State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	08/01/2020	07/31/2021	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 (07/01/20 - 06/30/21)
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 07/01/2020 - 06/30/2021** — $ 12,495,452
   (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 07/01/2020 - 06/30/2021** — $ -
   (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 Services07/01/2020 - 06/30/2021** — $ 12,495,452

Certification:

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

Explanation for "No" answers:

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

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

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

Brian Church	CHIEF FINANCIAL & ADMINISTRATIVE OFFICER	11/18/2021
Hospital CEO or CFO Signature	Title	Date
BRIAN CHURCH	229-312-4068	BCHURCH@PHOEBEHEALTH.COM
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

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

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

DSH Version 8.10 7/5/2022

D. General Cost Report Year Information 8/1/2020 - 7/31/2021

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

	8/1/2020 through 7/31/2021		
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: 6/15/2022

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	PHOEBE PUTNEY MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000001482A	Yes	PROVIDER NUMBER 000001482A & 000001416A
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001416A	No	1416A IS THE SECOND CAID NUMBER FOR PHOEBE . NOT SUBPROV
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	No	REHAB UNIT IS 11-T007
8. Medicare Provider Number:	110007	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

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

	State Name	Provider No.
9. State Name & Number	FLORIDA	913855200
10. State Name & Number	ALABAMA	PH0007N
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (08/01/2020 - 07/31/2021)

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)	$ 1,444,584	$ 1,183,607	$2,628,191
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,084,226	$ 10,087,326	$12,171,552
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)	$3,528,810	$11,270,933	$14,799,743
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	40.94%	10.50%	17.76%

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 (08/01/2020 - 07/31/2021)

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)	127,930 **(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	116,917
3.	Outpatient Hospital Subsidies	222,787
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 339,704
7.	Inpatient Hospital Charity Care Charges	41,455,958
8.	Outpatient Hospital Charity Care Charges	55,387,881
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 96,843,839

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	$155,089,831.00			$ 109,597,937	$ -	$ -	$ 45,491,894
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$701,849,327.00	$1,034,365,525.00		$ 495,978,608	$ 730,959,130	$ -	$ 509,277,114
20.	Outpatient Services		$93,440,164.00			$ 66,031,726	$ -	$ 27,408,438
21.	Home Health Agency			$4,424,156.00			$ 3,126,436	
22.	Ambulance			$ 525,240			$ 371,173	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,500,504.00			$ 3,887,063	
26.	Other	$10,148,760.00	$0.00	$59,614,712.00	$ 7,171,864	$ -	$ 42,128,162	$ 2,976,896
27.	Total	$ 867,087,918	$ 1,127,805,689	$ 70,064,612	$ 612,748,409	$ 796,990,856	$ 49,512,833	$ 585,154,341
28.	Total Hospital and Non Hospital		Total from Above	$ 2,064,958,219		Total from Above	$ 1,459,252,099	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,064,958,219	Total Contractual Adj. (G-3 Line 2)	1,454,308,081
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	4,944,018
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)"			-	
35.	Adjusted Contractual Adjustments				1,459,252,099
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2020-07/31/2021) | 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	$ 112,021,218	$ 1,498,251	$ -	$0.00	$ 113,519,469	99,427	$81,191,289.00		$ 1,141.74
2	03100	INTENSIVE CARE UNIT	$ 67,914,329	$ 27,087	$ -		$ 67,941,416	14,942	$49,029,152.00		$ 4,547.01
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ 11,538,370	$ -	$ -		$ 11,538,370	6,844	$18,933,959.00		$ 1,685.91
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 6,610,498	$ -	$ -		$ 6,610,498	10,882	$10,148,760.00		$ 607.47
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 198,084,415	$ 1,525,338	$ -	$ -	$ 199,609,753	132,095	$ 159,303,160		
19		Weighted Average									$ 1,511.11

Line #		Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	4,165	-	-	$ 4,755,347	$2,538,410.00	$3,397,021.00	$ 5,935,431	0.801180

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$27,058,092.00	$ 52,481	$ -		$ 27,110,573	$79,358,164.00	$149,534,839.00	$ 228,893,003	0.118442
22	5100	RECOVERY ROOM	$8,758,653.00	$ -	$ -		$ 8,758,653	$23,245,624.00	$33,852,665.00	$ 57,098,289	0.153396
23	5200	DELIVERY ROOM & LABOR ROOM	$9,338,435.00	$ 248,862	$ -		$ 9,587,297	$3,583,879.00	$2,314,878.00	$ 5,898,757	1.625308
24	5300	ANESTHESIOLOGY	$406,027.00	$ -	$ -		$ 406,027	$20,882,314.00	$37,467,150.00	$ 58,349,464	0.006959
25	5400	RADIOLOGY-DIAGNOSTIC	$18,352,162.00	$ 93,111	$ -		$ 18,445,273	$57,930,519.00	$143,693,174.00	$ 201,623,693	0.091484
26	5500	RADIOLOGY-THERAPEUTIC	$17,882,898.00	$ -	$ -		$ 17,882,898	$2,173,842.00	$48,622,464.00	$ 50,796,306	0.352051
27	6000	LABORATORY	$23,212,882.00	$ -	$ -		$ 23,212,882	$103,077,318.00	$95,288,540.00	$ 198,365,858	0.117021
28	6500	RESPIRATORY THERAPY	$9,454,711.00	$ -	$ -		$ 9,454,711	$29,881,651.00	$5,428,141.00	$ 35,309,792	0.267765
29	6600	PHYSICAL THERAPY	$8,521,460.00	$ -	$ -		$ 8,521,460	$11,657,541.00	$4,641,625.00	$ 16,299,166	0.522816
30	6700	OCCUPATIONAL THERAPY	$2,185,752.00	$ -	$ -		$ 2,185,752	$8,436,982.00	$1,212,235.00	$ 9,649,217	0.226521

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6800	SPEECH PATHOLOGY	$1,162,756.00	$ -	$ -		$ 1,162,756	$4,081,132.00	$1,180,741.00	$ 5,261,873	0.220978
32	6900	ELECTROCARDIOLOGY	$3,273,081.00	$ -	$ -		$ 3,273,081	$7,393,522.00	$14,282,935.00	$ 21,676,457	0.150997
33	7000	ELECTROENCEPHALOGRAPHY	$1,777,346.00	$ -	$ -		$ 1,777,346	$1,021,139.00	$4,195,814.00	$ 5,216,953	0.340687
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$41,538,728.00	$ -	$ -		$ 41,538,728	$93,245,025.00	$62,005,690.00	$ 155,250,715	0.267559
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,242,707.00	$ -	$ -		$ 16,242,707	$38,655,586.00	$60,349,482.00	$ 99,005,068	0.164059
36	7300	DRUGS CHARGED TO PATIENTS	$70,399,908.00	$ -	$ -		$ 70,399,908	$170,426,678.00	$300,168,291.00	$ 470,594,969	0.149598
37	7400	RENAL DIALYSIS	$2,552,844.00	$ -	$ -		$ 2,552,844	$6,061,143.00	$438,193.00	$ 6,499,336	0.392785
38	7600	ENDOSCOPY	$7,096,698.00	$ 93,111	$ -		$ 7,189,809	$3,064,021.00	$30,016,062.00	$ 33,080,083	0.217346
39	7601	HEART CATH LAB	$5,457,119.00	$ -	$ -		$ 5,457,119	$37,673,247.00	$39,672,606.00	$ 77,345,853	0.070555
40	9000	CLINIC	$10,654,565.00	$ -	$ -		$ 10,654,565	$1,254,369.00	$16,961,142.00	$ 18,215,511	0.584917
41	9100	EMERGENCY	$22,849,376.00	$ 262,405	$ 2,439,765		$ 25,551,546	$16,556,760.00	$58,667,893.00	$ 75,224,653	0.339670
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 308,176,200	$ 749,970	$ 2,439,765		$ 311,365,935	$ 722,198,866	$ 1,113,391,581	$ 1,835,590,447	
127	**Weighted Average**									0.172218
128	**Sub Totals**	$ 506,260,615	$ 2,275,308	$ 2,439,765		$ 510,975,688	$ 881,502,026	$ 1,113,391,581	$ 1,994,893,607	
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**					$ 510,975,688				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.45%				

* 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 (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,141.74		12,805		6,031		5,923		17,578		7,391		42,337		52.22%
2	03100 INTENSIVE CARE UNIT	$ 4,547.01		2,728		271		1,335		3,400		998		7,734		58.44%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,685.91		492		5,023				795		15		6,310		92.49%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 607.47		1,239		8,128				1,428		61		10,795		100.00%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	17,264		19,453		7,258		23,201		8,465		67,176		57.30%
19	Total Days per PS&R or Exhibit Detail			17,264		19,453		7,258		23,201		8,465				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 21,068,491		$ 27,458,653		$ 8,802,406		$ 27,834,445		$ 9,810,763		$ 85,163,995		59.65%
21.01	Calculated Routine Charge Per Diem			$ 1,220.37		$ 1,411.54		$ 1,212.79		$ 1,199.71		$ 1,158.98		$ 1,267.77		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.801180	1,794,100	258,379	467,438	473,907	176,419	129,201	573,711	271,650	292,063	307,012	$ 3,011,668	$ 1,133,137	79.94%
23	5000 OPERATING ROOM		0.118442	7,602,171	6,054,881	10,315,751	8,537,941	7,853,699	9,980,259	15,569,654	11,983,168	7,659,973	5,373,915	$ 41,341,275	$ 36,556,249	39.74%
24	5100 RECOVERY ROOM		0.153396	1,327,676	1,804,680	4,585,822	3,966,310	2,776,433	959,373	5,789,227	2,498,819	1,876,528	1,933,991	$ 14,479,158	$ 9,229,182	48.21%
25	5200 DELIVERY ROOM & LABOR ROOM		1.625308	313,779	86,620	3,368,928	101,589	4,290	728,331	1,083,642	47,090	36,276	669	$ 4,770,639	$ 963,630	97.85%
26	5300 ANESTHESIOLOGY		0.006959	1,884,176	1,972,802	2,334,819	3,141,374	1,286,073	3,504,689	3,638,061	2,033,200	2,298,718	1,657,286	$ 9,143,129	$ 10,652,065	40.72%
27	5400 RADIOLOGY-DIAGNOSTIC		0.091484	11,166,617	5,935,468	4,061,055	8,693,146	5,670,166		16,243,835	9,462,194	9,182,763	15,913,251	$ 37,141,673	$ 24,090,808	42.84%
28	5500 RADIOLOGY-THERAPEUTIC		0.352051	489,347	2,624,270	144,339	1,484,425	343,514	1,530,644	848,345	4,305,525	58,154	1,593,921	$ 1,825,545	$ 9,944,864	26.48%
29	6000 LABORATORY		0.117021	16,121,027	5,385,030	11,085,622	6,076,821	8,664,495	2,838,423	23,069,478	6,317,048	9,204,677	6,867,651	$ 58,940,622	$ 20,617,322	48.22%
30	6500 RESPIRATORY THERAPY		0.267765	5,515,506	180,046	3,577,002	117,822	2,409,130	82,739	6,704,766	228,112	1,403,693	132,645	$ 18,206,404	$ 608,719	57.64%
31	6600 PHYSICAL THERAPY		0.522816	1,574,539	299,832	554,288	330,306	882,676	169,252	2,184,436	528,327	501,227	205,934	$ 5,195,939	$ 1,327,717	44.37%
32	6700 OCCUPATIONAL THERAPY		0.226521	908,162	64,138	160,716	109,102	559,248	43,168	1,487,227	194,845	368,408	77,868	$ 3,115,353	$ 411,253	41.17%
33	6800 SPEECH PATHOLOGY		0.220978	430,557	29,547	1,243,460	265,719	237,394	28,464	612,970	226,901	107,790	22,197	$ 2,524,381	$ 550,631	60.95%
34	6900 ELECTROCARDIOLOGY		0.150997	561,925	307,824	463,278	562,660	855,143	324,792	2,285,252	870,342	940,152	1,218,123	$ 4,165,598	$ 2,065,618	38.71%
35	7000 ELECTROENCEPHALOGRAPHY		0.340687	136,672	416,042	74,840	473,814	87,424	119,650	191,436	365,216	75,887	168,139	$ 490,372	$ 1,374,722	40.43%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.267559	10,741,761	3,448,222	11,167,254	3,535,664	6,041,671	2,159,774	17,029,655	4,572,747	5,826,809	3,550,328	$ 44,980,341	$ 13,716,407	43.86%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.164059	3,405,235	2,667,245	884,925	1,425,912	2,402,061	2,314,092	7,346,904	3,815,947	2,627,293	1,873,641	$ 14,039,125	$ 10,223,196	29.05%
38	7300 DRUGS CHARGED TO PATIENTS		0.149598	26,710,811	19,879,658	11,956,050	12,864,993	12,202,215	11,732,487	34,951,760	24,276,185	14,844,260	12,067,263	$ 85,820,836	$ 68,753,323	38.58%
39	7400 RENAL DIALYSIS		0.392785	21,580	-			4,286		15,001	-	17,444	-	$ 40,867	$ -	0.90%
40	7600 ENDOSCOPY		0.217346	367,219	1,001,029	190,567	513,114	300,675	512,708	1,042,004	1,581,841	490,536	903,749	$ 1,900,465	$ 3,608,692	20.87%
41	7601 HEART CATH LAB		0.070555	3,466,113	677,022	1,388,047	911,666	1,935,948	1,095,030	6,042,703	2,400,339	3,877,473	1,289,352	$ 12,832,811	$ 5,084,057	29.85%
42	9000 CLINIC		0.584917	4,610	1,162,715	189,196	659,813	62,779	664,274	148,925	1,401,665	147,213	530,613	$ 405,510	$ 3,888,467	27.30%
43	9100 EMERGENCY		0.339670	3,522,214	3,037,843	2,032,555	8,326,699	1,949,001	1,720,829	4,765,799	4,267,213	3,077,478	11,478,860	$ 12,269,569	$ 17,352,584	58.76%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61			-											$ -	$ -	-
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
71			-											$ -	$ -	
72			-											$ -	$ -	
73			-											$ -	$ -	
74			-											$ -	$ -	
75			-											$ -	$ -	
76			-											$ -	$ -	
77			-											$ -	$ -	
78			-											$ -	$ -	
79			-											$ -	$ -	
80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
99			-											$ -	$ -	
100			-											$ -	$ -	
101			-											$ -	$ -	
102			-											$ -	$ -	
103			-											$ -	$ -	
104			-											$ -	$ -	
105			-											$ -	$ -	
106			-											$ -	$ -	
107			-											$ -	$ -	
108			-											$ -	$ -	
109			-											$ -	$ -	
110			-											$ -	$ -	
111			-											$ -	$ -	
112			-											$ -	$ -	
113			-											$ -	$ -	
114			-											$ -	$ -	
115			-											$ -	$ -	
116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 98,065,797	$ 57,293,293	$ 70,245,952	$ 62,572,797	$ 56,704,740	$ 40,638,179	$ 151,624,791	$ 81,648,374	$ 64,914,815	$ 67,166,408			

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

Cost Report Year (08/01/2020-07/31/2021) 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)		Uninsured		Total In-State Medicaid		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 119,134,288	$ 57,293,293	$ 97,704,605	$ 62,572,797	$ 65,507,146	$ 40,638,179	$ 179,459,236	$ 81,648,374	$ 74,725,578 (Agrees to Exhibit A)	$ 67,166,408 (Agrees to Exhibit A)	$ 461,805,275	$ 242,152,643	42.42%
129	Total Charges per PS&R or Exhibit Detail	$ 119,134,288	$ 57,293,293	$ 97,704,605	$ 62,572,797	$ 65,507,146	$ 40,638,179	$ 179,459,236	$ 81,648,374	$ 74,725,578	$ 67,166,408			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 46,444,114	$ 10,178,226	$ 38,551,378	$ 11,243,992	$ 22,182,722	$ 7,602,872	$ 64,374,872	$ 14,182,647	$ 23,122,806	$ 11,978,641	$ 171,553,086	$ 43,207,737	48.92%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 23,753,918	$ 9,249,205			$ 290,522	$ 737,754	$ 9,898,140	$ 2,351,828			$ 33,942,580	$ 12,338,787	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 28,685,446	$ 10,039,868			$ 821,282	$ 131,539			$ 29,506,728	$ 10,171,407	
134	Private Insurance (including primary and third party liability)			$ -	$ 9,373	$ 1,629	$ 657	$ 8,661,257	$ 4,224,552			$ 8,662,886	$ 4,234,582	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 250,942	$ 2,031	$ 402	$ 6,461	$ 161	$ 2,291	$ 35,754	$ 5,919			$ 287,259	$ 16,702	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 24,004,860	$ 9,251,236	$ 28,685,848	$ 10,055,702									
137	Medicaid Cost Settlement Payments (See Note B)		$ (138,187)									$ -	$ (138,187)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 17,854,434	$ 6,328,385	$ 1,013,750	$ 199,983			$ 18,868,184	$ 6,528,368	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 24,794,846	$ 9,307,638			$ 24,794,846	$ 9,307,638	
141	Medicare Cross-Over Bad Debt Payments					$ 613,738	$ 369,658					$ 613,738	$ 369,658	
142	Other Medicare Cross-Over Payments (See Note D)					$ 438,041	$ 294,079			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 438,041	$ 294,079	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,444,584	$ 1,183,607			
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)**	$ 22,439,254	$ 1,065,177	$ 9,865,530	$ 1,188,290	$ 2,984,197	$ (129,952)	$ 19,149,843	$ (2,038,812)	$ 21,678,222	$ 10,795,034	$ 54,438,824	$ 84,703	
146	**Calculated Payments as a Percentage of Cost**	52%	90%	74%	89%	87%	102%	70%	114%	6%	10%	68%	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)**					51,664								
148	**Percent of cross-over days to total Medicare days from the cost report**					14%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 1,141.74		18								18	
2	03100 INTENSIVE CARE UNIT	$ 4,547.01										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,685.91		1						4		5	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 607.47		1						25		26	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	20		-		-		29		49	
19	Total Days per PS&R or Exhibit Detail			20		-		-		29			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 16,980						$ 34,045		$ 51,025	
21.01	Calculated Routine Charge Per Diem			$ 849.00		$ -		$ -		$ 1,173.97		$ 1,041.33	
	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)		0.801180	1,193					-			$ 1,193	$ -
23	5000 OPERATING ROOM		0.118442	32,635						1,465		$ 34,100	$ -
24	5100 RECOVERY ROOM		0.153396	6,489						278		$ 6,767	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		1.625308	-						477		$ 477	$ -
26	5300 ANESTHESIOLOGY		0.006959	7,864						-		$ 7,864	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.091484	18,754	16,103				7,462	589		$ 19,343	$ 23,565
28	5500 RADIOLOGY-THERAPEUTIC		0.352051	-						-	30,909	$ -	$ 30,909
29	6000 LABORATORY		0.117021	10,762	4,429				4,172	6,773	494	$ 17,535	$ 9,095
30	6500 RESPIRATORY THERAPY		0.267765	63						949		$ 1,012	$ -
31	6600 PHYSICAL THERAPY		0.522816	562						1,080		$ 1,642	$ -
32	6700 OCCUPATIONAL THERAPY		0.226521	-						-		$ -	$ -
33	6800 SPEECH PATHOLOGY		0.220978	554						1,522		$ 2,076	$ -
34	6900 ELECTROCARDIOLOGY		0.150997	209	209				418	-		$ 209	$ 627
35	7000 ELECTROENCEPHALOGRAPHY		0.340687	-						-		$ -	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.267559	15,933	1,356				1,064	5,154	63	$ 21,087	$ 2,483
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.164059	-						-		$ -	$ -
38	7300 DRUGS CHARGED TO PATIENTS		0.149598	37,655	3,671				1,232	4,366		$ 42,021	$ 4,903
39	7400 RENAL DIALYSIS		0.392785	-						-		$ -	$ -
40	7600 ENDOSCOPY		0.217346	-						-		$ -	$ -
41	7601 HEART CATH LAB		0.070555	-						3,037		$ 3,037	$ -
42	9000 CLINIC		0.584917	339	50				701		334	$ 339	$ 1,085
43	9100 EMERGENCY		0.339670	6,495	10,867				4,302		710	$ 6,495	$ 15,879
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 139,507	$ 36,685	$ -	$ -	$ -	$ 19,351	$ 25,690	$ 32,510		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 156,487	$ 36,685	$ -	$ -	$ -	$ 19,351	$ 59,735	$ 32,510	$ 216,222	$ 88,546
129	Total Charges per PS&R or Exhibit Detail	$ 156,487	$ 36,685	$ -	$ -	$ -	$ 19,351	$ 59,735	$ 32,510		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 44,456	$ 6,655	$ -	$ -	$ -	$ 3,574	$ 27,170	$ 11,393	$ 71,626	$ 21,622
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 2,372							$ -	$ 2,372
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)							$ 43,405	$ 621	$ 43,405	$ 621
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 2,372	$ -	$ -						
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)						$ 1,210			$ -	$ 1,210
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 4,496	$ -	$ 4,496
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)**	$ 44,456	$ 4,283	$ -	$ -	$ -	$ 2,364	$ (16,235)	$ 6,276	$ 28,221	$ 12,923
144	**Calculated Payments as a Percentage of Cost**	0%	36%	0%	0%	0%	34%	160%	45%	61%	40%

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 (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

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

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

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

Cost Report Year (08/01/2020-07/31/2021) PHOEBE PUTNEY MEMORIAL HOSPITAL

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (08/01/2020-07/31/2021) 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)*		$ 6,783,074		
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)		$ 6,783,074	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		$ 6,783,074		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	704,262,686
19	Uninsured Hospital	**Charges Sec. G**	141,891,986
20	Total Hospital	**Charges Sec. G**	1,994,893,607
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		35.30%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.11%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*