MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

May 6, 2019

Karen McLeod
Taylor Regional Hospital
PO Box 1297
Hawkinsville, Georgia 31036

RE: DSH Medicaid Provider Examination

Provider Number:	110135
Provider Name:	Taylor Regional Hospital
DSH Year(s) under Examination:	June 30, 2016

Dear Ms. McLeod:

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

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

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

Sincerely,

Dianna M Hicks

DEDICATED TO GOVERNMENT HEALTH PROGRAMS
700 W 47th Street, Suite 1100 | Kansas City, MO 64112
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Georgia DSH Examination Results for 2016 **4/17/2019 12:54**

DSH UCC Cost & Payment Summary

Review Results

Provider Name	Taylor Regional Hospital
Mcaid Provider Number	000001548A
Mcare Provider Number	110135

In order to comply with the December 19, 2008 federal regulation regarding disproportionate share hospital (DSH) payments, surveys were submitted by all facilities that received DSH payments during the 2016 state DSH year. Reviews have been completed and below are the results of those reviews. The DSH payment for the 2016 state DSH year, as well as the uncompensated care calculation (UCC) are presented below. Column (G) presents the UCC prior to Medicare and private insurance payments. Column (K) presents the UCC after Medicare and private insurance payments.

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

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

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) % of Year Applicable to DSH Year	(D) Uninsured / Medicaid Cost		(E) Medicaid and Self-Pay Payments		(F) Cost Report Year Adjusted DSH SUB-TOTAL Uncompensated Care Cost (UCC)	(G) State DSH Year Adjusted DSH SUB-TOTAL Uncompensated Care Cost (UCC) (C) x (F)	(H) Medicare Payments	(I) Private Insurance Payments	(J) Cost Report Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (F) - (H) - (I)	(K) State DSH Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (C) x (J)
Cost Report Year 1 UCC:	4/1/2015	-	3/31/2016	75.14%	$ 5,429,712	-	$ 2,976,117	=	$ 2,453,595	$ 1,843,548	$ 1,946,878	$ 106,719	$ 399,998	$ 300,545
Cost Report Year 2 UCC:	4/1/2016	-	3/31/2017	24.93%	$ 5,998,035	-	$ 3,007,201	=	$ 2,990,834	$ 745,660	$ 1,796,239	$ 112,145	$ 1,082,450	$ 269,871
Cost Report Year 3 UCC:		-		0.00%		-		=	$ -	$ -				$ -
RHC Cost Report Year 1 UCC:		-		0.00%		-		=	$ -	$ -				$ -
RHC Cost Report Year 2 UCC:		-		0.00%		-		=	$ -	$ -				$ -
RHC Cost Report Year 3 UCC:		-		0.00%		-		=	$ -	$ -				$ -
State DSH Year Sub-Totals:					$ 5,575,102		$ 2,985,894			$ 2,589,210	$ 1,910,648	$ 108,144		$ 570,417
Less Supplemental Payments (UPL, etc.):										$ 60,048				$ 60,048
State DSH Year Adjusted Uncompensated Care Calculation (UCC):										$ 2,529,162				$ 510,369
Out-of-State DSH Payments:										$ -				$ -
DSH Payments:										$ 258,363				$ 258,363
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:										**$ -**				**$ -**
DSH Year Low Income Utilization Ratio (LIUR):														14.27%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):														34.93%

Observations (may be included in examination report):

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

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

All inquiries and additional documentation should be sent to the following

e-mail:	GADSH@mslc.com
Fax:	816-945-5301
Overnight Packages:	Myers and Stauffer LC Attn: DSH Examinations 700 W 47th Street, Suite 1100 Kansas City, MO 64112
Web Portal:	https://dsh.mslc.com
Phone Inquiries:	800-374-6858

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

DSH Version 5.20 1/26/2017

A. General DSH Year Information

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

Workpaper #:	1301	Reviewer:
Examiner:	DMH	AMM
Date:	1/16/2019	2/5/2019

2. Select Your Facility from the Drop-Down Menu Provided: TAYLOR REGIONAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	4/1/2016	3/31/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	000001548A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110135

B. DSH OB Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/15 -
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	4/1/1936

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2015 - 06/30/2016** $ 60,048 **4904**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers: 0
0
0

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

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

Karen McLeod	CFO	10/16/2017
Hospital CEO or CFO	Title	Date
Karen McLeod	478-783-0329	Karen.Mcleod@taylorregional.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Karen
Title	McLeod
Telephone Number	478-783-0329
E-Mail Address	Karen.Mcleod@taylorregional.org
Mailing Street Address	P.O. Box 1297
Mailing City, State, Zip	Hawkinsville, GA 31036

Outside Preparer:

Name	Jimmie D. Richter, Jr.
Title:	Partner
Firm Name:	Draffin & Tucker, LLP
Telephone Number	4047194059
E-Mail Address	jrichter@draffin-tucker.com

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

Medicaid DSH Survey Adjustments

PROVIDER: TAYLOR REGIONAL HOSPITAL
FROM: 7/1/2015 TO: 6/30/2016
Mcaid Number: 000001548A
Mcare Number: 110135

Myers and Stauffer DSH Survey Adjustments

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

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302	Reviewer:
Examiner:	DMH	AMM
Date:	1/16/2019	2/5/2019
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 4/1/2016 - 3/31/2017

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

1. Select Your Facility from the Drop-Down Menu Provided: TAYLOR REGIONAL HOSPITAL

	4/1/2016 through 3/31/2017		
2. Select Cost Report Year Covered by this Survey:	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 9/29/2017

	Data	Correct?	If Incorrect, Proper Information	
4. Hospital Name:	TAYLOR REGIONAL HOSPITAL	Yes		
5. Medicaid Provider Number:	000001548A	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:	110135	Yes		
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Private	No	Non-State Govt.	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes		

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (04/01/2016 - 03/31/2017

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

	Inpatient	Outpatient	Total	
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 8,208	$ 142,682	$150,890	5203
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 125,533	$ 1,122,409	$1,247,942	5203
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$133,741	$1,265,091	$1,398,832	
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.14%	11.28%	10.79%	

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 (04/01/2016 - 03/31/2017)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	4,125	1405

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

2.	Inpatient Hospital Subsidies	-	
3.	Outpatient Hospital Subsidies	-	
4.	Unspecified I/P and O/P Hospital Subsidies	216,062	
5.	Non-Hospital Subsidies	114,585	
6.	Total Hospital Subsidies	$ 330,647	6002
7.	Inpatient Hospital Charity Care Charges	200,507	
8.	Outpatient Hospital Charity Care Charges	109,880	
9.	Non-Hospital Charity Care Charges	-	
10.	Total Charity Care Charges	$ 310,387	1705

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
		1405	1405	1405				
11.	Hospital	$ 2,709,535	$ -	$ -	$ 1,522,685	$ -	$ -	$ 1,186,850
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ 5,100,543			$ 2,866,367	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 10,033,736	$ 33,668,050	$ -	$ 5,638,687	$ 18,920,531	$ -	$ 19,142,568
20.	Outpatient Services		$ 5,953,289	$ -		$ 3,345,587	$ -	$ 2,607,702
21.	Home Health Agency			$ 1,276,210			$ 717,195	
22.	Ambulance			$ 322,176			$ 181,054	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 11,524,705	$ -	$ -	$ 6,476,572	$ -
27.	Total	$ 12,743,271	$ 39,621,339	$ 18,223,634	$ 7,161,373	$ 22,266,118	$ 10,241,188	$ 22,937,120
28.	Total Hospital and Non Hospital		Total from Above	$ 70,588,244		Total from Above	$ 39,668,678	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 70,588,244	1405	Total Contractual Adj. (G-3 Line 2)	$ 39,340,475	1405
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ 328,203	
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					39,668,678	
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2016-03/31/2017) | TAYLOR REGIONAL 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):	1405	1405	1405	1405		1405	1405		
1	03000 ADULTS & PEDIATRICS	$ 2,274,694	$ -	$ -	$ -	**$ 2,274,694**	4,399	$ 1,613,230		**$ 517.09**
2	03100 INTENSIVE CARE UNIT	$ 969,871	$ -	$ -		**$ 969,871**	822	$ 891,526		**$ 1,179.89**
10	04300 NURSERY	$ 376,039	$ -	$ -		**$ 376,039**	339	$ 204,779		**$ 1,109.26**
18	Total Routine	$ 3,620,604	$ -	$ -	$ -	$ 3,620,604	5,560	$ 2,709,535		
19	Weighted Average									$ 651.18

			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)		1,435	-	-	**$ 742,024**	$ 612,038	$ 169,000	$ 781,038	**0.950049**
			1405				1405	1405		

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	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
		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*				
	Ancillary Cost Centers (from W/S C excluding Ob	1405	1405	1405			1405	1405		
21	5000 OPERATING ROOM	$ 2,080,040	$ -	$ -		**$ 2,080,040**	$ 2,266,715	$ 6,958,789	$ 9,225,504	**0.225466**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 742,812	$ -	$ -		**$ 742,812**	$ 130,626	$ 58,214	$ 188,840	**3.933552**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 1,922,206	$ -	$ -		**$ 1,922,206**	$ 1,179,596	$ 12,861,716	$ 14,041,312	**0.136896**
24	6000 LABORATORY	$ 1,719,506	$ -	$ -		**$ 1,719,506**	$ 1,357,526	$ 7,004,256	$ 8,361,782	**0.205639**
25	6500 RESPIRATORY THERAPY	$ 232,682	$ -	$ -		**$ 232,682**	$ 381,365	$ 175,971	$ 557,336	**0.417490**
26	6600 PHYSICAL THERAPY	$ 1,122,811	$ -	$ -		**$ 1,122,811**	$ 872,071	$ 2,255,545	$ 3,127,616	**0.358999**
27	6900 ELECTROCARDIOLOGY	$ 348,748	$ -	$ -		**$ 348,748**	$ 84,823	$ 833,091	$ 917,914	**0.379935**
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 960,042	$ -	$ -		**$ 960,042**	$ 920,578	$ 1,256,695	$ 2,177,273	**0.440938**
29	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 426,252	$ -	$ -		**$ 426,252**	$ 550,819	$ 111,425	$ 662,244	**0.643648**
30	7300 DRUGS CHARGED TO PATIENTS	$ 1,044,624	$ -	$ -		**$ 1,044,624**	$ 2,289,617	$ 2,152,348	$ 4,441,965	**0.235172**
31	9000 CLINIC	$ 3,142	$ -	$ -		**$ 3,142**	$ 5,000	$ 13,888	$ 18,888	**0.166349**
32	9100 EMERGENCY	$ 1,915,445	$ -	$ -		**$ 1,915,445**	$ 554,820	$ 4,598,573	$ 5,153,393	**0.371686**
126	**Total Ancillary**	$ 12,518,310	$ -	$ -		$ 12,518,310	$ 11,205,594	$ 38,449,511	$ 49,655,105	
127	**Weighted Average**									0.267049
128	**Sub Totals**	$ 16,138,914	$ -	$ -		$ 16,138,914	$ 13,915,129	$ 38,449,511	$ 52,364,640	
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)					$ 190,612				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01	Other Cost Adjustments (support must be submitted)					$ -				

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2016-03/31/2017) TAYLOR REGIONAL 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
132	**Grand Total**				**$**	**15,948,302**				
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 (04/01/2016-03/31/2017) TAYLOR REGIONAL 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	From Hospital's Own Internal			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 517.09		254		381		284		-		140		919		35.73%
2	03100 INTENSIVE CARE UNIT	$ 1,179.89		94		15		102		-		42		211		30.78%
10	04300 NURSERY	$ 1,109.26		24		251		-		-		5		275		82.60%
18			Total Days	372	4103	647	4203	386	4303	-	4403	187	5103	1,405		38.59%
19	Total Days per PS&R or Exhibit Detail			372		647		386		-		212				
20	Unreconciled Days (Explain Variance)			-		-		-		-		(25)				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 265,951	4103	$ 439,464	4203	$ 304,493	4303	$ -	4403	$ 136,046	5103	$ 1,009,908		42.29%
21.01	Calculated Routine Charge Per Diem			$ 714.92		$ 679.23		$ 788.84		$ -		$ 727.52		$ 718.80		
	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)		0.950049	$ 19,115	$ 43,234	$ 19,828	$ 135,898	$ 18,743	$ 80,135	$ -	$ -	$ 16,247	$ 49,418	$ 57,686	$ 259,267	48.99%
23	5000 OPERATING ROOM		0.225466	$ 188,142	$ 411,624	$ 321,477	$ 539,199	$ 265,554	$ 599,644	$ -	$ -	$ 160,459	$ 272,863	$ 775,173	$ 1,550,467	29.91%
24	5200 DELIVERY ROOM & LABOR ROOM		3.933552	$ 7,977	$ 4,664	$ 112,209	$ 51,283	$ -	$ -	$ -	$ -	$ 5,117	$ 1,060	$ 120,186	$ 55,947	96.54%
25	5400 RADIOLOGY-DIAGNOSTIC		0.136896	$ 120,713	$ 576,997	$ 105,076	$ 986,784	$ 175,516	$ 1,415,914	$ -	$ 1,309	$ 89,795	$ 679,624	$ 401,305	$ 2,981,004	29.57%
26	6000 LABORATORY		0.205639	$ 188,026	$ 359,270	$ 152,633	$ 450,391	$ 254,181	$ 500,183	$ -	$ 644	$ 111,922	$ 521,048	$ 594,840	$ 1,310,488	30.36%
27	6500 RESPIRATORY THERAPY		0.417490	$ 57,855	$ 6,580	$ 35,999	$ 9,435	$ 50,439	$ 11,620	$ -	$ -	$ 13,060	$ 6,508	$ 144,293	$ 27,635	34.36%
28	6600 PHYSICAL THERAPY		0.358999	$ 20,660	$ 11,455	$ 1,274	$ 29,955	$ 35,017	$ 236,254	$ -	$ -	$ 4,881	$ 24,941	$ 56,951	$ 277,664	11.65%
29	6900 ELECTROCARDIOLOGY		0.379935	$ 10,572	$ 21,477	$ 1,785	$ 16,213	$ 13,281	$ 66,605	$ -	$ -	$ 6,047	$ 40,056	$ 25,638	$ 104,295	19.18%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.440938	$ 90,988	$ 76,014	$ 96,430	$ 112,753	$ 118,912	$ 110,171	$ -	$ -	$ 45,475	$ 81,515	$ 306,330	$ 298,938	33.63%
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.643648	$ 40,792	$ -	$ 7,192	$ 330	$ 68,965	$ 5,193	$ -	$ -	$ 13,557	$ 6,789	$ 116,949	$ 5,523	21.57%
32	7300 DRUGS CHARGED TO PATIENTS		0.235172	$ 289,167	$ 141,675	$ 222,495	$ 218,907	$ 284,758	$ 249,555	$ -	$ -	$ 143,399	$ 195,960	$ 796,420	$ 610,137	39.31%
33	9000 CLINIC		0.166349	$ 110	$ 1,150	$ 78	$ 693	$ 340	$ 2,542	$ -	$ -	$ -	$ 878	$ 528	$ 4,385	30.66%
34	9100 EMERGENCY		0.371686	$ 61,913	$ 356,061	$ 22,931	$ 699,070	$ 79,983	$ 516,644	$ -	$ -	$ 48,006	$ 755,972	$ 164,827	$ 1,571,775	49.30%
				1,096,030	2,010,201	1,099,407	3,250,911	1,365,689	3,794,460	-	1,953	657,965	2,636,632			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 1,361,981	4103 $ 2,010,201	4103 $ 1,538,871	4203 $ 3,250,911	4203 $ 1,670,182	4303 $ 3,794,460	4303 $ -	4403 $ 1,953	4403 $ 794,011 (Agrees to Exhibit A)	5103 $ 2,636,632 (Agrees to Exhibit A)	5103 $ 4,571,034	$ 9,057,525	32.58%
129	Total Charges per PS&R or Exhibit Detail			$ 1,361,981	$ 2,010,201	$ 1,538,871	$ 3,250,911	$ 1,670,182	$ 3,794,460	$ -	$ 1,953	$ 794,011	$ 2,636,632			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 609,019	$ 519,485	$ 1,195,780	$ 1,062,323	$ 653,428	$ 926,055	$ -	$ 312	$ 324,390	$ 707,243	$ 2,458,227	$ 2,508,175	37.61%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 836,670	4103 $ 454,402	4103 $ -	$ -	$ 95,468	4303 $ 69,705	4303 $ -	$ -			$ 932,138	$ 524,107	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 751,071	4203 $ 630,836	4203 $ -	$ -	$ -	$ 36	4403		$ 751,071	$ 630,872	
134	Private Insurance (including primary and third party liability)			$ 11,969	4103 $ 12,109	4103 $ 45,540	4203 $ 40,751	4203 $ -	$ 1,776	4303 $ -	$ -			$ 57,509	$ 54,636	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	4103 $ 25	4203 $ 1,482	4203 $ -	$ -	$ -	$ -			$ 25	$ 1,482	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 848,639	$ 466,511	$ 796,636	$ 673,069									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ 16,616	4901 $ -	$ -							$ -	$ 16,616	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,000,012	4303 $ 745,329	4303 $ -	$ 306	4403		$ 1,000,012	$ 745,635	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ 93	4403		$ -	$ 93	
141	Medicare Cross-Over Bad Debt Payments							$ 16,897	1405 $ 33,602	1405 $ -	$ -			$ 16,897	$ 33,602	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 8,208	5203 $ 142,682	5203		
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ (239,620)	$ 36,358	$ 399,144	$ 389,254	$ (458,949)	$ 75,643	$ -	$ (123)	$ 316,182	$ 564,561	$ (299,425)	$ 501,132	
146	**Calculated Payments as a Percentage of Cost**			139%	93%	67%	63%	170%	92%	0%	139%	3%	20%	112%	80%	
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**							1,367	1405							
148	**Percent of cross-over days to total Medicare days from the cost report**							28%								

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 surve
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 payment
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 payment

I. Out-of-State Medicaid Data:

Cost Report Year (04/01/2016-03/31/2017) TAYLOR REGIONAL 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	$ 517.09		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ 1,179.89		-		-		-		-		-	
10	04300 NURSERY	$ 1,109.26		-		-		-		-		-	
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)		0.950049	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.225466	-	-	-	-	-	-	-	-	$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		3.933552	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.136896	-	-	-	-	-	-	-	-	$ -	$ -
26	6000 LABORATORY		0.205639	-	-	-	-	-	-	-	-	$ -	$ -
27	6500 RESPIRATORY THERAPY		0.417490	-	-	-	-	-	-	-	-	$ -	$ -
28	6600 PHYSICAL THERAPY		0.358999	-	-	-	-	-	-	-	-	$ -	$ -
29	6900 ELECTROCARDIOLOGY		0.379935	-	-	-	-	-	-	-	-	$ -	$ -
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.440938	-	-	-	-	-	-	-	-	$ -	$ -
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.643648	-	-	-	-	-	-	-	-	$ -	$ -
32	7300 DRUGS CHARGED TO PATIENTS		0.235172	-	-	-	-	-	-	-	-	$ -	$ -
33	9000 CLINIC		0.166349	-	-	-	-	-	-	-	-	$ -	$ -
34	9100 EMERGENCY		0.371686	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (04/01/2016-03/31/2017) TAYLOR REGIONAL HOSPITAL

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

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

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

Cost Report Year (04/01/2016-03/31/2017) TAYLOR REGIONAL HOSPITAL

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (04/01/2016-03/31/2017) TAYLOR REGIONAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 264,834	3001		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense		60256.000	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 264,834	3001	Line 5 Admin & Other	*(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		$ 264,834			

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -	

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

DSH Examination Eligibility Summary

Hospital Name	**TAYLOR REGIONAL HOSPITAL**
Hospital Medicaid Number	**000001548A**
Cost Report Period	From **4/1/2016** To **3/31/2017**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 2,957,652	$ 9,028	$ 2,966,680
2	Hospital Cash Subsidies	Survey F-2	$ 216,062	$ -	$ 216,062
3	Total		$ 3,173,714	$ 9,028	$ 3,182,742
4	Net Hospital Patient Revenue	Survey F-3	$ 22,937,120	$ -	$ 22,937,120
5	Medicaid Fraction		13.71%	0.04%	13.75%
6	Inpatient Charity Care Charges	Survey F-2	$ 200,507	$ -	$ 200,507
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ 216,062	$ -	$ 216,062
9	Adjusted Inpatient Charity Care		$ 147,927	$ -	$ 147,927
10	Inpatient Hospital Charges	Survey F-3	$ 12,743,271	$ -	$ 12,743,271
11	Inpatient Charity Fraction		1.16%	0.00%	1.16%
12	LIUR		14.87%	0.04%	14.91%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	1,405	-	1,405
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		1,405	-	1,405
16	Total Hospital Days (excludes swing-bed)	Survey F-1	4,125	-	4,125
17	MIUR		34.06%	0.00%	34.06%

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: **TAYLOR REGIONAL HOSPITAL**
Hospital Medicaid Number: **000001548A**
Cost Report Period: From **4/1/2016** To **3/31/2017**

As-Reported:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	609,019	836,670	-	11,969	-	-	-	-	-	-	-			848,639	(239,620)	139.35%
2	Medicaid Fee for Service	Outpatient	519,485	451,825	-	10,425	1,659	10,190	-	-	-	-	-			474,099	45,386	91.26%
3	Medicaid Managed Care	Inpatient	1,195,780	-	751,071	45,540	25	-	-							796,636	399,144	66.62%
4	Medicaid Managed Care	Outpatient	1,062,323	-	630,836	40,751	1,482	-	-							673,069	389,254	63.36%
5	Medicare Cross-over (FFS)	Inpatient	653,428	95,468	-	-	-		-	1,000,012	-	16,897	-			1,112,377	(458,949)	170.24%
6	Medicare Cross-over (FFS)	Outpatient	926,055	69,705	-	1,776	-		-	745,329	-	33,602	-			850,412	75,643	91.83%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8	Other Medicaid Eligibles	Outpatient	312	-	36	-	-			306	93	-	-			435	(123)	139.42%
9	Uninsured	Inpatient	338,502	-	-	-	-	-	-	-	-	-	-	6,756	-	6,756	331,746	2.00%
10	Uninsured	Outpatient	707,243	-	-	-	-	-	-	-	-	-	-	121,826	-	121,826	585,417	17.23%
11	In-State Sub-total	Inpatient	2,796,729	932,138	751,071	57,509	25	-	-	1,000,012	-	16,897	-	6,756	-	2,764,408	32,321	98.84%
12	In-State Sub-total	Outpatient	3,215,418	521,530	630,872	52,952	3,141	10,190	-	745,635	93	33,602	-	121,826	-	2,119,841	1,095,577	65.93%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	6,012,147	1,453,668	1,381,943	110,461	3,166	10,190	-	1,745,647	93	50,499	-	128,582	-	4,884,249	1,127,898	81.24%

Adjustments:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	2,577	-	1,684	(1,659)	6,426	-	-	-	-	-			9,028	(9,028)	1.74%
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	(14,112)	-	-	-	-	-	-	-	-	-	-	1,452	-	1,452	(15,564)	0.53%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	20,856	-	20,856	(20,856)	2.95%
11	In-State Sub-total	Inpatient	(14,112)	-	-	-	-	-	-	-	-	-	-	1,452	-	1,452	(15,564)	0.55%
12	In-State Sub-total	Outpatient	-	2,577	-	1,684	(1,659)	6,426	-	-	-	-	-	20,856	-	29,884	(29,884)	0.93%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	(14,112)	2,577	-	1,684	(1,659)	6,426	-	-	-	-	-	22,308	-	31,336	(45,448)	0.71%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **TAYLOR REGIONAL HOSPITAL**
Hospital Medicaid Number: **000001548A**
Cost Report Period: From **4/1/2016** To **3/31/2017**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	609,019	836,670	-	11,969	-	-	-	-	-	-	-			848,639	(239,620)	139.35%
2	Medicaid Fee for Service	Outpatient	519,485	454,402	-	12,109	-	16,616	-	-	-	-	-			483,127	36,358	93.00%
3	Medicaid Managed Care	Inpatient	1,195,780	-	751,071	45,540	25	-	-							796,636	399,144	66.62%
4	Medicaid Managed Care	Outpatient	1,062,323	-	630,836	40,751	1,482	-	-							673,069	389,254	63.36%
5	Medicare Cross-over (FFS)	Inpatient	653,428	95,468	-	-	-		-	1,000,012	-	16,897	-			1,112,377	(458,949)	170.24%
6	Medicare Cross-over (FFS)	Outpatient	926,055	69,705	-	1,776	-		-	745,329	-	33,602	-			850,412	75,643	91.83%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	n/a
8	Other Medicaid Eligibles	Outpatient	312	-	36	-	-			306	93	-	-			435	(123)	139.42%
9	Uninsured	Inpatient	324,390	-	-	-	-	-	-	-	-	-	-	8,208	-	8,208	316,182	2.53%
10	Uninsured	Outpatient	707,243	-	-	-	-	-	-	-	-	-	-	142,682	-	142,682	564,561	20.17%
11	In-State Sub-total	Inpatient	2,782,617	932,138	751,071	57,509	25	-	-	1,000,012	-	16,897	-	8,208	-	2,765,860	16,757	99.40%
12	In-State Sub-total	Outpatient	3,215,418	524,107	630,872	54,636	1,482	16,616	-	745,635	93	33,602	-	142,682	-	2,149,725	1,065,693	66.86%
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	5,998,035	1,456,245	1,381,943	112,145	1,507	16,616	-	1,745,647	93	50,499	-	150,890	-	4,915,585	1,082,450	81.95%

16 Less: Out of State DSH Payments from Adjusted Survey: -

17 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments: 1,082,450

Medicaid DSH Survey Adjustments

PROVIDER: TAYLOR REGIONAL HOSPITAL
FROM: 4/1/2016 TO: 3/31/2017
Mcaid Number: 000001548A
Mcare Number: 110135

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	E - Disclosure of Medicaid / Uninsured Payments	9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	1.00	Amount - Inpatient	Adjust to reclass insured payments to uninsured.	$ 6,756	$ 1,452	$ 8,208	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	1.00	Amount - Inpatient	Adjust to reclass insured payments to uninsured.	$ 126,985	$ (1,452)	$ 125,533	5203
1	E - Disclosure of Medicaid / Uninsured Payments	9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	2.00	Amount - Outpatient	Adjust to reclass insured payments to uninsured.	$ 121,826	$ 20,856	$ 142,682	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	2.00	Amount - Outpatient	Adjust to hospital's data.	$ 1,143,265	$ (20,856)	$ 1,122,409	5203
2	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to revised MMIS payments	$ 451,825	$ 2,577	$ 454,402	4103
2	H - In-State	134	Private Insurance (including primary and third party liabilit	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to revised MMIS payments	$ 10,425	$ 1,684	$ 12,109	4103
2	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to revised MMIS payments	$ 1,659	$ (1,659)	$ -	4103
3	H - In-State	137	Medicaid Cost Settlement Payments (See Note B	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to estimated OP settlement	$ 10,190	$ 6,426	$ 16,616	4901
4	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust to remove duplicate days	163	(23)	140	5103
4	H - In-State	10	NURSERY	13.00	Inpatient Uninsured	Adjust to remove duplicate days	7	(2)	5	5103
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	13.00	Inpatient Uninsured	Adjust to reclass insured payments to uninsured.	$ 6,756	$ 1,452	$ 8,208	5203
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	14.00	Outpatient Uninsured	Adjust to reclass insured payments to uninsured.	$ 121,826	$ 20,856	$ 142,682	5203

Medicaid DSH Report Notes

PROVIDER: TAYLOR REGIONAL HOSPITAL Mcaid Number: 000001548A
FROM: 4/1/2016 TO: 3/31/2017 Mcare Number: 110135

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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