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

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2017	06/30/2018

2. Select Your Facility from the Drop-Down Menu Provided: BARROW REGIONAL MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	10/01/2017	09/30/2018	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000002098A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110045

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

	DSH Examination Year (07/01/17 - 06/30/18)
During the DSH Examination Year:	
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?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1951

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

	DSH Payment Year (07/01/19 - 06/30/20)
During the Interim DSH Payment Year:	
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:

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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 229,980

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:

NGMC Barrow did not participate in the ICTF program during FY'18; however, any participation and receipt of funds would not have been limited.

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

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

Hospital CEO or CFO Signature	CFO - Northeast Georgia Health System Title	11/11/2019 Date
Brian D. Steines, MBA, CPA Hospital CEO or CFO Printed Name	770-219-7246 Hospital CEO or CFO Telephone Number	Brian.Steines@nghs.com Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Jimena Villamor	Name	Jeffrey L. Askey, CPA
Title	Exec. Director of Acctg. & Controller	Title:	Partner
Telephone Number	770-219-6659	Firm Name:	Draffin & Tucker, LLP
E-Mail Address	Jimena.Villamor@nghs.com	Telephone Number	229-883-7878
Mailing Street Address	743 Spring Street, N.E., Gainesville, GA 30501	E-Mail Address	jaskey@draffin-tucker.com

DSH Survey Submission Checklist

Please indicate with an "X" each item included or a "N/A" if not included. Consider a separate cover letter to explain any "N/A" answers to avoid additional documentation requests.

X	1. Electronic copy of the DSH Survey Part I - DSH Year Data - 07/01/2017 - 06/30/2018
X	2. Electronic copy of the DSH Survey Part II - Cost Report Data - Cost Report Year 10/01/2017 - 09/30/2018
N/A	3. N/A
N/A	4. N/A
X	5 (a). Electronic copy of Exhibit A - Uninsured Charges / Days - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key)
X	5 (b). Description of logic used to compile Exhibit A. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
X	6 (a). Electronic copy of Exhibit B - Self-Pay Payments - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	6 (b). Description of logic used to compile Exhibit B. Include a copy of all transaction codes utilized to post payments during the cost reporting period and a description of which codes were included or excluded if applicable.
X	7 (a). Electronic copy of Exhibit C for hospital-generated data (includes Medicaid eligibles, Medicare crossover, Medicaid MCO, or Out-Of-State Medicaid data that isn't supported by a state-provided or MCO-provided report) - Must be in Excel (.xls or .xlsx) or CSV (.csv) using either a TAB or | (pipe symbol above the ENTER key).
X	7 (b). Description of logic used to compile each Exhibit C. Include a copy of all financial classes and payer plan codes utilized during the cost report period and a description of which codes were included or excluded if applicable.
N/A	8. Copies of all out-of-state Medicaid fee-for-service PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	9. Copies of all out-of-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	10. Copies of in-state Medicaid managed care PS&Rs (Remittance Advice Summary or Paid Claims Summary including crossovers)
N/A	11. Support for Section 1011 (Undocumented Alien) payments if not applied at patient level in Exhibit B
N/A	12. Documentation supporting out-of-state DSH payments received - Examples may include remittances, detailed general ledgers, or add-on rates.
X	13. Financial statements or other documentation to support total charity care charges and subsidies reported on Section F of DSH Survey Part II
X	14. Revenue code cross-walk used to prepare cost report, or supporting grouping schedules
X	15a. A detailed working trial balance used to prepare each cost report (including revenues)
N/A	15b. A detailed revenue working trial balance by payer/contract. The schedule should show charges, contractual adjustments, and revenues by payer plan and contract (e.g., Medicare, each Medicaid agency payer, each Medicaid Managed care contract)
X	16. Electronic copy of all cost reports used to prepare each DSH Survey Part II
X	17. Documentation supporting cost report payments calculated for Medicaid/Medicare cross-overs (dual eligible cost report payments)
N/A	18. Documentation supporting Medicaid Managed Care Quality Incentive Payments, or any other Medicaid Managed Care lump sum payments

Please upload all checklist items above to the Myers and Stauffer Web Portal. If you are unable to access the Web Portal, please call or email. Web Portal Address:

https://dsh.mslc.com

All electronic (CD or DVD - CDs or DVDs must be encrypted and/or password protected) and paper documentation can be mailed (using certified or other traceable delivery) to:

Myers and Stauffer LC
ATTN: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, Missouri 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
E-Mail:

Please Call Myers and Stauffer if you have any questions on completing the DSH survey.

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S) **	Insurance Status When Services Were Provided (Insured or Uninsured) (T) *	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))*(N), 0) *****
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

Notes for Completing Exhibit B:

* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Surve

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

DSH Version 7.30 3/26/2019

D. General Cost Report Year Information 10/1/2017 - 9/30/2018

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

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

	10/1/2017 through 9/30/2018		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/18/2019

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	BARROW REGIONAL MEDICAL CENTER		
5. Medicaid Provider Number:	000002098A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110045		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private		
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban		

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		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2017 - 09/30/2018)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ -	$ 61,333	$61,333
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 85,622	$ 755,828	$841,450
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$85,622	$817,161	$902,783
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.00%	7.51%	6.79%

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 (10/01/2017 - 09/30/2018)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	3,863 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	3,860,427
8.	Outpatient Hospital Charity Care Charges	8,768,557
9.	Non-Hospital Charity Care Charges	606,068
10.	Total Charity Care Charges	$ 13,235,052

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$10,261,016.00			$ 8,723,934	$ -	$ -	$ 1,537,082
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$33,983,167.00	$83,503,596.00		$ 28,892,549	$ 70,994,905	$ -	$ 17,599,310
20.	Outpatient Services		$26,288,975.00			$ 22,350,933	$ -	$ 3,938,042
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 44,244,183	$ 109,792,571	$ -	$ 37,616,482	$ 93,345,838	$ -	$ 23,074,434
28.	Total Hospital and Non Hospital		Total from Above	$ 154,036,754		Total from Above	$ 130,962,320	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	154,036,754	Total Contractual Adj. (G-3 Line 2)	130,962,320
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				130,962,320

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) | BARROW REGIONAL MEDICAL CENTER

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 4,526,934	$ -	$ -	$0.00	$ 4,526,934	3,957	$4,160,870.00		$ 1,144.03
2	03100 INTENSIVE CARE UNIT	$ 2,325,638	$ -	$ -		$ 2,325,638	798	$2,144,942.00		$ 2,914.33
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 6,852,572	$ -	$ -	$ -	$ 6,852,572	4,755	$ 6,305,812		
19	Weighted Average									$ 1,441.13

Line #	Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200 Observation (Non-Distinct)	892	-	-	$ 1,020,475	$212,162.00	$1,421,303.00	$ 1,633,465	0.624730

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	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
21	5000 OPERATING ROOM	$3,632,034.00	$ -	$0.00		$ 3,632,034	$1,460,874.00	$5,864,174.00	$ 7,325,048	0.495838
22	5300 ANESTHESIOLOGY	$686,610.00	$ -	$0.00		$ 686,610	$846,523.00	$6,102,810.00	$ 6,949,333	0.098802
23	5400 RADIOLOGY-DIAGNOSTIC	$1,871,919.00	$ -	$0.00		$ 1,871,919	$447,193.00	$6,377,511.00	$ 6,824,704	0.274286
24	5401 ULTRASOUND	$538,373.00	$ -	$0.00		$ 538,373	$1,932,244.00	$4,291,360.00	$ 6,223,604	0.086505
25	5600 RADIOISOTOPE	$332,753.00	$ -	$0.00		$ 332,753	$476,743.00	$2,010,470.00	$ 2,487,213	0.133785
26	5700 CT SCAN	$648,826.00	$ -	$0.00		$ 648,826	$4,299,646.00	$26,835,655.00	$ 31,135,301	0.020839
27	5800 MRI	$600,926.00	$ -	$0.00		$ 600,926	$428,685.00	$3,670,642.00	$ 4,099,327	0.146591
28	6000 LABORATORY	$2,522,088.00	$ -	$0.00		$ 2,522,088	$5,099,779.00	$9,877,507.00	$ 14,977,286	0.168394
29	6500 RESPIRATORY THERAPY	$1,525,558.00	$ -	$0.00		$ 1,525,558	$4,559,314.00	$2,471,006.00	$ 7,030,320	0.216997
30	6600 PHYSICAL THERAPY	$162,752.00	$ -	$0.00		$ 162,752	$366,682.00	$24,480.00	$ 391,162	0.416073

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$2,398,139.00	$ -	$0.00		$ 2,398,139	$2,441,331.00	$2,655,755.00	$ 5,097,086	0.470492
32	7200	IMPL. DEV. CHARGED TO PATIENTS	$1,426,540.00	$ -	$0.00		$ 1,426,540	$1,349,989.00	$2,162,893.00	$ 3,512,882	0.406088
33	7300	DRUGS CHARGED TO PATIENTS	$4,008,367.00	$ -	$0.00		$ 4,008,367	$8,420,369.00	$15,062,422.00	$ 23,482,791	0.170694
34	7600	WOUND CARE	$1,085,691.00	$ -	$0.00		$ 1,085,691	$101,613.00	$2,495,260.00	$ 2,596,873	0.418076
35	9100	EMERGENCY	$5,455,166.00	$ -	$0.00		$ 5,455,166	$2,240,222.00	$21,429,377.00	$ 23,669,599	0.230471
36			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 26,895,742	$ -	$ -		$ 26,895,742	$ 34,683,369	$ 112,752,625	$ 147,435,994	
127	**Weighted Average**									0.189345
128	**Sub Totals**	$ 33,748,314	$ -	$ -		$ 33,748,314	$ 40,989,181	$ 112,752,625	$ 153,741,806	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 33,748,314				
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 (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,144.03		346		81		309		147		373		883		40.98%
2	03100 INTENSIVE CARE UNIT	$ 2,914.33		77		45		76		31		136		229		46.24%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	423		126		385		178		509		1,112		34.17%
19	Total Days per PS&R or Exhibit Detail			423		126		385		178		509				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 462,129		$ 215,400		$ 633,243		$ 260,346		$ 807,173		$ 1,571,118		37.88%
21.01	Calculated Routine Charge Per Diem			$ 1,092.50		$ 1,709.52		$ 1,644.79		$ 1,462.62		$ 1,585.80		$ 1,412.88		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.624730	28,967	197,785	19,847	108,583	70,834	544,452	29,253	28,929	60,550	272,733	$ 148,901	$ 879,749	83.69%
23	5000 OPERATING ROOM		0.495838	249,136	712,168	71,967	1,911,629	144,575	622,673	58,222	132,038	92,284	175,651	$ 523,900	$ 3,378,508	56.93%
24	5300 ANESTHESIOLOGY		0.098802	68,622	230,572	14,975	417,733	33,363	137,262	33,081	146,323	63,945	173,386	$ 150,041	$ 931,890	18.98%
25	5400 RADIOLOGY-DIAGNOSTIC		0.274286	77,755	492,162	23,984	1,058,728	89,229	418,963	23,743	115,283	55,907	1,063,020	$ 214,711	$ 2,085,136	50.19%
26	5401 ULTRASOUND		0.086505	142,282	129,286	53,080	281,697	42,597	98,915	68,354	106,119	236,770	421,855	$ 306,313	$ 616,017	25.51%
27	5600 RADIOISOTOPE		0.133785	61,305	93,591	-	89,590	54,160	154,538	11,544	10,546	51,555	316,081	$ 127,009	$ 348,265	33.89%
28	5700 CT SCAN		0.020839	520,277	1,855,818	172,703	2,504,073	498,320	2,021,671	128,245	316,279	700,479	5,418,149	$ 1,319,545	$ 6,697,841	45.56%
29	5800 MRI		0.146591	44,061	226,360	7,148	260,970	51,312	364,471	23,457	70,942	54,054	119,632	$ 125,978	$ 922,743	29.82%
30	6000 LABORATORY		0.168394	728,691	1,067,401	237,961	1,589,819	766,980	1,028,656	340,281	286,980	1,032,085	2,772,342	$ 2,073,913	$ 3,972,856	66.03%
31	6500 RESPIRATORY THERAPY		0.216997	495,447	200,724	167,448	227,346	784,443	371,161	198,449	38,871	424,415	515,813	$ 1,645,787	$ 838,102	48.91%
32	6600 PHYSICAL THERAPY		0.416073	29,327		7,074	46	55,489	1,114	6,943	541	12,616	1,364	$ 98,833	$ 1,701	29.40%
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.470492	253,171	214,359	60,099	334,843	282,000	237,338	98,139	85,856	147,474	127,896	$ 693,409	$ 872,396	36.13%
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.406088	196,462	45,717	54,393	148,992	122,653	134,901	32,246	46,460	21,690	82,838	$ 405,754	$ 376,070	25.23%
35	7300 DRUGS CHARGED TO PATIENTS		0.170694	952,394	895,072	443,454	2,288,105	984,414	1,359,660	426,186	264,107	1,202,655	3,053,124	$ 2,806,448	$ 4,806,944	50.70%
36	7600 WOUND CARE		0.418076	452	22,070	-	-	-	-	11,192	106,975	2,977	151,543	$ 11,644	$ 129,045	11.37%
37	9100 EMERGENCY		0.230471	245,093	1,922,422	75,977	4,312,436	219,979	1,308,191	89,825	245,256	357,861	5,652,482	$ 630,874	$ 7,788,305	61.20%
38			-											$ -	$ -	
39			-											$ -	$ -	
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
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78			-											$ -	$ -	
79			-											$ -	$ -	
80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	
83			-											$ -	$ -	

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

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
99			-											$ -	$ -	
100			-											$ -	$ -	
101			-											$ -	$ -	
102			-											$ -	$ -	
103			-											$ -	$ -	
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107			-											$ -	$ -	
108			-											$ -	$ -	
109			-											$ -	$ -	
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111			-											$ -	$ -	
112			-											$ -	$ -	
113			-											$ -	$ -	
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115			-											$ -	$ -	
116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 4,093,442	$ 8,305,506	$ 1,410,110	$ 15,534,590	$ 4,200,348	$ 8,803,966	$ 1,579,160	$ 2,001,506	$ 4,517,317	$ 20,317,909			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 4,555,571	$ 8,305,506	$ 1,625,510	$ 15,534,590	$ 4,833,591	$ 8,803,966	$ 1,839,506	$ 2,001,506	$ 5,324,490 (Agrees to Exhibit A)	$ 20,317,909 (Agrees to Exhibit A)	$ 12,854,178	$ 34,645,567	47.72%
129	Total Charges per PS&R or Exhibit Detail			$ 4,555,571	$ 8,305,506	$ 1,625,510	$ 15,534,590	$ 4,833,591	$ 8,803,966	$ 1,839,506	$ 2,001,506	$ 5,324,490	$ 20,317,909			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 1,488,343	$ 1,677,809	$ 512,111	$ 3,393,723	$ 1,471,223	$ 1,856,404	$ 589,660	$ 419,778	$ 1,616,553	$ 3,335,803	$ 4,061,337	$ 7,347,714	48.62%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,071,315	$ 1,497,197		$ -	$ 90,267	$ 111,121	$ 2,862	$ 2,357			$ 1,164,444	$ 1,610,675	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			-	-	$ 288,333	$ 1,737,030			$ 1,340	$ 9,160			$ 289,673	$ 1,746,190	
134	Private Insurance (including primary and third party liability)			$ 10,256	$ 831	$ -	$ -		$ 1,417	$ 96,394	$ 198,334			$ 106,650	$ 200,582	
135	Self-Pay (including Co-Pay and Spend-Down)				$ 1,995	$ -	$ 1,132			$ 61	$ 674			$ 61	$ 3,801	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,081,571	$ 1,500,023	$ 288,333	$ 1,738,162									
137	Medicaid Cost Settlement Payments (See Note B)				$ (136,440)									$ -	$ (136,440)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 893,997	$ 756,848	$ 248,044	$ 58,498			$ 1,142,041	$ 815,346	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 92,462	$ 56,570			$ 92,462	$ 56,570	
141	Medicare Cross-Over Bad Debt Payments							$ 13,292	$ 15,730			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 13,292	$ 15,730	
142	Other Medicare Cross-Over Payments (See Note D)													$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ -	$ 61,333			
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)**			$ 406,772	$ 314,226	$ 223,778	$ 1,655,561	$ 473,667	$ 971,288	$ 148,497	$ 94,185	$ 1,616,553	$ 3,274,470	$ 1,252,714	$ 3,035,260	
146	**Calculated Payments as a Percentage of Cost**			73%	81%	56%	51%	68%	48%	75%	78%	0%	2%	69%	59%	
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)**							2,023								
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.
NOTE: Outpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,144.03										-	
2	03100 INTENSIVE CARE UNIT	$ 2,914.33								4		4	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		4		4	
19	Total Days per PS&R or Exhibit Detail			-		-		-		4			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 10,260		$ 10,260	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 2,565.00		$ 2,565.00	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.624730	-	3,825					-	1,350	$ -	$ 5,175
23	5000 OPERATING ROOM		0.495838	-	-					-	-	$ -	$ -
24	5300 ANESTHESIOLOGY		0.098802	-	-					-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.274286	-	4,134					150	2,437	$ 150	$ 6,571
26	5401 ULTRASOUND		0.086505	-	4,162					2,809	-	$ 2,809	$ 4,162
27	5600 RADIOISOTOPE		0.133785	-	-					-	-	$ -	$ -
28	5700 CT SCAN		0.020839	-	41,630					2,255	4,907	$ 2,255	$ 46,537
29	5800 MRI		0.146591	-	-					-	-	$ -	$ -
30	6000 LABORATORY		0.168394	-	25,080					8,780	4,349	$ 8,780	$ 29,429
31	6500 RESPIRATORY THERAPY		0.216997	-	7,812					5,391	1,323	$ 5,391	$ 9,135
32	6600 PHYSICAL THERAPY		0.416073	-	477					-	-	$ -	$ 477
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.470492	-	294					-	-	$ -	$ 294
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.406088	-	-					-	-	$ -	$ -
35	7300 DRUGS CHARGED TO PATIENTS		0.170694	-	26,970					6,930	2,311	$ 6,930	$ 29,281
36	7600 WOUND CARE		0.418076	-	-					-	-	$ -	$ -
37	9100 EMERGENCY		0.230471	-	42,929					1,854	10,950	$ 1,854	$ 53,879
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
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67			-									$ -	$ -
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73			-									$ -	$ -
74			-									$ -	$ -
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79			-									$ -	$ -
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107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 157,313	$ -	$ -	$ -	$ -	$ 28,169	$ 27,627		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ 157,313	$ -	$ -	$ -	$ -	$ 38,429	$ 27,627	$ 38,429	$ 184,940
129	Total Charges per PS&R or Exhibit Detail			$ -	$ 157,313	$ -	$ -	$ -	$ -	$ 38,429	$ 27,627		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ 25,504	$ -	$ -	$ -	$ -	$ 16,247	$ 5,552	$ 16,247	$ 31,056
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ 558							$ -	$ 558
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)				$ 1,552						$ 694	$ -	$ 2,246
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 2,110	$ -	$ -						
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)										$ 32	$ -	$ 32
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 9,801	$ 2,465	$ 9,801	$ 2,465
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)**			$ -	$ 23,394	$ -	$ -	$ -	$ -	$ 6,446	$ 2,361	$ 6,446	$ 25,755
144	**Calculated Payments as a Percentage of Cost**			0%	8%	0%	0%	0%	0%	60%	57%	60%	17%

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 (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

			Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
								Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
			Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																
1		Lung Acquisition	$0.00	$ -	$ -		0										
2		Kidney Acquisition	$0.00	$ -	$ -		0										
3		Liver Acquisition	$0.00	$ -	$ -		0										
4		Heart Acquisition	$0.00	$ -	$ -		0										
5		Pancreas Acquisition	$0.00	$ -	$ -		0										
6		Intestinal Acquisition	$0.00	$ -	$ -		0										
7		Islet Acquisition	$0.00	$ -	$ -		0										
8			$0.00	$ -	$ -		0										
9		**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10		**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

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

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (10/01/2017-09/30/2018) BARROW REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 346,449		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	308001-69760	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 346,449	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4		*Reclassification Code*			*(Reclassified to / (from))*
5		*Reclassification Code*			*(Reclassified to / (from))*
6		*Reclassification Code*			*(Reclassified to / (from))*
7		*Reclassification Code*			*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8		*Reason for adjustment*			*(Adjusted to / (from))*
9		*Reason for adjustment*			*(Adjusted to / (from))*
10		*Reason for adjustment*			*(Adjusted to / (from))*
11		*Reason for adjustment*			*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12		*Reason for adjustment*			
13		*Reason for adjustment*			
14		*Reason for adjustment*			
15		*Reason for adjustment*			
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 346,449		

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**	47,723,114
19	Uninsured Hospital	**Charges Sec. G**	25,642,399
20	Total Hospital	**Charges Sec. G**	153,741,806
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		31.04%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		16.68%
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.*