

## A. General DSH Year Information

1. DSH Year: 

Begin	End
07/01/2017	06/30/2018

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

### Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1  
4. Cost Report Year 2 (if applicable)  
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
10/01/2017	09/30/2018

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

6. Medicaid Provider Number:  
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):  
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):  
9. Medicare Provider Number:

Data
000001922A
0
0
110095

## B. DSH OB Qualifying Information

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

### During the DSH Examination Year:

- 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.)
- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?

DSH Examination  
Year (07/01/17 -  
06/30/18)

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

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

### During the Interim DSH Payment Year:

- 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.)

DSH Payment Year  
(07/01/19 - 06/30/20)

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

- Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

**C. Disclosure of Other Medicaid Payments Received:**

**1. Medicaid Supplemental Payments for DSH Year 07/01/2017 - 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.)

\$ 2,428,499

**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:

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

10/22/19  
Date

Kim Wills  
Hospital CEO or CFO Printed Name

229-353-3397  
Hospital CEO or CFO Telephone Number

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

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

**Hospital Contact:**

Name	Tonia Waldrop
Title	Controller
Telephone Number	229-353-3804
E-Mail Address	Tonia.Waldrop@tiffregional.com
Mailing Street Address	901 East 18th Street

**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

DSH Version 7.30

3/26/2019

**D. General Cost Report Year Information** 10/1/2017 - 9/30/2018

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

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

TIFT REGIONAL MEDICAL CENTER

2. Select Cost Report Year Covered by this Survey (enter "X"):

10/1/2017 through 9/30/2018 X

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

1 - As Submitted

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

3/12/2019

4. Hospital Name:

TIFT REGIONAL MEDICAL CENTER

5. Medicaid Provider Number:

000001922A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110095

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

Non-State Govt.

DSH Pool Classification (Small Rural, Non-Small Rural, Urban):

Non-Small Rural

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

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)

State Name	Provider No.

**E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)**

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)

2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**

5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)

6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**

8. **Out-of-State DSH Payments (See Note 2)**

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

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)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-
\$-

Inpatient	Outpatient	Total
\$ 45,595	\$ 608,254	\$653,849
\$ 921,435	\$ 7,735,963	\$8,657,398
\$967,030	\$8,344,217	\$9,311,247
4.71%	7.29%	7.02%

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

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

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

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

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

\$-

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

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

## F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2017 - 09/30/2018)

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

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

44,707

(See Note in Section F-3, below)

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

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified I/P and O/P Hospital Subsidies
5. Non-Hospital Subsidies
6. Total Hospital Subsidies

\$ -

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

\$ -

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$54,212,163.00			\$ 38,463,156	\$ -	\$ -	\$ 15,749,007
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$306,984,106.00	\$696,628,073.00		\$ 217,803,107	\$ 494,252,816	\$ -	\$ 291,556,255
20. Outpatient Services		\$82,765,805.00			\$ 58,721,768	\$ -	\$ 24,044,037
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$5,174,661.00			\$ 3,671,386	
26. Other	\$27,074,898.00	\$162,139,718.00	\$0.00	\$ 19,209,454	\$ 115,037,012	\$ -	\$ 54,968,150
27. Total	\$ 388,271,167	\$ 941,533,596	\$ 5,174,661	\$ 275,475,717	\$ 668,011,597	\$ 3,671,386	\$ 386,317,449
28. Total Hospital and Non Hospital		Total from Above	\$ 1,334,979,424		Total from Above	\$ 947,158,700	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,334,979,424	Total Contractual Adj. (G-3 Line 2)	947,158,700
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				
35. Adjusted Contractual Adjustments				947,158,700

**G. Cost Report - Cost / Days / Charges**

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		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

**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.

**Routine Cost Centers (list below):**

1	03000	ADULTS & PEDIATRICS	\$ 34,979,564	\$ -	\$ -	\$0.00	\$ 34,979,564	43,568	\$35,123,256.00	\$ 802.87
2	03100	INTENSIVE CARE UNIT	\$ 10,592,984	\$ -	\$ -		\$ 10,592,984	5,770	\$19,088,907.00	\$ 1,835.87
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 1,289,574	\$ -	\$ -		\$ 1,289,574	3,708	\$3,545,559.00	\$ 347.78
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine		\$ 46,862,122	\$ -	\$ -	\$ -	\$ 46,862,122	53,046	\$ 57,757,722	
19	Weighted Average									\$ 883.42

**Observation Data (Non-Distinct)**

20	09200	Observation (Non-Distinct)		8,339	-	\$ 6,695,133	\$7,651,408.00	\$15,751,451.00	\$ 23,402,859	0.286082
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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

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	\$18,743,092.00	\$ -	\$0.00	\$ 18,743,092	\$24,212,487.00	\$70,018,061.00	\$ 94,230,548	0.198907
22	5100	RECOVERY ROOM	\$2,199,154.00	\$ -	\$0.00	\$ 2,199,154	\$2,893,487.00	\$4,437,882.00	\$ 7,331,369	0.299965
23	5200	DELIVERY ROOM & LABOR ROOM	\$2,824,339.00	\$ -	\$0.00	\$ 2,824,339	\$5,465,640.00	\$33,282.00	\$ 5,498,922	0.513617
24	5300	ANESTHESIOLOGY	\$4,646,651.00	\$ -	\$0.00	\$ 4,646,651	\$4,791,584.00	\$11,525,432.00	\$ 16,317,016	0.284773
25	5400	RADIOLOGY-DIAGNOSTIC	\$15,635,624.00	\$ -	\$0.00	\$ 15,635,624	\$10,791,145.00	\$61,545,577.00	\$ 72,336,722	0.216151
26	5700	CT SCAN	\$1,712,272.00	\$ -	\$0.00	\$ 1,712,272	\$19,887,195.00	\$66,415,226.00	\$ 86,302,421	0.019840
27	5800	MRI	\$1,583,284.00	\$ -	\$0.00	\$ 1,583,284	\$3,384,872.00	\$15,993,948.00	\$ 19,378,820	0.081702
28	6000	LABORATORY	\$13,824,998.00	\$ -	\$0.00	\$ 13,824,998	\$58,411,808.00	\$96,272,020.00	\$ 154,683,828	0.089376
29	6500	RESPIRATORY THERAPY	\$4,524,851.00	\$ -	\$0.00	\$ 4,524,851	\$19,293,148.00	\$4,416,503.00	\$ 23,709,651	0.190844
30	6600	PHYSICAL THERAPY	\$3,103,019.00	\$ -	\$0.00	\$ 3,103,019	\$4,800,311.00	\$4,821,339.00	\$ 9,621,650	0.322504
31	6900	ELECTROCARDIOLOGY	\$7,999,959.00	\$ -	\$0.00	\$ 7,999,959	\$20,747,141.00	\$40,426,724.00	\$ 61,173,865	0.130774

**G. Cost Report - Cost / Days / Charges**

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7000 ELECTROENCEPHALOGRAPHY	\$1,771,739.00	\$ -	\$0.00	\$ 1,771,739	\$1,079,936.00	\$10,606,099.00	\$ 11,686,035	0.151612
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$21,782,036.00	\$ -	\$0.00	\$ 21,782,036	\$19,720,478.00	\$16,338,079.00	\$ 36,058,557	0.604074
34	7200 IMPL. DEV. CHARGED TO PATIENTS	\$10,547,526.00	\$ -	\$0.00	\$ 10,547,526	\$21,706,552.00	\$19,855,819.00	\$ 41,562,371	0.253776
35	7300 DRUGS CHARGED TO PATIENTS	\$35,707,188.00	\$ -	\$0.00	\$ 35,707,188	\$84,823,126.00	\$210,433,066.00	\$ 295,256,192	0.120936
36	7400 RENAL DIALYSIS	\$4,443,598.00	\$ -	\$0.00	\$ 4,443,598	\$1,429,637.00	\$63,489,016.00	\$ 64,918,653	0.068449
37	9000 CLINIC	\$2,311,982.00	\$ -	\$0.00	\$ 2,311,982	\$0.00	\$1,282,726.00	\$ 1,282,726	1.802397
38	9100 EMERGENCY	\$13,771,064.00	\$ -	\$1,707,449.00	\$ 15,478,513	\$20,360,862.00	\$23,098,196.00	\$ 43,459,058	0.356163
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

**G. Cost Report - Cost / Days / Charges**

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	<b>Total Ancillary</b>	\$ 167,132,376	\$ -	\$ 1,707,449	\$ 168,839,825	\$ 331,450,817	\$ 736,760,446	\$ 1,068,211,263	
127	<b>Weighted Average</b>								0.164326
128	<b>Sub Totals</b>	\$ 213,994,498	\$ -	\$ 1,707,449	\$ 215,701,947	\$ 389,208,539	\$ 736,760,446	\$ 1,125,968,985	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	<b>Grand Total</b>				\$ 215,701,947				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

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

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals			
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)				
		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):																	
1	03000 ADULTS & PEDIATRICS	\$ 802.87		Days 2,834		Days 2,729		Days 4,363		Days 2,280		Days 3,389		Days 12,306	44.65%		
2	03100 INTENSIVE CARE UNIT	\$ 1,835.87		1,003		94		1,185		642		583		2,924	60.80%		
3	03300 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	\$ 347.78		221		2,397				40		114		2,658	74.81%		
11		\$ -												-			
12		\$ -												-			
13		\$ -												-			
14		\$ -												-			
15		\$ -												-			
16		\$ -												-			
17		\$ -												-			
18		\$ -												-			
Total Days				4,158		5,220		5,548		2,962		4,086		17,886	41.49%		
Total Days per PS&R or Exhibit Detail				4,158		5,220		5,548		2,962		4,086					
Unreconciled Days (Explain Variance)				-		-		-		-		-					
Routine Charges																	
Routine Charges		\$ 4,273,858		Routine Charges		\$ 5,447,480		Routine Charges		\$ 8,115,740		Routine Charges		\$ 3,804,233		\$ 21,847,311	45.54%
Calculated Routine Charge Per Diem		\$ 1,027.86		Routine Charges		\$ 1,043.58		Routine Charges		\$ 1,462.82		Routine Charges		\$ 1,264.35		\$ 1,200.82	
Ancillary Cost Centers (from W/S C) (from Section G):																	
22	06000 Observation (Non-District)	0.286082	629.886	Ancillary Charges	629.886	Ancillary Charges	797.481	Ancillary Charges	811.128	Ancillary Charges	1,265.508	Ancillary Charges	1,113.188	Ancillary Charges	2,496.133	Ancillary Charges	41.34%
23	8000 OPERATING ROOM	0.188907	1,249.839		2,225.801		2,517.980		5,059.465		2,558.568		6,672.812		1,250.068		39.22%
24	1100 RECOVERY ROOM	0.299865	142.965		317.387		204.321		736.553		313.820		822.012		153.224		47.28%
25	5200 DELIVERY ROOM & LABOR ROOM	0.513617	181.117		-		3,293.587		4,170		4,293		42.937		68.907		66.90%
26	5300 ANESTHESIOLOGY	0.284773	230.171		326.810		437.740		930.600		509.235		760.111		632.285		58.07%
27	5400 RADIOLOGY-DIAGNOSTIC	0.216151	823.334		2,920.948		1,486.129		3,255.106		1,729.221		7,130.085		2,668.399		33.63%
28	5700 CT SCAN	0.019840	1,479.890		3,157.715		484.070		4,700.693		7,384.471		1,052.317		5,664.992		38.41%
29	5800 MRI	0.081702	222.269		609.780		85.333		2,161.363		484.300		1,687.205		177.254		17.53%
30	6000 LABORATORY	0.089376	5,235.239		6,639.562		3,241.050		5,609.419		8,996.335		7,597.237		3,346.012		36.96%
31	6500 RESPIRATORY THERAPY	0.190844	978.604		131.134		244.910		137.666		1,238.482		912.691		67.293		40.70%
32	6600 PHYSICAL THERAPY	0.322504	341.462		513.349		71.867		193.118		811.017		302.266		362.666		27.28%
33	6800 ELECTROCARDIOLOGY	0.130774	1,077.024		886.503		342.609		1,049.176		3,338.176		5,223.469		1,403.870		29.28%
34	7000 ELECTROENCEPHALOGRAPHY	0.151612	36.565		50.372		10.703		17.138		198.155		1,467.305		121.793		43.36%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.604074	1,575.740		657.810		1,607.431		1,310.342		2,959.430		2,028.441		1,300.036		38.55%
36	7200 IMPL. DEV. CHARGED TO PATIENTS	0.253776	799.903		465.969		2,327.502		2,741.815		1,132.505		467.812		133.503		20.53%
37	7300 DRUGS CHARGED TO PATIENTS	0.120936	8,357.199		7,208.832		2,992.342		5,036.453		12,746.468		26,723.181		3,871.568		29.79%
38	7400 RENAL DIALYSIS	0.068449	165.861		-		18.347		-		280.350		108.817		-		0.98%
39	9000 CLINIC	1.802397	8.057		111.238		42.575		64.419		125.540		116.978		50.632		36.05%
40	9100 EMERGENCY	0.356163	1,972.121		2,563.563		401.423		4,697.516		3,456.065		3,063.392		694.755		69.22%
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**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

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

					In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Over (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Induced Elsewhere)		Uninsured		Total In-State Medicaid	% Survey				
86												\$ -	-				
87												\$ -	-				
88												\$ -	-				
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127												\$ -	-				
Totals / Payments																	
128	Total Charges (includes organ acquisition from Section J)				\$ 29,781,104	\$ 29,142,254	\$ 23,741,875	\$ 36,228,703	\$ 54,309,668	\$ 76,896,565	\$ 20,895,549	\$ 15,726,050	\$ 24,835,292	\$ 52,946,128	\$ 128,728,196	\$ 157,993,572	32.42%
129	Total Charges per PS&R or Exhibit Detail				\$ 29,781,104	\$ 29,142,254	\$ 23,741,875	\$ 36,228,703	\$ 54,309,668	\$ 76,896,565	\$ 20,895,549	\$ 15,726,050	\$ 24,835,292	\$ 52,946,128			
130	Unreconciled Charges (Explain Variance)																
131	Total Calculated Cost (includes organ acquisition from Section J)				\$ 8,934,596	\$ 4,867,593	\$ 8,105,493	\$ 6,749,464	\$ 14,159,248	\$ 12,692,782	\$ 6,390,433	\$ 2,324,200	\$ 7,510,395	\$ 8,698,951	\$ 37,589,770	\$ 26,634,039	37.34%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ 6,853,939	\$ 3,928,099			\$ 987,008	\$ 811,502	\$ 311,369	\$ 368,910			\$ 8,162,318	\$ 5,108,511	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)						\$ 6,110,577	\$ 4,936,252			\$ 10,631	\$ 3,048			\$ 6,121,208	\$ 4,939,300	
134	Private Insurance (including primary and third party liability)								\$ 523	\$ 7,452					\$ 691,953	\$ 102,224	
135	Self-Pay (including Co-Pay and Spend-Down)				\$ 75,763	\$ 24,489	\$ 34,423	\$ 14,546							\$ 110,402	\$ 38,456	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				\$ 6,929,702	\$ 3,952,588	\$ 6,145,000	\$ 4,950,798									
137	Medicaid Cost Settlement Payments (See Note B)					\$ 445,148											
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)																
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 10,590,670	\$ 9,496,748	\$ 10,538	\$ 4,032			\$ 10,601,009	\$ 9,500,791	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ 4,375,202	\$ 1,758,552				\$ 4,375,202	\$ 1,758,552	
141	Medicare Cross-Over Bad Debt Payments								\$ 128,982	\$ 298,847					\$ 128,982	\$ 298,847	
142	Other Medicare Cross-Over Payments (See Note D)																
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)												\$ 45,595	\$ 608,254			
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)				\$ 2,004,894	\$ 469,657	\$ 1,960,493	\$ 1,798,666	\$ 2,452,065	\$ 2,078,232	\$ 991,246	\$ 94,465	\$ 7,464,800	\$ 8,090,697	\$ 7,408,696	\$ 4,441,220	
146	Calculated Payments as a Percentage of Cost				78%	90%	76%	73%	83%	84%	84%	96%	1%	7%	80%	83%	
147	Total Medicare Days from WIS 5-3 of the Cost Report Excluding Swing-Bed (CIR, WIS 5-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)								23,950								
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 PSAR 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 PSAR).  
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.  
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).  
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

**I. Out-of-State Medicaid Data:**

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

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		From Section G	From Section G										
<b>Routine Cost Centers (list below):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>	
1	03000 ADULTS & PEDIATRICS	\$ 802.87		33								33	
2	03100 INTENSIVE CARE UNIT	\$ 1,835.87		1								1	
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	\$ 347.78		2								2	
11		\$ -										-	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
18		\$ -										-	
19			<b>Total Days</b>	36		-		-		-		36	
20	Total Days per PS&R or Exhibit Detail			36		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>		<b>Routine Charges</b>	
21.01	Calculated Routine Charge Per Diem			\$ 36,150		\$ -		\$ -		\$ -		\$ 36,150	
				\$ 1,004.17		\$ -		\$ -		\$ -		\$ 1,004.17	
<b>Ancillary Cost Centers (from W/S C) (list below):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>
22	09200 Observation (Non-Distinct)		0.286082	1,260	11,414							\$ 1,260	\$ 11,414
23	5000 OPERATING ROOM		0.198907	7,293	2,400							\$ 7,293	\$ 2,400
24	5100 RECOVERY ROOM		0.299965	959	232							\$ 959	\$ 232
25	5200 DELIVERY ROOM & LABOR ROOM		0.513617	9,631	-							\$ 9,631	\$ -
26	5300 ANESTHESIOLOGY		0.284773	2,946	818							\$ 2,946	\$ 818
27	5400 RADIOLOGY-DIAGNOSTIC		0.216151	454	24,048							\$ 454	\$ 24,048
28	5700 CT SCAN		0.019840	6,925	69,794							\$ 6,925	\$ 69,794
29	5800 MRI		0.081702	-	-							\$ -	\$ -
30	6000 LABORATORY		0.089376	32,461	66,527							\$ 32,461	\$ 66,527
31	6500 RESPIRATORY THERAPY		0.190844	3,198	4,844							\$ 3,198	\$ 4,844
32	6600 PHYSICAL THERAPY		0.322504	1,422	-							\$ 1,422	\$ -
33	6900 ELECTROCARDIOLOGY		0.130774	18,575	5,064							\$ 18,575	\$ 5,064
34	7000 ELECTROENCEPHALOGRAPHY		0.151612	-	-							\$ -	\$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.604074	7,325	2,893							\$ 7,325	\$ 2,893
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.253776	-	-							\$ -	\$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.120936	44,956	57,283							\$ 44,956	\$ 57,283
38	7400 RENAL DIALYSIS		0.068449	-	-							\$ -	\$ -
39	9000 CLINIC		1.802397	-	-							\$ -	\$ -
40	9100 EMERGENCY		0.356163	7,127	68,361							\$ 7,127	\$ 68,361
41			-									\$ -	\$ -
42			-									\$ -	\$ -
43			-									\$ -	\$ -
44			-									\$ -	\$ -
45			-									\$ -	\$ -
46			-									\$ -	\$ -
47			-									\$ -	\$ -
48			-									\$ -	\$ -
49			-									\$ -	\$ -

**I. Out-of-State Medicaid Data:**

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

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
50			-									\$ -	\$ -
51			-									\$ -	\$ -
52			-									\$ -	\$ -
53			-									\$ -	\$ -
54			-									\$ -	\$ -
55			-									\$ -	\$ -
56			-									\$ -	\$ -
57			-									\$ -	\$ -
58			-									\$ -	\$ -
59			-									\$ -	\$ -
60			-									\$ -	\$ -
61			-									\$ -	\$ -
62			-									\$ -	\$ -
63			-									\$ -	\$ -
64			-									\$ -	\$ -
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68			-									\$ -	\$ -
69			-									\$ -	\$ -
70			-									\$ -	\$ -
71			-									\$ -	\$ -
72			-									\$ -	\$ -
73			-									\$ -	\$ -
74			-									\$ -	\$ -
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81			-									\$ -	\$ -
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108			-									\$ -	\$ -
109			-									\$ -	\$ -
110			-									\$ -	\$ -
111			-									\$ -	\$ -

**I. Out-of-State Medicaid Data:**

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

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112				-									\$ -	\$ -
113				-									\$ -	\$ -
114				-									\$ -	\$ -
115				-									\$ -	\$ -
116				-									\$ -	\$ -
117				-									\$ -	\$ -
118				-									\$ -	\$ -
119				-									\$ -	\$ -
120				-									\$ -	\$ -
121				-									\$ -	\$ -
122				-									\$ -	\$ -
123				-									\$ -	\$ -
124				-									\$ -	\$ -
125				-									\$ -	\$ -
126				-									\$ -	\$ -
127				-									\$ -	\$ -
					\$ 144,532	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Totals / Payments</b>														
128	<b>Total Charges (includes organ acquisition from Section K)</b>				\$ 180,682	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 180,682	\$ 313,678
129	Total Charges per PS&R or Exhibit Detail				\$ 180,682	\$ 313,678	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-		
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>				\$ 55,945	\$ 51,183	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 55,945	\$ 51,183
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ 6,235	\$ 16,740							\$ 6,235	\$ 16,740
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 10,721	\$ 15,971							\$ 10,721	\$ 15,971
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)				\$ 16,956	\$ 32,711	\$ -	\$ -					\$ -	\$ -
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	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>				\$ 38,989	\$ 18,472	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 38,989	\$ 18,472
144	<b>Calculated Payments as a Percentage of Cost</b>				30%	64%	0%	0%	0%	0%	0%	0%	30%	64%

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

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

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

TIFT REGIONAL MEDICAL CENTER

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

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

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

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

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

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

TIFT REGIONAL MEDICAL CENTER

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

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

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

## L. Provider Tax Assessment Reconciliation / Adjustment

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

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

### Worksheet A Provider Tax Assessment Reconciliation:

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

### DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>	
18 Medicaid Hospital Charges Sec. G	287,216,128
19 Uninsured Hospital Charges Sec. G	77,781,420
20 Total Hospital Charges Sec. G	1,125,968,985
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	25.51%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	6.91%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC	\$ -

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

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