm	itted)							
	Grand Total	•			\$ 451,707,053	-			
	tal Intern/Resident Cost as a Percent of Othe				0.52%				

^{*} 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 (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL

			NEWORIAL HOSPITAL						FS Cross-Overs (with		dicaid Eligibles (Not					%
Line #	Cost Center Description	Medicald Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medica	outpatient	In-State Medicaid M	anaged Care Primary Outpatient	Medicaid	Secondary) Outpatient	Included	Elsewhere) Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Total In-Sta		to Cost Report Totals
Line #	Cost Center Description	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	From PS&R	From PS&R Summary (Note A)	From PS&R	From Hospital's Own Internal Analysis		трацен	Outpatient	Totals
	Cost Centers (from Section G): ADULTS & PEDIATRICS	\$ 1,048,54		Days 11.584		Days 5.597		Days 5.854		Days 13.262		Days 5.908		Days 36,297		54 149
03100 I 03200 0	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	\$ 1,048.54 \$ 2,063.42 \$ -		2,495		170		1,232		2,658		918		6,555 -		54.14%
03400 S	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE UNIT SUBPROVIDER I	\$ - \$ 1,410.65 \$ -		664		6,332				1,404				- 8,400 -		98.03%
04200 0 0 04300 f	SUBPROVIDER II OTHER SUBPROVIDER NURSERY	\$ - \$ - \$ 548.83		628		6,412				885		16		7,925		95.20%
1 2 3		\$ - \$ -												-		
5 6 7		\$ - \$ - \$ -												-		
8	2000 51332	Ψ	Total Days	15,371		18,511		7,086		18,209		6,842		59,177		54.75%
9 Total Days 0	s per PS&R or Exhibit Detail Unreconciled Days	(Explain Variance)		15,371		18,511		7,086		18,209		6,842				
	Routine Charges Calculated Routine Charge Per Diem			Routine Charges \$ 19,614,409 \$ 1,276.07		Routine Charges \$ 25,913,480 \$ 1,399.90		Routine Charges \$ 8,187,365 \$ 1,155.43		Routine Charges \$ 22,775,055 \$ 1,250.76		Routine Charges \$ 7,434,275 \$ 1,086.56		Routine Charges \$ 76.490,309 \$ 1,292.57		63.23%
2 09200 0	Cost Centers (from W/S C) (from Section Observation (Non-Distinct)	n G):	0.974869	Ancillary Charges 2,094,443	Ancillary Charges 613,725	Ancillary Charges 393,279	Ancillary Charges 1,030,074	Ancillary Charges 404,743	Ancillary Charges 421,446	Ancillary Charges 746,967	Ancillary Charges 900,278	Ancillary Charges 351,603	Ancillary Charges 917,800	Ancillary Charges \$ 3,639,432	Ancillary Charges \$ 2,965,523	
4 5100 F	OPERATING ROOM RECOVERY ROOM	-	0.134838 0.168697	9,222,825 1,507,268	6,191,407 1,958,511	7,960,989 2,789,345	9,189,912 4,681,860	5,846,771 799,705	14,828,365 1,437,298	13,151,449 2,466,396	9,380,149 2,432,396	6,329,257 1,187,768	5,787,723 1,888,069	\$ 36,182,034 \$ 7,562,714	\$ 39,589,833 \$ 10,510,065	
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	_	1.520546 0.005663	339,612 2,039,920	10,380 1,779,625	3,604,552 1,415,135	126,159 3,382,467	8,368 1,166,391	692 1,142,450	1,105,419 2,881,592	39,402 1,970,737	23,792 1,834,882	2,076 1,759,884	\$ 5,057,951 \$ 7,503,038	\$ 176,633 \$ 8,275,279	85.17% 36.11%
7 5400 F	RADIOLOGY-DIAGNOSTIC		0.105251	9,157,117	5,863,885	2,476,235	7,638,801	5,104,092	4,398,062	10,965,584	8,416,389	6,586,222	15,783,966	\$ 27,703,028	\$ 26,317,137	43.79%
	RADIOLOGY-THERAPEUTIC LABORATORY		0.402806 0.117895	555,868 14.899,587	3,098,812 5,792,879	30,609 8.452.701	1,930,758 6.064,585	88,749 7,722,137	2,326,595 3,590,356	722,088 16.534.932	4,036,012 6,727,693	167,616 7.059,501	1,644,158 7,599,361	\$ 1,397,314 \$ 47,609,357	\$ 11,392,177 \$ 22,175,513	27.45% 47.68%
0 6500 F	RESPIRATORY THERAPY		0.306298	5,376,891	131,513	2,436,337	197,886	2,180,112	274,962	5,246,109	365,777	1,520,478	290,544	\$ 15,239,449	\$ 970,138	58.96%
	PHYSICAL THERAPY OCCUPATIONAL THERAPY		0.561619 0.237995	1,683,673 1,045,902	328,597 30,446	465,861 67.857	290,323 48.441	848,732 536,247	171,976 27,088	1,755,135 1,179,135	454,383 173.153	501,771 322,227	269,280 89,460	\$ 4,753,401 \$ 2,829,141	\$ 1,245,279 \$ 279,128	41.82% 40.22%
3 6800 5	SPEECH PATHOLOGY		0.236964	443,909	48,259	1,203,433	319,914	155,003	38,078	498,714	147,003	123,465	35,221	\$ 2,301,059	\$ 553,254	61.76%
	ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY		0.163919 0.397250	557,019 98,403	379,574 429,184	420,832 30,980	643,260 371,537	782,932 60,852	454,790 98,593	1,588,751 103,971	827,809 340,037	740,232 27,405	1,261,996 110,759	\$ 3,349,534 \$ 294,206	\$ 2,305,433 \$ 1,239,351	38.74% 36.88%
6 7100	MEDICAL SUPPLIES CHARGED TO PATIEN	T	0.256802	11,019,821	3,722,826	8,879,062	3,596,237	5,934,970	3,444,166	13,464,143	4,435,589	5,196,556	4,091,782	\$ 39,297,996	\$ 15,198,818	44.73%
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		0.180966 0.152478	3,640,764 26,657,787	3,387,374 21,671,909	626,526 10,104,221	1,510,382 11,641,486	2,288,738 11,966,220	3,706,389 12,738,249	5,053,667 27,494,867	4,976,205 23,280,463	2,749,594 12,410,294	1,762,203 11,488,447	\$ 11,609,695 \$ 76,223,095	\$ 13,580,350 \$ 69,332,107	29.64% 38.29%
9 7400	RENAL DIALYSIS		0.462086	171,504	12,628	747,562	78,655	1,895,238	197,070	1,943,538	99,015	282,108	89,609	\$ 4,757,842	\$ 387,368	82.52%
	ENDOSCOPY HEART CATH LAB		0.315286	251,067 3,271,398	666,376 941,022	49,290 1,350,132	471,066 1,013,306	145,838 2.102,325	601,133	344,174 3,979,174	1,096,025 2,376,762	205,343 3,854,872	887,077 1,723,223	\$ 790,369 \$ 10,703,029	\$ 2,834,600 \$ 5,815,671	23.91% 31.76%
2 9000 (CLINIC		0.488816	3,349	1,069,840	255,215	606,572	62,217	806,975	120,382	1,352,290	142,507	896,708	\$ 441,163	\$ 3,835,677	28.99%
3 9100 E	EMERGENCY		0.342297	3,213,668	3,870,712	1,566,970	9,748,430	1,888,669	2,244,322	3,652,417	4,679,736	2,614,594	13,681,697	\$ 10,321,724	\$ 20,543,200	57.69%
5			-											\$ -	\$ -	ı
6			-											\$ -	\$ -	ŀ
7			-											\$ - \$ -	\$ -	ſ
9			-											\$ -	\$ -	ŧ
0			-						 		[\$ -	\$ -	ſ
2			-											\$ -	\$ -	ı
4			-											\$ -	\$ -	ſ
5			-											\$ -	\$ -	ı
3			-											\$ -	\$ -	r
3			-					-						\$ - \$ -	\$ -	í
9			-											\$ -	\$ -	ı
			-											\$ -	\$ -	ſ
1 2			-								 			\$ -	\$ -	ı
			1				1	1		1				1.	<u> </u>	

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

Cost Report Year (08/01/2019-07/31/2020)	PHOEBE PUTNEY MEMORIAL HOSPITAL

-		In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	70tal In-State Medicaid Surv
3			 	1			\$ - \$ -
4							\$ - \$ -
5							\$ - \$ -
6							\$ - \$ -
7	-						\$ - \$ -
8	-						\$ - \$ -
9							\$ - \$ -
0	-						\$ - \$ -
1	-						S - S -
2	-						\$ - \$ -
3							\$ - \$ -
4	-						S - S -
5							S - S -
6	-						\$ - \$ -
7							\$ - \$ -
в [-						S - S -
9							s - s -
5							S - S -
1							\$ - \$ -
2							s - s -
3							\$ - \$ -
<u> </u>	-		1	1			\$. \$
; +	-		1	1			\$ - \$ -
4 5	-		1	1			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
,	-		 	 			\$ - \$ -
8	-		 	 			3 - 3
9	-		 	 			3 . 3
			 	 			3 - 3 -
) [-		 	 			3 - 3 -
. [-		 	 			\$ - \$ -
: +			 	 			\$ - \$ - \$ - \$
3	-			 			5 - 5 -
: F				 			\$ - \$ -
5							\$ - \$ -
7							\$ - \$ -
′ L	-						\$ - \$ -
3							\$ - \$ -
9	-						\$ - \$ -
00							\$ - \$ -
)1							\$ - \$ -
)2	-						\$ - \$ -
03	-						\$ - \$ -
04							\$ - \$ -
05			<u> </u>				\$ - \$ -
06							\$ - \$ -
07							\$ - \$ -
8							\$ - \$ -
9							\$ - \$ -
0	-						\$ - \$ -
1							\$ - \$ -
2	-						\$ - \$ -
3							\$ - \$ -
4							\$ - \$ -
5							\$ - \$ -
6	-						\$ - \$ -
7							S - S -
8							\$ - \$ -
9							\$ - \$ -
ŏ							\$ - \$ -
1	-		1	1			<u> </u>
2	-		1	1			1 5
3	-		1	1			3 . 3
24	-		 	11			1 0
	-		1	1			S - S -
25	-		1	1			S - S -
26 27			1	1			3 . 3 .
	-	\$ 97,251,795 \$ 61,999,484	\$ 55,327,123 \$ 64,582,111	\$ 51,989,049 \$ 54,433,636	\$ 114,998,604 \$ 78,507,303	\$ 54,232,087 \$ 72,061,043	

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

Cost Report Year (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL

		In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	% Total In-State Medicaid Survey
	Totals / Payments						
128	Total Charges (includes organ acquisition from Section J)	\$ 116,866,204 \$ 61,999,484	\$ 81,240,603 \$ 64,582,111	\$ 60,176,414 \$ 54,433,636	\$ 137,773,659 \$ 78,507,303	\$ 61,666,362 \$ 72,061,043 (Agrees to Exhibit A) (Agrees to Exhibit A)	\$ 396,056,880 \$ 259,522,534 42.35%
129 130	Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance)	\$ 116,866,204 \$ 61,999,484	\$ 81,240,603 \$ 64,582,111	\$ 60,176,414 \$ 54,433,636	\$ 137,773,659 \$ 78,507,303	\$ 61,666,362 \$ 72,061,043	
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 37,690,425 \$ 11,812,314	\$ 33,790,905 \$ 12,960,706	\$ 18,459,929 \$ 9,830,637	\$ 44,296,964 \$ 15,040,260	\$ 17,253,600 \$ 14,422,727	\$ 134,238,223 \$ 49,643,917 47.83%
132 133 134 135 136 137 138 139 140 141	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) Private Insurance (including primary and third party liability) Self-Pay (including Co-Pay and Spend-Down) Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments) Medicaid Cost Settlement Payments (See Note B) Other Medicaid Payments Reported on Cost Report Year (See Note C) Medicare Taditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles) Medicare Cross-Over Bad Debt Payments Unter Medicare Cross-Over Payments (See Note D)	\$ 24,935,275 \$ 10,031,118	\$ 24,056,674 \$ 10,742,975 \$ 294 \$ 19,019 \$ 128 \$ 4,885 \$ 24,057,096 \$ 10,767,232	\$ 159,136 \$ 1.011,993 \$ 2.94 \$ 5.420 \$ \$ 7.578,670 \$ \$ 687,993 \$ 5.78,140 \$ 5.47,573 \$ 123,525	\$ 8,996,278 \$ 2,742,917 \$ 212,673 \$ 125,689 \$ 10,509,921 \$ 4,534,194 \$ 13,206 \$ 14,859 \$ \$ 1257,057 \$ \$ 158,314 \$ 17,450,155 \$ 7,137,847	(Agrees to Exhibit B and (Agrees to Exhibit B and B-1)	\$ 34,090,689 \$ 13,786,681 \$ 24,269,547 \$ 10,086,664 \$ 10,
143 144	Payment from Hospital Uninsured During Cost Report Year (Cash Basis) Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Sec	ction E)				\$ 1,416,285 \$ 1,030,350 \$ - \$ -	
145 146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$ 12,467,539 \$ 1,622,828 67% \$86%		\$ (1,665,650) \$ 532,595 109% 95%	\$ 5,857,874 \$ 326,440 98%	\$ 15,837,315 \	\$ 26,393,572 \$ 4,675,337 91%
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, C	Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less line	nes 5 & 6)	39,501			

148 Percent of cross-over days to total Medicare days from the cost report

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 5 - medical Medical Payments such as Quities and Non-Claim's Need in Specific payments. DSH payments should Not Did in it are for twinded. UPL payments pad ago in the Need Scale year basis should be reported in Section C of the survey.

Note C - Other Should include any other should not be survey.

Note D - Should include any other should not be survey.

Note D - Should include Any other should not be survey.

Note E - Medical Payments should be reported in Section C of the survey.

Note E - Medical Angaged Care payments should not be given by the survey.

Note E - Medical Managed Care payments should include all Medical Managed Care payments related to the services produce including, but not limited to, incomprehing payments.

I. Out-of-State Medicaid Data:

		Diem Cost for	Charge Ratio for	Out-of-State Med	licaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs id Secondary)	Out-of-State Other M Included E		Total Out-Of-	State Medicaid
Line #	Cost Center Description	Routine Cost Centers	Ancillary Cost Centers	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 Co	ost Centers (list below):			Days		Days		Days		Days		Days	
3000 ADU	ULTS & PEDIATRICS	\$ 1,048.54		71						42		113	
	ENSIVE CARE UNIT RONARY CARE UNIT	\$ 2,063.42 \$ -		24						7		31	
	RN INTENSIVE CARE UNIT	\$ -										-	
	RGICAL INTENSIVE CARE UNIT	\$ -										-	
	HER SPECIAL CARE UNIT BPROVIDER I	\$ 1,410.65 \$ -		1						13		14	
04100 SUB	BPROVIDER II	\$ -										-	
	HER SUBPROVIDER	\$ - \$ 548.83								20		-	
04300 NUF	RSERY	\$ 548.83		1						38		39	
		\$ -										-	
		\$ - \$ -										-	
		\$ -										-	
		\$ -										-	
		\$ -										-	
			Total Days	97						100		197	
Total Days p	per PS&R or Exhibit Detail			97		-		-		100			
	Unreconciled Days (E	Explain Variance)											
_		_		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	utine Charges culated Routine Charge Per Diem			\$ 109.995									
	odiated redding origing or or bronn			\$ 1,133.97		\$ -		\$ -		\$ 119,525 \$ 1,195.25		\$ 229,520 \$ 1,165.08	
	Cost Centers (from W/S C) (list below):	_		\$ 1,133.97 Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	Ancillary Charges	\$ 1,195.25 Ancillary Charges	Ancillary Charges	\$ 1,165.08 Ancillary Charges	Ancillary Cha
09200 Obs	Cost Centers (from W/S C) (list below): servation (Non-Distinct)		0.974869	\$ 1,133.97 Ancillary Charges 568	3,879	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	Ancillary Charges	\$ 1,195.25 Ancillary Charges 8,121	1,881	\$ 1,165.08 Ancillary Charges \$ 8,689	\$
09200 Obse 5000 OPE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM		0.134838	\$ 1,133.97 Ancillary Charges 568 19,948		\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges		\$ 1,195.25 Ancillary Charges 8,121 20,691	1,881 16,571	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639	\$
09200 Obs 5000 OPE 5100 REC 5200 DEL	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM		0.134838 0.168697 1.520546	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718	3,879 - - 1,333	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	1,314	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477	1,881 16,571 667	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195	\$ 16 \$
09200 Obse 5000 OPE 5100 REC 5200 DEL 5300 ANE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LUVERY ROOM & LABOR ROOM ESTHESIOLOGY		0.134838 0.168697 1.520546 0.005663	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156	3,879 - - 1,333 156	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges		\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477 4,949	1,881 16,571 667 - 156	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105	\$ 10 \$ 5 \$ 5
9200 Obse 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAD	cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC		0.134838 0.168697 1.520546 0.005663 0.105251	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718	3,879 - - 1,333	\$ - Ancillary Charges	Ancillary Charges	\$ Ancillary Charges	1,314	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477	1,881 16,571 667	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195	\$ 10 \$ 5 \$ 5
09200 Obset 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAD 5500 RAD 6000 LAB	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC JORATORY		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895	\$ 1,133.97 Ancillary Charges	3,879 - 1,333 156 7,930 - 16,604	\$ - Ancillary Charges	Ancillary Charges	S - Ancillary Charges	1,314	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477 4,949 65,944 - 68,059	1,881 16,571 667 - 156 22,814 - 18,987	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433	\$ 11 \$ 5 \$ 3 \$ 5 \$ 5
09200 Obsi 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAD 5500 RAD 6000 LAB 6500 RES	cost Centers (from W/S C) (list below): servation (Non-Distinct) servat		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298	\$ 1,133.97 Ancillary Charges	3,879 - - 1,333 156 7,930 -	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4777 4,949 65,944 - 68,059 20,137	1,881 16,571 667 - 156 22,814 - 18,987 1,627	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433 \$ 81,765	\$ 11 \$ 5 \$ 3 \$ 5 \$ 5
99200 Obsi 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAC 5500 RAC 6000 LAB 6500 RES 6600 PHY	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC JORATORY		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895	\$ 1,133.97 Ancillary Charges	3,879 - 1,333 156 7,930 - 16,604	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477 4,949 65,944 - 68,059	1,881 16,571 667 - 156 22,814 - 18,987	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433	\$ 11 \$ 5 \$ 3 \$ 5 \$ 5
09200 Obsi 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAC 5500 RAD 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE	cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC 3ORATORY SPIRATORY THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236995	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156 64,700 86,374 61,628 3,790 3,196	3,879	\$ - Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges	1,881 16,571 667 - 156 22,814 - 18,987 1,627 562 -	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253	\$ 1 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
9200 Obs 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAC 5500 RAC 6000 LAB 6500 RES 6600 PHY 6800 SPE 6900 ELE	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY CTROCARDIOLOGY		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156 64,700 6,374 61,628 3,790 3,196	3,879 - 1,333 156 7,930 - 16,604 230 - - - - 3,274	Ancillary Charges	Ancillary Charges	S - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 477 4,949 65,944 68,059 20,137 9,169 6,410 2,253 8,136	1,881 16,571 667 - 156 22,814 - 18,987 1,627 562 - 1,881	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045	\$ 1 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
99200 Obsi 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAC 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7000 ELE	COST Centers (from W/S C) (list below): Servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCARDIOLOGY CUTROCARDIOLOGY ECTROCARDIOLOGY CUTROCARDIOLOGY CUTROCARDI		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges	1,881 16,571 667 - 156 22,814 - 18,987 1,627 562 -	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253	\$ 1 \$ 5 \$ 5 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Obsi 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAD 5500 RAD 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7000 ELE 7100 MED	COST Centers (from W/S C) (list below): Servation (Non-Distinct) SERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC 30RATORY SPIRATORY THERAPY SPIRATORY THERAPY SPIRATORY THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCARDIOLOGY ELDEV. CHARGED TO PATIENT'S L. DEV. CHARGED TO PATIENT'S L. DEV. CHARGED TO PATIENT'S		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966	\$ 1,133,97 Ancillary Charges	3,879 - 1,333 156 7,930 - 16,604 230 - - - 3,274 - 3,596	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206 21,263 418 221	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,770 4,949 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600	1,881 16,571 667 	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 9,406 \$ 131,624 \$ 131,624	\$ 1 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Obs. 5000 OPE 5100 REC 5200 DEL 5300 ANE 5400 RAD 5500 RAD 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7000 ELE 7100 MED 7200 MPD 7300 DRL	COST Centers (from W/S C) (list below): Servation (Non-Distinct) SERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC BORDATORY SPIRATORY THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCARDIOLOGY COTROCARDIOLOGY COTROCARDIOLOGY DIOLOGY CONTROL TO PATIENTS USS CHARGED TO PATIENTS USS CHARGED TO PATIENTS USS CHARGED TO PATIENTS		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966 0.152478	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156 64,700 8,374 61,628 3,790 3,196 - 6,909 944 76,113 6,528 212,834	3,879 1,333 156 7,930 16,604 230 - - 3,274 3,596 26,481	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206	\$ 1,195.25 Ancillary Charges	1,881 16,571 667 - 156 22,814 - 18,987 1,627 562 - 1,881 4,183	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 130,644 \$ -2 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 13,644 \$ 17,65 \$ 11,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 13,644 \$ 7,928 \$ 131,624 \$ 7,928	\$ 1 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Óbs 5000 OPE 5000 REC 5200 DEL 5300 ANE 5400 RAD 5400 LAB 6600 LAB 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7100 MED 7200 IMPI 7200 IMPI 7200 IMPI 7400 RES	COST Centers (from W/S C) (list below): Servation (Non-Distinct) SERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC 30RATORY SPIRATORY THERAPY SPIRATORY THERAPY SPIRATORY THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCARDIOLOGY ELDEV. CHARGED TO PATIENT'S L. DEV. CHARGED TO PATIENT'S L. DEV. CHARGED TO PATIENT'S		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966	\$ 1,133,97 Ancillary Charges	3,879 - 1,333 156 7,930 - 16,604 230 - - - 3,274 - 3,596	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206 21,263 418 221	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,770 4,949 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600	1,881 16,571 667 	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 9,406 \$ 131,624 \$ 131,624	\$ 11 \$ 5 \$ 5 \$ 3 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Óbsa 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	COST Centers (from W/S C) (list below): servation (Non-Distinct) servation (Non-Distinct) servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC SORATORY SPIRATORY THERAPY SPIRATORY THERAPY SPIRATORY THERAPY CUPATIONAL THERAPY EECH PATHOLOGY COTROCARDIOLOGY COTROCARDIOLOGY LOCAL SUPPLIES CHARGED TO PATIENTS LOGS CHARGED TO PATIENTS NAL DIALLYSIS NAL DIALLYSIS NAL DIALLYSIS DOSCOPY ART CATH LAB		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236994 0.163919 0.397250 0.256802 0.182996 0.152478 0.462086 0.315286 0.064828	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156 64,700 86,374 61,628 3,196 6,009 944 76,113 6,328 212,834 7,817	3,879 1,333 156 7,930 16,604 230 - - - 3,274 - 3,596 - 26,481 231	Ancillary Charges	Ancillary Charges	S - Ancillary Charges	2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,747 4,949 65,944 68,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,298	1,881 16,571 667 - 156 22,814 18,987 1,627 562 - 1,881 - 4,183 - 16,871 77 - 2,862	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256	\$ 110 \$ 110
09200 Óbsi 5000 ÖPE 5000 ÖPE 5100 REC 5200 DEL 5300 ANE 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7200 IMP 7300 DRL 7400 REN 7600 ENC 7601 HEA	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCABOILOGY ECTROCABOILOGY POICAL SUPPLIES CHARGED TO PATIENT **L. DEV. CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **NAL DIALYSIS DOSCOPY ART CATH LAB NIC		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966 0.152478 0.462086 0.315286 0.315286	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	S - Ancillary Charges	1,314 2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,749 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,908 12,908	1,881 16,571 667 156 22,814 18,987 1,627 562 1,881 1,811 77 16,871 77 2,862 1,448	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,435 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256 \$ 22,663 \$ 22,663	\$ 10 \$ 10 \$ 2 \$ 2 \$ 3 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 2 \$ 2 \$ 3 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Óbsi 5000 OPE 5000 OPE 5200 DEL 5300 ANE 5300 ANE 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 9300 ELE 7200 IMPI 7300 DEL 7400 RED 7400 DEL 7500 DEL	COST Centers (from W/S C) (list below): servation (Non-Distinct) servation (Non-Distinct) servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-THERAPEUTIC SORATORY SPIRATORY THERAPY SPIRATORY THERAPY SPIRATORY THERAPY CUPATIONAL THERAPY EECH PATHOLOGY COTROCARDIOLOGY COTROCARDIOLOGY LOCAL SUPPLIES CHARGED TO PATIENTS LOGS CHARGED TO PATIENTS NAL DIALLYSIS NAL DIALLYSIS NAL DIALLYSIS DOSCOPY ART CATH LAB		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236994 0.163919 0.397250 0.256802 0.182996 0.152478 0.462086 0.315286 0.064828	\$ 1,133.97 Ancillary Charges 568 19,948 1,334 2,718 156 64,700 86,374 61,628 3,196 6,009 944 76,113 6,328 212,834 7,817	3,879	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,747 4,949 65,944 68,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,298	1,881 16,571 667 - 156 22,814 18,987 1,627 562 - 1,881 - 4,183 - 16,871 77 - 2,862	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,433 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256	\$ 11 \$ 11 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Óbsi 5000 OPE 5000 OPE 5100 REC 5200 DEL 5300 ANE 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7200 IMPI 7300 DRL 7400 REN 7600 ENC 7601 HEA	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCABOILOGY ECTROCABOILOGY POICAL SUPPLIES CHARGED TO PATIENT **L. DEV. CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **NAL DIALYSIS DOSCOPY ART CATH LAB NIC		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966 0.152478 0.462086 0.315286 0.315286	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	1,314 2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,749 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,908 12,908	1,881 16,571 667 156 22,814 18,987 1,627 562 1,881 1,811 77 16,871 77 2,862 1,448	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,435 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256 \$ 22,663 \$ 22,663	\$ 10 \$ 10 \$ 2 \$ 2 \$ 3 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 2 \$ 2 \$ 3 \$ 3 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
09200 Óbsi 5000 OPE 5000 OPE 5200 DEL 5300 ANE 5300 ANE 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 9300 ELE 7200 IMPI 7300 DEL 7400 RED 7400 DEL 7500 DEL	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCABOILOGY ECTROCABOILOGY POICAL SUPPLIES CHARGED TO PATIENT **L. DEV. CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **NAL DIALYSIS DOSCOPY ART CATH LAB NIC		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966 0.152478 0.462086 0.315286 0.342297	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	S - Ancillary Charges	1,314 2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,749 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,908 12,908	1,881 16,571 667 156 22,814 18,987 1,627 562 1,881 1,811 77 16,871 77 2,862 1,448	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,435 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256 \$ 22,663 \$ 22,663	Ancillary Cha \$
09200 Óbsi 5000 OPE 5000 OPE 5100 REC 5200 DEL 5300 ANE 5500 RAC 6000 LAB 6500 RES 6600 PHY 6700 OCC 6800 SPE 6900 ELE 7200 IMP 7300 DRL 7400 RED 7600 ENC 7601 HEA	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCABOILOGY ECTROCABOILOGY POICAL SUPPLIES CHARGED TO PATIENT **L. DEV. CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **NAL DIALYSIS DOSCOPY ART CATH LAB NIC		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.239964 0.163919 0.397250 0.256802 0.152478 0.462086 0.152478	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	S - Ancillary Charges	1,314 2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,749 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,908 12,908	1,881 16,571 667 156 22,814 18,987 1,627 562 1,881 1,811 77 16,871 77 2,862 1,448	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,435 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256 \$ 22,663 \$ 22,663	\$ 11 \$ 11 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5 \$ 5
99200 Óbsi 5000 OPE 5000 DEL 5200 DEL 5300 ANE 5500 RAD 6500 RAD 6600 PHY 6700 CC 6600 PHY 6700 CLE 7000 ELE 7200 IMPI 7400 RED 7400 RED 7601 HEA	COST Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM COVERY ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-THERAPEUTIC 300RATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY CUPATIONAL THERAPY EECH PATHOLOGY ECTROCABOILOGY ECTROCABOILOGY POICAL SUPPLIES CHARGED TO PATIENT **L. DEV. CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **UGS CHARGED TO PATIENTS **NAL DIALYSIS DOSCOPY ART CATH LAB NIC		0.134838 0.168697 1.520546 0.005663 0.105251 0.402806 0.117895 0.306298 0.561619 0.237995 0.236964 0.163919 0.397250 0.256802 0.180966 0.152478 0.462086 0.315286 0.342297	\$ 1,133,97 Ancillary Charges	3,879	Ancillary Charges	Ancillary Charges	\$ - Ancillary Charges	1,314 2,206 21,263 21,263 418 221 3,101	\$ 1,195.25 Ancillary Charges 8,121 20,691 4,730 4,749 65,944 66,059 20,137 9,169 6,410 2,253 8,136 55,511 1,600 73,966 4,361 2,298 12,908 12,908	1,881 16,571 667 156 22,814 18,987 1,627 562 1,881 1,811 77 16,871 77 2,862 1,448	\$ 1,165.08 Ancillary Charges \$ 8,689 \$ 40,639 \$ 6,064 \$ 3,195 \$ 5,105 \$ 130,644 \$ \$ 154,435 \$ 81,765 \$ 12,959 \$ 9,606 \$ 2,253 \$ 15,045 \$ 944 \$ 131,624 \$ 131,624 \$ 7,928 \$ 286,800 \$ 12,178 \$ 2,256 \$ 22,663 \$ 22,663	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5

I. Out-of-State Medicaid Data:

			Out-of-State Me	dicaid FFS Primary	icaid Managed Care mary	Out-of-State Medic (with Medica	are FFS Cross-Overs id Secondary)	Out-of-State Other Included	Medicaid Eligibles (Not Elsewhere)	Total Out-Of-	State Medicaid
		-								-	\$
		-								-	\$
		-							5		\$
		-									\$
		-									\$
											\$
		-									\$
											\$
-		-									\$
		-								-	\$
		-									\$
		-							9		\$
		-									\$
		-									\$
}		-			 		\vdash				\$
		-									S
-t		-									\$
		-									\$
		-									\$
		-								-	\$
		-									\$
		-	_								\$
		-									\$
		<u> </u>									\$
		-									\$
-+		-									, Q
											\$
		-							3		\$
		-									\$
		-							9	-	\$
		-							9		\$
		-									\$
		-									\$
		-	_								\$
		-									S
		-									\$
		-									\$
		-							9	-	\$
		-									\$
		<u> </u>									\$
		-									\$
		-									\$
+		-									\$
-+		-									\$
t		-	_								\$
T		-									\$
		-								-	\$
	-	-									\$
[-									\$
		-									\$
		-									\$
-+		-			 						\$
-+		-									\$
-+		-									S
-t											\$
		-									\$

I. Out-of-State Medicaid Data:

	Cost Report Year (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL										
		Out-of-State Med	dicaid FFS Primary		licaid Managed Care imary		dicare FFS Cross-Overs caid Secondary)		Medicaid Eligibles (Not I Elsewhere)	Total Out-Of-	State Medicaid
114	-									\$ -	\$ -
115	-									\$ -	\$ -
116	-									\$ -	\$ -
117	-									\$ -	\$ -
118 119					-		_			5 -	\$ -
120							-		-	\$ -	\$ -
121									1	\$ -	\$ -
122	-								1	\$ -	\$ -
123	-									\$ -	\$ -
124	-									\$ -	\$ -
125	-									\$ -	\$ -
126	-									\$ -	\$ -
127	-									\$ -	\$ -
		\$ 595,649	\$ 102,778	\$ -	\$ -	\$ -	\$ 34,830	\$ 387,503	\$ 110,027		
	Totals / Payments										
128	Total Charges (includes organ acquisition from Section K)	\$ 705,644		\$ -	\$ -	\$ -	\$ 34,830	\$ 507,028		\$ 1,212,672	\$ 247,635
129	Total Charges per PS&R or Exhibit Detail	\$ 705,644	\$ 102,778	\$ -	\$ -	\$	- \$ 34,830	\$ 507,028	\$ 110,027	J	
130	Unreconciled Charges (Explain Variance)				·		<u> </u>		. 		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 241,562	\$ 27,648	\$ -	\$ -	\$ -	\$ 7,116	\$ 175,248	\$ 21,173	\$ 416,810	\$ 55,937
400	T. (14 5 (18 (14) 4) 1) TRI O R (18)	0.047	0.700							11.100	A 0.000
132 133	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ 6,217	\$ 6,730				\$ 24	\$ 5,206	\$ 209	\$ 11,423	\$ 6,963
134	Private Insurance (including primary and third party liability)	\$ 10,244	\$ 82					\$ 196,363	\$ 1,040	\$ 206,607	\$ 1,122
135	Self-Pay (including Co-Pay and Spend-Down)	Ψ 10,211	<u> </u>				\$ 352	\$ -	\$ 106	\$ -	\$ 458
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 16.461	\$ 6,812	\$ -	\$ -			*	100	1	,
137	Medicaid Cost Settlement Payments (See Note B)		-	<u> </u>		ı				\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						\$ 2,904	\$ 29,874		\$ 29,874	\$ 9,795
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 35,045	\$ 5,172	\$ 35,045	\$ 5,172
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
440	Colorded at Decision of Characters (// assertes) / DRIOD TO CUIDDI EMENTAL DAVMENTO AND DOUB	e 005.404	e 00.000	1 6	1 6		e 0.000	r (04.040)	7.755	A22.004	6 20 407
143 144	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$ 225,101 7%	\$ 20,836 25%	- 0%] [\$ - 0%	- 09	\$ 3,836 % 46%	\$ (91,240) 152%			\$ 32,427 42%
144	Calculated Fayments as a Fercentage of Cost	1%	25%	0%	0%	0	70 40%	152%	63%	68%	42%

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 (08/01/2019-07/31/2020) PHOEBE PUTNEY MEMORIAL HOSPITAL

		Total		Revenue for			aid FFS Primary	In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Org	gan Acquisition Cost Centers (list below):															
1	Lung Acquisition	\$0.00	\$ -	\$ -		0										
2	Kidney Acquisition	\$0.00	s -	\$ -		0										
3	Liver Acquisition	\$0.00	s -	\$ -		0										
4	Heart Acquisition	\$0.00	\$ -	\$ -		0										
5	Pancreas Acquisition	\$0.00	s -	\$ -		0										
6	Intestinal Acquisition	\$0.00	\$ -	\$ -		0										
7	Islet Acquisition	\$0.00		\$ -		0										
8		\$0.00	\$ -	\$ -		0										
9	Totals	\$ -	s -	\$ -	\$ -	_	\$ -		\$ -		\$ -	_	\$ -	_	\$ -	-
10 Note A -	Total Cost These amounts must agree to your inpatient	and outpatient Med	dicaid naid claims s	ummary if available	(if not use hospital's logs	and submit with	survey)	-		-		-		-		_

Note A. Thass 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 payment dottal payment dottal payment and total payment of the 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

		Total			Revenue for	Total	Out-of-State Med	licaid FFS Primary	Out-of-State Medicaid	Managed Care Primary	Out-of-State Medicare Medicaid	FFS Cross-Overs (with Secondary)		Medicaid Eligibles (Not Elsewhere)
		Organ Acquisition Cost	Organ Intern/Resident Organ Acquisition Over / Uninsured	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		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)							
0	rgan Acquisition Cost Centers (list below):													
	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0								
	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0								
		\$ -	\$ -	\$ -	\$ -	0								
	Totals													

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 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 (08/01/2019-07/31/2020)	PHOEBE PUTNEY MEMORIAL HOSPITAL
003t Report Tear (00/01/2013-01/31/2020)	I HOUSE I OTHER MEMORIAL HOST HAL

worksneet A Prov	vider Tax Assessment Re	econciliation:					
					Dollar Amount	W/S A Cost Center Line	
1 Hospital	Gross Provider Tax Assessn	ment (from general ledger)*					
1a Working	Trial Balance Account Type	and Account # that include	s Gross Provider Tax Assessment				(WTB Account #)
2 Hospital	Gross Provider Tax Assessn	ment Included in Expense of	n the Cost Report (W/S A, Col. 2)				(Where is the cost included on w/s A?)
3 Differen	ce (Explain Here>)				\$ -		
Provide	r Tax Assessment Reclass	sifications (from w/s A-6 o	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))
8 9 10 11 DSH UC 12 13 14 15	Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment	ider Tax Assessment Adj	nents (from w/s A-8 of the Medicare cost ustments (from w/s A-8 of the Medicare		\$ -		(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
DSH UCC Provide	er Tax Assessment Adjus	stment:					
	,						
17 Gross A	llowable Assessment Not Incl	cluded in the Cost Report			\$ -		
Annorti	onment of Provider Tax Ass	sessment Adjustment to	Medicaid & Uninsured:				
18	Medicaid Hospital	Charges Sec. G			657,039,721		
19	Uninsured Hospital	Charges Sec. G			133,727,405		
20	Total Hospital	Charges Sec. G			1,867,052,680		
21		•	t to include in DSH Medicaid UCC		35.19%		
22			t to include in DSH Uninsured UCC		7.16%		
23	Medicaid Provider Tax As	ssessment Adjustment to D	SH UCC		\$ -		
24		Assessment Adjustment to			\$ -		
25 Provider	Tax Assessment Adjustmen	nt 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.