

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2016	06/30/2017

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	04/01/2016	03/31/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001262A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110132

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:

- | | |
|--|---|
| 1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) | DSH Examination Year (07/01/16 - 06/30/17)
<input type="text" value="Yes"/> |
| 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age? | <input type="text" value="No"/> |
| 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987? | <input type="text" value="No"/> |
| 3a. Was the hospital open as of December 22, 1987? | <input type="text" value="Yes"/> |
| 3b. What date did the hospital open? | <input type="text" value="4/1/1960"/> |

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:

- | | |
|--|---|
| 4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.) | DSH Payment Year (07/01/18 - 06/30/19)
<input type="text" value="Yes"/> |
| List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services: | |
| <input type="text" value="Dr. Whitney Vance"/> | |
| <input type="text" value="Dr. Jason Moye"/> | |
| 5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age? | <input type="text" value="No"/> |
| 6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987? | <input type="text" value="No"/> |

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017

(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 327,806

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.

	CEO	
Hospital CEO or CFO Signature	Title	Date
Jim Lambert	229-246-3500	JimL@mh-m.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Jim Lambert
Title	CEO
Telephone Number	229-246-3500
E-Mail Address	JimL@mh-m.org
Mailing Street Address	1500 East Shotwell Street
Mailing City, State, Zip	Bainbridge, GA 39818

Outside Preparer:

Name	Bert Bennett
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bbennett@draffin-tucker.com

D. General Cost Report Year Information 4/1/2016 - 3/31/2017

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

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

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

4/1/2016 through 3/31/2017		
	X	

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

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	MEMORIAL HOSPITAL & MANOR-BAINBRIDGE	Yes	
5. Medicaid Provider Number:	000001262A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110132	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (04/01/2016 - 03/31/2017)

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

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 23,716	\$ 225,962	\$249,678
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 177,859	\$ 1,236,602	\$1,414,461
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)	\$201,575	\$1,462,564	\$1,664,139
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.77%	15.45%	15.00%

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 (04/01/2016 - 03/31/2017)

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

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

6,846

(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

	2,514,066
	2,303,977
\$	4,818,043

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	\$5,701,420.00			\$ 3,759,413	\$ -	\$ -	\$ 1,942,007
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$2,478,517.00			\$ 1,634,289	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$7,158,410.00			\$ 4,720,126	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$22,194,590.00	\$47,725,127.00		\$ 14,634,710	\$ 31,469,084	\$ -	\$ 23,815,923
20. Outpatient Services		\$14,421,958.00			\$ 9,509,578	\$ -	\$ 4,912,380
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			\$24,553,901.00	\$ -	\$ -	\$ 16,190,397	\$ -
27. Total	\$ 27,896,010	\$ 62,147,085	\$ 34,190,828	\$ 18,394,123	\$ 40,978,661	\$ 22,544,812	\$ 30,670,310
28. Total Hospital and Non Hospital		Total from Above	\$ 124,233,923	Total from Above	\$ 81,917,597		

- 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1)
- 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient 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)
- 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

124,233,923

Total Contractual Adj. (G-3 Line 2)

81,206,989

	710,608
	81,917,597

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

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	\$ 5,107,726	\$ -	\$ -	\$282,524.00	\$ 4,825,202	6,901	\$4,466,883.00	\$ 699.20
2	03100	INTENSIVE CARE UNIT	\$ 1,750,375	\$ -	\$ -		\$ 1,750,375	1,020	\$1,335,908.00	\$ 1,716.05
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	\$ 228,482	\$ -	\$ -		\$ 228,482	750	\$456,360.00	\$ 304.64
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 7,086,583	\$ -	\$ -	\$ 282,524	\$ 6,804,059	8,671	\$ 6,259,151	
19		Weighted Average								\$ 784.69

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	1,825	-	-	\$ 1,276,040	\$354,546.00	\$3,405,438.00	\$ 3,759,984	0.339374

	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	\$2,342,321.00	\$ -	\$0.00	\$ 2,342,321	\$3,009,279.00	\$7,812,087.00	\$ 10,821,366	0.216453
22	5200	DELIVERY ROOM & LABOR ROOM	\$1,531,532.00	\$ -	\$0.00	\$ 1,531,532	\$2,327,295.00	\$387,235.00	\$ 2,714,530	0.564198
23	5400	RADIOLOGY-DIAGNOSTIC	\$2,476,376.00	\$ -	\$0.00	\$ 2,476,376	\$2,542,308.00	\$14,478,643.00	\$ 17,020,951	0.145490
24	6000	LABORATORY	\$3,368,258.00	\$ -	\$0.00	\$ 3,368,258	\$4,450,526.00	\$13,528,430.00	\$ 17,978,956	0.187344
25	6500	RESPIRATORY THERAPY	\$1,079,305.00	\$ -	\$0.00	\$ 1,079,305	\$3,654,184.00	\$2,541,124.00	\$ 6,195,308	0.174213
26	6600	PHYSICAL THERAPY	\$1,387,981.00	\$ -	\$0.00	\$ 1,387,981	\$1,915,615.00	\$2,145,788.00	\$ 4,061,403	0.341749
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$862,314.00	\$ -	\$0.00	\$ 862,314	\$1,701,434.00	\$3,548,807.00	\$ 5,250,241	0.164243
28	7300	DRUGS CHARGED TO PATIENTS	\$2,170,160.00	\$ -	\$0.00	\$ 2,170,160	\$3,364,759.00	\$3,234,245.00	\$ 6,599,004	0.328862
29	9000	CLINIC	\$125,165.00	\$ -	\$0.00	\$ 125,165	\$4,000.00	\$304,888.00	\$ 308,888	0.405212

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

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
30	9100 EMERGENCY	\$2,289,797.00	\$ -	\$28,217.00	\$ 2,318,014	\$1,801,151.00	\$9,773,765.00	\$ 11,574,916	0.200262
31		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
32		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

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
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
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	Total Ancillary	\$ 17,633,209	\$ -	\$ 28,217	\$ 17,661,426	\$ 25,125,097	\$ 61,160,450	\$ 86,285,547	
127	Weighted Average								0.219474
128	Sub Totals	\$ 24,719,792	\$ -	\$ 28,217	\$ 24,465,485	\$ 31,384,248	\$ 61,160,450	\$ 92,544,698	
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)				\$574,155.00				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total	\$ 23,891,330							
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 (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days			
1	03000 ADULTS & PEDIATRICS	\$ 699.20		564		681		643		380		521		2,268		55.75%	
2	03100 INTENSIVE CARE UNIT	\$ 1,716.05		82		12		153		90		129		337		46.18%	
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	\$ 304.64		62		564				45				671		90.53%	
11		\$ -															
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
18		\$ -															
				Total Days		708		1,257		796		515		650		3,276	45.90%
19	Total Days per PS&R or Exhibit Detail			708		1,257		796		515		650					
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-			
21				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem	\$ 507,966	\$ 717.47	\$ 787,274	\$ 626.31	\$ 746,574	\$ 937.91	\$ 446,376	\$ 866.75	\$ 517,733	\$ 796.51	\$ 2,488,190	\$ 759.52			48.67%	
22	Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	09200 Observation (Non-Distinct)	0.339374		16,487	116,857	45,233	254,157	66,324	241,792	32,185	100,228	2,117	165,222	160,889	717,032	28.07%	
23	5000 OPERATING ROOM	0.216453		309,162	293,753	1,073,211	790,217	223,144	785,283	330,436	247,600	27,447	1,935,953	2,116,853	41,29%		
24	5200 DELIVERY ROOM & LABOR ROOM	0.564198		159,802	1,607	1,976,076	214,789	-	866	283,375	27,447	2,733	2,419,253	244,709	98.91%		
25	5400 RADIOLOGY-DIAGNOSTIC	0.145490		266,054	875,075	49,276	1,533,613	421,191	1,398,245	188,812	438,130	351,834	1,523,781	925,333	4,245,063	41.80%	
26	6000 LABORATORY	0.187344		522,905	1,143,356	375,664	1,856,320	696,795	1,027,580	418,736	995,000	484,404	1,183,973	2,014,100	5,022,356	48.84%	
27	6500 RESPIRATORY THERAPY	0.174213		241,656	166,462	136,362	227,085	600,698	372,706	266,125	104,829	175,302	214,875	1,244,841	871,082	40.72%	
28	6600 PHYSICAL THERAPY	0.347749		20,186	27,735	1,881	240,207	31,202	333,488	28,227	93,340	3,415	7,119	81,496	694,770	19.39%	
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.164243		214,429	128,475	272,812	404,253	334,844	259,952	197,468	76,897	168,508	150,238	1,019,553	869,577	42.49%	
30	7300 DRUGS CHARGED TO PATIENTS	0.328862		408,692	276,581	326,303	528,086	502,416	662,180	324,216	180,654	405,019	670,496	1,561,627	1,647,501	65.74%	
31	9000 CLINIC	0.405212		-	-	-	-	-	-	-	-	-	-	-	-	0.00%	
32	9100 EMERGENCY	0.200262		163,027	960,748	37,248	1,698,491	221,956	769,336	118,467	214,996	193,283	1,652,787	540,696	3,643,571	52.85%	
33																	
34																	
35																	
36																	
37																	
38																	
39																	
40																	
41																	
42																	
43																	
44																	
45																	
46																	
47																	
48																	
49																	
50																	
51																	
52																	
53																	
54																	
55																	
56																	
57																	
58																	
59																	
60																	
61																	
62																	
63																	
64																	
65																	
66																	
67																	
68																	
69																	
70																	
71																	
72																	
73																	
74																	
75																	
76																	
77																	
78																	
79																	
80																	
81																	
82																	
83																	
84																	
85																	

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

Cost Report Year (04/01/2016-03/31/2017)

MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

	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		%
86													
87													
88													
89													
90													
91													
92													
93													
94													
95													
96													
97													
98													
99													
100													
101													
102													
103													
104													
105													
106													
107													
108													
109													
110													
111													
112													
113													
114													
115													
116													
117													
118													
119													
120													
121													
122													
123													
124													
125													
126													
127													
Totals / Payments													
	\$ 2,322,400	\$ 3,990,649	\$ 4,294,124	\$ 7,751,218	\$ 3,099,170	\$ 5,851,528	\$ 2,188,047	\$ 2,479,119	\$ 2,060,378	\$ 5,679,463			
128 Total Charges (includes organ acquisition from Section J)	\$ 2,830,366	\$ 3,990,649	\$ 5,081,398	\$ 7,751,218	\$ 3,845,744	\$ 5,851,528	\$ 2,634,423	\$ 2,479,119	\$ 2,578,111	\$ 5,679,463	\$ 14,391,931	\$ 20,072,514	46.62%
129 Total Charges per PS&R or Exhibit Detail	\$ 2,830,366	\$ 3,990,649	\$ 5,081,398	\$ 7,751,218	\$ 3,845,744	\$ 5,851,528	\$ 2,634,423	\$ 2,479,119	\$ 2,578,111	\$ 5,679,463			
130 Unreconciled Charges (Explain Variance)													
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 1,104,566	\$ 788,602	\$ 2,292,655	\$ 1,652,594	\$ 1,354,956	\$ 1,241,913	\$ 1,000,882	\$ 518,501	\$ 1,019,445	\$ 1,140,581	\$ 5,753,059	\$ 4,201,610	51.24%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 1,215,865	\$ 823,246			\$ 194,099	\$ 147,495	\$ 15,723	\$ 8,552			\$ 1,425,687	\$ 979,293	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 3,129	\$ 681							\$ 3,129	\$ 681	
134 Private Insurance (including primary and third party liability)	\$ 3,708	\$ 1,398	\$ 1,647,893	\$ 1,216,171	\$ 1,241	\$ 2,967	\$ 625,864	\$ 338,198			\$ 2,278,706	\$ 1,558,734	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 2,574	\$ 82	\$ 1,308				\$ 881			\$ 82	\$ 4,763	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 1,219,573	\$ 827,218	\$ 1,651,104	\$ 1,218,160									
137 Medicaid Cost Settlement Payments (See Note B)		\$ (157,065)									\$ -	\$ (157,065)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,074,192	\$ 815,830	\$ 357,742	\$ 120,920			\$ 1,431,934	\$ 936,750	
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)					\$ 139,099	\$ 41,829	\$ 49,565	\$ 7,685			\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 23,716	\$ 225,962	\$ -	\$ -	
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -	\$ -	\$ -	
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ (115,007)	\$ 118,449	\$ 641,551	\$ 434,434	\$ (53,675)	\$ 233,792	\$ (48,012)	\$ 42,265	\$ 995,729	\$ 914,619	\$ 424,857	\$ 828,940	
146 Calculated Payments as a Percentage of Cost	110%	85%	72%	74%	104%	81%	105%	92%	2%	20%	93%	80%	
147 Total Medicare Days with W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)													2,994
148 Percent of cross-over days to total Medicare days from the cost report													27%

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 summary).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay).
 Note E - Medicaid Managed Care payments should include Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pay.

I. Out-of-State Medicaid Data:

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 699.20		34						7		41	
2	03100 INTENSIVE CARE UNIT	\$ 1,716.05		5								5	
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	\$ 304.64		8								8	
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days	47						7		54	
19	Total Days per PS&R or Exhibit Detail			47						7			
20	Unreconciled Days (Explain Variance)												
21	Routine Charges			Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges
21.01	Calculated Routine Charge Per Diem			\$ 753.57	\$ -	\$ -	\$ -	\$ 4,690	\$ 670.00	\$ 40,108	\$ 742.74		
22	Ancillary Cost Centers (from W/S C) (list below):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.339374	5,790	3,261					6,740		3,261	
23	5000 OPERATING ROOM		0.216453	26,539	4,153					26,539		4,153	
24	5200 DELIVERY ROOM & LABOR ROOM		0.564198	17,228	1,129					17,228		1,129	
25	5400 RADIOLOGY-DIAGNOSTIC		0.145490	20,453	37,957				10,593	31,046		37,957	
26	6000 LABORATORY		0.187344	32,096	39,579				4,566	36,662		39,579	
27	6500 RESPIRATORY THERAPY		0.174213	9,814	5,680				1,137	10,951		5,680	
28	6600 PHYSICAL THERAPY		0.341749						861	861			
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.164243	17,872	3,377				1,586	19,458		3,377	
30	7300 DRUGS CHARGED TO PATIENTS		0.328862	30,205	19,519				3,494	33,699		19,519	
31	9000 CLINIC		0.405212										
32	9100 EMERGENCY		0.200262	15,108	69,745				1,575	16,683		69,745	
33													
34													
35													
36													
37													
38													
39													
40													
41													
42													
43													
44													
45													
46													
47													
48													
49													
50													
51													
52													
53													
54													
55													
56													
57													
58													
59													
60													
61													
62													
63													
64													
65													
66													
67													
68													
69													
70													
71													
72													
73													
74													
75													
76													
77													
78													

I. Out-of-State Medicaid Data:

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

	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		
79											
80											
81											
82											
83											
84											
85											
86											
87											
88											
89											
90											
91											
92											
93											
94											
95											
96											
97											
98											
99											
100											
101											
102											
103											
104											
105											
106											
107											
108											
109											
110											
111											
112											
113											
114											
115											
116											
117											
118											
119											
120											
121											
122											
123											
124											
125											
126											
127											
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 210,523	\$ 184,400	\$ -	\$ -	\$ -	\$ -	\$ 29,452	\$ -	\$ 239,975	\$ 184,400
129	Total Charges per PS&R or Exhibit Detail	\$ 210,523	\$ 184,400	\$ -	\$ -	\$ -	\$ -	\$ 29,452	\$ -		
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 78,812	\$ 37,510	\$ -	\$ -	\$ -	\$ -	\$ 9,831	\$ -	\$ 88,643	\$ 37,510
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 98							\$ -	\$ 98
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)	\$ 28,875	\$ 11,292							\$ 28,875	\$ 11,292
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 28,875	\$ 11,390	\$ -	\$ -						
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)							\$ 9,382		\$ 9,382	\$ -
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)	\$ 49,937	\$ 26,120	\$ -	\$ -	\$ -	\$ -	\$ 449	\$ -	\$ 50,386	\$ 26,120
144	Calculated Payments as a Percentage of Cost	37%	30%	0%	0%	0%	0%	95%	0%	43%	30%

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

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

Cost Report Year (04/01/2016-03/31/2017)

MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

	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)	
						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	
1	Lung Acquisition	\$0.00	\$ -	\$ -		0										
2	Kidney Acquisition	\$0.00	\$ -	\$ -		0										
3	Liver Acquisition	\$0.00	\$ -	\$ -		0										
4	Heart Acquisition	\$0.00	\$ -	\$ -		0										
5	Pancreas Acquisition	\$0.00	\$ -	\$ -		0										
6	Intestinal Acquisition	\$0.00	\$ -	\$ -		0										
7	Islet Acquisition	\$0.00	\$ -	\$ -		0										
8		\$0.00	\$ -	\$ -		0										
9	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost															

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

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

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

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

Cost Report Year (04/01/2016-03/31/2017)

MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

	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)
						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)
11	Lung Acquisition	\$ -	\$ -	\$ -	\$ -	0							
12	Kidney Acquisition	\$ -	\$ -	\$ -	\$ -	0							
13	Liver Acquisition	\$ -	\$ -	\$ -	\$ -	0							
14	Heart Acquisition	\$ -	\$ -	\$ -	\$ -	0							
15	Pancreas Acquisition	\$ -	\$ -	\$ -	\$ -	0							
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0							
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0							
18		\$ -	\$ -	\$ -	\$ -	0							
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	Total Cost												

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (04/01/2016-03/31/2017) MEMORIAL HOSPITAL & MANOR-BAINBRIDGE

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 383,423	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	9650.7740 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 383,423	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 383,423	

DSH UCC Provider Tax Assessment Adjustment:

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

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