March 27, 2020

Kyle H. 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, 2017

Dear Mr. Wilkinson:

Myers and Stauffer LC has completed the mandated examinations of Georgia's fiscal 2017 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,

Adrian Davis

Georgia DSH Examination Results for 2017 3/27/2020 15:22

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 2017 state DSH year. Reviews have been completed and below are the results of those reviews. The DSH payment for the 2017 state DSH year, as well as the uncompensated care calculation (UCC) are presented below. The UCC is presented including only Medicare and private insurance payments effective June 2, 2017 per the April 3, 2017 Final Rule.

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

Georgia Medicaid DSH Examination Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2016 - 6/30/2017

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)
	Cost Report Year Begin	Cost Report Year End	% of Year Applicable to DSH Year	% of Year Covering June 2, 2017 and On	Uninsured / Medicaid Cost	Medicaid and Self-Pay Payments	Medicare Payments	Private Insurance Payments (TPL)	Cost Report Year Adjusted DSH Uncompensated Care Cost (UCC) Including Medicare and TPL Payments as of June 2, 2017 (E)- (F)- (G+H)* (D)	State DSH Year Adjusted DSH Uncompensated Care Cost (UCC) Including Medicare and TPL Payments as of June 2, 2017 (C) x (I)
Cost Report Year 1 UCC:	7/1/2016 -	6/30/2017	100.00%	7.95%	$ 2,581,701	$ 838,181	$ 433,565	$ 20,104	$ 1,707,475	$ 1,707,475
Cost Report Year 2 UCC:	-		0.00%	0.00%					$ -	$ -
Cost Report Year 3 UCC:	-		0.00%	0.00%					$ -	$ -
State DSH Year Sub-Totals:					$ 2,581,701	$ 838,181	$ 433,565	$ 20,104		$ 1,707,475

Less Supplemental Payments (UPL, etc.):	$ 29,134
State DSH Year Adjusted Uncompensated Care Calculation (UCC):	$ 1,678,341
Out-of-State DSH Payments:	$ -
DSH Payments:	$ 724,523
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:	**$ -**
DSH Year Low Income Utilization Ratio (LIUR):	7.66%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	19.54%

Observations (may be included in examination report):

1. Please be advised that an estimated Medicaid settlement was calculated for the most recent cost reporting period under review. If you have a final Medicaid settlement for the most recent cost reporting period under review, please provide a copy of the NPR that was received. Initial results are subject to change if a final settlement is received from the state.

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

Overnight Packages: Myers and Stauffer LC
Attn: DSH Examinations
700 W 47th Street, Suite 1100
Kansas City, MO 64112

Web Portal: https://dsh.mslc.com

Phone Inquiries: 800-374-6858

DSH Version 5.20 11/1/2017

A. General DSH Year Information

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

Workpaper #:	1301	Reviewer:
Examiner:	JAK	BLB
Date:	11/20/2019	1/6/2020

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	07/01/2016	06/30/2017
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 (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1/1/1960

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

During the Interim DSH Payment Year:	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No

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

0

0

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?	Yes

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017** $ 29,134 **4904**
(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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.

Hospital CEO or CFO	Title	Date
0	CHIEF FINANCIAL OFFICER	**11/13/2018**

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

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

Hospital Contact:	
Name	KYLE H. WILKINSON
Title	CHIEF FINANCIAL OFFICER
Telephone Number	7067522284
E-Mail Address	KYLEW@MMH.ORG
Mailing Street Address	1077 S. MAIN ST
Mailing City, State, Zip	MADISON, GA 30650-2073

Outside Preparer:	
Name	JIMMIE D. RICHTER, JR.
Title:	PARTNER
Firm Name:	DRAFFIN & TUCKER, LLP
Telephone Number	4047194059
E-Mail Address	JRICHTER@DRAFFIN-TUCKER.COM

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

Medicaid DSH Survey Adjustments

PROVIDER: MORGAN MEMORIAL HOSPITAL
FROM: 7/1/2016 TO: 6/30/2017
Mcaid Number: 000694229A
Mcare Number: 111304

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Year	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302	Reviewer:
Examiner:	JAK	BLB
Date:	11/20/2019	1/6/2020
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 7/1/2016 - 6/30/2017

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

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

	7/1/2016 through 6/30/2017		
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: 12/27/2017

	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	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	111304	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2016 - 06/30/2017)

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

	Inpatient		Outpatient		Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 760	5203	$ 72,528	5203	$73,288
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 10,807	5203	$ 575,972	5203	$586,779
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$11,567		$648,500		$660,067
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.57%		11.18%		11.10%

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 (07/01/2016 - 06/30/2017)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	307	1405

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	14,889
8. Outpatient Hospital Charity Care Charges	28,353
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 43,242

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
	1405	1405	1405				
11. Hospital	$ 187,584	$ -	$ -	$ 83,057	$ -	$ -	$ 104,527
12. Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ 1,577,601			$ 698,516	
15. Swing Bed - NF			$ 1,018,458			$ 450,944	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 5,392,889	$ 8,949,948	$ -	$ 2,387,816	$ 3,962,779	$ -	$ 7,992,242
20. Outpatient Services		$ 5,222,991	$ -		$ 2,312,590	$ -	$ 2,910,401
21. Home Health Agency			$ -			$ -	
22. Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ -	$ -	$ 1,486,823	$ -	$ -	$ 658,322	$ -
27. Total	$ 5,580,473	$ 14,172,939	$ 4,082,882	$ 2,470,873	$ 6,275,370	$ 1,807,783	$ 11,007,170
28. Total Hospital and Non Hospital		Total from Above	$ 23,836,294		Total from Above	$ 10,554,025	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 23,836,294	1405	Total Contractual Adj. (G-3 Line 2)	$ 10,062,147 1405
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)				+	$ -
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)				+	$ 491,878
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					10,554,025
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) MORGAN MEMORIAL HOSPITAL

Line #	Code	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		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*	*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):	1405	1405	1405	1405		1405	1405		
1	03000	ADULTS & PEDIATRICS	$ 3,842,267	$ -	$ -	$ 3,346,172	$ 496,095	488	$ 2,783,643		$ 1,016.59
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	$ -	$ -	$ -		$ -	-	$ -		$ -
17		0	$ -	$ -	$ -		$ -	-	$ -		$ -
18		Total Routine	$ 3,842,267	$ -	$ -	$ 3,346,172	$ 496,095	488	$ 2,783,643		
19		Weighted Average									$ 1,016.59

Line #	Code	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
			1405				1405	1405		
20	09200	Observation (Non-Distinct)	181	-	-	$ 184,003	$ 13,494	$ 123,628	$ 137,122	1.341893

Line #	Code	Cost Center Description	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 Ob	1405	1405	1405			1405	1405		
21	5000	OPERATING ROOM	$ 289,433	$ -	$ -		$ 289,433	$ -	$ 673,331	$ 673,331	0.429852
22	5400	RADIOLOGY-DIAGNOSTIC	$ 916,070	$ -	$ -		$ 916,070	$ 60,380	$ 1,400,714	$ 1,461,094	0.626975
23	5700	CT SCAN	$ 399,091	$ -	$ -		$ 399,091	$ 70,068	$ 2,876,227	$ 2,946,295	0.135455
24	5800	MRI	$ 92,617	$ -	$ -		$ 92,617	$ 6,033	$ 114,098	$ 120,131	0.770967
25	6000	LABORATORY	$ 1,319,748	$ -	$ -		$ 1,319,748	$ 574,083	$ 2,263,481	$ 2,837,564	0.465099
26	6500	RESPIRATORY THERAPY	$ 494,917	$ -	$ -		$ 494,917	$ 441,164	$ 241,368	$ 682,532	0.725119
27	6600	PHYSICAL THERAPY	$ 913,088	$ -	$ -		$ 913,088	$ 1,237,112	$ 282,129	$ 1,519,241	0.601016
28	6700	OCCUPATIONAL THERAPY	$ 414,626	$ -	$ -		$ 414,626	$ 782,784	$ 150,379	$ 933,163	0.444323
29	6800	SPEECH PATHOLOGY	$ 31,117	$ -	$ -		$ 31,117	$ 77,924	$ 8,659	$ 86,583	0.359389
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 336,205	$ -	$ -		$ 336,205	$ 217,776	$ 218,266	$ 436,042	0.771038

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) MORGAN MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		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
31	7300	DRUGS CHARGED TO PATIENTS	$ 835,797	$ -	$ -		$ 835,797	$ 1,925,565	$ 721,296	$ 2,646,861	0.315769
32	9000	CLINIC	$ 67,822	$ -	$ -		$ 67,822	$ -	$ 19,226	$ 19,226	3.527619
33	9100	EMERGENCY	$ 2,564,866	$ -	$ -		$ 2,564,866	$ 17,062	$ 5,049,581	$ 5,066,643	0.506226
34			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 8,675,397	$ -	$ -		$ 8,675,397	$ 5,423,445	$ 14,142,383	$ 19,565,828	
127		**Weighted Average**									0.452800
128		**Sub Totals**	$ 12,517,664	$ -	$ -		$ 9,171,492	$ 8,207,088	$ 14,142,383	$ 22,349,471	
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)					$ 1,397,544	1405			
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**					**$ 7,773,948**				
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 (07/01/2016-06/30/2017) MORGAN MEMORIAL HOSPITAL

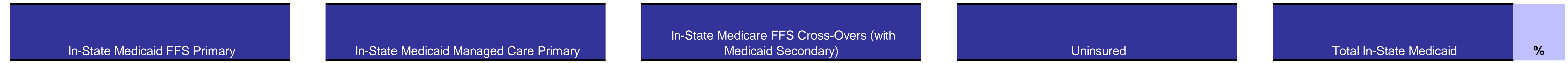
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,016.59		23		2		35		50		60		35.83%
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	$ -		-		-		-		-		-		
17	0	$ -		-		-		-		-		-		
18			Total Days	23 4103		2 4203		35 4303		50 5103		60		35.83%
19	Total Days per PS&R or Exhibit Detail			23		2		35		50				
20	Unreconciled Days (Explain Variance)			-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 14,172 4103		$ 1,152 4203		$ 21,756 4303		$ 29,100 5103		$ 37,080		2.38%
21.01	Calculated Routine Charge Per Diem			$ 616.17		$ 576.00		$ 621.60		$ 582.00		$ 618.00		
	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	
22	09200 Observation (Non-Distinct)		1.341893	$ -	$ 1,942	$ 616	$ 2,652	$ -	$ 19,274	$ 1,898	$ 10,696	$ 616	$ 23,868	27.04%
23	5000 OPERATING ROOM		0.429852	$ -	$ 65,492	$ -	$ 16,087	$ -	$ 54,830	$ -	$ -	$ -	$ 136,409	20.26%
24	5400 RADIOLOGY-DIAGNOSTIC		0.626975	$ -	$ 54,875	$ 2,302	$ 168,460	$ 6,144	$ 79,328	$ 604	$ 100,892	$ 8,446	$ 302,663	28.24%
25	5700 CT SCAN		0.135455	$ 5,500	$ 117,435	$ 2,700	$ 161,582	$ 8,000	$ 234,085	$ 5,200	$ 332,747	$ 16,200	$ 513,102	29.44%
26	5800 MRI		0.770967	$ -	$ 8,175	$ -	$ 16,050	$ 1,125	$ 4,500	$ -	$ -	$ 1,125	$ 28,725	24.85%
27	6000 LABORATORY		0.465099	$ 14,112	$ 1,836	$ 65	$ 130,994	$ 15,677	$ 169,929	$ 11,127	$ 383,693	$ 29,854	$ 302,759	25.64%
28	6500 RESPIRATORY THERAPY		0.725119	$ 515	$ 15,646	$ -	$ 20,891	$ 4,571	$ 31,807	$ 2,180	$ 56,342	$ 5,086	$ 68,344	19.33%
29	6600 PHYSICAL THERAPY		0.601016	$ 416	$ 1,595	$ -	$ 3,102	$ 247	$ 14,357	$ -	$ 12,765	$ 663	$ 19,054	2.14%
30	6700 OCCUPATIONAL THERAPY		0.444323	$ 342	$ 2,544	$ -	$ 3,961	$ -	$ 10,481	$ -	$ 4,569	$ 342	$ 16,986	2.35%
31	6800 SPEECH PATHOLOGY		0.359389	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,462	$ -	$ -	1.69%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.771038	$ 1,158	$ 11,141	$ 289	$ 15,621	$ 5,947	$ 28,661	$ 1,736	$ 27,320	$ 7,394	$ 55,423	21.07%
33	7300 DRUGS CHARGED TO PATIENTS		0.315769	$ 10,315	$ 144,011	$ 1,209	$ 60,705	$ 20,216	$ 45,638	$ 10,122	$ 131,244	$ 31,740	$ 250,354	16.00%
34	9000 CLINIC		3.527619	$ -	$ 1,348	$ -	$ -	$ -	$ 720	$ -	$ 423	$ -	$ 2,068	12.96%
35	9100 EMERGENCY		0.506226	$ 6,415	$ 271,950	$ -	$ 771,734	$ -	$ 357,250	$ -	$ 1,131,395	$ 6,415	$ 1,400,934	50.11%
36			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				38,773	697,990	7,181	1,371,839	61,927	1,050,860	32,867	2,193,548			
	Totals / Payments													
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 52,945 4103	$ 697,990 4103	$ 8,333 4203	$ 1,371,839 4203	$ 83,683 4303	$ 1,050,860 4303	$ 61,967 5103 (Agrees to Exhibit A)	$ 2,193,548 5103 (Agrees to Exhibit A)	$ 144,961	$ 3,120,689	24.70%
129	Total Charges per PS&R or Exhibit Detail			$ 52,945	$ 697,990	$ 8,333	$ 1,371,839	$ 83,683	$ 1,050,860	$ 61,967 5203	$ 2,193,548 5203			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 38,863	$ 298,149	$ 5,304	$ 651,938	$ 63,107	$ 469,629	$ 65,750	$ 988,961	$ 107,274	$ 1,419,716	33.21%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 33,803 4103	$ 269,322 4103	$ -	$ -	$ 15,082 4303	$ 74,862 4303			$ 48,885	$ 344,184	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 5,688 4203	$ 392,521 4203	$ -	$ -			$ 5,688	$ 392,521	
134	Private Insurance (including primary and third party liability)			$ -	$ 7,239 4103	$ -	$ 12,433 4203	$ -	$ 432 4303			$ -	$ 20,104	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 429 4103	$ 13 4203	$ 622 4203	$ -	$ -			$ 13	$ 1,051	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 33,803	$ 276,990	$ 5,701	$ 405,576							
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (27,449) 4901	$ -	$ -					$ -	$ (27,449)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -					$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 35,718 4303	$ 323,753 4303			$ 35,718	$ 323,753	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ 12,932 1405	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ 12,932	
142	Other Medicare Cross-Over Payments (See Note D)							$ 11,486 4304	$ 49,676 4304			$ 11,486	$ 49,676	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 760 5203	$ 72,528 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)**			$ 5,060	$ 48,608	$ (397)	$ 246,362	$ 821	$ 7,974	$ 64,990	$ 916,433	$ 5,484	$ 302,944	
146	**Calculated Payments as a Percentage of Cost**			87%	84%	107%	62%	99%	98%	1%	7%	95%	79%	
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)**							187						
148	**Percent of cross-over days to total Medicare days from the cost report**							19%						

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.

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

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

Cost Report Year (07/01/2016-06/30/2017) MORGAN MEMORIAL HOSPITAL



In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Uninsured	Total In-State Medicaid	%

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) 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	$ 1,016.59		-		-		-		-		-	
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			$ -		-		-		-		-		-	
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)		1.341893	-	-	-	-	-	-	-	-	$ -	$ -
23	5000	OPERATING ROOM		0.429852	-	-	-	-	-	-	-	-	$ -	$ -
24	5400	RADIOLOGY-DIAGNOSTIC		0.626975	-	-	-	-	-	-	-	-	$ -	$ -
25	5700	CT SCAN		0.135455	-	-	-	-	-	-	-	-	$ -	$ -
26	5800	MRI		0.770967	-	-	-	-	-	-	-	-	$ -	$ -
27	6000	LABORATORY		0.465099	-	-	-	-	-	-	-	-	$ -	$ -
28	6500	RESPIRATORY THERAPY		0.725119	-	-	-	-	-	-	-	-	$ -	$ -
29	6600	PHYSICAL THERAPY		0.601016	-	-	-	-	-	-	-	-	$ -	$ -
30	6700	OCCUPATIONAL THERAPY		0.444323	-	-	-	-	-	-	-	-	$ -	$ -
31	6800	SPEECH PATHOLOGY		0.359389	-	-	-	-	-	-	-	-	$ -	$ -
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.771038	-	-	-	-	-	-	-	-	$ -	$ -
33	7300	DRUGS CHARGED TO PATIENTS		0.315769	-	-	-	-	-	-	-	-	$ -	$ -
34	9000	CLINIC		3.527619	-	-	-	-	-	-	-	-	$ -	$ -
35	9100	EMERGENCY		0.506226	-	-	-	-	-	-	-	-	$ -	$ -
36				-	-	-	-	-	-	-	-	-	$ -	$ -
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)				$ -	$ -	$ -	$ -						
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.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) 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

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

Cost Report Year (07/01/2016-06/30/2017) 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)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	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 (07/01/2016-06/30/2017) 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 (07/01/2016-06/30/2017) MORGAN MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

#	Description	Explanation	Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -	3001		
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:

#	Description	Dollar Amount
17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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

DSH Examination Eligibility Summary

Hospital Name	**MORGAN MEMORIAL HOSPITAL**
Hospital Medicaid Number	**000694229A**
Cost Report Period	From **7/1/2016** To **6/30/2017**

			As-Reported	Adjustments	As-Adjusted
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 800,941	$ (16,376)	$ 784,565
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 800,941	$ (16,376)	$ 784,565
4	Net Hospital Patient Revenue	Survey F-3	$ 11,007,170	$ -	$ 11,007,170
5	Medicaid Fraction		7.28%	-0.15%	7.13%
6	Inpatient Charity Care Charges	Survey F-2	$ 14,889	$ -	$ 14,889
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 14,889	$ -	$ 14,889
10	Inpatient Hospital Charges	Survey F-3	$ 5,580,473	$ -	$ 5,580,473
11	Inpatient Charity Fraction		0.27%	0.00%	0.27%
12	LIUR		7.55%	-0.15%	7.40%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	60	-	60
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		60	-	60
16	Total Hospital Days (excludes swing-bed)	Survey F-1	307	-	307
17	MIUR		19.54%	0.00%	19.54%

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	7/1/2016	To	6/30/2017

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	38,863	33,803	-	-	-	-	-	-	-	-	-			33,803	5,060	86.98%
2 Medicaid Fee for Service	Outpatient	298,149	269,322	-	7,239	429	(11,073)	-	-	-	-	-			265,917	32,232	89.19%
3 Medicaid Managed Care	Inpatient	5,304	-	5,688	-	13	-	-							5,701	(397)	107.48%
4 Medicaid Managed Care	Outpatient	651,938	-	392,521	12,433	622	-	-							405,576	246,362	62.21%
5 Medicare Cross-over (FFS)	Inpatient	63,107	15,082	-	-	-		-	35,718	-	-	-			50,800	12,307	80.50%
6 Medicare Cross-over (FFS)	Outpatient	469,629	74,862	-	432	-		-	323,753	-	12,932	-			411,979	57,650	87.72%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
9 Uninsured	Inpatient	65,750	-	-	-	-	-	-	-	-	-	-	760	-	760	64,990	1.16%
10 Uninsured	Outpatient	988,961	-	-	-	-	-	-	-	-	-	-	72,528	-	72,528	916,433	7.33%
11 In-State Sub-total	Inpatient	173,024	48,885	5,688	-	13	-	-	35,718	-	-	-	760	-	91,064	81,960	52.63%
12 In-State Sub-total	Outpatient	2,408,677	344,184	392,521	20,104	1,051	(11,073)	-	323,753	-	12,932	-	72,528	-	1,156,000	1,252,677	47.99%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15 Sub-Total	I/P and O/P	2,581,701	393,069	398,209	20,104	1,064	(11,073)	-	359,471	-	12,932	-	73,288	-	1,247,064	1,334,637	48.30%

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	-	-	-	-	-	(16,376)	-	-	-	-	-			(16,376)	16,376	-5.49%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	11,486			11,486	(11,486)	18.20%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	49,676			49,676	(49,676)	10.58%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	11,486	-	-	11,486	(11,486)	6.64%
12 In-State Sub-total	Outpatient	-	-	-	-	-	(16,376)	-	-	-	-	49,676	-	-	33,300	(33,300)	1.38%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	(16,376)	-	-	-	-	61,162	-	-	44,786	(44,786)	1.73%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	MORGAN MEMORIAL HOSPITAL		
Hospital Medicaid Number	000694229A		
Cost Report Period	From 7/1/2016	To	6/30/2017

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	38,863	33,803	-	-	-	-	-	-	-	-	-			33,803	5,060	86.98%
2 Medicaid Fee for Service	Outpatient	298,149	269,322	-	7,239	429	(27,449)	-	-	-	-	-			249,541	48,608	83.70%
3 Medicaid Managed Care	Inpatient	5,304	-	5,688	-	13	-	-							5,701	(397)	107.48%
4 Medicaid Managed Care	Outpatient	651,938	-	392,521	12,433	622	-	-							405,576	246,362	62.21%
5 Medicare Cross-over (FFS)	Inpatient	63,107	15,082	-	-	-		-	35,718	-	-	11,486			62,286	821	98.70%
6 Medicare Cross-over (FFS)	Outpatient	469,629	74,862	-	432	-		-	323,753	-	12,932	49,676			461,655	7,974	98.30%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
9 Uninsured	Inpatient	65,750	-	-	-	-	-	-	-	-	-	-	760	-	760	64,990	1.16%
10 Uninsured	Outpatient	988,961	-	-	-	-	-	-	-	-	-	-	72,528	-	72,528	916,433	7.33%
11 In-State Sub-total	Inpatient	173,024	48,885	5,688	-	13	-	-	35,718	-	-	11,486	760	-	102,550	70,474	59.27%
12 In-State Sub-total	Outpatient	2,408,677	344,184	392,521	20,104	1,051	(27,449)	-	323,753	-	12,932	49,676	72,528	-	1,189,300	1,219,377	49.38%
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	2,581,701	393,069	398,209	20,104	1,064	(27,449)	-	359,471	-	12,932	61,162	73,288	-	1,291,850	1,289,851	50.04%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	1,289,851

Medicaid DSH Survey Adjustments

PROVIDER: MORGAN MEMORIAL HOSPITAL
Mcaid Number: 000694229A
FROM: 7/1/2016 TO: 6/30/2017
Mcare Number: 111304

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	H - In-State	137	Medicaid Cost Settlement Payments (See Note B)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to cost report settlement estimate.	$ (11,073)	$ (16,376)	$ (27,449)	4901
2	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.	$ -	$ 11,486	$ 11,486	4304
2	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.	$ -	$ 49,676	$ 49,676	4304

Medicaid DSH Report Notes

PROVIDER: MORGAN MEMORIAL HOSPITAL   Mcaid Number: 000694229A
FROM: 7/1/2016   TO: 6/30/2017   Mcare Number: 111304

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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