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

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	7/1/2017	6/30/2018

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	1/1/2018	12/31/2018
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?	9/1/1953

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 (07/01/19 - 06/30/20)
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:

Bradley Gordon Goldberg
Steven Charles Diamond

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 07/01/2017 - 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.)

$ 1,062,850

Certification:

	Answer
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.**	**Yes**

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CFO Title	Date
Martin Hutson Hospital CEO or CFO Printed Name	912-384-1900 Hospital CEO or CFO Telephone Number	martin.hutson@coffeeregional.org Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Deborah Massey	Name	
Title	Patient Financial Services Director	Title:	
Telephone Number	912-383-6982	Firm Name:	
E-Mail Address	deborah.massey@coffeeregional.org	Telephone Number	
Mailing Street Address	1101 Ocilla Rd, Douglas, GA 31533	E-Mail Address	

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D. General Cost Report Year Information 1/1/2018 - 12/31/2018

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

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

	1/1/2018 through 12/31/2018		
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: 6/21/2019

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	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: (01/01/2018 - 12/31/2018)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 69,273	$ 853,473	$922,746
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 442,443	$ 3,676,413	$4,118,856
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)	$511,716	$4,529,886	$5,041,602
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	13.54%	18.84%	18.30%

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 (01/01/2018 - 12/31/2018)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	17,537	**(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	23,312
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 23,312
7.	Inpatient Hospital Charity Care Charges	8,554,436
8.	Outpatient Hospital Charity Care Charges	12,767,291
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 21,321,727

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	$26,724,852.00			$ 18,347,135	$ -	$ -	$ 8,377,717
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	$93,911,754.00	$196,359,244.00		$ 64,472,261	$ 134,804,473	$ -	$ 90,994,264
20.	Outpatient Services		$61,689,356.00			$ 42,350,953	$ -	$ 19,338,403
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 4,395,447	-	-	$ 3,017,561	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$256,309.00	$2,011,426.00	$ -	$ 175,961	$ 1,380,883	$ 80,348
27.	Total	$ 120,636,606	$ 258,304,909	$ 6,406,873	$ 82,819,396	$ 177,331,387	$ 4,398,444	$ 118,790,732
28.	Total Hospital and Non Hospital		Total from Above	$ 385,348,388		Total from Above	$ 264,549,227	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	385,348,388	Total Contractual Adj. (G-3 Line 2)		264,549,227
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				-	
35.	Adjusted Contractual Adjustments					264,549,227

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2018-12/31/2018) | COFFEE REGIONAL MEDICAL CENTER

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.

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*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 14,797,146	$ -	$ -	$0.00	$ 14,797,146	21,798	$10,193,701.00		$ 678.83
2	03100 INTENSIVE CARE UNIT	$ 3,393,409	$ -	$ -		$ 3,393,409	2,531	$3,265,634.00		$ 1,340.74
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,786,444	$ -	$ -		$ 1,786,444	964	$730,218.00		$ 1,853.16
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 19,976,999	$ -	$ -	$ -	$ 19,976,999	25,293	$ 14,189,553		
19	Weighted Average									$ 789.82

Line #	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
20	09200 Observation (Non-Distinct)	7,756	-	-	$ 5,265,005	$1,759,118.00	$7,663,932.00	$ 9,423,050	0.558737

Line #		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	$5,021,811.00	$ -	$0.00		$ 5,021,811	$12,826,740.00	$34,082,423.00	$ 46,909,163	0.107054
22	5100 RECOVERY ROOM	$454,078.00	$ -	$0.00		$ 454,078	$567,800.00	$1,323,565.00	$ 1,891,365	0.240080
23	5200 DELIVERY ROOM & LABOR ROOM	$1,634,083.00	$ -	$0.00		$ 1,634,083	$1,574,892.00	$44,145.00	$ 1,619,037	1.009293
24	5300 ANESTHESIOLOGY	$154,957.00	$ -	$0.00		$ 154,957	$1,703,625.00	$5,360,808.00	$ 7,064,433	0.021935
25	5400 RADIOLOGY-DIAGNOSTIC	$2,103,997.00	$ -	$0.00		$ 2,103,997	$4,816,245.00	$21,200,401.00	$ 26,016,646	0.080871
26	5700 CT SCAN	$3,000,038.00	$ -	$0.00		$ 3,000,038	$6,185,647.00	$24,772,778.00	$ 30,958,425	0.096905
27	5800 MRI	$617,359.00	$ -	$0.00		$ 617,359	$949,700.00	$5,575,248.00	$ 6,524,948	0.094615
28	5900 CARDIAC CATHETERIZATION	$1,778,899.00	$ -	$0.00		$ 1,778,899	$3,250,105.00	$9,891,199.00	$ 13,141,304	0.135367
29	6000 LABORATORY	$4,672,515.00	$ -	$0.00		$ 4,672,515	$21,102,296.00	$31,235,427.00	$ 52,337,723	0.089276
30	6500 RESPIRATORY THERAPY	$1,335,297.00	$ -	$0.00		$ 1,335,297	$7,534,239.00	$3,054,813.00	$ 10,589,052	0.126102

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2018-12/31/2018) 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
31	6600	PHYSICAL THERAPY	$1,485,825.00	$ -	$0.00		$ 1,485,825	$1,260,900.00	$2,842,798.00	$ 4,103,698	0.362070
32	6800	SPEECH PATHOLOGY	$47,578.00	$ -	$0.00		$ 47,578	$172,470.00	$37,758.00	$ 210,228	0.226316
33	6900	ELECTROCARDIOLOGY	$143,347.00	$ -	$0.00		$ 143,347	$4,381,838.00	$6,771,158.00	$ 11,152,996	0.012853
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$4,857,368.00	$ -	$0.00		$ 4,857,368	$8,427,218.00	$16,285,036.00	$ 24,712,254	0.196557
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$5,981,183.00	$ -	$0.00		$ 5,981,183	$7,557,335.00	$8,277,862.00	$ 15,835,197	0.377714
36	7300	DRUGS CHARGED TO PATIENTS	$7,753,190.00	$ -	$0.00		$ 7,753,190	$12,983,698.00	$28,427,140.00	$ 41,410,838	0.187226
37	7400	RENAL DIALYSIS	$309,787.00	$ -	$0.00		$ 309,787	$853,356.00	$137,763.00	$ 991,119	0.312563
38	9001	WOUND CARE CLINIC	$631,017.00	$ -	$0.00		$ 631,017	$11,160.00	$818,795.00	$ 829,955	0.760303
39	9002	INFUSION CLINIC	$267,270.00	$ -	$0.00		$ 267,270	$5,888.00	$607,640.00	$ 613,528	0.435628
40	9100	EMERGENCY	$6,593,440.00	$ -	$0.00		$ 6,593,440	$2,896,896.00	$17,293,062.00	$ 20,189,958	0.326570
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2018-12/31/2018) 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
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**	$ 48,843,039	$ -	$ -		$ 48,843,039	$ 100,821,166	$ 225,703,751	$ 326,524,917	
127		**Weighted Average**									0.165709
128		**Sub Totals**	$ 68,820,038	$ -	$ -		$ 68,820,038	$ 115,010,719	$ 225,703,751	$ 340,714,470	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 68,820,038				
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 (01/01/2018-12/31/2018) 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		% 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	$ 678.83		1,305		1,065		2,177		675		1,419		5,222		47.47%
2	03100 INTENSIVE CARE UNIT	$ 1,340.74		317		24		259		144		201		744		37.34%
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	$ 1,853.16		51		577				179		24		807		86.20%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	1,673		1,666		2,436		998		1,644		6,773		33.38%
19	Total Days per PS&R or Exhibit Detail			1,673		1,666		2,436		998		1,644				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 1,460,858		$ 1,310,057		$ 2,445,689		$ 870,740		$ 1,411,544		$ 6,087,344		52.99%
21.01	Calculated Routine Charge Per Diem			$ 873.20		$ 786.35		$ 1,003.98		$ 872.48		$ 858.60		$ 898.77		
	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)		0.558737	193,610	1,117,490	164,917	610,030	335,723	2,518,847	89,931	213,573	172,721	709,732	$ 784,181	$ 4,459,940	65.19%
23	5000 OPERATING ROOM		0.107054	1,379,681	1,977,696	1,442,654	3,965,888	1,997,746	4,963,620	518,438	588,992	834,408	2,130,259	$ 5,338,519	$ 11,496,196	42.29%
24	5100 RECOVERY ROOM		0.240080	48,096	74,816	137,608	217,768	65,464	146,960	41,416	31,396	51,436	109,552	$ 292,584	$ 470,940	49.02%
25	5200 DELIVERY ROOM & LABOR ROOM		1.009293	49,899	1,152	591,846	14,430	1,238	-	198,275	2,372	26,302	1,649	$ 841,258	$ 17,954	54.80%
26	5300 ANESTHESIOLOGY		0.021935	148,250	322,912	370,906	754,213	193,702	663,453	123,591	106,663	170,371	364,656	$ 836,449	$ 1,847,241	45.70%
27	5400 RADIOLOGY-DIAGNOSTIC		0.080871	492,182	1,205,509	142,414	1,747,321	820,535	2,904,230	192,052	376,652	438,847	1,856,689	$ 1,647,183	$ 6,233,712	39.24%
28	5700 CT SCAN		0.096905	630,992	1,517,897	168,727	2,086,631	1,013,653	3,453,150	180,699	437,209	930,794	4,837,865	$ 1,994,071	$ 7,494,887	49.42%
29	5800 MRI		0.094615	70,017	311,380	23,593	489,232	146,763	960,606	15,114	52,896	153,671	333,393	$ 255,487	$ 1,814,114	39.18%
30	5900 CARDIAC CATHETERIZATION		0.135367	584,099	559,117	-	213,426	799,564	1,708,922	107,861	209,577	281,262	884,034	$ 1,491,524	$ 2,691,042	41.08%
31	6000 LABORATORY		0.089276	2,390,958	2,378,017	1,232,981	3,710,011	3,947,015	5,005,638	1,042,261	902,463	2,616,665	4,986,252	$ 8,613,215	$ 11,996,129	54.03%
32	6500 RESPIRATORY THERAPY		0.126102	731,639	250,749	167,088	233,678	1,357,146	581,446	371,910	51,185	518,630	301,610	$ 2,627,783	$ 1,117,058	43.22%
33	6600 PHYSICAL THERAPY		0.362070	109,824	58,490	13,662	247,588	259,266	359,069	55,566	74,551	80,977	88,987	$ 438,318	$ 739,698	32.86%
34	6800 SPEECH PATHOLOGY		0.226316	11,012	2,440	305	4,270	5,811	9,455	1,280	305	525	975	$ 18,408	$ 16,470	25.42%
35	6900 ELECTROCARDIOLOGY		0.012853	308,092	244,120	71,698	318,340	860,714	1,506,539	152,658	142,707	489,592	913,761	$ 1,393,162	$ 2,211,706	45.34%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.196557	687,440	1,026,831	857,881	1,614,301	1,373,933	2,786,083	508,038	328,065	867,675	2,174,052	$ 3,427,292	$ 5,755,280	49.54%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.377714	840,609	577,637	280,608	246,052	1,372,661	1,902,015	205,261	86,810	54,440	405,817	$ 2,699,139	$ 2,812,514	37.98%
38	7300 DRUGS CHARGED TO PATIENTS		0.187226	1,445,750	1,183,157	487,150	1,678,474	2,574,117	3,846,632	804,046	333,887	1,142,712	1,388,765	$ 5,311,063	$ 7,042,150	35.98%
39	7400 RENAL DIALYSIS		0.312563	100,962	-	-	-	183,438	42,606	49,770	1,578	15,642	45,606	$ 334,170	$ 44,184	44.43%
40	9001 WOUND CARE CLINIC		0.760303	630	127,145	-	10,721	5,379	197,233	-	29,079	203	19,662	$ 6,009	$ 364,178	47.20%
41	9002 INFUSION CLINIC		0.435628	-	-	-	24,229	825	57,296	-	1,401	-	6,630	$ 825	$ 82,926	15.19%
42	9100 EMERGENCY		0.326570	307,554	1,382,582	123,490	3,672,518	444,826	1,817,465	86,228	365,716	429,421	4,326,700	$ 962,098	$ 7,238,281	64.26%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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49			-											$ -	$ -	
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80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	

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

Cost Report Year (01/01/2018-12/31/2018) 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		%
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
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101			-											$ -	$ -	
102			-											$ -	$ -	
103			-											$ -	$ -	
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105			-											$ -	$ -	
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119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
	Totals / Payments			$ 10,531,296	$ 14,319,137	$ 6,277,528	$ 21,859,121	$ 17,759,519	$ 35,431,265	$ 4,744,395	$ 4,337,077	$ 9,276,394	$ 25,886,646			
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 11,992,154	$ 14,319,137	$ 7,587,585	$ 21,859,121	$ 20,205,208	$ 35,431,265	$ 5,615,135	$ 4,337,077	$ 10,687,938 (Agrees to Exhibit A)	$ 25,886,646 (Agrees to Exhibit A)	$ 45,400,082	$ 75,946,600	46.48%
129	Total Charges per PS&R or Exhibit Detail			$ 11,992,154	$ 14,319,137	$ 7,587,585	$ 21,859,121	$ 20,205,208	$ 35,431,265	$ 5,615,135	$ 4,337,077	$ 10,687,938	$ 25,886,646			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 3,120,799	$ 2,670,536	$ 3,282,841	$ 3,665,410	$ 4,641,719	$ 6,320,009	$ 1,884,546	$ 719,207	$ 2,569,085	$ 4,243,803	$ 12,929,905	$ 13,375,162	48.25%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 3,429,266	$ 2,152,794	$ 2,522,539	$ 2,541,292	$ 561,471	$ 400,568	$ 1,710,771	$ 1,214,542			$ 8,224,047	$ 6,309,196	
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)			$ 131,515	$ 221,991			$ 1,336	$ 1,827					$ 132,851	$ 223,818	
135	Self-Pay (including Co-Pay and Spend-Down)							$ 888	$ 6,295					$ 888	$ 6,295	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 3,560,781	$ 2,374,785	$ 2,522,539	$ 2,541,292									
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)							$ 4,023,012	$ 4,717,453					$ 4,023,012	$ 4,717,453	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ 170,037	$ 345,576					$ 170,037	$ 345,576	
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)											$ 69,273	$ 853,473			
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)**			$ (439,982)	$ 295,751	$ 760,302	$ 1,124,118	$ (115,025)	$ 848,290	$ 173,775	$ (495,335)	$ 2,499,812	$ 3,390,330	$ 379,070	$ 1,772,824	
146	**Calculated Payments as a Percentage of Cost**			114%	89%	77%	69%	102%	87%	91%	169%	3%	20%	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)**							9,336								
148	**Percent of cross-over days to total Medicare days from the cost report**							26%								

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 (01/01/2018-12/31/2018) 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	$ 678.83						25				25	
2	03100 INTENSIVE CARE UNIT	$ 1,340.74										-	
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	$ 1,853.16										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		25		-		25	
19	Total Days per PS&R or Exhibit Detail			-		-		25		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges							$ 19,950				$ 19,950	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ 798.00		$ -		$ 798.00	
	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)		0.558737		8,293			4,593	3,232			$ 4,593	$ 11,525
23	5000 OPERATING ROOM		0.107054		-			25,647	12,092			$ 25,647	$ 12,092
24	5100 RECOVERY ROOM		0.240080		-			2,004	668			$ 2,004	$ 668
25	5200 DELIVERY ROOM & LABOR ROOM		1.009293		-			-	-			$ -	$ -
26	5300 ANESTHESIOLOGY		0.021935		-			6,198	3,645			$ 6,198	$ 3,645
27	5400 RADIOLOGY-DIAGNOSTIC		0.080871		8,780			18,520	5,612			$ 18,520	$ 14,392
28	5700 CT SCAN		0.096905		8,936			11,037	20,931			$ 11,037	$ 29,867
29	5800 MRI		0.094615		-			-	-			$ -	$ -
30	5900 CARDIAC CATHETERIZATION		0.135367		-			48,006	2,441			$ 48,006	$ 2,441
31	6000 LABORATORY		0.089276		19,955			29,885	16,795			$ 29,885	$ 36,750
32	6500 RESPIRATORY THERAPY		0.126102		5,808			4,585	615			$ 4,585	$ 6,423
33	6600 PHYSICAL THERAPY		0.362070		-			667	-			$ 667	$ -
34	6800 SPEECH PATHOLOGY		0.226316		7,879			9,091	-			$ 9,091	$ 7,879
35	6900 ELECTROCARDIOLOGY		0.012853		11,683			34,475	2,062			$ 34,475	$ 13,745
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.196557		-			9,310	10,027			$ 9,310	$ 10,027
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.377714		5,703			35,522	1,320			$ 35,522	$ 7,023
38	7300 DRUGS CHARGED TO PATIENTS		0.187226					9,954	5,926			$ 9,954	$ 5,926
39	7400 RENAL DIALYSIS		0.312563					-	789			$ -	$ 789
40	9001 WOUND CARE CLINIC		0.760303					-	1,725			$ -	$ 1,725
41	9002 INFUSION CLINIC		0.435628					2,792	-			$ 2,792	$ -
42	9100 EMERGENCY		0.326570		8,035				10,319			$ -	$ 18,354
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2018-12/31/2018) 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	
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			-									$ -	$ -
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86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2018-12/31/2018) 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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 85,072	$ -	$ -	$ 252,286	$ 98,199	$ -	$ -		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ 85,072	$ -	$ -	$ 272,236	$ 98,199	$ -	$ -	$ 272,236	$ 183,271
129	Total Charges per PS&R or Exhibit Detail			$ -	$ 85,072	$ -	$ -	$ 272,236	$ 98,199	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ 15,435	$ -	$ -	$ 56,281	$ 16,264	$ -	$ -	$ 56,281	$ 31,699
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ 3,957			$ 65,762	$ 12,752			$ 65,762	$ 16,709
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)			$ -	$ 3,957	$ -	$ -						
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) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ 11,478	$ -	$ -	$ (9,481)	$ 3,512	$ -	$ -	$ (9,481)	$ 14,990
144	**Calculated Payments as a Percentage of Cost**			0%	26%	0%	0%	117%	78%	0%	0%	117%	53%

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 (01/01/2018-12/31/2018) 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 (01/01/2018-12/31/2018) 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 (01/01/2018-12/31/2018) 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)*		$ 1,238,710		
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 Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,238,710	Administrative and General	*(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		$ 1,238,710		

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 Sec. G**	121,802,189
19	Uninsured Hospital	**Charges Sec. G**	36,574,584
20	Total Hospital	**Charges Sec. G**	340,714,470
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		35.75%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.73%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

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

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