DSH Version 7.30 3/26/2019

D. General Cost Report Year Information 7/1/2017 - 6/30/2018

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: DEKALB MEDICAL CENTER

	7/1/2017 through 6/30/2018		
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: 12/21/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	DEKALB MEDICAL CENTER	No	Emory Decatur Hospital
5. Medicaid Provider Number:	000000536A	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:	110076	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	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		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2017 - 06/30/2018)

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)	$ 472,768	$ 1,453,921	$1,926,689
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,827,565	$ 10,496,777	$13,324,342
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)	$3,300,333	$11,950,698	$15,251,031
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.32%	12.17%	12.63%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2017 - 06/30/2018)

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)	100,910 (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	25,197,720
8.	Outpatient Hospital Charity Care Charges	19,769,165
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 44,966,885

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	$148,816,210.00			$ 107,221,140	$ -	$ -	$ 41,595,070
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$22,634,612.00			$ 16,308,095	$ -	$ -	$ 6,326,517
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	$376,403,027.00	$418,586,010.00		$ 271,196,005	$ 301,588,578	$ -	$ 222,204,453
20.	Outpatient Services		$156,548,249.00			$ 112,792,025	$ -	$ 43,756,224
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	$6,929,520.00	$1,376,799.00	$0.00	$ 4,992,675	$ 991,975	$ -	$ 2,321,669
27.	Total	$ 554,783,369	$ 576,511,058	$ -	$ 399,717,916	$ 415,372,579	$ -	$ 316,203,932
28.	Total Hospital and Non Hospital		Total from Above	$ 1,131,294,427		Total from Above	$ 815,090,495	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,131,294,427	Total Contractual Adj. (G-3 Line 2)	812,465,160
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)			+	2,625,335
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				815,090,495

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) | DEKALB 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	$ 77,749,982	$ 939,948	$ -	$0.00	$ 78,689,930	83,935	$119,613,733.00		$ 937.51
2	03100 INTENSIVE CARE UNIT	$ 15,217,774	$ -	$ -		$ 15,217,774	9,143	$26,653,639.00		$ 1,664.42
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	$ 9,539,293	$ -	$ -		$ 9,539,293	9,255	$25,183,450.00		$ 1,030.72
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II		$ -	$ -		$ -				$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 3,057,808	$ -	$ -		$ 3,057,808	7,031	$6,929,520.00		$ 434.90
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 105,564,857	$ 939,948	$ -	$ -	$ 106,504,805	109,364	$ 178,380,342		
19	Weighted Average									$ 973.86

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)	9,055	-	-	$ 8,489,153	$5,757,128.00	$8,845,719.00	$ 14,602,847	0.581335

Line #		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$32,706,858.00	$ 60,431	$0.00		$ 32,767,289	$57,493,842.00	$97,840,348.00	$ 155,334,190	0.210947
22	5200 DELIVERY ROOM & LABOR ROOM	$11,149,436.00	$ -	$0.00		$ 11,149,436	$22,357,745.00	$117,097.00	$ 22,474,842	0.496085
23	5400 RADIOLOGY-DIAGNOSTIC	$19,766,733.00	$ 21,671	$0.00		$ 19,788,404	$30,778,049.00	$94,337,981.00	$ 125,116,030	0.158160
24	5700 CT SCAN	$1,986,626.00	$ -	$0.00		$ 1,986,626	$17,108,787.00	$34,440,159.00	$ 51,548,946	0.038539
25	5800 MRI	$1,180,238.00	$ -	$0.00		$ 1,180,238	$4,103,321.00	$11,376,828.00	$ 15,480,149	0.076242
26	5900 CARDIAC CATHETERIZATION	$5,396,899.00	$ -	$0.00		$ 5,396,899	$11,457,856.00	$10,682,620.00	$ 22,140,476	0.243757
27	6000 LABORATORY	$16,966,475.00	$ 12,389	$0.00		$ 16,978,864	$56,625,299.00	$45,949,308.00	$ 102,574,607	0.165527
28	6500 RESPIRATORY THERAPY	$7,127,115.00	$ -	$0.00		$ 7,127,115	$30,003,561.00	$9,606,518.00	$ 39,610,079	0.179932
29	6600 PHYSICAL THERAPY	$7,573,801.00	$ -	$0.00		$ 7,573,801	$16,551,440.00	$10,755,986.00	$ 27,307,426	0.277353
30	6900 ELECTROCARDIOLOGY	$1,198,138.00	$ -	$0.00		$ 1,198,138	$11,751,307.00	$10,998,626.00	$ 22,749,933	0.052666

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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	7000	ELECTROENCEPHALOGRAPHY	$233,638.00	$ -	$0.00		$ 233,638	$1,000,452.00	$450,282.00	$ 1,450,734	0.161048
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$16,933,983.00	$ -	$0.00		$ 16,933,983	$16,309,156.00	$13,468,024.00	$ 29,777,180	0.568690
33	7200	IMPL. DEV. CHARGED TO PATIENTS	$18,097,915.00	$ -	$0.00		$ 18,097,915	$20,529,570.00	$13,960,109.00	$ 34,489,679	0.524734
34	7300	DRUGS CHARGED TO PATIENTS	$40,645,810.00	$ -	$0.00		$ 40,645,810	$76,449,889.00	$64,075,992.00	$ 140,525,881	0.289241
35	7600	NEPHROLOGY	$2,298,154.00	$ -	$0.00		$ 2,298,154	$3,882,753.00	$526,133.00	$ 4,408,886	0.521255
36	9001	DIAGNOSTIC TREATMENT CTR	$3,062,984.00	$ -	$0.00		$ 3,062,984	$1,939,970.00	$5,980,696.00	$ 7,920,666	0.386708
37	9004	KANN OP CANCER CENTER	$2,018,943.00	$ -	$0.00		$ 2,018,943	$61,528.00	$8,544,733.00	$ 8,606,261	0.234590
38	9006	WOUND CARE CLINIC	$1,767,603.00	$ -	$0.00		$ 1,767,603	$28,090.00	$5,972,398.00	$ 6,000,488	0.294577
39	9100	EMERGENCY	$18,209,944.00	$ 15,497	$0.00		$ 18,225,441	$35,219,964.00	$84,198,022.00	$ 119,417,986	0.152619
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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
91		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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**	$ 208,321,293	$ 109,988	$ -		$ 208,431,281	$ 419,409,707	$ 532,127,579	$ 951,537,286	
127	**Weighted Average**									0.227968
128	**Sub Totals**	$ 313,886,150	$ 1,049,936	$ -		$ 314,936,086	$ 597,790,049	$ 532,127,579	$ 1,129,917,628	
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**					$ 314,936,086				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.33%				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From 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	$ 937.51		7,184		7,789		5,094		5,761		5,875		25,828		42.75%
2	03100 INTENSIVE CARE UNIT	$ 1,664.42		24		97		912		891		731		1,924		29.24%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,030.72		1,465		5,311				258		62		7,034		77.80%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 434.90		1,657		4,738				321		129		6,716		97.82%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	10,330		17,935		6,006		7,231		6,797		41,502		44.59%
19	Total Days per PS&R or Exhibit Detail			10,330		17,935		6,006		7,231		6,797				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 13,956,204		$ 28,160,358		$ 10,423,560		$ 10,861,303		$ 10,203,925		$ 63,401,425		41.70%
21.01	Calculated Routine Charge Per Diem			$ 1,351.04		$ 1,570.13		$ 1,735.52		$ 1,502.05		$ 1,501.24		$ 1,527.67		
	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)		0.581335	744,744	658,266	1,597,779	479,605	412,892	1,295,704	699,342	1,212,259	232,183	1,219,980	$ 3,454,757	$ 3,645,834	59.17%
23	5000 OPERATING ROOM		0.210947	4,793,669	2,389,200	11,159,171	4,302,123	5,899,667	8,091,710	5,637,870	5,331,252	2,685,009	1,841,904	$ 27,490,377	$ 20,114,285	33.67%
24	5200 DELIVERY ROOM & LABOR ROOM		0.496085	435,345	-	4,127,395	1,657	41,632	-	551,253	-	131,844	-	$ 5,155,625	$ 1,657	23.61%
25	5400 RADIOLOGY-DIAGNOSTIC		0.158160	1,940,042	2,351,418	1,356,110	4,155,979	2,251,616	5,675,607	1,954,186	4,886,316	1,703,054	6,106,985	$ 7,501,954	$ 17,069,320	26.13%
26	5700 CT SCAN		0.038539	1,683,298	1,591,176	405,319	1,551,795	1,504,789	3,352,495	1,244,045	2,264,970	1,926,287	5,628,751	$ 4,837,451	$ 8,760,436	41.61%
27	5800 MRI		0.076242	383,265	241,850	100,305	219,437	348,059	898,252	307,292	751,493	425,270	304,373	$ 1,138,921	$ 2,111,032	25.89%
28	5900 CARDIAC CATHETERIZATION		0.243757	1,051,088	379,265	205,123	91,436	864,337	1,110,557	797,323	849,635	1,124,577	265,065	$ 2,917,871	$ 2,430,893	30.53%
29	6000 LABORATORY		0.165527	6,820,139	3,437,822	4,913,743	3,942,176	5,014,090	4,348,909	4,637,985	2,891,647	4,924,592	7,598,633	$ 21,385,957	$ 14,620,554	47.86%
30	6500 RESPIRATORY THERAPY		0.179932	3,688,642	162,806	3,215,386	655,270	2,785,194	426,593	2,477,314	420,594	1,426,222	352,296	$ 12,166,536	$ 1,665,263	39.61%
31	6600 PHYSICAL THERAPY		0.277353	2,461,928	245,599	1,570,225	145,576	1,611,714	705,081	1,519,818	907,406	1,210,726	132,070	$ 7,163,685	$ 2,003,661	38.71%
32	6900 ELECTROCARDIOLOGY		0.052666	517,761	554,954	466,756	497,651	1,147,058	1,355,537	903,242	945,374	1,080,399	1,763,879	$ 3,034,817	$ 3,353,516	41.08%
33	7000 ELECTROENCEPHALOGRAPHY		0.161048	118,663	8,506	25,350	15,311	107,862	51,549	91,701	40,673	86,424	18,714	$ 343,576	$ 116,039	39.53%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.568690	1,077,470	312,838	1,216,264	370,340	1,346,694	1,205,647	1,127,495	710,508	690,597	271,857	$ 4,767,923	$ 2,599,333	28.09%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.524734	701,705	266,154	178,475	189,020	1,900,127	1,445,220	1,479,649	790,741	444,655	139,530	$ 4,259,956	$ 2,691,135	21.86%
36	7300 DRUGS CHARGED TO PATIENTS		0.289241	8,669,033	3,940,082	5,152,503	1,490,434	6,434,959	5,821,269	6,036,027	5,197,821	5,200,408	2,116,207	$ 26,292,522	$ 16,449,606	35.82%
37	7600 NEPHROLOGY		0.521255	151,636	-	4,540	-	414,956	78,310	218,828	19,633	68,100	6,356	$ 789,960	$ 97,943	22.07%
38	9001 DIAGNOSTIC TREATMENT CTR		0.386708	173,796	46,203	16,468	29,701	177,224	258,077	163,066	158,344	142,773	19,593	$ 530,554	$ 492,325	15.01%
39	9004 KAREN P CANCER CENTER		0.234590	-	-	330,737	114,755	427,565	466,429	470,496	316,274	299,062	90,228	$ 1,228,798	$ 897,458	29.54%
40	9006 WOUND CARE CLINIC		0.294577	55,295	5,262	-	88,329	442	595,949	442	135,989	-	981	$ 56,179	$ 825,529	14.71%
41	9100 EMERGENCY		0.152619	3,104,907	6,028,659	3,814,712	11,288,471	2,814,909	6,784,806	2,424,547	5,168,264	3,847,933	21,865,845	$ 12,159,075	$ 29,270,200	57.16%
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
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82			-											$ -	$ -	
83			-											$ -	$ -	

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

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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		-											$ -	$ -	
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101		-											$ -	$ -	
102		-											$ -	$ -	
103		-											$ -	$ -	
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121		-											$ -	$ -	
122		-											$ -	$ -	
123		-											$ -	$ -	
124		-											$ -	$ -	
125		-											$ -	$ -	
126		-											$ -	$ -	
127		-											$ -	$ -	
			$ 38,572,426	$ 22,620,060	$ 39,856,361	$ 29,629,065	$ 35,505,786	$ 43,967,701	$ 32,741,921	$ 32,999,193	$ 27,650,109	$ 49,743,247			
	Totals / Payments														
128	**Total Charges** ***(includes organ acquisition from Section J)***		$ 52,528,630	$ 22,620,060	$ 68,016,719	$ 29,629,065	$ 45,929,346	$ 43,967,701	$ 43,603,224	$ 32,999,193	$ 37,854,034 (Agrees to Exhibit A)	$ 49,743,247 (Agrees to Exhibit A)	$ 210,077,919	$ 129,216,019	38.14%
129	Total Charges per PS&R or Exhibit Detail		$ 52,528,630	$ 22,620,060	$ 68,016,719	$ 29,629,065	$ 45,929,346	$ 43,967,701	$ 43,603,224	$ 32,999,193	$ 37,854,034	$ 49,743,247			
130	Unreconciled Charges (Explain Variance)		-	-	-		-	-	-	-		-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**		$ 17,969,541	$ 4,524,545	$ 25,416,796	$ 5,310,927	$ 14,745,107	$ 9,486,903	$ 15,252,102	$ 7,113,091	$ 12,618,242	$ 8,031,496	$ 73,383,546	$ 26,435,466	38.58%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 16,591,517	$ 3,618,964			$ 765,970	$ 528,374	$ 365,988	$ 236,971			$ 17,723,475	$ 4,384,309	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 20,522,069	$ 4,349,854			$ 48,505	$ 37,756			$ 20,570,574	$ 4,387,610	
134	Private Insurance (including primary and third party liability)				$ 6,281	$ 1,374	$ 7,744	$ 9,312	$ 3,119,461	$ 854,745			$ 3,133,486	$ 865,431	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 247,422	$ 14,531	$ (176,967)	$ (178,590)	$ 887	$ 8,557	$ 48,426	$ (13,393)			$ 119,768	$ (168,895)	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 16,838,939	$ 3,633,495	$ 20,351,383	$ 4,172,638									
137	Medicaid Cost Settlement Payments (See Note B)			$ (40,194)									$ -	$ (40,194)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)												$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						$ 13,354,056	$ 6,993,824					$ 13,354,056	$ 6,993,824	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 8,510,729	$ 4,303,478			$ 8,510,729	$ 4,303,478	
141	Medicare Cross-Over Bad Debt Payments						$ 313,699	$ 286,878					$ 313,699	$ 286,878	
142	Other Medicare Cross-Over Payments (See Note D)						$ 159,677	$ 15,262			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 159,677	$ 15,262	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										$ 472,768	$ 1,453,921			
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)**		$ 1,130,602	$ 931,244	$ 5,065,413	$ 1,138,289	$ 143,074	$ 1,644,696	$ 3,158,993	$ 1,693,534	$ 12,145,474	$ 6,577,575	$ 9,498,082	$ 5,407,763	
146	**Calculated Payments as a Percentage of Cost**		94%	79%	80%	79%	99%	83%	79%	76%	4%	18%	87%	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)**						38,614								
148	**Percent of cross-over days to total Medicare days from the cost report**						16%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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	$ 937.51		310								310	
2	03100 INTENSIVE CARE UNIT	$ 1,664.42		18								18	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,030.72		104								104	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 434.90		33								33	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	465		-		-		-		465	
19	Total Days per PS&R or Exhibit Detail			465		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 772,045								$ 772,045	
21.01	Calculated Routine Charge Per Diem			$ 1,660.31		$ -		$ -		$ -		$ 1,660.31	
	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)		0.581335	32,118	55,240							$ 32,118	$ 55,240
23	5000 OPERATING ROOM		0.210947	161,610	15,163							$ 161,610	$ 15,163
24	5200 DELIVERY ROOM & LABOR ROOM		0.496085	17,042	-							$ 17,042	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.158160	113,150	198,863							$ 113,150	$ 198,863
26	5700 CT SCAN		0.038539	112,694	184,174							$ 112,694	$ 184,174
27	5800 MRI		0.076242	25,146	2,994							$ 25,146	$ 2,994
28	5900 CARDIAC CATHETERIZATION		0.243757	10,908	10,908							$ 10,908	$ 10,908
29	6000 LABORATORY		0.165527	244,719	319,666							$ 244,719	$ 319,666
30	6500 RESPIRATORY THERAPY		0.179932	62,243	15,548							$ 62,243	$ 15,548
31	6600 PHYSICAL THERAPY		0.277353	51,771	7,721							$ 51,771	$ 7,721
32	6900 ELECTROCARDIOLOGY		0.052666	50,998	61,866							$ 50,998	$ 61,866
33	7000 ELECTROENCEPHALOGRAPHY		0.161048	8,678	-							$ 8,678	$ -
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.568690	27,365	6,756							$ 27,365	$ 6,756
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.524734	3,866	-							$ 3,866	$ -
36	7300 DRUGS CHARGED TO PATIENTS		0.289241	212,160	66,250							$ 212,160	$ 66,250
37	7600 NEPHROLOGY		0.521255	10,896	-							$ 10,896	$ -
38	9001 DIAGNOSTIC TREATMENT CTR		0.386708	3,432	284							$ 3,432	$ 284
39	9004 KANN OP CANCER CENTER		0.234590	27,031	-							$ 27,031	$ -
40	9006 WOUND CARE CLINIC		0.294577	-	-							$ -	$ -
41	9100 EMERGENCY		0.152619	221,101	889,403							$ 221,101	$ 889,403
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,396,928	$ 1,834,836	$ -	$ -	$ -	$ -	$ -	$ -		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ 2,168,973	$ 1,834,836	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,168,973	$ 1,834,836
129	Total Charges per PS&R or Exhibit Detail			$ 2,168,973	$ 1,834,836	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 726,364	$ 296,713	$ -	$ -	$ -	$ -	$ -	$ -	$ 726,364	$ 296,713
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 108,485	$ 33,093							$ 108,485	$ 33,093
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)			$ 108,485	$ 33,093	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 617,879	$ 263,620	$ -	$ -	$ -	$ -	$ -	$ -	$ 617,879	$ 263,620
144	**Calculated Payments as a Percentage of Cost**			15%	11%	0%	0%	0%	0%	0%	0%	15%	11%

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

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

Cost Report Year (07/01/2017-06/30/2018) DEKALB 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 (07/01/2017-06/30/2018) DEKALB 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 (07/01/2017-06/30/2018) DEKALB 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)*		4,260,988.00		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	8014-0000	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 4,260,988		*(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*		$ (4,260,988)	5.00	*(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		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 4,260,988
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	343,297,747
19	Uninsured Hospital	**Charges Sec. G**	87,597,281
20	Total Hospital	**Charges Sec. G**	1,129,917,628
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		30.38%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.75%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,294,597
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 330,335
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,624,932**

** 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.*