State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: COOK 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	07/01/2016	06/30/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001251A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110101

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
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?	7/1/1966

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

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

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

Shannon Price, MD
Thomas D. Fausett, MD

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 42,790

Certification:

Answer
Yes

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature

Sr. VP & CFO
Title

11/2/18
Date

Kim Wills
Hospital CEO or CFO Printed Name

229-353-3397
Hospital CEO or CFO Telephone Number

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

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

Hospital Contact:

Name	Michael Purvis
Title	CEO
Telephone Number	229-896-8000
E-Mail Address	Michael.purvis@tiftregional.com
Mailing Street Address	706 North Parrish Avenue
Mailing City, State, Zip	Adel, GA 31620

Outside Preparer:

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

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 7/1/2016 - 6/30/2017

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

1. Select Your Facility from the Drop-Down Menu Provided:	COOK MEDICAL CENTER			
	7/1/2016 through 6/30/2017			
2. Select Cost Report Year Covered by this Survey:	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:	12/21/2017			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	COOK MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000001251A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110101	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2016 - 06/30/2017)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ -	$ 58,279	$58,279
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 33,273	$ 335,290	$368,563
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$33,273	$393,569	$426,842
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	14.81%	13.65%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2016 - 06/30/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	3,267

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	181,611
8.	Outpatient Hospital Charity Care Charges	1,120,236
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 1,301,847

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 1,078,102	$ -	$ -	$ 661,072	$ -	$ -	$ 417,030
12.	Psych Subprovider	$ 3,640,735	$ -	$ -	$ 2,232,430	$ -	$ -	$ 1,408,305
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 96,480			$ 59,160	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ 6,139,861			$ 3,764,847	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 6,570,699	$ 15,657,475	$ -	$ 4,029,029	$ 9,600,869	$ -	$ 8,598,276
20.	Outpatient Services		$ 4,184,489	$ -		$ 2,565,850	$ -	$ 1,618,639
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 503,049	$ 3,532,208	$ 1,510,392	$ 308,460	$ 2,165,883	$ 926,144	$ 1,560,913
27.	Total	$ 11,792,585	$ 23,374,172	$ 7,746,733	$ 7,230,991	$ 14,332,602	$ 4,750,151	$ 13,603,164
28.	Total Hospital and Non Hospital		Total from Above	$ 42,913,490		Total from Above	$ 26,313,744	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 42,913,490	Total Contractual Adj. (G-3 Line 2)	$ 26,313,744
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	$ -
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
35.	Adjusted Contractual Adjustments				26,313,744
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) | COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		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	$ 3,448,581	$ -	$ -	$ 73,640	**$ 3,374,941**	3,473	$ 4,815,317		**$ 971.77**
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
11	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 3,448,581	$ -	$ -	$ 73,640	$ 3,374,941	3,473	$ 4,815,317		
19	Weighted Average									$ 971.77

Line #		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
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	206	-	-	**$ 200,185**	$ 11,559	$ 223,461	$ 235,020	**0.851779**

Line #		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
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$ 132,581	$ -	$ -		**$ 132,581**	$ 5,804	$ 227,209	$ 233,013	**0.568985**
22	5300 ANESTHESIOLOGY	$ 4,587	$ -	$ -		**$ 4,587**	$ 622	$ 39,627	$ 40,249	**0.113966**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 901,006	$ -	$ -		**$ 901,006**	$ 425,465	$ 6,198,951	$ 6,624,416	**0.136013**
24	6000 LABORATORY	$ 1,359,475	$ -	$ -		**$ 1,359,475**	$ 1,300,153	$ 4,742,517	$ 6,042,670	**0.224979**
25	6500 RESPIRATORY THERAPY	$ 114,716	$ -	$ -		**$ 114,716**	$ 198,548	$ 74,120	$ 272,668	**0.420717**
26	6600 PHYSICAL THERAPY	$ 321,008	$ -	$ -		**$ 321,008**	$ 616,227	$ 428,408	$ 1,044,635	**0.307292**
27	6601 PHYSICAL THERAPY - SNF	$ 386,314	$ -	$ -		**$ 386,314**	$ 855,261	$ 168,470	$ 1,023,731	**0.377359**
28	6900 ELECTROCARDIOLOGY	$ 36,811	$ -	$ -		**$ 36,811**	$ 192,413	$ 808,235	$ 1,000,648	**0.036787**
29	7000 ELECTROENCEPHALOGRAPHY	$ 36,526	$ -	$ -		**$ 36,526**	$ 10,000	$ 306,200	$ 316,200	**0.115515**
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 111,169	$ -	$ -		**$ 111,169**	$ 127,402	$ 159,349	$ 286,751	**0.387685**
31	7300 DRUGS CHARGED TO PATIENTS	$ 955,078	$ -	$ -		**$ 955,078**	$ 2,838,804	$ 2,504,389	$ 5,343,193	**0.178747**
32	9100 EMERGENCY	$ 878,773	$ -	$ -		**$ 878,773**	$ 257,433	$ 3,692,036	$ 3,949,469	**0.222504**

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
34		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
35		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
36		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
37		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
38		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
39		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
40		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
41		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
42		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
43		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
44		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
45		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
46		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
47		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
48		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
49		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
50		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
51		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
52		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
53		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
54		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
55		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
56		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
57		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
58		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
59		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
60		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
61		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
62		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
63		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
64		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
65		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
66		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
67		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
68		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
69		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
70		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
71		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
72		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
73		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
74		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
75		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
76		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
77		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
78		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
79		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
80		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
81		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
82		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
83		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
84		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
90		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
91		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
92		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
93		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
94		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126	**Total Ancillary**	$ 5,238,044	$ -	$ -		$ 5,238,044	$ 6,839,691	$ 19,572,972	$ 26,412,663	
127	**Weighted Average**									0.205895
128	**Sub Totals**	$ 8,686,625	$ -	$ -		$ 8,612,985	$ 11,655,008	$ 19,572,972	$ 31,227,980	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ 193,173				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01	Other Cost Adjustments (support must be submitted)					$ -				
132	**Grand Total**					**$ 8,419,812**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

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

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

Cost Report Year (07/01/2016-06/30/2017) COOK 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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 971.77		112		14		658		121		57		**905**		29.45%
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		-		
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300 NURSERY	$ -		-		-		-		-		-		-		
18			**Total Days**	112		14		658		121		57		905		29.45%
19	Total Days per PS&R or Exhibit Detail			109		14		658		121		57				
20	Unreconciled Days (Explain Variance)			**3**		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 100,800		$ 23,780		$ 880,460		$ 142,590		$ 61,420		$ 1,147,630		25.11%
21.01	Calculated Routine Charge Per Diem			$ 900.00		$ 1,698.57		$ 1,338.09		$ 1,178.43		$ 1,077.54		$ 1,268.10		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.851779	$ 1,002	$ 10,418	$ -	$ 12,026	$ 4,175	$ 50,705	$ 1,238	$ 12,790	$ 945	$ 51,919	$ 6,415	$ 85,939	61.79%
23	5000 OPERATING ROOM		0.568985	$ -	$ 21,131	$ -	$ 6,001	$ 51	$ 16,494	$ 25	$ 10,754	$ 76	$ 16,598	$ 76	$ 54,380	30.53%
24	5300 ANESTHESIOLOGY		0.113966	$ -	$ 2,327	$ -	$ 355	$ -	$ 942	$ -	$ 977	$ -	$ 1,173	$ -	$ 4,601	14.34%
25	5400 RADIOLOGY-DIAGNOSTIC		0.136013	**$ 16,912**	**$ 380,744**	$ 3,630	$ 549,210	$ 100,209	$ 679,571	$ 20,652	$ 291,649	$ 29,121	$ 1,224,904	$ 141,403	$ 1,901,174	49.76%
26	6000 LABORATORY		0.224979	**$ 56,091**	**$ 514,636**	$ 19,120	$ 168,250	$ 267,901	$ 386,271	$ 84,643	$ 257,273	$ 60,654	$ 899,646	$ 427,755	$ 1,326,430	44.92%
27	6500 RESPIRATORY THERAPY		0.420717	$ 3,007	$ 1,182	$ 238	$ 18,601	$ 5,568	$ 13,197	$ 8,214	$ 4,408	$ 2,525	$ 3,792	$ 17,027	$ 37,388	22.27%
28	6600 PHYSICAL THERAPY		0.307292	$ 22,496	$ 2,647	$ 792	$ 81,660	$ 72,143	$ 85,418	$ 11,541	$ 35,132	$ 1,972	$ 20,900	$ 106,972	$ 204,857	32.04%
29	6601 PHYSICAL THERAPY - SNF		0.377359	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
30	6900 ELECTROCARDIOLOGY		0.036787	$ 7,427	$ 18,404	$ 498	$ 4,569	$ 23,958	$ 81,735	$ 13,401	$ 29,157	$ 1,939	$ 47,643	$ 45,284	$ 133,865	22.86%
31	7000 ELECTROENCEPHALOGRAPHY		0.115515	$ -	$ -	$ -	$ 7,400	$ -	$ 57,170	$ -	$ 13,510	$ -	$ 31,500	$ -	$ 78,080	34.66%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.387685	**$ 6,004**	**$ 18,930**	$ 1,485	$ 24,077	$ 21,042	$ 23,328	$ 10,929	$ 8,449	$ 4,650	$ 45,733	$ 39,460	$ 74,784	57.41%
33	7300 DRUGS CHARGED TO PATIENTS		0.178747	**$ 109,410**	**$ 70,244**	$ 10,417	$ 124,585	$ 585,972	$ 288,540	$ 116,454	$ 84,303	$ 69,674	$ 432,525	$ 822,253	$ 567,672	35.41%
34	9100 EMERGENCY		0.222504	**$ 12,718**	**$ 295,586**	$ 3,941	$ 602,385	$ 54,225	$ 324,075	$ 16,414	$ 137,783	$ 17,324	$ 991,727	$ 87,298	$ 1,359,829	62.19%
35			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				235,067	1,336,249	40,121	1,599,119	1,135,244	2,007,444	283,511	886,185	188,880	3,768,060			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			**$ 335,867**	**$ 1,336,249**	**$ 63,901**	**$ 1,599,119**	**$ 2,015,704**	**$ 2,007,444**	**$ 426,101**	**$ 886,185**	**$ 250,300** (Agrees to Exhibit A)	**$ 3,768,060** (Agrees to Exhibit A)	**$ 2,841,573**	**$ 5,828,997**	40.63%
129	Total Charges per PS&R or Exhibit Detail			$ 323,744	$ 1,309,257	$ 63,901	$ 1,599,119	$ 2,015,704	$ 2,007,444	$ 426,101	$ 886,185	$ 250,300	$ 3,768,060			
130	Unreconciled Charges (Explain Variance)			12,123	26,992	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 157,777**	**$ 276,382**	**$ 22,077**	**$ 325,830**	**$ 867,268**	**$ 406,153**	**$ 176,705**	**$ 178,959**	**$ 93,697**	**$ 751,920**	$ 1,223,827	$ 1,187,324	38.68%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			**$ 108,203**	**$ 238,827**	$ -	$ -	$ 55,815	$ 36,935	$ 17,209	$ 17,210			$ 181,227	$ 292,972	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 33,959	$ 287,204	$ -	$ -	$ -	$ -			$ 33,959	$ 287,204	
134	Private Insurance (including primary and third party liability)			$ 212	**$ 89**	$ -	$ -	$ -	$ -	$ 164,173	$ 174,442			$ 164,385	$ 174,531	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	**$ 945**	$ -	$ 4,590	$ 808	$ 1,147	$ -	$ 224			$ 808	$ 6,906	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 108,415	$ 239,861	$ 33,959	$ 291,794									
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)							$ 561,777	$ 225,608	$ -	$ -			$ 561,777	$ 225,608	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ 725			$ -	$ 725	
141	Medicare Cross-Over Bad Debt Payments							$ 6,252	$ 9,534	$ -	$ -			$ 6,252	$ 9,534	
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)											$ -	$ 58,279			
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)**			$ 49,362	$ 36,521	$ (11,882)	$ 34,036	$ 242,616	$ 132,929	$ (4,677)	$ (13,642)	$ 93,697	$ 693,641	$ 275,419	$ 189,844	
146	**Calculated Payments as a Percentage of Cost**			69%	87%	154%	90%	72%	67%	103%	108%	0%	8%	77%	84%	
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)**							2,872								
148	**Percent of cross-over days to total Medicare days from the cost report**							23%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if 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 pay
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From 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	$ 971.77		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
11		$ -		-		-		-		-		-	
12		$ -		-		-		-		-		-	
13		$ -		-		-		-		-		-	
14		$ -		-		-		-		-		-	
15		$ -		-		-		-		-		-	
16		$ -		-		-		-		-		-	
17		$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.851779	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.568985	-	-	-	-	-	-	-	-	$ -	$ -
24	5300 ANESTHESIOLOGY		0.113966	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.136013	-	-	-	-	-	-	-	-	$ -	$ -
26	6000 LABORATORY		0.224979	-	-	-	-	-	-	-	-	$ -	$ -
27	6500 RESPIRATORY THERAPY		0.420717	-	-	-	-	-	-	-	-	$ -	$ -
28	6600 PHYSICAL THERAPY		0.307292	-	-	-	-	-	-	-	-	$ -	$ -
29	6601 PHYSICAL THERAPY - SNF		0.377359	-	-	-	-	-	-	-	-	$ -	$ -
30	6900 ELECTROCARDIOLOGY		0.036787	-	-	-	-	-	-	-	-	$ -	$ -
31	7000 ELECTROENCEPHALOGRAPHY		0.115515	-	-	-	-	-	-	-	-	$ -	$ -
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.387685	-	-	-	-	-	-	-	-	$ -	$ -
33	7300 DRUGS CHARGED TO PATIENTS		0.178747	-	-	-	-	-	-	-	-	$ -	$ -
34	9100 EMERGENCY		0.222504	-	-	-	-	-	-	-	-	$ -	$ -
35			-	-	-	-	-	-	-	-	-	$ -	$ -
36			-	-	-	-	-	-	-	-	-	$ -	$ -
37			-	-	-	-	-	-	-	-	-	$ -	$ -
38			-	-	-	-	-	-	-	-	-	$ -	$ -
39			-	-	-	-	-	-	-	-	-	$ -	$ -
40			-	-	-	-	-	-	-	-	-	$ -	$ -
41			-	-	-	-	-	-	-	-	-	$ -	$ -
42			-	-	-	-	-	-	-	-	-	$ -	$ -
43			-	-	-	-	-	-	-	-	-	$ -	$ -
44			-	-	-	-	-	-	-	-	-	$ -	$ -
45			-	-	-	-	-	-	-	-	-	$ -	$ -
46			-	-	-	-	-	-	-	-	-	$ -	$ -
47			-	-	-	-	-	-	-	-	-	$ -	$ -
48			-	-	-	-	-	-	-	-	-	$ -	$ -
49			-	-	-	-	-	-	-	-	-	$ -	$ -
50			-	-	-	-	-	-	-	-	-	$ -	$ -
51			-	-	-	-	-	-	-	-	-	$ -	$ -
52			-	-	-	-	-	-	-	-	-	$ -	$ -
53			-	-	-	-	-	-	-	-	-	$ -	$ -
54			-	-	-	-	-	-	-	-	-	$ -	$ -
55			-	-	-	-	-	-	-	-	-	$ -	$ -
56			-	-	-	-	-	-	-	-	-	$ -	$ -
57			-	-	-	-	-	-	-	-	-	$ -	$ -
58			-	-	-	-	-	-	-	-	-	$ -	$ -
59			-	-	-	-	-	-	-	-	-	$ -	$ -
60			-	-	-	-	-	-	-	-	-	$ -	$ -
61			-	-	-	-	-	-	-	-	-	$ -	$ -
62			-	-	-	-	-	-	-	-	-	$ -	$ -
63			-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
73			-	-	-	-	-	-	-	-	-	$ -	$ -
74			-	-	-	-	-	-	-	-	-	$ -	$ -
75			-	-	-	-	-	-	-	-	-	$ -	$ -
76			-	-	-	-	-	-	-	-	-	$ -	$ -
77			-	-	-	-	-	-	-	-	-	$ -	$ -
78			-	-	-	-	-	-	-	-	-	$ -	$ -
79			-	-	-	-	-	-	-	-	-	$ -	$ -
80			-	-	-	-	-	-	-	-	-	$ -	$ -
81			-	-	-	-	-	-	-	-	-	$ -	$ -
82			-	-	-	-	-	-	-	-	-	$ -	$ -
83			-	-	-	-	-	-	-	-	-	$ -	$ -
84			-	-	-	-	-	-	-	-	-	$ -	$ -
85			-	-	-	-	-	-	-	-	-	$ -	$ -
86			-	-	-	-	-	-	-	-	-	$ -	$ -
87			-	-	-	-	-	-	-	-	-	$ -	$ -
88			-	-	-	-	-	-	-	-	-	$ -	$ -
89			-	-	-	-	-	-	-	-	-	$ -	$ -
90			-	-	-	-	-	-	-	-	-	$ -	$ -
91			-	-	-	-	-	-	-	-	-	$ -	$ -
92			-	-	-	-	-	-	-	-	-	$ -	$ -
93			-	-	-	-	-	-	-	-	-	$ -	$ -
94			-	-	-	-	-	-	-	-	-	$ -	$ -
95			-	-	-	-	-	-	-	-	-	$ -	$ -
96			-	-	-	-	-	-	-	-	-	$ -	$ -
97			-	-	-	-	-	-	-	-	-	$ -	$ -
98			-	-	-	-	-	-	-	-	-	$ -	$ -
99			-	-	-	-	-	-	-	-	-	$ -	$ -
100			-	-	-	-	-	-	-	-	-	$ -	$ -
101			-	-	-	-	-	-	-	-	-	$ -	$ -
102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
104			-	-	-	-	-	-	-	-	-	$ -	$ -
105			-	-	-	-	-	-	-	-	-	$ -	$ -
106			-	-	-	-	-	-	-	-	-	$ -	$ -
107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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

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

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

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

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

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

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion 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	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2016-06/30/2017) COOK MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 130,536		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	72460-70893	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 130,536	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 130,536		

DSH UCC Provider Tax Assessment Adjustment:

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

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

DSH Examination Eligibility Summary

Hospital Name	**COOK MEDICAL CENTER**
Hospital Medicaid Number	**000001251A**
Cost Report Period	From **7/1/2016** To **6/30/2017**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 555,784	$ 245,414	$ 801,198
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 555,784	$ 245,414	$ 801,198
4	Net Hospital Patient Revenue	Survey F-3	$ 13,603,164	$ -	$ 13,603,164
5	Medicaid Fraction		4.09%	1.80%	5.89%
6	Inpatient Charity Care Charges	Survey F-2	$ 181,611	$ -	$ 181,611
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 181,611	$ -	$ 181,611
10	Inpatient Hospital Charges	Survey F-3	$ 11,792,585	$ -	$ 11,792,585
11	Inpatient Charity Fraction		1.54%	0.00%	1.54%
12	LIUR		5.63%	1.80%	7.43%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	902	3	905
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		902	3	905
16	Total Hospital Days (excludes swing-bed)	Survey F-1	3,267	-	3,267
17	MIUR		27.61%	0.09%	27.70%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **COOK MEDICAL CENTER**
Hospital Medicaid Number: **000001251A**
Cost Report Period: From **7/1/2016** To **6/30/2017**

As-Reported:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	152,911	102,650	-	212	-	-	-	-	-	-	-			102,862	50,049	67.27%
2 Medicaid Fee for Service	Outpatient	267,318	-	-	-	-	-	-	-	-	-	-			-	267,318	0.00%
3 Medicaid Managed Care	Inpatient	22,077	-	33,959	-	-	-	-							33,959	(11,882)	153.82%
4 Medicaid Managed Care	Outpatient	325,830	-	287,204	-	4,590	-	-							291,794	34,036	89.55%
5 Medicare Cross-over (FFS)	Inpatient	867,268	55,815	-	-	808		-	561,777	-	6,252	-			624,652	242,616	72.03%
6 Medicare Cross-over (FFS)	Outpatient	406,153	36,935	-	-	1,147		-	225,608	-	9,534	-			273,224	132,929	67.27%
7 Other Medicaid Eligibles	Inpatient	176,705	17,209	-	164,173	-			-	-	-	-			181,382	(4,677)	102.65%
8 Other Medicaid Eligibles	Outpatient	178,959	17,210	-	174,442	224			-	725	-	-			192,601	(13,642)	107.62%
9 Uninsured	Inpatient	93,697	-	-	-	-	-	-	-	-	-	-	-	-	-	93,697	0.00%
10 Uninsured	Outpatient	751,920	-	-	-	-	-	-	-	-	-	-	58,279	-	58,279	693,641	7.75%
11 In-State Sub-total	Inpatient	1,312,658	175,674	33,959	164,385	808	-	-	561,777	-	6,252	-	-	-	942,855	369,803	71.83%
12 In-State Sub-total	Outpatient	1,930,180	54,145	287,204	174,442	5,961	-	-	225,608	725	9,534	-	58,279	-	815,898	1,114,282	42.27%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15 Sub-Total	I/P and O/P	3,242,838	229,819	321,163	338,827	6,769	-	-	787,385	725	15,786	-	58,279	-	1,758,753	1,484,085	54.23%

Adjustments:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	4,866	5,553	-	-	-	-	-	-	-	-	-			5,553	(687)	1.44%
2 Medicaid Fee for Service	Outpatient	9,064	238,827	-	89	945	-	-	-	-	-	-			239,861	(230,797)	86.79%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	4,866	5,553	-	-	-	-	-	-	-	-	-	-	-	5,553	(687)	0.16%
12 In-State Sub-total	Outpatient	9,064	238,827	-	89	945	-	-	-	-	-	-	-	-	239,861	(230,797)	12.17%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15 Sub-Total	I/P and O/P	13,930	244,380	-	89	945	-	-	-	-	-	-	-	-	245,414	(231,484)	7.30%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **COOK MEDICAL CENTER**
Hospital Medicaid Number: **000001251A**
Cost Report Period: From **7/1/2016** To **6/30/2017**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	157,777	108,203	-	212	-	-	-	-	-	-	-			108,415	49,362	68.71%
2	Medicaid Fee for Service	Outpatient	276,382	238,827	-	89	945	-	-	-	-	-	-			239,861	36,521	86.79%
3	Medicaid Managed Care	Inpatient	22,077	-	33,959	-	-	-	-							33,959	(11,882)	153.82%
4	Medicaid Managed Care	Outpatient	325,830	-	287,204	-	4,590	-	-							291,794	34,036	89.55%
5	Medicare Cross-over (FFS)	Inpatient	867,268	55,815	-	-	808		-	561,777	-	6,252	-			624,652	242,616	72.03%
6	Medicare Cross-over (FFS)	Outpatient	406,153	36,935	-	-	1,147		-	225,608	-	9,534	-			273,224	132,929	67.27%
7	Other Medicaid Eligibles	Inpatient	176,705	17,209	-	164,173	-			-	-	-	-			181,382	(4,677)	102.65%
8	Other Medicaid Eligibles	Outpatient	178,959	17,210	-	174,442	224			-	725	-	-			192,601	(13,642)	107.62%
9	Uninsured	Inpatient	93,697	-	-	-	-	-	-	-	-	-	-	-	-	-	93,697	0.00%
10	Uninsured	Outpatient	751,920	-	-	-	-	-	-	-	-	-	-	58,279	-	58,279	693,641	7.75%
11	In-State Sub-total	Inpatient	1,317,524	181,227	33,959	164,385	808	-	-	561,777	-	6,252	-	-	-	948,408	369,116	71.98%
12	In-State Sub-total	Outpatient	1,939,244	292,972	287,204	174,531	6,906	-	-	225,608	725	9,534	-	58,279	-	1,055,759	883,485	54.44%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	3,256,768	474,199	321,163	338,916	7,714	-	-	787,385	725	15,786	-	58,279	-	2,004,167	1,252,601	61.54%

16 Less: Out of State DSH Payments from Adjusted Survey -
17 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments 1,252,601

Medicaid DSH Survey Adjustments

PROVIDER: COOK MEDICAL CENTER
FROM: 7/1/2016 TO: 6/30/2017
Mcaid Number: 000001251A
Mcare Number: 110101

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	H - In-State	1	ADULTS & PEDIATRICS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	109	3	112	HS&R
	H - In-State	21	Routine Charges	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 98,100	$ 2,700	$ 100,800	HS&R
	H - In-State	25	RADIOLOGY-DIAGNOSTIC	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 16,432	$ 480	$ 16,912	HS&R
	H - In-State	26	LABORATORY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 55,253	$ 838	$ 56,091	HS&R
	H - In-State	32	MEDICAL SUPPLIES CHARGED TO PATIENT	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 5,223	$ 781	$ 6,004	HS&R
	H - In-State	33	DRUGS CHARGED TO PATIENTS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 104,010	$ 5,400	$ 109,410	HS&R
	H - In-State	34	EMERGENCY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 10,794	$ 1,924	$ 12,718	HS&R
	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dowr	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 102,650	$ 5,553	$ 108,203	HS&R
	H - In-State	23	OPERATING ROOM	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 11,531	$ 9,600	$ 21,131	HS&R
	H - In-State	25	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 377,537	$ 3,207	$ 380,744	HS&R
	H - In-State	26	LABORATORY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 505,029	$ 9,607	$ 514,636	HS&R
	H - In-State	32	MEDICAL SUPPLIES CHARGED TO PATIENT	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 18,769	$ 161	$ 18,930	HS&R
	H - In-State	33	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 69,314	$ 930	$ 70,244	HS&R
	H - In-State	34	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ 292,099	$ 3,487	$ 295,586	HS&R
	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dowr	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ -	$ 238,827	$ 238,827	HS&R
	H - In-State	134	Private Insurance (including primary and third party liabilit	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ -	$ 89	$ 89	HS&R
	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to most recent HS&R report	$ -	$ 945	$ 945	HS&R

Medicaid DSH Report Notes

PROVIDER: COOK MEDICAL CENTER
Mcaid Number: 000001251A
FROM: 7/1/2016 TO: 6/30/2017
Mcare Number: 110101

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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