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

DSH Version 5.25 04/17/2019

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: SHEPHERD 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	04/01/2017	03/31/2018
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	0002480694
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	112003

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 (07/01/17 - 06/30/18)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	08/01/1975

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 (07/01/19 - 06/30/20)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No

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

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

C. Disclosure of Other Medicaid Payments Received:

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

$ 484,009

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:

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	Chief Financial Officer Title	Date
Stephen B. Holleman Hospital CEO or CFO Printed Name	404-350-7776 Hospital CEO or CFO Telephone Number	steve_holleman@shgherd.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	John McDaniel
Title	Director of Finance
Telephone Number	404-350-7329
E-Mail Address	john_mcdaniel@shepherd.org
Mailing Street Address	2020 Peachtree Road, NW

Outside Preparer:

Name	Jonathan Skaggs
Title	Senior Manager
Firm Name	PKA, P.C.
Telephone Number	678-441-0645
E-Mail Address	skaggs@pkapc.com

DSH Version 7.30 03/26/2019

D. General Cost Report Year Information 04/01/2017 - 03/31/2018

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:	SHEPHERD CENTER		
	04/01/2017 through 03/31/2018		
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:	09/17/2018		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SHEPHERD CENTER	Yes	
5. Medicaid Provider Number:	000248069A	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:	112003	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	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: (04/01/2017 - 03/31/2018)

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)	$ 525,600	$ 235,989	$761,589
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 472,725	$ 1,166,916	$1,639,641
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (h) on Exhibit B, less physician and non-hospital portion of payments)	$996,325	$1,402,905	$2,401,230
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	52.65%	16.82%	31.72%

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 (04/01/2017 - 03/31/2018)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, WkS S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	46,917 (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	4,655,615
8.	Outpatient Hospital Charity Care Charges	7,556,114
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 12,211,729

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	$76,821,552.00			$ 40,731,854	$ -	$ -	$ 36,089,698
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$205,934,232.00	$178,659,430.00		$ 109,189,190	$ 94,727,711	$ -	$ 180,676,762
20.	Outpatient Services		$13,663,661.00			$ 7,244,663	$ -	$ 6,418,998
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 282,755,784	$ 192,323,091	$ -	$ 149,921,043	$ 101,972,374	$ -	$ 223,185,458
28.	Total Hospital and Non Hospital		Total from Above	$ 475,078,875		Total from Above	$ 251,893,417	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	475,078,875
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)		
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)		
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)		
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)		
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)		
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"		
36.	Adjusted Contractual Adjustments		

	Total Contractual Adj. (G-3 Line 2)	251,893,417
+		
+		
+		
+		
-		
-		
		251,893,417

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2017-03/31/2018) SHEPHERD 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	$ 48,945,878	$ -	$ -	$0.00	$ 48,945,878	46,917	$74,559,751.00		$ 1,043.24
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 48,945,878	$ -	$ -	$ -	$ 48,945,878	46,917	$ 74,559,751		
19	Weighted Average									$ 1,043.24

Line #		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	-	-	-	$ -	$0.00	$0.00	$ -	-

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	$6,484,880.00	$ -	$0.00		$ 6,484,880	$12,531,409.00	$38,720.00	$ 12,570,129	0.515896
22	5400 RADIOLOGY-DIAGNOSTIC	$1,964,463.00	$ -	$0.00		$ 1,964,463	$5,549,975.00	$578,650.00	$ 6,128,625	0.320539
23	5700 CT SCAN	$1,894,860.00	$ -	$0.00		$ 1,894,860	$3,999,587.00	$0.00	$ 3,999,587	0.473764
24	5800 MRI	$1,549,089.00	$ -	$0.00		$ 1,549,089	$436,104.00	$17,096,450.00	$ 17,532,554	0.088355
25	6000 LABORATORY	$3,044,587.00	$ -	$0.00		$ 3,044,587	$8,050,416.00	$6,919,651.00	$ 14,970,067	0.203378
26	6500 RESPIRATORY THERAPY	$4,766,737.00	$ -	$0.00		$ 4,766,737	$47,638,996.00	$50,996.00	$ 47,689,996	0.099953
27	6600 PHYSICAL THERAPY	$12,877,180.00	$ -	$0.00		$ 12,877,180	$19,004,320.00	$11,130,535.00	$ 30,134,855	0.427318
28	6700 OCCUPATIONAL THERAPY	$10,985,471.00	$ -	$0.00		$ 10,985,471	$17,360,848.00	$8,749,510.00	$ 26,110,358	0.420732
29	6800 SPEECH PATHOLOGY	$6,082,412.00	$ -	$0.00		$ 6,082,412	$8,580,575.00	$4,326,352.00	$ 12,906,927	0.471252
30	6900 ELECTROCARDIOLOGY	$180,548.00	$ -	$0.00		$ 180,548	$637,386.00	$89,668.00	$ 727,054	0.248328

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2017-03/31/2018) SHEPHERD CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$3,688,196.00	$ -	$0.00		$ 3,688,196	$31,466,061.00	$225,199.00	$ 31,691,260	0.116379
32	7200	IMPL. DEV. CHARGED TO PATIENTS	$40,916.00	$ -	$0.00		$ 40,916	$86,095.00	$77,115.00	$ 163,210	0.250695
33	7300	DRUGS CHARGED TO PATIENTS	$53,989,056.00	$ -	$0.00		$ 53,989,056	$45,340,475.00	$106,606,014.00	$ 151,946,489	0.355316
34	7500	OTHER PATIENT SERVICES	$4,954,739.00	$ -	$0.00		$ 4,954,739	$3,765,935.00	$4,469,450.00	$ 8,235,385	0.601640
35	9000	CLINIC	$15,435,684.00	$ -	$2,608,203.00		$ 18,043,887	$126,591.00	$16,838,518.00	$ 16,965,109	1.063569
36			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year: (04/01/2017-03/31/2018) SHEPHERD 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**	$ 127,938,818	$ -	$ 2,608,203		$ 130,547,021	$ 204,574,775	$ 177,196,830	$ 381,771,605	
127	**Weighted Average**									0.341950
128	**Sub Totals**	$ 176,884,696	$ -	$ 2,608,203		$ 179,492,899	$ 279,134,526	$ 177,196,830	$ 456,331,356	
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**					$ 179,492,899				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

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

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

[illegible] SHEPHERD 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 – Inpatient	In-State Medicare FFS Cross-Overs – Outpatient	In-State Other Medicaid Eligibles – Inpatient	In-State Other Medicaid Eligibles – Outpatient	Uninsured – Inpatient	Uninsured – Outpatient	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		
1–17	[illegible]	[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]
18	Total Days			[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]
19	Total Days per PS&R or Exhibit Detail			[illegible]		[illegible]		[illegible]		[illegible]		[illegible]				
20	Unreconciled Days (Explain Variance)			[illegible]		[illegible]		[illegible]		[illegible]		[illegible]				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]
21.01	Calculated Routine Charge Per Diem			[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		[illegible]		
	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	
22–37	[illegible]		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
38–82																

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

[redacted] WARNERS CENTER

		In-State Medicaid FFS Patients		In-state Medicaid Managed Care Patients		In-State Medicaid FFS Low Income (HRS Worksheet Numbers)		In-state Other Medicaid Eligible (NOT Included in Columns A-D)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** (Include organ acquisition from Section J)	$ 16,107,864	$ 5,196,999	$ 1,904,398	$ 1,022,583	$ 192,704	$ 10,473,167	$ 11,598,974	$ 2,178,747	$ 9,545,899 (Agrees to Schedule H)	$ 3,714,237 (Agrees to Schedule H)	$ 53,081,481	$ 23,402,545	% of Total
129	Total Charges per FSSR or Earlier Detail	$ 16,107,864	$ 5,196,999	$ 1,904,398	$ 1,022,583	$ 192,704	$ 10,473,167	$ 11,598,974	$ 2,178,747	$ 9,545,899	$ 3,714,237			
130	Unreconciled Charges (Explain Variance)													
131	**Total Calculated Cost (Includes organ acquisition from Section J)**	$ 4,212,819	$ 1,322,726	$ 445,511	$ 261,430	$ 48,954	$ 4,601,736	$ 4,104,864	$ 1,041,824	$ 1,574,133	$ 1,987,244	$ 11,886,648	$ 6,173,980	% of Total
132	Total Medicaid Paid Amount (exclude TPL, Co-Pay and Spend-Down)	$ 2,215,181	$ 1,287,827	$ 445,704	$ 261,313	$ 48,954	$ 4,601,736	$ -	$ 1,041,824			$ 8,540,389	$ 3,119,598	
133	Total Medicaid Managed Care Paid Amount (exclude TPL, Co-Pay and Spend-Down) (See Note E)								$ 7,153			$ -	$ 7,153	
134	Private Insurance (including primary and third party liability)		$ 34,899					$ 4,597,811	$ 1,041,824			$ 4,632,710	$ 1,076,723	
135	Self Pay (including Co-Pay and Spend-Down)		$ 1,018	$ 807	$ 142	$ 18	$ 1,018		$ 4,153			$ 2,025	$ 6,331	
136	Total Allowed Amount from Medicaid FFS/BR or RA Detail (All Payments)	$ 2,215,181	$ 1,322,726	$ 445,511	$ 261,455							$ -	$ -	
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ 58,148	$ 1,415,257	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 131,749	$ 1,911,411		$ 1,133,671			$ 776,149	$ 1,175,124	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 927	Agrees to Exhibit B and B-1	Agrees to Exhibit B and B-1	$ -	$ 927	
141	Medicare Cross-Over Bad Debt Payments									$ 1,574,133	$ 1,987,244	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -			
143	Payment from Hospital (Included During Cost Report Year) (Cash Basis)													
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Columns B & B-1 - From Section E)													
145	**Calculated Payment Shortfall / (Surplus) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 197,364	$ 322,912	$ 229,534	$ 74,940	$ 47,214	$ 690,564	$ 684,840	$ 332,237	$ 2,148,533	$ 1,741,386	$ 14,983	$ 1,780,533	
146	**Calculated Payments as a Percentage of Cost**	22%	98%	52%	71%	96%	15%	17%	32%	37%	12%	26%	97%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing Bed (LIR, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					1,276								
148	**Percent of cross-over days to total Medicare days from the cost report**					1%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other providers (see the Hospital's host if FSSR summaries are not available) submit data with numbers
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 FSSR).
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 (04/01/2017-03/31/2018) SHEPHERD 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	02000 ADULTS & PEDIATRICS	$ 1,043.24										-	
2	02100 INTENSIVE CARE UNIT	$ -										-	
3	02200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from WIS 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)		-									$ -	$ -
23	5000 OPERATING ROOM		0.515896									$ -	$ -
24	5400 RADIOLOGY-DIAGNOSTIC		0.320539									$ -	$ -
25	5700 CT SCAN		0.473764									$ -	$ -
26	5800 MRI		0.088355									$ -	$ -
27	6000 LABORATORY		0.203178									$ -	$ -
28	6500 RESPIRATORY THERAPY		0.099953									$ -	$ -
29	6600 PHYSICAL THERAPY		0.427318									$ -	$ -
30	6700 OCCUPATIONAL THERAPY		0.429732									$ -	$ -
31	6800 SPEECH PATHOLOGY		0.471252									$ -	$ -
32	6900 ELECTROCARDIOLOGY		0.248328									$ -	$ -
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.116379									$ -	$ -
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.200695									$ -	$ -
35	7300 DRUGS CHARGED TO PATIENTS		0.355218									$ -	$ -
36	7501 OTHER PATIENT SERVICES		0.601645									$ -	$ -
37	9000 CLINIC		1.363588									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (06/01/2017-03/31/2018) SHEPHERD 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 (04/01/2017-03/31/2018) SHEPHERD 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			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -
134	Private Insurance (including primary and third party liability)											$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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 Reporting Period (MM/DD/YYYY to MM/DD/YYYY): SHEPHERD 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	$ -	$ -											
2		Kidney Acquisition	$0.00	$ -	$ -											
3		Liver Acquisition	$0.00	$ -	$ -											
4		Heart Acquisition	$0.00	$ -	$ -											
5		Pancreas Acquisition	$0.00	$ -	$ -											
6		Intestinal Acquisition	$0.00	$ -	$ -											
7		Islet Acquisition	$0.00	$ -	$ -											
8			$0.00	$ -	$ -											
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 K 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 Reporting Period (MM/DD/YYYY to MM/DD/YYYY): SHEPHERD 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 (04/01/2017-03/31/2018) SHEPHERD CENTER

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*			
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*			*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)			*(Where is the cost included on w/s A?)*
3	Difference (Explain Here --------->)	$ -		
	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	$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -	
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital Charges Sec. G	55,588,106	
19	Uninsured Hospital Charges Sec. G	12,109,021	
20	Total Hospital Charges Sec. G	456,331,356	
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	12.18%	
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	2.65%	
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	$ -	
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	$ -	
25	Provider Tax Assessment Adjustment to DSH UCC	$ -	

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

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