

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2016	06/30/2017

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2016	09/30/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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 07/01/2016 - 06/30/2017

\$ 1,150,667

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

Certification:

Answer

Yes

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.

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

11/2/18
 Date

Kim Wills
 Hospital CEO or CFO Printed Name

229-353-3397
 Hospital CEO or CFO Telephone Number

Kim.Wills@lifrregional.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@lifrregional.com
Mailing Street Address	901 East 18th Street
Mailing City, State, Zip	Tifton, GA 31793

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

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 10/1/2016 - 9/30/2017

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:

10/1/2016 through 9/30/2017		
X		

3. Status of Cost Report Used for this Survey (Should be audited if available): **1 - As Submitted**

3a. Date CMS processed the HCRIS file into the HCRIS database: **1/0/1900**

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

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

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)	\$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$ -
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)	\$-
8. Out-of-State DSH Payments (See Note 2)	\$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 101,185	\$ 401,522	\$502,707
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 729,520	\$ 5,451,022	\$6,180,542
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$830,705	\$5,852,544	\$6,683,249
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.18%	6.86%	7.52%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? **No**
 Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	\$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	\$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2016 - 09/30/2017)

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) 41,435

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	13,722,144
8. Outpatient Hospital Charity Care Charges	29,978,631
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 43,700,775

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

	Total Patient Revenues (Charges)			Contractual Adjustments			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 50,433,775	\$ -	\$ -	\$ 35,882,917	\$ -	\$ -	\$ 14,550,858
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF	-	-	-	-	-	-	-
15. Swing Bed - NF	-	-	-	-	-	-	-
16. Skilled Nursing Facility	-	-	-	-	-	-	-
17. Nursing Facility	-	-	-	-	-	-	-
18. Other Long-Term Care	-	-	-	-	-	-	-
19. Ancillary Services	\$299,844,537.00	\$ 644,794,377	\$ -	\$ 213,335,145	\$ 458,762,075	\$ -	\$ 272,541,695
20. Outpatient Services	-	\$ 79,275,630	\$ -	-	\$ 56,403,489	\$ -	\$ 22,872,141
21. Home Health Agency	-	-	-	-	-	-	-
22. Ambulance	-	-	-	-	-	-	-
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice	-	-	-	-	-	-	-
26. Other	\$ -	\$ -	\$ 183,492,055	\$ -	\$ -	\$ 130,552,000	\$ -
27. Total	\$ 350,278,312	\$ 724,070,007	\$ 183,492,055	\$ 249,218,062	\$ 515,165,563	\$ 130,552,000	\$ 309,964,693
28. Total Hospital and Non Hospital		Total from Above	\$ 1,257,840,374		Total from Above	\$ 894,935,626	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 1,257,840,374		Total Contractual Adj. (G-3 Line 2)	\$ 890,898,839	
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)					+	\$ -	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)					+	\$ 4,036,787	
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						894,935,626	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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)	Net 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 33,745,863	\$ -	\$ -	\$ -	\$ 33,745,863	40,614	\$ -	\$ 830.89
2	03100	INTENSIVE CARE UNIT	\$ 7,089,909	\$ -	\$ -	\$ -	\$ 7,089,909	5,792	\$ -	\$ 1,224.09
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	\$ 1,257,785	\$ -	\$ -	\$ -	\$ 1,257,785	3,242	\$ -	\$ 387.97
11			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
12			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
15			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
16			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
17			\$ 0	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
18		Total Routine	\$ 42,093,557	\$ -	\$ -	\$ -	\$ 42,093,557	49,648	\$ -	\$ -
19		Weighted Average								\$ 847.84

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
09200 Observation (Non-Distinct)	8,213	-	-	\$ 6,824,100	\$ 6,915,666	\$ 15,582,239	\$ 22,497,905	0.303322

	<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$ 16,065,842	\$ -	\$ -	\$ 16,065,842	\$ 27,552,813	\$ 64,657,783	\$ 92,210,596	0.174230
22	5100	RECOVERY ROOM	\$ 2,003,195	\$ -	\$ -	\$ 2,003,195	\$ 3,112,873	\$ 3,456,944	\$ 6,569,817	0.304909
23	5200	DELIVERY ROOM & LABOR ROOM	\$ 2,451,351	\$ -	\$ -	\$ 2,451,351	\$ 5,438,883	\$ 20,572	\$ 5,459,455	0.449010
24	5300	ANESTHESIOLOGY	\$ 1,627,923	\$ -	\$ -	\$ 1,627,923	\$ 5,340,290	\$ 11,095,758	\$ 16,436,048	0.099046
25	5400	RADIOLOGY-DIAGNOSTIC	\$ 10,656,261	\$ -	\$ -	\$ 10,656,261	\$ 10,807,748	\$ 61,509,329	\$ 72,317,077	0.147355
26	5700	CT SCAN	\$ 1,498,567	\$ -	\$ -	\$ 1,498,567	\$ 18,478,245	\$ 60,900,853	\$ 79,379,098	0.018879
27	5800	MAGNETIC RESONANCE IMAGING (MRI)	\$ 1,422,130	\$ -	\$ -	\$ 1,422,130	\$ 3,048,755	\$ 16,472,585	\$ 19,521,340	0.072850
28	6000	LABORATORY	\$ 14,094,716	\$ -	\$ -	\$ 14,094,716	\$ 53,790,314	\$ 95,798,471	\$ 149,588,785	0.094223
29	6500	RESPIRATORY THERAPY	\$ 4,174,385	\$ -	\$ -	\$ 4,174,385	\$ 18,116,876	\$ 4,323,634	\$ 22,440,510	0.186020
30	6600	PHYSICAL THERAPY	\$ 3,146,329	\$ -	\$ -	\$ 3,146,329	\$ 5,333,381	\$ 4,833,872	\$ 10,167,253	0.309457
31	6900	ELECTROCARDIOLOGY	\$ 6,989,853	\$ -	\$ -	\$ 6,989,853	\$ 19,846,334	\$ 36,230,405	\$ 56,076,739	0.124648
32	7000	ELECTROENCEPHALOGRAPHY	\$ 1,477,375	\$ -	\$ -	\$ 1,477,375	\$ 1,043,086	\$ 10,508,142	\$ 11,551,228	0.127898

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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)	Net Cost	I/P Routine		Total Charges	Medicaid Per Diem / Cost or Other Ratios
						I/P Days and I/P Ancillary Charges	Charges and O/P Ancillary Charges		
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	\$ 16,828,544	\$ -	\$ -	\$ 16,828,544	\$ 19,728,260	\$ 15,705,526	\$ 35,433,786	0.474929
34	7200 IMPL. DEV. CHARGED TO PATIENT	\$ 9,870,304	\$ -	\$ -	\$ 9,870,304	\$ 25,351,147	\$ 12,612,485	\$ 37,963,632	0.259994
35	7300 DRUGS CHARGED TO PATIENTS	\$ 35,240,022	\$ -	\$ -	\$ 35,240,022	\$ 78,593,893	\$ 185,927,766	\$ 264,521,659	0.133222
36	7400 RENAL DIALYSIS	\$ 4,338,647	\$ -	\$ -	\$ 4,338,647	\$ 948,105	\$ 60,740,252	\$ 61,688,357	0.070332
37	9000 CLINIC	\$ 2,152,325	\$ -	\$ -	\$ 2,152,325	\$ 8,793	\$ 1,847,204	\$ 1,855,997	1.159660
38	9100 EMERGENCY	\$ 11,447,238	\$ -	\$ -	\$ 11,447,238	\$ 11,743,521	\$ 29,992,261	\$ 41,735,782	0.274279
39		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
40		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
41		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
42		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
43		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
44		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
45		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
46		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
47		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
48		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
49		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
50		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
51		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
52		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
53		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
54		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
55		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
56		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
57		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
58		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
59		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
60		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
61		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
62		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
63		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
64		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
65		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
66		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
67		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
68		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
69		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
70		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
71		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
72		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
73		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
74		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
75		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
76		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
77		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
78		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
79		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
80		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
81		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
82		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
83		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
84		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
85		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
86		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
87		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
88		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
89		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
90		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
91		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
92		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
93		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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)	Net 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
94		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
95		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
96		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
97		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
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99		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
100		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
101		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
102		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
103		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
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115		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
116		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
117		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
118		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
119		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
120		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
121		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
122		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
123		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
124		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
125		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-
126	Total Ancillary	\$ 145,485,007	\$ -	\$ -	\$ 145,485,007	\$ 315,198,983	\$ 692,216,081	\$ 1,007,415,064	
127	Weighted Average								0.151188
128	Sub Totals	\$ 187,578,564	\$ -	\$ -	\$ 187,578,564	\$ 315,198,983	\$ 692,216,081	\$ 1,007,415,064	
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)				\$ -				
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)				\$ -				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)				\$ -				
131.01	Other Cost Adjustments (support must be submitted)				\$ -				
132	Grand Total				\$ 187,578,564				
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 (10/01/2016-09/30/2017) 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	%							
85														
86														
87														
88														
89														
90														
91														
92														
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95														
96														
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126														
127														
	24,891,730	35,677,611	17,659,166	36,707,489	43,170,649	80,800,495	1,959,881	1,945,460	23,659,013	63,110,717				
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)	\$ 28,843,240	\$ 35,677,611	\$ 22,847,646	\$ 36,707,489	\$ 50,280,479	\$ 80,800,495	\$ 2,348,331	\$ 1,945,460	\$ 27,977,553	\$ 63,110,717	\$ 104,319,696	\$ 155,131,055	34.80%
129	Total Charges per PS&R or Exhibit Detail	\$ 28,843,240	\$ 35,677,611	\$ 22,847,646	\$ 36,707,489	\$ 50,280,479	\$ 80,800,495	\$ 2,348,331	\$ 1,945,460	\$ 27,977,553	\$ 63,110,717			
130	Unreconciled Charges (Explain Variance)													
131.01	Sampling Cost Adjustment (if applicable)													
131.02	Total Calculated Cost (includes organ acquisition from Section J)	\$ 7,809,976	\$ 5,321,180	\$ 7,040,980	\$ 5,384,121	\$ 11,877,451	\$ 12,766,133	\$ 636,220	\$ 298,261	\$ 6,634,631	\$ 9,146,305	\$ 27,364,627	\$ 23,769,695	35.67%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,966,873	\$ 5,052,518	\$ -	\$ -	\$ 1,174,443	\$ 901,932	\$ -	\$ -			\$ 8,141,316	\$ 5,954,450	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 6,125,788	\$ 4,368,124	\$ -	\$ -	\$ 285,965	\$ 139,665			\$ 6,411,753	\$ 4,507,789	
134	Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 288,207	\$ 96,623			\$ 288,207	\$ 96,623	
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 41,795	\$ 29,230	\$ 22,067	\$ 21,277	\$ 1,036	\$ 25,368	\$ 260	\$ 2,322			\$ 65,158	\$ 78,197	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 7,008,668	\$ 5,081,748	\$ 6,147,855	\$ 4,389,401									
137	Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (248,338)	\$ -	\$ -								\$ (248,338)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -								\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 9,104,791	\$ 10,146,015	\$ -	\$ -			\$ 9,104,791	\$ 10,146,015	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 137,793	\$ 206,980			\$ 137,793	\$ 206,980	
141	Medicare Cross-Over Bad Debt Payments					\$ 125,016	\$ 125,016	\$ -	\$ -			\$ 125,016	\$ 125,016	
142	Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 101,185	\$ 401,522			
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)	\$ 801,306	\$ 487,770	\$ 893,125	\$ 994,720	\$ 1,472,165	\$ 1,567,802	\$ (76,005)	\$ (147,329)	\$ 6,533,446	\$ 8,744,783	\$ 3,090,593	\$ 2,902,963	
146	Calculated Payments as a Percentage of Cost	90%	91%	87%	82%	88%	88%	112%	149%	2%	4%	88%	88%	
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 1)					21,700								
148	Percent of cross-over days to total Medicare days from the cost report					22%								

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 a 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 pay)
 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 pay;

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		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):													
1	03000 ADULTS & PEDIATRICS	\$ 830.89											
2	03100 INTENSIVE CARE UNIT	\$ 1,224.09											
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	\$ 387.97											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
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):													
22	09200 Observation (Non-Distinct)	0.303322											
23	5000 OPERATING ROOM	0.174230											
24	5100 RECOVERY ROOM	0.304909											
25	5200 DELIVERY ROOM & LABOR ROOM	0.449010											
26	5300 ANESTHESIOLOGY	0.099046											
27	5400 RADIOLOGY-DIAGNOSTIC	0.147355											
28	5700 CT SCAN	0.018879											
29	5800 MAGNETIC RESONANCE IMAGING (MRI)	0.072850											
30	6000 LABORATORY	0.094223											
31	6500 RESPIRATORY THERAPY	0.186020											
32	6600 PHYSICAL THERAPY	0.309457											
33	6900 ELECTROCARDIOLOGY	0.124648											
34	7000 ELECTROENCEPHALOGRAPHY	0.127898											
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.474929											
36	7200 IMPL. DEV. CHARGED TO PATIENT	0.259994											
37	7300 DRUGS CHARGED TO PATIENTS	0.133222											
38	7400 RENAL DIALYSIS	0.070332											
39	9000 CLINIC	1.159660											
40	9100 EMERGENCY	0.274279											
41													
42													
43													
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) 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	
64			-	-	-	-	-	-	-	-	\$	-
65			-	-	-	-	-	-	-	-	\$	-
66			-	-	-	-	-	-	-	-	\$	-
67			-	-	-	-	-	-	-	-	\$	-
68			-	-	-	-	-	-	-	-	\$	-
69			-	-	-	-	-	-	-	-	\$	-
70			-	-	-	-	-	-	-	-	\$	-
71			-	-	-	-	-	-	-	-	\$	-
72			-	-	-	-	-	-	-	-	\$	-
73			-	-	-	-	-	-	-	-	\$	-
74			-	-	-	-	-	-	-	-	\$	-
75			-	-	-	-	-	-	-	-	\$	-
76			-	-	-	-	-	-	-	-	\$	-
77			-	-	-	-	-	-	-	-	\$	-
78			-	-	-	-	-	-	-	-	\$	-
79			-	-	-	-	-	-	-	-	\$	-
80			-	-	-	-	-	-	-	-	\$	-
81			-	-	-	-	-	-	-	-	\$	-
82			-	-	-	-	-	-	-	-	\$	-
83			-	-	-	-	-	-	-	-	\$	-
84			-	-	-	-	-	-	-	-	\$	-
85			-	-	-	-	-	-	-	-	\$	-
86			-	-	-	-	-	-	-	-	\$	-
87			-	-	-	-	-	-	-	-	\$	-
88			-	-	-	-	-	-	-	-	\$	-
89			-	-	-	-	-	-	-	-	\$	-
90			-	-	-	-	-	-	-	-	\$	-
91			-	-	-	-	-	-	-	-	\$	-
92			-	-	-	-	-	-	-	-	\$	-
93			-	-	-	-	-	-	-	-	\$	-
94			-	-	-	-	-	-	-	-	\$	-
95			-	-	-	-	-	-	-	-	\$	-
96			-	-	-	-	-	-	-	-	\$	-
97			-	-	-	-	-	-	-	-	\$	-
98			-	-	-	-	-	-	-	-	\$	-
99			-	-	-	-	-	-	-	-	\$	-
100			-	-	-	-	-	-	-	-	\$	-
101			-	-	-	-	-	-	-	-	\$	-
102			-	-	-	-	-	-	-	-	\$	-
103			-	-	-	-	-	-	-	-	\$	-
104			-	-	-	-	-	-	-	-	\$	-
105			-	-	-	-	-	-	-	-	\$	-
106			-	-	-	-	-	-	-	-	\$	-
107			-	-	-	-	-	-	-	-	\$	-
108			-	-	-	-	-	-	-	-	\$	-
109			-	-	-	-	-	-	-	-	\$	-
110			-	-	-	-	-	-	-	-	\$	-
111			-	-	-	-	-	-	-	-	\$	-
112			-	-	-	-	-	-	-	-	\$	-
113			-	-	-	-	-	-	-	-	\$	-
114			-	-	-	-	-	-	-	-	\$	-
115			-	-	-	-	-	-	-	-	\$	-
116			-	-	-	-	-	-	-	-	\$	-
117			-	-	-	-	-	-	-	-	\$	-
118			-	-	-	-	-	-	-	-	\$	-
119			-	-	-	-	-	-	-	-	\$	-
120			-	-	-	-	-	-	-	-	\$	-
121			-	-	-	-	-	-	-	-	\$	-
122			-	-	-	-	-	-	-	-	\$	-
123			-	-	-	-	-	-	-	-	\$	-
124			-	-	-	-	-	-	-	-	\$	-
125			-	-	-	-	-	-	-	-	\$	-
126			-	-	-	-	-	-	-	-	\$	-
127			-	-	-	-	-	-	-	-	\$	-

Totals / Payments

128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-
131.01	Sampling Cost Adjustment (if applicable)										\$ -	\$ -
131.02	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) 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	
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)					\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
143.02 Calculated Payment Shortfall / (Longfall)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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 (10/01/2016-09/30/2017) 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	
<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>												
Organ Acquisition Cost Centers (list below):																
1	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
2	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
3	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
4	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
5	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
8		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
9	Totals	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	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 D 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 (10/01/2016-09/30/2017) 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)
<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>									
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
17	Islet Acquisition	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
18		\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
19	Totals	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	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 E 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 (10/01/2016-09/30/2017) 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)*	\$ 3,336,107		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	83110-70893	(WTB Account #)
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 3,336,107	Admin & General	(Where is the cost included on w/s A?)
3	Difference (Explain Here ----->)	0		
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	Reclassification Code	0	-	(Reclassified to / (from))
5	Reclassification Code	0	-	(Reclassified to / (from))
6	Reclassification Code	0	-	(Reclassified to / (from))
7	Reclassification Code	0	-	(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	Reason for adjustment	0	-	(Adjusted to / (from))
9	Reason for adjustment	0	-	(Adjusted to / (from))
10	Reason for adjustment	0	-	(Adjusted to / (from))
11	Reason for adjustment	0	-	(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	0	-	
13	Reason for adjustment	0	-	
14	Reason for adjustment	0	-	
15	Reason for adjustment	0	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 3,336,107		

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report \$ -

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

DSH Examination Eligibility Summary

Hospital Name	TIFT REGIONAL MEDICAL CENTER			
Hospital Medicaid Number	000001922A			
Cost Report Period	From	10/1/2016	To	9/30/2017

		As-Reported	Adjustments	As-Adjusted
LIUR				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 24,881,339	\$ -	\$ 24,881,339
2 Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
3 Total		\$ 24,881,339	\$ -	\$ 24,881,339
4 Net Hospital Patient Revenue	Survey F-3	\$ 309,964,693	\$ -	\$ 309,964,693
5 Medicaid Fraction		8.03%	0.00%	8.03%
6 Inpatient Charity Care Charges	Survey F-2	\$ 13,722,144	\$ -	\$ 13,722,144
7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2	\$ -	\$ -	\$ -
9 Adjusted Inpatient Charity Care		\$ 13,722,144	\$ -	\$ 13,722,144
10 Inpatient Hospital Charges	Survey F-3	\$ 368,946,292	\$ (18,667,980)	\$ 350,278,312
11 Inpatient Charity Fraction		3.72%	0.20%	3.92%
12 LIUR		11.75%	0.20%	11.95%
MIUR				
13 In-State Medicaid Eligible Days	Survey H	13,102	-	13,102
14 Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15 Total Medicaid Eligible Days		13,102	-	13,102
16 Total Hospital Days (excludes swing-bed)	Survey F-1	41,435	-	41,435
17 MIUR		31.62%	0.00%	31.62%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary

Georgia

Hospital Name **TIFT REGIONAL MEDICAL CENTER**
 Hospital Medicaid Number **000001922A**
 Cost Report Period From **10/1/2016** To **9/30/2017**

As-Reported:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	7,809,976	6,966,873	-	-	41,795	-	-	-	-	-	-	-	-	7,008,668	801,308	89.74%
2 Medicaid Fee for Service	Outpatient	5,321,180	5,052,518	-	-	29,230	(248,338)	-	-	-	-	-	-	-	4,833,410	487,770	90.83%
3 Medicaid Managed Care	Inpatient	7,040,980	-	6,125,788	-	22,067	-	-	-	-	-	-	-	-	6,147,855	893,125	87.32%
4 Medicaid Managed Care	Outpatient	5,384,121	-	4,368,124	-	21,277	-	-	-	-	-	-	-	-	4,389,401	994,720	81.52%
5 Medicare Cross-over (FFS)	Inpatient	11,877,451	1,174,443	-	-	1,036	-	9,104,791	-	125,016	-	-	-	-	10,405,286	1,472,165	87.61%
6 Medicare Cross-over (FFS)	Outpatient	12,766,133	901,932	-	-	25,368	-	10,146,015	-	125,016	-	-	-	-	11,198,331	1,567,802	87.72%
7 Other Medicaid Eligibles	Inpatient	636,220	-	285,965	288,207	260	-	-	137,793	-	-	-	-	-	712,225	(76,005)	111.95%
8 Other Medicaid Eligibles	Outpatient	298,261	-	139,665	96,623	2,322	-	-	206,980	-	-	-	-	-	445,590	(147,329)	149.40%
9 Uninsured	Inpatient	6,634,631	-	-	-	-	-	-	-	-	-	-	101,185	-	101,185	6,533,446	1.53%
10 Uninsured	Outpatient	9,146,305	-	-	-	-	-	-	-	-	-	-	401,522	-	401,522	8,744,783	4.39%
11 In-State Sub-total	Inpatient	33,999,258	8,141,316	6,411,753	288,207	65,158	-	9,104,791	137,793	125,016	-	-	101,185	-	24,375,219	9,624,039	71.69%
12 In-State Sub-total	Outpatient	32,916,000	5,954,450	4,507,789	96,623	78,197	(248,338)	10,146,015	206,980	125,016	-	-	401,522	-	21,268,254	11,647,746	64.61%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
15 Sub-Total	I/P and O/P	66,915,258	14,095,766	10,919,542	384,830	143,355	(248,338)	19,250,806	344,773	250,032	-	-	502,707	-	45,643,473	21,271,785	68.21%

Adjustments:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary

Georgia

Hospital Name **TIFT REGIONAL MEDICAL CENTER**
 Hospital Medicaid Number **00001922A**
 Cost Report Period From **10/1/2016** To **9/30/2017**

As-Adjusted:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E		
1 Medicaid Fee for Service	Inpatient	7,809,976	6,966,873	-	-	41,795	-	-	-	-	-	-	-	-	7,008,668	801,308	89.74%
2 Medicaid Fee for Service	Outpatient	5,321,180	5,052,518	-	-	29,230	(248,338)	-	-	-	-	-	-	-	4,833,410	487,770	90.83%
3 Medicaid Managed Care	Inpatient	7,040,980	-	6,125,788	-	22,067	-	-	-	-	-	-	-	-	6,147,855	893,125	87.32%
4 Medicaid Managed Care	Outpatient	5,384,121	-	4,368,124	-	21,277	-	-	-	-	-	-	-	-	4,389,401	994,720	81.52%
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8 Other Medicaid Eligibles	Outpatient	298,261	-	139,665	96,623	2,322	-	-	-	206,980	-	-	-	445,590	(147,329)	149.40%	
9 Uninsured	Inpatient	6,634,631	-	-	-	-	-	-	-	-	-	-	101,185	-	101,185	6,533,446	1.53%
10 Uninsured	Outpatient	9,146,305	-	-	-	-	-	-	-	-	-	-	401,522	-	401,522	8,744,783	4.39%
11 In-State Sub-total	Inpatient	33,999,258	8,141,316	6,411,753	288,207	65,158	-	-	9,104,791	137,793	125,016	-	101,185	-	24,375,219	9,624,039	71.69%
12 In-State Sub-total	Outpatient	32,916,000	5,954,450	4,507,789	96,623	78,197	(248,338)	-	10,146,015	206,980	125,016	-	401,522	-	21,268,254	11,647,746	64.61%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	n/a
15 Cost Report Year Sub-Total	I/P and O/P	66,915,258	14,095,766	10,919,542	384,830	143,355	(248,338)	-	19,250,806	344,773	250,032	-	502,707	-	45,643,473	21,271,785	68.21%

16
17

Less: Out of State DSH Payments from Adjusted Survey
 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments

-
21,271,785

Medicaid DSH Survey Adjustments

PROVIDER: TIFT REGIONAL MEDICAL CENTER
FROM: 10/1/2016

TO: 9/30/2017

Mcaid Number: 000001922A
Mcare Number: 110095

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
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Medicaid DSH Report Notes

PROVIDER: TIFT REGIONAL MEDICAL CENTER

Mcaid Number: 000001922A

FROM: 10/1/2016 TO: 9/30/2017

Mcare Number: 110095

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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