GA DSH Payment Results for SFY 2021 **2/26/2021 10:08**

DSH Uncompensated Care Cost & Allocation Factor Summary

Preliminary Results

Provider Name	MORGAN MEMORIAL HOSPITAL
Mcaid Provider Number	000694229A
Mcare Provider Number	111304

Below is the preliminary uncompensated care cost and allocation factor used as a basis for the 2021 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Select hospitals will receive additional validation during the next few weeks. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2020 - 6/30/2021

	(A)	(B)	(C)	(D)	(E)
	Cost Report Year Begin	Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	7/1/2018 -	6/30/2019	$ 1,943,407	$ -	$ 1,943,407
Less: 2019 Net UPL Payments					$ 23,816
Less: GME Payments					$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)					$ 1,676
Uncompensated Care Allocation Factor					$ 1,921,267
2021 Eligibility					**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):					9.17%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):					40.09%

If you disagree with the findings presented above please respond within five 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 Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.00	3/31/2020

D. General Cost Report Year Information 7/1/2018 - 6/30/2019

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		
	7/1/2018 through 6/30/2019		
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:	11/26/2019		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	MORGAN MEMORIAL HOSPITAL	No	Morgan Medical Center
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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2018 - 06/30/2019

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)	$ 738	$ 66,636	$67,374
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 12,872	$ 417,176	$430,048
11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (N) on Exhibit B)	$13,610	$483,812	$497,422
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.42%	13.77%	13.54%

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 (07/01/2018 - 06/30/2019)

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)	232

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	24,905
8.	Outpatient Hospital Charity Care Charges	416,950
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 441,855

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			
11.	Hospital	$ 179,890	$ -	$ -	$ 69,877	$ -	$ -	$ 110,013
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 1,951,701			$ 758,120	
15.	Swing Bed - NF			$ 1,466,357			$ 569,593	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 4,950,848	$ 9,690,480	$ -	$ 1,923,112	$ 3,764,178	$ -	$ 8,954,038
20.	Outpatient Services		$ 5,788,324	$ -		$ 2,248,421	$ -	$ 3,539,903
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	

28.	Total Hospital and Non Hospital	Total from Above	$ 26,429,464	Total from Above	$ 10,266,283	
29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 26,429,464	Total Contractual Adj. (G-3 Line 2)	$ 9,829,503	
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)				+ $ 436,780	
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				10,266,283	
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) | 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
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 5,231,981	$ -	$ -	$ 4,575,299	**$ 656,682**	442	$ 3,597,948		**$ 1,485.71**
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	$ 5,231,981	$ -	$ -	$ 4,575,299	$ 656,682	442	$ 3,597,948		
19	Weighted Average									$ 1,485.71

		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)	210	-	-	**$ 311,999**	$ 2,986	$ 166,111	$ 169,097	**1.845089**

		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):								
21	5000 OPERATING ROOM	$ 750,014	$ -	$ -	**$ 750,014**	$ -	$ 355,571	$ 355,571	**2.109323**
22	5300 ANESTHESIOLOGY	$ 17,507	$ -	$ -	**$ 17,507**	$ -	$ 221,016	$ 221,016	**0.079211**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 1,453,601	$ -	$ -	**$ 1,453,601**	$ 29,108	$ 1,458,354	$ 1,487,462	**0.977236**
24	5700 CT SCAN	$ 462,464	$ -	$ -	**$ 462,464**	$ 33,432	$ 2,984,219	$ 3,017,651	**0.153253**
25	5800 MRI	$ 130,259	$ -	$ -	**$ 130,259**	$ -	$ 107,028	$ 107,028	**1.217055**
26	6000 LABORATORY	$ 1,795,753	$ -	$ -	**$ 1,795,753**	$ 406,365	$ 2,273,575	$ 2,679,940	**0.670072**
27	6500 RESPIRATORY THERAPY	$ 705,098	$ -	$ -	**$ 705,098**	$ 342,376	$ 589,574	$ 931,950	**0.756584**
28	6600 PHYSICAL THERAPY	$ 1,162,530	$ -	$ -	**$ 1,162,530**	$ 1,086,574	$ 367,306	$ 1,453,880	**0.799605**
29	6700 OCCUPATIONAL THERAPY	$ 470,137	$ -	$ -	**$ 470,137**	$ 660,954	$ 139,041	$ 799,995	**0.587675**
30	6800 SPEECH PATHOLOGY	$ 99,722	$ -	$ -	**$ 99,722**	$ 185,640	$ 14,864	$ 200,504	**0.497357**
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 371,867	$ -	$ -	**$ 371,867**	$ 343,152	$ 298,151	$ 641,303	**0.579862**
32	7300 DRUGS CHARGED TO PATIENTS	$ 920,628	$ -	$ -	**$ 920,628**	$ 1,863,247	$ 881,781	$ 2,745,028	**0.335380**
33	9000 CLINIC	$ 80,494	$ -	$ -	**$ 80,494**	$ -	$ 44,347	$ 44,347	**1.815095**
34	9100 EMERGENCY	$ 3,118,606	$ -	$ -	**$ 3,118,606**	$ 3,858	$ 5,571,022	$ 5,574,880	**0.559403**
126	**Total Ancillary**	$ 11,538,680	$ -	$ -	$ 11,538,680	$ 4,957,692	$ 15,471,960	$ 20,429,652	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) | 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
127	**Weighted Average**								**0.580072**
128	**Sub Totals**	$ 16,770,661	$ -	$ -	$ 12,195,362	$ 8,555,640	$ 15,471,960	$ 24,027,600	
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)				$ 1,442,968				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)				$ -				
131.01	Other Cost Adjustments (support must be submitted)				$ -				
132	**Grand Total**				**$ 10,752,394**				
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 (07/01/2018-06/30/2019) MORGAN MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 1,485.71		8		-		38		47		35		93		55.17%
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 Days**	8		-		38		47		35		93		55.17%
19	Total Days per PS&R or Exhibit Detail			8		-		38		47		35				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 4,608		$ -		$ 30,010		$ 27,886		$ 28,440		$ 62,504		2.53%
21.01	Calculated Routine Charge Per Dien			$ 576.00		$ -		$ 789.74		$ 593.32		$ 812.57		$ 672.09		
	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		1.845089	$ -	$ 8,036	$ -	$ 2,232	$ -	$ 17,762	$ -	$ 11,446	$ -	$ 24,330	$ -	$ 39,476	37.73%
23	5000 OPERATING ROOM		2.109323	$ -	$ 3,465	$ -	$ 2,483	$ -	$ 5,711	$ -	$ 16,509	$ -	$ -	$ -	$ 28,168	7.92%
24	5300 ANESTHESIOLOGY		0.079211	$ -	$ 1,625	$ -	$ 1,625	$ -	$ 4,135	$ -	$ 11,226	$ -	$ -	$ -	$ 18,612	8.42%
25	5400 RADIOLOGY-DIAGNOSTIC		0.977236	$ 427	$ 55,317	$ -	$ 159,161	$ 2,769	$ 55,532	$ 1,606	$ 68,476	$ 1,071	$ 106,164	$ 4,802	$ 338,487	30.29%
26	5700 CT SCAN		0.153253	$ -	$ 87,952	$ -	$ 225,695	$ 1,500	$ 176,815	$ -	$ 173,088	$ -	$ 387,481	$ 1,500	$ 663,550	34.88%
27	5800 MRI		1.217055	$ -	$ 9,050	$ -	$ 10,575	$ -	$ 1,125	$ -	$ 1,100	$ -	$ 5,850	$ -	$ 21,850	25.88%
28	6000 LABORATORY		0.670072	$ 4,848	$ 100,640	$ -	$ 140,216	$ 10,880	$ 177,587	$ 11,120	$ 124,651	$ 5,871	$ 371,491	$ 26,848	$ 543,095	35.35%
29	6500 RESPIRATORY THERAPY		0.756584	$ 3,945	$ 16,091	$ -	$ 27,623	$ 9,309	$ 21,966	$ 17,432	$ 32,658	$ 5,348	$ 82,277	$ 30,686	$ 98,338	23.25%
30	6600 PHYSICAL THERAPY		0.799605	$ -	$ 4,339	$ -	$ 11,746	$ -	$ 5,219	$ 4,738	$ 6,174	$ -	$ 3,224	$ 4,738	$ 27,478	2.44%
31	6700 OCCUPATIONAL THERAPY		0.587675	$ -	$ -	$ -	$ 2,127	$ 486	$ 5,701	$ 3,526	$ -	$ -	$ 1,504	$ 4,012	$ 7,828	1.67%
32	6800 SPEECH PATHOLOGY		0.497357	$ -	$ -	$ -	$ -	$ 984	$ 211	$ 776	$ -	$ -	$ -	$ 1,760	$ 211	0.98%
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.579862	$ 3,591	$ 9,308	$ -	$ 12,636	$ 7,019	$ 15,509	$ 5,803	$ 16,367	$ 2,604	$ 29,948	$ 16,413	$ 53,820	16.03%
34	7300 DRUGS CHARGED TO PATIENTS		0.335380	$ 3,651	$ 28,694	$ -	$ 64,497	$ 12,590	$ 35,733	$ 22,623	$ 32,450	$ 9,794	$ 149,759	$ 38,865	$ 161,375	13.11%
35	9000 CLINIC		1.815095	$ -	$ -	$ -	$ 1,032	$ -	$ 2,743	$ -	$ 3,322	$ -	$ 9,289	$ -	$ 7,097	36.95%
36	9100 EMERGENCY		0.559403	$ 3,089	$ 257,470	$ -	$ 871,107	$ -	$ 263,858	$ -	$ 242,006	$ -	$ 1,308,968	$ 3,089	$ 1,634,441	52.85%
				19,552	581,987	-	1,532,756	45,537	789,608	67,624	739,475	24,688	2,480,283			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			**$ 24,160**	**$ 581,987**	**$ -**	**$ 1,532,756**	**$ 75,547**	**$ 789,608**	**$ 95,510**	**$ 739,475**	**$ 53,128** (Agrees to Exhibit A)	**$ 2,480,283** (Agrees to Exhibit A)	**$ 195,217**	**$ 3,643,826**	**26.52%**
129	Total Charges per PS&R or Exhibit Detail			$ 24,160	$ 581,987	$ -	$ 1,532,756	$ 75,547	$ 789,608	$ 95,510	$ 739,475	$ 53,128	$ 2,480,283			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 23,572**	**$ 342,945**	**$ -**	**$ 856,109**	**$ 82,794**	**$ 444,684**	**$ 109,237**	**$ 426,567**	**$ 65,821**	**$ 1,346,468**	$ 215,603	$ 2,070,305	34.39%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 14,848	$ 215,912	$ -	$ -	$ 6,378	$ 48,122	$ 4,780	$ 12,856			$ 26,006	$ 276,890	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ -	$ 510,711	$ -	$ -	$ 35,160	$ 164,827			$ 35,160	$ 675,538	
134	Private Insurance (including primary and third party liability)			$ -	$ 820	$ -	$ 2,000	$ -	$ -	$ -	$ 48,433			$ -	$ 51,253	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 303	$ -	$ 683	$ -	$ 220	$ 90	$ 63			$ 90	$ 1,269	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 14,848	$ 217,035	$ -	$ 513,394									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ 52,691	$ -	$ -							$ -	$ 52,691	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 56,734	$ 225,179	$ -	$ 2,254			$ 56,734	$ 227,433	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 24,985	$ 87,831			$ 24,985	$ 87,831	
141	Medicare Cross-Over Bad Debt Payments							$ 9,405	$ 29,014	$ -	$ -			$ 9,405	$ 29,014	
142	Other Medicare Cross-Over Payments (See Note D)							$ 4,538	$ 128,579	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 4,538	$ 128,579	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 738	$ 66,636			
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)**			$ 8,724	$ 73,219	$ -	$ 342,715	$ 5,739	$ 13,570	$ 44,222	$ 110,303	$ 65,083	$ 1,279,832	$ 58,685	$ 539,807	
146	**Calculated Payments as a Percentage of Cost**			63%	79%	0%	60%	93%	97%	60%	74%	1%	5%	73%	74%	
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**							132								

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

Cost Report Year (07/01/2018-06/30/2019 | MORGAN MEMORIAL HOSPITAL

		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
148	**Percent of cross-over days to total Medicare days from the cost report**			29%				

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 s
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 P
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 s
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 pay
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 pa

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) MORGAN MEMORIAL HOSPITAL

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	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	$ 1,485.71		-		-		-		-		-	
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 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)		1.845089	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		2.109323	-	-	-	-	-	-	-	-	$ -	$ -
24	5300 ANESTHESIOLOGY		0.079211	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.977236	-	-	-	-	-	-	-	-	$ -	$ -
26	5700 CT SCAN		0.153253	-	-	-	-	-	-	-	-	$ -	$ -
27	5800 MRI		1.217055	-	-	-	-	-	-	-	-	$ -	$ -
28	6000 LABORATORY		0.670072	-	-	-	-	-	-	-	-	$ -	$ -
29	6500 RESPIRATORY THERAPY		0.756584	-	-	-	-	-	-	-	-	$ -	$ -
30	6600 PHYSICAL THERAPY		0.799605	-	-	-	-	-	-	-	-	$ -	$ -
31	6700 OCCUPATIONAL THERAPY		0.587675	-	-	-	-	-	-	-	-	$ -	$ -
32	6800 SPEECH PATHOLOGY		0.497357	-	-	-	-	-	-	-	-	$ -	$ -
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.579862	-	-	-	-	-	-	-	-	$ -	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.335380	-	-	-	-	-	-	-	-	$ -	$ -
35	9000 CLINIC		1.815095	-	-	-	-	-	-	-	-	$ -	$ -
36	9100 EMERGENCY		0.559403	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	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	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) 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

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 (07/01/2018-06/30/2019) 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below)															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	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 (07/01/2018-06/30/2019) 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 Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below)													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	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 examinatic surveys.

Cost Report Year (07/01/2018-06/30/2019) 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. G**	3,839,043
19	Uninsured Hospital	**Charges Sec. G**	2,533,411
20	Total Hospital	**Charges Sec. G**	24,027,600
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		15.98%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.54%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		$ -

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

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

DSH Examination Eligibility Summary

Hospital Name	**Morgan Medical Center**
Hospital Medicaid Number	**000694229A**
Cost Report Period	From **7/1/2018** To **6/30/2019**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 1,070,091	$ -	$ 1,070,091
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 1,070,091	$ -	$ 1,070,091
4	Net Hospital Patient Revenue	Survey F-3	$ 12,603,954	$ -	$ 12,603,954
5	Medicaid Fraction		8.49%	0.00%	8.49%
6	Inpatient Charity Care Charges	Survey F-2	$ 24,905	$ -	$ 24,905
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 24,905	$ -	$ 24,905
10	Inpatient Hospital Charges	Survey F-3	$ 5,130,738	$ -	$ 5,130,738
11	Inpatient Charity Fraction		0.49%	0.00%	0.49%
12	LIUR		8.98%	0.00%	8.98%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	93	-	93
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		93	-	93
16	Total Hospital Days (excludes swing-bed)	Survey F-1	232	-	232
17	MIUR		40.09%	0.00%	40.09%

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 Medical Center**
Hospital Medicaid Number: **000694229A**
Cost Report Period: From **7/1/2018** To **6/30/2019**

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	23,572	14,848	-	-	-	-	-	-	-	-	-			14,848	8,724	62.99%
2	Medicaid Fee for Service	Outpatient	342,945	215,912	-	820	303	52,691	-	-	-	-	-			269,726	73,219	78.65%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	n/a
4	Medicaid Managed Care	Outpatient	856,109	-	510,711	2,000	683	-	-							513,394	342,715	59.97%
5	Medicare Cross-over (FFS)	Inpatient	82,794	6,378	-	-	-		-	56,734	-	9,405	4,538			77,055	5,739	93.07%
6	Medicare Cross-over (FFS)	Outpatient	444,684	48,122	-	-	220		-	225,179	-	29,014	128,579			431,114	13,570	96.95%
7	Other Medicaid Eligibles	Inpatient	109,237	4,780	35,160	-	90			-	24,985	-	-			65,015	44,222	59.52%
8	Other Medicaid Eligibles	Outpatient	426,567	12,856	164,827	48,433	63			2,254	87,831	-	-			316,264	110,303	74.14%
9	Uninsured	Inpatient	65,821	-	-	-	-	-	-	-	-	-	-	738	-	738	65,083	1.12%
10	Uninsured	Outpatient	1,346,468	-	-	-	-	-	-	-	-	-	-	66,636	-	66,636	1,279,832	4.95%
11	In-State Sub-total	Inpatient	281,424	26,006	35,160	-	90	-	-	56,734	24,985	9,405	4,538	738	-	157,656	123,768	56.02%
12	In-State Sub-total	Outpatient	3,416,773	276,890	675,538	51,253	1,269	52,691	-	227,433	87,831	29,014	128,579	66,636	-	1,597,134	1,819,639	46.74%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	3,698,197	302,896	710,698	51,253	1,359	52,691	-	284,167	112,816	38,419	133,117	67,374	-	1,754,790	1,943,407	47.45%

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
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	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **Morgan Medical Center**
Hospital Medicaid Number: **000694229A**
Cost Report Period: From **7/1/2018** To **6/30/2019**
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
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2	Medicaid Fee for Service	Outpatient	342,945	215,912	-	820	303	52,691	-	-	-	-	-			269,726	73,219	78.65%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	n/a
4	Medicaid Managed Care	Outpatient	856,109	-	510,711	2,000	683	-	-							513,394	342,715	59.97%
5	Medicare Cross-over (FFS)	Inpatient	82,794	6,378	-	-	-		-	56,734	-	9,405	4,538			77,055	5,739	93.07%
6	Medicare Cross-over (FFS)	Outpatient	444,684	48,122	-	-	220		-	225,179	-	29,014	128,579			431,114	13,570	96.95%
7	Other Medicaid Eligibles	Inpatient	109,237	4,780	35,160	-	90			-	24,985	-	-			65,015	44,222	59.52%
8	Other Medicaid Eligibles	Outpatient	426,567	12,856	164,827	48,433	63			2,254	87,831	-	-			316,264	110,303	74.14%
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10	Uninsured	Outpatient	1,346,468	-	-	-	-	-	-	-	-	-	-	66,636	-	66,636	1,279,832	4.95%
11	In-State Sub-total	Inpatient	281,424	26,006	35,160	-	90	-	-	56,734	24,985	9,405	4,538	738	-	157,656	123,768	56.02%
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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	3,698,197	302,896	710,698	51,253	1,359	52,691	-	284,167	112,816	38,419	133,117	67,374	-	1,754,790	1,943,407	47.45%
16																Less: Out of State DSH Payments from Adjusted Survey		-
17																Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		1,943,407

Medicaid DSH Survey Adjustments

PROVIDER: MORGAN MEMORIAL HOSPITAL
FROM: 7/1/2018 TO: 6/30/2019
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.

Medicaid DSH Report Notes

PROVIDER: MORGAN MEMORIAL HOSPITAL Mcaid Number: 000694229A
FROM: 7/1/2018 TO: 6/30/2019 Mcare Number: 111304

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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