State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2018

		DSH Version	1 5.25	4/17/2019
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:	TIFT REGIONAL MEDICAL CENTER			
Identification of cost reports needed to cover the DSH Year:				
	Cost Report Cost Report			
3. Cost Report Year 1 4. Cost Report Year 2 (if applicable) 5. Cost Report Year 3 (if applicable)	Begin Date(s) End Date(s) 10/01/2017 09/30/2018	Must also complete a separate survey file for each of	ost report period listed	- SEE DSH SURVEY PART II FILE
	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			
3. DSH OB Qualifying Information				
Questions 1-3, below, should be answered in the accordance w	rith 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 privileg provide obstetric services to Medicaid-eligible individuals during the located in a rural area, the term "obstetrician" includes any physiciar hospital to perform nonemergency obstetric procedures.)	DSH year? (In the case of a hospital	DSH Examination Year (07/01/17 - 06/30/18) Yes]	
Was the hospital exempt from the requirement listed under #1 abov	e because the hospital's	No	1	
inpatients are predominantly under 18 years of age?				
Was the hospital exempt from the requirement listed under #1 abov emergency obstetric services to the general population when federa were enacted on December 22, 1987?		No	ļ	
3a. Was the hospital open as of December 22, 1987?		Yes]	
3b. What date did the hospital open?		11/1/1965]	
Questions 4-6, below, should be answered in the accordance w	ith 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 priv provide obstetric services to Medicaid-eligible individuals during the located in a rural area, the term "obstetrician" includes any physician hospital to perform nonemergency obstetric procedures.)	DSH year? (In the case of a hospital	DSH Payment Year (07/01/19 - 06/30/20) Yes		
List the Names of the two Obstetricians (or case of rural hospital, Ph Shannon Price, MD	ysicians) who have agreed to perform OB services:			
Sandra Brickman, MD				
5. Is the hospital exempt from the requirement listed under #1 above b inpatients are predominantly under 18 years of age?	ecause the hospital's	No]	
6. Is the hospital exempt from the requirement listed under #1 above by	ecause it did not offer non-	No	Î	
emergency obstetric services to the general population when federal were enacted on December 22, 1987?		Į NO	1	

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iscal year. However, DSH payments should NOT be included.)	\$ 2,428,499
question "no". If your	Yes
	1
vate insurance coverage, have been reported on the DSH survithe Medicaid program's compliance with federal Disproportional	ey regardless of whether the hospital received te Share Hospital (DSH) eligibility and payments
Sr. VP & CFO Title	10/22/19 Date
229-353-3397 Hospital CEO or CFO Telephone Number	Kim Wills@tiftregional.com Hospital CEO or CFO E-Mail
d to this survey:	
óp 14 op@liftregional.com	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
	Title 229-353-3397

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DSH Version 7.30 3/26/2019 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. TIFT REGIONAL MEDICAL CENTER 1. Select Your Facility from the Drop-Down Menu Provided: 10/1/2017 through 9/30/2018 2. Select Cost Report Year Covered by this Survey (enter "X"): 3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted 3a. Date CMS processed the HCRIS file into the HCRIS database: 3/12/2019 Correct? Data If Incorrect, Proper Information TIFT REGIONAL MEDICAL CENTER 4. Hospital Name: 5. Medicaid Provider Number: 000001922A 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): 110095 8. Medicare Provider Number: 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: 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 15. State Name & Number (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) Total Inpatient Outpatient 45,595 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 608 254 \$653,849 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 921,435 7.735.963 \$8.657.398 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) \$967.030 \$8,344,217 \$9.311.247 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 4.71% 7.02% 7.29%

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	\$-

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.

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

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

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
- Non-Hospital Subsidies
- Total Hospital Subsidies
- 7. Inpatient Hospital Charity Care Charges
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

11. Hospital
12. Subprovider I (Psych or Rehab)
13. Subprovider II (Psych or Rehab)
14. Swing Bed - SNF
15. Swing Bed - NF
16. Skilled Nursing Facility
17. Nursing Facility
18. Other Long-Term Care
19. Ancillary Services
20. Outpatient Services
21. Home Health Agency
22. Ambulance

23. Outpatient Rehab Providers 24. ASC

25. Hospice 26. Other

27. Total28. Total Hospital and Non Hospital

Contractual Adjustments (formulas below can be overwritten if amounts are Total Patient Revenues (Charges) known) Inpatient Hospital **Outpatient Hospital** Non-Hospital Inpatient Hospital Non-Hospital Net Hospital Revenue **Outpatient Hospital** \$54,212,163,00 38 463 156 15 749 007 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$306,984,106,00 \$696.628.073.00 494.252.816 291,556,255 \$82 765 805 00 58 721 768 24 044 037 \$0.00 \$0.00 \$0.00 \$0.00 \$27,074,898,00 \$0.00 54.968.150 388.271.167 \$ 941.533.596 5.174.661 275,475,717 386,317,449 \$ \$ 668 011 597 \$ 3 671 386 \$ \$ Total from Above 1,334,979,424 Total from Above 947,158,700 1,334,979,424 Total Contractual Adj. (G-3

29. Total Per Cost Report

Total Patient Revenues (G-3 Line 1)

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

 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

Line 2)		947,158,700
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	+	
	-	
	-	047.450.700
		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
hospital complet has a me be upda	. If dat ed usir ore rec ted to t	a in this section must be verified by the a is already present in this section, it was ng CMS HCRIS cost report data. If the hospital cent version of the cost report, the data should the hospital's version of the cost report. be overwritten as needed with actual data.	Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)		Calculated Per Diem
	Routin	ne Cost Centers (list below):									
1	03000	ADULTS & PEDIATRICS	\$ 34,979,564	\$ -	\$ -	\$0.00		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 5	03300	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	\$ - \$ -		\$ - \$ -		\$ -	-	\$0.00 \$0.00		\$ - \$ -
5 6	03400	OTHER SPECIAL CARE UNIT	\$ -	•	\$ -		\$ - \$ -	-	\$0.00		\$ - \$ -
7	04000	SUBPROVIDER I	\$ -		\$ -		\$ -		\$0.00		\$ -
8	04100	SUBPROVIDER II	\$ -	T	\$ -		\$ -	-	\$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		\$ -
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17			\$ - \$ -	7	\$ - \$ -		\$ -	-	\$0.00		\$ - \$ -
18		Total Routine	\$ 46,862,122			\$ -	\$ 46,862,122	53,046			Φ -
19		Weighted Average	\$ 40,002,122	Φ -	Φ -	5 -	Φ 40,002,122	55,046	\$ 31,131,122	1	\$ 883.42
19		Weighted Average									ψ 003.42
				Hospital Observation Days -	Subprovider I Observation Days -	Subprovider II Observation Days -	Calculated (Per	Inpatient Charges - Cost Report	Outpatient Charges - Cost Report	Total Charges - Cost Report	Medicaid Calculated
				Cost Report W/S S-	Cost Report W/S S-	Cost Report W/S S-	Diems Above	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Cost-to-Charge Ratio
				3, Pt. I, Line 28, Col.	3, Pt. I, Line 28.01,	3, Pt. I, Line 28.02,	Multiplied by Days)	Col. 6	Col. 7	Col. 8	Cool to Charge Hallo
	Obser	vation Data (Non-Distinct)		8	Col. 8	Col. 8		555			
20	09200	Observation (Non-Distinct)		8.339	-	_	\$ 6,695,133	\$7,651,408.00	\$15,751,451.00	\$ 23,402,859	0.286082
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			Cost Report	Worksheet B,	Cost Report Worksheet C.			Inpatient Charges - Cost Report	Outpatient Charges - Cost Report	Total Charges - Cost Report	Medicaid Calculated
			Worksheet B,	Part I, Col. 25	Part I, Col.2 and		Calculated	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Worksheet C, Pt. I,	Cost-to-Charge Ratio
			Part I, Col. 26	(Intern & Resident	Col. 4			Col. 6	Col. 7	Col. 8	Cool to Charge Hallo
				Offset ONLY)*				000	00	000	
	Ancill	ary Cost Centers (from W/S C excluding Observ	ration) (list below)								
21		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		\$ 7,331,369	0.299965
23		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		\$4,646,651.00	•	\$0.00		\$ 4,646,651	\$4,791,584.00	\$11,525,432.00	\$ 16,317,016	0.284773
25	5400		\$15,635,624.00		\$0.00		\$ 15,635,624	\$10,791,145.00	\$61,545,577.00	\$ 72,336,722	0.216151
26	5700		\$1,712,272.00	•	\$0.00		\$ 1,712,272	\$19,887,195.00	\$66,415,226.00	\$ 86,302,421	0.019840
27 28	5800 6000	MRI LABORATORY	\$1,583,284.00 \$13,824,998.00		\$0.00 \$0.00		\$ 1,583,284 \$ 13,824,998	\$3,384,872.00 \$58,411,808.00	\$15,993,948.00 \$96,272,020.00	\$ 19,378,820 \$ 154,683,828	0.081702 0.089376
28 29			\$4,524,851.00		\$0.00		\$ 13,824,998 \$ 4,524,851	\$19,293,148.00	\$96,272,020.00	\$ 154,683,828	0.089376
30	6600		\$3.103.019.00		\$0.00		\$ 3,103,019	\$4.800.311.00	\$4,410,303.00	\$ 9.621.650	0.322504
31		ELECTROCARDIOLOGY	\$7,999,959.00	•	\$0.00		\$ 7,999,959	\$20,747,141.00	\$40,426,724.00	+ -,- ,	0.130774
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G. Cost Report - Cost / Days / Charges

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

ROOS 1.00	Line		Total Allowable	Intern & Resident Costs Removed on	• • •			I/P Days and I/P	I/P Routine Charges and O/P		Medicaid Per Diem /
Trop Info: Company Str.	#	Cost Center Description	Cost	Cost Report *	Applicable)		Total Cost	Ancillary Charges	Ancillary Charges	Total Charges	Cost or Other Ratios
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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
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00	•	-
		\$0.00		\$0.00	\$	\$0.00	****	\$ -	-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00	•	-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
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		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
		\$0.00		\$0.00	\$	\$0.00	\$0.00		-
	Total Ancillary	\$ 167,132,376			\$ 168,839,825				ı
	Weighted Average	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		• .,,	* *************************************	• • • • • • • • • • • • • • • • • • • •	, , , , , , , , , , , , , , , , , , , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.164326
	Sub Totals	\$ 213,994,498	\$ -	\$ 1,707,449	\$ 215,701,947	\$ 389,208,539	\$ 736,760,446	\$ 1,125,968,985	
V	NF, SNF, and Swing Bed Cost for Medicaid (Su Worksheet D, Part V, Title 19, Column 5-7, Line	200)	,		\$0.00				
V	NF, SNF, and Swing Bed Cost for Medicare (Su Worksheet D, Part V, Title 18, Column 5-7, Line	200)	•	, ,	\$0.00				
N	IF, SNF, and Swing Bed Cost for Other Payers	(Hospital must calculat	e. Submit support for ca	alculation of cost.)					
С	Other Cost Adjustments (support must be subm	itted)							
	Grand Total	•			\$ 215,701,947	,			

^{*} 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

	Cost Rep	port Year (10/01/2017-09/30/2018)	TIFT REGIONAL ME	DICAL CENTER													
			Medicaid Per	Medicaid Cost to	In-State Medic	aid FFS Primary	In-State Medicaid M	anaged Care Primary	In-State Medicare FI Medicaid S	FS Cross-Overs (with Secondary)	In-State Other Me Included I	dicaid Eligibles (Not Elsewhere)	Unir	sured	Total In-Sta	te Medicaid	% Survey
	Line #	Cost Center Description	Diem Cost for Routine Cost	Charge Ratio for Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient		Report Totals
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
1 2 3 4 5 6	03000 03100 03200 03300 03400 03500 04000	Cost Centers (from Section G): ADULTS A PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER I SUBPROVIDER II	\$ 802.87 \$ 1,835.87 \$ - \$ - \$ - \$ - \$ - \$ -		Days 2,934 1,003		Days 2,729 94		Days 4,363 1,185		2,280 642		Days 3,389 583		Days 12,306 2,924		44.65% 60.80%
9 10 11 12 13 14 15 16 17	04200	OTHER SUBPROVIDER NURSERY	\$ 347.78 \$ 347.78 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Total Days	221		2,397		5.548		2.962		114		2,658		74.81%
19 20	Total Day	sys per PS&R or Exhibit Detail Unreconciled Days (Ex	plain Variance)	Total Days	4,158		5,220		5,548		2,962		4,086		17,000		41.49%
21 21.01		Routine Charges Calculated Routine Charge Per Diem			Routine Charges \$ 4,273,858 \$ 1,027.86		Routine Charges \$ 5,447,480 \$ 1,043,58		Routine Charges \$ 8,115,740 \$ 1,462.82		Routine Charges \$ 3,804,233 \$ 1,284,35		Routine Charges \$ 4,625,849 \$ 1,132,12		Routine Charges \$ 21,641,311 \$ 1,209.82		45.54%
22 22 44 25 6 27 73 23 23 25 25 25 25 25 25 25 25 25 25 25 25 25	09200 5000 5100 5100 5200 5300 5400 5700 5800 6000 65000 7000 7200 7300 7400	VICUI CARRES (FURN WS C) (FOR Section Of Determinen New Distriction) OPERATING ROOM OPERATIN		0.285082 0.198007 0.29986 0.513617 0.28473 0.01973 0.01973 0.01973 0.01973 0.01973 0.008376 0.108502 0.008377 0.008377 0.0	Ancillary Charges 5.25.25.25.25.25.25.25.25.25.25.25.25.25	Ancillary Charges 77,681 317,576 326,801 32,807 326,810 326,81	Ancillary Charges	Ancillary Charges 1.565,506 1.5	Ancillary Charges 1.113.183 3.113.623 4.263 5.255.568 3.13.255.568 1.175.271 3.157.271	Ancillary Charges 2, 265, 133 (197, 207, 207, 207, 207, 207, 207, 207, 20	Ancillary Charges 463.102 463.102 1,250.008 1,150.008 602.007 602.008 603.008 1,150.00	Ancillary Charges 33 1-351 33 1-351 33 1-351 34 1-352 34 1-352 34 1-352 35	Ancillary Charges 377,810 378,110 378,117 88,907 778,607 778,607 394,848 4,382,044 624,604 18,205 11,170,871 48,717 11,170,307	Ancillary Charges 1 37-2-1 1 37-2-1 1 37-2-1 1 37-2-1 1 37-2-1 1 38-2-1 1 3	\$ 3,023,304 \$ 7,576,455 \$ 7,576,455 \$ 3,521,509 \$ 3,521,509 \$ 1,699,455 \$ 4,607,635 \$ 5,664,592 \$ 20,786,536 \$ 337,4687 \$ 1,587,012 \$ 3,374,687 \$ 1,587,012 \$ 3,374,687 \$ 5,615,320 \$ 3,374,687 \$ 1,587,012 \$ 3,374,687 \$ 1,587,012 \$ 3,374,687 \$ 1,587,012 \$ 3,374,687 \$ 1,587,012 \$ 3,374,687 \$ 1,587,012 \$ 2,7966,177 \$ 5,504,562 \$ 5,	Aucillary Charges	41.91%, 30.22%, 47.26%, 66.02%, 33.46%, 56.02%, 33.46%, 56.02%, 33.46%, 56.02%, 33.46%, 56.02%, 33.46%, 56.02%, 34.65%, 56.02%, 36.00%, 56.02%
77 78 79 80 81 82 83 84 85															\$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	l

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

The Colors Process The Colors Col				In	-State Medicaio	t FFS Primary	In-State	Madicald Ma	inaged Care Prima	anv	In-State Medicare FF Medicaid S		rs (with		Medicaid Eligibles (Not d Elsewhere)		Unins	urad	Total In	-State Medi	iroid	% Survey
The Chapter potation product register page page product register page page page page page page page page	86				-State Wedical	a FFO Filliday	III-State	medicald mai	ilaged Cale Fillik	si y	Wedicald C	secondary)		mode	u Elsewilele)		Offilitie	salea	S.		icaiu -	Juliey
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Total Charges (relate copy expectate from Section 1) \$2,000,000	105														_				\$		-	
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11	115																		\$		-	
Total Charges (include organ expectation from Section 4) \$ 2,000,734 \$ 23,142,254 \$ 18,254,055 \$ 3,020,203 \$ 4,180,200 \$ 7,080,050 \$ 17,091,316 \$ 15,726,050 \$ 20,204,15 \$ 13,726,100 \$ 13,726,050 \$ 20,204,15 \$ 20,204,15 \$ 20,204,1			-												-				\$		-	
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Total Medical Payments (Explain Variance) Total Medical Cost Sentence Provided Payment (seculated PRAM Provided Provided Provided PRAM Provided PRAM Provided P															_				\$	- \$	-	
Total Payments Total Payments (Includes organ acquisition from Section 4) \$ 20,781,108 \$ 20,142,254 \$ 23,741,875 \$ 36,229,703 \$ 54,309,666 \$ 76,806,565 \$ 20,805,548 \$ 15,776,050 \$ 24,855,202 \$ 128,726,106 \$ 128,7	127				25 507 246	\$ 20 142 254	s 1	8 204 305	\$ 36.228	703	\$ 46 103 028	\$ 76	896 565	\$ 17.001.316	R \$ 15.726.050	\$ 20	200 443	\$ 52,046,128	\$	- 3	-	
Total Charges per PSAR or Enhibit Detail \$2,014,02264 \$2,014,0264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,		Totals / Payments		, T				.,,,					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
Total Charges per PSAR or Enhibit Detail \$2,014,02264 \$2,014,0264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,02264 \$2,014,				_			-		r.						1.			r-				
Total Charges per PSR C Exhibit Detail \$29.781.04 \$29.781.04 \$29.781.04 \$29.781.04 \$29.781.04 \$29.781.04 \$29.781.072 \$39.228.703 \$4.208.088 \$78.898.985 \$2.0895.540 \$2.0895.540 \$2.485.2302 \$2.346.123 \$2.348.85292 \$2.346.123 \$2.348.85292 \$2	128	Total Charges (includes organ acquisition from Section 2	J)	\$	29,781,104	\$ 29,142,254	\$ 2	3,741,875	\$ 36,228	,703	\$ 54,309,668	\$ 76	3,896,565	\$ 20,895,549	9 \$ 15,726,050				\$ 128,728,1	96 \$	157,993,572	32.42%
Uneconcide Charges (Explain Variance) 131 Total Calculated Cost (Includes organ acquisition from Section J)	129	Total Charges per PS&R or Exhibit Detail		S	29 781 104	\$ 29 142 254	S 2	3 741 875	\$ 36.228	703	\$ 54,309,668	\$ 76	896 565	\$ 20,895,549	9 \$ 15.726.050							
Total Medicare Days from Wagner Resident to Input (excludes TPL, Co-Pay and Spend-Down) (See Note E) S. 0.853,393 S. 3,328,099 S. 0.110,777 S. 4,996,222 S. 0.113,009 S. 0.1					-	-		-		-	-		-				-	-				
Total Medicare Days from Wagner Resident to Input (excludes TPL, Co-Pay and Spend-Down) (See Note E) S. 0.853,393 S. 3,328,099 S. 0.110,777 S. 4,996,222 S. 0.113,009 S. 0.1	404		et 0		0.004.500	6 4 007 500		0.405.400	£ 0.740	404	£ 44450.040	e 40	000 700	£ 0.000 400	e 2.004.000		540.005	6 0.000.054	e 27.500.7	70 e	00.004.000	
131 Total Medicard Parl Amount (excludes TPL, Co-Phy and Spend-Down) (See Note E) 132	131	Total Calculated Cost (Includes organ acquisition from Sect	tion J)	9	0,934,590	\$ 4,007,593	3	6,105,493	\$ 0,749	,464	\$ 14,159,246	\$ 12	2,092,702	\$ 6,390,43.	3 2,324,200	\$ 7,	510,395	\$ 0,090,951	\$ 37,569,7	70 3	20,034,039	37.34%
Private Instrumen (including corrinary and thirty party lability)	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$	6,853,939	\$ 3,928,099					\$ 987,008	\$	811,502	\$ 311,369	9 \$ 368,910				\$ 8,152,3	16 \$	5,108,511	
\$ \$8F-Pay (including Co-Pay and Spend-Down) \$ \$75,703 \$ \$ 3.44690 \$ \$ \$ 4.4500 \$ \$ \$ 4.690,7786	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-	Down) (See Note E)				\$	6,110,577	\$ 4,936	,252				\$ 10,63	1 \$ 3,048				\$ 6,121,2	08 \$	4,939,300	
136 Total Allowed Amount from Medicale PSAR Or RA Detail (All Pymentsh) \$ 0.5025/02 \$ 3.3952,588 \$ 0.145,000 \$ 4.999,798 \$ 3.952,588 \$ 0.145,000 \$ 4.999,798 \$ 3.905,781 \$ 3.405,148 \$ 3.4											\$ 523	\$	7,452									
137 Medicaid Cost Settlement Payments (See Note B) S				\$			\$							\$ 21	6 \$ 421				\$ 110,4	02 \$	39,456	
33 Other Medicare Pymers Reported on Cost Report Year (See Note C) \$ 1,0590,870 \$ 9,466,749 \$ 1,0338 \$ 4,032 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870 \$ 9,466,749 \$ 1,0590,870				\$	6,929,702		\$	6,145,000	\$ 4,950	,798												
Medicare Traditional (non-HMO) Paid Amount (excludes consumance) deductibles) \$ 1,0590,070 \$ 9,496,740 \$ 1,0339 \$ 4,032 \$ 1,786,552 \$ 1,786,552 \$ 1,786,552 \$ 1,786,552 \$ 1,786,552 \$ 1,786,552 \$ 1,886,740 \$ 1,886,872 \$ 1,886,87				_		\$ 445,148				-									5	-	445,148	
Medicare Namaged Care (PMO) Pial A mount (excludes consumance/deductables) \$ 4,375,202 \$ 1,726,552 \$ 4,375,202 \$ 1,206,552 \$ 4,375,202 \$ 1,206,552 \$ 1,206,552 \$ 1,206,552 \$ 1,206,552 \$ 1,206,453 \$ 1,206			e)							┙,	\$ 10.500.670	e 0	106 740	\$ 10.99	9 4.022				\$ 10,604.0		9 500 784	
Medicare Cross-Ore Pad Debt Payments											₩ 10,050,070	¥ 8	,,430,740									
142 Other Medicare Cross-Over Payments (See Note D) S S S S			٥,								\$ 128.982	s	298 847	w 4,375,202	1,730,002							
143 Payment from Hospital Uninswired During Coal Report Year (Cash Basis) \$ 608,254 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$, eq		1	(Agrees to Exhit	nii is and is-	(Agrees to Exhibit B and B- 1)	\$	- \$		
Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits 8 & 8-1 (from Section E) Calculated Payment Shortfall (Long/align (PRIOS TO SUPPLEMENTAL PAYMENTS AND DSH) \$ 2,004.884 \$ 469.857 \$ 1,980,493 \$ 1,798,886 \$ 2,452,085 \$ 991,246 \$ 94,465 \$ 7,664,800 \$ 8,490,697 \$ 7,408,688 \$ 4,441,220 \$ 84% \$ 95% \$ 1% \$ 7% \$ 50% \$ 83% \$ 1 7,701 \$ 1,001 \$ 1,										•						\$	45,595	\$ 608,254				
146 Calculated Payments as a Percentage of Cost 75% 50% 75% 75% 53% 54% 54% 56% 56% 15% 75% 50% 53% 53% 54% 54% 56% 56% 15% 75% 50% 53% 53% 54% 54% 56% 56% 15% 75% 50% 53% 54% 54% 56% 56% 56% 56% 56% 56% 56% 56% 56% 56	144		xhibits B & B-1 (from Sec	ction E)												\$	-	\$ -				
146 Calculated Payments as a Percentage of Cost 75% 50% 75% 75% 53% 54% 54% 56% 56% 15% 75% 50% 53% 53% 54% 54% 56% 56% 15% 75% 50% 53% 53% 54% 54% 56% 56% 15% 75% 50% 53% 54% 54% 56% 56% 56% 56% 56% 56% 56% 56% 56% 56	145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SURD) EMENTAL DA	VMENTS AND DSU	¢	2 004 894	¢ 460 057	ę	1 060 40?	¢ 1700	666	\$ 2.452.00E	e 2	0.078.232	\$ 001.24	6 04.400	ę 7	464 800	\$ 8,000,007	\$ 7,000	08 E	4 441 220	
147 Total Medicare Days from WiS S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, P.L. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6) 23/6 Percent of cross-over days to total Medicare days from the cost report 23/6		Calculated Payments as a Percentage of Cost	······································	9								<u> </u>										
148 Percent of cross-over days to total Medicare days from the cost report 23%																						
			1 (C/R, W/S S-3, Pt. I, Co	I. 6, Sum of	Lns. 2, 3, 4, 14	, 16, 17, 18 less lines	5 & 6)			L												
	140		old cloims summany. For	Monaged Co	uro Crono Oune	data and other clinible	o uso the he	onitolo logo i	if DC 9 D oummorie			with oursess)				NOTE: In-						

Note A. Those amounts must agree to your impatient and outputsiner Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PSAR summaries are not available (usulmit 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 (R4 summary or PSAR).
Note C. Other Medicaid Payments such as Outliers and Not-Cailing Specific payments. Delt payments and both XPT be included. UPL payments insuit as should be reported in Section C of the survey.
Note C. Other Medicaid Payments such as Outliers and Not-Cailing Specific payments. Delt payments and both XPT be included. UPL payments insuit as should be reported in Section C of the survey.
Note D. Should include other Medicaire cross-over payments not included in the padd claims data reported above. This includes payments paid based on the Medicaire cost report settlement (e.g., Medicaire Graduate Medicaire Cailing Cailing Payments).
Note E. Medicaire of the Medicaire Cailing Cailing Payments (e.g., Medicaire Graduate Medicaire Cailing Cailing Payments).

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

				Out-of-State Med	dicaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs aid Secondary)		Medicaid Eligibles (Not Elsewhere)	Total Out-Of-	State Medicaid
Line#	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatie
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	st Centers (list below):			Days		Days		Days		Days		Days	
	LTS & PEDIATRICS NSIVE CARE UNIT	\$ 802.87 \$ 1,835.87		33								33	
	ONARY CARE UNIT	\$ 1,835.87		1								1	
	N INTENSIVE CARE UNIT	\$ -										-	
	GICAL INTENSIVE CARE UNIT	\$ -										-	
	ER SPECIAL CARE UNIT	\$ -										-	
	PROVIDER I	\$ -										-	
	PROVIDER II	\$ -										-	
04300 NUR	ER SUBPROVIDER SERV	\$ - \$ 347.78		2								- 2	
J-JUU INUK	OLIVI	\$ 347.76		2								- 2	
		\$ -										-	
		\$ -										-	
		\$ -										-	
		\$ -										-	
		\$ - \$ -										-	
		\$ -	Total Days	36		_		_		-		36	
Routi	er PS&R or Exhibit Detail Unreconciled Days (E: ine Charges	Explain Variance)		36 - Routine Charges \$ 36,150		- Routine Charges		- Routine Charges		- Routine Charges]	Routine Charges \$ 36,150	
Routi	Unreconciled Days (E:	Explain Variance)		Routine Charges		Routine Charges		Routine Charges		Routine Charges] -]		
Routi Calcu Ancillary Co	Unreconciled Days (Eine Charges Ulated Routine Charge Per Dierr Dost Centers (from W/S C) (list below):	Explain Variance)	0.286082	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges	Ancillary Charges	-	Ancillary Charges	-	Ancillary Charges	-	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges	Ancillary (
Routi Calcu Ancillary Co	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr	Explain Variance)	0.286082 0.198907	Routine Charges \$ 36,150 \$ 1,004.17	Ancillary Charges 11,414 2,400	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17	Ancillary (
Routi Calcu Ancillary Co 09200 Obse 5000 OPE 5100 REC	Unreconciled Days (E- ine Charges ulated Routine Charge Per Dierr bost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM	Explain Variance)	0.198907 0.299965	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 955	11,414 2,400 232	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959	Ancillary C
Routi Calcu Ancillary Cc 09200 Obse 5000 OPE 5100 REC 5200 DELI	Unreconciled Days (E. ine Charges ulated Routine Charge Per Dierr bot Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM	Explain Variance)	0.198907 0.299965 0.513617	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 959 9,631	11,414 2,400 232	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631	Ancillary (
Routi Calcu Ancillary Cc 09200 Obse 5000 OPEL 5100 REC 5200 DELI 5300 ANES	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): avation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY	Explain Variance)	0.198907 0.299965 0.513617 0.284773	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946	11,414 2,400 232 - 818	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946	Ancillary (
Routi Calcu Ancillary Cc 09200 Obse 5000 OPE 5000 DELI 5200 DELI 5300 ANE: 5400 RADI	Unreconciled Days (E- ine Charges ulated Routine Charge Per Dierr ine Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGMOSTIC	Explain Variance)	0.198907 0.299965 0.513617 0.284773 0.216151	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454	11,414 2,400 232 - 818 24,048	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454	Ancillary (
Routi Calco Ancillary Cc 99200 Obse 5000 OPE 5100 REC 5200 DELI 5300 ANE3 5400 RAD 5700 CT S	Unreconciled Days (E- ine Charges ulated Routine Charge Per Dierr ine Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGMOSTIC	Explain Variance)	0.198907 0.299965 0.513617 0.284773 0.216151 0.019840	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 959 9,631 2,946 445 46,925	11,414 2,400 232 - 818	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946	Ancillary (
Routi Calcu D9200 Obse 5000 OPE 5100 REC: 5200 DELI 5300 ANE: 5400 RAD: 5700 CT S 5800 MRI 6000 LABC	Unreconciled Days (E- ine Charges ulated Routine Charge Per Dierr set Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC IOLOGY-DIAGNOSTIC IOLOGY-DIAGNOSTIC	Explain Variance)	0.198907 0.299965 0.513617 0.284773 0.216151	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925 - 32,461	11,414 2,400 232 - 818 24,048 69,794 - 66,527	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36,150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454	Ancillary () \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi Calcu Description Obses 5000 OPE 5100 REC 5200 DELI 5300 ANES 5400 RAD 5700 CT S 5800 MRI 6000 LABG	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC CAN DRATTORY PIRATORY THERAPY	Explain Variance)	0.198907 0.299965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925 	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ 32,461 \$ 3,198	Ancillary C \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi Calcu Description Rec 5000 OPE 5000 DELI 5300 ANE: 5400 RADI 5700 CT S 5800 MRI 6000 LABG 6600 PHY:	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr bost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN OPATORY PIRATORY PIRATORY FIRATORY SICAL THERAPY SICAL THERAPY	Explain Variance)	0.198907 0.299965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925 - 32,461 3,198 1,422	11,414 2,400 232 818 24,048 69,794 66,527 4,844	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 2,946 \$ 454 \$ 6,925 \$ 5 \$ 32,461 \$ 3,198 \$ 3,198	\$ \$ \$ \$ \$ \$ \$
Routical Reviews Revie	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC SCAN DRATORY PIRATORY PIRATORY STRATORY STRAT	Explain Variance)	0.198907 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.32504 0.130774	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925 - 32,461 3,198 1,422 18,575	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844 - 5,064	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ 32,461 \$ 3,198	\$ \$ \$ \$ \$ \$ \$
Routi Calco	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): arvation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DRATIORY PIRATORY THERAPY SICAL THERAPY CTROCARDIOLOGY CTROCKCEPHALOGRAPHY		0.198907 0.299965 0.513617 0.284773 0.216151 0.019840 0.081702 0.09376 0.190844 0.322504 0.130774	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925 - 32,461 3,198 1,422 18,575	11,414 2,400 232 818 24,048 69,794 66,527 4,844	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ 32,461 \$ 3,198 \$ 14,22 \$ 18,575 \$.	\$ \$ \$ \$ \$ \$ \$
Routic Calculation Routic Ca	Unreconciled Days (E- ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM VERY ROOM SLABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DRATORY PIRATORY THERAPY SICAL THERAPY CTROCARDIOLOGY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENT		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925 - 32,461 3,198 1,422 18,575	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844 - 5,064	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 2,946 \$ 454 \$ 6,925 \$ 5 \$ 32,461 \$ 3,198 \$ 3,198	\$ \$ \$ \$ \$ \$ \$
Routillary Cc 39200 Obsession	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr bot Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM 8 LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC IOLOGY-DIAGNOST		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.08772 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 4,524 6,925	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844 - 5,064	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ 32,461 \$ 3,198 \$ 14,22 \$ 18,575 \$.	\$ \$ \$ \$ \$ \$ \$
Routil Calculation Routil Ca	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM VERY ROOM VERY ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC IOLOGY-D		0.198907 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844 - 5,064 - 2,893 - 57,283	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 1,422 \$ 18.575 \$ 7,326	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.18807 0.29965 0.513617 0.284773 0.216151 0.018940 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120336 0.068449 1.802397	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routil Calculation Routil Ca	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004.17 Ancillary Charges 1,260 7,293 9,631 2,946 454 6,925	11,414 2,400 232 - 818 24,048 69,794 - 66,527 4,844 - 5,064 - 2,893 - 57,283	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 959 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 1,422 \$ 18.575 \$ 7,326	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.198907 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449 1.802397 0.36663	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120336 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routil Calcular Calcu	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.198907 0.29965 0.513617 0.284773 0.246151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.2253776 0.120936 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7,293 \$ 9631 \$ 9,631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 3,198 \$ 11,422 \$ 18,575 \$ 7,325 \$ 7,325 \$ 7,325	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi	Unreconciled Days (E: ine Charges ulated Routine Charge Per Dierr ost Centers (from W/S C) (list below): ervation (Non-Distinct) RATING ROOM OVERY ROOM & LABOR ROOM STHESIOLOGY IOLOGY-DIAGNOSTIC ICAN DIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY CTROENCEPHALOGRAPHY ICAL SUPPLIES CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS GS CHARGED TO PATIENTS AL DIALVSIS		0.19807 0.29965 0.513617 0.284773 0.216151 0.019840 0.081702 0.089376 0.190844 0.322504 0.130774 0.151612 0.604074 0.253776 0.120936 0.068449 1.802397 0.356163	Routine Charges \$ 36,150 \$ 1,004,17 Ancillary Charges 1,260 7,293 959 9,631 2,946 454 6,925	11,414 2,400 232 818 24,048 69,794 	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	Routine Charges	Ancillary Charges	\$ 36.150 \$ 1,004.17 Ancillary Charges \$ 1,260 \$ 7.293 \$ 959 \$ 9.631 \$ 2,946 \$ 454 \$ 6,925 \$ \$ 31,98 \$ 18,575 \$ \$ 7,325 \$ \$ 7,325 \$ \$ 7,127 \$	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$

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-Overs (with Medicaid Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Total Out-Of-State Medicaid
50 -					\$ - \$ -
51 -					\$ - \$
52 -					\$ - \$ -
53					\$ - \$ - \$ -
55 -					\$ - \$ -
56 -					\$ - \$ -
57 -					\$ - \$ -
58					\$ - \$ -
59 -					\$ - \$
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106	 				\$ - \$ -
107					\$ - \$ -
109					\$ - \$ -
110 -					\$ - \$ -
111					\$ - \$ -

	Cost Report Year (10/01/2017-09/30/2018) TIFT REGIONAL MEDICAL CENTER										
		Out-of-State Med	dicaid FFS Primary		edicaid Managed Care rimary	Out-of-State Medicare FF3 (with Medicaid Seco			Medicaid Eligibles (Not Elsewhere)		Of-State Medicaid
112	-			 						\$	- \$ -
113 114				l	-					\$	- \$ -
115				1	-					\$	\$
116				1	1					\$	\$ -
117										\$	- \$ -
118	-									\$	- \$
119	-									\$	- \$ -
120	-									\$	- \$ -
121	-									\$	- \$ -
122 123				l	-	<u> </u>				\$	- \$ -
123	-			1	1					\$	
125					1					\$	- \$ -
126	-									\$	- \$ -
127	-									\$	- \$ -
		\$ 144,532	\$ 313,678	\$ -	\$ -	\$ - \$	-	\$ -	\$ -		
	Totals / Payments										
128	Total Charges (includes organ acquisition from Section K)	\$ 180,682	\$ 313,678	\$ -	\$ -	\$ - \$	-	\$ -	\$ -	\$ 180,682	2 \$ 313,678
129	Total Charges per PS&R or Exhibit Detail	\$ 180,682	\$ 313,678	\$ -	- \$ -	\$ - \$	-	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)			· ——	<u> </u>						
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 55,945	\$ 51,183	\$ -	\$ -	\$ - \$	_	\$ -	\$ -	\$ 55,945	5 \$ 51,183
	, , , , , , , , , , , , , , , , , , , ,										
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,235	\$ 16,740							\$ 6,235	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ 10,721	\$ 15,971							\$ 10,721	1 \$ 15,971
134	Private Insurance (including primary and third party liability)									\$	- \$ -
135 136	Self-Pay (including Co-Pay and Spend-Down) Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 16,956	\$ 32,711							\$	- \$
136	Medicaid Cost Settlement Payments (See Note B)	\$ 16,956	\$ 32,711	<u> </u>	\$ -					•	¢
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)									\$	- \$ -
			<u></u>	1 1-	1						
143 144	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$ 38,989 30%	\$ 18,472 64%		\$ -	\$ - \$	- 00/	\$ -	\$ -	\$ 38,989	\$ 18,472 64%
144	Calculated Payments as a Percentage of Cost	30%	64%	0%	· 0%	U%	0%	0%	0%	30%	o 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 Medicale 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			Revenue for	Total	In-State Medic	caid FFS Primary	In-State Medicaid N	Managed Care Primary		FS Cross-Overs (with Secondary)	In-State Other Me Included E	dicaid Eligibles (Not Elsewhere)	Unins	sured
Organ Acquisition Cos	Intern/Resident	n Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organ (Count)
Cost Report	Add-On Cost Facto	or Sum of Cost Report	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln		From Boid Claims	From Boid Claims	From Boid Claims	From Boid Claims	From Boild Claims	From Roid Claims	From Roid Claims	From Roid Claims		

		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	122 v Total Cont	Sum of Cost Report Organ Acquisition Cost and the Add- On Cost	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 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										
0	Totale	e .	e .	e .	e .		e .	_	e .	_	e .	_	e .		e .	

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			Revenue for	Total	Out-of-State Mea	dicaid FFS Primary	Out-of-State Medicaid	d Managed Care Priman		are FFS Cross-Overs id Secondary)		Medicaid Eligibles (Not Elsewhere)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)						
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	122 v Total Cont	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)							
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	s -	\$ -	\$ -	\$ -	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

TIFT REGIONAL MEDICAL CENTER

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

Worksheet A Provider Tax Assessment Reconciliation:

An adjustment is necessary to properly reflect 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.

			Dellas America	W/S A Cost Center
1 Hospi	tal Gross Provider Tax Assessment (from	a gonoral lodger)*	Dollar Amount	Line
				(MTD Account #)
		ount # that includes Gross Provider Tax Assessment		(WTB Account #)
2 Hospit	tal Gross Provider Tax Assessment Includ	ded in Expense on the Cost Report (W/S A, Col. 2)		(Where is the cost included on w/s A?
2 Diffor	ence (Explain Here>)		¢	
3 Dillele	ence (Explain Here>)		a -	
Provi	der 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))
1				
'	, tooladomeanon edae			(rissings to / (risiny)
DSH U		essment Adjustments (from w/s A-8 of the Medicare cost report)		
DSH U		essment Adjustments (from w/s A-8 of the Medicare cost report)		(Adjusted to / (from))
DSH U	JCC ALLOWABLE - Provider Tax Asse	essment Adjustments (from w/s A-8 of the Medicare cost report)		
8 9	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment	essment Adjustments (from w/s A-8 of the Medicare cost report)		(Adjusted to / (from))
7 DSH L 8 9 10 11	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment	essment Adjustments (from w/s A-8 of the Medicare cost report)		(Adjusted to / (from)) (Adjusted to / (from))
8 9	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment Reason for adjustment	essment Adjustments (from w/s A-8 of the Medicare cost report)		(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
8 9 10 11	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment	essment Adjustments (from w/s A-8 of the Medicare cost report) Assessment Adjustments (from w/s A-8 of the Medicare cost report)		(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
8 9 10 11 DSH U	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment			(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
8 9 10 11 DSH U	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment JCC NON-ALLOWABLE Provider Tax A Reason for adjustment			(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
8 9 10 11	JCC ALLOWABLE - Provider Tax Asse Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment JCC NON-ALLOWABLE Provider Tax A			(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))

Medicaid Provider Tax Assessment Adjustment to DSH UCC Uninsured Provider Tax Assessment Adjustment to DSH UCC

Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:

Charges Sec. G

Charges Sec. G

Charges Sec. G

Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC

Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC

16 Total Net Provider Tax Assessment Expense Included in the Cost Report

17 Gross Allowable Assessment Not Included in the Cost Report

DSH UCC Provider Tax Assessment Adjustment:

Medicaid Hospital

Total Hospital

Uninsured Hospital

25 Provider Tax Assessment Adjustment to DSH UCC

18

19

20

21

22

23

24

287,216,128

77.781.420

6.91%

1.125.968.985

^{*} 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.

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part 1 For State DSH Year 2018

				DSH Version	5.25	4/17/2019
A. General DSH Year Information	JEWASS -					
1 DSH Year:	Begin 07/01/2017	End 06/30/2018				
	UTO TIZOTT	00/00/2010				
$2_{\scriptscriptstyle \parallel}$ Select Your Facility from the Drop-Down Menu Provided:	COOK MEDICAL CENTER					
Identification of cost reports needed to cover the DSH Year:	Cost Report	Cost Report				
	Begin Date(s)	End Date(s)				
3. Cost Report Year 1	07/01/2017	06/30/2018	Must also complete a sepa	arate survey file for each cos	t report period listed - S	EE DSH SURVEY PART II FILES
4 Cost Report Year 2 (if applicable) 5 Cost Report Year 3 (if applicable)						
3 Cost Neport Teal 3 (II applicable)						
	Data					
6 Medicaid Provider Number:		000001251A				
7 Medicaid Subprovider Number 1 (Psychiatric or Rehab):		0.				
8 Medicaid Subprovider Number 2 (Psychiatric or Rehab):		0				
9 Medicare Provider Number:		110101				
B. DSH OB Qualifying Information						
Questions 1-3, below, should be answered in the accordance	with Sec. 1923(d) of the Socia	l Security Act.				
During the DSH Examination Year: 1. Did the hospital have at least two obstetricians who had staff privil provide obstetric services to Medicaid-eligible individuals during the located in a rural area, the term "obstetrician" includes any physici hospital to perform nonemergency obstetric procedures.) 2. Was the hospital exempt from the requirement listed under #1 about inpatients are predominantly under 18 years of age? 3. Was the hospital exempt from the requirement listed under #1 about emergency obstetric services to the general population when feder were enacted on December 22, 1987?	ne DSH year? (In the case of a hain with staff privileges at the ove because the hospital's ove because it did not offer non-			DSH Examination Year (07/01/17 - 06/30/18) Yes No No Yes		
3b. What date did the hospital open?				7/1/1966		
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 provide obstetric services to Medicaid-eligible individuals during the located in a rural area, the term "obstetrician" includes any physici hospital to perform nonemergency obstetric procedures.)	rivileges at the hospital who have te DSH year? (In the case of a h an with staff privileges at the	agreed to ospital		DSH Payment Year (07/01/19 - 06/30/20) Yes		
List the Names of the two Obstetricians (or case of rural hospital, I	Physicians) who have agreed to p	perform OB services:				
Shannon Price, MD						
Thomas D. Fausett, MD						
5. Is the hospital exempt from the requirement listed under #1 above	because the hospital's			No		
inpatients are predominantly under 18 years of age?						
6. Is the hospital exempt from the requirement listed under #1 above				No		
emergency obstetric services to the general population when fede were enacted on December 22, 1987?	ral Medicaid DSH regulations					

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:

Hospital CEO or CFO Printed Name

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 Telephone Number

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@tiftregional.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 nuiz@rsgga.com

Page 1

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part II

DSH Version 7.30 3/26/2019 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. COOK MEDICAL CENTER 1. Select Your Facility from the Drop-Down Menu Provided: 7/1/2017 through 6/30/2018 2. Select Cost Report Year Covered by this Survey (enter "X"): 3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted 3a. Date CMS processed the HCRIS file into the HCRIS database: 5/10/2019 Correct? Data If Incorrect, Proper Information COOK MEDICAL CENTER 4. Hospital Name: 5. Medicaid Provider Number: 000001251A Yes 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): Yes 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): Yes 110101 8. Medicare Provider Number: Yes Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt. Yes DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Small Rural Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year: Provider No. State Name 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) 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) Total Inpatient Outpatient 24,120 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) \$24,120 28,483 149,666 \$178,149 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) \$28,483 \$173,786 \$202,269 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 0.00% 13.88% 11.92% 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

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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

Printed 6/24/2020

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

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)

4.157 (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 Contractual Adjustments (formulas below can be overwritten if amounts are report data. If the hospital has a more recent version of the cost report, Total Patient Revenues (Charges) known) the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data. Inpatient Hospital **Outpatient Hospital** Non-Hospital Inpatient Hospital Non-Hospital Net Hospital Revenue **Outpatient Hospital** 11. Hospital \$634,409.00 306,997 327.412 12. Subprovider I (Psych or Rehab) \$4,823,983.00 2,334,377 2,489,606 13. Subprovider II (Psych or Rehab) \$0.00 14. Swing Bed - SNF \$84,675.00 40,975 15. Swing Bed - NF \$0.00 16. Skilled Nursing Facility \$5,969,868.00 2,888,883 17. Nursing Facility \$0.00 18. Other Long-Term Care \$0.00 19. Ancillary Services \$7,271,161,00 \$10.918.224.00 3 518 592 5.283.445 9.387.348 20. Outpatient Services \$447 765 00 216 678 231,087 21. Home Health Agency \$0.00 22 Ambulance 23. Outpatient Rehab Providers \$0.00 24. ASC \$0.00 \$0.00 25. Hospice 26. Other \$560,399,00 \$2,450,234.00 271,183 289,216 27. Total 13.289.952 \$ 11.365.989 8.504.777 6.431.149 12,724,668 \$ \$ 5 500 123 \$ 4 115 552 \$ 28. Total Hospital and Non Hospital Total from Above 33,160,718 Total from Above 16,046,825 16,046,825 33,160,718 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) Total Contractual Adj. (G-3 Line 2) 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 16.046.825

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G. Cost Report - Cost / Days / Charges

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

Routine Cost Centers (list below):		Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
1 05000/DAULTS & PEDATRICS \$ 3,987,401 \$ - \$ - \$ 50.00 \$ 3,987,401 \$ - \$ - \$ 50.00 \$ 5	hospita comple has a m be upda	il. If dat ted usir nore rec ated to t	ia is already present in this section, it was ng CMS HCRIS cost report data. If the hospital ent version of the cost report, the data should the hospital's version of the cost report.	Worksheet B,	Worksheet B, Part I, Col. 25 (Intern & Resident	Worksheet C, Part I, Col.2 and	Out - Cost Report Worksheet D-1,	Calculated	W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for	Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges		Calculated Per Diem
2		Routin	ne Cost Centers (list below):									
33200CORRONARY CARE UNIT S S S S S S S S S	1	03000		\$ 3,987,401			\$0.00	\$ 3,987,401	4,275	\$5,543,067.00		
G3000 BURN INTENSIVE CARE UNIT \$				\$ -					-			
Second SURRICICAL INTENSIVE CARE UNIT S				•	•	•			-			
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Total Routine \$ 3,987,401 \$ - \$ - \$ - \$ 3,987,401 \$ 4,275 \$ 5,543,067				*	T	•			-			
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Hospital Observation Days - Cost Report Wis S- S. Pt. I, Line 28, Ct. Cost Report Wis S- Cost Report W				\$ 3,987,401	5 -	5 -	5 -	\$ 3,987,401	4,275	\$ 5,543,067		A 200 70
Observation Days Cost Report W/S S Cost Report W/S S S, P. I., Line 28, Col. 8	19		Weighted Average									\$ 932.73
Observation Days Cost Report W/S S Cost Report W/S S S, P. I., Line 28, Col. 8					Hospital	Subprovidor I	Subprovidor II					
Cost Report W/S S S, Pt. I, Line 28, Ot. S Post I W/S S Cost Report W/S S S, Pt. I, Line 28, Ot. S Post I								Calculated (Per				
Observation Data (Non-Distinct) 20								,	'	,	,	Medicaid Calculated
Cost Report Worksheet B, Part I, Col. 26 Col. 8 Col. 4 Col. 25 Col. 8												Cost-to-Charge Ratio
Cost Report Worksheet B, Part I, Col. 26 Cost Resident Col. 4 Col. 4 Col. 4 Col. 4 Col. 4 Col. 4 Col. 6 Cost Report Worksheet C, Pt. I, Col. 7 Col. 8 Cost Report Worksheet C, Pt. I, Col. 8 Cost Report Worksheet C, Pt. I, Col. 7 Col. 8 Cost Report Worksheet C, Pt. I, Col. 8 Cost Report Workshee		01	antina Data (Nan Distinat)						Col. 6	Col. 7	Col. 8	
Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Colfs (NLY)* Col. 4 Col. 4 Col. 4 Col. 4 Col. 4 Col. 6 Col. 6 Col. 6 Col. 7 Col. 6 Col. 6 Col. 7 Col. 7 Col. 6 Col. 7			,		-							
Cost Report Worksheet B, Part I, Col. 25 P	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. 25 P												
Cost Report Worksheet B, Part I, Col. 26 Part I, Col. 25 Part I, Col. 26 Part I, Col. 25 Part I, Col. 26 Part I, Col. 25 Part I, Col. 26 Part I, Col. 26 Part I, Col. 26 Part I, Col. 26 Part I, Col. 27 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 29 Part I, Col. 29 Part I, Col. 20 P			Г									
Morksheet B, Part I, Col. 26 Part I, Col. 26 Part I, Col. 26 Part I, Col. 25 Part I, Col. 24 Part I, Col. 24 Part I, Col. 26 Part I, Col. 26 Part I, Col. 26 Part I, Col. 26 Part I, Col. 27 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 28 Part I, Col. 29 Part I, Col. 29 Part I, Col. 25 Part I, Col. 25 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 29 Part I, Col. 25 Part I, Col. 25 Part I, Col. 25 Part I, Col. 26 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 25 Part I, Col. 27 Part I, Col. 28 Part I, Col. 28 Part I, Col. 25 Part I, Col. 28 Part I, Col. 25 Part I, Col. 28 Part I, Col. 25 Part I, Col. 27 Part I, Col. 28 Part I, Col. 25 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 25 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28						Cost Poport			Innationt Charges -	Outpatient Charges	Total Charges -	
Morksheet B, Part I, Col. 26 Part I, Col. 24 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 27 Part I, Col. 24 Part I, Col. 25 Part I, Col. 27 Part I, Col. 27 Part I, Col. 24 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27 Part I, Col. 28 Part I, Col. 27						,					•	Medicaid Calculated
Ancillary Cost Centers (from W/S C excluding Observation) (list below) 21								Calculated				Cost-to-Charge Ratio
Ancillary Cost Centers (from W/S C excluding Observation) (list below) 21				Part I, Col. 26								ood to onargo riado
21					Offset ONLY)*							
21		Ancill	ary Cost Centers (from W/S C excluding Observ	ration) (list below)								
23	21				\$ -	\$0.00		\$ 155,357	\$100.00	\$417,267.00	\$ 417,367	0.372231
24 6500 RESPIRATORY THERAPY \$129,465.00 \$ - \$0.00 \$ 129,465 \$93,584.00 \$23,053.00 \$ 116,637 \$1 \$25 6600 PHYSICAL THERAPY \$365,884.00 \$ - \$0.00 \$ 365,884 \$794,094.00 \$430,076.00 \$ 1,224,170 \$0.00 \$ 6601 PHYSICAL THERAPY - SNF \$426,443.00 \$ - \$0.00 \$ 426,443 \$1,425,683.00 \$100,376.00 \$ 1,526,059 \$0.00 \$ 426,443 \$1,425,683.00 \$100,376.00 \$ 1,526,059 \$0.00 \$ 37,456 \$121,183.00 \$1,065,841.00 \$ 1,187,024 \$0.00 \$100,000 \$1,00	22	5400	RADIOLOGY-DIAGNOSTIC	\$762,113.00	\$ -	\$0.00			\$294,307.00	\$3,995,071.00	\$ 4,289,378	0.177674
25 6600 PHYSICAL THERAPY \$365,884.00 \$ - \$0.00 \$ 365,884 \$794,094.00 \$430,076.00 \$ 1,224,170 C C C C C C C C C C C C C C C C C C C	23			\$1,138,819.00	\$ -	\$0.00		\$ 1,138,819		\$3,127,805.00		0.273425
26 6601 PHYSICAL THERAPY - SNF \$426,443.00 \$ - \$0.00 \$426,443 \$1,425,683.00 \$100,376.00 \$1,526,059 0 27 6900 ELECTROCARDIOLOGY \$37,456.00 \$ - \$0.00 \$37,456 \$121,183.00 \$1,065,841.00 \$1,187,024 0 28 7000 ELECTROENCEPHALOGRAPHY \$34,117.00 \$ - \$0.00 \$34,117 \$0.00 \$275,100.00 \$275,100.00 \$275,100.00 \$275,100.00 \$24,032 0 29 7100 MEDICAL SUPPLIES CHARGED TO PATIENT \$98,959.00 \$ - \$0.00 \$98,959 \$206,713.00 \$17,319.00 \$224,032 0				*	•				* 1	+ -/		1.109982
27 6900 ELECTROCARDIOLOGY \$37,456.00 \$ - \$0.00 \$ 37,456 \$121,183.00 \$1,065,841.00 \$ 1,187,024 \$0.00 \$1,000 ELECTROENCEPHALOGRAPHY \$34,117.00 \$ - \$0.00 \$ 34,117 \$0.00 \$275,100.00 \$ 275,100.00 \$ 275,100 \$0.00 \$17,319.00 \$1												0.298883
28												0.279441
29 7100 MEDICAL SUPPLIES CHARGED TO PATIENT \$98,959.00 \$ - \$0.00 \$ 98,959 \$206,713.00 \$17,319.00 \$ 224,032 C												0.031555
												0.124017
				* /								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 C	30	7300	DRUGS CHARGED TO PATIENTS			\$0.00		\$ 912,279		\$1,466,316.00	\$ 4,764,605	0.191470
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G. Cost Report - Cost / Days / Charges

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

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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
		\$0.00	\$ -	\$0.00	\$	- \$0.00	\$0.00	\$ -	-
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	Total Ancillary	\$ 4,060,892	\$ - 9	-	\$ 4,060,89	2 \$ 7,324,351	\$ 11,312,799	\$ 18,637,150	
	Weighted Average								0.223798
	Sub Totals	\$ 8,048,293	\$ - 9	-	\$ 8,048,29	3 \$ 12,867,418	\$ 11,312,799	\$ 24,180,217	
Wo NF,	SNF, and Swing Bed Cost for Medicaid (Strksheet D, Part V, Title 19, Column 5-7, Line SNF, and Swing Bed Cost for Medicare (St	e 200) um of applicable Cost Re	•	· ·	\$0.00 \$234,293.0				
	rksheet D, Part V, Title 18, Column 5-7, Line SNF, and Swing Bed Cost for Other Payers	,	e. Submit support for ca	lculation of cost.)					
	er Cost Adjustments (support must be subn		**	,					
Out	Grand Total				\$ 7,814,00				
	GIANG IOLAI								

^{*} 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

	Cost F	Report Year (07/01/2017-06/30/2018)	COOK MEDICAL CE	NTER													
									In-State Medicare F	FS Cross-Overs (with	In-State Other Me	dicaid Eligibles (Not					%
			Medicald Per	Medicaid Cost to	In-State Medic	aid FFS Primary	In-State Medicaid N	lanaged Care Primary	Medicaid :	Secondary)	Included I	Elsewhere)	Unir	sured	Total In-Sta	le Medicaid	Survey to Cost
		a Cont Contro December	Diem Cost for	Charge Ratio for	Inpatient	Out-attant	Inpatient	0		Outputlant	tt	Outrotton.	Inpatient	Outpatient (See Exhibit A)	to a street	Out-attant	Report
	Line	e # Cost Center Description	Routine Cost	Ancillary Cost	From PS&R	Outpatient From PS&R	From PS&R	Outpatient From PS&R	Inpatient From PS&R	Outpatient From PS&R	Inpatient From PS&R	Outpatient From PS&R	(See Exhibit A) From Hospital's Own		Inpatient	Outpatient	Totals
			From Section G	From Section G							Summary (Note A)	Summary (Note A)					
	Routin	ine Cost Centers (from Section G): D ADULTS & PEDIATRICS	\$ 932.73		Days 128		Days		Days 995		Days 32		Days 20		Days 1,162		28.43%
2	03100	INTENSIVE CARE UNIT	\$ 932.73		128				995		32		20		1,102		28.43%
3	03200	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	\$ - \$ -														
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -												-		
6	03500	O OTHER SPECIAL CARE UNIT	\$ - \$ -												-		
8	04100	D SUBPROVIDER I D SUBPROVIDER II D OTHER SUBPROVIDER	\$ - \$ -												-		
10	04300	0 NURSERY	\$ -												-		
11 12			s -												-		
13			\$ -												-		
14 15			S -												-		
16 17			\$ -												-		
18				Total Days	128		7		995		32		20		1,162		27.65%
19	Total I	Days per PS&R or Exhibit Detail			128		7	1	995		32		20				
20	roun .	Unreconciled Days (Ex	plain Variance)		-	! :		<u> </u> -	-								
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21 21.01		Routine Charges Calculated Routine Charge Per Diem			\$ 125,866 \$ 983.33		\$ 7,000 \$ 1,000.00		\$ 1,451,670 \$ 1,458.96		\$ 40,590 \$ 1,268.44		\$ 20,810 \$ 1,040.50		\$ 1,625,126 \$ 1,398.56		29.69%
21.01		llary Cost Centers (from W/S C) (from Section G								Anaillana Chargas				Anoillany Charges			
22	09200	Observation (Non-Distinct)): 	0.245803	Ancillary Charges 3,676	Ancillary Charges 8,944	Ancillary Charges	10,587	Ancillary Charges 3,202	Ancillary Charges 38,212	Ancillary Charges 2,232	Ancillary Charges 18,664	Ancillary Charges 237	Ancillary Charges 11,712	Ancillary Charges \$ 9,110	Ancillary Charges \$ 76,407	
23 24		000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC		0.372231 0.177674	11,732	5,530 163,076	16.258	16,956 263,163	177 52,124	45,138 497,362	8,817	13,610 227,650	76 8.146	20,246 326,378	\$ 177 \$ 88,931	\$ 81,234 \$ 1,151,251	25.06% 36.74%
25	60	000 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 27	66	500 RESPIRATORY THERAPY 600 PHYSICAL THERAPY		1.109982 0.298883	2,871 14,243	574 1,533	1,332 1,059	28,651 31,777	4,808 133,398	2,955 69,335	732 4,629	1,334 47,173	1,723	583 33,414	\$ 9,743 \$ 153,329	\$ 33,514 \$ 149,818	39.06% 27.49%
28 29		601 PHYSICAL THERAPY - SNF 900 ELECTROCARDIOLOGY		0.279441 0.031555	4.718	19.539	-	-	7.458	133 565	747	64 667	249	49 612	\$ - \$ 12,923	\$ - \$ 217.771	0.00%
30	70	000 ELECTROCARDIOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.124017		-	-	-	-	73,650	-	16,700	-	11,100	s -	\$ 90,350	36.88%
31 32	71	100 MEDICAL SUPPLIES CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS		0.441718 0.191470	4,608 100,145	3,715 21,861	764 1,300	1,142 5.816	14,392 843,154	8,074 280,033	2,481 22,025	2,122 77.863	2,069 19.879	2,240 97,120	\$ 22,245 \$ 966,624	\$ 15,053 \$ 385,573	18.60% 30.84%
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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 Chair Madison	FFS Cross-Overs (.165	In Charle Cale of Ma	dicaid Eligibles (Not						%
			In-	-State Medicaid FF	S Primary	In-State Medic	aid Managed C	are Primary		d Secondary)	MUT		Elsewhere)		Uninsured		Total In-Stat	Medicaid	Survey
86		•														\$		\$ -	
87 88		-					_			-						\$ \$		\$ - \$ -	-
89		-														\$		\$ -	j
90 91							_			_						\$		\$ - \$ -	4
92																\$		\$ -	1
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94 95		-					_			-						\$ \$		\$ - \$ -	-
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99																\$	-	\$ -	1
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104 105							_			-						\$		\$ - \$ -	4
106																\$		\$ -	1
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109							_			-						\$	-	\$ -	1
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111 112		-								-						\$	-	\$ - \$ -	-
113		-														\$	-	\$ -	j
114 115							_			_	_					\$	-		4
116		-					_			-						\$		\$ -	4
117		•														\$	-	\$ -	1
118 119				———						-						\$		\$ -	-
120		-														\$		\$ -	1
121 122		<u> </u>					_			_						\$		\$ - \$ -	4
123							_			-						\$		\$ -	1
124 125		-														\$		\$ -	1
126		-					_			-						\$	-		1
127																\$	-	\$ -	-]
	Totals / Payments		\$	211,373 \$	444,740	\$ 26	180 \$	468,614	\$ 1,334,47	8 \$ 1,25	6,296 \$	64,415	\$ 631,595	\$ 51,	698 \$ 78	,710			
																			_
128	Total Charges (includes organ acquisition from Section J)	\$	337,239 \$	444,740	\$ 33	180 \$	468,614	\$ 2,786,14	B \$ 1,25	6,296 \$	105,005	\$ 631,595	\$ 72, (Agrees to Exhibit	508 \$ 78° A) (Agrees to Exhib	,710 \$	3,261,572	\$ 2,801,245	28.64%
129	Total Charges per PS&R or Exhibit Detail		\$	337,239 \$	444,740	\$ 33	180 \$	468,614	\$ 2,786,14	B \$ 1,25	6,296 \$	105,005	\$ 631,595			,710			
130	Unreconciled Charges (Explain Variance)				-		-					-							
131	Total Calculated Cost (includes organ acquisition from Sect	ion J)	\$	170,151 \$	100,915	\$ 13	294 \$	128,808	\$ 1,226,82	\$ 23	8,621 \$	45,716	\$ 129,882	\$ 32	111 \$ 164	1,263 \$	1,455,981	\$ 598,226	28.83%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$	135,116 \$	72,211	\$ 14	670 \$	85,563	\$ 21,42	7 \$ 2	0,264 \$	4,973	\$ 9,643			\$	176,186		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-E	Down) (See Note E)					_				450	04.100	\$ 2,692			\$		\$ 2,692	
134 135	Private Insurance (including primary and third party liability) Self-Pay (including Co-Pay and Spend-Down)		\vdash	s	611		s	527	\$ 1,18	2	156 \$	21,177	\$ 74,959 \$ 602			\$		\$ 75,115 \$ 1,740	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$	135,116 \$	72,822	\$ 14	670 \$	86,090					- 002					1,740	i
137	Medicaid Cost Settlement Payments (See Note B)			\$	(56)											\$		\$ (56)
138 139	Other Medicaid Payments Reported on Cost Report Year (See Note C) Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles	4							\$ 912,85	3 6 49	0.927		¢ 24			\$		\$ - \$ 130.988	d
140	Medicare Traditional (non-nino) Paid Amount (excludes coinsurance/deductibles Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles								y 512,00	13	\$	9.059	\$ 2.135			s		\$ 2,135	
141	Medicare Cross-Over Bad Debt Payments	•							\$ 58,73	9 \$	6,128	2,000	2,100	(Agrees to Exhibit B a	nd B- (Agrees to Exhibit B	and B- \$		\$ 6,128	
142	Other Medicare Cross-Over Payments (See Note D)													1)	1)	\$	-	\$	_
143 144	Payment from Hospital Uninsured During Cost Report Year (Cash Basis) Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Ex	chibits B & B-1 (from Se	ction E)											s	- \$,120			
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PA		s	35,035 \$	28,149	S (1	376) \$	42,718	\$ 232.61	7 8 ^	1,146 \$	10.507	\$ 39,790	e 22	111 S 140	0.143 \$	276,783	\$ 191.803	а
146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PA	AND DON)		79%	72%		10%	67%	81		66%	77%	5 39,790	w 32,	0%	15%	81%	689	
147 148	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed Percent of cross-over days to total Medicare days from the cost report	(C/R, W/S S-3, Pt. I, Co	ol. 6, Sum of L	Lns. 2, 3, 4, 14, 16	, 17, 18 less lines	i & 6)			3,30										
	Note A - These amounts must agree to your inpatient and outpatient Medicaid pa	id claims summary. For	Managed Ca	are. Cross-Over dat	a, and other eligible	s, use the hospital	s logs if PS&R	summaries are r	ot available (submit I	as with survey).				NOTE: Innatient	uninsured payment ra	te is outside	normal ranges.	lease verify this	

Note A. Those amounts must agree to you're inpatient and outsigned the discidal paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PSAR summaries are not available (usufmal 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 (R4 summary or PSAR). Note B. Medicaid cost settlements payments refer to payments made by Medicaid during a cost report settlement of a summary (R4 summary or PSAR). Note C. Other Medicaid Payments such as Outliers and Not-Cailing Specific payments. Delt payments and MOH To' le included. UPL payments insist should be reported in Section C of the survey, Note D. Should include other Medicaic cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicaic cost report settlement (e.g., Medicaic Graduate Medicaic Equation payments). Note E. Medicaic of intending the payments in the control of the survey, and the payment is referred to the services provided, including, but not inhead to, incentive payments, bottom payments, payments, and the payment is referred to the services provided, including, but not inhead to, incentive payments, bottom payments, payments, and the payment is referred to the services provided, including, but not inhead to, incentive payments, bottom payments, capitation and substance, capitation and subs

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

				Out-of-State Med	Out-of-State Medicaid FFS Primary		icaid Managed Care mary	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-	State Medicaid
_ine #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatie
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
Routine Cost	t Centers (list below):			Days		Days		Days		Days		Days	
	TS & PEDIATRICS	\$ 932.73										-	
	NSIVE CARE UNIT	\$ - \$ -										-	
	I INTENSIVE CARE UNIT	\$ - \$ -										-	
	SICAL INTENSIVE CARE UNIT	\$ -										_	
	R SPECIAL CARE UNIT	\$ -										-	
4000 SUBP		\$ -										-	
	PROVIDER II	\$ -										-	
	R SUBPROVIDER	\$ -										-	
04300 NURS	SERY	\$ -										-	
		\$ - \$ -										-	
		\$ -										-	
		\$ -											
		\$ -										-	
		\$ -										-	
		\$ -										-	
			Total Days	-		-		-		-		-	
Routir	er PS&R or Exhibit Detail Unreconciled Days (E	Explain Variance)		Routine Charges		- Routine Charges		- Routine Charges		- Routine Charges] - 1	Routine Charges	
Routir	Unreconciled Days (E	Explain Variance)		-		Routine Charges		Routine Charges		-			
Routir Calcu	Unreconciled Days (Ene Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below):	Explain Variance)	0.245803	-	Ancillary Charges	Routine Charges \$ - Ancillary Charges	Ancillary Charges	Routine Charges \$ Ancillary Charges	Ancillary Charges	-	Ancillary Charges		Ancillary (
Routir Calcu uncillary Cos 9200 Obser	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr	Explain Variance)	0.245803 0.372231	Routine Charges		\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	Ancillary (
Routir Calcul ncillary Cos 9200 Obser 5000 OPER	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vvation (Non-Distinct)	Explain Variance)		Routine Charges	-	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	Ancillary (
Routin Calcul Incillary Cos 9200 Obser 5000 OPER 5400 RADIG 6000 LABO	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vvation (Non-Distinct) RATING ROOM DIAGNOSTIC RATORY	Explain Variance)	0.372231 0.177674 0.273425	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	\$
Routir Calcu Mancillary Cos 9200 Obser 5000 OPER 5400 RADIG 6000 LABO 6500 RESP	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) AATING ROOM OLOGY-DIAGNOSTIC RATORY IRATORY IRATORY IRATORY IRATORY IRATORY IRATORY	Explain Variance)	0.372231 0.177674 0.273425 1.109982	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$	\$ \$ \$
Routin Calcu Incillary Cos 9200 Obser 5000 OPER 5400 RADIO 6500 RESP 6600 PHYS	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): rvation (Non-Distinct) rATING ROOM UCGY-DIAGNOSTIC RATORY PIRATORY PIRATORY THERAPY SICAL THERAPY	Explain Variance)	0.372231 0.177674 0.273425 1.109982 0.298883	Routine Charges	2,876 1,404 2,997 -	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	\$ \$ \$ \$
Routin Calculary Cos 9200 Obser 5000 OPER 5400 RADIO 6000 LABO 6500 RESP 6600 PHYS	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vvation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC IRATORY IRATORY THERAPY SIGAL THERAPY SIGAL THERAPY - SNF	Explain Variance)	0.372231 0.177674 0.273425 1.109982 0.298883 0.279441	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$
Routin Calculary Cos 9200 Obser 5000 OPER 5400 RADIG 6600 LABO 6500 RESP 6601 PHYS 6601 PHYS	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vating ROOM DLOGY-DIAGNOSTIC RATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY	Explain Variance)	0.372231 0.177674 0.273425 1.10982 0.298883 0.279441 0.031555	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ Ancillary Charges \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	\$ \$ \$ \$ \$ \$
Routin Calcu Incillary Cos 9200 Obser 5000 OPER 5400 RADIG 6600 LABO 6500 RESP 6600 PHYS 6601 PHYS 6601 PHYS 6600 ELEC	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): rvation (Non-Distinct) rATING ROOM UOGY-DIAGNOSTIC IRATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROCARDIOLOGY TROCARDIOLOGY TROCARDIOLOGY TROCARDHOLOGRAPHY		0.372231 0.177674 0.273425 1.109982 0.298883 0.279441 0.031555 0.124017	Routine Charges	2,876 1,404 2,997 - - - -	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$ - \$ \$ - \$ \$ - \$ \$ - \$ \$ - \$ \$ - \$ \$	\$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CAICULAR CAICULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vating ROOM DLOGY-DIAGNOSTIC RATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY		0.372231 0.177674 0.273425 1.10982 0.298883 0.279441 0.031555	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CAICULAR CAICULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CAICULAR CAICULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CALCULAR CALCULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CALCULAR CALCULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 6 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CALCULAR CALCULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CALCULAR CALCULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.298883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 55000 OPER 5400 RADIG 6600 LABO 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Cal	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 77000 ELEC 7100 MEDIG Calcular Calc	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routin Calculary Cos 99200 Obser 5400 RADIG 6000 LABO 6500 RESP 6600 PHYS 6601 PHYS 6900 ELEC 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG 7100 MEDIG CALCULAR CALCULA	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr st Centers (from W/S C) (list below): vation (Non-Distinct) vation (Non-Distinct) vation (Non-Distinct) RATING ROOM DLOGY-DIAGNOSTIC RATORY IRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF TROCARDIOLOGY TROENCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5

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					5 - \$ -
51					\$ - \$ - \$ - \$
52					5 - 5
54					- \$
55					- \$ -
56					\$ - \$ -
58					5 - 5
59					\$ -
60					\$ - \$ - \$ - \$
62					
63					\$ -
-					- \$ -
65	——————————————————————————————————————				\$ - \$ - \$ - \$
-					\$ -
69		<u> </u>			\$ - \$ - \$ -
71 -					5 - 5 -
72					\$ -
73 -					
74					
76					\$ -
77 -					- \$ -
78					\$ - \$ - \$ -
80					5 - 5
81 -					\$ -
82		<u> </u>			5 - \$ - 5 - \$ -
84					- 5
85					\$ -
86					\$ - \$ - \$ - \$
87					
89					\$ -
90					- \$ -
91 - 92					5 - \$ - 5 - \$ -
93					5 - \$ -
94					
95 96					5 - \$ - 5 - \$ -
97					5 - \$ -
98					\$ -
99					\$ - \$ -
100					5 - S -
102					\$ -
103					
104					5 - \$ - 5 - \$ -
106					
107					\$ -
108					5 - \$ - 5 - \$
110					5 - S -
111					

	Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER														
		Out-of-State Med	icaid FFS Primary	C		icaid Managed Care mary		Out-of-State Medicard		Out-of-State Oth	er Medicaid ed Elsewher		Tot	tal Out-Of-Sta	ate Medicaid
112	-						_ [\$	- 9	
113	-			_			 -				_		\$	- 9	-
114 115	-			-							_		\$	3	-
116													\$	- 3	, -
117				-			⊣⊦						\$	—— H	-
118				1			⊣ ⊦				-		\$		
119	-			1			-1						\$	- 3	-
120	-			1			-1						\$	- 17	-
121	-						71						\$	- !	-
122	-						7						\$	- !	-
123	-] [\$	- 5	-
124	-												\$	- 9	-
125	-						_						\$	- (-
126	-						_						\$	- 9	-
127	-												\$		-
		\$ -	\$ 7,568	\$	-	\$ -		\$ -	\$ -	\$ -	\$	-			
	Totals / Payments														
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 7,568	- Te	_ 1	\$ -	— r	s - I	\$ -	\$ -	s	_	\$	- 1	7,568
		Ψ -			-	Ψ -	_	Ψ -	Ψ -	Ψ -			Ψ		7,500
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 7,568	\$	-	\$	-	\$ -	\$ -	\$	- \$	-			
130	Unreconciled Charges (Explain Variance)						<u> </u>		-		<u> </u>	-			
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 2,210	\$	-	\$ -	ПΓ	\$ -	\$ -	\$ -	\$	-	\$	- 9	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)			4			41						\$	- 9	-
134	Private Insurance (including primary and third party liability)						41						\$	- 9	-
135	Self-Pay (including Co-Pay and Spend-Down)			4 —									\$	- 9	-
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$	-	\$ -	_								
137	Medicaid Cost Settlement Payments (See Note B)												\$	- 9	-
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						┙,				_		\$!	j -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						L						\$!	j -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						-						\$		-
141	Medicare Cross-Over Bad Debt Payments						<u> </u>						\$	- 9	-
142	Other Medicare Cross-Over Payments (See Note D)						L						\$	3	-
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	s -	\$ 2,210			\$ -	— г	s -	\$ -	\$ -	s		¢	- 9	3 2,210
144	Calculated Payments as a Percentage of Cost	0%	Ψ 2,210 09	<u> </u>	0%	00)%	0%	0%	(<u>"</u>	0%	Ψ	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 Medicale 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	Total		Revenue for	Total	In-State Medic	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	
	Organ Additional Add-In Total Adju Intern/Resident Organ Acquisition Cost Cost Cost		Organ Acquisition	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organ (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 Hospital's Own Internal Analysis	From Hospital's C Internal Analysi						
Acquisition Cost Centers (list below):																
Lung Acquisition	\$0.00		\$ -		0											
Kidney Acquisition Liver Acquisition	\$0.00 \$0.00		\$ -		0											
Heart Acquisition			\$ -		0											
Pancreas Acquisition	\$0.00		\$ -		0											
Intestinal Acquisition	\$0.00 \$0.00		\$ -		0											
	\$0.00		\$ -		0											
Islet Acquisition	\$0.00		\$ -		0											
	\$0.00	-	\$ -		U											
Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -		
Total Cost																

Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments

Note C: Enter Organ Acquisition regiments in section in as per to you in 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 (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			Revenue for	Total	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Priman			are FFS Cross-Overs id Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		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)						
Organ A	cquisition 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 Note A	Total Cost These amounts must agree to your innation	t and autnations M	ndianid naid alaima	cummery if eveileble	(if not use beenitel's le	age and cubmit w	ith curvey					-		-

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 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

Worksneet A Pro	ovider Tax Assessment Re	econcination:				
				Dollar Amount	W/S A Cost Center Line	
1 Hospita	al Gross Provider Tax Assessn	nent (from general ledger)*				
		and Account # that includes Gross Provider Tax As				(WTB Account #)
2 Hospita	al Gross Provider Tax Assessm	nent Included in Expense on the Cost Report (W/S A	A, Col. 2)			(Where is the cost included on w/s A?)
3 Differer	nce (Explain Here>)			\$ -		
Provide		fications (from w/s A-6 of the Medicare cost rep	ort)			
4	Reclassification Code					(Reclassified to / (from))
5	Reclassification Code					(Reclassified to / (from))
6	Reclassification Code					(Reclassified to / (from))
7	Reclassification Code					(Reclassified to / (from))
		Tax Assessment Adjustments (from w/s A-8 of th	ne Medicare cost report)			lan a saman
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 U	CC NON-ALLOWABLE Provi	der 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					
		xpense Included in the Cost Report		\$ -		
DSH UCC Provid	ler Tax Assessment Adjus	tment:				
17 Gross A	Allowable Assessment Not Incl	uded in the Cost Report		\$ -		
Apport		sessment 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 T	ax Assessment Adjustment to include in DSH Medic	caid UCC	25.10%		
22		ax Assessment Adjustment to include in DSH Unins	sured UCC	3.53%		
23	Medicaid Provider Tax As	ssessment Adjustment to DSH UCC		\$ -		
24	Uninsured Provider Tax A	Assessment Adjustment to DSH UCC		\$ -		
25 Provide	er Tax Assessment Adjustment			\$ -		
	•					

^{*} 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.