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

DSH Version 5.20 11/01/2017

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: 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	01/01/2017	12/31/2017
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:	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 (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	09/01/1953

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

During the Interim DSH Payment Year:

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

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

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

C. Disclosure of Other Medicaid Payments Received:

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

$ 1,077,892

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	Date
Lavonda Cravey Hospital CEO or CFO Printed Name	912-383-5600 Hospital CEO or CFO Telephone Number	lavonda.cravey@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	Patient Financial Services Director
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	

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D. General Cost Report Year Information 01/01/2017 - 12/31/2017

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:	COFFEE REGIONAL MEDICAL CENTER		
	01/01/2017 through 12/31/2017		
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:	06/25/2018		

	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	
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	FLORIDA STATE MEDICAID	014116100
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: (01/01/2017 - 12/31/2017)

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)	$ 77,109	$ 692,446	$769,555
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 463,300	$ 3,110,490	$3,573,790
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)	$540,409	$3,802,936	$4,343,345
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.27%	18.21%	17.72%

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 (01/01/2017 - 12/31/2017)

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)	14,923 (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	36,550
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 36,550
7.	Inpatient Hospital Charity Care Charges	5,842,438
8.	Outpatient Hospital Charity Care Charges	5,034,625
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 10,877,063

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	$22,579,581.00			$ 15,099,518	$ -	$ -	$ 7,480,063
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	$81,063,403.00	$166,462,186.00		$ 54,209,080	$ 111,317,334	$ -	$ 81,999,175
20.	Outpatient Services		$55,606,364.00			$ 37,185,335	$ -	$ 18,421,029
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 4,138,670			$ 2,767,630	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$257,121.00	$1,915,190.00	$ -	$ 171,943	$ 1,280,734	$ 85,178
27.	Total	$ 103,642,984	$ 222,325,671	$ 6,053,860	$ 69,308,598	$ 148,674,612	$ 4,048,364	$ 107,985,445
28.	Total Hospital and Non Hospital		Total from Above	$ 332,022,515		Total from Above	$ 222,031,574	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	332,022,515	Total Contractual Adj. (G-3 Line 2)	222,031,574
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	222,031,574

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) 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 Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
126	**Total Ancillary**	$ 43,244,185	$ -	$ -	$ 43,244,185	$ 86,473,197	$ 192,678,432	$ 279,151,629	
127	**Weighted Average**								0.171602
128	**Sub Totals**	$ 61,392,393	$ -	$ -	$ 61,392,393	$ 98,590,650	$ 192,678,432	$ 291,269,082	
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.)*								
131.01	Other Cost Adjustments (support must be submitted)								
132	**Grand Total**				$ 61,392,393				
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 (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Dsch Cost for Routine Cost Centers	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		% Survey to Cost Report Totals
				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	$ 749.93		1,100		908		1,638		494		1,212		4,208		45.88%
2	03100 INTENSIVE CARE UNIT	$ 1,396.79		249		59		194		40		293		542		38.71%
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	$ 1,709.38		57		668				134		19		799		88.11%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	1,486		1,573		1,832		668		1,524		5,549		38.46%
19	Total Days per PS&R or Exhibit Detail			1,486		1,573		1,832		668		1,524				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,244,612		$ 1,262,410		$ 1,773,656		$ 551,481		$ 1,363,570		$ 4,832,159		51.14%
21.01	Calculated Routine Charge Per Diem			$ 831.96		$ 802.55		$ 978.64		$ 825.57		$ 894.73		$ 870.82		
	Ancillary Cost Centers (from WS 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)		0.575685	104,037	1,030,708	152,784	774,808	229,204	1,672,978	58,554	153,634	180,065	617,795	$ 600,499	$ 3,632,218	60.77%
23	5000 OPERATING ROOM		0.110436	1,449,175	1,750,329	1,294,945	3,980,881	1,795,981	3,926,475	465,927	244,467	949,515	1,590,299	$ 5,955,108	$ 9,908,362	60.99%
24	5100 RECOVERY ROOM		0.261927	47,428	69,472	90,156	222,444	49,405	132,932	32,708	17,368	47,428	88,178	$ 219,705	$ 442,216	66.11%
25	5200 DELIVERY ROOM & LABOR ROOM		0.952158	48,719	593	645,706	9,358	7,555	619,252	168,780	1,779	13,527	2,329	$ 878,850	$ 631,082	91.25%
26	5300 ANESTHESIOLOGY		0.012651	165,147	261,874	303,973	789,251	577,234	2,505,902	129,460	61,549	158,916	316,356	$ 763,947	$ 3,698,974	73.05%
27	5400 RADIOLOGY-DIAGNOSTIC		0.087492	95,162	1,140,309	103,916	1,777,333	512,809	3,140,456	64,644	315,360	408,859	1,697,530	$ 745,831	$ 8,373,518	39.61%
28	5700 CT SCAN		0.106785	504,846	1,489,201	129,492	1,892,173	784,208	812,003	94,156	357,464	763,660	4,066,065	$ 1,517,702	$ 4,550,841	40.49%
29	5800 MRI		0.105425	354,980	334,475	3,022	437,622	112,441	1,743,322	8,475	77,552	168,924	238,694	$ 488,918	$ 2,507,971	56.11%
30	5900 CARDIAC CATHETERIZATION		0.114749	433,502	512,305	47,444	104,731	519,811	4,189,103	7,763	124,220	470,491	528,049	$ 1,008,940	$ 4,900,358	53.87%
31	6000 LABORATORY		0.093643	2,019,223	2,290,548	965,031	3,764,844	3,008,650	504,058	543,487	602,368	2,372,828	4,661,302	$ 6,564,391	$ 7,151,614	48.51%
32	6500 RESPIRATORY THERAPY		0.124633	641,326	212,195	147,798	289,459	975,522	359,053	150,172	32,704	516,538	272,104	$ 1,914,818	$ 878,471	41.71%
33	6600 PHYSICAL THERAPY		0.300123	98,563	54,885	5,057	261,382	197,750	6,405	18,966	60,627	128,715	61,895	$ 320,368	$ 389,290	23.99%
34	6800 SPEECH PATHOLOGY		0.617779	10,710	610	306	2,135	3,610	-	810	305	8,190	-	$ 15,235	$ 3,050	47.69%
35	6900 ELECTROCARDIOLOGY		0.013374	258,003	249,233	46,431	297,137	712,438	1,203,329	77,413	57,063	504,432	768,223	$ 1,089,885	$ 1,900,759	45.36%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.221266	647,608	1,009,918	801,103	1,590,267	1,149,509	2,317,522	325,945	237,722	803,299	2,099,626	$ 2,923,765	$ 5,161,479	50.12%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.392150	691,573	482,000	230,265	308,864	1,031,466	1,697,718	16,301	21,532	117,083	130,378	$ 1,945,725	$ 2,560,594	25.54%
38	7300 DRUGS CHARGED TO PATIENTS		0.208998	1,444,193	787,544	437,904	740,798	1,885,491	2,280,535	450,895	120,897	1,325,080	1,062,409	$ 4,218,483	$ 3,924,774	38.91%
39	7400 RENAL DIALYSIS		0.367448	32,706	-	-	-	150,576	41,028	12,798	780	44,082	15,024	$ 202,080	$ 41,817	36.78%
40	9001 WOUND CARE CLINIC		0.577436	-	-	-	1,731	7,286	220,703	203	32,745		14,500	$ 7,489	$ 269,269	37.62%
41	9002 INFUSION CLINIC		0.179153	540	108,649	-	-	-	16,747	-	-	1,352	5,549	$ 1,892	$ 125,596	27.34%
42	9100 EMERGENCY		0.314025	232,676	1,442,397	84,718	3,949,264	355,077	1,750,383	47,594	291,355	340,707	4,358,441	$ 720,065	$ 7,433,399	65.63%
43				-										$ -	$ -	
44				-										$ -	$ -	
45				-										$ -	$ -	
46				-										$ -	$ -	
47				-										$ -	$ -	
48				-										$ -	$ -	
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63				-										$ -	$ -	
64				-										$ -	$ -	

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

Cost Report Year (01/01/2017-12/31/2017) 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		Survey
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
71			-											$ -	$ -	
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98			-											$ -	$ -	
99			-											$ -	$ -	
100			-											$ -	$ -	
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102			-											$ -	$ -	
103			-											$ -	$ -	
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116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	

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

Cost Report Year (01/01/2017-12/31/2017) 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		% Survey
125												$ -	$ -	
126												$ -	$ -	
127												$ -	$ -	
		$ 9,280,717	$ 13,253,295	$ 5,522,260	$ 21,229,322	$ 13,666,036	$ 29,296,077	$ 2,659,424	$ 2,817,498	$ 9,390,240	$ 22,578,732			
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 10,525,329	$ 13,253,295	$ 6,784,670	$ 21,229,322	$ 15,439,692	$ 29,296,077	$ 3,210,905	$ 2,817,498	$ 10,753,810 (Agrees to Exhibit A)	$ 22,578,732 (Agrees to Exhibit A)	$ 35,960,596	$ 66,596,192	46.71%
129	Total Charges per PS&R or Exhibit Detail	$ 10,525,329	$ 13,253,295	$ 6,784,670	$ 21,229,322	$ 15,439,692	$ 29,296,077	$ 3,210,905	$ 2,817,498	$ 10,753,810	$ 22,578,732			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 2,903,903	$ 2,475,249	$ 3,204,620	$ 3,756,944	$ 3,746,145	$ 5,541,125	$ 1,198,599	$ 493,098	$ 2,750,862	$ 3,846,784	$ 11,053,267	$ 12,266,416	48.77%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,990,206	$ 1,938,304			$ 434,062	$ 317,758	$ 1,254,565	$ 769,126			$ 4,676,833	$ 3,025,186	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,348,039	$ 3,288,256	$ -	$ -					$ 2,348,039	$ 3,288,256	
134	Private Insurance (including primary and third party liability)	$ 100,039	$ 32,358			$ 1,271	$ 7,198					$ 101,310	$ 39,556	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 48	$ 1,653			$ 13	$ 14,465			$ 61	$ 16,118	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,090,245	$ 1,970,662	$ 2,348,087	$ 3,289,909									
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)					$ 3,412,820	$ 3,976,546					$ 3,412,820	$ 3,976,546	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 188,833	$ 325,761					$ 188,833	$ 325,761	
142	Other Medicare Cross-Over Payments (See Note D)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 77,109	$ 692,446			
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)**	$ (186,342)	$ 504,587	$ 856,533	$ 467,035	$ (290,841)	$ 913,864	$ (55,979)	$ (290,493)	$ 2,673,553	$ 3,154,318	$ 323,371	$ 1,594,993	
146	**Calculated Payments as a Percentage of Cost**	106%	80%	73%	88%	108%	84%	105%	159%	3%	18%	97%	87%	

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)** 7,828

148 **Percent of cross-over days to total Medicare days from the cost report** 24%

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 (01/01/2017-12/31/2017) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 749.23						1				1	
2	03100 INTENSIVE CARE UNIT	$ 1,398.70										-	
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	$ 1,709.36										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-	-	-	-	1	-	-	-	1	
19	Total Days per PS&R or Exhibit Detail			-		-		1		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges							$ 687				$ 687	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ 687.00		$ -		$ 687.00	
	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)		0.575685		1,165			1,173	5,980			$ 1,173	$ 7,154
23	5000 OPERATING ROOM		0.110438									$ -	$ -
24	5100 RECOVERY ROOM		0.261927									$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.952158									$ -	$ -
26	5300 ANESTHESIOLOGY		0.012651									$ -	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.087492		1,198			2,171	13,990			$ 2,171	$ 15,188
28	5700 CT SCAN		0.108765		7,666				9,128			$ -	$ 15,794
29	5800 MRI		0.105425						5,451			$ -	$ 5,451
30	5900 CARDIAC CATHETERIZATION		0.114740		12,422							$ -	$ 12,422
31	6000 LABORATORY		0.093643		11,394			4,416	18,919			$ 4,416	$ 30,313
32	6500 RESPIRATORY THERAPY		0.124633		228			1,632	4,574			$ 1,632	$ 4,802
33	6600 PHYSICAL THERAPY		0.360123						1,065			$ -	$ 1,065
34	6800 SPEECH PATHOLOGY		0.677779									$ -	$ -
35	6900 ELECTROCARDIOLOGY		0.013374		3,554			1,462	6,525			$ 1,462	$ 10,079
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.221266		2,329			896	9,507			$ 896	$ 11,836
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.392150		729							$ -	$ 729
38	7300 DRUGS CHARGED TO PATIENTS		0.208998		1,591			1,498	5,021			$ 1,498	$ 6,612
39	7400 RENAL DIALYSIS		0.387448									$ -	$ -
40	9001 WOUND CARE CLINIC		0.577436									$ -	$ -
41	9002 INFUSION CLINIC		0.170153									$ -	$ -
42	9100 EMERGENCY		0.314025		6,864			705	9,135			$ 705	$ 15,999
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
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71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) 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	
79										$ -	$ -
80										$ -	$ -
81										$ -	$ -
82										$ -	$ -
83										$ -	$ -
84										$ -	$ -
85										$ -	$ -
86										$ -	$ -
87										$ -	$ -
88										$ -	$ -
89										$ -	$ -
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120										$ -	$ -
121										$ -	$ -
122										$ -	$ -
123										$ -	$ -
124										$ -	$ -
125										$ -	$ -
126										$ -	$ -
127										$ -	$ -
		$ -	$ 49,140	$ -	$ -	$ 14,043	$ 88,304	$ -	$ -		

Totals / Payments

128	**Total Charges (Includes organ acquisition from Section K)**	$ -	$ 49,140	$ -	$ -	$ 14,730	$ 88,304	$ -	$ -	$ 14,730	$ 137,444
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 49,140	$ -	$ -	$ 14,730	$ 88,304	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ 7,451	$ -	$ -	$ 3,012	$ 14,948	$ -	$ -	$ 3,012	$ 22,399
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 4,405			$ 4,004	$ 11,491			$ 4,004	$ 15,896
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)	$ -	$ 4,405	$ -	$ -						
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)**	$ -	$ 3,046	$ -	$ -	$ (992)	$ 3,457	$ -	$ -	$ (992)	$ 6,503
144	**Calculated Payments as a Percentage of Cost**	0%	59%	0%	0%	133%	77%	0%	0%	133%	71%

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 (01/01/2017-12/31/2017) 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured) See Note C below*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	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		$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 (01/01/2017-12/31/2017) 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured) See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	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 (01/01/2017-12/31/2017) 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)*		$ 1,238,310		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7701-3570	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Incluced in Expense on the Cost Report (W/S A, Col. 2)		$ 1,238,310	Administrative and General	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 0		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(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		$ 1,238,310		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 0	

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