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

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Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act. During the Interim DSH Payment Year: Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) List the Names of the two Obstetricians (or case of rural hospital. Physicians) who have agreed to perform OB services: 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? 6. Is the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations	3b. What date did the hospital open?			1	7/1/1966		
During the Interim DSH Payment Year: Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services: Shannon Price, MD Thomas D. Fausett, MD Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age? 6. Is the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations				11	77171800		
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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? 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	List the Names of the two Obstetricians (or case of rural hospital, P	hysicians) who have agreed to pe	form OB services:				
5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age? 6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations	Shannon Price, MD						
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emergency obstetric services to the general population when federal Medicaid DSH regulations		·					
				· [No		
	emergency obstetric services to the general population when federal were enacted on December 22, 1987?	al Medicaid DSH regulations					

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018 (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) 96 984

Certification:

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

Answer	
Yes	

Explanation for "No" answers:

Hospital CEO or CFO Printed Name

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

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

Hospital CEO or CFO Telephone Number

Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name Stuart Hastings

Title Affiliate Controller Telephone Number 229-896-8139

E-Mail Address Stuart Hasty@tiftregional.com Mailing Street Address

Outside Preparer:

Name Jesus F. Ruiz, CPA

Title: President

Firm Name: Reimbursement Solutions Group, LLC

Telephone Number 404-788-4861

E-Mail Address jesus nuiz@rsgga.com

Page 1

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

DSH Version 7.30 3/26/2019 D. General Cost Report Year Information 7/1/2017 6/30/2018 The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey. COOK MEDICAL CENTER 1. Select Your Facility from the Drop-Down Menu Provided: 7/1/2017 through 6/30/2018 2. Select Cost Report Year Covered by this Survey (enter "X"): 3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted 3a. Date CMS processed the HCRIS file into the HCRIS database: 5/10/2019 Correct? Data If Incorrect, Proper Information COOK MEDICAL CENTER 4. Hospital Name: 5. Medicaid Provider Number: 000001251A Yes 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab): Yes 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab): Yes 110101 8. Medicare Provider Number: Yes Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt. Yes DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Small Rural Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year: Provider No. State Name 9. State Name & Number 10. State Name & Number 11. State Name & Number 12. State Name & Number 13. State Name & Number 14. State Name & Number 15. State Name & Number (List additional states on a separate attachment) E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2017 - 06/30/2018) 1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1) 2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 4. Total Section 1011 Payments Related to Hospital Services (See Note 1) 5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1) 6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) 7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1) 8. Out-of-State DSH Payments (See Note 2) Total Inpatient Outpatient 24,120 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) \$24,120 28,483 149,666 \$178,149 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments) \$28,483 \$173,786 \$202,269 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 0.00% 13.88% 11.92% 13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? No Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments. 14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services

Property of Myers and Stauffer LC

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

16. Total Medicaid managed care non-claims payments (see question 13 above) received

Printed 6/24/2020

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2017 - 06/30/2018)

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

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

(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.

1. Hospital
Subprovider I (Psych or Rehab)
3. Subprovider II (Psych or Rehab)
4. Swing Bed - SNF
5. Swing Bed - NF
Skilled Nursing Facility
7. Nursing Facility
8. Other Long-Term Care
9. Ancillary Services
20. Outpatient Services
21. Home Health Agency
22. Ambulance
23. Outpatient Rehab Providers
24. ASC
25. Hospice
26. Other

35. Adjusted Contractual Adjustments

13. Subprovider II (Psych or Rehab)		\$0.00			
14. Swing Bed - SNF					\$84,675.00
15. Swing Bed - NF					\$0.00
16. Skilled Nursing Facility					\$5,969,868.00
17. Nursing Facility					\$0.00
18. Other Long-Term Care					\$0.00
19. Ancillary Services		\$7,271,161.00		\$10,918,224.00	
20. Outpatient Services				\$447,765.00	
21. Home Health Agency					\$0.00
22. Ambulance					\$ -
23. Outpatient Rehab Providers					\$0.00
24. ASC		\$0.00		\$0.00	
25. Hospice					\$0.00
26. Other		\$560,399.00		\$0.00	\$2,450,234.00
27. Total	\$	13,289,952	\$	11,365,989	\$ 8,504,777
28. Total Hospital and Non Hospital				Total from Above	\$ 33,160,718
29. Total Per Cost Report		Total Patier	nt Rev	enues (G-3 Line 1)	33,160,718
 Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheerenue) 	heet G-	3, Line 2 (impact is a	decre	ase in net patient	
 Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDI net patient revenue) 	ED on v	worksheet G-3, Line 2	(impa	act is a decrease in	
 Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revent decrease in net patient revenue) 	ue INCI	LUDED on worksheet	G-3, I	ine 2 (impact is a	
 Increase worksheet G-3, Line 2 to reverse offset of State and Local Patier Line 2 (impact is a decrease in net patient revenue) 	nt Care	Cash Subsidies INCL	.UDE[on worksheet G-3,	
 Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCI increase in net patient revenue) 	LUDED	on worksheet G-3, Li	ne 2 (impact is an	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"	y Care	Charges related to ins	ured p	patients INCLUDED	

	Total	Patie	nt Revenues (Charge	es)		Contra	ctual Adjustments	(formul	as below can be o	verwrit	ten if amounts are		
Inp	atient Hospital		utpatient Hospital		Non-Hospital	Inpat	ient Hospital	Outp	atient Hospital	١	Ion-Hospital	Net	Hospital Revenue
	\$634,409.00 \$4,823,983.00 \$0.00					\$ \$ \$	306,997 2,334,377	\$ \$		\$ \$	-	\$ \$ \$	327,412 2,489,606
					\$84,675.00 \$0.00 \$5,969,868.00 \$0.00					\$ \$ \$	40,975 - 2,888,883		
	\$7,271,161.00		\$10,918,224.00 \$447,765.00		\$0.00	\$	3,518,592	\$	5,283,445 216,678	\$	-	\$	9,387,348 231,087
	\$0.00		\$0.00	\$	\$0.00 \$0.00	\$	-	\$	-	\$ \$ \$	-	\$	-
	\$560,399.00		\$0.00		\$2,450,234.00	\$	271,183	\$	-	\$	1,185,694	\$	289,216
\$	13,289,952	\$	11,365,989 Total from Above	\$ \$	8,504,777 33,160,718	\$	6,431,149	\$ Total f	5,500,123 from Above	\$ \$	4,115,552 16,046,825	\$	12,724,668

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${\bf State~of~Georgia}$ Disproportionate Share Hospital (DSH) Examination Survey Part II

G. Cost Report - Cost / Days / Charges

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

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. Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* Routine Cost Centers (list below): Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y)* Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet D-1, Part I, Line 26 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Report Worksheet D-1, Part I, Line 26 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet C, Part I, Col. 2 and Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet C, Part I, Col. 2 and Col. 4 Cost Report Worksheet C, Part I, Col. 2	rient Routine rges - Cost rt Worksheet Pt. I, Col. 6 mational only pass used in on L charges llocation)	Calculated Per Diem
1 03000 ADULTS & PEDIATRICS \$ 3,987,401 \$ - \$ - \$0.00 \$ 3,987,401 \$ 4,275 \$		
2 03100 INTENSIVE CARE UNIT \$ - \\$ - \\$	5,543,067.00	\$ 932.73
		\$ -
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 \$ - \\$ - \\$ \		\$ - \$ -
7		\$ -
9 04200 OTHER SUBPROVIDER		\$ -
10 04300 NURSERY		\$ -
11		\$ -
		\$ -
13 \$ - \$ - \$ - \$	\$0.00	\$ -
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15 \$ - \$ - \$ - \$	\$0.00	\$ -
16 \$ - \$ - \$ - \$		\$ -
17 \$ - \\$ - \\$ - \-	\$0.00	\$ -
18 Total Routine \$ 3,987,401 \$ - \$ - \$ 3,987,401 4,275 \$	5,543,067	
19 Weighted Average		\$ 932.73
Hospital Subprovider I Subprovider II Inpatient Charges - Outpa	tient Charges - Total Charges -	
Observation Days - Observation Days - Observation Days - Calculated (Per Cost Report Cost	ost Report Cost Report	Medicaid Calculated
Cost Report W/S S- Cost Report W/S S- Diems Above Workshoot C Pt 1 Worksho	sheet C, Pt. I, Worksheet C, Pt. I,	Cost-to-Charge Ratio
3, Pt. I, Line 28, Col. 3, Pt. I, Line 28.02, Multiplied by Days)	Col. 7 Col. 8	Cost-to-Charge Natio
Observation Data (Non-Distinct) 8 Col. 8 Col. 8	301.7	
20 09200 Observation (Non-Distinct) 118 \$ 110,062 \$53,190.00	\$394,575.00 \$ 447,765	0.245803
20 (05200 (Observation (Noti-Distinct))	\$394,373.00 \$ 447,703	0.243003
Cost Report Cost Report Inpatient Charges - Outpa	tient Charges - Total Charges -	
Cost Report Worksheet B, Worksheet C	ost Report Cost Report	Medicaid Calculated
Worksheet B, Part I, Col. 25 Part I, Col. 25 Part I, Col. 2 and Calculated Worksheet C, Pt. I, Worksheet C	sheet C, Pt. I, Worksheet C, Pt. I,	Cost-to-Charge Ratio
Part I, Col. 26 (Intern & Resident Col. 4) Col. 4 Vol. 31 Col. 6	Col. 7 Col. 8	
Offset ONLY)*		
Ancillary Cost Centers (from W/S C excluding Observation) (list below)		
21 5000 OPERATING ROOM \$155,357.00 \$ - \$0.00 \$ 155,357 \$100.00	\$417,267.00 \$ 417,367	0.372231
	3,995,071.00 \$ 4,289,378	0.177674
	3,127,805.00 \$ 4,165,013	0.273425
24 6500 RESPIRATORY THERAPY \$129,465.00 \$ - \$0.00 \$ 129,465 \$93,584.00	\$23,053.00 \$ 116,637	1.109982
25 6600 PHYSICAL THERAPY \$365,884.00 \$ - \$0.00 \$ 365,884 \$794,094.00	\$430,076.00 \$ 1,224,170	0.298883
26 6601 PHYSICAL THERAPY - SNF \$426,443.00 \$ - \$0.00 \$ \$426,443 \$1,425,683.00	\$100,376.00 \$ 1,526,059	0.279441
	1,065,841.00 \$ 1,187,024	0.031555
28	\$275,100.00 \$ 275,100 \$17,319.00 \$ 224,032	0.124017 0.441718
The state of the s	\$17,319.00 \$ 224,032 1,466,316.00 \$ 4,764,605	0.441718
30 7300 DROGS CHARGED TO PATIENTS \$912,279.00 \$ - \$0.00 \$ 912,279 \$3,298,289.00 \$ 31	\$0.00 \$	0.191470
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G. Cost Report - Cost / Days / Charges

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

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

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		\$0.00	\$ -	\$0.00	\$	- \$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	- \$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	- \$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	- \$0.00	\$0.00	\$ -	-
		\$0.00	\$ -	\$0.00	\$	- \$0.00			-
		\$0.00		\$0.00	\$	- \$0.00			-
		\$0.00		\$0.00	\$	- \$0.00		\$ -	-
		\$0.00	•	\$0.00	\$	- \$0.00		\$ -	-
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		\$0.00		\$0.00	\$	- \$0.00			-
		\$0.00		\$0.00	\$	- \$0.00		\$ -	-
		\$0.00		\$0.00	\$	- \$0.00			<u>-</u>
		\$0.00		\$0.00	\$	- \$0.00			-
	Total Ancillary	\$ 4.060.892			\$ 4.060.8				
	Weighted Average	4,000,092	- ·	-	φ 4,000,0	σz ψ 7,324,331	ψ 11,312,799	φ 10,037,130	0.223798
	Sub Totals	\$ 8,048,293	\$ - :	\$ -	\$ 8,048,2	93 \$ 12,867,418	\$ 11,312,799	\$ 24,180,217	
Work NF, S	SNF, and Swing Bed Cost for Medicaid (S (Sheet D, Part V, Title 19, Column 5-7, Lir SNF, and Swing Bed Cost for Medicare (S	ne 200) Sum of applicable Cost Re	,		\$0. \$234,293.				
	sheet D, Part V, Title 18, Column 5-7, Lir SNF, and Swing Bed Cost for Other Paye	,	e. Submit support for ca	alculation of cost.)		_			
	r Cost Adjustments (support must be sub								
Other		mineu)				00			
	Grand Total				\$ 7,814,0				
Total	Intern/Resident Cost as a Percent of Oth	er Allowable Cost			0.0	0%			

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

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

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

	Cost F	Report Year (07/01/2017-06/30/2018)	COOK MEDICAL CE	NTER													
									In-State Medicare F	FS Cross-Overs (with	In-State Other Me	dicaid Eligibles (Not					%
			Medicald Per	Medicaid Cost to	In-State Medic	aid FFS Primary	In-State Medicaid N	lanaged Care Primary	Medicaid :	Secondary)	Included I	Elsewhere)	Unir	sured	Total In-Sta	le Medicaid	Survey to Cost
		a Cont Contro December	Diem Cost for	Charge Ratio for	Inpatient	Out-attant	Inpatient	0	tt	Outputlant	tt	Outrotton.	Inpatient	Outpatient (See Exhibit A)	to a street	Out-attant	Report
	Line	e # Cost Center Description	Routine Cost	Ancillary Cost	From PS&R	Outpatient From PS&R	From PS&R	Outpatient From PS&R	Inpatient From PS&R	Outpatient From PS&R	Inpatient From PS&R	Outpatient From PS&R	(See Exhibit A) From Hospital's Own		Inpatient	Outpatient	Totals
			From Section G	From Section G							Summary (Note A)	Summary (Note A)					
	Routin	ine Cost Centers (from Section G): D ADULTS & PEDIATRICS	\$ 932.73		Days 128		Days		Days 995		Days 32		Days 20		Days 1,162		28.43%
2	03100	INTENSIVE CARE UNIT	\$ 932.73		128				995		32		20		1,102		28.43%
3	03200	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	\$ - \$ -														
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -												-		
6	03500	O OTHER SPECIAL CARE UNIT	\$ - \$ -												-		
8	04100	D SUBPROVIDER I D SUBPROVIDER II D OTHER SUBPROVIDER	\$ - \$ -												-		
10	04300	0 NURSERY	\$ -												-		
11 12			s -												-		
13			\$ -												-		
14 15			s -												-		
16 17			\$ -												-		
18				Total Days	128		7		995		32		20		1,162		27.65%
19	Total I	Days per PS&R or Exhibit Detail			128		7	1	995		32		20				
20	roun .	Unreconciled Days (Ex	plain Variance)		-	! :		<u> </u> -	-								
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21 21.01		Routine Charges Calculated Routine Charge Per Diem			\$ 125,866 \$ 983.33		\$ 7,000 \$ 1,000.00		\$ 1,451,670 \$ 1,458.96		\$ 40,590 \$ 1,268.44		\$ 20,810 \$ 1,040.50		\$ 1,625,126 \$ 1,398.56		29.69%
21.01		llary Cost Centers (from W/S C) (from Section G								Anaillana Chargas				Anoillany Charges			
22	09200	Observation (Non-Distinct)): 	0.245803	Ancillary Charges 3,676	Ancillary Charges 8,944	Ancillary Charges	10,587	Ancillary Charges 3,202	Ancillary Charges 38,212	Ancillary Charges 2,232	Ancillary Charges 18,664	Ancillary Charges 237	Ancillary Charges 11,712	Ancillary Charges \$ 9,110	Ancillary Charges \$ 76,407	
23 24		000 OPERATING ROOM 400 RADIOLOGY-DIAGNOSTIC		0.372231 0.177674	11,732	5,530 163,076	16.258	16,956 263,163	177 52,124	45,138 497,362	8,817	13,610 227,650	76 8.146	20,246 326,378	\$ 177 \$ 88,931	\$ 81,234 \$ 1,151,251	25.06% 36.74%
25	60	000 LABORATORY		0.273425	69,380	219,968	5,467	110,522	275,766	107,971	22,752	161,812	19,319	229,305	\$ 373,365	\$ 600,273	29.42%
26 27	66	500 RESPIRATORY THERAPY 600 PHYSICAL THERAPY		1.109982 0.298883	2,871 14,243	574 1,533	1,332 1,059	28,651 31,777	4,808 133,398	2,955 69,335	732 4,629	1,334 47,173	1,723	583 33,414	\$ 9,743 \$ 153,329	\$ 33,514 \$ 149,818	39.06% 27.49%
28 29		601 PHYSICAL THERAPY - SNF 900 ELECTROCARDIOLOGY		0.279441 0.031555	4.718	19.539	-	-	7.458	133 565	747	64 667	249	49 612	\$ - \$ 12,923	\$ - \$ 217.771	0.00%
30	70	000 ELECTROCARDIOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.124017		-	-	-	-	73,650	-	16,700	-	11,100	s -	\$ 90,350	36.88%
31 32	71	100 MEDICAL SUPPLIES CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS		0.441718 0.191470	4,608 100,145	3,715 21,861	764 1,300	1,142 5.816	14,392 843,154	8,074 280,033	2,481 22,025	2,122 77.863	2,069 19.879	2,240 97,120	\$ 22,245 \$ 966,624	\$ 15,053 \$ 385,573	18.60% 30.84%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

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

									In-State Medicare F	FS Cross-Overs (with	In-State Oth	her Medicaid Eligibles (Not				%
			lr.	-State Medicaid FFS F	Primary	In-State Med	licaid Managed C	are Primary	Medicaid	Secondary)	Inc	duded Elsewhere)		Uninsured	Total In-	tate Medicaid Surve
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127			<u>s</u>	211,373 \$	444,740	\$ 2	6,180 \$	468.614	\$ 1,334,478	\$ 1,256,296	\$ 6	4,415 \$ 631,	95 \$ 51,6	98 \$ 781,710		
	Totals / Payments															
					-			1	r -	ı r.		10.	- C-	1.0	1.	11.
128	Total Charges (includes organ acquisition from Section	J)	\$	337,239 \$	444,740	\$ 3	\$ \$	468,614	\$ 2,786,148	\$ 1,256,296	\$ 10	5,005 \$ 631,	95 \$ 72,5 (Agrees to Exhibit	\$ 781,710 A) (Agrees to Exhibit A)	\$ 3,261,572	\$ 2,801,245 28.64
129	Total Charges per PS&R or Exhibit Detail		e	337,239 \$	444,740	e -	3.180 \$	468,614	\$ 2,786,148	\$ 1,256,296	S 10	5,005 \$ 631,			1	
130	Unreconciled Charges (Explain Variance)				444,740			400,014	2,700,140	1,200,200	10.	- 001,		. 101,710	1	
			_			F-					10.				1	10-
131	Total Calculated Cost (includes organ acquisition from Sec	ction J)	\$	170,151 \$	100,915	\$ 1	3,294 \$	128,808	\$ 1,226,820	\$ 238,621	\$ 4:	5,716 \$ 129,	82 \$ 32,	11 \$ 164,263	\$ 1,455,98	\$ 598,226 28.83
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		S	135,116 \$	72,211	S 1	4,670 \$	85,563	\$ 21,427	\$ 20,264	S .	4,973 \$ 9,	43		\$ 176,18	\$ 187,681
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-	-Down) (See Note F)	-				- 1 -	,0			t F	\$ 2,			\$	\$ 2,692
134	Private Insurance (including primary and third party liability)	,,(====================================					-		\$ 1,184	\$ 156	\$ 2	1,177 \$ 74,			\$ 22,36	
135	Self-Pay (including Co-Pay and Spend-Down)			S	611		\$	527					02		\$	\$ 1,740
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$	135,116 \$	72,822	\$ 1	4,670 \$	86,090								
137	Medicaid Cost Settlement Payments (See Note B)			\$	(56)										\$	\$ (56)
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)														\$	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductible								\$ 912,853	\$ 130,927	-	9.059 \$ 2	51		\$ 912,853	
140 141	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductible Medicare Cross-Over Bad Debt Payments	15)							\$ 58.739	\$ 6.126	5	9,059 \$ 2,			\$ 9,050 \$ 58,730	
141	Other Medicare Cross-Over Bad Debt Payments Other Medicare Cross-Over Payments (See Note D)								φ 56,739	o 6,128	1		(Agrees to Exhibit B ar	d B- (Agrees to Exhibit B and B-	φ 58,735 ¢	9 0,120
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)								1		-			\$ 24,120	1.7	11-
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in E	Exhibits B & B-1 (from Se	ection E)										s	S -		
																7.
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PA	AYMENTS AND DSH)	\$	35,035 \$	28,149	\$	(1,376) \$	42,718	\$ 232,617			0,507 \$ 39,		11 \$ 140,143		
146	Calculated Payments as a Percentage of Cost			79%	72%		110%	67%	81%	665		77%	9%	0% 15%	819	68%
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Ber	d (C/R, W/S S-3, Pt. I. Co	ol. 6, Sum of	Lns. 2, 3, 4, 14, 16. 1	7, 18 less lines	8.6)			3,306	1						
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 p	aid claims summary Fo	r Managed C	are. Cross-Over data	and other eligible	s, use the hosnit	al's logs if PS&R	summaries are n	ot available (submit Ion	s with survey).			NOTE: Innations	ininsured payment rate is	outside normal range	s. please verify this
	Note B - Medicaid cost settlement payments refer to payments made by Medical Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific pay	id during a cost report se	ttlement that	are not reflected on the	claims paid sur	nmary (RA summ	nary or PS&R).						is correct.	paymon rate is		a, p. a.a.o roiny uno

Note A. Those amounts must agree to you'r inpatient and output inpatient i

I. Out-of-State Medicaid Data:

				Out-of-State Med	dicaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs aid Secondary)		Medicaid Eligibles (Not Elsewhere)	Total Out-Of-	State Medicaid
Line#	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatie
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
Routine Cos	st Centers (list below):			Days		Days		Days		Days		Days	
	LTS & PEDIATRICS	\$ 932.73										-	
	NSIVE CARE UNIT ONARY CARE UNIT	\$ - \$ -										-	
	N INTENSIVE CARE UNIT	\$ - \$ -										-	
	GICAL INTENSIVE CARE UNIT	\$ -										_	
	ER SPECIAL CARE UNIT	\$ -										-	
	PROVIDER I	\$ -										-	
	PROVIDER II	\$ -										-	
	ER SUBPROVIDER	\$ -										-	
04300 NUR	SERY	\$ -										-	
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		\$ -										-	
			Total Days	-		-		-		-		-	
Routi	er PS&R or Exhibit Detail Unreconciled Days (E	Explain Variance)		- Routine Charges		- Routine Charges		- Routine Charges		- Routine Charges] -]	Routine Charges	
Routi	Unreconciled Days (E	Explain Variance)		-		Routine Charges		Routine Charges		-] -		
Routi Calcu Ancillary Co	Unreconciled Days (E ine Charges ulated Routine Charge Per Dierr lost Centers (from W/S C) (list below):	Explain Variance)	0.245803	-	Ancillary Charges	Routine Charges \$ - Ancillary Charges	Ancillary Charges	Routine Charges \$ - Ancillary Charges	Ancillary Charges	-	Ancillary Charges		Ancillary (
Routi Calcu Ancillary Co	Unreconciled Days (E ine Charges alated Routine Charge Per Dierr	Explain Variance)	0.245803 0.372231	Routine Charges		\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	Ancillary (
Routi Calcu Ancillary Co 09200 Obse 5000 OPEI 5400 RADI	Unreconciled Days (E ine Charges lated Routine Charge Per Dierr lated Routine Charge Per Dierr lated Routine (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC	Explain Variance)	0.372231 0.177674	Routine Charges	2,876 1,404	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	Ancillary (
Routi Calcu Ancillary Co 09200 Obse 5000 OPEI 5400 RADI 6000 LABO	Unreconciled Days (E ine Charges Jalated Routine Charge Per Dierr ist Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM JOLOGY-DIAGNOSTIC JRATORY	Explain Variance)	0.372231 0.177674 0.273425	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ -	\$ \$ \$
Routi Calcu Ancillary Co 09200 Obse 5000 OPE1 5400 RADI 6000 LABO 6500 RESI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr lest Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY PIRATORY PIRATORY	Explain Variance)	0.372231 0.177674 0.273425 1.109982	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ Ancillary Charges \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$
Routi Calcu Page O Obse 5000 OPEI 5000 LABO 6500 RESI 6600 PHY3	Unreconciled Days (E ine Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY PIRATORY PHERAPY SICAL THERAPY	Explain Variance)	0.372231 0.177674 0.273425 1.109982 0.298883	Routine Charges	2,876 1,404 2,997 -	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - \$ Ancillary Charges \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$
Routi Calcu Pancillary Co 19200 Obse 5000 OPEI 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY	Unreconciled Days (E ine Charges Jated Routine Charge Per Dierr Inst Centers (from W/S C) (list below): Invation (Non-Distinct) RATING ROOM JOLOGY-DIAGNOSTIC JRATORY JRATORY JRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF	Explain Variance)	0.372231 0.177674 0.273425 1.109982 0.298883 0.279441	Routine Charges	2,876 1,404 2,997	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$
Routi Calcu 99200 Obse 5000 OPEI 5400 RADI 6000 LABC 6500 PHY3 6600 PHY3 6900 ELEC	Unreconciled Days (E ine Charges lated Routine Charge Per Dierr lest Centers (from W/S C) (list below): invation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY SICAL THERAPY STROCARDIOLOGY	Explain Variance)	0.372231 0.177674 0.273425 1.10982 0.298883 0.279441 0.031555	Routine Charges	2,876 1,404 2,997 -	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$	\$ \$ \$ \$ \$
Routi Calculary Co 19200 Obse 5000 OPEI 5400 RADI 6000 LABC 6500 RESI 6600 PHY3 6601 PHY3 6900 ELEC	Unreconciled Days (E ine Charges Jated Routine Charge Per Dierr Inst Centers (from W/S C) (list below): Invation (Non-Distinct) RATING ROOM JOLOGY-DIAGNOSTIC JRATORY JRATORY JRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF		0.372231 0.177674 0.273425 1.109982 0.298883 0.279441	Routine Charges	- 2,876 1,404 2,997 - - -	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	\$ - Ancillary Charges \$ - \$ \$ - \$ \$ - \$ \$ \$ - \$ \$	\$ \$ \$ \$ \$
Routi Calco	Unreconciled Days (E ine Charges Jated Routine Charge Per Dierr Interest Centers (from W/S C) (list below): Invation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SIGAL THERAPY SIGAL THERAPY SIGAL THERAPY - SNF STROCARDIOLOGY STROCARDIOLOGY STROCENCEPHALOGRAPHY		0.372231 0.177674 0.273425 1.109982 0.298883 0.279441 0.031555 0.124017	Routine Charges	2,876 1,404 2,997 	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi Calco	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi Calco	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco Calco Ancillary Co 90900 Obsee 5000 OPE 5400 RADI 6000 LABC 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Routi Calco	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco Ancillary Co 909200 Obsee 5000 OPEE 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco Ancillary Co 909200 Obsee 5000 OPEE 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco Ancillary Co 909200 Obsee 5000 OPEE 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco Calco Ancillary Co 90900 Obsee 5000 OPE 5400 RADI 6000 LABC 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	
Routi Calco	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routi Calco Ancillary Co 909200 Obsee 5000 OPEE 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routi Calco Ancillary Co 909200 Obsee 5000 OPEE 5400 RADI 6000 LABC 6500 RESI 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routi Calco Calco Ancillary Co 90900 Obsee 5000 OPE 5400 RADI 6000 LABC 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges lated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM IOLOGY-DIAGNOSTIC DRATORY PIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routi Calco Calco Ancillary Co 90900 Obsee 5000 OPE 5400 RADI 6000 LABC 6600 PHY 6601 PHY 6900 ELEC 7100 MEDI	Unreconciled Days (E ne Charges Jated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY JIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
Routi Calco	Unreconciled Days (E ne Charges Jated Routine Charge Per Dierr set Centers (from W/S C) (list below): rivation (Non-Distinct) RATING ROOM OLOGY-DIAGNOSTIC DRATORY JIRATORY THERAPY SICAL THERAPY SICAL THERAPY - SNF CTROCARDIOLOGY CTROCARDIOLOGY CTROCONCEPHALOGRAPHY CAL SUPPLIES CHARGED TO PATIENT		0.372231 0.177674 0.273425 1.109982 0.29883 0.279441 0.031555 0.124017 0.441718 0.191470	Routine Charges	2,876 1,404 2,997 - - - - - - - - 59	\$ -	Ancillary Charges	\$ -	Ancillary Charges	Routine Charges	Ancillary Charges	S	\$ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL	CENTER					
	Out-of-S	tate Medicaid FFS Primary	Out-of-State Medicaid Managed Care Primary	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Total Out-Of-State Medicaid
50						\$ - \$
51						\$ - \$ - \$ - \$
52 53						\$ - \$ - \$ - \$
54	-					\$ - \$
55	-					\$ - \$
56 57						\$ - \$ - \$ - \$ -
58						\$ - \$
59	-					\$ -
60						\$ - \$ - \$ - \$
62	-					\$ - \$ -
63	-					\$ - \$ -
64	-					\$ -
65 66		——				\$ - \$ - \$ - \$
67						\$ - \$
68	-					\$ - \$
69 70	-			<u> </u>		\$ - \$ - \$ -
71						\$ - \$ - \$ - \$
72	-					\$ - \$ -
73	-					
74 75	-					\$ - \$ - \$ -
76						\$ - \$
77	-					\$ - \$ -
78	-					\$ -
79 80						\$ - \$ - \$ - \$
81	-					\$ - \$ -
82	-					\$ - \$
83 84						\$ - \$ - \$ - \$
85						\$ - \$
86	-					\$ - \$ -
87	-					\$ - \$ -
88 89	-	——				\$ - \$ - \$ - \$
90	-					\$ - \$ -
91	-					\$ - \$ -
92 93						\$ - \$ - \$ - \$
93						\$ - \ \\$ - \
95	-					\$ - \$ -
96	-					\$ -
97 98						\$ - \$ - \$ - \$
99						\$ - \$ -
100	-					\$ - \$ -
101	-					\$ - \$ -
102						\$ - \$ - \$ - \$
104	-					\$ - \$ -
105	-					\$ -
106	-	——				\$ - \$ - \$ - \$
107 108						\$ - \$ - \$ - \$ -
109	-					\$ - \$ -
110	-					\$ -
111	-					\$ - \$ -

I. Out-of-State Medicaid Data:

	Cost Report Year (07/01/2017-06/30/2018) COOK MEDICAL CENTER															
		Out-of-State Med	icaid FFS Primary	C		icaid Managed Care mary		Out-of-State Medica (with Medicai				ledicaid Eligibles (Not Elsewhere)		Total Out-Of-S	tate Medica	iid
112	-												\$		\$	-
113	-			4			_						\$	-	\$	-
114 115	-			4			_						\$	-	\$	-
115				┥┝──									\$	-	\$	-
117				┪┝──			- 1				_		\$		\$	
118	-			1 —			- 1						\$	_	\$	
119	-			1 -			-						\$	_	\$	-
120				1 -			-						\$	-	\$	-
121	-												\$	-	\$	-
122	-												\$	-	\$	-
123	-												\$	-	\$	-
124	-												\$	-	\$	-
125	-												\$	-	\$	-
126	-												\$	-	\$	-
127	-												\$	-	\$	-
		\$ -	\$ 7,568	\$	-	\$ -		\$ -	\$ -	\$	-	\$ -				
	Totals / Payments															
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 7,568		_	\$ -	— 1	\$ -	\$ -	e	-	s -	\$	-1	¢	7,568
		Ψ -			-	ų -	_ '	Ψ -	Ψ -	Ψ		-	Ψ		Ψ	7,500
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 7,568	\$	-	\$	-	\$ -	\$ -	\$	-	\$ -				
130	Unreconciled Charges (Explain Variance)				-		<u> </u>					-				
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 2,210	\$	-	\$ -	- 11	\$ -	\$ -	\$	-	\$ -	\$	-	\$	2,210
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)												\$	-	\$	-
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)						_						\$	-	\$	-
134	Private Insurance (including primary and third party liability)												\$	-	\$	-
135	Self-Pay (including Co-Pay and Spend-Down)			4 📖									\$	-	\$	-
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$	-	\$ -										
137	Medicaid Cost Settlement Payments (See Note B)												\$	-	\$	-
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						Щ,						\$	-	\$	-
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)												\$	-	\$	-
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)												\$	-	\$	-
141	Medicare Cross-Over Bad Debt Payments										_		\$		\$	-
142	Other Medicare Cross-Over Payments (See Note D)												\$		\$	-
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ 2,210		_	\$ -	– 11	\$ -	\$ -	e	_	s -	e		\$	2,210
143	Calculated Payments as a Percentage of Cost	- 0%	2,210	<u> </u>	- 0%	- (0%	- 0%	Ψ - 0%	Ÿ	0%	- 0%	Ψ	0%	Ψ	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medicale Education payments). Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

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

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

	Total		Revenue for	Total	In-State Medic	caid FFS Primary	In-State Medicaid	Managed Care Primary		FFS Cross-Overs (with Secondary)		edicaid Eligibles (Not Elsewhere)	Unir	nsured	
	Organ Acquisition Cost			Medicaid/ Cross- Over / Uninsured Organs Sold			Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organ (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add- On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D- 4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's C Internal Analysi							
Acquisition Cost Centers (list below):															
Lung Acquisition	\$0.00		\$ -		0										
Kidney Acquisition Liver Acquisition	\$0.00 \$0.00		\$ -		0										
Heart Acquisition			\$ -		0										
Pancreas Acquisition	\$0.00		\$ -		0										
Intestinal Acquisition	\$0.00 \$0.00		\$ -		0										
	\$0.00		\$ -		0										
Islet Acquisition	\$0.00		\$ -		0										
	\$0.00	-	\$ -		U										
Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	
Total Cost															

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

Note C: Enter Organ Acquisition regiments in section in as per to you in included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

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

		Total			Revenue for	Total	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add- On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid' Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D- 4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)				
Organ A	cquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	\$ -		\$ -	-	\$ -	-	\$ -	-	\$ -	-
20 Note A	Total Cost These amounts must agree to your innation	t and outpatient M	ndicaid naid claime	cummary if available	lif not use hespital's k	age and euhmit w	ith curvey	-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

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

Worksheet A Provid	ler Tax Assessment Reconcil	liation:			
			Dollar Amount	W/S A Cost Center Line	
1 Hospital G	ross Provider Tax Assessment (fro	om general ledger)*			
		count # that includes Gross Provider Tax Assessment			(WTB Account #)
		luded 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 1	ax Assessment Reclassification	ns (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))
8 9 10 11	Reason for adjustment Reason for adjustment Reason for adjustment Reason for adjustment	sessment Adjustments (from w/s A-8 of the Medicare cost report) A Assessment Adjustments (from w/s A-8 of the Medicare cost report)			(Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from)) (Adjusted to / (from))
15	Reason for adjustment				
	Provider Tax Assessment Expense Tax Assessment Adjustment:	·	-		
DOI! COO! TOVIGO!	rax riosessment rajustinent				
17 Gross Allo	wable Assessment Not Included in	the Cost Report	\$ -		
Apportion	ment of Provider Tax Assessme	nt Adjustment to Medicaid & Uninsured:			
18	Medicaid Hospital Charg	ges Sec. G	6,070,385		
19	Uninsured Hospital Charg	ges Sec. G	854,218		
20	Total Hospital Charg	ges Sec. G	24,180,217		
21	Percentage of Provider Tax Asse	essment Adjustment to include in DSH Medicaid UCC	25.10%		
22	Percentage of Provider Tax Asse	essment Adjustment to include in DSH Uninsured UCC	3.53%		
23	Medicaid Provider Tax Assessme	ent Adjustment to DSH UCC	\$ -		
24	Uninsured Provider Tax Assessn	nent Adjustment to DSH UCC	\$ -		
25 Provider T	ax Assessment Adjustment to DSF	HUCC	\$ -		

^{*} 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.