

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2017	06/30/2018

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)
10/01/2017	09/30/2018

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

Data	
6. Medicaid Provider Number:	000001922A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110095

B. DSH OB 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:

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.)

2. Was the hospital exempt from the requirement listed under #1 above because the hospital's 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-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

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

3b. What date did the hospital open?

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

6. Is 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?

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018

(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 2,428,499

Certification:

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.

Answer

Yes

Explanation for "No" answers:

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

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


 Hospital CEO or CFO Signature

Sr. VP & CFO
 Title

10/22/19
 Date

Kim Wills
 Hospital CEO or CFO Printed Name

229-353-3397
 Hospital CEO or CFO Telephone Number

Kim.Wills@tiffregional.com
 Hospital CEO or CFO E-Mail

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

Hospital Contact:
 Name: Tonia Waldrop
 Title: Controller
 Telephone Number: 229-353-3804
 E-Mail Address: Tonia.Waldrop@tiffregional.com
 Mailing Street Address: 901 East 18th Street

Outside Preparer:
 Name: Jesus F. Ruiz, CPA
 Title: Consultant
 Firm Name: Reimbursement Solutions Group, LLC
 Telephone Number: 404-788-4861
 E-Mail Address: jesus.ruiz@rsgga.com

D. General Cost Report Year Information **10/1/2017 - 9/30/2018**

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:

TIFT REGIONAL MEDICAL CENTER

2. Select Cost Report Year Covered by this Survey (enter "X"):

10/1/2017 through 9/30/2018		
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:

3/12/2019

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
TIFT REGIONAL MEDICAL CENTER		
5. Medicaid Provider Number: 000001922A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0		
8. Medicare Provider Number: 110095		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt.		
DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Non-Small Rural		

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

- 9. State Name & Number
- 10. State Name & Number
- 11. State Name & Number
- 12. State Name & Number
- 13. State Name & Number
- 14. State Name & Number
- 15. State Name & Number

State Name	Provider No.

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)

- 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)**

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- 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 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:

	Inpatient	Outpatient	Total
	\$ 45,595	\$ 608,254	\$653,849
	\$ 921,435	\$ 7,735,963	\$8,657,398
	\$967,030	\$8,344,217	\$9,311,247
	4.71%	7.29%	7.02%

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.

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- 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 (10/01/2017 - 09/30/2018)

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)

44,707 (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.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$54,212,163.00			\$ 38,463,156	\$ -	\$ -	\$ 15,749,007
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	\$306,984,106.00	\$696,628,073.00		\$ 217,803,107	\$ 494,252,816	\$ -	\$ 291,556,255
20. Outpatient Services		\$82,765,805.00			\$ 58,721,768	\$ -	\$ 24,044,037
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$5,174,661.00			\$ 3,671,386	
26. Other	\$27,074,898.00	\$162,139,718.00	\$0.00	\$ 19,209,454	\$ 115,037,012	\$ -	\$ 54,968,150
27. Total	\$ 388,271,167	\$ 941,533,596	\$ 5,174,661	\$ 275,475,717	\$ 668,011,597	\$ 3,671,386	\$ 386,317,449
28. Total Hospital and Non Hospital		Total from Above	\$ 1,334,979,424	Total from Above	\$ 947,158,700		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,334,979,424	Total Contractual Adj. (G-3 Line 2)	947,158,700
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				
35. Adjusted Contractual Adjustments				947,158,700

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		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. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 34,979,564	\$ -	\$ -	\$ 0.00	\$ 34,979,564	43,568	\$ 35,123,256.00	\$ 802.87
2	03100	INTENSIVE CARE UNIT	\$ 10,592,984	\$ -	\$ -	\$ -	\$ 10,592,984	5,770	\$ 19,088,907.00	\$ 1,835.87
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	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
10	04300	NURSERY	\$ 1,289,574	\$ -	\$ -	\$ -	\$ 1,289,574	3,708	\$ 3,545,559.00	\$ 347.78
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
18		Total Routine	\$ 46,862,122	\$ -	\$ -	\$ -	\$ 46,862,122	53,046	\$ 57,757,722	
19		Weighted Average								\$ 883.42

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	8,339	-	-	\$ 6,695,133	\$ 7,651,408.00	\$ 15,751,451.00	\$ 23,402,859	0.286082

	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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5000	OPERATING ROOM	\$ 18,743,092.00	\$ -	\$ 0.00	\$ 18,743,092	\$ 24,212,487.00	\$ 70,018,061.00	\$ 94,230,548	0.198907
22	5100	RECOVERY ROOM	\$ 2,199,154.00	\$ -	\$ 0.00	\$ 2,199,154	\$ 2,893,487.00	\$ 4,437,882.00	\$ 7,331,369	0.299965
23	5200	DELIVERY ROOM & LABOR ROOM	\$ 2,824,339.00	\$ -	\$ 0.00	\$ 2,824,339	\$ 5,465,640.00	\$ 33,282.00	\$ 5,498,922	0.513617
24	5300	ANESTHESIOLOGY	\$ 4,646,651.00	\$ -	\$ 0.00	\$ 4,646,651	\$ 4,791,584.00	\$ 11,525,432.00	\$ 16,317,016	0.284773
25	5400	RADIOLOGY-DIAGNOSTIC	\$ 15,635,624.00	\$ -	\$ 0.00	\$ 15,635,624	\$ 10,791,145.00	\$ 61,545,577.00	\$ 72,336,722	0.216151
26	5700	CT SCAN	\$ 1,712,272.00	\$ -	\$ 0.00	\$ 1,712,272	\$ 19,887,195.00	\$ 66,415,226.00	\$ 86,302,421	0.019840
27	5800	MRI	\$ 1,583,284.00	\$ -	\$ 0.00	\$ 1,583,284	\$ 3,384,872.00	\$ 15,993,948.00	\$ 19,378,820	0.081702
28	6000	LABORATORY	\$ 13,824,998.00	\$ -	\$ 0.00	\$ 13,824,998	\$ 58,411,808.00	\$ 96,272,020.00	\$ 154,683,828	0.089376
29	6500	RESPIRATORY THERAPY	\$ 4,524,851.00	\$ -	\$ 0.00	\$ 4,524,851	\$ 19,293,148.00	\$ 4,416,503.00	\$ 23,709,651	0.190844
30	6600	PHYSICAL THERAPY	\$ 3,103,019.00	\$ -	\$ 0.00	\$ 3,103,019	\$ 4,800,311.00	\$ 4,821,339.00	\$ 9,621,650	0.322504
31	6900	ELECTROCARDIOLOGY	\$ 7,999,959.00	\$ -	\$ 0.00	\$ 7,999,959	\$ 20,747,141.00	\$ 40,426,724.00	\$ 61,173,865	0.130774

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7000 ELECTROENCEPHALOGRAPHY	\$1,771,739.00	\$ -	\$0.00	\$ 1,771,739	\$1,079,936.00	\$10,606,099.00	\$ 11,686,035	0.151612
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$21,782,036.00	\$ -	\$0.00	\$ 21,782,036	\$19,720,478.00	\$16,338,079.00	\$ 36,058,557	0.604074
34	7200 IMPL. DEV. CHARGED TO PATIENTS	\$10,547,526.00	\$ -	\$0.00	\$ 10,547,526	\$21,706,552.00	\$19,855,819.00	\$ 41,562,371	0.253776
35	7300 DRUGS CHARGED TO PATIENTS	\$35,707,188.00	\$ -	\$0.00	\$ 35,707,188	\$84,823,126.00	\$210,433,066.00	\$ 295,256,192	0.120936
36	7400 RENAL DIALYSIS	\$4,443,598.00	\$ -	\$0.00	\$ 4,443,598	\$1,429,637.00	\$63,489,016.00	\$ 64,918,653	0.068449
37	9000 CLINIC	\$2,311,982.00	\$ -	\$0.00	\$ 2,311,982	\$0.00	\$1,282,726.00	\$ 1,282,726	1.802397
38	9100 EMERGENCY	\$13,771,064.00	\$ -	\$1,707,449.00	\$ 15,478,513	\$20,360,862.00	\$23,098,196.00	\$ 43,459,058	0.356163
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 167,132,376	\$ -	\$ 1,707,449	\$ 168,839,825	\$ 331,450,817	\$ 736,760,446	\$ 1,068,211,263	
127	Weighted Average								0.164326
128	Sub Totals	\$ 213,994,498	\$ -	\$ 1,707,449	\$ 215,701,947	\$ 389,208,539	\$ 736,760,446	\$ 1,125,968,985	
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				\$ 215,701,947				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

Cost Report Year (10/01/2017-09/30/2018)

TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals				
				Inpatient		Outpatient		Inpatient		Outpatient		Inpatient		Outpatient			Inpatient		Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis		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 (from Section G):				Days		Days		Days		Days		Days		Days						
1	03900 ADULTS & PEDIATRICS	\$ 802.87		2,934		2,729		4,363		2,280		3,389		12,306		44.65%				
2	03100 INTENSIVE CARE UNIT	\$ 1,835.87		1,053		94		1,185		642		593		2,924		60.80%				
3	03300 ICORINARY CARE UNIT	\$ -																		
4	03390 BURN INTENSIVE CARE UNIT	\$ -																		
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -																		
6	03500 OTHER SPECIAL CARE UNIT	\$ -																		
7	04000 SUBPROVIDER I	\$ -																		
8	04100 SUBPROVIDER II	\$ -																		
9	04200 OTHER SUBPROVIDER	\$ -																		
10	04300 NURSERY	\$ 347.78		221		2,397				40		114		2,658		74.81%				
11	\$ -																			
12	\$ -																			
13	\$ -																			
14	\$ -																			
15	\$ -																			
16	\$ -																			
17	\$ -																			
18	\$ -																			
19	Total Days			4,158		5,220		5,548		2,962		4,086		17,888		41.49%				
20	Total Days per PS&R or Exhibit Detail			4,158		5,220		5,548		2,962		4,086								
20	Unreconciled Days (Explain Variance)																			
21	Routine Charges			\$ 4,273,858		\$ 5,447,480		\$ 8,115,740		\$ 3,804,233		\$ 4,825,249		\$ 21,847,311		45.54%				
21.01	Calculated Routine Charge Per Diem			1,027.86		1,043.58		1,462.92		1,284.36		1,132.12		1,200.82						
22	Ancillary Cost Centers (from Section G):			Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges				
22	09200 Observation (Non-District)	0.286082		629,886	797,481	811,128	1,265,508	1,113,188	2,496,133	469,102	331,341	372,410	1,379,759	3,023,304	4,990,461	41.34%				
23	5000 OPERATING ROOM	0.198907		1,249,839	2,225,801	2,044,321	5,059,465	2,558,580	6,872,812	1,250,068	1,163,687	1,915,211	3,963,040	7,576,455	15,021,765	30.20%				
24	5100 RECOVERY ROOM	0.299865		142,965	317,387	204,321	736,553	313,320	822,012	153,724	107,261	234,917	430,366	814,830	1,383,213	47.26%				
25	5200 DELIVERY ROOM & LABOR ROOM	0.513617		181,117	423,597	3,293,587	4,170	4,298	42,937			68,507	3,521,909	4,170	65.92%					
26	5300 ANESTHESIOLOGY	0.284773		230,171	326,810	437,740	930,600	509,235	760,111	632,285	364,947	778,657	1,236,791	1,809,431	2,382,468	38.07%				
27	5400 RADIOLOGY-DIAGNOSTIC	0.216151		623,334	2,920,948	1,486,129	3,255,106	1,729,221	7,130,685	568,999	1,396,540	661,699	4,320,753	4,607,583	14,703,179	63.63%				
28	5700 CT SCAN	0.019540		1,479,890	3,157,715	484,070	4,703,593	3,156,418	7,384,671	542,614	1,409,232	1,052,517	5,683,231	5,666,962	16,682,311	39.41%				
29	5800 MRI	0.081702		222,269	609,780	85,333	2,161,363	484,300	1,687,205	177,254	383,993	384,888	1,068,795	969,156	4,842,341	37.53%				
30	6000 LABORATORY	0.089976		5,235,239	3,241,659	3,241,659	5,639,419	8,996,335	7,597,237	3,346,012	1,259,088	4,362,654	10,699,949	20,796,686	21,106,306	60.90%				
31	6200 RESPIRATORY THERAPY	0.198944		978,604	131,134	344,510	137,686	1,238,492	209,256	912,691	67,293	624,660	354,318	3,374,687	545,348	60.70%				
32	6600 PHYSICAL THERAPY	0.322504		341,462	51,349	71,867	183,116	811,817	302,266	362,666	68,376	219,206	211,713	1,587,012	605,109	37.28%				
33	6800 ELECTROCARDIOLOGY	0.130774		1,077,024	896,503	342,959	1,049,176	3,338,176	5,223,469	1,403,870	634,178	1,869,536	2,285,198	8,161,929	7,793,346	29.28%				
34	7000 ELECTROENCEPHALOGRAPHY	0.151812		36,565	50,372	10,703	17,138	198,156	1,467,305	141,793	32,139	477,560	29,192	387,216	1,656,194	32.96%				
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.604074		1,675,740	657,810	1,607,431	1,310,342	2,959,430	2,028,441	1,300,036	232,979	1,190,871	1,027,939	7,442,637	4,229,572	38.55%				
36	7200 IMPL. DEV. CHARGED TO PATIENTS	0.253776		799,903	465,989		2,327,552	2,741,815	11,325,525		444,036		4,260,760	3,361,087	30,639,000	60.63%				
37	7300 DRUGS CHARGED TO PATIENTS	0.120536		8,357,199	7,208,332	2,992,342	5,036,453	12,746,468	26,723,181	3,871,668	7,440,146	4,910,722	8,577,622	27,965,172	46,608,911	39.79%				
38	7400 RENAL DIALYSIS	0.068449		165,861		18,347		280,350	21,315	108,617		38,676	4,403	573,175	21,315	0.98%				
39	9000 CLINIC	1.802397		8,057	111,238	42,575	64,419	125,540			34	116,978	50,632	301,231	36,559	0.85%				
40	9100 EMERGENCY	0.356183		1,972,121	2,563,583	401,423	4,697,516	3,456,065	3,663,392	694,755	422,074	1,176,307	6,681,718	6,524,364	11,276,545	39.29%				
41																				
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey	
86														
87														
88														
89														
90														
91														
92														
93														
94														
95														
96														
97														
98														
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127														
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)	\$ 29,781,104	\$ 29,142,254	\$ 23,741,875	\$ 36,228,703	\$ 54,309,688	\$ 76,896,565	\$ 20,895,549	\$ 15,728,050	\$ 24,835,292	\$ 52,946,128	\$ 128,728,195	\$ 157,993,572	32.42%
129	Total Charges per PSAR or Exhibit Detail	\$ 29,781,104	\$ 29,142,254	\$ 23,741,875	\$ 36,228,703	\$ 54,309,688	\$ 76,896,565	\$ 20,895,549	\$ 15,728,050	\$ 24,835,292	\$ 52,946,128			
130	Unreconciled Charges (Explain Variance)													
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 8,934,596	\$ 4,867,593	\$ 8,105,493	\$ 6,749,464	\$ 14,159,248	\$ 12,692,782	\$ 6,390,433	\$ 2,324,200	\$ 7,510,395	\$ 8,698,951	\$ 37,589,770	\$ 26,634,039	37.34%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,933,939	\$ 3,928,099			\$ 987,008	\$ 811,502	\$ 311,369	\$ 368,910			\$ 8,152,316	\$ 5,106,511	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 6,110,577	\$ 4,936,252			\$ 10,631	\$ 3,048			\$ 6,121,208	\$ 4,939,300	
134	Private Insurance (including primary and third party liability)					\$ 523	\$ 7,452	\$ 691,430	\$ 94,772			\$ 691,953	\$ 102,224	
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 75,763	\$ 24,489	\$ 34,423	\$ 14,546			\$ 216	\$ 421			\$ 110,402	\$ 39,456	
136	Total Allowed Amount from Medicaid PSAR or RA Detail (All Payments)	\$ 6,929,702	\$ 3,952,588	\$ 6,145,000	\$ 4,950,798									
137	Medicaid Cost Settlement Payments (See Note B)		\$ 445,148										\$ 445,148	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 10,590,670	\$ 8,496,749	\$ 10,339	\$ 4,032			\$ 10,601,009	\$ 9,500,791	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 4,375,202	\$ 1,758,552			\$ 4,375,202	\$ 1,758,552	
141	Medicare Cross-Over Bad Debt Payments					\$ 128,982	\$ 298,847					\$ 128,982	\$ 298,847	
142	Other Medicare Cross-Over Payments (See Note D)													
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 45,595	\$ 608,254			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)													
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 2,004,894	\$ 469,657	\$ 1,960,493	\$ 1,798,666	\$ 2,452,065	\$ 2,078,232	\$ 991,246	\$ 94,465	\$ 7,464,800	\$ 8,090,697	\$ 7,408,699	\$ 4,441,220	
146	Calculated Payments as a Percentage of Cost	76%	90%	76%	73%	83%	84%	84%	96%	1%	7%	80%	83%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CR, WIS S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					23,950								
148	Percent of cross-over days to total Medicare days from the cost report					23%								

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 PSAR 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 PSAR).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Diem Cost for Routine Cost Centers From Section G	Charge Ratio for Ancillary Cost Centers From Section G	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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 PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 802.87		33								33	
2	03100 INTENSIVE CARE UNIT	\$ 1,835.87		1								1	
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ 347.78		2								2	
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
19													
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21													
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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										\$ -	\$ -
		\$ 144,532	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 180,682	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 180,682	\$ 313,678
129	Total Charges per PS&R or Exhibit Detail	\$ 180,682	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 55,945	\$ 51,183	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 55,945	\$ 51,183
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,235	\$ 16,740							\$ 6,235	\$ 16,740
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ 10,721	\$ 15,971							\$ 10,721	\$ 15,971
134	Private Insurance (including primary and third party liability)									\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 16,956	\$ 32,711	\$ -	\$ -					\$ -	\$ -
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)									\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 38,989	\$ 18,472	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 38,989	\$ 18,472
144	Calculated Payments as a Percentage of Cost	30%	64%	0%	0%	0%	0%	0%	0%	30%	64%

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 (10/01/2017-09/30/2018)

TIFT REGIONAL MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (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)	
						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 (10/01/2017-09/30/2018)

TIFT REGIONAL MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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)
						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 (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

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

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	287,216,128
19 Uninsured Hospital Charges Sec. G	77,781,420
20 Total Hospital Charges Sec. G	1,125,968,985
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	25.51%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.91%
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.

A. General DSH Year Information

1. DSH Year:

2. Select Your Facility from the Drop-Down Menu Provided:

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
 4. Cost Report Year 2 (if applicable)
 5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2017	06/30/2018

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

6. Medicaid Provider Number:
 7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
 8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
 9. Medicare Provider Number:

Data
000001251A
0
0
110101

B. DSH OB 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:

- 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.)
- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

- Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

- Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- Is 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?

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018

(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 96,984

Certification:

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.

Answer
 Yes

Explanation for "No" answers:

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

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


 Hospital CEO or CFO Signature

Kim Wills
 Hospital CEO or CFO Printed Name

Sr. VP & CFO
 Title

229-353-3397
 Hospital CEO or CFO Telephone Number

10/31/19
 Date

Kim.Wills@ttrregional.com
 Hospital CEO or CFO E-Mail

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

Hospital Contact:
 Name: Stuart Hastings
 Title: Affiliate Controller
 Telephone Number: 229-896-8139
 E-Mail Address: Stuart.Hasty@ttrregional.com
 Mailing Street Address:

Outside Preparer:
 Name: Jesus F. Ruiz, CPA
 Title: President
 Firm Name: Reimbursement Solutions Group, LLC
 Telephone Number: 404-788-4861
 E-Mail Address: jesus.ruiz@rsqga.com

D. General Cost Report Year Information **7/1/2017 - 6/30/2018**

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:

COOK MEDICAL CENTER

2. Select Cost Report Year Covered by this Survey (enter "X"):

7/1/2017 through 6/30/2018		
X		

3. Status of Cost Report Used for this Survey (Should be audited if available):

1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database:

5/10/2019

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
COOK MEDICAL CENTER	Yes	
000001251A	Yes	
0	Yes	
0	Yes	
110101	Yes	
Non-State Govt.	Yes	
Small Rural	Yes	

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

8. Medicare Provider Number:

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

DSH Pool Classification (Small Rural, Non-Small Rural, Urban):

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

9. State Name & Number

10. State Name & Number

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)

State Name	Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2017 - 06/30/2018)

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)**

\$ -

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

Inpatient	Outpatient	Total
\$ -	\$ 24,120	\$24,120

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

\$ 28,483	\$ 149,666	\$178,149
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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)

\$28,483	\$173,786	\$202,269
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12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

0.00%	13.88%	11.92%
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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

\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		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. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 3,987,401	\$ -	\$ -	\$ 0.00	\$ 3,987,401	4,275	\$ 5,543,067.00	\$ 932.73
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -	\$ -
18		Total Routine	\$ 3,987,401	\$ -	\$ -	\$ -	\$ 3,987,401	4,275	\$ 5,543,067	
19		Weighted Average								\$ 932.73

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)	118	\$ -	\$ 110,062	\$ 53,190.00	\$ 394,575.00	\$ 447,765	0.245803

		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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5000	OPERATING ROOM	\$155,357.00	\$ -	\$ 0.00	\$ 155,357	\$ 100.00	\$ 417,267.00	\$ 417,367	0.372231
22	5400	RADIOLOGY-DIAGNOSTIC	\$762,113.00	\$ -	\$ 0.00	\$ 762,113	\$ 294,307.00	\$ 3,995,071.00	\$ 4,289,378	0.177674
23	6000	LABORATORY	\$1,138,819.00	\$ -	\$ 0.00	\$ 1,138,819	\$ 1,037,208.00	\$ 3,127,805.00	\$ 4,165,013	0.273425
24	6500	RESPIRATORY THERAPY	\$129,465.00	\$ -	\$ 0.00	\$ 129,465	\$ 93,584.00	\$ 23,053.00	\$ 116,637	1.109982
25	6600	PHYSICAL THERAPY	\$365,884.00	\$ -	\$ 0.00	\$ 365,884	\$ 794,094.00	\$ 430,076.00	\$ 1,224,170	0.298883
26	6601	PHYSICAL THERAPY - SNF	\$426,443.00	\$ -	\$ 0.00	\$ 426,443	\$ 1,425,683.00	\$ 100,376.00	\$ 1,526,059	0.279441
27	6900	ELECTROCARDIOLOGY	\$37,456.00	\$ -	\$ 0.00	\$ 37,456	\$ 121,183.00	\$ 1,065,841.00	\$ 1,187,024	0.031555
28	7000	ELECTROENCEPHALOGRAPHY	\$34,117.00	\$ -	\$ 0.00	\$ 34,117	\$ 0.00	\$ 275,100.00	\$ 275,100	0.124017
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$98,959.00	\$ -	\$ 0.00	\$ 98,959	\$ 206,713.00	\$ 17,319.00	\$ 224,032	0.441718
30	7300	DRUGS CHARGED TO PATIENTS	\$912,279.00	\$ -	\$ 0.00	\$ 912,279	\$ 3,298,289.00	\$ 1,466,316.00	\$ 4,764,605	0.191470
31			\$ 0.00	\$ -	\$ 0.00	\$ -	\$ 0.00	\$ 0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 4,060,892	\$ -	\$ -	\$ 4,060,892	\$ 7,324,351	\$ 11,312,799	\$ 18,637,150	
127	Weighted Average								0.223798
128	Sub Totals	\$ 8,048,293	\$ -	\$ -	\$ 8,048,293	\$ 12,867,418	\$ 11,312,799	\$ 24,180,217	
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)				\$234,293.00				
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				\$ 7,814,000				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				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	Inpatient	Outpatient	
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03900 ADULTS & PEDIATRICS	\$ 932.73		128	7	995	32	20		1,162						28.43%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03300 ICORONARY CARE UNIT	\$ -														
4	03390 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ -														
11	\$ -															
12	\$ -															
13	\$ -															
14	\$ -															
15	\$ -															
16	\$ -															
17	\$ -															
18	\$ -															
19	Total Days per PS&R or Exhibit Detail			128	7	995	32	20		1,162						27.65%
20	Unreconciled Days (Explain Variance)															
21	Routine Charges			\$ 725,996	\$ 7,000	\$ 1,451,670	\$ 40,590	\$ 20,810		\$ 1,625,126						29.69%
21.01	Calculated Routine Charge Per Diem			\$ 983.53	\$ 1,000.00	\$ 1,458.96	\$ 1,268.44	\$ 1,040.50		\$ 1,398.56						
Ancillary Cost Centers (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-District)	0.245803		3,676	8,944	-	10,587	3,202	38,212	2,232	18,664	237	11,712	9,110	76,407	21.77%
23	5000 OPERATING ROOM	0.372231		5,330		16,956		177	45,138		13,610	76	20,246	177	81,234	25.06%
24	5400 RADIOLOGY-DIAGNOSTIC	0.177874		11,732	163,076	16,258	363,163	52,124	497,362	8,817	227,650	8,146	338,378	88,931	1,151,251	36.74%
25	6000 LABORATORY	0.273425		69,380	219,968	5,467	110,522	275,766	107,971	22,752	161,812	19,319	229,305	373,365	600,273	29.42%
26	6500 RESPIRATORY THERAPY	1.109982		2,871	874	1,332	28,651	4,808	2,955	732	1,334	1,723	583	9,743	33,514	19.06%
27	6600 PHYSICAL THERAPY	0.298863		14,243	1,533	1,059	31,777	133,398	69,335	4,629	47,173	-	33,414	153,329	149,618	27.49%
28	6901 PHYSICAL THERAPY - SNF	0.279541		-	-	-	-	-	-	-	-	-	-	-	-	0.00%
29	6900 ELECTROCARDIOLOGY	0.031555		4,718	19,539	-	-	7,458	133,665	747	64,667	249	49,612	12,923	217,771	23.64%
30	7000 ELECTROENCEPHALOGRAPHY	0.124017		-	-	-	-	73,650	8,074	2,481	16,700	11,100	11,100	11,100	90,350	16.98%
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.441718		4,608	3,715	764	1,142	14,392	8,074	2,481	2,122	2,069	2,246	22,246	15,093	16.80%
32	7300 DRUGS CHARGED TO PATIENTS	0.191470		100,145	21,861	1,300	5,816	843,154	280,033	22,025	77,863	19,879	97,120	966,624	385,573	30.84%
33	-															
34	-															
35	-															
36	-															
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82	-															
83	-															
84	-															
85	-															

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

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

				In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	Total In-State Medicaid	% Survey				
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									\$ -	-				
	Totals / Payments			\$ 211,373	\$ 444,740	\$ 26,180	\$ 468,614	\$ 1,334,478	\$ 1,256,296	\$ 64,415	\$ 631,595	\$ 51,698	\$ 781,710	
128	Total Charges (includes organ acquisition from Section J)	\$ 337,239	\$ 444,740	\$ 33,180	\$ 468,614	\$ 2,786,148	\$ 1,256,296	\$ 105,005	\$ 631,595	\$ 72,508	\$ 781,710	\$ 3,261,572	\$ 2,801,245	28.64%
129	Total Charges per PSAR or Exhibit Detail	\$ 337,239	\$ 444,740	\$ 33,180	\$ 468,614	\$ 2,786,148	\$ 1,256,296	\$ 105,005	\$ 631,595	\$ 72,508	\$ 781,710			
130	Unreconciled Charges (Explain Variance)													
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 170,151	\$ 100,915	\$ 13,294	\$ 128,808	\$ 1,226,820	\$ 238,621	\$ 45,716	\$ 129,882	\$ 32,111	\$ 164,263	\$ 1,455,981	\$ 598,226	28.83%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 135,116	\$ 72,211	\$ 14,870	\$ 85,563	\$ 21,427	\$ 20,264	\$ 4,973	\$ 9,643		\$ 176,180	\$ 187,681		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											\$ 2,692	\$ 2,692	
134	Private Insurance (including primary and third party liability)					\$ 1,184	\$ 156	\$ 21,177	\$ 74,959		\$ 22,361	\$ 75,115		
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 611		\$ 527				\$ 602			\$ 1,740		
136	Total Allowed Amount from Medicaid PSAR or RA Detail (All Payments)	\$ 135,116	\$ 72,822	\$ 14,870	\$ 86,090									
137	Medicaid Cost Settlement Payments (See Note B)		\$ (56)										\$ (56)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 912,853	\$ 130,927		\$ 61			\$ 912,853	\$ 130,968	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 9,059	\$ 2,135			\$ 9,059	\$ 2,135	
141	Medicare Cross-Over Bad Debt Payments					\$ 58,739	\$ 6,128					\$ 58,739	\$ 6,128	
142	Other Medicare Cross-Over Payments (See Note D)													
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 24,120		
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)	\$ 35,035	\$ 28,149	\$ (1,376)	\$ 42,718	\$ 232,617	\$ 81,146	\$ 10,507	\$ 39,790	\$ 32,111	\$ 140,143	\$ 276,783	\$ 191,803	
146	Calculated Payments as a Percentage of Cost	79%	72%	110%	67%	81%	66%	77%	69%	0%	15%	81%	68%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CR, WIS S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					3,306								
148	Percent of cross-over days to total Medicare days from the cost report					30%								

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 PSAR 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 PSAR).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Line #	Cost Center Description	Diem Cost for Routine Cost Centers From Section G	Charge Ratio for Ancillary Cost Centers From Section G	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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 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	\$ 932.73											
2	03100 INTENSIVE CARE UNIT	\$ -											
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ -											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days										
19	Total Days per PS&R or Exhibit Detail												
20	Unreconciled Days (Explain Variance)												
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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)	0.245803											
23	5000 OPERATING ROOM	0.372231			2,876							2,876	
24	5400 RADIOLOGY-DIAGNOSTIC	0.177674			1,404							1,404	
25	6000 LABORATORY	0.273425			2,997							2,997	
26	6500 RESPIRATORY THERAPY	1.109982			-							-	
27	6600 PHYSICAL THERAPY	0.298883			-							-	
28	6601 PHYSICAL THERAPY - SNF	0.279441			-							-	
29	6900 ELECTROCARDIOLOGY	0.031555			-							-	
30	7000 ELECTROENCEPHALOGRAPHY	0.124017			-							-	
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.441718			59							59	
32	7300 DRUGS CHARGED TO PATIENTS	0.191470			232							232	
33													
34													
35													
36													
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48													
49													

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
50											\$	\$
51											\$	\$
52											\$	\$
53											\$	\$
54											\$	\$
55											\$	\$
56											\$	\$
57											\$	\$
58											\$	\$
59											\$	\$
60											\$	\$
61											\$	\$
62											\$	\$
63											\$	\$
64											\$	\$
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66											\$	\$
67											\$	\$
68											\$	\$
69											\$	\$
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87											\$	\$
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89											\$	\$
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96											\$	\$
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100											\$	\$
101											\$	\$
102											\$	\$
103											\$	\$
104											\$	\$
105											\$	\$
106											\$	\$
107											\$	\$
108											\$	\$
109											\$	\$
110											\$	\$
111											\$	\$

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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										\$ -	\$ -
		\$ -	\$ 7,568	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 7,568	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 7,568
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 7,568	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 2,210	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,210
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									\$ -	\$ -
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)									\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -
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)									\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ 2,210	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,210
144	Calculated Payments as a Percentage of Cost	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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 (07/01/2017-06/30/2018)

COOK MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (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	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -		\$ -	
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 (07/01/2017-06/30/2018)

COOK MEDICAL CENTER

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -	
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 (07/01/2017-06/30/2018) COOK MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

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

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	6,070,385
19 Uninsured Hospital Charges Sec. G	854,218
20 Total Hospital Charges Sec. G	24,180,217
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	25.10%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	3.53%
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.