State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

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 Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2022	09/30/2023
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

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

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/24 - 06/30/25)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	11/1/1965

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** $ 5,373,085
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025** $ 2,969,539
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** $ 8,342,624

Certification:

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

Explanation for "No" answers:

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.

Troy B Brooks	SVP & CFO	
Hospital CEO or CFO Signature	Title	Date
Troy Brooks	229-353-3397	troy.brooks@mysouthwell.com
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Tonia Waldrop
Title	Controller
Telephone Number	229-353-3804
E-Mail Address	Tonia.Waldrop@tiftregional.com
Mailing Street Address	901 East 18th Street
Mailing City, State, Zip	Tifton, GA 31794

Outside Preparer:	
Name	Hal Guthrie
Title	Partner
Firm Name	Forvis Mazars
Telephone Number	404-575-8947
E-Mail Address	hal.guthrie@us.forvismazars.com

Troy B Brooks

DSH Version 9.00 9/11/2024

D. General Cost Report Year Information 10/1/2022 - 9/30/2023

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: TIFT REGIONAL MEDICAL CENTER

	10/1/2022 through 9/30/2023		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 3/4/2024

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

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: (10/01/2022 - 09/30/2023)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 153,921	$ 1,054,025	$1,207,946
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,231,050	$ 9,257,233	$10,488,283
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)	$1,384,971	$10,311,258	$11,696,229
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.11%	10.22%	10.33%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 09/30/2023)

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)	50,085	**(See Note in Section F-3, below)**

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

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

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$62,731,793.00			$ 45,513,194	$ -	$ -	$ 17,218,599
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$328,185,404.00	$762,539,595.00		$ 238,105,195	$ 553,238,008	$ -	$ 299,381,795
20.	Outpatient Services		$70,025,570.00			$ 50,804,977	$ -	$ 19,220,593
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,311,794.00			$ 3,853,815	
26.	Other	$45,892,800.00	$143,109,559.00	$0.00	$ 33,296,161	$ 103,828,900	$ -	$ 51,877,298
27.	Total	$ 436,809,997	$ 975,674,724	$ 5,311,794	$ 316,914,550	$ 707,871,886	$ 3,853,815	$ 387,698,285
28.	Total Hospital and Non Hospital		Total from Above	$ 1,417,796,515		Total from Above	$ 1,028,640,251	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,417,796,515	Total Contractual Adj. (G-3 Line 2)	1,028,640,251
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)"			-	
36.	Adjusted Contractual Adjustments				1,028,640,251
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) | TIFT REGIONAL MEDICAL CENTER

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

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 63,409,578	$ -	$ -	$0.00	$ 63,409,578	46,980	$50,873,079.00		$ 1,349.71
2	03100	INTENSIVE CARE UNIT	$ 12,003,052	$ -	$ -		$ 12,003,052	4,748	$11,858,714.00		$ 2,528.02
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 1,930,088	$ -	$ -		$ 1,930,088	3,943	$4,262,542.00		$ 489.50
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 77,342,718	$ -	$ -	$ -	$ 77,342,718	55,671	$ 66,994,335		
19		Weighted Average									$ 1,389.28

Line #		Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)		5,586	-	-	$ 7,539,480	$10,406,230.00	$12,323,357.00	$ 22,729,587	0.331703

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$22,129,056.00	$ -	$ -		$ 22,129,056	$21,094,577.00	$77,315,432.00	$ 98,410,009	0.224866
22	5100	RECOVERY ROOM	$2,934,825.00	$ -	$ -		$ 2,934,825	$2,199,312.00	$7,608,343.00	$ 9,807,655	0.299238
23	5200	DELIVERY ROOM & LABOR ROOM	$5,368,768.00	$ -	$ -		$ 5,368,768	$9,338,170.00	$124,200.00	$ 9,462,370	0.567381
24	5300	ANESTHESIOLOGY	$2,323,002.00	$ -	$ -		$ 2,323,002	$5,346,317.00	$15,072,734.00	$ 20,419,051	0.113766
25	5400	RADIOLOGY-DIAGNOSTIC	$12,781,726.00	$ -	$ -		$ 12,781,726	$15,061,910.00	$56,795,719.00	$ 71,857,629	0.177876
26	5500	RADIOLOGY-THERAPEUTIC	$8,173,608.00	$ -	$ -		$ 8,173,608	$101,651.00	$13,625,747.00	$ 13,727,398	0.595423
27	5700	CT SCAN	$2,279,829.00	$ -	$ -		$ 2,279,829	$28,115,839.00	$73,772,035.00	$ 101,887,874	0.022376
28	5800	MRI	$1,729,513.00	$ -	$ -		$ 1,729,513	$2,762,240.00	$13,758,547.00	$ 16,520,787	0.104687
29	6000	LABORATORY	$23,134,604.00	$ -	$ -		$ 23,134,604	$72,515,075.00	$108,855,702.00	$ 181,370,777	0.127554
30	6500	RESPIRATORY THERAPY	$7,041,280.00	$ -	$ -		$ 7,041,280	$9,623,525.00	$4,164,114.00	$ 13,787,639	0.510695

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
31	6600	PHYSICAL THERAPY	$4,251,885.00	$ -	$ -		$ 4,251,885	$5,572,079.00	$6,204,237.00	$ 11,776,316	0.361054
32	6900	ELECTROCARDIOLOGY	$10,357,714.00	$ -	$ -		$ 10,357,714	$21,615,739.00	$34,638,647.00	$ 56,254,386	0.184123
33	7000	ELECTROENCEPHALOGRAPHY	$2,187,521.00	$ -	$ -		$ 2,187,521	$820,955.00	$11,710,155.00	$ 12,531,110	0.174567
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$18,785,004.00	$ -	$ -		$ 18,785,004	$17,811,099.00	$17,150,275.00	$ 34,961,374	0.537307
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,072,776.00	$ -	$ -		$ 16,072,776	$10,913,549.00	$21,185,196.00	$ 32,098,745	0.500729
36	7300	DRUGS CHARGED TO PATIENTS	$44,217,892.00	$ -	$ -		$ 44,217,892	$103,592,271.00	$252,227,925.00	$ 355,820,196	0.124270
37	7400	RENAL DIALYSIS	$5,417,615.00	$ -	$ -		$ 5,417,615	$1,701,096.00	$48,330,587.00	$ 50,031,683	0.108284
38	9000	CLINIC	$1,044,994.00	$ -	$ -		$ 1,044,994	$38,403.00	$3,138,661.00	$ 3,177,064	0.328918
39	9100	EMERGENCY	$26,298,626.00	$ -	$ 2,398,390		$ 28,697,016	$12,989,450.00	$31,129,469.00	$ 44,118,919	0.650447
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 216,530,238	$ -	$ 2,398,390		$ 218,928,628	$ 351,619,487	$ 809,131,082	$ 1,160,750,569	
127		**Weighted Average**									0.195105
128		**Sub Totals**	$ 293,872,956	$ -	$ 2,398,390		$ 296,271,346	$ 418,613,822	$ 809,131,082	$ 1,227,744,904	

129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$0.00
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 296,271,346
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

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

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,349.71		3,051		2,801		7,244		8,940		9		3,157		22,045		61.21%
2	03100 INTENSIVE CARE UNIT	$ 2,528.02		1,160		114		658		923				362		2,855		67.94%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 489.50		248		2,459		1		275		2		114		2,985		78.67%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	4,459		5,374		7,903		10,138		11		3,633		27,885		56.88%
19	Total Days per PS&R or Exhibit Detail			4,459		5,374		7,903		10,138		11		3,633				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,247,586		$ 6,090,452		$ 10,872,036		$ 13,491,813		$ 11,656		$ 4,812,797		$ 36,701,887		62.24%
21.01	Calculated Routine Charge Per Diem			$ 1,401.12		$ 1,133.32		$ 1,375.68		$ 1,330.82		$ 1,059.64		$ 1,324.74		$ 1,316.19		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.331703	1,147,811	965,151	1,140,060	1,573,169	2,504,232	1,000,254	2,453,079	1,718,369	3,367	255,570	507,344	1,239,654	$ 7,245,182	$ 5,256,943	64.00%
23	5000 OPERATING ROOM		0.224866	1,077,295	1,887,544	3,038,355	6,382,780	2,349,602	4,742,250	3,467,438	8,396,545	9,733	518,863	1,643,179	5,068,308	$ 9,932,690	$ 21,409,119	39.28%
24	5100 RECOVERY ROOM		0.299238	98,019	246,264	242,066	758,717	275,989	484,849	346,743	870,871	420	5,635	185,000	476,040	$ 962,817	$ 2,360,701	40.74%
25	5200 DELIVERY ROOM & LABOR ROOM		0.567381	232,126	4,998	4,928,950	49,406	3,947	1,330	1,455,346	6,328	38,229	-	261,775	3,632	$ 6,620,369	$ 62,062	73.89%
26	5300 ANESTHESIOLOGY		0.113766	260,301	435,814	657,569	1,723,221	609,106	805,989	856,609	1,521,380	1,314	871	439,757	1,013,382	$ 2,383,585	$ 4,486,404	40.85%
27	5400 RADIOLOGY-DIAGNOSTIC		0.177876	1,257,539	2,429,308	702,886	4,855,128	2,498,311	4,406,120	3,237,671	7,490,327	49,291	150,716	1,190,434	5,381,904	$ 7,696,407	$ 19,180,883	47.02%
28	5500 RADIOLOGY-THERAPEUTIC		0.595423	1,503	420,606	-	591,862	6,390	1,276,065	12,058	2,131,971	-	159,458	-	362,236	$ 19,951	$ 4,420,504	36.15%
29	5700 CT SCAN		0.022376	2,276,968	3,470,524	845,295	6,978,372	4,716,824	5,457,032	5,767,924	9,311,489	66,476	253,141	2,819,994	12,191,371	$ 13,607,011	$ 25,217,417	53.43%
30	5800 MRI		0.104687	196,706	443,621	58,309	562,740	402,446	1,173,237	568,219	1,875,010	-	46,675	265,975	1,133,691	$ 1,225,880	$ 4,054,608	40.89%
31	6000 LABORATORY		0.127554	6,318,874	6,544,950	4,433,095	12,673,509	12,505,969	5,760,234	15,797,467	14,129,288	420,300	368,278	6,134,532	13,263,838	$ 39,055,405	$ 39,107,981	54.48%
32	6500 RESPIRATORY THERAPY		0.510695	1,118,149	265,429	497,397	237,948	1,822,122	376,298	2,225,681	652,011	-	8,005	575,879	289,414	$ 5,663,349	$ 1,531,686	58.74%
33	6600 PHYSICAL THERAPY		0.361054	379,067	3,659	75,266	390,598	997,964	103,704	1,194,405	527,364	19,544	91,823	265,859	218,613	$ 2,646,702	$ 1,025,325	36.32%
34	6900 ELECTROCARDIOLOGY		0.184123	897,905	666,951	339,113	1,703,768	2,857,299	2,875,972	4,166,612	5,145,322	7,260	253,850	1,933,282	2,802,781	$ 8,260,929	$ 10,392,013	42.17%
35	7000 ELECTROENCEPHALOGRAPHY		0.174567	20,429	28,029	27,349	992,056	89,513	1,083,422	151,072	1,774,717	-	10,068	36,675	807,605	$ 288,363	$ 3,878,224	40.14%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.537307	1,628,260	523,937	1,358,340	1,192,993	2,990,413	1,202,817	3,696,838	2,269,948	8,285	199,962	1,274,725	1,125,587	$ 9,673,851	$ 5,189,695	50.12%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.500729	376,533	352	251,176	499,799	1,481,247	1,470,853	1,723,911	2,571,329	8,278	602,533	262,535	602,352	$ 3,832,867	$ 4,542,333	30.86%
38	7300 DRUGS CHARGED TO PATIENTS		0.124270	9,815,645	14,638,125	5,940,048	12,310,662	17,512,477	22,560,853	21,847,048	37,792,816	54,434	1,667,993	7,950,939	9,213,636	$ 55,115,218	$ 87,302,456	45.49%
39	7400 RENAL DIALYSIS		0.108284	120,390	-	2,373	-	432,153	-	595,283	2,373	-	-	66,541	2,332	$ 1,150,199	$ 2,373	2.44%
40	9000 CLINIC		0.328918	4,574	169,922	277	110,213	4,760	297,798	9,757	509,702	963	3,345	1,352	157,669	$ 19,368	$ 1,087,635	40.12%
41	9100 EMERGENCY		0.650447	1,157,373	2,239,653	465,475	5,459,702	2,180,102	1,885,036	2,779,038	3,570,656	146	147,423	1,249,292	6,277,045	$ 6,581,988	$ 13,155,047	62.58%
42			-													$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2022-09/30/2023) | TIFT REGIONAL MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
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126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 28,385,467	$ 35,384,837	$ 25,003,399	$ 59,046,643	$ 56,240,866	$ 56,964,113	$ 72,352,199	$ 102,267,816	$ 688,040	$ 4,744,209	$ 27,065,069	$ 61,631,090			

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 34,633,053	$ 35,384,837	$ 31,093,851	$ 59,046,643	$ 67,112,902	$ 56,964,113	$ 85,844,012	$ 102,267,816	$ 699,696	$ 4,744,209	$ 31,877,866 (Agrees to Exhibit A)	$ 61,631,090 (Agrees to Exhibit A)	$ 218,683,818	$ 253,663,409	46.27%
129	Total Charges per PS&R or Exhibit Detail	$ 34,633,053	$ 35,384,837	$ 31,093,851	$ 59,046,643	$ 67,112,902	$ 56,964,113	$ 85,844,012	$ 102,267,816	$ 699,696	$ 4,744,209	$ 31,877,866	$ 61,631,090			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 13,014,958	$ 6,390,188	$ 12,238,445	$ 12,213,883	$ 22,969,148	$ 10,617,667	$ 29,742,592	$ 19,178,725	$ 126,430	$ 1,181,671	$ 10,485,997	$ 12,137,161	$ 77,965,143	$ 48,400,463	50.50%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,450,836	$ 5,969,599		$ 32,765	$ 317,794	$ 929,471	$ 322,927	$ 1,447,887					$ 7,091,557	$ 8,379,722	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ (28,603)		$ 8,443,946	$ 8,620,547			$ 306,115	$ 191,382					$ 8,721,458	$ 8,811,929	
134	Private Insurance (including primary and third party liability)	$ 304		$ 3,413	$ 233,703		$ 21,141	$ 4,711,090	$ 4,061,300					$ 4,714,807	$ 4,316,144	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 68,183	$ 46,536	$ 431	$ 19,798			$ 36,962	$ 71,280					$ 105,576	$ 137,614	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 6,490,720	$ 6,016,135	$ 8,447,790	$ 8,906,813											
137	Medicaid Cost Settlement Payments (See Note B)		$ (321,227)											$ -	$ (321,227)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ 128,642				$ 14,975,049	$ 7,020,218	$ 142,266	$ 43,434					$ 15,245,957	$ 7,063,652	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 16,769,568	$ 12,835,756					$ 16,769,568	$ 12,835,756	
141	Medicare Cross-Over Bad Debt Payments					$ 259,580	$ 77,499							$ 259,580	$ 77,499	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 153,921	$ 1,054,025			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 6,395,596	$ 695,280	$ 3,790,655	$ 3,307,070	$ 7,416,725	$ 2,569,338	$ 7,453,664	$ 527,686	$ 126,430	$ 1,181,671	$ 10,332,076	$ 11,083,136	$ 25,056,640	$ 7,099,374	
146	**Calculated Payments as a Percentage of Cost**	51%	89%	69%	73%	68%	76%	75%	97%	0%	0%	1%	9%	68%	85%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					26,278										
148	**Percent of cross-over days to total Medicare days from the cost report**					30%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,349.71		89				16		30		135	
2	03100 INTENSIVE CARE UNIT	$ 2,528.02		4				2		3		9	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 489.50		3								3	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	96		-		18		33		147	
19	Total Days per PS&R or Exhibit Detail			96		-		18		33			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 116,372				$ 23,912		$ 39,794		$ 180,078	
21.01	Calculated Routine Charge Per Diem			$ 1,212.21		$ -		$ 1,328.44		$ 1,205.88		$ 1,225.02	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.331703	7,513	15,803			2,756	8,090	3,375	2,254	$ 13,644	$ 26,147
23	5000 OPERATING ROOM		0.224866	22,565	4,492			4,928	-	31,863	13,255	$ 59,356	$ 17,747
24	5100 RECOVERY ROOM		0.299238	1,629	630			335	-	2,020	866	$ 3,984	$ 1,496
25	5200 DELIVERY ROOM & LABOR ROOM		0.567381	5,762	-			-	-	-	-	$ 5,762	$ -
26	5300 ANESTHESIOLOGY		0.113766	4,888	2,627			720	-	5,765	2,347	$ 11,373	$ 4,974
27	5400 RADIOLOGY-DIAGNOSTIC		0.177876	20,658	67,422			4,761	18,657	6,160	17,905	$ 31,579	$ 103,984
28	5500 RADIOLOGY-THERAPEUTIC		0.595423	-	209			-	-	-	643	$ -	$ 852
29	5700 CT SCAN		0.022376	45,315	125,055			33,587	11,977	20,562	48,125	$ 99,464	$ 185,157
30	5800 MRI		0.104687	9,126	-			3,042	6,084	7,363	3,042	$ 19,531	$ 9,126
31	6000 LABORATORY		0.127554	117,464	147,411			36,916	53,435	64,613	39,219	$ 218,993	$ 240,065
32	6500 RESPIRATORY THERAPY		0.510695	12,670	6,407			10,121	500	-	425	$ 22,791	$ 7,332
33	6600 PHYSICAL THERAPY		0.361054	4,521	-			1,556	-	3,472	206	$ 9,549	$ 206
34	6900 ELECTROCARDIOLOGY		0.184123	17,831	26,131			9,230	6,030	6,161	6,948	$ 33,222	$ 39,109
35	7000 ELECTROENCEPHALOGRAPHY		0.174567	-	87			-	8,695	-	832	$ -	$ 9,614
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.537307	12,354	5,433			5,093	834	11,777	14,949	$ 29,224	$ 21,216
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.500729	7,353	-			-	-	1,030	46,080	$ 8,383	$ 46,080
38	7300 DRUGS CHARGED TO PATIENTS		0.124270	158,917	95,935			36,480	9,424	116,713	136,213	$ 312,110	$ 241,572
39	7400 RENAL DIALYSIS		0.108284	-	-			-	-	1,541	-	$ 1,541	$ -
40	9000 CLINIC		0.328918	944	1,860			-	-	-	1,381	$ 944	$ 3,241
41	9100 EMERGENCY		0.650447	23,193	103,684			9,879	26,572	8,433	25,172	$ 41,505	$ 155,428
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
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107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 472,703	$ 603,186	$ -	$ -	$ 159,404	$ 150,298	$ 290,848	$ 359,862		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 589,075	$ 603,186	$ -	$ -	$ 183,316	$ 150,298	$ 330,642	$ 359,862	$ 1,103,033	$ 1,113,346
129	Total Charges per PS&R or Exhibit Detail			$ 589,075	$ 603,186	$ -	$ -	$ 183,316	$ 150,298	$ 330,642	$ 359,862		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 221,061	$ 131,450	$ -	$ -	$ 56,607	$ 35,509	$ 97,576	$ 80,796	$ 375,244	$ 247,755
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 22,562	$ 13,672				$ 2,133		$ 350	$ 22,562	$ 16,155
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -
134	Private Insurance (including primary and third party liability)				$ 621						$ 20,525	$ -	$ 21,146
135	Self-Pay (including Co-Pay and Spend-Down)			$ 25	$ 5,359				$ 47		$ 85	$ 25	$ 5,491
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 22,587	$ 19,652	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)							$ 55,954	$ 21,187		$ -	$ 55,954	$ 21,187
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 57,593	$ 40,072	$ 57,593	$ 40,072
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 198,474	$ 111,798	$ -	$ -	$ 653	$ 12,142	$ 39,983	$ 19,764	$ 239,110	$ 143,704
144	**Calculated Payments as a Percentage of Cost**			10%	15%	0%	0%	99%	66%	59%	76%	36%	42%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

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

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

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*				
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*				*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	480,007,511
19	Uninsured Hospital	**Charges Sec. G**	93,508,956
20	Total Hospital	**Charges Sec. G**	1,227,744,904
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		39.10%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.62%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$** -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	161,350,645
27	Uninsured Hospital	**Charges Sec. G**	98,952,861
28	Total Hospital	**Charges Sec. G**	1,227,744,904
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		13.14%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.06%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$** -

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

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

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*

DSH Version 9.00 9/11/2024

D. General Cost Report Year Information 10/1/2022 - 9/30/2023

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: TIFT REGIONAL MEDICAL CENTER

	10/1/2022 through 9/30/2023		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 3/4/2024

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

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: (10/01/2022 - 09/30/2023)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 153,921	$ 1,054,025	$1,207,946
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,231,050	$ 9,257,233	$10,488,283
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)	$1,384,971	$10,311,258	$11,696,229
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.11%	10.22%	10.33%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 09/30/2023)

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)	50,085	**(See Note in Section F-3, below)**

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

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

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$62,731,793.00			$ 45,513,194	$ -	$ -	$ 17,218,599
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$328,185,404.00	$762,539,595.00		$ 238,105,195	$ 553,238,008	$ -	$ 299,381,795
20.	Outpatient Services		$70,025,570.00			$ 50,804,977	$ -	$ 19,220,593
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$5,311,794.00			$ 3,853,815	
26.	Other	$45,892,800.00	$143,109,559.00	$0.00	$ 33,296,161	$ 103,828,900	$ -	$ 51,877,298
27.	Total	$ 436,809,997	$ 975,674,724	$ 5,311,794	$ 316,914,550	$ 707,871,886	$ 3,853,815	$ 387,698,285
28.	Total Hospital and Non Hospital		Total from Above	$ 1,417,796,515		Total from Above	$ 1,028,640,251	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,417,796,515	Total Contractual Adj. (G-3 Line 2)	1,028,640,251
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)"			-	
36.	Adjusted Contractual Adjustments				1,028,640,251
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) | TIFT REGIONAL MEDICAL CENTER

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

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 63,409,578	$ -	$ -	$0.00	$ 63,409,578	46,980	$50,873,079.00		$ 1,349.71
2	03100	INTENSIVE CARE UNIT	$ 12,003,052	$ -	$ -		$ 12,003,052	4,748	$11,858,714.00		$ 2,528.02
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 1,930,088	$ -	$ -		$ 1,930,088	3,943	$4,262,542.00		$ 489.50
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 77,342,718	$ -	$ -	$ -	$ 77,342,718	55,671	$ 66,994,335		
19		Weighted Average									$ 1,389.28

Line #		Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)		5,586	-	-	$ 7,539,480	$10,406,230.00	$12,323,357.00	$ 22,729,587	0.331703

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$22,129,056.00	$ -	$ -		$ 22,129,056	$21,094,577.00	$77,315,432.00	$ 98,410,009	0.224866
22	5100	RECOVERY ROOM	$2,934,825.00	$ -	$ -		$ 2,934,825	$2,199,312.00	$7,608,343.00	$ 9,807,655	0.299238
23	5200	DELIVERY ROOM & LABOR ROOM	$5,368,768.00	$ -	$ -		$ 5,368,768	$9,338,170.00	$124,200.00	$ 9,462,370	0.567381
24	5300	ANESTHESIOLOGY	$2,323,002.00	$ -	$ -		$ 2,323,002	$5,346,317.00	$15,072,734.00	$ 20,419,051	0.113766
25	5400	RADIOLOGY-DIAGNOSTIC	$12,781,726.00	$ -	$ -		$ 12,781,726	$15,061,910.00	$56,795,719.00	$ 71,857,629	0.177876
26	5500	RADIOLOGY-THERAPEUTIC	$8,173,608.00	$ -	$ -		$ 8,173,608	$101,651.00	$13,625,747.00	$ 13,727,398	0.595423
27	5700	CT SCAN	$2,279,829.00	$ -	$ -		$ 2,279,829	$28,115,839.00	$73,772,035.00	$ 101,887,874	0.022376
28	5800	MRI	$1,729,513.00	$ -	$ -		$ 1,729,513	$2,762,240.00	$13,758,547.00	$ 16,520,787	0.104687
29	6000	LABORATORY	$23,134,604.00	$ -	$ -		$ 23,134,604	$72,515,075.00	$108,855,702.00	$ 181,370,777	0.127554
30	6500	RESPIRATORY THERAPY	$7,041,280.00	$ -	$ -		$ 7,041,280	$9,623,525.00	$4,164,114.00	$ 13,787,639	0.510695

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
31	6600	PHYSICAL THERAPY	$4,251,885.00	$ -	$ -		$ 4,251,885	$5,572,079.00	$6,204,237.00	$ 11,776,316	0.361054
32	6900	ELECTROCARDIOLOGY	$10,357,714.00	$ -	$ -		$ 10,357,714	$21,615,739.00	$34,638,647.00	$ 56,254,386	0.184123
33	7000	ELECTROENCEPHALOGRAPHY	$2,187,521.00	$ -	$ -		$ 2,187,521	$820,955.00	$11,710,155.00	$ 12,531,110	0.174567
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$18,785,004.00	$ -	$ -		$ 18,785,004	$17,811,099.00	$17,150,275.00	$ 34,961,374	0.537307
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,072,776.00	$ -	$ -		$ 16,072,776	$10,913,549.00	$21,185,196.00	$ 32,098,745	0.500729
36	7300	DRUGS CHARGED TO PATIENTS	$44,217,892.00	$ -	$ -		$ 44,217,892	$103,592,271.00	$252,227,925.00	$ 355,820,196	0.124270
37	7400	RENAL DIALYSIS	$5,417,615.00	$ -	$ -		$ 5,417,615	$1,701,096.00	$48,330,587.00	$ 50,031,683	0.108284
38	9000	CLINIC	$1,044,994.00	$ -	$ -		$ 1,044,994	$38,403.00	$3,138,661.00	$ 3,177,064	0.328918
39	9100	EMERGENCY	$26,298,626.00	$ -	$ 2,398,390		$ 28,697,016	$12,989,450.00	$31,129,469.00	$ 44,118,919	0.650447
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 216,530,238	$ -	$ 2,398,390		$ 218,928,628	$ 351,619,487	$ 809,131,082	$ 1,160,750,569	
127		**Weighted Average**									0.195105
128		**Sub Totals**	$ 293,872,956	$ -	$ 2,398,390		$ 296,271,346	$ 418,613,822	$ 809,131,082	$ 1,227,744,904	

129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$0.00
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 296,271,346
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

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

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,349.71		3,051		2,801		7,244		8,940		9		3,157		22,045		61.21%
2	03100 INTENSIVE CARE UNIT	$ 2,528.02		1,160		114		658		923				362		2,855		67.94%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 489.50		248		2,459		1		275		2		114		2,985		78.67%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	4,459		5,374		7,903		10,138		11		3,633		27,885		56.88%
19	Total Days per PS&R or Exhibit Detail			4,459		5,374		7,903		10,138		11		3,633				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,247,586		$ 6,090,452		$ 10,872,036		$ 13,491,813		$ 11,656		$ 4,812,797		$ 36,701,887		62.24%
21.01	Calculated Routine Charge Per Diem			$ 1,401.12		$ 1,133.32		$ 1,375.68		$ 1,330.82		$ 1,059.64		$ 1,324.74		$ 1,316.19		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.331703	1,147,811	965,151	1,140,060	1,573,169	2,504,232	1,000,254	2,453,079	1,718,369	3,367	255,570	507,344	1,239,654	$ 7,245,182	$ 5,256,943	64.00%
23	5000 OPERATING ROOM		0.224866	1,077,295	1,887,544	3,038,355	6,382,780	2,349,602	4,742,250	3,467,438	8,396,545	9,733	518,863	1,643,179	5,068,308	$ 9,932,690	$ 21,409,119	39.28%
24	5100 RECOVERY ROOM		0.299238	98,019	246,264	242,066	758,717	275,989	484,849	346,743	870,871	420	5,635	185,000	476,040	$ 962,817	$ 2,360,701	40.74%
25	5200 DELIVERY ROOM & LABOR ROOM		0.567381	232,126	4,998	4,928,950	49,406	3,947	1,330	1,455,346	6,328	38,229	-	261,775	3,632	$ 6,620,369	$ 62,062	73.89%
26	5300 ANESTHESIOLOGY		0.113766	260,301	435,814	657,569	1,723,221	609,106	805,989	856,609	1,521,380	1,314	871	439,757	1,013,382	$ 2,383,585	$ 4,486,404	40.85%
27	5400 RADIOLOGY-DIAGNOSTIC		0.177876	1,257,539	2,429,308	702,886	4,855,128	2,498,311	4,406,120	3,237,671	7,490,327	49,291	150,716	1,190,434	5,381,904	$ 7,696,407	$ 19,180,883	47.02%
28	5500 RADIOLOGY-THERAPEUTIC		0.595423	1,503	420,606	-	591,862	6,390	1,276,065	12,058	2,131,971	-	159,458	-	362,236	$ 19,951	$ 4,420,504	36.15%
29	5700 CT SCAN		0.022376	2,276,968	3,470,524	845,295	6,978,372	4,716,824	5,457,032	5,767,924	9,311,489	66,476	253,141	2,819,994	12,191,371	$ 13,607,011	$ 25,217,417	53.43%
30	5800 MRI		0.104687	196,706	443,621	58,309	562,740	402,446	1,173,237	568,219	1,875,010	-	46,675	265,975	1,133,691	$ 1,225,880	$ 4,054,608	40.89%
31	6000 LABORATORY		0.127554	6,318,874	6,544,950	4,433,095	12,673,509	12,505,969	5,760,234	15,797,467	14,129,288	420,300	368,278	6,134,532	13,263,838	$ 39,055,405	$ 39,107,981	54.48%
32	6500 RESPIRATORY THERAPY		0.510695	1,118,149	265,429	497,397	237,948	1,822,122	376,298	2,225,681	652,011	-	8,005	575,879	289,414	$ 5,663,349	$ 1,531,686	58.74%
33	6600 PHYSICAL THERAPY		0.361054	379,067	3,659	75,266	390,598	997,964	103,704	1,194,405	527,364	19,544	91,823	265,859	218,613	$ 2,646,702	$ 1,025,325	36.32%
34	6900 ELECTROCARDIOLOGY		0.184123	897,905	666,951	339,113	1,703,768	2,857,299	2,875,972	4,166,612	5,145,322	7,260	253,850	1,933,282	2,802,781	$ 8,260,929	$ 10,392,013	42.17%
35	7000 ELECTROENCEPHALOGRAPHY		0.174567	20,429	28,029	27,349	992,056	89,513	1,083,422	151,072	1,774,717	-	10,068	36,675	807,605	$ 288,363	$ 3,878,224	40.14%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.537307	1,628,260	523,937	1,358,340	1,192,993	2,990,413	1,202,817	3,696,838	2,269,948	8,285	199,962	1,274,725	1,125,587	$ 9,673,851	$ 5,189,695	50.12%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.500729	376,533	352	251,176	499,799	1,481,247	1,470,853	1,723,911	2,571,329	8,278	602,533	262,535	602,352	$ 3,832,867	$ 4,542,333	30.86%
38	7300 DRUGS CHARGED TO PATIENTS		0.124270	9,815,645	14,638,125	5,940,048	12,310,662	17,512,477	22,560,853	21,847,048	37,792,816	54,434	1,667,993	7,950,939	9,213,636	$ 55,115,218	$ 87,302,456	45.49%
39	7400 RENAL DIALYSIS		0.108284	120,390	-	2,373	-	432,153	-	595,283	2,373	-	-	66,541	2,332	$ 1,150,199	$ 2,373	2.44%
40	9000 CLINIC		0.328918	4,574	169,922	277	110,213	4,760	297,798	9,757	509,702	963	3,345	1,352	157,669	$ 19,368	$ 1,087,635	40.12%
41	9100 EMERGENCY		0.650447	1,157,373	2,239,653	465,475	5,459,702	2,180,102	1,885,036	2,779,038	3,570,656	146	147,423	1,249,292	6,277,045	$ 6,581,988	$ 13,155,047	62.58%
42			-													$ -	$ -	
43			-													$ -	$ -	
44			-													$ -	$ -	
45			-													$ -	$ -	
46			-													$ -	$ -	
47			-													$ -	$ -	
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70			-													$ -	$ -	

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

Cost Report Year (10/01/2022-09/30/2023) | TIFT REGIONAL MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
75				-													$ -	$ -	
76				-													$ -	$ -	
77				-													$ -	$ -	
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124				-													$ -	$ -	
125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 28,385,467	$ 35,384,837	$ 25,003,399	$ 59,046,643	$ 56,240,866	$ 56,964,113	$ 72,352,199	$ 102,267,816	$ 688,040	$ 4,744,209	$ 27,065,069	$ 61,631,090			

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 34,633,053	$ 35,384,837	$ 31,093,851	$ 59,046,643	$ 67,112,902	$ 56,964,113	$ 85,844,012	$ 102,267,816	$ 699,696	$ 4,744,209	$ 31,877,866 (Agrees to Exhibit A)	$ 61,631,090 (Agrees to Exhibit A)	$ 218,683,818	$ 253,663,409	46.27%
129	Total Charges per PS&R or Exhibit Detail	$ 34,633,053	$ 35,384,837	$ 31,093,851	$ 59,046,643	$ 67,112,902	$ 56,964,113	$ 85,844,012	$ 102,267,816	$ 699,696	$ 4,744,209	$ 31,877,866	$ 61,631,090			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 13,014,958	$ 6,390,188	$ 12,238,445	$ 12,213,883	$ 22,969,148	$ 10,617,667	$ 29,742,592	$ 19,178,725	$ 126,430	$ 1,181,671	$ 10,485,997	$ 12,137,161	$ 77,965,143	$ 48,400,463	50.50%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,450,836	$ 5,969,599		$ 32,765	$ 317,794	$ 929,471	$ 322,927	$ 1,447,887					$ 7,091,557	$ 8,379,722	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ (28,603)		$ 8,443,946	$ 8,620,547			$ 306,115	$ 191,382					$ 8,721,458	$ 8,811,929	
134	Private Insurance (including primary and third party liability)	$ 304		$ 3,413	$ 233,703		$ 21,141	$ 4,711,090	$ 4,061,300					$ 4,714,807	$ 4,316,144	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 68,183	$ 46,536	$ 431	$ 19,798			$ 36,962	$ 71,280					$ 105,576	$ 137,614	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 6,490,720	$ 6,016,135	$ 8,447,790	$ 8,906,813											
137	Medicaid Cost Settlement Payments (See Note B)		$ (321,227)											$ -	$ (321,227)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ 128,642				$ 14,975,049	$ 7,020,218	$ 142,266	$ 43,434					$ 15,245,957	$ 7,063,652	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 16,769,568	$ 12,835,756					$ 16,769,568	$ 12,835,756	
141	Medicare Cross-Over Bad Debt Payments					$ 259,580	$ 77,499							$ 259,580	$ 77,499	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 153,921	$ 1,054,025			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 6,395,596	$ 695,280	$ 3,790,655	$ 3,307,070	$ 7,416,725	$ 2,569,338	$ 7,453,664	$ 527,686	$ 126,430	$ 1,181,671	$ 10,332,076	$ 11,083,136	$ 25,056,640	$ 7,099,374	
146	**Calculated Payments as a Percentage of Cost**	51%	89%	69%	73%	68%	76%	75%	97%	0%	0%	1%	9%	68%	85%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					26,278										
148	**Percent of cross-over days to total Medicare days from the cost report**					30%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,349.71		89				16		30		135	
2	03100 INTENSIVE CARE UNIT	$ 2,528.02		4				2		3		9	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 489.50		3								3	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	96		-		18		33		147	
19	Total Days per PS&R or Exhibit Detail			96		-		18		33			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 116,372				$ 23,912		$ 39,794		$ 180,078	
21.01	Calculated Routine Charge Per Diem			$ 1,212.21		$ -		$ 1,328.44		$ 1,205.88		$ 1,225.02	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.331703	7,513	15,803			2,756	8,090	3,375	2,254	$ 13,644	$ 26,147
23	5000 OPERATING ROOM		0.224866	22,565	4,492			4,928	-	31,863	13,255	$ 59,356	$ 17,747
24	5100 RECOVERY ROOM		0.299238	1,629	630			335	-	2,020	866	$ 3,984	$ 1,496
25	5200 DELIVERY ROOM & LABOR ROOM		0.567381	5,762	-			-	-	-	-	$ 5,762	$ -
26	5300 ANESTHESIOLOGY		0.113766	4,888	2,627			720	-	5,765	2,347	$ 11,373	$ 4,974
27	5400 RADIOLOGY-DIAGNOSTIC		0.177876	20,658	67,422			4,761	18,657	6,160	17,905	$ 31,579	$ 103,984
28	5500 RADIOLOGY-THERAPEUTIC		0.595423	-	209			-	-	-	643	$ -	$ 852
29	5700 CT SCAN		0.022376	45,315	125,055			33,587	11,977	20,562	48,125	$ 99,464	$ 185,157
30	5800 MRI		0.104687	9,126	-			3,042	6,084	7,363	3,042	$ 19,531	$ 9,126
31	6000 LABORATORY		0.127554	117,464	147,411			36,916	53,435	64,613	39,219	$ 218,993	$ 240,065
32	6500 RESPIRATORY THERAPY		0.510695	12,670	6,407			10,121	500	-	425	$ 22,791	$ 7,332
33	6600 PHYSICAL THERAPY		0.361054	4,521	-			1,556	-	3,472	206	$ 9,549	$ 206
34	6900 ELECTROCARDIOLOGY		0.184123	17,831	26,131			9,230	6,030	6,161	6,948	$ 33,222	$ 39,109
35	7000 ELECTROENCEPHALOGRAPHY		0.174567	-	87			-	8,695	-	832	$ -	$ 9,614
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.537307	12,354	5,433			5,093	834	11,777	14,949	$ 29,224	$ 21,216
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.500729	7,353	-			-	-	1,030	46,080	$ 8,383	$ 46,080
38	7300 DRUGS CHARGED TO PATIENTS		0.124270	158,917	95,935			36,480	9,424	116,713	136,213	$ 312,110	$ 241,572
39	7400 RENAL DIALYSIS		0.108284	-	-			-	-	1,541	-	$ 1,541	$ -
40	9000 CLINIC		0.328918	944	1,860			-	-	-	1,381	$ 944	$ 3,241
41	9100 EMERGENCY		0.650447	23,193	103,684			9,879	26,572	8,433	25,172	$ 41,505	$ 155,428
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
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109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 472,703	$ 603,186	$ -	$ -	$ 159,404	$ 150,298	$ 290,848	$ 359,862		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 589,075	$ 603,186	$ -	$ -	$ 183,316	$ 150,298	$ 330,642	$ 359,862	$ 1,103,033	$ 1,113,346
129	Total Charges per PS&R or Exhibit Detail			$ 589,075	$ 603,186	$ -	$ -	$ 183,316	$ 150,298	$ 330,642	$ 359,862		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 221,061	$ 131,450	$ -	$ -	$ 56,607	$ 35,509	$ 97,576	$ 80,796	$ 375,244	$ 247,755
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 22,562	$ 13,672				$ 2,133		$ 350	$ 22,562	$ 16,155
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -
134	Private Insurance (including primary and third party liability)				$ 621						$ 20,525	$ -	$ 21,146
135	Self-Pay (including Co-Pay and Spend-Down)			$ 25	$ 5,359				$ 47		$ 85	$ 25	$ 5,491
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 22,587	$ 19,652	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)							$ 55,954	$ 21,187		$ -	$ 55,954	$ 21,187
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 57,593	$ 40,072	$ 57,593	$ 40,072
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 198,474	$ 111,798	$ -	$ -	$ 653	$ 12,142	$ 39,983	$ 19,764	$ 239,110	$ 143,704
144	**Calculated Payments as a Percentage of Cost**			10%	15%	0%	0%	99%	66%	59%	76%	36%	42%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

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

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

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2022-09/30/2023) TIFT REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*				
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*				*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	480,007,511
19	Uninsured Hospital	**Charges Sec. G**	93,508,956
20	Total Hospital	**Charges Sec. G**	1,227,744,904
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		39.10%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.62%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$** -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	161,350,645
27	Uninsured Hospital	**Charges Sec. G**	98,952,861
28	Total Hospital	**Charges Sec. G**	1,227,744,904
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		13.14%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.06%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$** -

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

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

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*