MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

August 23, 2019

Kyle Wilkinson
Morgan Memorial Hospital
1077 S. Main Street
Madison, Georgia 30650

RE: DSH Medicaid Provider Examination

Provider Number:	111304
Provider Name:	Morgan Memorial Hospital
DSH Year(s) under Examination:	June 30, 2016

Dear Mr. Wilkinson:

Myers and Stauffer LC has completed the mandated examinations of Georgia's fiscal 2016 DSH year to comply with the federal regulation regarding disproportionate share hospital (DSH) payments issued by CMS on December 19, 2008.

Your hospital's results are enclosed. These results are based on our examination of the DSH survey document, claims level analysis to support the uninsured services provided and payments received during each cost report year covered by a portion of the DSH year.

Thank you for your cooperation and assistance in providing the information and documentation for completing the examination. If you have any questions or concerns regarding your hospital's results, please contact us at the address or phone number below.

Sincerely,

Katie Reilly

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
700 W 47th Street, Suite 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
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GA DSH Examination Results for 2016 **8/23/2019 16:05**

DSH UCC Cost & Payment Summary

Review Results

Provider Name	Morgan Memorial Hospital
Mcaid Provider Number	000694229A
Mcare Provider Number	111304

In order to comply with the December 19, 2008 federal regulation regarding disproportionate share hospital (DSH) payments, surveys were submitted by all facilities that received DSH payments during the 2016 state DSH year. Reviews have been completed and below are the results of those reviews. We are supplying you with the adjusted uncompensated care calculation (UCC) and DSH payment for the 2016 state DSH year.

NOTE: If your hospital is selected for further testing or field work, the results may change and you may be notified at that time.

GA Medicaid DSH Examination Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2015 - 6/30/2016

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) Adjusted DSH Uncompensated Care Cost (UCC)		(D) % of Year Applicable		(E) Totals
Cost Report Year 1 UCC:	7/1/2015	-	6/30/2016	$ 1,356,030	X	100.00%	=	$ 1,356,030
Cost Report Year 2 UCC:		-			X	0.00%	=	$ -
Cost Report Year 3 UCC:		-			X	0.00%	=	$ -
	Sub-Total:							$ 1,356,030
Less Supplemental Payments (UPL, etc.):								$ 13,904
Total Uncompensated Care Calculation (UCC):								$ 1,342,126
Out-of-State DSH Payment:								$ -
DSH Payment:								$ 725,294
In-State DSH Payment In Excess of UCC:								**$ -**
DSH Year Low Income Utilization Ratio (LIUR):								7.96%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):								18.18%

If you disagree with the findings presented above please respond within ten days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail:	gadsh@mslc.com
Fax:	816-945-5301
Web Portal:	https://dsh.mslc.com
Phone Inquiries:	800-374-6858

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

DSH Version 5.20 1/26/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2015	06/30/2016

Workpaper #:	1301	Reviewer:
Examiner:	CW	CKL
Date:	1/9/2019	1/17/2019

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

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	7/1/2015	6/30/2016
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	000694229A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111304

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 (07/01/15 - 06/30/16)
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?	1/1/1960

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2015 - 06/30/2016**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 13,904 **4904**

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: 0

0

0

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.

KYLE H. WILKINSON	CFO, CPA	10/12/2017
Hospital CEO or CFO	Title	Date

KYLE H. WILKINSON	(706) 752-2284	KYLEW@MMH.ORG
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	KYLE H. WILKINSON
Title	CFO, CPA
Telephone Number	(706) 752-2284
E-Mail Address	KYLEW@MMH.ORG
Mailing Street Address	1077 S. MAIN STREET
Mailing City, State, Zip	MADISON, GA 30650-2073

Outside Preparer:	
Name	0
Title:	0
Firm Name:	0
Telephone Number	0
E-Mail Address	0

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302	Reviewer:
Examiner:	CW	CKL
Date:	1/9/2019	8/23/2019
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 7/1/2015 - 6/30/2016

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

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

	7/1/2015 through 6/30/2016		
2. Select Cost Report Year Covered by this Survey:	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: 12/21/2016

	Data	Correct?	If Incorrect, Proper Information	
4. Hospital Name:	MORGAN MEMORIAL HOSPITAL	Yes		-
5. Medicaid Provider Number:	000694229A	Yes		-
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	0	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	0	
8. Medicare Provider Number:	111304	Yes	0	

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	0	0
10. State Name & Number	0	0
11. State Name & Number	0	0
12. State Name & Number	0	0
13. State Name & Number	0	0
14. State Name & Number	0	0
15. State Name & Number	0	0

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2015 - 06/30/2016)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-	5205
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)**	$-	5205
8. **Out-of-State DSH Payments (See Note 2)**	$ -	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 1,440	$ 65,383	$66,823
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 30,992	$ 435,903	$466,895
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$32,432	$501,286	$533,718
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	4.44%	13.04%	12.52%

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 (07/01/2015 - 06/30/2016)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	407	1505

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

2.	Inpatient Hospital Subsidies	-	
3.	Outpatient Hospital Subsidies	-	
4.	Unspecified I/P and O/P Hospital Subsidies	-	
5.	Non-Hospital Subsidies	-	
6.	Total Hospital Subsidies	$ -	
7.	Inpatient Hospital Charity Care Charges	9,548	
8.	Outpatient Hospital Charity Care Charges	54,110	
9.	Non-Hospital Charity Care Charges	-	
10.	Total Charity Care Charges	$ 63,658	1705

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
		1505 ↓	1505 ↓	1505 ↓				
11.	Hospital	$ 135,868	$ -	$ -	$ 61,205	$ -	$ -	$ 74,663
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 1,952,487			$ 879,550	
15.	Swing Bed - NF			$ 860,546			$ 387,656	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 5,707,096	$ 8,557,415	$ -	$ 2,570,915	$ 3,854,918	$ -	$ 7,838,678
20.	Outpatient Services		$ 4,731,870	$ -		$ 2,131,598	$ -	$ 2,600,272
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 1,504,376	$ -	$ -	$ 677,687	$ -
27.	Total	$ 5,842,964	$ 13,289,285	$ 4,317,409	$ 2,632,120	$ 5,986,516	$ 1,944,893	$ 10,513,613
28.	Total Hospital and Non Hospital		Total from Above	$ 23,449,658		Total from Above	$ 10,563,529	

			1505	
29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 23,449,658	Total Contractual Adj. (G-3 Line 2) $ 10,073,339
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)			+ $ 490,190
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			10,563,529
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0) $ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2015-06/30/2016) | MORGAN MEMORIAL HOSPITAL

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Provider Tax Assessment	Net 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*	*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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):		1505 ↓	1505 ↓	1505 ↓	1505 ↓			1505 ↓			
1	03000	ADULTS & PEDIATRICS	$ 3,823,221	$ -	$ -	$ 3,293,995	$ -	$ 529,226	635	$ 2,948,901		$ 833.43
2	03100	INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
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	$ -	$ -	$ -		$ -	$ -	-	$ -		$ -
18		Total Routine	$ 3,823,221	$ -	$ -	$ 3,293,995	$ -	$ 529,226	635	$ 2,948,901		
19		Weighted Average										$ 833.43

			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*
	Observation Data (Non-Distinct)										
20	09200	Observation (Non-Distinct)	228	-	-		$ 190,022	$ 5,381	$ 169,651	$ 175,032	1.085641

			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*		*Allocation of Provider Tax from Section L of the Survey Based on Total Cost*	*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 Ob		1505 ↓	1505 ↓	1505 ↓				1505 ↓	1505 ↓		
21	5000	OPERATING ROOM	$ 352,070	$ -	$ -		$ -	$ 352,070	$ -	$ 657,375	$ 657,375	0.535569
22	5400	RADIOLOGY-DIAGNOSTIC	$ 917,087	$ -	$ -		$ -	$ 917,087	$ 78,441	$ 1,453,237	$ 1,531,678	0.598747
23	5700	CT SCAN	$ 369,981	$ -	$ -		$ -	$ 369,981	$ 53,005	$ 2,387,948	$ 2,440,953	0.151572
24	5800	MRI	$ 23,966	$ -	$ -		$ -	$ 23,966	$ 2,250	$ 37,618	$ 39,868	0.601134
25	6000	LABORATORY	$ 1,313,281	$ -	$ -		$ -	$ 1,313,281	$ 599,556	$ 2,124,675	$ 2,724,231	0.482074
26	6500	RESPIRATORY THERAPY	$ 532,276	$ -	$ -		$ -	$ 532,276	$ 452,796	$ 170,434	$ 623,230	0.854060
27	6600	PHYSICAL THERAPY	$ 918,121	$ -	$ -		$ -	$ 918,121	$ 1,301,044	$ 328,442	$ 1,629,486	0.563442
28	6700	OCCUPATIONAL THERAPY	$ 486,469	$ -	$ -		$ -	$ 486,469	$ 874,313	$ 158,137	$ 1,032,450	0.471179
29	6800	SPEECH PATHOLOGY	$ 32,805	$ -	$ -		$ -	$ 32,805	$ 72,691	$ 13,179	$ 85,870	0.382031
30	6900	ELECTROCARDIOLOGY	$ 23,322	$ -	$ -		$ -	$ 23,322	$ 13,024	$ 170,294	$ 183,318	0.127222
31	7100	MEDICAL SUPPLIES CHARGED TO PAT	$ 249,296	$ -	$ -		$ -	$ 249,296	$ 251,289	$ 192,692	$ 443,981	0.561502
32	7300	DRUGS CHARGED TO PATIENTS	$ 824,002	$ -	$ -		$ -	$ 824,002	$ 2,008,687	$ 863,384	$ 2,872,071	0.286902
33	9000	CLINIC	$ 54,496	$ -	$ -		$ -	$ 54,496	$ -	$ 17,916	$ 17,916	3.041750
34	9100	EMERGENCY	$ 2,427,329	$ -	$ -		$ -	$ 2,427,329	$ 6,238	$ 4,532,684	$ 4,538,922	0.534781
126		**Total Ancillary**	$ 8,524,501	$ -	$ -		$ -	$ 8,524,501	$ 5,718,715	$ 13,277,666	$ 18,996,381	
127		**Weighted Average**										0.458746

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Provider Tax Assessment	Net 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
128	**Sub Totals**	$ 12,347,722	$ -	$ -	$ -	$ 9,053,727	$ 8,667,616	$ 13,277,666	$ 21,945,282	
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)					$ -				
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)					$ 1,632,328	1505			
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**					**$ 7,421,399**				
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 (07/01/2015-06/30/2016) | MORGAN MEMORIAL HOSPITAL

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	$ 833.43		10		2		62		-		20		74		23.10%
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
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	$ -		-		-		-		-		-		-		
11	0	$ -		-		-		-		-		-		-		
12	0	$ -		-		-		-		-		-		-		
13	0	$ -		-		-		-		-		-		-		
14	0	$ -		-		-		-		-		-		-		
15	0	$ -		-		-		-		-		-		-		
16	0	$ -		-		-		-		-		-		-		
17	0	$ -		-		-		-		-		-		-		
18			Total Days	10 4103		2 4203		62 4303		-		20 5103		74		23.10%
19	Total Days per PS&R or Exhibit Detail			10		2		62		-		20				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 5,256 4103		$ 1,152 4203		$ 38,820 4303		$ -		$ 12,096 5103		$ 45,228		1.94%
21.01	Calculated Routine Charge Per Diem			$ 525.60		$ 576.00		$ 626.13		$ -		$ 604.80		$ 611.19		
	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)		1.085641	$ -	$ 5,270	$ 476	$ 4,366	$ 272	$ 34,056	$ -	$ -	$ 2,996	$ 19,582	$ 748	$ 43,692	38.29%
23	5000 OPERATING ROOM		0.535569	$ -	$ 53,355	$ -	$ 16,037	$ -	$ 67,378	$ -	$ -	$ -	$ 41	$ -	$ 136,770	20.81%
24	5400 RADIOLOGY-DIAGNOSTIC		0.598747	$ 941	$ 69,797	$ 147	$ 295,402	$ 3,348	$ 152,522	$ -	$ -	$ 3,287	$ 116,208	$ 4,436	$ 517,721	41.89%
25	5700 CT SCAN		0.151572	$ 1,200	$ 89,040	$ -	$ -	$ 6,900	$ 175,767	$ -	$ -	$ 5,400	$ 320,419	$ 8,100	$ 264,807	24.53%
26	5800 MRI		0.601134	$ -	$ 1,125	$ -	$ -	$ 1,125	$ 5,775	$ -	$ -	$ -	$ -	$ 1,125	$ 6,900	20.13%
27	6000 LABORATORY		0.482074	$ 9,213	$ 117,189	$ 1,564	$ 333,273	$ 21,620	$ 188,604	$ -	$ -	$ 12,344	$ 336,797	$ 32,397	$ 639,066	37.46%
28	6500 RESPIRATORY THERAPY		0.854060	$ 2,574	$ 10,921	$ 1,245	$ 22,578	$ 9,179	$ 18,997	$ -	$ -	$ 3,017	$ 42,141	$ 12,998	$ 52,496	17.75%
29	6600 PHYSICAL THERAPY		0.563442	$ -	$ 182	$ -	$ 16,963	$ 669	$ 23,162	$ -	$ -	$ -	$ -	$ 669	$ 40,307	2.51%
30	6700 OCCUPATIONAL THERAPY		0.471179	$ -	$ 677	$ -	$ -	$ -	$ 6,767	$ -	$ -	$ -	$ -	$ -	$ 7,444	0.72%
31	6800 SPEECH PATHOLOGY		0.382031	$ -	$ -	$ -	$ -	$ 710	$ 2,250	$ -	$ -	$ -	$ -	$ 710	$ 2,250	3.45%
32	6900 ELECTROCARDIOLOGY		0.127222	$ -	$ 6,656	$ -	$ 3,200	$ 384	$ 16,276	$ -	$ -	$ -	$ -	$ 384	$ 26,132	14.46%
33	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.561502	$ 2,073	$ 9,858	$ 722	$ 31,633	$ 9,535	$ 23,122	$ -	$ -	$ 2,616	$ 26,528	$ 12,330	$ 64,613	23.89%
34	7300 DRUGS CHARGED TO PATIENTS		0.286902	$ 7,022	$ 44,559	$ 1,818	$ 64,063	$ 25,515	$ 39,231	$ -	$ -	$ 14,271	$ 102,543	$ 34,355	$ 147,853	10.41%
35	9000 CLINIC		3.041750	$ -	$ 4,042	$ -	$ -	$ -	$ 1,392	$ -	$ -	$ -	$ -	$ -	$ 5,434	30.33%
36	9100 EMERGENCY		0.534781	$ 4,250	$ 279,891	$ 761	$ 754,346	$ -	$ 312,950	$ -	$ -	$ 184	$ 970,200	$ 5,011	$ 1,347,187	51.17%
127	0		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				27,273 4103	692,562 4103	6,733 4203	1,541,861 4203	79,257 4303	1,068,249 4303	-	-	44,115 5103	1,934,459 5103			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 32,529	$ 692,562	$ 7,885	$ 1,541,861	$ 118,077	$ 1,068,249	$ -	$ -	$ 56,211 (Agrees to Exhibit A)	$ 1,934,459 (Agrees to Exhibit A)	$ 158,491	$ 3,302,672	24.84%
129	Total Charges per PS&R or Exhibit Detail			$ 32,529	$ 692,562	$ 7,885	$ 1,541,861	$ 118,077	$ 1,068,249	$ -	$ -	$ 56,211	$ 1,934,459			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 21,171	$ 337,643	$ 5,423	$ 819,662	$ 87,328	$ 516,640	$ -	$ -	$ 36,897	$ 900,939	$ 113,922	$ 1,673,945	36.73%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 16,557 4103	$ 256,629 4103	$ -	$ -	$ 14,819 4303	$ 72,658 4303	$ -	$ -			$ 31,376	$ 329,287	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 5,914 4203	$ 420,783 4203	$ -	$ -	$ -	$ -			$ 5,914	$ 420,783	
134	Private Insurance (including primary and third party liability)			$ -	$ 4,560 4103	$ -	$ 10,897	$ -	$ 791 4303	$ -	$ -			$ -	$ 16,248	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ 1,029	$ -	$ -	$ -	$ -			$ -	$ 1,029	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 16,557	$ 261,189	$ 5,914	$ 432,709									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ 2,081 4901	$ -	$ -							$ -	$ 2,081	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 64,549 4303	$ 348,199 4303	$ -	$ -			$ 64,549	$ 348,199	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ 16,710 1505	$ -	$ -			$ -	$ 16,710	
142	Other Medicare Cross-Over Payments (See Note D)							$ 5,455 4304	$ 61,219 4304	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 5,455	$ 61,219	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 1,440 5203	$ 65,383 5203			
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)**			$ 4,614	$ 74,373	$ (491)	$ 386,953	$ 2,505	$ 17,063	$ -	$ -	$ 35,457	$ 835,556	$ 6,628	$ 478,389	
146	**Calculated Payments as a Percentage of Cost**			78%	78%	109%	53%	97%	97%	0%	0%	4%	7%	94%	71%	

ERROR! No other eligibles reported! See certification statement on DSH Survey Part I.

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)** 250 1505 — **Total Medicare Days**

148 **Percent of cross-over days to total Medicare days from the cost report** 25% — **XO to MCR Day Ratio**

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 (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

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	$ 833.43		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
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	$ -		-		-		-		-		-	
11		$ -		-		-		-		-		-	
12		$ -		-		-		-		-		-	
13		$ -		-		-		-		-		-	
14		$ -		-		-		-		-		-	
15		$ -		-		-		-		-		-	
16		$ -		-		-		-		-		-	
17		$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		1.085641	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.535569	-	-	-	-	-	-	-	-	$ -	$ -
24	5400 RADIOLOGY-DIAGNOSTIC		0.598747	-	-	-	-	-	-	-	-	$ -	$ -
25	5700 CT SCAN		0.151572	-	-	-	-	-	-	-	-	$ -	$ -
26	5800 MRI		0.601134	-	-	-	-	-	-	-	-	$ -	$ -
27	6000 LABORATORY		0.482074	-	-	-	-	-	-	-	-	$ -	$ -
28	6500 RESPIRATORY THERAPY		0.854060	-	-	-	-	-	-	-	-	$ -	$ -
29	6600 PHYSICAL THERAPY		0.563442	-	-	-	-	-	-	-	-	$ -	$ -
30	6700 OCCUPATIONAL THERAPY		0.471179	-	-	-	-	-	-	-	-	$ -	$ -
31	6800 SPEECH PATHOLOGY		0.382031	-	-	-	-	-	-	-	-	$ -	$ -
32	6900 ELECTROCARDIOLOGY		0.127222	-	-	-	-	-	-	-	-	$ -	$ -
33	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.561502	-	-	-	-	-	-	-	-	$ -	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.286902	-	-	-	-	-	-	-	-	$ -	$ -
35	9000 CLINIC		3.041750	-	-	-	-	-	-	-	-	$ -	$ -
36	9100 EMERGENCY		0.534781	-	-	-	-	-	-	-	-	$ -	$ -
37			-	-	-	-	-	-	-	-	-	$ -	$ -
38			-	-	-	-	-	-	-	-	-	$ -	$ -
39			-	-	-	-	-	-	-	-	-	$ -	$ -
40			-	-	-	-	-	-	-	-	-	$ -	$ -
41			-	-	-	-	-	-	-	-	-	$ -	$ -
42			-	-	-	-	-	-	-	-	-	$ -	$ -
43			-	-	-	-	-	-	-	-	-	$ -	$ -
44			-	-	-	-	-	-	-	-	-	$ -	$ -
45			-	-	-	-	-	-	-	-	-	$ -	$ -
46			-	-	-	-	-	-	-	-	-	$ -	$ -
47			-	-	-	-	-	-	-	-	-	$ -	$ -
48			-	-	-	-	-	-	-	-	-	$ -	$ -
49			-	-	-	-	-	-	-	-	-	$ -	$ -
50			-	-	-	-	-	-	-	-	-	$ -	$ -
51			-	-	-	-	-	-	-	-	-	$ -	$ -
52			-	-	-	-	-	-	-	-	-	$ -	$ -
53			-	-	-	-	-	-	-	-	-	$ -	$ -
54			-	-	-	-	-	-	-	-	-	$ -	$ -
55			-	-	-	-	-	-	-	-	-	$ -	$ -
56			-	-	-	-	-	-	-	-	-	$ -	$ -
57			-	-	-	-	-	-	-	-	-	$ -	$ -
58			-	-	-	-	-	-	-	-	-	$ -	$ -
59			-	-	-	-	-	-	-	-	-	$ -	$ -
60			-	-	-	-	-	-	-	-	-	$ -	$ -
61			-	-	-	-	-	-	-	-	-	$ -	$ -
62			-	-	-	-	-	-	-	-	-	$ -	$ -
63			-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

				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	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
73			-	-	-	-	-	-	-	-	-	$ -	$ -
74			-	-	-	-	-	-	-	-	-	$ -	$ -
75			-	-	-	-	-	-	-	-	-	$ -	$ -
76			-	-	-	-	-	-	-	-	-	$ -	$ -
77			-	-	-	-	-	-	-	-	-	$ -	$ -
78			-	-	-	-	-	-	-	-	-	$ -	$ -
79			-	-	-	-	-	-	-	-	-	$ -	$ -
80			-	-	-	-	-	-	-	-	-	$ -	$ -
81			-	-	-	-	-	-	-	-	-	$ -	$ -
82			-	-	-	-	-	-	-	-	-	$ -	$ -
83			-	-	-	-	-	-	-	-	-	$ -	$ -
84			-	-	-	-	-	-	-	-	-	$ -	$ -
85			-	-	-	-	-	-	-	-	-	$ -	$ -
86			-	-	-	-	-	-	-	-	-	$ -	$ -
87			-	-	-	-	-	-	-	-	-	$ -	$ -
88			-	-	-	-	-	-	-	-	-	$ -	$ -
89			-	-	-	-	-	-	-	-	-	$ -	$ -
90			-	-	-	-	-	-	-	-	-	$ -	$ -
91			-	-	-	-	-	-	-	-	-	$ -	$ -
92			-	-	-	-	-	-	-	-	-	$ -	$ -
93			-	-	-	-	-	-	-	-	-	$ -	$ -
94			-	-	-	-	-	-	-	-	-	$ -	$ -
95			-	-	-	-	-	-	-	-	-	$ -	$ -
96			-	-	-	-	-	-	-	-	-	$ -	$ -
97			-	-	-	-	-	-	-	-	-	$ -	$ -
98			-	-	-	-	-	-	-	-	-	$ -	$ -
99			-	-	-	-	-	-	-	-	-	$ -	$ -
100			-	-	-	-	-	-	-	-	-	$ -	$ -
101			-	-	-	-	-	-	-	-	-	$ -	$ -
102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
104			-	-	-	-	-	-	-	-	-	$ -	$ -
105			-	-	-	-	-	-	-	-	-	$ -	$ -
106			-	-	-	-	-	-	-	-	-	$ -	$ -
107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
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)	$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

		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	
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)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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 (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

		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)										State/Local-Only Indigent Care Program		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From 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 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	0 Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	0 Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	0 Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	0 Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	0 Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	0 Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	0 Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8	0	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 D 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 (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 E 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 (07/01/2015-06/30/2016) MORGAN MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. F-3**	3,461,163
19	Uninsured Hospital	**Charges Sec. F-3**	1,990,670
20	Total Hospital	**Charges Sec. F-3**	19,132,249
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		18.09%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.40%
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. F-3 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.*

DSH Examination Eligibility Summary

Hospital Name	**MORGAN MEMORIAL HOSPITAL**
Hospital Medicaid Number	**000694229A**
Cost Report Period	From **7/1/2015** To **6/30/2016**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 806,378	$ (451)	$ 805,927
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 806,378	$ (451)	$ 805,927
4	Net Hospital Patient Revenue	Survey F-3	$ 10,513,613	$ (0)	$ 10,513,613
5	Medicaid Fraction		7.67%	0.00%	7.67%
6	Inpatient Charity Care Charges	Survey F-2	$ 9,548	$ -	$ 9,548
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 9,548	$ -	$ 9,548
10	Inpatient Hospital Charges	Survey F-3	$ 5,842,964	$ -	$ 5,842,964
11	Inpatient Charity Fraction		0.16%	0.00%	0.16%
12	LIUR		7.83%	0.00%	7.83%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	74	-	74
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		74	-	74
16	Total Hospital Days (excludes swing-bed)	Survey F-1	407	-	407
17	MIUR		18.18%	0.00%	18.18%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **MORGAN MEMORIAL HOSPITAL**
Hospital Medicaid Number: **000694229A**
Cost Report Period: From **7/1/2015** To **6/30/2016**

As-Reported:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	21,171	16,557	-	-	-	-	-	-	-	-	-			16,557	4,614	78.21%
2	Medicaid Fee for Service	Outpatient	337,643	255,290	-	3,962	591	3,878	-	-	-	-	-			263,721	73,922	78.11%
3	Medicaid Managed Care	Inpatient	5,423	-	5,914	-	-	-	-							5,914	(491)	109.05%
4	Medicaid Managed Care	Outpatient	819,662	-	420,783	10,897	1,029	-	-							432,709	386,953	52.79%
5	Medicare Cross-over (FFS)	Inpatient	87,328	14,819	-	-	-		-	64,549	-	-	-			79,368	7,960	90.88%
6	Medicare Cross-over (FFS)	Outpatient	516,640	72,658	-	791	-		-	348,199	-	16,710	-			438,358	78,282	84.85%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
9	Uninsured	Inpatient	36,897											720	-	720	36,177	1.95%
10	Uninsured	Outpatient	900,939											66,103	-	66,103	834,836	7.34%
11	In-State Sub-total	Inpatient	150,819	31,376	5,914	-	-	-	-	64,549	-	-	-	720	-	102,559	48,260	68.00%
12	In-State Sub-total	Outpatient	2,574,884	327,948	420,783	15,650	1,620	3,878	-	348,199	-	16,710	-	66,103	-	1,200,891	1,373,993	46.64%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	2,725,703	359,324	426,697	15,650	1,620	3,878	-	412,748	-	16,710	-	66,823	-	1,303,450	1,422,253	47.82%

Adjustments:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	1,339	-	598	(591)	(1,797)	-	-	-	-	-			(451)	451	-0.13%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	5,455			5,455	(5,455)	6.25%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	61,219			61,219	(61,219)	11.85%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-											720	-	720	(720)	1.95%
10	Uninsured	Outpatient	-											(720)	-	(720)	720	-0.08%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	5,455	720	-	6,175	(6,175)	4.09%
12	In-State Sub-total	Outpatient	-	1,339	-	598	(591)	(1,797)	-	-	-	-	61,219	(720)	-	60,048	(60,048)	2.33%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	1,339	-	598	(591)	(1,797)	-	-	-	-	66,674	(0)	-	66,223	(66,223)	2.43%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **MORGAN MEMORIAL HOSPITAL**
Hospital Medicaid Number: **000694229A**
Cost Report Period: From **7/1/2015** To **6/30/2016**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	21,171	16,557	-	-	-	-	-	-	-	-	-			16,557	4,614	78.21%
2	Medicaid Fee for Service	Outpatient	337,643	256,629	-	4,560	-	2,081	-	-	-	-	-			263,270	74,373	77.97%
3	Medicaid Managed Care	Inpatient	5,423	-	5,914	-	-	-	-							5,914	(491)	109.05%
4	Medicaid Managed Care	Outpatient	819,662	-	420,783	10,897	1,029	-	-							432,709	386,953	52.79%
5	Medicare Cross-over (FFS)	Inpatient	87,328	14,819	-	-	-		-	64,549	-	-	5,455			84,823	2,505	97.13%
6	Medicare Cross-over (FFS)	Outpatient	516,640	72,658	-	791	-		-	348,199	-	16,710	61,219			499,577	17,063	96.70%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
9	Uninsured	Inpatient	36,897	-	-	-	-	-	-	-	-	-	-	1,440	-	1,440	35,457	3.90%
10	Uninsured	Outpatient	900,939	-	-	-	-	-	-	-	-	-	-	65,383	-	65,383	835,556	7.26%
11	In-State Sub-total	Inpatient	150,819	31,376	5,914	-	-	-	-	64,549	-	-	5,455	1,440	-	108,734	42,085	72.10%
12	In-State Sub-total	Outpatient	2,574,884	329,287	420,783	16,248	1,029	2,081	-	348,199	-	16,710	61,219	65,383	-	1,260,939	1,313,945	48.97%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	2,725,703	360,663	426,697	16,248	1,029	2,081	-	412,748	-	16,710	66,674	66,823	-	1,369,673	1,356,030	50.25%

16 Less: Out of State DSH Payments from Adjusted Survey -
17 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments 1,356,030

Medicaid DSH Survey Adjustments

PROVIDER: MORGAN MEMORIAL HOSPITAL
FROM: 7/1/2015 TO: 6/30/2016
Mcaid Number: 000694229A
Mcare Number: 111304

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	E - Disclosure of Medicaid / Uninsured Payments	9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	1.00	Amount - Inpatient	Adjust to hospital's uninsured data.	$ 720	$ 720	$ 1,440	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	1.00	Amount - Inpatient	Adjust to hospital's data.	$ 15,496	$ 15,496	$ 30,992	5203
1	E - Disclosure of Medicaid / Uninsured Payments	9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	2.00	Amount - Outpatient	Adjust to hospital's uninsured data.	$ 66,103	$ (720)	$ 65,383	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	2.00	Amount - Outpatient	Adjust to hospital's data.	$ 451,399	$ (15,496)	$ 435,903	5203
2	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dowr	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to paid claims data.	$ 255,290	$ 1,339	$ 256,629	4103
2	H - In-State	134	Private Insurance (including primary and third party liabilit	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to paid claims data.	$ 3,962	$ 598	$ 4,560	4103
2	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to paid claims data.	$ 591	$ (591)	$ -	4103
2	H - In-State	137	Medicaid Cost Settlement Payments (See Note B)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to Cost Report Settlement data.	$ 3,878	$ (1,797)	$ 2,081	4901
3	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 5,455	$ 5,455	4304
3	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 61,219	$ 61,219	4304
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis	13.00	Inpatient Uninsured	Adjust to hospital's data	$ 720	$ 720	$ 1,440	5203
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis	14.00	Outpatient Uninsured	Adjust to hospital's data	$ 66,103	$ (720)	$ 65,383	5203

Medicaid DSH Report Notes

PROVIDER: MORGAN MEMORIAL HOSPITAL Mcaid Number: 000694229A
FROM: 7/1/2015 TO: 6/30/2016 Mcare Number: 111304

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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DSH Cost & Payment Summary

Georgia

Total Med
Total Med

Hospital Name	**MORGAN MEMORIAL HOSPITAL**		
Hospital Medicaid Number	**00069229A**		
Cost Report Period	From **7/1/2015**	To	**6/30/2016**

A	B	C	D	E	F	G	H	I	J	K	L	M	N	K
Regular IP/OP Medicaid FFS Rate Payments	IP/OP Medicaid MCO Payments	Total Medicaid IP/OP Payments (A+B) [1]	Total Cost of Care - Medicaid IP/OP Services	Total Medicaid Net Cost (D-C)	Total IP/OP Indigent Care/Self-Pay Revenues	Total Applicable Section 1011 Payments	Total IP/OP Uninsured Cost of Care	Total Uninsured Uncompensated Care Cost (H-G-F)	Total Cost Report Period UCC* (E+I)	Total Cumulative Trend (See Table Below)	Trended Total Estimated Net Cost (J*K)	Trended Estimated Medicaid Net Cost (E*K)	Trended Estimated Uninsured Uncompensated Care Cost (UCC) (I*K)	Out of State (OOS) DSH Payment
$ 864,227	$ 438,623	$ 1,302,850	$ 1,787,867	$ 485,017	$ 66,823	$ -	$ 937,836	$ 871,013	$ 1,356,030	104.57%	$ 1,418,000	$ 507,182	$ 910,818	$ -

* Note 1: Total Medicaid payments do not include other Medicaid payments paid during the state DSH year (i.e., supplemental payments, GME, UPL, etc.) which must be included in the final uncompensated care cost calculation in determining the DSH UCC.