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

DSH Version 5.20 01/26/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2017	06/30/2018

2. Select Your Facility from the Drop-Down Menu Provided: COFFEE REGIONAL MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2016	12/31/2016
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:	000000448A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110089

B. DSH OB Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/17 - 06/30/18)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	09/01/1953

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.)

$ 758,795

Certification:

Answer
Yes

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature

CFO
Title

10/13/17
Date

William Phillips, CFO
Hospital CEO or CFO Printed Name

912-383-6944
Hospital CEO or CFO Telephone Number

william.phillips@coffeeregional.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Deborah Massey
Title	Reimbursement Supervisor
Telephone Number	912-383-6982
E-Mail Address	deborah.massey@coffeeregional.org
Mailing Street Address	1101 Ocilla Rd
Mailing City, State, Zip	Douglas, GA 31533

Outside Preparer:

Name	
Title:	
Firm Name:	
Telephone Number	
E-Mail Address	

DSH Version 7.25 3/21/2017

D. General Cost Report Year Information 1/1/2016 - 12/31/2016

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:	COFFEE REGIONAL MEDICAL CENTER		
		1/1/2016 through 12/31/2016		
2.	Select Cost Report Year Covered by this Survey (enter "X"):	X		
3.	Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a.	Date CMS processed the HCRIS file into the HCRIS database:	6/26/2017		

		Data	Correct?	If Incorrect, Proper Information
4.	Hospital Name:	COFFEE REGIONAL MEDICAL CENTER	Yes	
5.	Medicaid Provider Number:	000000448A	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:	110089	Yes	
9.	Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10	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.
11.	State Name & Number	FLORIDA STATE MEDICAID	014116100
12.	State Name & Number		
13.	State Name & Number		
14.	State Name & Number		
15.	State Name & Number		
16.	State Name & Number		
17.	State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2016 - 12/31/2016)

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)	$ 68,865	$ 574,696	$643,561
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 476,572	$ 3,326,591	$3,803,163
11.	Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$545,437	$3,901,287	$4,446,724
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.63%	14.73%	14.47%

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

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2016 - 12/31/2016)

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)	16,270 (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	47,231
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 47,231
7.	Inpatient Charity Care Charges	4,708,611
8.	Outpatient Charity Care Charges	6,259,548
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 10,968,159

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$23,648,209.00			$ 15,658,687	$ -	$ -	$ 7,989,522
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	$84,848,524.00	$156,578,500.00		$ 56,182,541	$ 103,678,621	$ -	$ 81,565,862
20.	Outpatient Services		$55,808,939.00			$ 36,953,949	$ -	$ 18,854,990
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 4,076,539	-	-	$ 2,699,285	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -

25. Hospice			$0.00			$ -	
26. Other	$0.00	$222,788.00	$1,387,052.00	$ -	$ 147,519	$ 918,438	$ 75,269
27. Total	$ 108,496,733	$ 212,610,227	$ 5,463,591	$ 71,841,228	$ 140,780,089	$ 3,617,723	$ 108,485,644
28. Total Hospital and Non Hospital		Total from Above	$ 326,570,551		Total from Above	$ 216,239,039	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	326,570,551	Total Contractual Adj. (G-3 Line 2)	216,239,039
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				216,239,039

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2016-12/31/2016) COFFEE 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	O/P Charges	Total Charges	Medicaid Per Diem / Cost-to-Charge Ratios
126	**Total Ancillary**	$ 42,147,941	$ -	$ -	$ 42,147,941	$ 90,571,673	$ 179,531,416	$ 270,103,089	
127	**Weighted Average**								0.171941
128	**Sub Totals**	$ 60,635,149	$ -	$ -	$ 60,635,149				
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 Payors *(Hospital must calculate. Submit support for calculation of cost.)*								
132	**Grand Totals**				$ 60,635,149				
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 (01/01/2016-12/31/2016) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From 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	$ 736.12		1,275		1,067		1,970		571		1,251		4,883	
2	03100 INTENSIVE CARE UNIT	$ 1,185.92		371		42		340		30		190		783	
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	$ 1,840.53		92		553				152		3		797	
11		$ -												-	
12		$ -												-	
13		$ -												-	
14		$ -												-	
15		$ -												-	
16		$ -												-	
17		$ -												-	
18			**Total Days**	1,738		1,662		2,310		753		1,444		6,463	
19	Total Days per PS&R or Exhibit Detail			1,738		1,662		2,310		753		1,444			
20	Unreconciled Days (Explain Variance)			-		-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 1,449,189		$ 1,265,287		$ 2,188,374		$ 585,252		$ 1,198,513		$ 5,488,102	
21.01	Calculated Routine Charge Per Diem			$ 833.83		$ 761.30		$ 947.35		$ 777.23		$ 830.00		$ 849.16	
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.644712	163,064	676,393	121,449	453,482	246,555	1,060,592	72,837	88,032	145,837	411,637	$ 603,905	$ 2,278,499
23	5000 OPERATING ROOM		0.091254	956,617	2,576,697	1,476,848	4,249,442	2,279,908	5,024,606	446,054	618,916	873,229	1,914,109	$ 5,159,427	$ 12,469,661
24	5100 RECOVERY ROOM		0.261636	45,080	98,532	104,303	208,656	60,536	142,968	32,200	28,980	50,207	84,364	$ 242,119	$ 479,136
25	5200 DELIVERY ROOM & LABOR ROOM		0.997439	45,521	15,849	440,607	159,823	-	-	149,777	37,871	7,648	7,613	$ 635,905	$ 213,543
26	5300 ANESTHESIOLOGY		0.018511	143,153	396,668	335,878	745,851	205,700	644,263	108,157	104,147	160,048	311,531	$ 792,888	$ 1,890,929
27	5400 RADIOLOGY-DIAGNOSTIC		0.108407	285,847	940,981	130,823	1,490,279	544,031	2,027,287	78,576	306,635	330,108	1,318,724	$ 1,039,277	$ 4,765,182
28	5700 CT SCAN		0.115052	482,852	1,187,491	176,976	1,722,024	694,496	2,743,792	129,311	392,518	586,344	2,939,271	$ 1,483,635	$ 6,045,825
29	5800 MRI		0.132303	121,413	286,383	8,948	417,700	135,447	744,445	11,073	30,258	129,393	180,216	$ 276,881	$ 1,478,786
30	5900 CARDIAC CATHETERIZATION		0.165430	421,243	127,663	23,934	71,826	432,898	1,112,640	31,432	8,944	49,034	87,382	$ 909,507	$ 1,321,073
31	6000 LABORATORY		0.091719	2,168,449	2,243,748	1,080,554	3,322,291	3,053,318	4,091,936	676,457	352,115	1,930,750	3,859,096	$ 6,978,778	$ 10,010,090
32	6500 RESPIRATORY THERAPY		0.114970	721,918	179,106	158,223	216,881	1,169,251	358,204	170,841	23,176	372,548	221,062	$ 2,220,233	$ 777,367
33	6600 PHYSICAL THERAPY		0.390136	82,656	51,618	11,158	212,367	179,908	319,148	26,666	53,349	56,472	47,612	$ 300,388	$ 636,482
34	6800 SPEECH PATHOLOGY		0.675400	12,996	2,058	-	2,940	13,673	11,761	294	294	5,628	588	$ 26,963	$ 17,053
35	6900 ELECTROCARDIOLOGY		0.015601	272,169	236,868	89,075	275,719	663,823	914,849	117,697	37,416	348,445	576,034	$ 1,142,764	$ 1,464,852
36	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.225970	725,123	1,156,799	838,707	1,507,901	1,293,906	2,187,805	356,386	257,167	773,372	1,875,495	$ 3,214,122	$ 5,109,672
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.412645	334,817	313,642	295,551	282,099	1,519,688	1,220,625	42,541	120,190	32,146	311,746	$ 2,192,597	$ 1,936,556
38	7300 DRUGS CHARGED TO PATIENTS		0.198183	1,400,054	667,152	503,665	690,237	1,979,785	2,103,465	382,242	128,368	946,804	939,990	$ 4,265,746	$ 3,589,222
39	7400 RENAL DIALYSIS		0.388261	59,670	-	-	-	234,617	100,408	26,720	2,635	94,255	15,455	$ 321,007	$ 103,043
40	9100 EMERGENCY		0.302425	280,578	1,791,030	122,360	3,713,693	368,622	1,812,055	62,693	354,341	299,941	4,039,543	$ 834,253	$ 7,671,119
41			-											$ -	$ -
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2016-12/31/2016) COFFEE 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	
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2016-12/31/2016) COFFEE 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	
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 8,723,220	$ 12,948,678	$ 5,919,059	$ 19,743,211	$ 15,076,162	$ 26,620,849	$ 2,921,954	$ 2,945,352	$ 7,192,209	$ 19,141,468		
	Totals / Payments														
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 10,172,409	$ 12,948,678	$ 7,184,346	$ 19,743,211	$ 17,264,536	$ 26,620,849	$ 3,507,206	$ 2,945,352	$ 8,390,722 (Agrees to Exhibit A)	$ 19,141,468 (Agrees to Exhibit A)	$ 38,128,497	$ 62,258,090
129	Total Charges per PS&R or Exhibit Detail			$ 10,172,409	$ 12,948,678	$ 7,184,346	$ 19,743,211	$ 17,264,536	$ 26,620,849	$ 3,507,206	$ 2,945,352	$ 8,390,722	$ 19,141,468		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 2,987,084	$ 2,334,089	$ 3,150,146	$ 3,470,625	$ 4,487,101	$ 4,574,778	$ 1,310,505	$ 542,291	$ 2,231,802	$ 3,368,639	$ 11,934,836	$ 10,921,783
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 3,106,311	$ 1,970,662	$ 2,687,235	$ 3,027,054	$ 505,812	$ 332,309	$ 1,158,798	$ 1,215,132			$ 7,458,156	$ 6,545,157
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)			$ 121,414	$ 154,153			$ 1,781	$ 6,665					$ 123,195	$ 160,818
135	Self-Pay (including Co-Pay and Spend-Down)													$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 3,227,725	$ 2,124,815	$ 2,687,235	$ 3,027,054								
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)							$ 4,051,375	$ 3,572,502					$ 4,051,375	$ 3,572,502
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -
141	Medicare Cross-Over Bad Debt Payments							$ 182,514	$ 292,573			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 182,514	$ 292,573
142	Other Medicare Cross-Over Payments (See Note D)													$ -	$ -
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 68,865	$ 574,696		
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)**			$ (240,641)	$ 209,274	$ 462,911	$ 443,571	$ (254,381)	$ 370,729	$ 151,707	$ (672,841)	$ 2,162,937	$ 2,793,943	$ 119,596	$ 350,733
146	**Calculated Payments as a Percentage of Cost**			108%	91%	85%	87%	106%	92%	88%	224%	3%	17%	99%	97%
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**							9,328							
148	**Percent of cross-over days to total Medicare days from the cost report**							25%							

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.

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2016-12/31/2016) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 736.12						5				5	
2	03100 INTENSIVE CARE UNIT	$ 1,185.92						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	$ 1,840.53										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		6		-		6	
19	Total Days per PS&R or Exhibit Detail			-		-		6		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges							$ 5,022				$ 5,022	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ 837.00		$ -		$ 837.00	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.644712					1,815	3,997			$ 1,815	$ 3,997
23	5000 OPERATING ROOM		0.091254						3,006			$ -	$ 3,006
24	5100 RECOVERY ROOM		0.261636									$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.997439									$ -	$ -
26	5300 ANESTHESIOLOGY		0.018511									$ -	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.108407					2,640	5,166			$ 2,640	$ 5,166
28	5700 CT SCAN		0.115052		4,289			1,594	5,057			$ 1,594	$ 9,346
29	5800 MRI		0.132303									$ -	$ -
30	5900 CARDIAC CATHETERIZATION		0.165430									$ -	$ -
31	6000 LABORATORY		0.091719		962			8,701	13,896			$ 8,701	$ 14,858
32	6500 RESPIRATORY THERAPY		0.114970		351			4,105	6,349			$ 4,105	$ 6,700
33	6600 PHYSICAL THERAPY		0.390136									$ -	$ -
34	6800 SPEECH PATHOLOGY		0.675400									$ -	$ -
35	6900 ELECTROCARDIOLOGY		0.015601					6,789	4,675			$ 6,789	$ 4,675
36	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.225970		28			3,417	7,857			$ 3,417	$ 7,885
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.412645						7,576			$ -	$ 7,576
38	7300 DRUGS CHARGED TO PATIENTS		0.198183		33			5,170				$ 5,170	$ 33
39	7400 RENAL DIALYSIS		0.388261					12,370	9,248			$ 12,370	$ 9,248
40	9100 EMERGENCY		0.302425		2,847			2,336	6,984			$ 2,336	$ 9,831
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
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61			-									$ -	$ -
62			-									$ -	$ -
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66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2016-12/31/2016) COFFEE 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	
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 8,510	$ -	$ -	$ 48,937	$ 73,811	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**		$ -	$ 8,510	$ -	$ -	$ 53,959	$ 73,811	$ -	$ -	$ 53,959	$ 82,321
129	Total Charges per PS&R or Exhibit Detail		$ -	$ 8,510	$ -	$ -	$ 53,959	$ 73,811	$ -	$ -		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ -	$ 1,496	$ -	$ -	$ 15,188	$ 16,675	$ -	$ -	$ 15,188	$ 18,171
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 823			$ 14,777	$ 12,556			$ 14,777	$ 13,379
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)										$ -	$ -
134	Private Insurance (including primary and third party liability)										$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)										$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ -	$ 823	$ -	$ -						
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	**Calculated Payment Shortfall / (Longfall)**		$ -	$ 673	$ -	$ -	$ 411	$ 4,119	$ -	$ -	$ 411	$ 4,792
144	**Calculated Payments as a Percentage of Cost**		0%	55%	0%	0%	97%	75%	0%	0%	97%	74%

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 (01/01/2016-12/31/2016) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
Organ Acquisition Cost Centers (list below):																
1	Lung Acquisition	$0.00	$ -	$ -		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			$ -	$ -												
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 (01/01/2016-12/31/2016) COFFEE REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
Organ Acquisition Cost Centers (list below):														
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
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 (01/01/2016-12/31/2016) COFFEE REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -	
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital **Charges**	100,522,867	
19	Uninsured Hospital **Charges**	27,532,190	
20	Total Hospital **Charges**	321,106,960	
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	31.31%	
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	8.57%	
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 including 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 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.*