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

DSH Version 5.20 11/1/2017

A. General DSH Year Information

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

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2016	06/30/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	000000756A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110054

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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?	7/1/1966

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

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

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

Pickens, Christopher J. M.D.
Freeman, Dixon L. M.D.

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

DSH Version 7.25 5/3/2018

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

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

1. Select Your Facility from the Drop-Down Menu Provided:	FLOYD MEDICAL CENTER		
	7/1/2016 through 6/30/2017		
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:	12/22/2017		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	FLOYD MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000756A	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:	110054	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	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	Alabama	FLO0054P
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: (07/01/2016 - 06/30/2017)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 206,506	$ 1,020,523	$1,227,029
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,967,188	$ 8,187,183	$10,154,371
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)	$2,173,694	$9,207,706	$11,381,400
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.50%	11.08%	10.78%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2016 - 06/30/2017)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	78,212 **(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	19,432,310
8.	Outpatient Hospital Charity Care Charges	34,679,622
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 54,111,932

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	$98,869,509.00			$ 74,329,414	$ -	$ -	$ 24,540,095
12.	Subprovider I (Psych or Rehab)	$5,333,175.00			$ 4,009,444	$ -	$ -	$ 1,323,731
13.	Subprovider II (Psych or Rehab)	$3,425,400.00			$ 2,575,192	$ -	$ -	$ 850,208
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	$508,144,468.00	$575,482,494.00		$ 382,019,500	$ 432,643,763	$ -	$ 268,963,699
20.	Outpatient Services		$174,611,451.00			$ 131,271,682	$ -	$ 43,339,769
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$7,016,238.00			$ 5,274,759	
26.	Other			$223,587.00	$ -	$ -	$ 168,091	$ -
27.	Total	$ 615,772,552	$ 750,093,945	$ 7,239,825	$ 462,933,550	$ 563,915,445	$ 5,442,850	$ 339,017,501
28.	Total Hospital and Non Hospital		Total from Above	$ 1,373,106,322		Total from Above	$ 1,032,291,846	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,373,106,322	Total Contractual Adj. (G-3 Line 2)	1,027,513,917
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)			+	4,777,929
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				1,032,291,846

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) | FLOYD 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	$ 68,549,772	$ 3,006,869	$ -	$0.00	$ 71,556,641	73,567	$40,968,149.00		$ 972.67
2	03100	INTENSIVE CARE UNIT	$ 12,393,232	$ 426,734	$ -		$ 12,819,966	7,085	$11,213,024.00		$ 1,809.45
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 7,790,306	$ -	$ -		$ 7,790,306	9,707	$12,548,668.00		$ 802.55
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 88,733,310	$ 3,433,603	$ -	$ -	$ 92,166,913	90,359	$ 64,729,841		
19		Weighted Average									$ 1,020.01

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)	12,147	-	-	$ 11,815,022	$5,765,550.00	$14,158,394.00	$ 19,923,944	0.593006

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$22,307,101.00	$ 981,791	$0.00		$ 23,288,892	$63,517,553.00	$161,372,299.00	$ 224,889,852	0.103557
22	5001	LITHOTRIPSY	$574,915.00	$ -	$0.00		$ 574,915	$0.00	$3,319,874.00	$ 3,319,874	0.173174
23	5100	RECOVERY ROOM	$5,841,594.00	$ -	$0.00		$ 5,841,594	$7,323,171.00	$13,983,707.00	$ 21,306,878	0.274165
24	5200	DELIVERY ROOM & LABOR ROOM	$5,821,142.00	$ -	$0.00		$ 5,821,142	$14,297,770.00	$534,460.00	$ 14,832,230	0.392466
25	5300	ANESTHESIOLOGY	$878,556.00	$ -	$0.00		$ 878,556	$11,550,743.00	$16,464,133.00	$ 28,014,876	0.031360
26	5400	RADIOLOGY-DIAGNOSTIC	$17,585,089.00	$ 173,545	$0.00		$ 17,758,634	$36,575,982.00	$104,535,766.00	$ 141,111,748	0.125848
27	6000	LABORATORY	$16,868,970.00	$ 147,766	$0.00		$ 17,016,736	$86,819,779.00	$97,055,725.00	$ 183,875,504	0.092545
28	6500	RESPIRATORY THERAPY	$7,421,432.00	$ -	$0.00		$ 7,421,432	$35,276,540.00	$1,673,269.00	$ 36,949,809	0.200852
29	6600	PHYSICAL THERAPY	$15,495,602.00	$ -	$0.00		$ 15,495,602	$5,148,375.00	$13,923,026.00	$ 19,071,401	0.812505
30	6800	SPEECH PATHOLOGY	$560,958.00	$ -	$0.00		$ 560,958	$1,262,879.00	$0.00	$ 1,262,879	0.444190

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) FLOYD 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	6900	ELECTROCARDIOLOGY	$9,955,390.00	$ 388,137	$0.00		$ 10,343,527	$42,810,238.00	$28,969,954.00	$ 71,780,192	0.144100
32	6901	CARDIO-PULMONARY REHAB	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$13,048,555.00	$ -	$0.00		$ 13,048,555	$37,626,594.00	$52,199,925.00	$ 89,826,519	0.145264
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$16,129,630.00	$ -	$0.00		$ 16,129,630	$67,794,349.00	$12,994,316.00	$ 80,788,665	0.199652
35	7300	DRUGS CHARGED TO PATIENTS	$26,695,662.00	$ -	$0.00		$ 26,695,662	$116,606,512.00	$72,285,012.00	$ 188,891,524	0.141328
36	7400	RENAL DIALYSIS	$1,657,113.00	$ -	$0.00		$ 1,657,113	$3,463,094.00	$0.00	$ 3,463,094	0.478507
37	7601	CHEMICAL DEPENDENCY	$636,641.00	$ -	$0.00		$ 636,641	$0.00	$378,745.00	$ 378,745	1.680923
38	9000	CLINIC	$5,146,200.00	$ 2,878,402	$0.00		$ 8,024,602	$0.00	$7,723,167.00	$ 7,723,167	1.039030
39	9001	CLINIC	$837,131.00	$ -	$0.00		$ 837,131	$23,400.00	$98,540.00	$ 121,940	6.865106
40	9003	HYPERBARIC	$154,869.00	$ -	$0.00		$ 154,869	$0.00	$298,474.00	$ 298,474	0.518869
41	9100	EMERGENCY	$20,207,762.00	$ -	$433,675.00		$ 20,641,437	$29,604,775.00	$122,159,596.00	$ 151,764,371	0.136010
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44		69.01 was combined with 65 given the only charges	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45		and cost in this cost center are 948 pulmonary rehab	$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 (07/01/2016-06/30/2017) FLOYD 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**	$ 187,824,312	$ 4,569,641	$ 433,675		$ 192,827,628	$ 565,467,304	$ 724,128,382	$ 1,289,595,686	
127	**Weighted Average**									0.158688
128	**Sub Totals**	$ 276,557,622	$ 8,003,244	$ 433,675		$ 284,994,541	$ 630,197,145	$ 724,128,382	$ 1,354,325,527	
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 Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 284,994,541				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					2.89%				

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

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

Cost Report Year (07/01/2016-06/30/2017) FLOYD 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	$ 972.67		5,638		4,787		4,929		3,794		3,668		19,148		37.85%
2	03100 INTENSIVE CARE UNIT	$ 1,809.45		2,956		159		686		298		402		4,099		64.21%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 802.55		1,478		5,018		2		563		164		7,061		74.50%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	10,072		9,964		5,617		4,655		4,234		30,308		38.77%
19	Total Days per PS&R or Exhibit Detail			10,072		9,964		5,617		4,655		4,234				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 8,312,058		$ 9,348,060		$ 5,118,630		$ 3,723,247		$ 3,290,776		$ 26,501,995		46.64%
21.01	Calculated Routine Charge Per Diem			$ 825.26		$ 938.18		$ 911.27		$ 799.84		$ 777.23		$ 874.42		
	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)		0.593006	138,845	1,424,627	379,853	1,885,995	348,151	1,433,818	232,094	820,506	41,795	2,472,261	$ 1,098,943	$ 5,564,946	46.73%
23	5000 OPERATING ROOM		0.103557	6,339,390	5,793,375	6,705,705	13,880,149	6,591,601	7,110,115	3,724,195	3,456,355	4,818,046	7,871,772	$ 23,360,891	$ 30,239,994	29.80%
24	5001 LITHOTRIPSY		0.173174	-	97,044		97,044	-	32,348		64,696	-	226,436	$ -	$ 291,132	16.56%
25	5100 RECOVERY ROOM		0.274165	615,578	730,324	863,816	1,697,755	519,808	835,326	459,346	404,282	425,477	837,088	$ 2,458,548	$ 3,667,687	35.04%
26	5200 DELIVERY ROOM & LABOR ROOM		0.392466	973,414	108,628	4,753,783	1,983,412	78,796	40,735	1,697,844	512,671	84,591	165,801	$ 7,503,837	$ 2,645,446	70.29%
27	5300 ANESTHESIOLOGY		0.031360	834,163	786,062	1,349,561	1,696,573	750,921	887,942	640,517	420,292	577,728	942,925	$ 3,575,162	$ 3,790,869	32.04%
28	5400 RADIOLOGY-DIAGNOSTIC		0.125848	3,693,513	6,685,522	1,158,878	9,121,644	3,770,383	7,241,957	1,551,339	2,874,505	3,137,798	16,804,507	$ 10,174,113	$ 25,923,628	40.43%
29	6000 LABORATORY		0.092545	10,610,039	8,480,382	5,263,405	11,948,442	9,111,353	6,950,274	4,449,698	3,182,157	5,670,196	16,406,094	$ 29,434,495	$ 30,561,255	45.47%
30	6500 RESPIRATORY THERAPY		0.200852	4,591,590	142,365	1,150,405	292,295	4,206,826	376,151	1,798,700	181,309	1,076,993	238,221	$ 11,747,521	$ 992,120	38.93%
31	6600 PHYSICAL THERAPY		0.812505	159,458	137,669	96,807	373,182	174,043	496,981	133,512	240,215	165,138	354,243	$ 563,820	$ 1,248,047	12.28%
32	6800 SPEECH PATHOLOGY		0.444190	63,930	2,660	7,323	3,952	76,680	20,338	36,139	8,767	31,095	25,313	$ 184,072	$ 35,717	22.31%
33	6900 ELECTROCARDIOLOGY		0.144100	3,181,907	2,077,995	1,485,877	2,325,111	4,722,820	3,161,232	2,068,072	1,075,155	2,365,347	3,782,529	$ 11,458,676	$ 8,639,493	37.26%
34	6901 CARDIO-PULMONARY REHAB		-	-	-	-	-	-	-		-		-	$ -	$ -	
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.145264	5,009,844	2,447,028	3,676,312	3,320,385	4,871,599	2,993,244	2,703,701	1,143,017	2,493,753	4,483,877	$ 16,261,456	$ 9,903,674	37.46%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.199652	3,310,017	723,815	703,939	1,080,765	5,607,763	1,642,769	2,219,155	565,729	1,493,941	1,168,396	$ 11,840,874	$ 4,013,078	23.12%
37	7300 DRUGS CHARGED TO PATIENTS		0.141328	12,999,847	10,071,591	7,720,762	8,084,912	9,885,647	6,148,078	5,619,158	2,643,637	6,926,132	9,669,169	$ 36,225,414	$ 26,948,217	42.84%
38	7400 RENAL DIALYSIS		0.478507	251,914	-	20,578	2,000	270,143	126,491	158,274	28,729	44,609	760,590	$ 700,909	$ 157,220	48.94%
39	7601 CHEMICAL DEPENDENCY		1.680923	-	-	-	16,755	-	16,220		5,085		-	$ -	$ 38,060	10.05%
40	9000 CLINIC		1.039030	9,336	464,669	2,455	91,957	11,918	1,584,093	1,255	65,755	-	-	$ 24,964	$ 2,206,474	28.93%
41	9001 CLINIC		6.865106	-	-	3,368	24,731	6,832	6,259	2,712	10,322	-	-	$ 12,912	$ 41,312	45.15%
42	9003 HYPERBARIC		0.518869	-	-	-	-	-	-		-		-	$ -	$ -	0.00%
43	9100 EMERGENCY		0.136010	3,643,484	10,188,795	784,402	21,345,430	3,572,221	8,887,034	1,347,978	4,139,903	2,521,243	31,262,087	$ 9,348,085	$ 44,561,162	58.57%
44			-											$ -	$ -	
45			-											$ -	$ -	
46	69.01 was combined with 65 given the only charges		-											$ -	$ -	
47	and cost in this cost center are 948 pulmonary rehab		-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
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61			-											$ -	$ -	
62			-											$ -	$ -	
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67			-											$ -	$ -	
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73			-											$ -	$ -	
74			-											$ -	$ -	
75			-											$ -	$ -	
76			-											$ -	$ -	
77			-											$ -	$ -	
78			-											$ -	$ -	
79			-											$ -	$ -	
80			-											$ -	$ -	
81			-											$ -	$ -	
82			-											$ -	$ -	

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

Cost Report Year (07/01/2016-06/30/2017) FLOYD 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		%
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			-											$ -	$ -	
112			-											$ -	$ -	
113			-											$ -	$ -	
114			-											$ -	$ -	
115			-											$ -	$ -	
116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 56,426,269	$ 50,362,551	$ 36,127,229	$ 79,272,489	$ 54,577,505	$ 49,991,405	$ 28,843,689	$ 21,843,086	$ 31,873,881	$ 97,471,309			

Totals / Payments

128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 64,738,327	$ 50,362,551	$ 45,475,289	$ 79,272,489	$ 59,696,135	$ 49,991,405	$ 32,566,936	$ 21,843,086	$ 35,164,657 (Agrees to Exhibit A)	$ 97,471,309 (Agrees to Exhibit A)	$ 202,476,687	$ 201,469,531	40.20%
129	Total Charges per PS&R or Exhibit Detail	$ 64,738,327	$ 50,362,551	$ 45,475,289	$ 79,272,489	$ 59,696,135	$ 49,991,405	$ 32,566,936	$ 21,843,086	$ 35,164,657	$ 97,471,309			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 20,171,667	$ 7,588,281	$ 15,103,570	$ 11,860,497	$ 14,040,708	$ 8,980,627	$ 9,316,824	$ 3,604,738	$ 8,746,886	$ 14,036,737	$ 58,632,769	$ 32,034,143	40.36%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 15,421,933	$ 7,160,132			$ 992,403	$ 661,937	$ 349,267	$ 199,858			$ 16,763,603	$ 8,021,927	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 10,751,913	$ 11,326,651			$ 367,774	$ 242,975			$ 11,119,687	$ 11,569,626	
134	Private Insurance (including primary and third party liability)	$ 66,984	$ 14,545			$ 775	$ 5,764	$ 3,591,081	$ 3,684,318			$ 3,658,840	$ 3,704,627	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 15,891					$ 3,405	$ 8,766			$ 3,405	$ 24,657	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 15,488,917	$ 7,190,568	$ 10,751,913	$ 11,326,651									
137	Medicaid Cost Settlement Payments (See Note B)		$ (503,508)									$ -	$ (503,508)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 11,566,178	$ 5,055,853	$ 3,948,665	$ 1,289,326			$ 15,514,843	$ 6,345,179	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 178,119	$ 114,155					$ 178,119	$ 114,155	
142	Other Medicare Cross-Over Payments (See Note D)					$ 199,219	$ 71,953			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 199,219	$ 71,953	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 206,506	$ 1,020,523			
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)**	$ 4,682,750	$ 901,221	$ 4,351,657	$ 533,846	$ 1,104,014	$ 3,070,965	$ 1,056,632	$ (1,820,505)	$ 8,540,380	$ 13,016,214	$ 11,195,053	$ 2,685,527	
146	**Calculated Payments as a Percentage of Cost**	77%	88%	71%	95%	92%	66%	89%	151%	2%	7%	81%	92%	

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)**	36,294
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 (07/01/2016-06/30/2017) FLOYD 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	$ 972.67		157				243		33		433	
2	03100 INTENSIVE CARE UNIT	$ 1,809.45		5				34		9		48	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 802.55		7								7	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	169		-		277		42		488	
19	Total Days per PS&R or Exhibit Detail			169		-		277		42			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 138,015		$ -		$ 225,115		$ 32,340		$ 395,470	
21.01	Calculated Routine Charge Per Diem			$ 816.66		$ -		$ 812.69		$ 770.00		$ 810.39	
	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)		0.593006	510	56,260			11,825	52,389	2,460	8,430	$ 14,795	$ 117,079
23	5000 OPERATING ROOM		0.103557	135,904	138,759			284,394	79,090	55,785	23,593	$ 476,083	$ 241,442
24	5001 LITHOTRIPSY		0.173174	-	-			-	-	-	32,348	$ -	$ 32,348
25	5100 RECOVERY ROOM		0.274165	17,753	16,125			22,930	6,716	6,721	6,416	$ 47,404	$ 29,257
26	5200 DELIVERY ROOM & LABOR ROOM		0.392466	5,122	3,151			392	49	16,528	-	$ 22,042	$ 3,200
27	5300 ANESTHESIOLOGY		0.031360	18,532	16,425			29,010	10,245	7,633	6,045	$ 55,175	$ 32,715
28	5400 RADIOLOGY-DIAGNOSTIC		0.125848	121,059	450,053			164,808	174,280	24,244	79,692	$ 310,111	$ 704,025
29	6000 LABORATORY		0.092545	228,889	501,057			438,303	251,338	70,907	50,400	$ 738,099	$ 802,795
30	6500 RESPIRATORY THERAPY		0.200852	85,261	8,666			211,646	9,747	14,504	159	$ 311,411	$ 18,572
31	6600 PHYSICAL THERAPY		0.812505	2,401	152			6,115	1,663	532	228	$ 9,048	$ 2,043
32	6800 SPEECH PATHOLOGY		0.444190	614	304			4,268	304	-	-	$ 4,882	$ 608
33	6900 ELECTROCARDIOLOGY		0.144100	125,153	135,256			153,763	63,783	7,166	10,898	$ 286,082	$ 209,937
34	6901 CARDIO-PULMONARY REHAB		-	-	-			-	-	-	-	$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.145264	104,355	78,101			241,694	41,578	30,528	10,667	$ 376,577	$ 130,346
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.199652	42,425	23,126			87,375	821	4,876	685	$ 134,676	$ 24,632
37	7300 DRUGS CHARGED TO PATIENTS		0.141328	271,477	140,783			562,662	78,026	75,457	26,402	$ 909,596	$ 245,211
38	7400 RENAL DIALYSIS		0.478507	-	-			28,589	3,000	-	-	$ 28,589	$ 3,000
39	7601 CHEMICAL DEPENDENCY		1.680923	-	-			-	-	-	-	$ -	$ -
40	9000 CLINIC		1.039030	-	190			250	2,580	-	-	$ 250	$ 2,770
41	9001 CLINIC		6.865106	192	352			192	32	32	32	$ 416	$ 416
42	9003 HYPERBARIC		0.518869	-	-			-	-	-	-	$ -	$ -
43	9100 EMERGENCY		0.136010	83,968	675,399			122,778	205,262	20,682	81,805	$ 227,428	$ 962,466
44			-									$ -	$ -
45			-									$ -	$ -
46	69.01 was combined with 65 given the only charges		-									$ -	$ -
47	and cost in this cost center are 948 pulmonary rehab		-									$ -	$ -
48			-									$ -	$ -
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			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) FLOYD 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	
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			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
	Totals / Payments			$ 1,243,615	$ 2,244,159	$ -	$ -	$ 2,370,994	$ 980,903	$ 338,055	$ 337,800		
128	**Total Charges (includes organ acquisition from Section K)**			$ 1,381,630	$ 2,244,159	$ -	$ -	$ 2,596,109	$ 980,903	$ 370,395	$ 337,800	$ 4,348,134	$ 3,562,862
129	Total Charges per PS&R or Exhibit Detail			$ 1,381,630	$ 2,244,159	$ -	$ -	$ 2,596,109	$ 980,903	$ 370,395	$ 337,800		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 337,745	$ 308,737	$ -	$ -	$ 638,559	$ 148,752	$ 97,284	$ 48,237	$ 1,073,588	$ 505,726
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 182,826	$ 88,599			$ 28,383	$ 557	$ -	$ 1,562	$ 211,209	$ 90,718
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)							$ -	$ 920	$ 29,837	$ 53,524	$ 29,837	$ 54,444
135	Self-Pay (including Co-Pay and Spend-Down)							$ -	$ -	$ -	$ 232	$ -	$ 232
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 182,826	$ 88,599	$ -	$ -						
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)							$ 441,317	$ 82,874			$ 441,317	$ 82,874
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 51,470	$ 9,911	$ 51,470	$ 9,911
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**			$ 154,919	$ 220,138	$ -	$ -	$ 168,859	$ 64,401	$ 15,977	$ (16,992)	$ 339,755	$ 267,547
144	**Calculated Payments as a Percentage of Cost**			54%	29%	0%	0%	74%	57%	84%	135%	68%	47%

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 (07/01/2016-06/30/2017) FLOYD 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 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	$0.00	$ -	$ -		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 (07/01/2016-06/30/2017) FLOYD 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 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								
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 (07/01/2016-06/30/2017) FLOYD 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)*		$ 3,803,004		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	950000-6628	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 3,803,004	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 3,803,004		

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.*

C. Disclosure of Other Medicaid Payments Received:

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

$ 5,252,702

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: Other Protested Item: "New Hampshire Hospital Association v. Azar" We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Cost.

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

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

Hospital CEO or CFO Signature	Title	Date
	Chief Financial Officer	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Richard T. Sheerin	(706) 509-6074	rsheerin@floyd.org

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

Hospital Contact:	
Name	Richard T. Sheerin
Title	CFO
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Mailing City, State, Zip	Rome, Georgia 30162

Outside Preparer:	
Name	Bert Bennett
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