HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED FINANCIAL STATEMENTS

for the years ended September 30, 2022 and 2021

Draffin Tucker

Let's Think Together.®

CONTENTS

Draffin Tucker

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Hospital Authority of Colquitt County
Moultrie, Georgia

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying combined financial statements of Hospital Authority of Colquitt County (Authority), a component unit of Colquitt County, Georgia, which comprise the combined balance sheets as of September 30, 2022 and 2021, and the related combined statements of revenues, expenses and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

In our opinion, the accompanying combined financial statements present fairly, in all material respects, the financial position of the Authority as of September 30, 2022 and 2021, and the changes in its financial position and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Authority and to meet our other ethical responsibilities in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Change in Accounting Principle

As described in Note 1 to the combined financial statements, in 2022 the Authority adopted new accounting guidance, Governmental Accounting Standards Board Statement No. 87, *Leases*. Our opinion is not modified with respect to this matter.

Continued

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the combined financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the combined financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the combined financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Authority's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the combined financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgement of a reasonable user based on these combined financial statements.

In performing an audit in accordance with generally accepted auditing standards and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.

- Identify and assess the risks of material misstatement of the combined financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the combined financial statements.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control. Accordingly, no such opinion is expressed.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the combined financial statements.

- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Authority's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Continued

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 4 through 7 be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated January 23, 2023, on our consideration of the Authority's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Authority's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Authority's internal control over financial reporting and compliance.

Draffin & Tucker, LLP

Albany, Georgia
January 23, 2023

COLQUITT REGIONAL
MEDICAL CENTER

Management's Discussion and Analysis
For The Year Ended September 30, 2022

This section of the Hospital Authority of Colquitt County's (Authority) annual financial report presents our discussion and analysis of the Authority's financial performance during the fiscal years ended September 30, 2022, 2021, and 2020. Please read it in conjunction with the Authority's combined financial statements and accompanying notes.

This annual financial report consists of two parts: Management's Discussion and Analysis (this section) and the basic combined financial statements. The Authority is a self-supporting entity and follows enterprise fund reporting; accordingly, the combined financial statements are presented using full accrual accounting.

The Balance Sheet and Statement of Revenues, Expenses, and Changes in Net Position

One of the most important questions asked about the Authority's finances is, "Is the Authority as a whole better or worse off as a result of the year's activities?" The combined balance sheet and the combined statement of revenues, expenses, and changes in net position report information about the Authority's resources and its activities in a way that helps answer this question. These combined statements include all restricted and unrestricted assets and all liabilities using the accrual basis of accounting. All of the current year's revenues and expenses are taken into account regardless of when cash is received or paid.

These two combined statements report the Authority's net position and its changes. You can think of the Authority's net position - the difference between assets, plus deferred outflows of resources, and liabilities - as one way to measure the Authority's financial health, or financial position. Over time, increases or decreases in the Authority's net position are one indicator of whether its financial health is improving or deteriorating. You will need to consider other nonfinancial factors, however, such as changes in the Authority's patient base and measures of the quality of service it provides to the community, as well as local economic factors to assess the overall health of the Authority.

Continued

3131 SOUTH MAIN STREET, P.O. BOX 40 • MOULTRIE, GEORGIA 31776-0040 • (229) 985-3420
www.colquittregional.com

The Combined Statement of Cash Flows

The final required statement is the statement of cash flows. The statement reports cash receipts, cash payments, and net changes in cash resulting from operating, investing, and financing activities. It provides answers to such questions as "Where did cash come from?", "What was cash used for?" and "What was the change in cash balance during the reporting period?".

Financial Analysis of the Authority

The following table summarizes the balance sheets as of September 30, 2022, 2021, and 2020:

Combined Balance Sheet

	Dollars in Thousands		
	2022	2021	2020
Current assets	$ 46,767	$ 59,998	$ 74,029
Capital assets	115,794	110,648	94,032
Other noncurrent assets	89,242	95,228	60,808
Total assets	$ 251,803	$ 265,874	$ 228,869
Current liabilities	$ 36,068	$ 50,614	$ 49,535
Noncurrent liabilities	49,723	49,882	56,091
Total liabilities	85,791	100,496	105,626
Net position:			
Net investment in capital assets	66,515	56,457	43,323
Restricted	3,004	4,261	2,998
Unrestricted	96,493	104,660	76,922
Total net position	166,012	165,378	123,243
Total liabilities and net position	$ 251,803	$ 265,874	$ 228,869

The Authority's total assets decreased by $14,100,000 in year 2022. Most of this decrease is related to the decrease in cash and cash equivalents, used to pay Medicare advanced payments, and the rest was related to purchases in capital acquisition. In 2021, we had major construction projects like the cancer center, PCU unit and Geriatric Psych unit.

The Authority's total liabilities decreased by $14,700,000 which is mainly related to the repayment of the Medicare advance payment.

Long-term debt decreased by $1,000,00 compared to fiscal year 2021. Debt to capitalization for the year was 23.1% for 2022 compared to 23.2% for 2021.

During 2022, the Authority purchased a skilled nursing facility for $5,900,000 using debt to fund the purchase price.

Continued

Financial Analysis of the Authority, Continued

The following table summarizes the statement of revenues, expenses and changes in net position as of September 30, 2022, 2021, and 2020:

Combined Statements of Revenues, Expenses and Changes in Net Position

	Dollars in Thousands		
	2022	2021	2020
Net patient service revenue	$ 200,782	$ 198,983	$ 167,109
Other revenue	5,620	4,634	3,779
Total operating revenues	206,402	203,617	170,888
Salaries and employee benefits	99,239	87,964	82,127
Other operating expenses	89,283	87,490	78,906
Depreciation and amortization	13,353	11,217	10,324
Total operating expenses	201,875	186,671	171,357
Net operating income (loss)	4,527	16,946	(469)
Nonoperating revenues (expenses):			
Investment income	(15,918)	14,238	2,871
Interest expense	(1,378)	(1,325)	(1,550)
Provider relief fund grants	8,850	7,060	7,148
Other	4,168	4,232	3,248
Total nonoperating revenues (expenses)	(4,278)	24,205	11,717
Excess of revenues before contributions	249	41,151	11,248
Contributions for property acquisitions	385	985	257
Increase in net position	634	42,136	11,505
Net position, beginning of year	165,378	123,242	111,738
Net position, end of year	$ 166,012	$ 165,378	$ 123,243

Fiscal year 2022 was a good year for the Authority. The Medical Center did experience an increase in admissions, elective procedures, and visits. Along with the volume increases, our expenses also increased due to staffing issues and health insurance cost.

Continued

Combined Statements of Revenues, Expenses and Changes in Net Position, Continued

Total operating revenue grew by $2,800,000 compared to prior year. This increase is related to volume and the addition of the skilled nursing facility.

Total operating expenses increased by $15,200,000. The major portion was related to salaries, yearly incentives, health insurance claims, and supplies.

Overall, the operating income decreased by $12,400,000 compared to the 2021 financial statements.

Operating income in 2022 was $4,500,000 operating margin of 2.2%. This compares to operating income of $16,900,000 in 2021, and an operating margin of 8.3%.

In 2022, the Authority recorded a total non-operating loss of $4,300,000 which was a decrease of $28,500,000 compared to 2021. This decrease is attributed to reduction of investment income.

At the end of 2022, the Authority had $115,800,000 invested in capital assets, net of accumulated depreciation. In 2022, the Authority's capital spending was related to buying of the skilled nursing facility, parking lot project, DaVinci Robot and other capital equipment.

As of September 30, 2022, the Authority had $48,500,000 in revenue certificates, $7,300,000 in other long-term debt, which is a total debt increase of $1,000,000 compared to 2021.

Master Plan and Construction

In 2023, the Authority will finish the construction of the new education building and renovation of the skilled nursing facility. The Authority also plans to continue to invest in new technology and equipment as needed.

Contacting the Authority's Financial Management

This financial report is designed to provide a general overview of the Authority's finances. If you have questions about this report or need additional financial information, contact the Authority finance department at Hospital Authority of Colquitt County, 3131 South Main Street, P. O. Box 40, Moultrie, GA 31776-0040.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED BALANCE SHEETS
September 30, 2022 and 2021

	2022	2021
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets:		
Cash and cash equivalents	$ 7,953,773	$ 19,480,881
Current portion of designated funds	4,985,475	5,716,995
Patient accounts receivable, net of estimated uncollectibles of $56,162,077 in 2022 and $58,061,518 in 2021	23,743,643	23,671,874
Supplies	4,661,481	4,690,499
Notes receivable, current portion	480,610	264,547
Other current assets	4,941,840	6,173,414
Total current assets	46,766,822	59,998,210
Noncurrent cash and investments:		
Internally designated for:		
Capital acquisition	78,275,552	86,491,649
Employee benefits	635,000	635,000
Malpractice funding arrangement	1,300,580	1,400,811
Restricted by:		
Revenue Certificates - debt service reserve fund	3,508,101	3,818,200
2019 MRI loan - collateral	-	1,000,000
Total noncurrent cash and investments	83,719,233	93,345,660
Capital assets:		
Nondepreciable capital assets	5,909,744	9,768,187
Depreciable capital assets, net of accumulated depreciation	109,647,283	100,879,439
Intangible right-to-use lease assets, net of accumulated amortization	236,932	-
Total capital assets, net	115,793,959	110,647,626
Other assets:		
Notes receivable, excluding current portion	458,780	529,220
Other assets	1,671,152	1,353,724
Total other assets	2,129,932	1,882,944
Total assets	248,409,946	265,874,440
Deferred outflows of resources:		
Goodwill	3,392,706	-
Total assets and deferred outflows of resources	$ 251,802,652	$ 265,874,440

Continued

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED BALANCE SHEETS, Continued
September 30, 2022 and 2021

	2022	2021
LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION		
Current liabilities:		
Current installments of long-term debt	$ 6,311,366	$ 5,112,999
Current portion of Medicare advance payments	179,435	10,895,082
Accounts payable	7,164,184	10,485,279
Accrued expenses	18,562,987	17,693,729
Estimated third-party payor settlements	805,215	643,117
Grant stimulus unearned revenue	3,044,939	5,784,006
Total current liabilities	36,068,126	50,614,212
Long-term debt, excluding current installments	49,711,730	49,881,788
Total liabilities	85,779,856	100,496,000
Deferred inflows of resources	11,215	-
Total liabilities and deferred inflows of resources	85,791,071	100,496,000
Net position:		
Net investment in capital assets	66,515,004	56,456,710
Restricted	3,004,156	4,260,980
Unrestricted	96,492,421	104,660,750
Total net position	166,011,581	165,378,440
Total liabilities, deferred inflows of resources, and net position	$ 251,802,652	$ 265,874,440

The accompanying notes are an integral part of these combined financial statements.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION
for the years ended September 30, 2022 and 2021

	2022	2021
Operating revenues:		
Net patient service revenue (net of provision for bad debts of approximately $36,296,000 in 2022 and $39,270,000 in 2021)	$ 200,782,330	$ 198,982,875
Other revenue	5,619,598	4,634,248
Total operating revenues	206,401,928	203,617,123
Operating expenses:		
Salaries and wages	80,487,917	73,150,094
Employee health and welfare	18,751,306	14,814,094
Medical supplies and other expense	64,356,758	63,982,775
Professional fees	18,029,123	17,857,590
Purchased services	6,896,659	5,649,742
Depreciation and amortization	13,353,328	11,216,903
Total operating expenses	201,875,091	186,671,198
Operating income	4,526,837	16,945,925
Nonoperating revenues (expenses):		
Investment income (loss)	(15,918,356)	14,237,902
Interest expense	(1,378,036)	(1,324,899)
Grant stimulus funding	8,850,223	7,060,260
Rural hospital tax credit and other	4,167,728	4,231,750
Total nonoperating revenues (expenses)	(4,278,441)	24,205,013
Excess revenues	248,396	41,150,938
Contributions for property acquisitions	384,745	984,713
Increase in net position	633,141	42,135,651
Net position, beginning of year	165,378,440	123,242,789
Net position, end of year	$ 166,011,581	$ 165,378,440

The accompanying notes are an integral part of these combined financial statements.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED STATEMENTS OF CASH FLOWS
for the years ended September 30, 2022 and 2021

	2022	2021
Cash flows from operating activities:		
Received from patients and payors	$ 206,492,257	$ 198,321,116
Repayments of Medicare advance payments	(10,715,647)	(3,560,983)
Payments to vendors and other suppliers	(92,084,900)	(89,856,559)
Payments to employees and physicians	(98,180,827)	(86,284,320)
Net cash provided by operating activities	5,510,883	18,619,254
Cash flows from noncapital financing activities:		
Grant stimulus funding	6,111,156	197,277
Rural hospital tax credit	4,158,470	4,235,990
Net cash provided by noncapital financing activities	10,269,626	4,433,267
Cash flows from capital and related financing activities:		
Proceeds from issuance of long-term debt	6,500,000	8,425,865
Principal paid on long-term debt and lease liabilities	(5,711,218)	(5,943,862)
Interest paid on long-term debt and lease liabilities	(1,378,036)	(1,324,899)
Purchase of capital assets	(18,048,066)	(27,033,017)
Capital contributions	384,745	984,713
Net cash used by capital and related financing activities	(18,252,575)	(24,891,200)
Cash flows from investing activities:		
Interest and dividends	1,673,300	7,078,402
Purchase of CRSC	(3,494,633)	-
Purchase of investments	(49,030,312)	(64,459,745)
Sale of investments	40,025,261	34,467,927
Net cash used by investing activities	(10,826,384)	(22,913,416)
Net decrease in cash and cash equivalents	(13,298,450)	(24,752,095)
Cash and cash equivalents, beginning of year	25,688,351	50,440,446
Cash and cash equivalents, end of year	$ 12,389,901	$ 25,688,351

Continued

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)

COMBINED STATEMENTS OF CASH FLOWS, Continued
for the years ended September 30, 2022 and 2021

	2022	2021
Reconciliation of cash and cash equivalents to the balance sheets:		
Cash and cash equivalents in current assets	$ 7,953,773	$ 19,480,881
Cash and cash equivalents in designated cash and investments:		
Internally designated for capital acquisition	3,746,602	2,660,948
Internally designated for employee benefits	451,694	2,337,717
Internally designated for malpractice funding	197,065	102,264
Restricted by debt	40,767	1,106,541
Total cash and cash equivalents	$ 12,389,901	$ 25,688,351
Reconciliation of operating income to net cash flows from operating activities:		
Operating income	$ 4,526,837	$ 16,945,925
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	13,353,328	11,216,903
Provision for bad debts	36,295,683	39,269,629
Changes in:		
Patient accounts receivable	(36,367,452)	(43,634,772)
Estimated third-party payor settlements	162,098	(930,864)
Supplies	29,018	210,092
Other assets	824,477	(4,037,130)
Notes receivable	(145,622)	201,678
Accounts payable	(3,321,095)	1,850,289
Other accrued expenses	869,258	1,088,487
Medicare advance payments	(10,715,647)	(3,560,983)
Net cash provided by operating activities	$ 5,510,883	$ 18,619,254
Noncash investing activities (nearest thousand):		
Change in fair value of investments	$(17,592,000)	$ 7,160,000

During 2021, the Authority refunded the outstanding 2018 Series Revenue Certificates of $19,236,000 using the 2020B Series Revenue Certificates. See Note 9 for more information.

During 2022, the Authority purchased a skilled nursing facility. See Note 21 for more information.

The accompanying notes are an integral part of these combined financial statements.

1. Description of Reporting Entity and Summary of Significant Accounting Policies

Reporting Entity

The Hospital Authority of Colquitt County (Authority), doing business as Colquitt Regional Medical Center (Medical Center), is a public corporation that operates an acute care hospital. In 2022, the Medical Center purchased a skilled nursing facility, which is now operated as Colquitt Regional Senior Care and Rehabilitation. Additionally, the Authority operates Colquitt Regional Health, Inc., which provides home health care, hospice care, and non-emergency transportation services and is a blended component unit of the Authority. The Authority is the sole member of Colquitt Regional Medical, Inc. (CRM, Inc.). CRM, Inc. was created to acquire and administer funds and property for physician practices in the Moultrie, Georgia area. Upon dissolution of CRM, Inc., all assets will revert to the Authority. The Authority elects the Board members for CRM, Inc. CRM, Inc. is a blended component unit of the Authority.

In 2022, the Authority established a segregated portfolio plan in the Georgia Health Care Insurance Company, SPC (GHCIC), which is incorporated in the Cayman Islands. The name of the plan is Colquitt Regional Medical Insurance Segregated Portfolio (Segregated Portfolio). The Segregated Portfolio provides professional and general liability self-insurance to the Authority. The Segregated Portfolio is managed by Willis Management (Cayman), Ltd. in Grand Cayman, Cayman Islands. The Segregated Portfolio is a blended component unit of the Authority.

The combined financial statements include the Medical Center, CRM, Inc., Colquitt Regional Health, Inc., and the Segregated Portfolio. All intercompany transactions have been eliminated in the combined financial statements.

Authority board members are nominated by the Colquitt County Commission and appointed by the Authority. Also, the County Commissioners have guaranteed debt of the Authority. For these reasons, the Authority is considered to be a component unit of Colquitt County.

Use of Estimates

The preparation of combined financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the combined financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Enterprise Fund Accounting

The Authority uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus.

The Authority prepares its combined financial statements as a business-type activity in conformity with applicable pronouncements of the Governmental Accounting Standards Board (GASB).

Cash and Cash Equivalents

Cash and cash equivalents include investments in highly liquid instruments with an original maturity of three months or less.

Allowance for Doubtful Accounts

The Authority provides an allowance for doubtful accounts based on the evaluation of the overall collectability of the accounts receivable. As accounts are known to be uncollectible, the account is charged against the allowance.

Supplies

Supplies are valued at the average purchase cost using the first-in, first-out method.

Noncurrent Cash and Investments

Noncurrent cash and investments include assets designated by the Board of Directors for future capital acquisition, various employee benefits, and a malpractice funding arrangement. The Board retains control over these designated funds and may, at its discretion, subsequently use them for other purposes. Noncurrent cash and investments also include assets restricted by the 2016 and 2020 Revenue Certificates issuance and assets set aside as collateral for the 2019 MRI loan. Amounts required to meet current liabilities of the Authority have been reclassified in the balance sheet at September 30, 2022 and 2021.

Investments in Debt and Equity Securities

Investments in debt and equity securities are carried at fair value except for investments in debt securities with maturities of less than one year at the time of purchase. These investments are reported at amortized cost, which approximates fair value. Interest, dividends, and gains and losses, both realized and unrealized, on investments in debt and equity securities are included in nonoperating revenue when earned.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Capital Assets

The Authority's capital assets are reported at historical cost. Contributed capital assets are reported at their acquisition value at the time of their donation. All purchases exceeding $5,000, with an estimated useful life greater than one year, are capitalized by the Authority. All capital assets other than land are depreciated or amortized (in the case of leased assets) using the straight-line method of depreciation using these asset lives:

Land improvements	15 to 25 years
Buildings and building improvements	20 to 40 years
Equipment, computers and furniture	3 to 10 years
Right-to-use lease assets	3 to 10 years

Costs of Borrowing

Costs related to the issuance of long-term debt are expensed in the period in which the debt was incurred. Interest cost incurred on borrowed funds during the period of construction of capital assets is expensed in the period in which the cost is incurred.

Compensated Absences

The Authority's employees earn vacation days at varying rates depending on years of service. Employees also earn sick leave benefits based on varying rates depending on full-time or part-time status. Employees may accumulate vacation days and sick leave up to a specified maximum. Employees are not paid for accumulated sick leave if they leave before retirement.

Unearned Revenue

Unearned revenue arises when assets are recognized before revenue recognition criteria have been satisfied. Government stimulus advance payments are reported as unearned revenue until all applicable eligibility requirements are met. See Note 19 for additional information.

Net Position

Net position of the Authority is classified into three components. *Net investment in capital assets* consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* are noncapital assets reduced by liabilities and deferred inflows of resources related to those assets that must be used for a particular purpose, as specified by creditors, grantors, or contributors external to the Authority, including amounts deposited with trustees as required by revenue certificate agreements, as discussed in Note 8. *Unrestricted net position* is the remaining amount of net position that does not meet the definition of *net investment in capital assets* or *restricted net position*.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Net Patient Service Revenue

The Authority has agreements with third-party payors that provide for payments to the Authority at amounts different from its established rates. Payment arrangements include prospectively determined rates per discharge, reimbursed costs, discounted charges, and per diem payments.

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined.

Charity Care

The Authority provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the Authority does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue.

Operating Revenues and Expenses

The Authority's statement of revenues, expenses and changes in net position distinguishes between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services - the Authority's principal activity. Nonexchange revenues, including taxes, grants, and contributions received for purposes other than capital asset acquisition, are reported as nonoperating revenues. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

Grants and Contributions

From time to time, the Authority receives grants from the State of Georgia as well as contributions from individuals and private organizations. Revenues from grants and contributions (including contributions of capital assets) are recognized when all eligibility requirements, including time requirements are met. Grants and contributions may be restricted for either specific operating purposes or for capital purposes. Amounts that are unrestricted or that are restricted to a specific operating purpose are reported as nonoperating revenues. Amounts restricted to capital acquisitions are reported after nonoperating revenues and expenses.

Restricted Resources

When the Authority has both restricted and unrestricted resources available to finance a particular program, it is the Authority's policy to use restricted resources before unrestricted resources.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Income Taxes

The Authority is a governmental entity and is exempt from income taxes. Accordingly, no provision for income taxes has been considered in the accompanying combined financial statements.

Colquitt Regional Health, Inc. is a not-for-profit corporation that has been recognized as tax-exempt pursuant to Section 501(c)(3) of the Internal Revenue Code.

CRM, Inc. is a federally taxable entity organized as a not-for-profit corporation under state law and has not incurred tax expense due to operating losses.

The Segregated Portfolio conducts its affairs in a manner in which it will not be subject to U.S. Federal income tax or Georgia income tax.

The Authority applies accounting policies that prescribe when to recognize and how to measure the financial statement effects of income tax positions taken or expected to be taken on its income tax returns. These rules require management to evaluate the likelihood that, upon examination by the relevant taxing jurisdictions, those income tax positions would be sustained. Based on that evaluation, the Authority only recognizes the maximum benefit of each income tax position that is more than 50% likely of being sustained. To the extent that all or a portion of the benefits of an income tax position are not recognized, a liability would be recognized for the unrecognized benefits, along with any interest and penalties that would result from disallowance of the position. Should any such penalties and interest be incurred, they would be recognized as operating expenses.

Based on the results of management's evaluation, no liability is recognized in the accompanying balance sheet for unrecognized income tax positions. Further, no interest or penalties have been accrued or charged to expense as of September 30, 2022 and 2021 or for the years then ended. Colquitt Regional Health, Inc. and CRM, Inc.'s tax returns are subject to possible examination by the taxing authorities. For federal income tax purposes, the tax returns essentially remain open for possible examination for a period of three years after the respective filing deadlines of those returns.

Risk Management

The Authority is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; medical malpractice and employee health, dental, and accident benefits. Commercial insurance coverage is purchased for claims arising from such matters. Settled claims have not exceeded this commercial coverage in any of the three preceding years. The Authority is partially self-insured for medical malpractice claims and judgments, as well as employee health and worker's compensation claims, as discussed in Notes 12 and 13.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Impairment of Long-Lived Assets

The Authority evaluates on an ongoing basis the recoverability of its assets for impairment whenever events or changes in circumstances indicate that the carrying amount may not be recoverable. The impairment loss to be recognized is the amount by which the carrying value of the long-lived asset exceeds the asset's fair value. In most instances, the fair value is determined by discounted estimated future cash flows using an appropriate interest rate. The Authority has not recorded any impairment charges in the accompanying combined statements of revenues, expenses and changes in net position for the years ended September 30, 2022 and 2021.

Fair Value Measurements

GASB Statement No. 72 - *Fair Value Measurement and Application* defines fair value as the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. Fair value is an exit price at the measurement date from the perspective of a market participant that controls the asset or is obligated for the liability. GASB No. 72 also establishes a hierarchy of inputs to valuation techniques used to measure fair value. If a price for an identical asset or liability is not observable, a government should measure fair value using another valuation technique that maximizes the use of relevant observable inputs and minimizes the use of unobservable inputs. GASB No. 72 describes the following three levels of inputs that may be used:

- *Level 1:* Quoted prices (unadjusted) in active markets that are accessible at the measurement date for identical assets and liabilities. The fair value hierarchy gives the highest priority to Level 1 inputs.

- *Level 2:* Observable inputs such as quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, or inputs other than quoted prices that are observable for the asset or liability.

- *Level 3:* Unobservable inputs when there is little or no market data available, thereby requiring an entity to develop its own assumptions. The fair value hierarchy gives the lowest priority to Level 3 inputs.

Deferred Outflows and Inflows of Resources

Deferred outflows and inflows of resources represent the consumption or acquisition, respectively, of the Authority's net position applicable to a future reporting period. Deferred outflows of resources consist of goodwill, net of accumulated amortization, as of September 30, 2022 and 2021. See Note 20 for additional information. Deferred inflows of resources relate to lessor leases that is amortized to lease income over the least terms.

Continued

1. Description of Reporting Entity and Summary of Significant Accounting Policies, Continued

Recently Adopted Accounting Pronouncement

In June 2017, the GASB issued Statement No. 87, *Leases* (GASB 87). GASB 87 establishes standards of accounting and financial reporting by lessees and lessors and establishes a single model for lease accounting based on the foundational principle that leases are financings of the right to use an underlying asset. GASB 87 will require a lessee to recognize a lease liability and an intangible right-to-use lease asset at the commencement of the lease term, with certain exceptions, and will require a lessor to recognize a lease receivable and a deferred inflow of resources at the commencement of the lease term, with certain exceptions. The Authority adopted GASB 87 on October 1, 2021, and retroactively implemented the statement effective October 1, 2020. The adoption of this statement resulted in an increase in lease obligations and related right-to-use lease assets of approximately $340,000 as of October 1, 2021. Leases for fiscal year 2021 were not material. The adoption had no impact on net position.

Prior Year Reclassifications

Certain reclassifications have been made to the fiscal year 2021 financial statements to conform to the fiscal year 2022 presentation. These reclassifications had no impact on the change in net position in the accompanying financial statements.

2. Net Patient Service Revenue

The Authority has agreements with third-party payors that provide for payments at amounts different from its established rates. The Authority does not believe that there are any significant credit risks associated with receivables due from third-party payors.

Revenue from the Medicare and Medicaid programs accounted for approximately 52% and 9%, respectively, of the Authority's net patient service revenue for the year ended 2022 and 48% and 5%, respectively, of the Authority's net patient service revenue for the year ended 2021. Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term.

The Authority believes that it is in compliance with all applicable laws and regulations and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing. However, there has been an increase in regulatory initiatives at the state and federal levels including the initiation of the Recovery Audit Contractor (RAC) program and the Medicaid Integrity Contractor (MIC) program. These programs were created to review Medicare and Medicaid claims for medical necessity and coding appropriateness. The RAC's have authority to pursue improper payments with a three year look back from the date the claim was paid. Compliance with such laws and regulations can be subject to future government review and interpretation as well as significant regulatory action including fines, penalties and exclusion from the Medicare and Medicaid programs.

Continued

2. Net Patient Service Revenue, Continued

A summary of the payment arrangements with major third-party payors follows:

- Medicare

  Inpatient acute care services and outpatient services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic, and other factors.

  Nursing home services rendered to Medicare program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient-driven payment methodology.

  The Authority is reimbursed for certain reimbursable items at a tentative rate with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the Medicare Administrative Contractor (MAC). The Medical Center's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with the Authority. The Authority's Medicare cost reports have been audited by the MAC through September 30, 2018.

- Medicaid

  Inpatient acute care services rendered to Medicaid program beneficiaries are paid at prospectively determined rates. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Certain outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost reimbursement methodology.

  The Authority is reimbursed for outpatient services at a tentative rate with final settlement determined after submission of annual cost reports by the Authority and audits thereof by the Medicaid fiscal intermediary. The Authority's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through September 30, 2019.

  Long-term care services are reimbursed by the Medicaid program based on a prospectively determined per diem. The per diem is determined by the facility's historical allowable operating costs adjusted for certain incentives and inflation factors.

  The Authority also contracts with certain managed care organizations to receive reimbursement for providing services to selected enrolled Medicaid beneficiaries. Payment arrangements with these managed care organizations consist primarily of prospectively determined rates per discharge, discounts from established charges, or prospectively determined per diems.

Continued

2. Net Patient Service Revenue, Continued, Continued

- Medicaid, Continued

The state of Georgia enacted legislation known as the Provider Payment Agreement Act (Act) whereby hospitals in the state of Georgia are assessed a "provider payment" in the amount of 1.45% of their net patient service revenue. The Act became effective July 1, 2010, the beginning of state fiscal year 2011. The provider payments are due on a quarterly basis to the Department of Community Health. The payments are to be used for the sole purpose of obtaining federal financial participation for medical assistance payments to providers on behalf of Medicaid recipients. The provider payment results in an increase in hospital payments for Medicaid services of approximately 11.88%. Approximately $1,609,000 and $1,570,000 relating to the Act is included in medical supplies and other expense in the accompanying statements of revenues, expenses and changes in net position for the years ended September 30, 2022 and 2021, respectively.

The Authority participates in the Georgia Indigent Care Trust Fund (ICTF) Program. The Authority receives ICTF payments for treating a disproportionate number of Medicaid and other indigent patients. ICTF payments are based on the Authority's estimated uncompensated cost of services to Medicaid and uninsured patients. The 2022 and 2021 combined financial statements include payment adjustments of approximately $1,306,000 and $6,694,000, respectively, which are reflected in net patient service revenue.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 provides for payment adjustments to certain facilities based on the Medicaid Upper Payment Limit (UPL). The UPL payment adjustments are based on a measure of the difference between Medicaid payments and the amount that could be paid based on Medicare payment principles. The Authority has accrued or received enhanced payments of approximately $3,599,000 and $4,006,000 for 2022 and 2021, respectively, which is reflected in net patient service revenue.

The Authority also participates in the Medicaid Managed Care Directed Payment Program, which is a supplemental payment program for hospitals through the Georgia Department of Community Health. The 2022 combined financial statements include payment adjustments of approximately $820,000 which are reflected in net patient service revenue.

- Other Agreements

The Authority has also entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations. The basis for payment to the Authority under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

Continued

3. Uncompensated Services

The Authority was compensated for services at amounts less than its established rates. Charges for uncompensated services for 2022 and 2021 were approximately $475,365,000 and $425,921,000, respectively.

Uncompensated services include charity and indigent care services of approximately $8,180,000 and $9,466,000 in 2022 and 2021, respectively. The cost of charity and indigent care services provided during 2022 and 2021 was approximately $2,442,000 and $2,823,000, respectively, computed by applying a total cost factor to the charges foregone.

The following is a summary of uncompensated services and a reconciliation of gross patient charges to net patient service revenue for 2022 and 2021:

	2022	2021
Gross patient charges	$ 676,147,312	$ 624,903,841
Uncompensated services:		
Charity and indigent care	8,180,082	9,466,235
Medicare	185,413,488	169,874,719
Medicaid	55,758,247	43,968,816
Other allowances	189,717,482	163,341,567
Provision for bad debts	36,295,683	39,269,629
Total uncompensated care	475,364,982	425,920,966
Net patient service revenue	$ 200,782,330	$ 198,982,875

4. Designated Net Position

Of the approximately $96,492,000 and $104,661,000 of unrestricted net position reported in 2022 and 2021, approximately $85,197,000 and $94,244,000, respectively, have been designated by the Authority for capital improvements, various employee benefit plans, and malpractice. Designated funds remain under the control of the Board of Directors, which may at its discretion later use the funds for other purposes.

Continued

5. Deposits and Investments

Noncurrent cash and investments are reported in current assets if they are required for obligations classified as current liabilities. As discussed in Note 1, the Authority's investments are generally carried at fair value.

The composition of noncurrent cash and investments at September 30, 2022 and 2021, is set forth in the following table:

	2022	2021
Internally designated for capital acquisition:		
Cash and cash equivalents	$ 3,746,602	$ 2,660,948
U.S. Treasury obligations	2,557,314	1,869,534
U.S. Government Agency securities	1,266,668	1,517,199
Other fixed income	11,284,087	13,873,570
Equity securities	52,788,121	60,572,254
Mutual fund - commodities	751,576	538,800
Public hedge funds	5,881,184	5,459,344
	$ 78,275,552	$ 86,491,649
Internally designated for employee benefits:		
Cash and cash equivalents	$ 451,694	$ 2,337,717
Certificates of deposit	635,000	635,000
Equity securities	1,886,023	-
	2,972,717	2,972,717
Less current portion	2,337,717	2,337,717
	$ 635,000	$ 635,000
Internally designated for malpractice funding arrangement:		
Cash and cash equivalents	$ 197,065	$ 102,264
Other fixed income	628,660	728,655
Equity securities	2,581,413	3,362,416
Mutual fund - commodities	55,704	52,208
Public hedge funds	485,496	534,546
	3,948,338	4,780,089
Less current portion	2,647,758	3,379,278
	$ 1,300,580	$ 1,400,811

Continued

5. Deposits and Investments, Continued

	2022	2021
Restricted by 2016 and 2020 Revenue Certificates - debt service reserve fund:		
Cash and cash equivalents	$ 40,767	$ 106,541
Other fixed income	3,467,334	3,711,659
	$ 3,508,101	$ 3,818,200
Restricted by 2019 MRI loan - collateral:		
Cash and cash equivalents	$ -	$ 1,000,000
Total designated cash and investments	$ 88,704,708	$ 99,062,655
Less current portion of designated funds	(4,985,475)	(5,716,995)
Noncurrent cash and investments reported as long-term	$ 83,719,233	$ 93,345,660
Carrying amount:		
Deposits	$ 8,588,773	$ 23,453,598
Investments	88,069,708	95,089,938
Total cash and investments	$ 96,658,481	$ 118,543,536
Included in the following balance sheet options:		
Cash and cash equivalents	$ 7,953,773	$ 19,480,881
Current portion of designated funds	4,985,475	5,716,995
Noncurrent cash and investments	83,719,233	93,345,660
Total cash and investments	$ 96,658,481	$ 118,543,536

Custodial credit risk - deposits. Custodial credit risk is the risk that in the event of a bank failure, the Authority's deposits may not be returned to them or will not be able to recover collateral securities that are in the possession of an outside party. As of September 30, 2022, the Authority has no deposits exposed to custodial credit risk.

Custodial credit risk - investments. For an investment, this is the risk that, in the event of the failure of the counterparty, the Authority will not be able to recover the value of its investments or collateral securities that are in the possession of an outside party. As of September 30, 2022, the Authority has no investments exposed to custodial credit risk.

Continued

5. Deposits and Investments, Continued

Concentration of credit risk. As of September 30, 2022, the Authority has no investment in any one issuer that is in excess of 5% of the Authority's total investments.

As of September 30, 2022 and 2021, the Authority had the following debt securities:

September 30, 2022

Investment Type	Fair Value	Maturity
U.S. Treasury obligations	$ 2,557,314	March 31, 2025 - May 15, 2049 rating quality AA+
U.S. Government Agency securities	1,266,668	March 1, 2031 - May 1, 2051 rating quality AA+ to AAA
Other fixed income	15,380,081	Average maturity of 12 years, rating quality BBB- to AAA
Total	$ 19,204,063	

September 30, 2021

Investment Type	Fair Value	Maturity
U.S. Treasury obligations	$ 1,869,534	March 31, 2022 - May 15, 2050 rating quality AA+
U.S. Government Agency securities	1,517,199	July 1, 2028 - December 1, 2050 rating quality AA+ to AAA
Other fixed income	18,313,884	Average maturity of 11 years, rating quality BBB- to AAA
Total	$ 21,700,617	

Continued

6. Accounts Receivable and Payable

Patient accounts receivable and accounts payable (including accrued expenses) reported as current assets and liabilities by the Authority at September 30, 2022 and 2021 consisted of these amounts:

	2022	2021
Patient accounts receivable:		
Receivable from patients and their insurance carriers	$ 39,868,083	$ 44,706,083
Receivable from Medicare	30,383,249	28,928,151
Receivable from Medicaid	9,654,388	8,099,158
Total patient accounts receivable	79,905,720	81,733,392
Less allowance for uncollectible amounts and contractual adjustments	56,162,077	58,061,518
Patient accounts receivable, net	$ 23,743,643	$ 23,671,874
Accounts payable and accrued expenses:		
Payable to employees (including payroll taxes)	$ 15,915,229	$ 14,314,451
Payable to suppliers	7,164,184	10,485,279
Other accrued expenses	2,647,758	3,379,278
Total accounts payable and accrued expenses	$ 25,727,171	$ 28,179,008

Continued

7. Capital Assets

A summary of capital assets at September 30, 2022 and 2021 follows:

	Balance September 30, 2021	Increase	Decrease	Balance September 30, 2022
Capital assets not being depreciated:				
Land	$ 1,616,040	$ 13,599	$ -	$ 1,629,639
Projects-in-progress	8,152,147	18,289,910	22,161,952	4,280,105
Total capital assets not being depreciated	9,768,187	18,303,509	22,161,952	5,909,744
Capital assets being depreciated:				
Land improvements	3,784,336	1,677,218	-	5,461,554
Buildings	115,087,954	9,763,147	-	124,851,101
Equipment	116,577,347	10,498,600	427,695	126,648,252
Total capital assets being depreciated	235,449,637	21,938,965	427,695	256,960,907
Less accumulated depreciation:				
Land improvements	2,833,544	372,257	-	3,205,801
Buildings	46,602,476	4,775,886	3,082	51,375,280
Equipment	85,134,178	8,009,067	410,702	92,732,543
Total depreciation	134,570,198	13,157,210	413,784	147,313,624
Leased buildings and equipment	-	340,410	-	340,410
Less: accumulated amortization for leased buildings and equipment	-	103,478	-	103,478
Intangible right-to-use lease assets, net	-	236,932	-	236,932
Net capital assets	$ 110,647,626	$ 27,322,196	$ 22,175,863	$ 115,793,959

Continued

7. Capital Assets, Continued

	Balance September 30, 2020	Increase	Decrease	Balance September 30, 2021
Capital assets not being depreciated:				
Land	$ 1,524,440	$ 91,600	$ -	$ 1,616,040
Projects-in-progress	4,879,425	27,886,961	24,614,239	8,152,147
Total capital assets not being depreciated	6,403,865	27,978,561	24,614,239	9,768,187
Capital assets being depreciated:				
Land improvements	3,578,483	205,853	-	3,784,336
Buildings	102,779,960	12,307,994	-	115,087,954
Equipment	104,701,518	12,008,792	132,963	116,577,347
Total capital assets being depreciated	211,059,961	24,522,639	132,963	235,449,637
Less accumulated depreciation:				
Land improvements	2,559,055	274,489	-	2,833,544
Buildings	42,507,860	4,094,616	-	46,602,476
Equipment	78,365,032	6,897,869	128,723	85,134,178
Total depreciation	123,431,947	11,266,974	128,723	134,570,198
Net capital assets	$ 94,031,879	$ 41,234,226	$ 24,618,479	$ 110,647,626

The Authority has construction and equipment contracts of approximately $15.2 million for the renovation and construction of facilities and purchase of equipment in addition to the commitments discussed in Note 8. At September 30, 2022, the remaining commitment on these contracts approximated $13.9 million.

Continued

8. Long-Term Debt

A schedule of changes in the Authority's noncurrent liabilities for 2022 and 2021 follows:

	2021 Balance	Additions	Reductions	2022 Balance	Amounts Due Within One Year
Direct placement:					
Revenue Certificates 2016	$ 26,657,819	$ -	$ 3,504,438	$ 23,153,381	$ 3,575,443
Revenue Certificates 2020	26,594,409	-	1,294,054	25,300,355	1,324,042
Direct borrowings:					
Notes payable	1,742,559	6,500,000	912,726	7,329,833	1,331,764
Lease liabilities	-	338,660	99,133	239,527	80,117
Total noncurrent liabilities	$ 54,994,787	$ 6,838,660	$ 5,810,351	$ 56,023,096	$ 6,311,366

	2020 Balance	Additions	Reductions	2021 Balance	Amounts Due Within One Year
Direct placement:					
Revenue Certificates 2016	$ 30,086,751	$ -	$ 3,428,932	$ 26,657,819	$ 3,498,170
Revenue Certificates 2018	19,504,460	-	19,504,460	-	-
Revenue Certificates 2020	-	27,661,865	1,067,456	26,594,409	1,184,997
Direct borrowings:					
Notes payable	1,278,940	803,873	340,254	1,742,559	429,832
Other	838,760	-	838,760	-	-
Total noncurrent liabilities	$ 51,708,911	$ 28,465,738	$ 25,179,862	$ 54,994,787	$ 5,112,999

Continued

8. Long-Term Debt, Continued

The terms and due dates of the Authority's long-term debt at September 30, 2022 and 2021 follow:

- 2016 Revenue Certificates, consisting of Series 2016A and Series 2016B, each collateralized by a pledge of the Authority's gross receipts. Series 2016A bears interest of 2.32%, principal maturing in monthly installments of $153,106, final payment due September 5, 2031. Series 2016B bears a fixed interest rate of 2.09%, payable in monthly installments of $185,570, final payment due September 5, 2021. The 2016 Revenue Certificates contain a provision that in an event of default, the timing of repayment of outstanding amounts may become immediately due if the Authority does not make payments according to the repayment terms or is rendered incapable of fulfilling its obligations. The Authority issued the 2016 Revenue Certificates to redeem the 2012-B Revenue Certificates, the 2013 Revenue Certificates, the 2014 Revenue Certificates, all active notes payable and to acquire the Sterling Center building. As a result of the early redemption, the Authority decreased its total debt service payments by approximately $3.2 million which results in an economic savings (the difference between the present value of the debt service payments on the old and new debt) of approximately $2.7 million which is 7% of the principal amount refunded.

- Series 2018 Revenue Certificates, collateralized by a pledge of the Authority's gross receipts. Series 2018 was issued as an amendment to the 2016 Revenue Certificates. Series 2018 bears interest of 3.85% with interest only payments through the period of construction, and then 3.85%, with principal maturing in monthly installments. During 2021 the Authority redeemed the 2018 Revenue Certificates with proceeds from the 2020 Revenue Certificates.

- 2020 Revenue Certificates, consisting of Series 2020A and Series 2020B, each collateralized by a pledge of the Authority's gross receipts. Series 2020 was issued as an amendment to the 2016 Revenue Certificates. Series 2020A bears interest of 2.50% with interest only payments through the period of construction, then 2.50% with principal maturing in monthly installments amortized over the remaining term, with the final payment due December 2040. Series 2020B bears an interest rate of 2.50%, payable in monthly installments of $144,465, final payment due December 2033. The 2020 Revenue Certificates contain a provision that in an event of default, the timing of repayment of outstanding amounts may become immediately due if the Authority does not make payments according to the repayment terms or is rendered incapable of fulfilling its obligations. The Authority issued the 2020A Revenue Certificates for construction of a Geriatric Psychiatry Center and make system wide infrastructure upgrades. Proceeds from Series 2020A can be drawn as construction progresses up to an amount of $14,000,000. As of September 30, 2022, the Authority has drawn approximately $8,426,000. The Authority issued the 2020B Revenue Certificates to redeem the 2018 Revenue Certificates. As a result of the early redemption, the Authority increased its total debt service payments by approximately $2.3 million which results in an economic loss (the difference between the present value of the debt service payments on the old and new debt) of approximately $1.9 million which is 11% of the principal amount refunded.

Continued

8. Long-Term Debt, Continued

- Note payable, related to the purchase of Colquitt Senior Care and Rehabilitation, unsecured with monthly payments of $84,128 including interest of 2.35%.

- Note payable, collateralized by $1 million in a deposit account and equipment, with monthly payments of $31,775 including interest at a rate of 3.6%. The Authority's note payable contains a provision that the timing of repayment of outstanding amounts may become immediately due upon the creation of, or contract for the creation of, any lien, encumbrance, transfer, or sale of the property defined by the loan. In 2022, the Authority received a release of collateral from the lender and is no longer required to maintain deposits as collateral for this loan.

- Note payable, purchase of Stryker equipment, with seven varying yearly payments beginning in FY 2022 and ending in FY 2028, including an interest rate at 3.25%.

The 2016 and 2020 Revenue Certificates place limits on the incurrence of additional borrowings and require that the Authority maintain a reserve fund sufficient to service a half year's total debt service payments on the Revenue Certificates. Management believes the Authority was in compliance with these requirements.

Colquitt County has agreed to guarantee payment of the 2016 and 2020 Revenue Certificates in the event that the revenues of the Authority are not sufficient to make scheduled debt payments. To date, no payments by Colquitt County under the guarantee have been required.

Scheduled principal and interest repayments on long-term debt are as follows:

Year Ending September 30	Direct Placements/Borrowings		Lease Liabilities	
	Principal	Interest	Principal	Interest
2023	$ 6,231,249	$ 1,138,066	$ 80,117	$ 5,959
2024	6,533,253	833,417	57,179	3,942
2025	6,587,832	880,647	40,924	2,490
2026	6,566,878	997,637	33,360	1,375
2027	4,642,524	10,081,134	27,947	386
2028-2032	18,665,685	6,585,918	-	-
2033-2037	4,657,353	443,983	-	-
2038-2041	1,898,795	80,159	-	-
Total	$ 55,783,569	$ 21,040,961	$ 239,527	$ 14,152

Continued

9. Leases

The Authority is a lessee for noncancellable lease assets. The Authority recognizes a lease liability and an intangible right-to-use lease asset (lease asset) in its financial statements. At the commencement of a lease, the Authority initially measures the lease liability at the present value of payments expected to be made during the lease term. Subsequently, the lease liability is reduced by the principal portion of lease payments made. The lease asset is initially measured as the initial amount of the lease liability, adjusted for lease payments made at or before the lease commencement date, plus certain initial direct costs. Subsequently, the lease asset is amortized on a straight-line basis over its useful life.

Key estimates and judgments related to leases include how the Authority determines (1) the discount rate it uses to discount the expected lease payments to present value, (2) lease term, and (3) lease payments.

- The Authority uses the implicit interest rate charged by the lessor as the discount rate. When the interest rate charged by the lessor is not provided or cannot be imputed, the Authority generally uses its estimated incremental borrowing rate as the discount rate for leases.

- The lease term includes the noncancellable period of the lease. Lease payments included in the measurement of the lease liability are composed of fixed payments and purchase option price that the Authority is reasonably certain to exercise.

The Authority monitors changes in circumstances that would require a remeasurement of its lease and will remeasure the lease asset and liability if certain changes occur that are expected to significantly affect the amount of the lease liability.

Lease assets are reported with capital assets and lease liabilities are reported with long-term debt on the balance sheets.

None of the leases contain provisions for variable payments or residual value guarantees. Additionally, there are no other payments such as residual value guarantees or termination penalties, not previously included in the measurement of the lease liability reflected as outflows of resources.

Expenses for the leasing activity of the Authority as the lessee for the years ended September 30, 2022 and 2021 are as follows:

	2022	2021
Short-term lease expense	$ 739,360	$ 664,592
Right-to-use lease asset amortization	103,478	-
Lease liability interest expense	7,788	-
Total lease cost	$ 850,626	$ 664,592

Continued

10. Defined Contribution Retirement Plan

The Authority has a defined contribution retirement plan pursuant to Section 403(b) of the Internal Revenue Code covering substantially all Hospital employees. Additionally, the Authority sponsors defined contribution plans pursuant to Sections 401(a) and 457(f) of the Internal Revenue Code, which are for employer contributions only. Retirement expense was approximately $3,368,000 and $3,157,000 in 2022 and 2021, respectively. As of September 30, 2022 and 2021, the Authority accrued approximately $2,625,000 and $2,655,000, respectively, for employer portion payable that is included in accrued expenses on the balance sheet. Effective January 1, 2016, the Authority amended its defined contribution retirement plan pursuant to Section 403(b). Employees hired before January 1, 2016 are subject to the rules of the retirement plan before that date and employees hired after December 31, 2015 are subject to the new provisions of the retirement plan.

The terms of the 403(b) retirement plan are as follows:

Eligibility

In order to receive an employer contribution into the retirement plan, an eligible employee is defined as any employee employed as either ***Regular Full-Time with Benefits*** or ***Regular Part-Time with Benefits***.

Eligibility provisions vary by contribution type and/or group as outlined below:

Any Eligible Employee Hired Before January 1, 2016

- Employer Annual Discretionary

  An eligible employee is eligible to participate in the plan for purposes of this contribution(s):

  - Upon attaining age twenty-one (21)
  - Upon completing three (3) years of serv

Any Eligible Employee Hired After December 31, 2015

- Employer Matching

  An eligible employee is eligible to participate in the plan for purposes of this contribution(s):

  - Upon attaining age twenty-one (21)
  - Upon completing three (3) months of service
  - Automatic enrollment will occur following three (3) months of employment
  - May waive automatic enrollment by affirmative election.

Continued

10. Defined Contribution Retirement Plan, Continued

Eligibility, Continued

Employer Contributions

For Employees Hired Before January 1, 2016

The Authority provides an employer discretionary nonelective contribution of 10% of the eligible employee's base pay for each eligible plan year. An eligible employee must:

- have completed at least three (3) years of service and have reached age twenty-one (21)
- have earned eligible compensation to an eligible class during the plan year
- be employed as an eligible employee on the last day of the plan year (December 31st).

For Employees Hired After December 31, 2015

Colquitt Regional Medical Center provides an employer matching contribution for each eligible employee beginning with the first payroll following ninety (90) days of employment.

The employee match is 100% of the first 5% of salary reduction contribution.

Vesting

The annual employer discretionary nonelective contributions for eligible employees hired before January 1, 2016, are subject to the following vesting schedule:

Years of Service	Vesting Percent
1	0%
2	0%
3	30%
4	40%
5	50%
6	60%
7	70%
8	80%
9	90%
10	100%

Continued

10. Defined Contribution Retirement Plan, Continued

Vesting, Continued

The matching employer contributions for eligible employees hired after December 31, 2015, are subject to the following vesting schedule:

Years of Service	Vesting Percent
1 - 2	0%
3	25%
4	50%
5	75%
6 or more	100%

11. Related Party

The Colquitt Regional Medical Foundation is a not-for-profit organization established for the purpose of supporting the Medical Center and the health care community of Colquitt County.

A summary of the Foundation's assets, liabilities, net assets, and changes in net assets follows:

	Unaudited 2022	2021
Assets, principally cash, investments, unconditional promises to give, and property	$ 9,724,796	$ 10,924,464
Liabilities, principally accounts payable, amounts due to related party, and use obligation subject to life estate	$ 272,383	$ 34,968
Net assets	9,452,413	10,889,496
Total liabilities and net assets	$ 9,724,796	$ 10,924,464
Revenues and investment income (losses)	$(931,595)	$ 2,755,837
Expenses	505,488	1,260,757
Increase (decrease) in net assets	(1,437,083)	1,495,080
Net assets, beginning of year	10,889,496	9,394,416
Net assets, end of year	$ 9,452,413	$ 10,889,496

Continued

12. Commitments and Contingencies

Health and Worker's Compensation Claims

The Authority is partially self-insured for employee health and worker's compensation claims. The Authority's self-insurance program for employee health utilizes a third-party administrator that processes and pays claims. The Authority reimburses the third-party administrator for claims incurred and paid and has purchased stop-loss insurance coverage for claims in excess of $200,000 for each individual employee. The stop-loss coverage is also subject to an aggregating deductible of $78,000 per policy year. Total expenses relative to this plan were approximately $6,454,000 and $4,448,000 for 2022 and 2021, respectively. The Authority's self-insurance program for worker's compensation has purchased stop-loss insurance coverage for claims in excess of $450,000 for each individual employee. Stop-loss coverage for the worker's compensation plan is capped at $1 million. Total expenses relative to this plan were approximately $402,000 and $494,000 for 2022 and 2021, respectively. The Authority accrues liabilities for estimated incurred but unpaid claims based on historical experience and an evaluation of incidents reported under its incident reporting system. The Authority reports accrued claims in accrued expenses on the combined balance sheets. At September 30, 2022 and 2021, the Authority had investments of approximately $635,000 designated for worker's compensation claims. At September 30, 2022 and 2021, the Authority had investments of approximately $850,000, designated for employee health insurance claims.

Litigation

During the normal course of operations, the Authority is potentially subject to liabilities arising from the treatment of patients and the normal operations of the Authority. In the opinion of management and legal counsel, the Authority has adequate liability insurance protection to indemnify any material asserted or unasserted claims as of September 30, 2022 and 2021. See malpractice insurance disclosures in Note 13.

Regulatory Compliance

The healthcare industry has been subjected to increased scrutiny from governmental agencies at both the federal and state level with respect to compliance with regulations. Areas of noncompliance identified at the national level include Medicare and Medicaid, Internal Revenue Service, and other regulations governing the healthcare industry. In addition, the Reform Legislation includes provisions aimed at reducing fraud, waste, and abuse in the healthcare industry. These provisions allocate significant additional resources to federal enforcement agencies and expand the use of private contractors to recover potentially inappropriate Medicare and Medicaid payments. The Authority has implemented a compliance plan focusing on such issues. There can be no assurance that the Authority will not be subjected to future investigations with accompanying monetary damages.

Continued

13. Medical Malpractice Claims

The Authority is partially self-insured with respect to medical malpractice risks. Claims in excess of the self-insurance amounts of $1 million per occurrence and $3.5 million in aggregate are insured by a commercial carrier. Beginning March 1, 2022, the Segregated Portfolio insures losses for physician medical malpractice claims exceeding $1 million per occurrence and $3 million in aggregate. Losses from asserted and unasserted claims are accrued based on claims reported and estimated claims incurred but not reported as derived from the Authority's incident reporting system. The Authority reports accrued claims in accrued expenses as a liability.

At September 30, 2022 and 2021, the Authority had investments of approximately $3,948,000 and $4,780,000 which are designated by the Board of Directors for potential malpractice claims.

14. Concentrations of Credit Risk

The Authority is located in Moultrie, Georgia. The Authority grants credit without collateral to its patients, most of whom are local residents and are insured under third-party payor agreements. See Note 6 for a mix of receivables from patients and third-party payors at September 30, 2022 and 2021.

15. Health Care Reform

There has been increasing pressure on Congress and some state legislatures to control and reduce the cost of healthcare at the national and the state levels. Legislation has been passed that includes cost controls on healthcare providers, insurance market reforms, delivery system reforms and various individual and business mandates among other provisions. The costs of these provisions are and will be funded in part by reductions in payments by government programs, including Medicare and Medicaid. There can be no assurance that these changes will not adversely affect the Authority.

Continued

16. Fair Value of Financial Instruments

The following methods and assumptions were used by the Authority in estimating the fair value of its financial instruments:

- *Cash and cash equivalents, current portion of designated funds, estimated third-party payor settlements, accounts payable, accrued expenses, grant stimulus unearned revenue, and Medicare advance payments: The* carrying amount reported in the balance sheets approximates their fair value due to the short-term nature of these instruments.

- *Noncurrent cash and investments:* These assets consist primarily of cash, cash equivalents, certificates of deposit, investments and interest receivable. Fair values, which are the amounts reported in the balance sheets, are based on quoted market prices, if available, or estimated using quoted market prices for similar securities or other market conditions. See Note 17 for fair value measurement disclosure.

- *Long-term debt:* The fair value of the Authority's remaining long-term debt is estimated using discounted cash flow analyses, based on the Authority's current incremental borrowing rates for similar types of borrowing arrangements.

The carrying amounts and fair values of the Authority's long-term debt at September 30, 2022 and 2021, are as follows:

	2022		2021	
	Carrying Amount	Fair Value	Carrying Amount	Fair Value
Long-term debt	$ 55,783,569	$ 53,854,504	$ 54,994,787	$ 58,391,304

Continued

17. Fair Value Measurement

Fair value of assets and liabilities measured on a recurring basis at September 30, 2022 and 2021 is as follows:

		Fair Value Measurements at Reporting Date Using		
	Fair Value	Quoted Prices In Active Markets For Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
September 30, 2022				
Assets:				
Cash equivalents	$ 4,436,128	$ 4,436,128	$ -	$ -
U.S. Treasury obligations	2,557,314	2,557,314	-	-
U.S. Government Agency securities	1,266,668	3,157	1,263,511	-
Other fixed income	15,380,081	5,323,201	10,056,880	-
Equity securities	57,255,557	57,255,557	-	-
Mutual funds - commodities	807,280	807,280	-	-
Public hedge funds	6,366,680	6,366,680	-	-
Total assets	$ 88,069,708	$ 76,749,317	$ 11,320,391	$ -
September 30, 2021				
Assets:				
Cash equivalents	$ 2,869,753	$ 2,869,753	$ -	$ -
U.S. Treasury obligations	1,869,534	1,869,534	-	-
U.S. Government Agency securities	1,517,199	3,317	1,513,882	-
Other fixed income	18,313,884	6,087,907	12,225,977	-
Equity securities	63,934,670	63,888,389	46,281	-
Mutual funds - commodities	591,008	591,008	-	-
Public hedge funds	5,993,890	5,993,890	-	-
Total assets	$ 95,089,938	$ 81,303,798	$ 13,786,140	$ -

Financial assets valued using Level 1 inputs are based on unadjusted quoted market prices within active markets. Financial assets valued using Level 2 inputs are based primarily on quoted prices for similar investments in active or inactive markets. All assets and liabilities have been valued using a market approach.

Certain cash equivalents are valued at amortized cost, which approximates fair value.

Continued

17. Fair Value Measurement, Continued

U.S. Government Agency securities and other fixed income are primarily valued using pricing models maximizing the use of observable inputs for similar securities. This includes basing value on yields currently available on comparable securities of issuers with similar credit ratings.

18. Rural Hospital Tax Credit Contributions

The State of Georgia (State) passed legislation which allows individuals or corporations to receive a State tax credit for making a contribution to certain qualified rural hospital organizations. The Authority submitted the necessary documentation and was approved by the State to participate in the rural hospital tax credit program effective for calendar years 2022 and 2021. Contributions received under the program approximated $4,158,000 and $4,236,000 during the Authority's fiscal year 2022 and 2021, respectively.

19. Coronavirus (COVID-19)

As a result of the spread of the COVID-19 coronavirus, economic uncertainties have arisen. The outbreak has put an unprecedented strain on the U.S. healthcare system, disrupted or delayed production and delivery of materials and products in the supply chain, and caused staffing shortages. The extent of the impact of COVID-19 on the Authority's operational and financial performance will depend on certain developments, including the duration and spread of the outbreak, remedial actions and stimulus measures adopted by local, state, and federal governments, and impact on the Authority's patients, employees, and vendors, all of which are uncertain and cannot be predicted. At this point, the extent to which COVID-19 may impact the Authority's financial position or results of operations is uncertain.

On March 27, 2020, the President signed the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act). Certain provisions of the CARES Act provide relief funds to hospitals and other healthcare providers. The funding will be used to support healthcare-related expenses or lost revenue attributable to COVID-19. The U.S. Department of Health and Human Services (HHS) began distributing funds on April 10, 2020 to eligible providers in an effort to provide relief to both providers in areas heavily impacted by COVID-19 and those providers who are struggling to keep their doors open due to healthy patients delaying care and canceling elective services. On April 24, 2020, the *Paycheck Protection Program and Health Care Enhancement Act* was passed. This Act provides additional funding to replenish and supplement key programs under the CARES Act, including funds to healthcare providers for COVID-19 testing. On March 11, 2021, the *American Rescue Plan Act* (ARP) was passed. This Act provides additional funding to replenish and supplement key programs, including funds to hospitals and other providers that serve patients living in rural areas. Grant and contribution advance payments are reported as unearned revenue until all eligibility requirements are met. Recognized revenue is reported as nonoperating revenues in the statements of revenues, expenses, and changes in net position. The Authority received approximately $26.1 million in grant stimulus funding in FY 2020, FY 2021, and FY 2022. The CARES and ARP Act funding may be subject to audits. While the Authority currently believes

Continued

19. Coronavirus (COVID-19), Continued

its use of the funds is in compliance with applicable terms and conditions, there is a possibility payments could be recouped based on changes in reporting requirements or audit results. The Authority recognized approximately $8.9 million, $7.1 million, and $7.1 million as revenue in FY 2022, FY 2021 and FY 2020, respectively.

The CARES Act expanded the existing Medicare Accelerated and Advance Payment (MAAP) program by allowing qualifying providers to receive an advanced Medicare payment. The advanced payment will have to be repaid. Recoupment begins one year after the date of receipt of the advanced payment with 25% of each Medicare remittance advice withheld for the first 11 months of repayment, and 50% for the six months afterward. After the 29-month period, CMS will issue letters requiring payment of any outstanding balance, subject to an interest rate of 4%. In April 2020, the Authority received approximately $14.5 million in MAAP payments. The Authority made repayments of approximately $3,561,000 in FY 2021 and $10,700,000 in FY 2022.

20. Deferred Outflows of Resources

Deferred outflows of resources consisted of the following:

	2022	2021
Goodwill, net of amortization	$ 3,392,706	$ -

Goodwill is reported net of accumulated amortization expense and is amortized over sixty months. Amortization expense is reported in depreciation and amortization in the amount of approximately $102,000 for 2022.

21. Acquisition of Cobblestone Rehabilitation and Healthcare Center

In February 2022, the Authority acquired Cobblestone Rehabilitation and Healthcare Center, a skilled nursing facility. The Authority operates the skilled nursing facility as Colquitt Regional Senior Care and Rehabilitation (CRSC), which is a hospital-based department of the Medical Center. The Authority acquired CRSC to expand its senior care and rehabilitation services within the community. The Authority acquired CRSC for $5.9 million. See Note 20 for goodwill amounts, net of amortization as of the balance sheet dates. The following assets were recognized from the purchase (at fair value):

Land	$ 405,367
Buildings	2,000,000
Goodwill	3,494,633
Total	$ 5,900,000

Continued

22. Notes Receivable

Notes receivable consist primarily of loans secured by promissory notes to physicians under recruiting arrangements. In general, the loans are being forgiven over a period of time in which the physician practices medicine locally. If the physician discontinues medical practice locally, the outstanding principal and accrued interest becomes due immediately. The amounts forgiven and charged to expense during 2022 and 2021 were approximately $335,000 and $390,000, respectively.

Notes receivable also consist of educational loans to physicians. In general, the educational loans are forgiven over a period of time in which the employee works for the Authority.

Draffin Tucker

INDEPENDENT AUDITOR'S REPORT ON COMBINING INFORMATION

Board of Directors
Hospital Authority of Colquitt County
Moultrie, Georgia

We have audited the combined financial statements of the Hospital Authority of Colquitt County (Authority), a component unit of Colquitt County, Georgia, as of and for the years ended September 30, 2022 and 2021, and our report thereon dated January 23, 2023, which expressed an unmodified opinion on those combined financial statements, appears on pages 1 through 3. Our audits were conducted for the purpose of forming an opinion on the combined financial statements as a whole. The combining information included in this report on pages 44 to 49, inclusive, is presented for purposes of additional analysis of the combined financial statements rather than to present the balance sheet and statement of revenues and expenses of the individual companies, and is not a required part of the combined financial statements. Accordingly, we do not express an opinion on the financial position and results of operations of the individual companies.

The combining information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the combined financial statements. Such information has been subjected to the auditing procedures applied in the audits of the combined financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the combined financial statements or to the combined financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the combining information is fairly stated in all material respects in relation to the combined financial statements as a whole.

Draffin & Tucker, LLP

Albany, Georgia
January 23, 2023

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING BALANCE SHEET
September 30, 2022

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Current assets:							
Cash and cash equivalents	$ 7,222,933	$ 112,667	$ 257,263	$ 360,910	$ 7,953,773	$ -	$ 7,953,773
Current portion of designated funds	4,985,475	-	-	-	4,985,475	-	4,985,475
Patient accounts receivable, net	20,471,936	452,220	2,819,487	-	23,743,643	-	23,743,643
Supplies	4,661,481	-	-	-	4,661,481	-	4,661,481
Due from related parties	1,350,990	-	-	-	1,350,990	(1,350,990)	-
Notes receivable, current portion	480,610	-	-	-	480,610	-	480,610
Other current assets	4,942,702	-	(6,290)	5,428	4,941,840	-	4,941,840
Total current assets	44,116,127	564,887	3,070,460	366,338	48,117,812	(1,350,990)	46,766,822
Noncurrent cash and investments	83,719,233	-	-	-	83,719,233	-	83,719,233
Capital assets, net	115,622,700	171,259	-	-	115,793,959	-	115,793,959
Other assets	2,200,866	23,066	6,000	-	2,229,932	(100,000)	2,129,932
Total assets	245,658,926	759,212	3,076,460	366,338	249,860,936	(1,450,990)	248,409,946
Deferred outflows of resources:							
Goodwill	3,392,706	-	-	-	3,392,706	-	3,392,706
Total assets and deferred outflows of resources	$ 249,051,632	$ 759,212	$ 3,076,460	$ 366,338	$ 253,253,642	$(1,450,990)	$ 251,802,652

Continued

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING BALANCE SHEET, Continued
September 30, 2022

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Current liabilities:							
Current installments of long-term debt	$ 6,311,366	$ -	$ -	$ -	$ 6,311,366	$ -	$ 6,311,366
Current portion of Medicare advance payments	121,915	-	57,520	-	179,435	-	179,435
Accounts payable	6,099,265	2,419	1,014,225	48,275	7,164,184	-	7,164,184
Accrued expenses	17,419,982	-	999,737	183,643	18,603,362	(40,375)	18,562,987
Estimated third-party payor settlements	805,215	-	-	-	805,215	-	805,215
Due to related parties	-	493,212	857,778	-	1,350,990	(1,350,990)	-
Grant stimulus unearned revenue	3,034,826	-	10,113	-	3,044,939	-	3,044,939
Total current liabilities	33,792,569	495,631	2,939,373	231,918	37,459,491	(1,391,365)	36,068,126
Long-term debt, excluding current installments	49,711,730	-	-	-	49,711,730	-	49,711,730
Total liabilities	83,504,299	495,631	2,939,373	231,918	87,171,221	(1,391,365)	85,779,856
Deferred inflows of resources	11,215	-	-	-	11,215	-	11,215
Total liabilities and deferred inflows of resources	83,515,514	495,631	2,939,373	231,918	87,182,436	(1,391,365)	85,791,071
Net position	165,536,118	263,581	137,087	134,420	166,071,206	(59,625)	166,011,581
Total liabilities, deferred inflows of resources, and net position	$ 249,051,632	$ 759,212	$ 3,076,460	$ 366,338	$ 253,253,642	$(1,450,990)	$ 251,802,652

See accompanying auditor's report on combining information.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING BALANCE SHEET
September 30, 2021

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Current assets:							
Cash and cash equivalents	$ 18,067,610	$ 421,588	$ 991,683	$ -	$ 19,480,881	$ -	$ 19,480,881
Current portion of designated funds	5,716,995	-	-	-	5,716,995	-	5,716,995
Patient accounts receivable, net	20,323,093	485,206	2,863,575	-	23,671,874	-	23,671,874
Supplies	4,690,499	-	-	-	4,690,499	-	4,690,499
Due from related parties	1,471,324	-	-	-	1,471,324	(1,471,324)	-
Notes receivable, current portion	264,547	-	-	-	264,547	-	264,547
Other current assets	6,103,828	-	69,586	-	6,173,414	-	6,173,414
Total current assets	56,637,896	906,794	3,924,844	-	61,469,534	(1,471,324)	59,998,210
Noncurrent cash and investments	93,345,660	-	-	-	93,345,660	-	93,345,660
Capital assets, net	110,459,827	187,799	-	-	110,647,626	-	110,647,626
Other assets	1,853,878	23,066	6,000	-	1,882,944	-	1,882,944
Total assets	$ 262,297,261	$ 1,117,659	$ 3,930,844	$ -	$ 267,345,764	$(1,471,324)	$ 265,874,440

Continued

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING BALANCE SHEET, Continued
September 30, 2021

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Current liabilities:							
Current installments of long-term debt	$ 5,112,999	$ -	$ -	$ -	$ 5,112,999	$ -	$ 5,112,999
Current portion of Medicare advance payments	10,258,728	-	636,354	-	10,895,082	-	10,895,082
Accounts payable	9,051,593	3,683	1,430,003	-	10,485,279	-	10,485,279
Accrued expenses	16,563,979	-	1,129,750	-	17,693,729	-	17,693,729
Estimated third-party payor settlements	643,117	-	-	-	643,117	-	643,117
Due to related parties	-	983,892	487,432	-	1,471,324	(1,471,324)	-
Grant stimulus unearned revenue	5,790,096	-	(6,090)	-	5,784,006	-	5,784,006
Total current liabilities	47,420,512	987,575	3,677,449	-	52,085,536	(1,471,324)	50,614,212
Long-term debt, excluding current installments	49,881,788	-	-	-	49,881,788	-	49,881,788
Total liabilities	97,302,300	987,575	3,677,449	-	101,967,324	(1,471,324)	100,496,000
Net position	164,994,961	130,084	253,395	-	165,378,440	-	165,378,440
Total liabilities and net position	$ 262,297,261	$ 1,117,659	$ 3,930,844	$ -	$ 267,345,764	$(1,471,324)	$ 265,874,440

See accompanying auditor's report on combining information.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING STATEMENT OF REVENUES AND EXPENSES
September 30, 2022

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Operating revenues:							
Net patient service revenue	$ 173,999,412	$ 2,544,770	$ 24,712,902	$ -	$ 201,257,084	$(474,754)	$ 200,782,330
Other revenue	7,167,250	739,538	-	282,625	8,189,413	(2,569,815)	5,619,598
Total operating revenues	181,166,662	3,284,308	24,712,902	282,625	209,446,497	(3,044,569)	206,401,928
Operating expenses:							
Salaries and wages	71,336,052	2,060,786	7,091,079	-	80,487,917	-	80,487,917
Employee health and welfare	16,063,425	571,552	2,116,329	-	18,751,306	-	18,751,306
Medical supplies and other expense	61,071,650	411,528	5,446,223	248,205	67,177,606	(2,820,848)	64,356,758
Professional fees	5,093,235	-	13,199,984	-	18,293,219	(264,096)	18,029,123
Purchased services	6,565,111	75,479	256,069	-	6,896,659	-	6,896,659
Depreciation and amortization	13,125,295	31,466	196,567	-	13,353,328	-	13,353,328
Total operating expenses	173,254,768	3,150,811	28,306,251	248,205	204,960,035	(3,084,944)	201,875,091
Operating income (loss)	7,911,894	133,497	(3,593,349)	34,420	4,846,462	40,375	4,526,837
Nonoperating revenues (expenses):							
Investment income (loss)	(15,918,356)	-	-	-	(15,918,356)	-	(15,918,356)
Interest expense	(1,378,036)	-	-	-	(1,378,036)	-	(1,378,036)
Grant stimulus funding	8,750,223	-	100,000	-	8,850,223	-	8,850,223
Rural hospital tax credit and other	4,167,728	-	-	-	4,167,728	-	4,167,728
Total nonoperating revenues (expenses)	(4,378,441)	-	100,000	-	(4,278,441)	-	(4,278,441)
Excess revenues (expenses)	$ 3,533,453	$ 133,497	$(3,493,349)	$ 34,420	$ 208,021	$ 40,375	$ 248,396

See accompanying auditor's report on combining information.

HOSPITAL AUTHORITY OF COLQUITT COUNTY
(A Component Unit of Colquitt County, Georgia)
COMBINING STATEMENT OF REVENUES AND EXPENSES
September 30, 2021

	Colquitt Regional Medical Center	Colquitt Regional Health, Inc.	Colquitt Regional Medical, Inc.	Colquitt Regional Medical Center Insurance Segregated Portfolio	Combined Total	Eliminating Journal Entries	Hospital Authority of Colquitt County
Operating revenues:							
Net patient service revenue	$ 173,026,773	$ 2,733,045	$ 23,867,173	$ -	$ 199,626,991	$(644,116)	$ 198,982,875
Other revenue	6,284,657	500,354	9,750	-	6,794,761	(2,160,513)	4,634,248
Total operating revenues	179,311,430	3,233,399	23,876,923	-	206,421,752	(2,804,629)	203,617,123
Operating expenses:							
Salaries and wages	64,321,631	2,063,974	6,764,489	-	73,150,094	-	73,150,094
Employee health and welfare	12,598,065	538,045	1,677,984	-	14,814,094	-	14,814,094
Medical supplies and other expense	60,615,028	386,593	5,359,449	-	66,361,070	(2,378,295)	63,982,775
Professional fees	5,428,471	-	12,855,453	-	18,283,924	(426,334)	17,857,590
Purchased services	5,190,052	79,654	380,036	-	5,649,742	-	5,649,742
Depreciation and amortization	10,973,724	30,167	213,012	-	11,216,903	-	11,216,903
Total operating expenses	159,126,971	3,098,433	27,250,423	-	189,475,827	(2,804,629)	186,671,198
Operating income (loss)	20,184,459	134,966	(3,373,500)	-	16,945,925	-	16,945,925
Nonoperating revenues (expenses):							
Investment income	14,237,902	-	-	-	14,237,902	-	14,237,902
Interest expense	(1,324,899)	-	-	-	(1,324,899)	-	(1,324,899)
Grant stimulus funding	6,917,825	-	142,435	-	7,060,260	-	7,060,260
Rural hospital tax credit and other	4,231,750	-	-	-	4,231,750	-	4,231,750
Total nonoperating revenues	24,062,578	-	142,435	-	24,205,013	-	24,205,013
Excess revenues (expenses)	$ 44,247,037	$ 134,966	$(3,231,065)	$ -	$ 41,150,938	$ -	$ 41,150,938

See accompanying auditor's report on combining information.

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Draffin Tucker

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Hospital Authority of Colquitt County
Moultrie, Georgia

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the combined financial statements of the Hospital Authority of Colquitt County (Authority), a component unit of Colquitt County, Georgia which comprise the combined balance sheet as of September 30, 2022, and the related combined statements of revenues, expenses and changes in net position, and cash flows for the year then ended, and the related notes to the combined financial statements, and have issued our report thereon dated January 23, 2023.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the Authority's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Authority's internal control. Accordingly, we do not express an opinion on the effectiveness of the Authority's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's combined financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Continued

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that were not identified.

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Authority's combined financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the combined financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instance of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Authority's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Authority's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Draffin & Tucker, LLP

Albany, Georgia
January 23, 2023

2022 Qualified Rural Hospital Organization Expense Tax Credit Proxy for IRS Form 990
Net Assets or Fund Balances

1. Total Assets	Beginning of Current Year	End of Year
a. Cash - Non-Interest Bearing	58,956,626.00	42,365,287.00
b. Savings and Temporary Cash Investments	58,480,637.00	53,408,014.00
c. Pledges and Grants Receivable, Net		
d. Accounts Receivable, Net	20,463,265.00	18,279,850.00
e. Loans and Other Receivables From Current and Former Officers, Directors, Trustees, Key Employees, and Highest Compensated Employees	0.00	0.00
f. Notes and Loans Receivable, Net		
g. Inventories for sale or use	4,690,499.00	4,661,481.00
h. Prepaid expenses and deferred charges	4,678,561.00	5,021,232.00
i. Land, buildings, and equipment: cost or other basis.		
Less Accumulated Depreciation	110,647,626.00	113,138,735.00
j. Investments- Publicly Traded Securities		
k. Investments- Other Securities		
l. Investments- Program-Related		
m. Intangible Assets		
n. Other Assets	4,420,236.00	13,002,052.00
o. Total a - n above	$262,337,450.00	249,876,651.00

2. Total Liabilities	Beginning of Current Year	End of Year
a. Accounts Payable and Accrued Expenses	36,521,101.00	24,431,959.00
b. Grants Payable		
c. Deferred Revenue	5,790,096.00	3,046,042.00
d. Tax-Exempt Bond Liabilities	53,252,228.00	48,453,736.00
e. Escrow or Custodial Account Liability		
f. Loans and Other Payables to Current and Former Officers, Directors, Trustees, Key Employees, Highest Compensated Employees, and Disqualified Persons		
g. Secured Mortgages and Notes Payable to Unrelated Third Parties		
h. Unsecured Notes and Loans Payable to Unrelated Third Parties		
i. Other Liabilities (including Federal Income Tax, Payables to Related Third Parties, and Other Liabilities Not Included in Lines a through h).	1,742,559.00	7,569,361.00
h. Total a - i above	$97,305,984.00	$83,501,098.00

	Beginning of Current Year	End of Year
3. Net Assets or Fund Balances. Subtract line 2h from line 1o.	**$165,031,466.00**	**$166,375,553.00**

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2022 Annual Hospital Questionnaire

Part A : General Information

1. Identification

UID:HOSP524

Facility Name: Colquitt Regional Medical Center

County: Colquitt

Street Address: P O Box 40

City: Moultrie

Zip: 31776-0040

Mailing Address: P O Box 40

Mailing City: Moultrie

Mailing Zip: 31776-0040

Medicaid Provider Number: 00002021

Medicare Provider Number: 110105

2. Report Period

Report Data for the full twelve month period- January 1, 2022 through December 31, 2022.
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Julie Bhavnani

Contact Title: Vice President Finance

Phone: 229-890-3566

Fax: 229-891-2117

E-mail: scausbey@colquittregional.com

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Hospital Authority of Colquitt County	Hospital Authority	12/6/1948

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
N/A	Not Applicable	

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

3. Check the box to the right if your facility is part of a health care system ☐
Name:
City: **State:**

4. Check the box to the right if your hospital is a division or subsidiary of a holding company. ☐
Name:
City: **State:**

5. Check the box to the right if the hospital itself operates subsidiary corporations ☑
Name: Colquitt Regional Health, Inc
City: Moultrie **State:** GA

6. Check the box to the right if your hospital is a member of an alliance. ☐
Name:
City: **State:**

7. Check the box to the right if your hospital is a participant in a health care network ☐
Name:
City: **State:**

8. Check the box to the right if the hospital has a policy or policies and a peer review process related to medical errors. ☑

9. Check the box to the right if the hospital owns or operates a primary care physician group practice. ☑

10a. Managed Care Information: Formal Written Contract
Does the hospital have a formal written contract that specifies the obligations of each party with each of the following? (check the appropriate boxes)

1. Health Maintenance Organization(HMO) ☑

2. Preferred Provider Organization(PPO) ☑

3. Physician Hospital Organization(PH0) ☐

4. Provider Service Organization(PSO) ☐

5. Other Managed Care or Prepaid Plan ☐

10b. Managed Care Information: Insurance Products
Check the appropriate boxes to indicate if any of the following insurance products have been developed by the hospital, health care system, network, or as a joint venture with an insurer:

Type of Insurance Product	Hospital	Health Care System	Network	Joint Venture with Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐
Another Insurance Product Not Listed Above	☐	☐	☐	☐

11. Owner or Owner Parent Based in Another State
If the owner or owner parent at Part C, Question 1(A&B) is an entity based in another state please report the location in which the entity is based. (City and State)

Part D : Inpatient Services

1. Utilization of Beds as Set Up and Staffed(SUS):

Please indicate the following information. Dod not include newborn and neonatal services. Do not include long-term care untits, such as Skilled Nursing Facility beds, if not licensed as hospital beds. If your facility is approved for LTCH beds report them below.

Category	SUS Beds	Admissions	Inpatient Days	Discharges	Discharge Days
Obstetrics (no GYN, include LDRP)	11	645	1,533	648	1,540
Pediatrics (Non ICU)	0	0	0	0	0
Pediatric ICU	0	0	0	0	0
Gynecology (No OB)	0	0	0	0	0
General Medicine	0	0	0	0	0
General Surgery	0	0	0	0	0
Medical/Surgical	68	4,960	22,282	5,056	22,713
Intensive Care	10	316	3,011	227	2,163
Psychiatry	10	105	813	100	774
Substance Abuse	0	0	0	0	0
Adult Physical Rehabilitation (18 & Up)	0	0	0	0	0
Pediatric Physical Rehabilitation (0-17)	0	0	0	0	0
Burn Care	0	0	0	0	0
Swing Bed (Include All Utilization)	0	0	0	0	0
Long Term Care Hospital (LTCH)	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
	0	0	0	0	0
Total	**99**	**6,026**	**27,639**	**6,031**	**27,190**

2. Race/Ethnicity

Please report admissions and inpatient days for the hospital by the following race and ethnicity categories. Exclude newborn and neonatal.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	23	119
Asian	17	65
Black/African American	1,640	7,991
Hispanic/Latino	434	1,500
Pacific Islander/Hawaiian	5	5
White	3,883	17,786
Multi-Racial	24	173
Total	**6,026**	**27,639**

3. Gender

Please report admissions and inpatient days by gender. Exclude newborn and neonatal.

Gender	Admissions	Inpatient Days
Male	3,480	14,948
Female	2,546	12,691
Total	**6,026**	**27,639**

4. Payment Source

Please report admissions and inpatient days by primary payment source. Exclude newborn and neonatal.

Primary Payment Source	Admissions	Inpatient Days
Medicare	3,286	17,208
Medicaid	1,166	4,554
Peachare	0	0
Third-Party	1,082	3,961
Self-Pay	492	1,916
Other	0	0

5. Discharges to Death

Report the total number of inpatient admissions discharged during the reporting period due to death.

168

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2022 (to the nearest whole dollar).

Service	Charge
Private Room Rate	783
Semi-Private Room Rate	754
Operating Room: Average Charge for the First Hour	4,216
Average Total Charge for an Inpatient Day	6,845

Part E : Emergency Department and Outpatient Services

1. Emergency Visits
Please report the number of emergency visits only.

33,765

2. Inpatient Admissions from ER
Please report inpatient admssions to the Hospital from the ER for emergency cases ONLY.

3,984

3. Beds Available
Please report the number of beds available in ER as of the last day of the report period.

24

4. Utilization by Specific type of ER bed or room for the report period.

Type of ER Bed or Room	Beds	Visits
Beds dedicated for Trauma	2	0
Beds or Rooms dedicated for Psychiatric /Substance Abuse cases	2	681
General Beds	20	33,084
	0	0
	0	0
	0	0
	0	0

5. Transfers
Please provide the number of Transfers to another institution from the Emergency Department.

889

6. Non-Emergency Visits
Please provide the number of Outpatient/Clinic/All Other Non-Emergency visits to the hospital.

191,821

7. Observation Visits/Cases
Please provide the total number of Observation visits/cases for the entire report period.

2,219

8. Diverted Cases
Please provide the number of cases your ED diverted while on Ambulance Diversion for the entire report period.

0

9. Ambulance Diversion Hours
Please provide the total number of Ambulance Diversion hours for your ED for the entire report period

0

10. Untreated Cases

Please provide the number of patients who sought care in your ED but who left without or before being treated. Do not include patients who were transferred or cases that were diverted.

1,421

Part F : Services and Facilities

1a. Services and Facilities

Please report services offered onsite for in-house and contract services as requested. Please reflect the status of the service during the report period. *(Use the blank lines to specify other services.)*

Site Codes
1 = In-House - Provided by the Hospital
2 = Contract - Provided by a contractor but onsite
3 = Not Applicable

Status Codes
1 = On-Going
2 = Newly Initiated
3 = Discontinued
4 = Not Applicable

Service/Facilities	Site Code	Service Status
Podatric Services	0	0
Renal Dialysis	1	1
ESWL	1	1
Billiary Lithotropter	0	0
Kidney Transplants	0	0
Heart Transplants	0	0
Other-Organ/Tissues Transplants	0	0
Diagnostic X-Ray	1	1
Computerized Tomography Scanner (CTS)	1	1
Radioisotope, Diagnositic	1	1
Positron Emission Tomography (PET)	2	1
Radioisotope, Therapeutic	1	1
Magnetic Resonance Imaging (MRI)	1	1
Chemotherapy	1	1
Respiratory Therapy	1	1
Occupational Therapy	1	1
Physical Therapy	1	1
Speech Pathology Therapy	1	1
Gamma Ray Knife	0	0
Audiology Services	0	0
HIV/AIDS Diagnostic Treatment/Services	0	0
Ambulance Services	2	1
Hospice	2	1
Respite Care Services	2	1
Ultrasound/Medical Sonography	1	1
	0	0
	0	0
	0	0

1b. Report Period Workload Totals

Please report the workload totals for in-house and contract services as requested. The number of units should equal the number of machines.

Category	Total
Number of Podiatric Patients	0
Number of Dialysis Treatments	8,447
Number of ESWL Patients	90
Number of ESWL Procedures	90
Number of ESWL Units	1
Number of Biliary Lithotripter Procedures	0
Number of Biliary Lithotripter Units	0
Number of Kidney Transplants	0
Number of Heart Transplants	0
Number of Other-Organ/Tissues Treatments	0
Number of Diagnostic X-Ray Procedures	36,404
Number of CTS Units (machines)	2
Number of CTS Procedures	22,093
Number of Diagnostic Radioisotope Procedures	606
Number of PET Units (machines)	1
Number of PET Procedures	208
Number of Therapeautic Radioisotope Procedures	10
Number of Number of MRI Units	1
Number of Number of MRI Procedures	2,656
Number of Chemotherapy Treatments	1,460
Number of Respiratory Therapy Treatments	136,716
Number of Occupational Therapy Treatments	21,411
Number of Physical Therapy Treatments	64,469
Number of Speech Pathology Patients	28,600
Number of Gamma Ray Knife Procedures	0
Number of Gamma Ray Knife Units	0
Number of Audiology Patients	0
Number of HIV/AIDS Diagnostic Procedures	0
Number of HIV/AIDS Patients	0
Number of Ambulance Trips	8,500
Number of Hospice Patients	212
Number of Respite care Patients	6
Number of Ultrasound/Medical Sonography Units	3
Number of Ultrasound/Medical Sonography Procedures	10,260
Number of Treatments, Procedures, or Patients (Other 1)	0
Number of Treatments, Procedures, or Patients (Other 2)	0
Number of Treatments, Procedures, or Patients (Other 3)	0

2. Medical Ventilators

Provide the number of computerized/mechanical Ventilator Machines that were in use or available

for immediate use as of the last day of the report period (12/31).

19

3. Robotic Surgery System

Please report the number of units, number of procedures, and type of unit(s).

# Units	# Procedures	Type of Unit(s)
2	547	XI Robot

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2022. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2022.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Licensed Physicians	59.00	0.00	0.00
Physician Assistants Only (not including Licensed Physicians)	10.00	0.00	0.00
Registered Nurses (RNs-Advanced Practice*)	370.00	12.00	0.00
Licensed Practical Nurses (LPNs)	67.00	1.00	0.00
Pharmacists	8.00	1.00	0.00
Other Health Services Professionals*	342.00	25.00	0.00
Administration and Support	335.00	11.00	0.00
All Other Hospital Personnel (not included above)	356.00	12.00	0.00

2. Filling Vacancies

Using the drop-down menus, please select the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Physician's Assistants	30 Days or Less
Registered Nurses (RNs-Advance Practice)	30 Days or Less
Licensed Practical Nurses (LPNs)	30 Days or Less
Pharmacists	30 Days or Less
Other Health Services Professionals	30 Days or Less
All Other Hospital Personnel (not included above)	30 Days or Less

3. Race/Ethnicity of Physicians

Please report the number of physicians with admitting privileges by race.

Race/Ethnicity	Number of Physicians
American Indian/Alaska Native	0
Asian	2
Black/African American	14
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	64
Multi-Racial	16

4. Medical Staff

Please report the number of active and associate/provisional medical staff for the following specialty categories. Keep in mind that physicians may be counted in more than one specialty. Please

indicate whether the specialty group(s) is hospital-based. Also, indicate how many of each medical specialty are enrolled as providers in Georgia Medicaid/PeachCare for Kids and/or the Public Employee Health Benefit Plans (PEHB-State Health Benefit Plant and/or Board of Regents Benefit Plan).

Medical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
General and Family Practice	15	☐	0	0
General Internal Medicine	3	☐	0	0
Pediatricians	6	☐	0	0
Other Medical Specialties	31	☐	0	0

Surgical Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Obstetrics	4	☐	0	0
Non-OB Physicians Providing OB Services	1	☐	0	0
Gynecology	1	☐	0	0
Ophthalmology Surgery	1	☐	0	0
Orthopedic Surgery	3	☐	0	0
Plastic Surgery	1	☐	0	0
General Surgery	3	☐	0	0
Thoracic Surgery	0	☐	0	0
Other Surgical Specialties	7	☐	0	0

Other Specialties	Number of Medical Staff	Check if Any are Hospital Based	Number Enrolled as Providers in Medicaid/PeachCare	Number Enrolled as Providers in PEHB Plan
Anesthesiology	4	☐	0	0
Dermatology	1	☐	0	0
Emergency Medicine	6	☐	0	0
Nuclear Medicine	0	☐	0	0
Pathology	2	☐	0	0
Psychiatry	4	☐	0	0
Radiology	3	☐	0	0
	0	☐	0	0
	0	☐	0	0
	0	☐	0	0

5a. Non-Physicians

Please report the number of professionals for the categories below. Exclude any hospital-based staff reported in Part G, Questions 1,2,3 and 4 above.

Profession	Number
Dentists (include oral surgeons) with Admitting Privleges	0
Podiatrists	2
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	9

5b. Name of Other Professions

Please provide the names of professions classified as "Other Staff Affiliates with Clinical Privileges" above.

Comments and Suggestions:

Part H : Physician Name and License Number

1. Physicians on Staff

Please report the full name and license number of each physician on staff. **(Due to the large number of entries, this section has been moved to a separate PDF file.)**

Part I : Patient Origin Table

1. Patient Origin

Please report the county of origin for the inpatient admissions or discharges excluding newborns (except surgical services should include outpatients only).

Inpat=Inpatient Services
Surg=Outpatient Surgical
OB=Obstetric
P18+=Acute psychiatric adult 18 and over
P13-17=Acute psychiatric adolescent 13-17
P0-12=Acute psychiatric children 12 and under
Rehab=Inpatient Rehabilitation
S18+=Substance abuse adult 18 and over
S13-17=Substance abuse adolescent 13-17
E18+=Extended care adult 18 and over
E13-17=Extended care adolescent 13-17
E0-12=Extended care children 0-12
LTCH=Long Term Care Hospital

County	Inpat	Surg	OB	P18+	P13-17	P0-12	S18+	S13-17	E18+	E13-17	E0-12	LTCH	Rehab
Alabama	14	3	0	1	0	0	0	0	0	0	0	0	0
Appling	0	2	0	0	0	0	0	0	0	0	0	0	0
Atkinson	0	6	0	0	0	0	0	0	0	0	0	0	0
Bacon	0	1	0	0	0	0	0	0	0	0	0	0	0
Baker	1	6	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	12	42	1	0	0	0	0	0	0	0	0	0	0
Berrien	35	76	3	2	0	0	0	0	0	0	0	0	0
Bibb	4	1	0	0	0	0	0	0	0	0	0	0	0
Brooks	49	57	0	0	0	0	0	0	0	0	0	0	0
Burke	0	1	0	0	0	0	0	0	0	0	0	0	0
Butts	1	0	0	0	0	0	0	0	0	0	0	0	0
Calhoun	1	6	0	0	0	0	0	0	0	0	0	0	0
Camden	1	0	0	0	0	0	0	0	0	0	0	0	0
Charlton	1	2	0	1	0	0	0	0	0	0	0	0	0
Chatham	2	0	0	0	0	0	0	0	0	0	0	0	0
Cherokee	1	0	0	0	0	0	0	0	0	0	0	0	0
Clayton	1	0	0	0	0	0	0	0	0	0	0	0	0
Clinch	3	4	0	0	0	0	0	0	0	0	0	0	0
Cobb	1	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	9	15	0	0	0	0	0	0	0	0	0	0	0
Colquitt	4,711	3,346	484	74	0	0	0	0	0	0	0	0	0
Cook	125	130	25	3	0	0	0	0	0	0	0	0	0
Crisp	4	7	1	0	0	0	0	0	0	0	0	0	0
Decatur	17	39	1	0	0	0	0	0	0	0	0	0	0
DeKalb	5	0	0	0	0	0	0	0	0	0	0	0	0
Dodge	1	0	0	0	0	0	0	0	0	0	0	0	0
Dougherty	70	61	11	0	0	0	0	0	0	0	0	0	0

Early	0	1	0	0	0	0	0	0	0	0	0	0	0
Florida	35	43	2	3	0	0	0	0	0	0	0	0	0
Floyd	2	0	0	0	0	0	0	0	0	0	0	0	0
Fulton	2	1	0	2	0	0	0	0	0	0	0	0	0
Grady	30	61	4	6	0	0	0	0	0	0	0	0	0
Gwinnett	1	0	0	0	0	0	0	0	0	0	0	0	0
Hall	1	0	0	1	0	0	0	0	0	0	0	0	0
Houston	0	2	0	1	0	0	0	0	0	0	0	0	0
Irwin	8	17	1	0	0	0	0	0	0	0	0	0	0
Lamar	0	0	0	1	0	0	0	0	0	0	0	0	0
Lanier	4	6	1	0	0	0	0	0	0	0	0	0	0
Lee	10	20	1	0	0	0	0	0	0	0	0	0	0
Liberty	1	0	0	0	0	0	0	0	0	0	0	0	0
Lowndes	100	238	18	2	0	0	0	0	0	0	0	0	0
Macon	1	0	0	0	0	0	0	0	0	0	0	0	0
Miller	4	9	0	0	0	0	0	0	0	0	0	0	0
Mitchell	127	93	29	1	0	0	0	0	0	0	0	0	0
Monroe	1	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	1	0	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	52	2	1	1	0	0	0	0	0	0	0	0	0
Peach	1	0	1	0	0	0	0	0	0	0	0	0	0
Pierce	0	3	0	0	0	0	0	0	0	0	0	0	0
Pulaski	0	1	0	0	0	0	0	0	0	0	0	0	0
Putnam	0	1	0	0	0	0	0	0	0	0	0	0	0
Quitman	0	1	0	0	0	0	0	0	0	0	0	0	0
Randolph	1	1	0	0	0	0	0	0	0	0	0	0	0
Screven	1	0	0	0	0	0	0	0	0	0	0	0	0
Seminole	0	5	0	0	0	0	0	0	0	0	0	0	0
Spalding	1	0	0	0	0	0	0	0	0	0	0	0	0
Stewart	0	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	4	5	0	1	0	0	0	0	0	0	0	0	0
Telfair	0	2	0	0	0	0	0	0	0	0	0	0	0
Terrell	4	4	1	0	0	0	0	0	0	0	0	0	0
Thomas	340	383	35	4	0	0	0	0	0	0	0	0	0
Tift	157	209	18	0	0	0	0	0	0	0	0	0	0
Toombs	0	1	0	0	0	0	0	0	0	0	0	0	0
Treutlen	0	2	0	0	0	0	0	0	0	0	0	0	0
Turner	10	22	1	1	0	0	0	0	0	0	0	0	0
Walton	2	0	0	0	0	0	0	0	0	0	0	0	0
Ware	2	5	0	0	0	0	0	0	0	0	0	0	0
Wilcox	3	5	0	0	0	0	0	0	0	0	0	0	0
Worth	51	68	6	0	0	0	0	0	0	0	0	0	0
Total	**6,026**	**5,017**	**645**	**105**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Surgical Services Addendum

Part A : Surgical Services Utilization

1. Surgery Rooms in the OR Suite

Please report the Number of Surgery Rooms, (as of the end of the report period). Report only the rooms in CON-Approved Operating Room Suites pursuant to Rule 111-2-2-.40 and 111-8-48-.28.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Rooms
General Operating	0	0	8
Cystoscopy (OR Suite)	0	0	0
Endoscopy (OR Suite)	0	0	2
	0	0	0
Total	**0**	**0**	**10**

2. Procedures by Type of Room

Please report the number of procedures by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	0	4,398
Cystoscopy	0	0	0	322
Endoscopy	0	0	0	2,355
	0	0	0	0
Total	**0**	**0**	**0**	**7,075**

3. Patients by Type of Room

Please report the number of patients by type of room.

Room Type	Dedicated Inpatient Rooms	Dedicated Outpatient Rooms	Shared Inpatient Rooms	Shared Outpatient Rooms
General Operating	0	0	0	4,398
Cystoscopy	0	0	0	322
Endoscopy	0	0	0	2,355
	0	0	0	0
Total	**0**	**0**	**0**	**7,075**

Part B : Ambulatory Patient Race/Ethnicity, Age, Gender and Payment Source

1. Race/Ethnicity of Ambulatory Patients

Please report the total number of ambulatory patients for both dedicated outpatient and shared room environment.

Race/Ethnicity	Number of Ambulatory Patients
American Indian/Alaska Native	10
Asian	20
Black/African American	1,065
Hispanic/Latino	283
Pacific Islander/Hawaiian	9
White	3,616
Multi-Racial	14
Total	**5,017**

2. Age Grouping

Please report the total number of ambulatory patients by age grouping.

Age of Patient	Number of Ambulatory Patients
Ages 0-14	299
Ages 15-64	3,223
Ages 65-74	1,048
Ages 75-85	392
Ages 85 and Up	55
Total	**5,017**

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,906
Female	3,111
Total	**5,017**

4. Payment Source

Please report the total number of ambulatory patients by payment source.

Primary Payment Source	Number of Patients
Medicare	1,824
Medicaid	720
Third-Party	2,286
Self-Pay	187

Perinatal Services Addendum

Part A : Obstetrical Services Utilization

Please report the following obstetrical services information for the report period. Include all deliveries and births in any unit of th hospital or anywhere on its grounds.

1. Number of Delivery Rooms: 0

2. Number of Birthing Rooms: 0

3. Number of LDR Rooms: 4

4. Number of LDRP Rooms: 0

5. Number of Cesarean Sections: 193

6. Total Live Births: 604

7. Total Births (Live and Late Fetal Deaths): 612

8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 618

Part B : Newborn and Neonatal Nursery Services

1. Nursery Services

Please Report the following newborn and neonatal nursery information for the report period.

Type of Nursery	Set-Up and Staffed Beds/Station	Neonatal Admissions	Inpatient Days	Transfers within Hospital
Normal Newborn (Basic)	10	604	1,181	0
Specialty Care (Intermediate Neonatal Care)	2	19	22	0
Subspecialty Care (Intensive Neonatal Care)	0	0	0	0

Part C : Obstetrical Charges and Utilization by Mother's Race/Ethnicity and Age

1. Race/Ethnicity

Please provide the number of admissions and inpatient days for mothers by the mother's race using race/ethnicity classifications.

Race/Ethnicity	Admissions by Mother's Race	Inpatient Days
American Indian/Alaska Native	4	8
Asian	2	5
Black/African American	162	394
Hispanic/Latino	167	380
Pacific Islander/Hawaiian	0	0
White	305	735
Multi-Racial	5	11
Total	**645**	**1,533**

2. Age Grouping
Please provide the number of admissions by the following age groupings.

Age of Patient	Number of Admissions	Inpatient Days
Ages 0-14	1	3
Ages 15-44	632	1,508
Ages 45 and Up	12	22
Total	**645**	**1,533**

3. Average Charge for an Uncomplicated Delivery
Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

$7,864.00

4. Average Charge for a Premature Delivery
Please report the average hospital charge for a premature delivery.

$11,283.00

LTCH Addendum

Part A : General Information

1a. Accreditation Check the box to the right if your Long Term Care Hospital is accredited. ☐
If you checked the box for yes, please specify the agency that accredits your facility in the space below.

1b. Level/Status of Accreditation
Please provide your organization's level/status of accreditation.

2. Number of Licensed LTCH Beds: 0

3. Permit Effective Date:

4. Permit Designation:

5. Number of CON Beds: 0

6. Number of SUS Beds: 0

7. Total Patient Days: 0

8. Total Discharges: 0

9. Total LTCH Admissions: 0

Part B : Utilization by Race, Age, Gender and Payment Source

1. Race/Ethnicity
Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0
Total	**0**	**0**

2. Age of LTCH Patient

Please provide the number of admissions and inpatient days by the following age groupings.

Age of Patient	Admissions	Inpatient Days
Ages 0-64	0	0
Ages 65-74	0	0
Ages 75-84	0	0
Ages 85 and Up	0	0
Total	**0**	**0**

3. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	0	0
Female	0	0
Total	**0**	**0**

4. Payment Source

Please indicate the number of patients by the payment source. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	0	0
Third-Party	0	0
Self-Pay	0	0
Other	0	0

Psychiatric/Substance Abuse Services Addendum

Part A : Psychiatric and Substance Abuse Data by Program

1. Beds

Please report the number of beds as of the last day of the report period. Report beds only for officially recognized programs. Use the blank row to report combined beds. For combined bed programs, please report each of the combined bed programs and the number of combined beds. Indicate the combined programs using letters A through H, for example,"AB"

Patient Type	Distribution of CON-Authorized Beds	Set-Up and Staffed Beds
A- General Acute Psychiatric Adults 18 and over	10	10
B- General Acute Psychiatric Adolescents 13-17	0	0
C- General Acute Psychiatric Children 12 and under	0	0
D- Acute Substance Abuse Adults 18 and over	0	0
E- Acute Substance Abuse Adolescents 13-17	0	0
F-Extended Care Adults 18 and over	0	0
G- Extended Care Adolescents 13-17	0	0
H- Extended Care Adolescents 0-12	0	0
	0	0

2. Admissions, Days, Discharges, Accreditation

Please report the following utilization for the report period. Report only for officially recognized programs.

Program Type	Admissions	Inpatient Days	Discharges	Discharge Days	Average Charge Per Patient Day	Check if the Program is JCAHO Accredited
General Acute Psychiatric Adults 18 and over	105	813	100	774	2,048	☑
General Acute Psychiatric Adolescents 13-17	0	0	0	0	0	☐
General Acute Psychiatric Children 12 and Under	0	0	0	0	0	☐
Acute Substance Abuse Adults 18 and over	0	0	0	0	0	☐
Acute Substance Abuse Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adults 18 and over	0	0	0	0	0	☐
Extended Care Adolescents 13-17	0	0	0	0	0	☐
Extended Care Adolescents 0-12	0	0	0	0	0	☐

Part B : Psych/SA Utilization by Race/Ethnicity, Gender, and Payment Source

1. Race/Ethnicity

Please provide the number of admissions and inpatient days using the following race/ethnicity classifications.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	40	314
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	65	499
Multi-Racial	0	0
Total	**105**	**813**

2. Gender

Please provide the number of admissions and inpatient days by the following gender classifications.

Gender of Patient	Admissions	Inpatient Days
Male	52	368
Female	53	445
Total	**105**	**813**

3. Payment Source

Please indicate the number of patients by the following payment sources. Please note that individuals may have multiple payment sources.

Primary Payment Source	Number of Patients	Inpatient Days
Medicare	89	712
Medicaid	8	52
Third Party	6	40
Self-Pay	2	9
PeachCare	0	0

Georgia Minority Health Advisory Council Addendum

Because of Georgia's racial and ethnic diversity, and a dramatic increase in segments of the population with Limited English Proficiency, the Georgia Minority Health Advisory Council is working with the Department of Community Health to assess our health systems' ability to provide Culturally and Linguistically Appropriate Services (CLAS) to all segments of our population. We appreciate your willingness to provide information on the following questions:

1. Do you have paid medical interpreters on staff? *(Check the box, if yes.)* ☑
If you checked yes, how many? 1 (FTE's)
What languages do they interpret?
Spanish

2. When a paid medical interpreter is not available for a limited-English proficiency patient, what alternative mechanisms do you use to assure the provision of Linguistically Appropriate Services? *(Check all that apply)*

Bilingual Hospital Staff Member ☑	Bilingual Member of Patient's Family ☐
Community Volunteer Intrepreter ☐	Telephone Interpreter Service ☑
Refer Patient to Outside Agency ☐	Other (please describe): ☐

3. Please complete the following grid to show the proportion of patients you serve who prefer speaking various languages (name the 3 most common non-English languages spoken.)

Top 3 most common non-English languages spoken by your patients	Percent of patients for whom this is their preferred language	# of physicians on staff who speak this language	# of nurses on staff who speak this language	# of other employed staff who speak this language
Spanish		0	0	0
		0	0	0
		0	0	0

4. What **training** have you provided to your staff to assure cultural competency and the provision of **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

5. What is the most urgent tool or resource you need in order to increase your ability to provide **Culturally and Linguistically Appropriate Services (CLAS)** to your patients?

6. In what languages are the signs written that direct patients within your facility?

1. English
2.
3.
4.

7. If an uninsured patient visits your emergency department, is there a community health center, federally-qualified health center, free clinic, or other reduced-fee safety net clinic nearby to which you could refer that patient in order to provide him or her an affordable primary care medical home regardless of ability to pay? *(Check the box, if yes)* ☐
If you checked yes, what is the name and location of that health care center or clinic?

Comprehensive Inpatient Physical Rehabilitation Addendum

Part A : Rehab Utilization by Race/Ethnicity, Gender, and Payment Source

1. Admissions and Days of Care by Race

Please report the number of inpatient physical rehabilitation admissions and inpatient days for the hospital by the following race and ethnicity categories.

Race/Ethnicity	Admissions	Inpatient Days
American Indian/Alaska Native	0	0
Asian	0	0
Black/African American	0	0
Hispanic/Latino	0	0
Pacific Islander/Hawaiian	0	0
White	0	0
Multi-Racial	0	0

2. Admissions and Days of care by Gender

Please report the number of inpatient physical rehabilitation admissions and inpatient days by gender.

Gender	Admissions	Inpatient Days
Male	0	0
Female	0	0

3. Admissions and Days of Care by Age Cohort

Please report the number of inpatient physical rehabilitation admissions and inpatient days by age cohort.

Gender	Admissions	Inpatient Days
0-17	0	0
18-64	0	0
65-84	0	0
85 Up	0	0

Part B : Referral Source

1. Referral Source

Please report the number of inpatient physical rehabilitation admissions during the report period from each of the following sources.

Referral Source	Admissions
Acute Care Hospital/General Hospital	0
Long Term Care Hospital	0
Skilled Nursing Facility	0
Traumatic Brain Injury Facility	0

	0

1. Payers

Please report the number of inpatient physical rehabilitation admissions by each of the following payer categories.

Primary Payment Source	Admissions
Medicare	0
Third Party/Commercial	0
Self Pay	0
Other	0

2. Uncompensated Indigent and Charity Care

Please report the number of inpatietn physical rehabilitation patients qualifying as uncompensated indigent or charity care

0

Part D : Admissions by Diagnosis Code

1. Admissions by Diagnosis Code

Please report the number of inpatient physical rehabilitation admissions by the "CMS 13" diagnosis of the patient listed below.

Diagnosis	Admissions
1. Stroke	0
2. Brain Injury	0
3. Amputation	0
4. Spinal Cord	0
5. Fracture of the femur	0
6. Neurological disorders	0
7. Multiple Trauma	0
8. Congenital deformity	0
9. Burns	0
10. Osteoarthritis	0
11. Rheumatoid arthritis	0
12. Systemic vasculidities	0
13. Joint replacement	0
All Other	0

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and

completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: Julie Bhavnani

Date: 3/1/2023

Title: Chief Financial Officer/VP

Comments:

Monday, June 13, 2022

AHA Annual Survey - 2021

This printout of the survey includes all the data that has been entered so far. If no data has been entered all the fields will be empty. If you have entered some or all of the data, it will be represented here (except responses to 'write-in' or 'dropdown' questions, where only the first item will print). Please keep a copy of the most complete survey for your records. If you have any questions, please contact the Health Forum/AHA Support Team.

Thank You.

Colquitt Regional Medical Center (6380890)

3131 South Main Street

Moultrie, Georgia 31768

Colquitt County

Survey Status
Submitted

Date Started	Date Last Edited	Date Submitted
APR-04-22	APR-26-22	APR-26-22

Survey Administrators
James Matney

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Reporting Period	Completed	04/25/2022	James L Matney

Section A: Question	Description	Answer
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	10/01/2020
	To (mm/dd/yyyy)	09/30/2021
2a. Were you in operation 12 full months at the end of your reporting period?		Yes
2b. Number of days open during reporting period:		365
3. Indicate the beginning of your current fiscal year	mm/dd/yyyy	10/01/2021

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Organizational Structure	Completed	04/25/2022	James L Matney

Section B: Question	Answer
1. Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. SELECT ONLY ONE:	16 Hospital district or authority (Government, non-federal)
2. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:	10 General medical and surgical
Other-specify treatment area:	

OTHER

3a. Does your hospital restrict admissions primarily to children?	No
3b. Does the hospital itself operate subsidiary corporations?	Yes
3c. Is the hospital contract managed? If yes, please provide the name, city, and state of the organization	No

Name	City	State

3d. Is your hospital owned in whole or in part by physicians or a physician group?	No
3e. If you checked 80 Acute long-term care hospital (LTCH) in the section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.	

If you are arranged in a general acute care hospital, what is your host hospital's name, city and state?

Name	City	State

3f. Are any other types of hospitals co-located in your hospital?	No

3g. If you checked yes for 3f, what type of hospital is co-located? (Check all that apply)

- ☐ 1. Cancer
- ☐ 2. Cardiac
- ☐ 3. Orthopedic
- ☐ 4. Pediatric
- ☐ 5. Psychiatric
- ☐ 6. Surgical
- ☐ 7. Other

Colquitt Regional Medical Center (6380890)

3h. Is your hospital designated as a state, jurisdiction, or federal Ebola or other Special Pathogens facility? (Check all that apply.)

- ☐ 1. Federal designation: Regional Emerging Special Pathogen Treatment Center
- ☐ 2. State/Jurisdiction designation: Special Pathogen Treatment Center
- ☐ 3. State/Jurisdiction designation: Special Pathogen Assessment Hospital
- ☐ 4. Frontline facility

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	04/25/2022	James L Matney

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
1. General medical - surgical care	[X] (#Beds: 65)	[ ]	[ ]	[ ]
2. Pediatric medical - surgical care	[X] (#Beds: 13)	[ ]	[ ]	[ ]
3. Obstetrics [Hospital level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	[X] (#Beds: 11) Level: 1	[ ]	[ ]	[ ]
4. Medical-surgical intensive care	[X] (#Beds: 5)	[ ]	[ ]	[ ]
5. Cardiac intensive care	[X] (#Beds: 5)	[ ]	[ ]	[ ]
6. Neonatal intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
7. Neonatal intermediate care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
8. Pediatric intensive care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
9. Burn care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
12. Physical rehabilitation	[ ] (#Beds: ____)	[ ]	[ ]	[X]
13. Substance use disorder	[ ] (#Beds: ____)	[ ]	[ ]	[X]
14. Psychiatric care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
15. Skilled nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
16. Intermediate nursing care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
17. Acute long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
18. Other long-term care	[ ] (#Beds: ____)	[ ]	[ ]	[X]
19. Biocontainment patient care unit	[ ] (#Beds: ____)	[ ]	[ ]	[X]
20. Other care (Please specify the type of other care provided by the hospital if applicable.)	[ ] (#Beds: ____) (Specify: ____)	[ ]	[ ]	[X]
21. Adult day care program	[ ]	[ ]	[ ]	[X]
22. Airborne infection isolation room (Please specify the number of rooms)	[X] # Rooms: 5	[ ]	[ ]	[ ]
23. Alzheimer Center	[ ]	[ ]	[ ]	[X]

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
24. Ambulance services	X			
25. Air Ambulance services				X
26. Ambulatory surgery center				X
27. Arthritis treatment center				X
28. Auxiliary	X			
29. Bariatric/weight control services	X			
30. Birthing room - LDR room - LDRP room	X			
31. Blood Donor Center				X
32. Breast cancer screening / mammograms	X			
33. Cardiology and cardiac surgery services: 33a. Adult cardiology services				X
33b. Pediatric cardiology services				X
33c. Adult diagnostic catheterization	X			
33d. Pediatric diagnostic catheterization				X
33e. Adult interventional cardiac catheterization				X
33f. Pediatric interventional cardiac catheterization				X
33g. Adult cardiac surgery				X
33h. Pediatric cardiac surgery				X
33i. Adult cardiac electrophysiology				X
33j. Pediatric cardiac electrophysiology				X
33k. Cardiac rehabilitation				X
34. Case management	X			
35. Chaplaincy/pastoral care services	X			
36. Chemotherapy	X			
37. Children's wellness program	X			
38. Chiropractic services				X
39. Community outreach	X			
40. Complementary and alternative medicine services				X

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
41. Computer assisted orthopedic surgery (CAOS)	☐	☐	☒	☐
42. Crisis prevention	☐	☐	☒	☐
43. Dental services	☐	☐	☐	☒
44. Diabetes prevention program	☐	☐	☐	☒
45. Emergency services: 45a. On-campus emergency department	☒	☐	☐	☐
45b. Off-campus emergency department	☐	☐	☐	☒
45c. Pediatric emergency department	☐	☐	☐	☒
45d. Trauma center (certified) [Hospital Level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☐ (Level: ____)	☐	☐	☒
46. Enabling services	☐	☐	☐	☒
47. Endoscopic services: 47a.Optical colonoscopy	☒	☐	☐	☐
47b. Endoscopic ultrasound	☐	☐	☐	☒
47c. Ablation of Barrett's esophagus	☒	☐	☐	☐
47d. Esophageal impedance study	☒	☐	☐	☐
47e. Endoscopic retrograde cholangiopancreatography (ERCP)	☒	☐	☐	☐
48. Enrollment (insurance) assistance services	☐	☐	☐	☒
49. Employment support services	☐	☐	☐	☒
50. Extracorporeal shock wave lithotripter (ESWL)	☐	☐	☐	☒
51. Fertility clinic	☐	☐	☐	☒
52. Fitness center	☐	☐	☐	☒
53. Freestanding outpatient care center	☐	☐	☒	☐
54. Geriatric services	☐	☒	☐	☐
55. Health fair	☒	☐	☐	☐
56. Community health education	☒	☐	☐	☐
57. Genetic testing/counseling	☐	☐	☐	☒
58. Health screenings	☒	☐	☐	☐
59. Health research	☐	☐	☐	☒

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
60. Hemodialysis	X			
61. HIV - AIDS services	X			
62. Home health services	X			
63. Hospice program	X			
64. Hospital - based outpatient care center - services				X
65. Housing services:				
65a. Assisted living				X
65b. Retirement housing				X
65c. Supportive housing services				X
66. Immunization program	X			
67. Indigent care clinic				X
68. Linguistic/translation services	X			
69. Meal delivery services				X
70. Mobile health services				X
71. Neurological services	X			
72. Nutrition programs	X			
73. Occupational health services	X			
74. Oncology services	X			
75. Orthopedic services	X			
76. Outpatient surgery	X			
77. Pain management program	X			
78. Palliative care program				X
79. Palliative care inpatient unit				X
80. Patient Controlled Analgesia (PCA)	X			
81. Patient education center	X			
82. Patient representative services	X			
83. Physical rehabilitation services:				
83a. Assistive technology center	X			
83b. Electrodiagnostic services				X

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
83c. Physical rehabilitation outpatient services	X			
83d. Prosthetic and orthotic services				X
83e. Robot-assisted walking therapy				X
83f. Simulated rehabilitation environment				X
84. Primary care department	X			
85. Psychiatric services: 85a.Psychiatric consultation - liaison services				X
85b. Psychiatric pediatric care	(#Beds: ____)			X
85c. Psychiatric geriatric services	(#Beds: ____)			X
85d. Psychiatric education services				X
85e. Psychiatric emergency services				X
85f. Psychiatric outpatient services				X
85g. Psychiatric intensive outpatient services				X
85h. Social and Community psychiatry				X
85i. Forensic psychiatry				X
85j. Prenatal psychiatry and Postpartum psychiatry				X
85k. Psychiatric partial hospitalization services - adult				X
85l. Psychiatric partial hospitalization services - pediatric				X
85m. Psychiatric residential treatment - adult				X
85n. Psychiatric residential treatment - pediatric				X
85o. Suicide prevention services				X
86. Radiology, diagnostic: 86a. CT scanner	X			
86b. Diagnostic radioisotope facility	X			
86c. Electron beam computed tomography (EBCT)				X
86d. Full-field digital mammography(FFDM)	X			
86e. Magnetic resonance imaging (MRI)	X			
86f. Intraoperative magnetic resonance imaging				X

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
86g. Magnetoencephalography (MEG)	☐	☐	☐	☒
86h. Multi-slice spiral computed tomography(<64 + slice CT)	☐	☐	☐	☒
86i. Multi-slice spiral computed tomography (64+ slice CT)	☒	☐	☐	☐
86j. Positron emission tomography (PET)	☐	☐	☐	☒
86k. Positron emission tomography/CT (PET/ CT)	☐	☐	☒	☐
86l. Single photon emission computerized tomography (SPECT)	☐	☐	☐	☒
86m. Ultrasound	☒	☐	☐	☐
87. Radiology therapeutic: 87a. Image-guided Radiation Therapy(IGRT)	☐	☐	☐	☒
87b. Intensity-Modulated Radiation Therapy (IMRT)	☐	☐	☐	☒
87c. Proton beam therapy	☐	☐	☐	☒
87d. Shaped Beam Radiation System	☐	☐	☐	☒
87e. Stereotactic radiosurgery	☐	☐	☒	☐
87f. Basic interventional radiology	☐	☐	☐	☒
88. Robotic surgery	☒	☐	☐	☐
89. Rural health clinic	☒	☐	☐	☐
90. Sleep center	☒	☐	☐	☐
91. Social work services	☒	☐	☐	☐
92. Sports medicine	☒	☐	☐	☐
93. Substance use disorder care Services 93a. Substance use disorder pediatric services	☐ (#Beds: ____)	☐	☐	☒
93b. Substance use disorder outpatient services	☐	☐	☐	☒
93c. Substance use disorder partial hospitalization services	☐	☐	☐	☒
93d. Medication Assisted Treatment for Opioid Use Disorder	☐	☐	☐	☒
93e. Medication Assisted Treatment for other substance use disorders	☐	☐	☐	☒
94. Support groups	☒	☐	☐	☐
95. Swing bed services	☒	☐	☐	☐
96. Teen outreach services	☐	☐	☐	☒

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section C: Facilities and Services	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my system (In my local community)	(4) Do Not Provide
97. Tobacco treatment / cessation program	X			
98. Telehealth 98a. Consultation and office visits				X
98b. eICU				X
98c. Stroke care				X
98d. Psychiatric and addiction treatment				X
98e. Remote patient monitoring: 1. Post-discharge.				X
2. Ongoing chronic care management				X
3. Other remote patient monitoring				X
98f. Other telehealth				X
99. Transplant services: 99a. Bone marrow				X
99b. Heart				X
99c. Kidney				X
99d. Liver				X
99e. Lung				X
99f. Tissue				X
99g. Other				X
100. Transportation to health facilities (non-emergency)	X			
101. Urgent care center				X
102. Violence Prevention Programs: 102a. For the workplace				X
102b. For the community				X
103. Virtual Colonoscopy				X
104. Volunteer services department	X			
105. Women's health center / services	X			
106. Wound management services	X			

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section C: Physician Arrangements	Answer	Answer (History)
107a. Does your organization routinely offer psychiatric consultation & liaison services in the following care areas?		
1. Emergency Services	No	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	No
107b. Does your organization routinely offer addiction/substance use disorder consultation & liaison services in the following care areas?		
1. Emergency Services	No	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	No
107c. Does your organization routinely screen for psychiatric disorders in the following care areas?		
1. Emergency Services	No	
2. Primary Care Services	No	
3. Acute inpatient care	No	
4. Extended care	No	
107d. Does your organization routinely screen for substance use disorders in the following care areas?		
1. Emergency Services	No	
2. Primary Care Services	No	
3. Acute inpatient care	No	
4. Extended care	No	

Consultation-liaison psychiatrists, medical physicians, or advanced practice providers (APPs) work to help people suffering from a combination of mental and physical illness by consulting with them and liaising with other members of their care team.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Emergency Services	No			
2. Primary Care Services	No			
3. Acute inpatient care	No			
4. Extended care	No			

Colquitt Regional Medical Center (6380890)

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Emergency Services	No			
2. Primary Care Services	No			
3. Acute inpatient care	No			
4. Extended care	No			

Screens can include, but are not limited to the PHQ-2 and PHQ9 depression screen, the Columbia DISC Depression Scale, and/or the GAD-2 and GAD-7 for anxiety disorders

	Percent %	Number of Physicians
1. Emergency Services		No
2. Primary Care Services		No
3. Acute inpatient care		No
4. Extended care		No

	Answer	Answer (History)
108d. Of the physician practices owned by the hospital, what percentage are primary care?	20	20
108e. Of the physician practices owned by the hospital, what percentage are specialty care?	80	80
109. Looking across all the relationships identified in question 108a, what is the total number of physicians (count each physician only once) that are engaged in an arrangement with your hospital that allows for joint contracting with payors or shared responsibility for financial risk or clinical performance between the hospital and physician (arrangement may be any type of ownership)?	0	0
110a. Does your hospital participate in any joint venture arrangements with physicians or physician groups?	No	No

110b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply).

- ☐ 1. Limited Service Hospital
- ☐ 2. Ambulatory surgical centers
- ☐ 3. Imaging Centers
- ☐ 4. Other

110c. If you selected '1'. Limited Service Hospital' please tell us what type(s) of services are provided (Check all that apply).

- ☐ 1. Cardiac
- ☐ 2. Orthopedic
- ☐ 3. Surgical
- ☐ 4. Other

	Answer	Answer (History)
110d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

	Answer	Answer (History)
111a. Bed changes: a. Was there a temporary increase in the total number of beds set up and staffed for use during the reporting period?	No	No
111b. Bed changes: b. Was there a temporary increase in the total number of ICU beds set up and staffed for use during the reporting period?	No	No

112. Airborne infection isolation rooms:

	Answer	Answer (History)
a. Please indicate the total number of airborne infection isolation rooms set up at the start of the reporting period?		
b. Please indicate the total number of airborne infection isolation rooms set up at the end of the reporting period?		
c. Please indicate how many rooms not set up as airborne infection isolation rooms at the end of the reporting period can be converted to airborne isolation rooms?		
113. Temporary spaces: Please indicate if any temporary spaces such as tents or other spaces not typically used for clinical purposes were set up for using in triage, testing or treatment during the reporting period.		

114. Ventilators:

a. How many adult (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period?		
b. How many adult (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?		
c. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the start of the reporting period??		
d. How many pediatric/NICU (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?		

	Answer	Answer (History)
115. Was there a temporary increase in the total number of emergency department beds set up and staffed for use during the reporting period?	No	

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Insurance and Alternative Payment Models	Completed	04/25/2022	James L Matney

Section D: Question	Answer
1. Does your hospital own or jointly own a health plan?	No
1a. In what states? (Select all that apply)	
2. Does your system own or jointly own a health plan?	No
2a. In what states? (Select all that apply)	
3. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan?	No
3a. In what states? (Select all that apply)	

4. Insurance
If yes, to 1, 2 and/or 3, please indicate the insurance products and the total medical enrollment (check all that apply)

Insurance Product	Hospital	System	JV	Medical Enrollment	New Product	No	Do Not Know
a. Medicare Advantage	☐	☐	☐		☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐		☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐		☐	☐	☐
d. Other Individual Market	☐	☐	☐		☐	☐	☐
e. Small Group	☐	☐	☐		☐	☐	☐
f. Large Group	☐	☐	☐		☐	☐	☐
g. Other	☐	☐	☐		☐	☐	☐

	Answer
If yes, to 4.g. Other Please specify:	

5. Does your health plan make capitated payments to physicians either within or outside of your network for specific groups or enrollees?

a. Physicians within your network	
b. Physicians outside your network	
c. If yes, which specialties?	

Colquitt Regional Medical Center (6380890)

6. Does your health plan make bundled payments to providers in your network or to outside providers?

	Answer
a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

7. Does your health plan offer shared risk contracts either to providers in your network or to outside providers? (i.e., other than capitation or bundled payment)

a. Providers within your network	
b. Providers outside your network	
c. If yes, which specialties?	

8. Does your hospital or health system fund the health benefits for your employees?	No
a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)?	
9. What percentage of the hospital's net patient revenue is paid on a capitated basis?	0
9a. In total, how many enrollees do you serve under capitated contracts?	
10. Does your hospital participate in any bundled payment arrangement?	No

10a. If yes, with which of the following types of payers does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Traditional Medicare
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan including ACA participants, individual, group or employer markets
- ☐ 4. Medicaid

10b. For which of the following medical/surgical conditions does your hospital have a bundled payment arrangement? (Select all that apply)

- ☐ 1. Cardiovascular
- ☐ 2. Orthopedic
- ☐ 3. Oncologic
- ☐ 4. Neurology
- ☐ 5. Hematology
- ☐ 6. Gastrointestinal
- ☐ 7. Pulmonary
- ☐ 8. Infectious disease
- ☐ 9. Other please specify:

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

	Answer
10c.what percentage of the hospital's patient revenue is paid through bundled payment arrangements	
11.Does your hospital participate in a bundled payment program involving care settings outside of the hospital (e.g. physician, outpatient, post acute)?	No
11a.If yes, does your hospital share upside or downside risk with any of those outside providers?	No
12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?	0
13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?	No
14.Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?	No
15a. Has your hospital or health care system established an accountable care organization (ACO)?	4. My hospital/system has never participated or led an ACO

15b. With which of the following types of payers does your hospital/system have an accountable care contract? (Select all that apply)

- ☐ 1. Traditional Medicare (MSSP and NextGen)
- ☐ 2. A Medicare Advantage plan
- ☐ 3. A commercial insurance plan (including ACA participants, individual, group, and employer markets)
- ☐ 4. Medicaid

15c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Select all that apply)

- ☐ 1. MSSP BASIC Track, Level A
- ☐ 2. MSSP BASIC Track, Level B
- ☐ 3. MSSP BASIC Track, Level C
- ☐ 4. MSSP BASIC Track, Level D
- ☐ 5. MSSP BASIC Track, Level E
- ☐ 6. MSSP ENHANCED Track
- ☐ 7. Original MSSP program, Tracks 1, 1+, 2 or 3
- ☐ 8. Comprehensive ESRD Care

15d. What percentage of your hospital's/system patients are covered by accountable care contracts?	
15e. What percentage of your hospital's/system patient revenue came from ACO contracts in 2021?	
16. Has your hospital/system ever considered participating in an ACO?	c. No, we have not even considered it

Colquitt Regional Medical Center (6380890)

17. Do any hospitals and/or physician groups within your system or the system itself, plan to participate in any of the following risk arrangements in the next three years? (Check all that apply)

- [ ] a. Shared Savings/Losses
- [ ] b. Bundled payment
- [ ] c. Capitation
- [ ] d. ACO (Ownership)
- [ ] e. ACO (Joint Venture)
- [ ] f. Health Plan (Ownership)
- [ ] g. Health Plan (Joint Venture)
- [ ] h. Primary care transformation, including direct contracting
- [ ] i. Other, please specify:
- [x] j. None

18. Does your hospital/system have an established medical home program?

	Answer
a. Hospital	No
b. System	No

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Total Facility Beds, Utilization, Finances & Staffing	Completed	04/25/2022	James L Matney

Section E: Question	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
1. BEDS AND UTILIZATION				
a. Total licensed beds.	99	99		
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	99	99		
c. Bassinets set up and staffed for use at the end of the reporting period	12	12		
d. Births (exclude fetal deaths)	599	554		
e. Admissions (exclude newborns, include neonatal & swing admissions)	5,914	5,027		
f. Inpatient days (exclude newborns, include neonatal & swing days)	25,441	21,939		
g. Emergency department visits	32,038	31,294		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	187,861	155,546		
i. Inpatient surgical operations	735	672		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	3,090	2,603		

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
Medicare/Medicaid				
2. MEDICARE/MEDICAID UTILIZATION (exclude newborns, Include neonatal & swing days &				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	3,690	3,143		
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	1,324	1,064		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	16,353	13,770		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	5,869	4,659		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	1,026	922		
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	528	413		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	4,546	4,037		
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	2,339	1,824		

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: Question (continued)	Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)
3. FINANCIAL				
*a. Net patient revenue (treat bad debt as a deduction from revenue)	173,026,773	144,289,294		
*b. Tax appropriations	0	0		
*c. Other operating revenue	5,881,056	5,139,218		
*d. Nonoperating revenue	25,386,365	12,337,257		
*e. TOTAL REVENUE (add 3a thru 3d)	204,294,194	161,765,769		
f. Payroll expenses (only)	64,326,414	58,208,267		
g. Employee benefits	14,006,286	14,121,293		
h. Depreciation expense (for reporting period only)	10,973,724	10,032,708		
i. Interest expense	1,324,899	1,550,166		
j. Pharmacy Expense	4,008,540	3,807,242		
k. Supply expense (other than pharmacy)	30,942,121	23,321,208		
l. All other expenses	32,910,844	31,798,912		
m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)	158,492,828	142,839,796		

	Answer	Answer (History)
n. Do your total expenses (E3.m) reflect full allocation from your corporate office?	Yes	Yes
*4. Revenue By type		
a. Total gross inpatient revenue	196181876	158985117
b. Total gross outpatient revenue	355965580	282978000
c. Total gross patient revenue	552147456	441963117

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

*5. Uncompensated Care & Provider Taxes

a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)	37821961	30645869
1. Are you able to distinguish bad debt derived from patients with or without insurance?	No	No
2. If yes, how much is from patients with insurance?		
b. Financial assistance (Includes charity care) (Revenue forgone at full-established rates. Include in gross revenue.)	9462360	10608417
c. Is your bad debt (5a.) reported on the basis of full charges?	No	No
d. Does your state have a provider Medicaid tax/assessment program?	Yes	Yes
e. If yes, please report the total gross amount paid into the program	1569946	1424730
f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in:		
Deductions from net Patient Revenue.....	No	No
Total Expenses.....	Yes	Yes

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: Question (continued)

6. REVENUE BY PAYOR (report total facility gross and net figures)

	(1) Gross	(1) Gross (History)	(2) Net	(2) Net (History)
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	210,134,685	160,785,986	31,243,192	31,950,874
6a1b. Managed care revenue	117,639,000	82,229,374	34,393,743	22,206,921
6a1c. Total (a + b)	327,773,685	243,015,360	65,636,935	54,157,795
6a2. Medicaid:				
6a2a. Fee for service patient revenue	32,401,460	32,842,857	17,147,431	9,416,767
6a2b. Managed care revenue	34,346,570	27,062,705	3,721,449	4,580,266
6a2c. Medicaid Graduate Medical Education (GME) payments			2,048,730	1,377,969
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			6,693,808	3,529,388
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments			4,005,810	556,885
6a2f. Other Medicaid			0	0
6a2g. Total (a-f)	66,748,030	59,905,562	33,617,228	19,461,275
6a3. Other Government:	8,867,756	5,706,931	2,090,498	1,453,509
*6b. NONGOVERNMENT				
6b1. Self-pay	44,748,505	37,524,399	5,940,351	4,518,981
6b2. Third-party payers:				
6b2a. Managed care (includes HMO and PPO)	78,828,473	70,666,090	59,189,016	53,096,440
6b2b. Other third - party payers	14,833,726	14,342,385	3,348,617	3,159,074
6b2c. Total Third - party payers (a+b)	93,662,199	85,008,475	62,537,633	56,255,514
6b3. All Other nongovernment	10,347,281	10,802,390	3,204,128	8,442,220
*6c. TOTAL	552,147,456	441,963,117	173,026,773	144,289,294

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: Question (continued)	Inpatient	Inpatient (History)	Outpatient	Outpatient (History)
*6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.				
Medicaid supplemental payments				

	Answer	Answer (History)
*6e. If you are a government owned facility(control codes 12-16 section b), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditure program.		

*6f. If yes, please report gross and net revenue.	Gross	Net

	Answer	Answer (History)
*6g. Are the financial data reported from your audited financial statement?	Yes	Yes
6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?	No	No

7. COVID RELIEF FUNDS

*Include all funds received from federal and state governments for COVID relief, such as CARES Act Provider Relief Fund payments. Do not include any funds that constitute a loan and may be on the balance sheet as a liability.

	Answer	Answer (History)
*7a. Provider/COVID Relief Funds recognized as revenue in 2021	6,917,825	
On which survey line did you report this revenue?		
1. Net patient revenue	No	
2. Other operating revenue	No	
3. Nonoperating revenue	Yes	
*7c. Provider/COVID Relief Funds recognized as revenue in 2020 (please do not include these dollars in 7a)	6,217,615	
*7d. Did you include these funds as revenue on the 2020 survey?	Yes	
*7e. If yes, on which survey line did you report this revenue?		
1. Net patient revenue	No	
2. Other operating revenue	No	
3. Nonoperating revenue	Yes	

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

	Answer	Answer (History)
*8. FINANCIAL PERFORMANCE - MARGIN		
*a. Total Margin		
*b. Operating Margin		
*c. EBITDA Margin		
*d. Medicare Margin		
*e. Medicaid Margin		
9. Fixed Assets		
9a. Property, plant and equipment at cost	243,623,874	215,869,877
9b. Accumulated depreciation	133,164,047	122,066,788
9c. Net property, plant and equipment (a - b)	110,459,827	93,803,089
9d. Total gross square feet of your physical plant used for or in support of your healthcare activities	307,171	307,171
10. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	27,886,959	13,054,895
11. INFORMATION TECHNOLOGY AND CYBERSECURITY		
a. IT Operating Expense	4,144,357	3,260,988
b. IT Capital Expense.	2,465,167	1,091,184
c. Number of Employed IT staff (in FTEs).	18	16
d. Number of outsourced IT staff (in FTEs).	0	0
*e. What percentage of your IT budget is spent on security?	20	20

*f. Which of the following cybersecurity measures does your hospital or health system currently deploy?

- [ ] a. Annual risk assessment
- [ ] b. Incident response plan
- [ ] c. Intrusion detection systems
- [ ] d. Mobile device encryption
- [ ] e. Mobile device data wiping
- [ ] f. Penetration testing to identify security vulnerabilities
- [ ] g. Strong password requirements
- [ ] h. Two-factor authentication

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

	Answer	Answer (History)
CYBERSECURITY		
*g. Does your hospital or health system board oversight of risk management and reduction specifically include consideration of cybersecurity risk?	Yes	Yes
*h. Does your hospital or health system have cybersecurity insurance?	Yes	Yes
*i. Is your hospital or health system participating in cybersecurity information-sharing activities with an outside information Sharing and Analysis Organization to identify threats and vulnerabilities?	Yes	Yes

*These data will be treated as confidential and not released without written permission. AHA will, however, share these data with your respective state hospital association and, if requested, with your appropriate metropolitan/regional association.

	Answer	Answer (History)
*For members of the Catholic Health Association of the United States (CHA), AHA will also share these data with CHA unless there are objections expressed by checking this box.		

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: 12. Staffing	Full-Time (35 hr/wk or more) On Payroll	Full-Time (History)	Part-Time (<35 hr/wk) On Payroll	Part-Time (History)	FTE	Vacancies	Vacancies (History)
a. Physicians	28	31	0	0	28	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	18	17	0	0	18	0	0
d. Dental residents/interns	0	0	0	0	0	0	0
e. Other trainees	0	20	0	0	0	7	0
f. Registered nurses	153	247	95	51	200	16	18
g. Licensed practical (vocational) nurses	35	36	4	2	36	7	2
h. Nursing assistive personnel	84	72	60	8	114	5	3
i. Radiology technicians	30	18	4	6	32	0	0
j. Laboratory technicians	34	18	7	9	37	2	3
k. Pharmacists, licensed	6	9	2	0	7	0	0
l. Pharmacy technicians	10	8	0	0	10	0	0
m. Respiratory therapists	14	18	4	11	16	1	0
n. All other personnel	710	618	114	125	798	60	53
o.Total facility personnel (add 12a through 12n)(Total facility personnel (a-o) should include hospital plus nursing home type unit/facility personnel reported in 12p and 12q)	1122	1112	290	212	1296	98	79
p. Nursing home type unit/facility Registered Nurses	0	0	0	0	0	0	0
q. Nursing home type unit/facility personnel	0	0	0	0	0	0	0

	Answer	Answer (History)
r. For your employed RN FTEs reported above (E.12f, column 3) please report the number of full-time equivalents who are involved in direct patient care.	198	260

s. For your medical residents/interns reported above (E.12c. column 1) please indicate the number of full-time on payroll by specialty.

	Answer	Answer (History)
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	18	17
2. Other Specialties	0	0

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section E: 13. Privileged Physicians	(1) Total Employed	(2) Total Individual	(3) Total Group Contract	(4) Not Employed or Under Contract	(5) Total Privileged
a. Primary care (general practitioner, general internal medicine, family practice, general	11	4	1	2	18
b. Obstetrics/gynecology	4	0	0	0	4
c. Emergency medicine	0	0	6	0	6
d. Hospitalist	13	0	0	0	13
e. Intensivist	0	0	0	0	0
f. Radiologist/pathologist/anesthesiologist	0	5	3	0	8
g. Other specialist	0	21	8	2	31
h. Total (add 13a-13g)	28	30	18	4	80

14. HOSPITALISTS

	Answer	Answer (History)
14a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.13d.)	Yes	Yes
14b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	13	14

15. INTENSIVISTS

	Answer	Answer (History)
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 16.) (if yes, please report in E.13e.)	No	No

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are allowed to care for ICU patients.)

	FTE	Closed	FTE (History)	Closed (History)
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

16. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	Answer	Answer (History)
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 17.)	Yes	Yes
b. If yes, please report the number of full time, part time and FTE advanced practice nurses/physician assistants who provide care for patients in your hospital.		
Advanced Practice Registered Nurses Full-time	18	21
Advanced Practice Registered Nurses Part-time	0	0
Advanced Practice Registered Nurses FTE	18	21
Physician Assistants Full-time	8	6
Physician Assistants Part-time	0	0
Physician Assistants FTE	8	6
c. If yes, please indicate the type of service(s) provided. (Please check all that apply)	1. Primary care, 2. Anesthesia services, 3. Emergency department care, 4. Other specialty care	Primary care, Anesthesia services, Emergency department care, Other specialty care
a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2021 vs. 2020?	Same	Did not hire foreign nurses
b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)		

18a. Does your hospital use artificial intelligence (AI) or machine learning in the following: (Check all that apply):

- [ ] 1. Predicting staffing needs
- [ ] 2. Predicting patient demand
- [ ] 3. Staff scheduling
- [ ] 4. Automating routine tasks
- [ ] 5. Optimizing administrative and clinical workflows

18b. How is your hospital incorporating workforce as part of the strategic planning process (Check all that apply):

- [X] 1. Conduct needs assessment
- [X] 2. Leadership succession planning
- [X] 3. Talent development plan
- [X] 4. Recruitment and retention planning
- [X] 5. Partnerships with elementary/HS to develop interest in health care careers
- [X] 6. Training program partnership with community colleges, vocational training programs

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Addressing Patient Social Needs and Community Social Determinants of Health	Completed	04/25/2022	James L Matney

Section F: Addressing Patient Social Needs and Community Social Determinants of Health

1. Which social needs of patients/social determinants of health in communities does your hospital or health system have programs or strategies to address? (Check all that apply)

- [ ] a. Housing (instability, quality, financing)
- [ ] b. Food insecurity or hunger
- [ ] c. Utility needs
- [ ] d. Interpersonal violence
- [X] e. Transportation
- [ ] f. Employment and income
- [ ] g. Education
- [ ] h. Social isolation (lack of family and social support)
- [ ] i. Health behaviors
- [ ] j. Other, please describe

	Answer
2. Does your hospital or health system screen patients for social needs?	c. No

2a. If yes, please indicate which social needs are assessed. Check all that apply.

- [ ] 1. Housing (instability, quality, financing)
- [ ] 2. Food insecurity or hunger
- [ ] 3. Utility need
- [ ] 4. Interpersonal violence
- [ ] 5. Transportation
- [ ] 6. Employment and income
- [ ] 7. Education
- [ ] 8. Social isolation (lack of family and social support)
- [ ] 9. Health behaviors
- [ ] 10. Other, please describe

	Answer
2b. If yes, does your hospital or health system record the social needs screening results in your electronic health record?	
3. Does your hospital or health system utilize outcome metrics (for example, cost of care or readmission rates) to assess the effectiveness of interventions to address the patients' social needs?	Yes

Colquitt Regional Medical Center (6380890)

4. Has your hospital or health system been able to gather data indicating that activities used to address the social determinants of health and patient social needs have resulted in any of the following (check all that apply):

- [X] a. Better health outcomes for patients
- [ ] b. Decreased utilization of hospital or health system services
- [ ] c. Decreased health care costs
- [ ] d. Improved community health status

5. Who in your hospital or health care system is accountable for meeting health equity goals? (Check all that apply):

- [ ] a. CEO
- [ ] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders
- [ ] f. Employee Resource Group

6. Who in your hospital or health care system is accountable for implementing strategies for health equity goals? (Check all that apply):

- [ ] a. CEO
- [ ] b. Designated Senior Executive (Chief Diversity Office, VP for DEI, etc.)
- [ ] c. Middle Management
- [ ] d. Committee or Task Force
- [ ] e. Division/Department Leaders
- [ ] f. Employee Resource Group

7. Does your hospital or health care system use DEI disaggregated data to inform decisions on the following? (Check all that apply):

- [ ] a. Patient outcomes
- [ ] b. Procurement
- [ ] c. Supply chain
- [ ] d. Training
- [ ] e. Professional development

8. Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply):

- [ ] a. Equitable and inclusive organizational policies
- [ ] b. Systematic and shared accountability for health equity
- [ ] c. Diverse representation in hospital and health care system leadership
- [ ] d. Diverse representation in hospital and health care system governance
- [ ] e. Community engagement
- [ ] f. Collection and use of segmented data to drive action
- [ ] g. Culturally appropriate patient care

Colquitt Regional Medical Center (6380890)

9. Please indicate the extent of your hospital's current partnerships with external partners for population and/or community health initiatives. Which types of organizations do you currently partner with in each of the following activities? (Check all that apply)

	Not involved	Work together to meet patient social needs	Participates in our Community	Work together to implement community-level initiatives
a. Health care providers outside of your systems	☐	☐	☐	☒
b. Health insurance providers outside of your own system	☒	☐	☐	☐
c. Local or state public health departments/organizations	☐	☒	☐	☐
d. Other local or state government agencies or social service organizations	☐	☒	☐	☐
e. Faith based organizations	☒	☐	☐	☐
f. Local organizations addressing food insecurity	☐	☒	☐	☐
g. Local organizations addressing transportation needs	☐	☒	☐	☐
h. Local organizations addressing housing insecurity	☒	☐	☐	☐
i. Local organizations providing legal assistance for individuals	☒	☐	☐	☐
j. Other community non-profit organizations	☐	☐	☒	☐
k. K - 12 Schools	☐	☐	☒	☐
l. Colleges or universities	☒	☐	☐	☐
m. Local businesses or chambers of commerce	☐	☐	☒	☐
n. Law enforcement/safety forces	☒	☐	☐	☐
o. Area Behavioral Health Providers	☐	☐	☐	☐
p. Area Agencies on Aging (AAA)	☐	☐	☐	☐

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	04/25/2022	James L Matney

Section G: Supplemental Information

	Answer
1. Does the hospital participate in a group purchasing arrangement? If yes, please provide the name, city, and state of your primary group purchasing organization:	Yes

Name	City	State
Healthtrust	Brentwood	TN

	Answer
2. Does the hospital purchase medical/surgical supplies directly through a distributor?	Yes

If yes, please provide the name(s) of the primary distributor.

Name: Owens & Minor

Name: Cardinal

Name:

	Answer
3. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?	15
4. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?	No
5. Utilization of telehealth/virtual care	
a. Number of video visits: Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication.	
b. Number of audio visits: Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication.	
c. Number of patients being monitored through remote patient monitoring (RPM): Asynchronous or synchronous interactions between and patient and a provider that are not co-located involving the collection, transmission, evaluation, and communication of physiological data.	
d. Number of patients receiving other virtual services: All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely including messages, eConsults, and virtual check-ins.	
6. Does your hospital have a partnership with a Community Mental Health Center or a Certified Community Behavioral Health Center?	
a. Community Mental Health Center	No
b. Certified Community Behavioral Health Center	No

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Decarbonization Goals

	Answer
7. Which of the following describe(s) your organizations decarbonization efforts?	
If yes to, have your hospital set a decarbonization percentage reduction.	
% Reduction goal (e.g. xxx.xx)	
Target year to meet goal	
Baseline year	
If yes to, net-zero emissions goal	
Target year to meet goal?	
Baseline year	

Please feel free to expand on your response in the box below:

8. The federal government has recently released ambitious goals for federal facilities. It includes achieving a carbon pollution-free electricity sector by 2035 and net-zero emissions economy-wide by no later than 2050 with a 65% reduction in Scope 1 and 2 GHG emissions from Federal operations by 2030 (from 2008 levels). Irrespective of the exact targets and years, would your organization, in principle, be willing to support similar types of goals for the health sector? You can read the announcement by clicking on the question mark in red.

Please feel free to expand on your response in the box below:

9. Do you believe the decarbonization goals for the health sector should be similar, more ambitious, or less ambitious than the targets set by the federal government? (check one of the following)

Please feel free to expand on your response in the box below:

10. Does your organization have an executive leader responsible for environmental sustainability, including climate change mitigation?

Please feel free to expand on your response in the box below:

Please indicate below whether or not you agree to these types of disclosure:	I hereby grant AHA permission to release my hospital's revenue data to external users that the AHA determines have a legitimate and worthwhile need to gain access to these data subject to the user's agreement with the AHA not to release hospital specific information.

Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.

AHA Annual Survey - 2021

Colquitt Regional Medical Center (6380890)

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted

Your Name & Title	Julie Bhavnani
Your Name & Title	CFO
Your Email Address	cdesalvo@colquittregional.com
Your Phone Number	(229) 890-3513
Your Fax Number	(229) 891-9335

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 Cardiac Catheterization Survey

Part A : General Information

1. Identification

UID:HOSP524

Facility Name: Colquitt Regional Medical Center
County: Colquitt
Street Address: 3131 South Main Street
City: Moltrie
Zip: 31768
Mailing Address: P O Box 40
Mailing City: Moultrie
Mailing Zip: 31776-0040
Medicare Provider Number: 110105
Medicaid Provider Number: 000002021A

2. Report Period

Report Data for the full twelve month period, January 1, 2021 - December 31, 2021 (365 days).
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐

If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: David Spence
Contact Title: Director of Imaging Services
Phone: 229-891-9287
Fax: 229-891-4089
E-mail: dspence@colquittregional.com

Part C : Catheterization Services Utilization

1A. Number of Cardiac Catheterization Services Labs or Rooms

Please report the total number of Cardiac Catheterization services labs or rooms. Include all labs or rooms that are authorized to provide cardiac catheterizations pursuant to Rule 111-2-2-21. Include both general purpose and dedicated rooms or labs.

1

1B. Room Detail

Please provide details on each of the labs or rooms reported in 1A above. Report each lab or room on a separate row. The name of the lab or room should be the name used in your facility.

Room Name	Operational Date	Dedicated Room?	# Cath Procedures	If Dedicated What Type?
Cardiac Cath Lab	9/1/2004	Yes	195	Cardiac Cath

1C. Other Rooms

If your facility has other rooms that are equiped and capable of performing a cardiac catheterization (other than what is preorted in Part C, Q1 A and B above) please indicate the number of those other rooms below.

0

2. Cardiac Catheterization by Procedure Type

Report by age and procedure type the total number of cardiac catheterization procedures performed during the report year in the cardiac catheterization rooms reported in question #1 above. Report actual cardiac cath procedures performed by the categories provided. Do not report cardiac catheterization sessions, but the procedures. Please refer to the definitions of procedure and session in the instructions.

2A. Therapeutic Cardiac Catheterizations

Therapeutic Cardiac Catheterizations	Ages 0-14	Ages 15+	Total
PCI balloon angioplasty procedures	0	0	0
PCI procedures utilizing drug eluting stent	0	0	0
PCI procedures utilizing non drug eluting stent	0	0	0
Rotational Atherectomy	0	0	0
Directional Atherectomy	0	0	0
Laser Atherectomy	0	0	0
Excisional Atherectomy	0	0	0
Use of Cutting Balloon	0	0	0
Closure or patent ductus areriosus > 28 days, by card. cath.	0	0	0
Closure or patent ductus arteriosus < 28 days, by card. cath.	0	0	0
	0	0	0
Total	**0**	**0**	**0**

2B.1 Diagnostic Cardiac Catheterizations

Diagnostic Cardiac Catheterizations	Ages 0-14	Ages 15+	Total
Left Heart Diagnostic Cardiac Catheterizations	0	193	193
Right Heart Diagnostic Cardiac Catheterizations	0	2	2
Total Diagnostic Cardiac Catheterization Procedures	**0**	**195**	**195**
Grand Total (All Cardiac Catheterization Procedures)	**0**	**195**	**195**

2B.2 Left Heart Cardiac Catheterization Details

Report the number of diagnostic left heart cardiac catheterizations that were not followed by a therapeutic cardiac cath procedure and then provide the number that were followed by PCI in the same sitting.

Left Heart Diagnostic Cardiac Catheterization Details	Ages 0-14	Ages 15+	Total
Left Heart Diagnostic Cardiac Cath Only (without PCI)	0	193	193
Left Heart Diagnostic Cardiac Cath Followed by PCI	0	0	0

2C. Peripheral Catheterization by Patient Type

Report the total number of peripheral catheterization procedures.

Ages 0-14	Ages 15+	Total
0	75	75

2D. Major Coronary Circulation Vessels Treated per Patient

Report the number of major coronary circulation vessels treated per patient by therapeutic cardiac catheterizations.

PCI Type	1 Vessel	2 Vessels	3 Vessels	4 Vessels	Total
PCI balloon angioplasty and/or stent	0	0	0	0	0
All other types of PCI (e.g. laser, etc.)	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**

2E. Cardiac Catheterization Sessions

Report by patient type and procedure type the total number of inpatient and outpatient cardiac catheterization sessions performed during the report year.

Cardiac Catheterizations by Patient Type	Ages 0-14	Ages 15+	Total
Inpatient Diagnostic Cardiac Catheterizations	0	56	56
Outpatient Diagnostic Cardiac Catheterizations	0	139	139
Inpatient Therapeutic Cardiac Catheterizations	0	0	0
Outpatient Therapeutic Cardiac Catheterizations	0	0	0
Total	**0**	**195**	**195**

3A. Other Procedures Performed During Cardiac Catheterization Session

Report by age of patient and procedure type the total number of non-cardiac catheterization procedures that were performed during the cardiac catheterization session. Report by procedure code and procedure description.

Procedure Code	Procedure Description	Ages 0-14	Ages 15+	Total

3B. Non-Cardiac Catheterization in Cardiac Catheterization Facilities

Report by age and procedure type the total number of catheterization procedures, other than cardiac catheterizations, performed during the report year that were performed in the authorized cardiac catheterization labs or rooms reported in Part C Question 1A.

Procedure Type	Ages 0-14	Ages 15+	Total
Electrophysiologic Studies	0	0	0
Pacemaker Insertions	0	23	23
Angiograms/Venograms	0	65	65
Angioplasty	0	15	15
Stents	0	5	5
Thrombolysis Procedures	0	0	0
Embolizations	0	0	0
Venocava filter insertions	0	1	1
Biliary/Nephrostomy	0	0	0
Perm cath/pic line placements	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	**0**	**109**	**109**

3C. Non-Cardiac Catheterization Procedures Performed in Other Rooms

Report by age and procedure type the total number of catheterization procedures, other than cardiac catheterizations, performed during the report year that were performed in any other room that is equiped and capable of performing cardiac catheterization reported in Part C Question 1C.

Procedure Type	Ages 0-14	Ages 15+	Total
Electrophysiologic Studies	0	0	0
Pacemaker Insertions	0	0	0
Angiograms/Venograms	0	0	0
Angioplasty	0	0	0
Stents	0	0	0
Thrombolysis Procedures	0	0	0
Embolizations	0	0	0
Venocava filter insertions	0	0	0
Biliary/Nephrostomy	0	0	0
Perm cath/pic line placements	0	0	0

	0	0	0
	0	0	0
	0	0	0
Total	**0**	**0**	**0**

3D. Medical Specialties

List all of the medical specialties of the physicians performing non-cardiac catheterization procedures listed in 3B or 3C.

Interventionalist

4. Cardiac Catheterization Patients by Race/Ethnicity

Please report the number who recieved one or more cardiac catheterization procedures during the report period using the race and ethnicity categories provided. Please report patients as unduplicated. A patient should be counted once only.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	55
Hispanic/Latino	3
Pacific Islander/Hawaiian	0
White	135
Multi-Racial	0
Total	**193**

5. Cardiac Catheterization Patients by Gender

Please report the number of cardiac catheterization patients by gender served during the report period. Count a patient only once for an unduplicated patient count.

Gender	Number of Patients
Male	81
Female	112
Total	**193**

Part D : Charges

1. Average Total Charge and Average Actual Reimbursement

If applicable, report the average total charge from admission to discharge (excluding Medicare outliers) for each of the following DRGs and report the average actual reimbursement for each DRG received from Medicare, Medicaid and all third parties (excluding individual self-payors, indigents and those payors whose charge was 'written off'). Please note that Average Total Charges, the number of cases used in the average, and the average reimbursement should be for services provided within authorized cardiac catheterization labs.

Selected DRGs Diseases/Disorders of the Circulatory System	Average Total Inpatient Charge in Lab	Cases Included in Calculation of Average	Actual Hospital Total Cases	Average Reimbursement in Lab
Major Cardiovascular Procedures w/CC(MS-DRG 268-272)	0	0	0	0
Cds w/AMI and CV Complication, Discharged Alive (MS-DRG 280)	42,048	1	1	12,914
Cds w/AMI w/o CV Complication, Discharged Alive (MS-DRG 281 & 282)	31,110	1	3	5
Cds except AMI w/Cardiac Cath and Complex Diagnosis (MS-DRG 286)	60,483	1	12	12,938
Cds except AMI w/Cardiac Cath and Complex Diagnosis (MS-DRG 287)	28,881	1	19	12,561
Heart Failure and Shock (MS-DRG 291, 292, 293)	0	0	0	0
Peripheral Vascular Disorders w/CC (MS-DRG 299)	0	0	0	0
Cardiac arhytmia and conduction disorders w/CC (MS-DRG 308)	0	0	0	0
Angina Pectoris (MS-DRG 311)	0	0	0	0

2. Mean, Median and Range of Total Charges

Where applicable, report the mean, median and range of total charges for all cases for which each of the following ICD-9-CM codes was the principal procedure.

Dilation of Coronary Artery, One Artery

(ICD-10 Codes: 02703ZZ, 02704ZZ, 02703DZ; CPT Codes: 92920, 92928)

Patient Category	Mean	Median	Range Low	Range High	# of Cases Included in Calculations
Inpatient	$0	$0	$0	$0	0
Outpatient	$0	$0	$0	$0	0

Measurement of Cardiac Sampling and Pressure, Left Heart, Percutaneous Approach

(ICD-10 Code: 4A023N7; CPT Codes: 93452, 93458, 93459)

Patient Category	Mean	Median	Range Low	Range High	# of Cases Included in Calculations
Inpatient	$0	$0	$0	$0	0
Outpatient	$0	$0	$0	$0	0

3. Total Charges and Actual Reimbursement for Cardiac Catheterization Services

Please report the total charges and actual reimbursement received for cardiac catheterization services provided during the report period.

Total Charges	Actual Reimbursement
$6,214,074	$1,370,558

4. Total Uncompensated Charges for Cardiac Catheterization Services

Please report the total uncompensatedcharges for cardiac catheterization services provided to patients that qualified as indigent or charity care cases where the facility did not receive any compensation.

Total Uncompensated Charges	Total Uncompensated I/C Patients
$362,730	15

5. Adjusted Gross Revenue for Cardiac Catheterization Services

Please report the Adjusted Gross Revenue for cardiac catheterization services provided during the report period.

Adjusted Gross Revenue
$1,395,732

6. Primary Payment Source

Please report the total number of unduplicated cardiac catheterization patients, procedures, total charges and reimbursement by the patient's PRIMARY payer source. Report Peachcare for Kids patients with Third-Party. Then also provide the number of unduplicated patients, procedures, charges and reimbursement for patients who were qualified as Indigent or Charity Care cases. Patients do not have to balance or be unduplicated between two tables.

	Primary Payment Source				
	Medicare	Medicaid	3rd Party (Including Peachcare)	Individual Self-Pay	I/C Care Account
Number of Cardiac Catheterization Patients (unduplicated)	0	0	23	15	15
Number of Procedures Billed	0	0	23	15	15
Number of Procedures Not Billed or Written Off	0	0	0	0	0
Total Charges	$0	$0	$237,506	$933,314	$362,730
Actual Reimbursement	$0	$0	$73,627	$293,994	$0

Part E : Peer Review, Joint Commission Accreditation, OHS Referrals and Treatment Complicat

1. Check the box to the right if your program/facility participates in an external or national peer review and outcomes reporting system. ☐

If you indicated yes above, please provide the name(s) of the peer review/outcomes reporting organization(s) below.

2. Check the box to the right if your program/facility is Joint Commission ac☑edited.

Enter your accreditation category in the space below.

HOSPITAL

3. How many community education programs has your program/facility participated in during the reporting period?

4

4. OHSS Referrals

If your facility referred patients for open heart surgery services (regardless of whether your facility does or does not provide OHSS), please list the hospital(s) to which patients have been referred and the number referred. If your facility referred patients to out-ofstate providers please select the state from the pull-down menu.

Referral Hospital	Number of Referrals

----------	0
----------	

5. Cardiac Catheterization Treatment Session Complications

Please provide the number of both inpatient and outpatient therapeutic and diagnostic cardiac catheterization sessions which encountered or resulted in major and/or minor complications. (Total therapeutic and total diagnostic catheterization sessions are provided based on what was reported in Part C, Question 2B). Please refer to the instructions for guidelines regarding major versus minor classifications. Report complications occurring during the procedures or before discharge.

Cardiac Catheterization Category	Total Cath Sessions from Part C	Major Complications	Minor Complications	Total Complications
Therapeutic Cardiac Catheterizations Inpatient and Outpatient	0	0	0	0
Diagnostic Cardiac Catheterizations Inpatient and Outpatient	195	0	0	0
Total	**195**	**0**	**0**	**0**

Part F : Patient Origin 2021

Please report the number of cardiac catheterization patients by county and age category. The total number of patients reported here must balance to the totals reported in Part C, Questions 4 and 5.

County	Patients 0-14	Patients 15+	Total
Colquitt	0	193	193
Total Patients	**0**	**193**	**193**

Part G : Comments

Please enter below any comments and suggestions that you have about this survey.

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal oficer) of the facility. The signature can be

completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affimative review of the entire completed survey, this completed survey contans no untrue statement or inaccurate data, nor omits requested material, information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my orginal signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: JULIE BHAVNANI

Title: CFO

Date: 7/11/2022

Comments:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP524

Facility Name: Colquitt Regional Medical Center

County: Colquitt

Street Address: P O Box 40

City: Moultrie

Zip: 31776-0040

Mailing Address: P O Box 40

Mailing City: Moultrie

Mailing Zip: 31776-0040

2. Report Period

Please report data for the hospital fiscal year ending during calender year 2021 only.
Do not use a different report period.

Please indicate your hospital fiscal year.
From: 10/1/2020 To:9/30/2021

Please indicate your cost report year.
From: 10/01/2020 To:09/30/2021

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

3. Trauma Center Designation Change During the Report Period

Check the box to the right if your facility experienced a change in trauma center designation during the report period.
If your facility's trauma center designation changed, provide the date and type of change. ☐

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: julie bhavnani
Contact Title: CFO
Phone: 229-300-2288
Fax: 229-891-9335
E-mail: Jbhavnani@colquittregional.com

Part C : Financial Data and Indigent and Charity Care

1. Financial Table

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
Inpatient Gross Patient Revenue	190,107,090
Total Inpatient Admissions accounting for Inpatient Revenue	5,903
Outpatient Gross Patient Revenue	252,301,739
Total Outpatient Visits accounting for Outpatient Revenue	195,264
Medicare Contractual Adjustments	143,844,179
Medicaid Contractual Adjustments	42,873,522
Other Contractual Adjustments:	84,341,539
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	32,953,128
Gross Indigent Care:	7,820,594
Gross Charity Care:	1,491,696
Uncompensated Indigent Care (net):	7,820,594
Uncompensated Charity Care (net):	1,491,696
Other Free Care:	1,221,952
Other Revenue/Gains:	23,578,509
Total Expenses:	125,159,630

2. Types of Other Free Care

Please enter the amount for each type of other free care. The amounts entered here must equal the total "Other Free Care" reported in Part C. Question 1. Use the blank line to indicate the type description and amount for other free care that is not included in the types listed.

Other Free Care Type	Other Free Care Amount
Self-Pay/Uninsured Discounts	0
Admin Discounts	0
Employee Discounts	1,221,952
	0
Total	**1,221,952**

Part D : Indigent/Charity Care Policies and Agreements

1. Formal Written Policy

Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during 2021? (Check box if yes.) ☐

2. Effective Date

What was the effective date of the policy or policies in effect during 2021?

11/01/2003

3. Person Responsible

Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.?

AVP OF REVENUE CYCLE

4. Charity Care Provisions

Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)? (Check box if yes.) ☑

5. Maximum Income Level

If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?

250%

6. Agreements Concerning the Receipt of Government Funds

Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during 2021? (Check box if yes.) ☐

Part E : Indigent And Charity Care

1. Gross Indigent and Charity Care Charges

Please indicate the totals for indigent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	2,560,712	508,106	3,068,818
Outpatient	5,259,882	983,590	6,243,472
Total	**7,820,594**	**1,491,696**	**9,312,290**

2. Sources of Indigent and Charity Care Funding

Please indicate the source of funding for indigent and/or charity care in the table below.

Source of Funding	Amount
Home County	0
Other Counties	0
City Or Cities	0
Hospital Authority	0
State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	0
Federal Government	0
Non-Government Sources	0
Charitable Contributions	0
Trust Fund From Sale Of Public Hospital	0
All Other	0
Total	**0**

3. Net Uncompensated Indigent and Charity Care Charges

Total net indigent care must balance to Part C net indigent care and total net charity care must balance to Part C net charity care.

Patient Type	Indigent Care	Charity Care	Total
Inpatient	2,560,712	508,106	3,068,818
Outpatient	5,259,882	983,590	6,243,472
Total	**7,820,594**	**1,491,696**	**9,312,290**

Part F : Patient Origin

1. Total Gross Indigent/Charity Care By Charges County

Please report Indigent/Charity Care by County in the following categories. For non Georgia use Alabama, Florida, North Carolina, South Carolina, Tennessee, or Other-Out-of-State.
To add a row press the button. To delete a row press the minus button at the end of the row.
(You may enter the data on the web form or upload the data to the web form using the .csv file.)

Inp Ad-I = Inpatient Admissions (Indigent Care)
Inp Ch-I = Inpatient Charges (Indigent Care)
Out Vis-I = Outpatient Visits (Indigent Care)
Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)
Inp Ch-C = Inpatient Charges (Charity Care)
Out Vis-C = Outpatient Visits (Charity Care)
Out Ch-C = Outpatient Charges (Charity Care)

County	Inp Ad-I	Inp Ch-I	Out Vis-I	Out Ch-I	Inp Ad-C	Inp Ch-C	Out Vis-C	Out Ch-C
Atkinson	0	0	1	3,577	0	0	0	0
Ben Hill	0	0	1	1,296	0	0	0	0
Berrien	0	0	10	51,064	0	0	34	9,120
Brooks	7	40,178	162	351,223	2	2,593	27	22,043
Catoosa	0	0	0	0	0	0	1	1,378
Cobb	1	2	0	0	3	4,382	6	974
Coffee	0	0	4	3,326	0	0	1	948
Colquitt	267	2,225,097	3,703	4,184,404	93	410,594	1,776	796,056
Cook	5	43,965	82	139,783	0	0	21	10,992
Crisp	0	0	0	0	1	32,491	1	0
DeKalb	0	0	0	0	0	0	2	15,362
Dodge	0	0	1	76	0	0	0	0
Dougherty	2	4,828	30	79,444	2	23,292	10	13,080
Franklin	0	0	2	3,755	0	0	0	0
Gwinnett	0	0	0	0	1	485	0	0
Habersham	1	15,663	0	0	0	0	0	0
Irwin	0	0	1	90	0	0	1	613
Lee	1	4,077	8	3,516	0	0	1	1,917
Lowndes	2	3,701	30	11,639	0	0	23	14,288
Macon	0	0	9	1,545	0	0	0	0
Mitchell	3	2,887	72	86,917	2	2,818	34	11,674
Newton	0	0	0	0	1	1,410	12	1,996
Other Out of State	4	101,686	37	63,291	1	1,484	30	11,880
Pierce	0	0	10	24,245	0	0	0	0
Thomas	6	32,143	149	98,273	3	28,557	21	20,883
Tift	6	80,410	106	88,930	0	0	37	38,256
Turner	0	0	7	15,040	0	0	0	0
Twiggs	0	0	0	0	0	0	26	8,864
Webster	0	0	1	299	0	0	0	0
Wilcox	0	0	2	965	0	0	0	0
Worth	4	6,075	26	47,184	0	0	14	3,266
Total	**309**	**2,560,712**	**4,454**	**5,259,882**	**109**	**508,106**	**2,078**	**983,590**

Indigent Care Trust Fund Addendum

1. Indigent Care Trust Fund

Did your hospital receive funds from the Indigent Care Trust Fund during its Fiscal Year 2021? (Check box if yes.) ☐

2. Amount Charged to ICTF

Indicate the amount charged to the ICTF by each State Fiscal Year (SFY) and for each of the patient categories indicated below during Hospital Fiscal Year 2021.

	Patient Category	SFY 2018 7/1/17-6/30/18	SFY2021 7/1/18-6/30/19	SFY2021 7/1/19-6/30/20
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	7,820,594	0
B.	Medically Indigent Patients with incomes between 125% and 200% of the Federal Poverty Level Guidelines where adjustments were made to patient amounts due in accordance with an established sliding scale.	0	1,491,696	0
C.	Other Patients in accordance with the department approved policy.	0	0	0

3. Patients Served

Indicate the number of patients served by SFY.

SFY 2018 7/1/17-6/30/18	SFY2021 7/1/18-6/30/19	SFY2021 7/1/19-6/30/20
0	6,950	0

Reconciliation Addendum

This section is printed in landscape format on a separate PDF file.

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Chief Executive: JAMES L. MATNEY

Date: 7/7/2022

Title: PRESIDENT/CEO

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Financial Officer: JULIE BHAVNANI

Date: 7/7/2022

Title: CFO

Comments:

2021 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum
HOSP524- Colquitt Regional Medical Center

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):											
		Contractual Adj's, Hill Burton, Bad Debt, Gross Indigent and Charity Care, and Other Free Care									
HFS Source:	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part E, 1	Part E, 1	Part C, 1		
	Gross Patient Charges	Medicare Contractual Adjs	Medicaid Contractual Adjs	Other Contractual Adjs	Hill Burton Obligations	Bad Debt	Gross Indigent Care (IP & OP)	Gross Charity Care (IP & OP)	Other Free Care	Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	1	2	3	4	5	6	7	8	9	10	11
Inpatient Gross Patient Revenue	190,107,090										
Outpatient Gross Patient Revenue	252,301,739										
Per Part C, 1. Financial Table		143,844,179	42,873,522	84,341,539	0	32,953,128			1,221,952		
Per Part E, 1. Indigent and Charity Care							7,820,594	1,491,696			
Totals per HFS	442,408,829	143,844,179	42,873,522	84,341,539	0	32,953,128	7,820,594	1,491,696	1,221,952	314,546,610	127,862,219
Section 2: Reconciling Items to Financial Statements:									(B)		(B)
Non-Hospital Services:											
> Professional Fees	19,079,766									11,973,085	
> Home Health Agency	3,261,889									528,844	
> SNF/NF Swing Bed Services	1,066,375									750,920	
> Nursing Home	0									0	
> Hospice	2,282,503									310,989	
> Freestanding Ambulatory Surg. Centers	0									0	
> PRIVATE DUTY	459,084									0	
> CLINICS	70,166,273									46,299,099	
> RHC	2,714,199									1,532,210	
> AMBULANCE	5,584,210									3,620,319	
> DIALYSIS	77,880,713									54,842,021	
> NA	0									0	
Bad Debt (Expense per Financials) (A)										0	
Indigent Care Trust Fund Income										0	
Other Reconciling Items:											
> ICTF	0									-6,693,808	
> CARES FUNDS	0									-1,789,323	
> NA	0									0	
> NA	0									0	
Total Reconciling Items	182,495,012									111,374,356	71,120,656
Total Per Form	624,903,841									425,920,966	198,982,875
Total Per Financial Statements	624,903,841										198,982,875
Unreconciled Difference (Must be Zero)	0										0

(A) Due to specific differences in the presentation of data on the HFS, Bad Debt per Financials may differ from the amount reported on the HFS-proper (Part C).

(B) Taxable Net Patient Revenue will equal Net Patient Revenue in Section 1 column 11, plus Other Free Care in Section 1 column 9.

Compensation/Benefits Report – Administrative Positions in Colquitt Regional Medical Center (HB 321)						
(A) Position Title					**(B) Retirement and other Deferred Compensation**	**(C) Nontaxable Benefits**
	(i) Base Compensation	(ii) Bonus & Incentive Comp.	(iii) Taxable Deferred Comp. Accrued in Prior Years	(iv) Other Reportable Compensation		
President	$1,090,925.93	$341,636.38	$0.00	$180,798.00	$122,000.00	$10,000.00
Vice President	$532,271.57	$72,535.45	$0.00	$0.00	$107,685.06	$0.00
Vice President	$330,115.66	$44,810.82	$0.00	$0.00	$66,058.83	$0.00
Vice President	$253,971.50	$59,048.79	$0.00	$0.00	$47,946.78	$0.00
Vice President	$328,130.15	$44,926.00	$0.00	$0.00	$63,266.50	$0.00
Vice President	$324,017.72	$43,616.48	$0.00	$0.00	$64,140.21	$0.00
Vice President	$300,337.44	$41,271.91	$0.00	$0.00	$62,548.70	$0.00
Vice President	$180,678.44	$24,713.41	$0.00	$0.00	$36,290.36	$0.00
Asst Vice President	$197,428.99	$27,272.64	$0.00	$0.00	$19,479.54	$0.00
Vice President	$211,047.78	$53,739.25	$0.00	$0.00	$17,939.95	$0.00

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet S Parts I-III Date/Time Prepared: 3/31/2023 2:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: 3/31/2023 Time: 2:25 pm
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR Of PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COLQUITT REGIONAL MEDICAL CENTER (11-0105) for the cost reporting period beginning 10/01/2021 and ending 09/30/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	Julie Bhavnani		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Julie Bhavnani			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	-346,592	-464,939	0	2,297,096	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	-21,617	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		24,978		0	10.00
200.00	TOTAL	0	-368,209	-439,961	0	2,297,096	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 3131 SOUTH MAIN STREET	PO Box: 40			1.00
2.00	City: MOULTRIE	State: GA	Zip Code: 31768-	County: COLQUITT	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	COLQUITT REGIONAL MEDICAL CENTER	110105	99911	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	COLQUITT REGIONAL MEDICAL CENTER SWB	11U105	99911		04/16/2013	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	COLQUITT REGIONAL SENIOR CARE	115667	99911		03/01/2022	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	CRMC HOSPICE	111542	99911		07/15/1998				14.00
15.00	Hospital-Based Health Clinic - RHC	COLQUITT REGIONAL RHC	113422	99911		03/01/1995	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis	COLQUITT REGIONAL DIALYSIS UNIT	112314	99911		01/01/2004				18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2021	09/30/2022	20.00
21.00	Type of Control (see instructions)	9		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,716	327	0	0	2,239	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	10/01/2021	09/30/2022	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	Y	Y		56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.	Y			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/31/2023 2:25 pm

		V	XVIII	XIX	
		1.00	2.00	3.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/31/2023 2:25 pm

				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part I Date/Time Prepared: 3/31/2023 2:25 pm

		1.00	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)		
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments	
		1.00	2.00	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		0	88.00

		Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	0.00		0	89.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/31/2023 2:25 pm

		V	XIX	
		1.00	2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N			112.00
113.00	Did this hospital participate in the Community Health Access and Rural Transformation (CHART) model for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no.				113.00
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,638,000	70,940	1,405,252	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	Y		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	Y	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.			123.00
	Certified Transplant Center Information			
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part I Date/Time Prepared: 3/31/2023 2:25 pm

					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)			168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		9.99	169.00
		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Y/N	Date	
		1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE			
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	01/23/2023	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Y	01/19/2023	Y	01/19/2023	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-2 Part II Date/Time Prepared: 3/31/2023 2:25 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BERT	BENNETT	41.00
42.00	Enter the employer/company name of the cost report preparer.	DRAFFIN & TUCKER, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	229-883-7878	BBENNETT@DRAFFIN-TUCKER.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet S-2 Part II Date/Time Prepared: 3/31/2023 2:25 pm

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CPA/PARTNER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I Date/Time Prepared: 3/31/2023 2:25 pm

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	89	32,485	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		89	32,485	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	10	3,650	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36,135	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	59	12,567		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	35	12,775			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		193				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		4	1,460			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	5,725	1,932	24,024			1.00
2.00	HMO and other (see instructions)	9,809	2,566				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	92	0	92			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	424			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,817	1,932	24,540			7.00
8.00	INTENSIVE CARE UNIT	1,004	424	3,011			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		182	1,181			13.00
14.00	Total (see instructions)	6,821	2,538	28,732	17.47	1,156.68	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	257	8,293	11,078	0.00	26.56	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	12.13	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,550	9,339	17,153	0.00	16.29	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				17.47	1,211.66	27.00
28.00	Observation Bed Days		59	1,594			28.00
29.00	Ambulance Trips	1,466					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	178	229			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,277	620	5,939	1.00
2.00	HMO and other (see instructions)			1,820	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1,277	620	5,939	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part II Date/Time Prepared: 3/31/2023 2:25 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	80,487,926	0	80,487,926	2,465,013.00	32.65	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	377,872	377,872	2,717.00	139.08	4.01
5.00	Physician and Non Physician-Part B		0	249,908	249,908	2,388.00	104.65	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		434,997	0	434,997	33,893.00	12.83	6.00
7.00	Interns & residents (in an approved program)	21.00	2,126,364	-303,120	1,823,244	36,336.00	50.18	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,325,949	0	1,325,949	55,242.00	24.00	9.00
10.00	Excluded area salaries (see instructions)		13,368,191	-999,700	12,368,491	495,443.00	24.96	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		174,228	0	174,228	647.00	269.29	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		15,074,964	0	15,074,964			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,780,552	0	2,780,552			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		84,949	0	84,949			22.01
23.00	Physician Part B		56,182	0	56,182			23.00
24.00	Wage-related costs (RHC/FQHC)		97,791	0	97,791			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	822,514	0	822,514	17,656.00	46.59	26.00
27.00	Administrative & General	5.00	18,518,553	337,426	18,855,979	475,261.00	39.67	27.00
28.00	Administrative & General under contract (see inst.)		343,770	0	343,770	1,992.00	172.58	28.00
29.00	Maintenance & Repairs	6.00	1,356,925	0	1,356,925	65,829.00	20.61	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	69,172	0	69,172	3,708.00	18.65	31.00
32.00	Housekeeping	9.00	1,141,229	0	1,141,229	72,428.00	15.76	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,192,978	-748,483	444,495	29,786.00	14.92	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	748,483	748,483	38,007.00	19.69	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	675,601	386,954	1,062,555	20,290.00	52.37	38.00
39.00	Central Services and Supply	14.00	812,731	-270,022	542,709	26,364.00	20.59	39.00
40.00	Pharmacy	15.00	1,338,933	-202,907	1,136,026	31,428.00	36.15	40.00
41.00	Medical Records & Medical Records Library	16.00	314,334	0	314,334	16,493.00	19.06	41.00
42.00	Social Service	17.00	173,673	0	173,673	11,096.00	15.65	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part III Date/Time Prepared: 3/31/2023 2:25 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		78,270,335	-324,660	77,945,675	2,391,671.00	32.59	1.00
2.00	Excluded area salaries (see instructions)		14,694,140	-999,700	13,694,440	550,685.00	24.87	2.00
3.00	Subtotal salaries (line 1 minus line 2)		63,576,195	675,040	64,251,235	1,840,986.00	34.90	3.00
4.00	Subtotal other wages & related costs (see inst.)		174,228	0	174,228	647.00	269.29	4.00
5.00	Subtotal wage-related costs (see inst.)		15,074,964	0	15,074,964	0.00	23.46	5.00
6.00	Total (sum of lines 3 thru 5)		78,825,387	675,040	79,500,427	1,841,633.00	43.17	6.00
7.00	Total overhead cost (see instructions)		26,760,413	251,451	27,011,864	810,338.00	33.33	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part IV Date/Time Prepared: 3/31/2023 2:25 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	3,367,846	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	81,600	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,674,113	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	72,520	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	63,885	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	402,006	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,358,756	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	6,983	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	66,729	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	18,094,438	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-3 Part V Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	18,094,438	1.00
2.00	Hospital	0	15,058,724	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	298,792	8.00
9.00	NURSING FACILITY			9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice	0	174,969	13.00
14.00	Hospital-Based Health Clinic RHC	0	159,282	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	2,402,671	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-5 | Date/Time Prepared: 3/31/2023 2:25 pm

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	80	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	3.00	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	4.50	0.00	0.00	0.00			3.00
4.00	CAPD exchanges per day				0.00		0.00	4.00
5.00	Number of days in year dialysis furnished	313	0					5.00
6.00	Number of stations	26	0	0	0			6.00
7.00	Treatment capacity per day per station	2	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00

		Y/N	
		1.00	
	ESRD PPS		
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" for yes or "N" for no. (see instructions)	N	10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)	Y	10.02

		Prior to 1/1	After 12/31	
		1.00	2.00	
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)	0	0	10.03
	TRANSPLANT INFORMATION			
11.00	Number of patients on transplant list	2		11.00
12.00	Number of patients transplanted during the cost reporting period	2		12.00
	EPOETIN			
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
	ARANESP			
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

		MCP	INITIAL METHOD	
		1.00	2.00	
	PHYSICIAN PAYMENT METHOD			
21.00	Enter "X" if method(s) is applicable	X		21.00

		ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1.00	2.00	3.00	4.00	5.00	
	ESAs						
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)	EPOGEN	158,559	0	81,372,000	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-5 | Date/Time Prepared: 3/31/2023 2:25 pm

		CCN	Treatments	
		1.00	2.00	
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)		0	23.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA | Provider CCN: 11-0105 | Component CCN: 11-3422 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-8 | Date/Time Prepared: 3/31/2023 2:25 pm

RHC I | Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			3131 SOUTH MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	MOULTRIE		GA	31768	2.00
					1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
			Grant Award		Date	
			1.00		2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)					5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)					6.00
7.00	Appalachian Regional Commission					7.00
8.00	Look-Alikes					8.00
9.00	OTHER (SPECIFY)					9.00
9.01	OTHER (SPECIFY)					9.01
9.02	OTHER (SPECIFY)					9.02
9.03	OTHER (SPECIFY)					9.03
9.04	OTHER (SPECIFY)					9.04
9.05	OTHER (SPECIFY)					9.05
9.06	OTHER (SPECIFY)					9.06
9.07	OTHER (SPECIFY)					9.07
9.08	OTHER (SPECIFY)					9.08
9.09	OTHER (SPECIFY)					9.09
9.10	OTHER (SPECIFY)					9.10
				1.00	2.00	
10.00	Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	CLINIC			09:00	18:00	09:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
				Provider name	CCN	
				1.00	2.00	
14.00	RHC/FQHC name, CCN					14.00

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00

HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	Provider CCN: 11-0105 Component CCN: 11-3422	Period: From 10/01/2021 To 09/30/2022	Worksheet S-8 Date/Time Prepared: 3/31/2023 2:25 pm
		RHC I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		COLQUITT				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	18:00	09:00	18:00	09:00	18:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	CLINIC	09:00	18:00	09:00	12:00		11.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015							
6.00	Number of patients receiving hospice care							6.00
7.00	Total number of unduplicated Continuous Care hours billable to Medicare							7.00
8.00	Average Length of Stay (line 5 / line 6)							8.00
9.00	Unduplicated census count							9.00

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	0	0	0	0	10.00
11.00	Hospice Routine Home Care	11,464	438	332	12,234	11.00
12.00	Hospice Inpatient Respite Care	20	0	0	20	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	11,484	438	332	12,254	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet S-10 | Date/Time Prepared: 3/31/2023 2:25 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.248600	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	12,036,994	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	3,871,071	5.00
6.00	Medicaid charges	64,258,815	6.00
7.00	Medicaid cost (line 1 times line 6)	15,974,741	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	66,676	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	24,435	9.00
10.00	Stand-alone CHIP charges	1,347,594	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	335,012	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	310,577	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	377,253	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,048,843	557,797	6,606,640	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,503,742	557,797	2,061,539	21.00
22.00	Payments received from patients for amounts previously written off as charity care	14,485	2,992	17,477	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,489,257	554,805	2,044,062	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	27,006,142	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	672,239	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,034,213	27.01
28.00	Non-Medicare bad debt expense (see instructions)	25,971,929	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	6,818,596	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	8,862,658	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	9,239,911	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		5,486,250	5,486,250	1,970,552	7,456,802	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		7,261,639	7,261,639	1,788,609	9,050,248	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	822,514	10,972,165	11,794,679	933,626	12,728,305	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,518,553	17,130,481	35,649,034	-1,440,578	34,208,456	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,356,925	3,367,169	4,724,094	0	4,724,094	6.00
7.00	00700	OPERATION OF PLANT	0	1,771,181	1,771,181	-15,061	1,756,120	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,172	631,708	700,880	0	700,880	8.00
9.00	00900	HOUSEKEEPING	1,141,229	370,837	1,512,066	-34,637	1,477,429	9.00
10.00	01000	DIETARY	1,192,978	1,252,762	2,445,740	-1,534,753	910,987	10.00
11.00	01100	CAFETERIA	0	0	0	1,534,475	1,534,475	11.00
13.00	01300	NURSING ADMINISTRATION	675,601	182,988	858,589	386,954	1,245,543	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	812,731	192,533	1,005,264	-302,874	702,390	14.00
15.00	01500	PHARMACY	1,338,933	7,356,123	8,695,056	-1,522,390	7,172,666	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	314,334	152,828	467,162	-8,926	458,236	16.00
17.00	01700	SOCIAL SERVICE	173,673	14,794	188,467	0	188,467	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,126,364	0	2,126,364	-303,120	1,823,244	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	368,891	368,891	377,872	746,763	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,300,075	3,754,721	17,054,796	-230,997	16,823,799	30.00
31.00	03100	INTENSIVE CARE UNIT	2,311,850	251,269	2,563,119	86	2,563,205	31.00
40.00	04000	SUBPROVIDER - IPF	439,106	155,958	595,064	-595,064	0	40.00
43.00	04300	NURSERY	156,845	42,328	199,173	348,742	547,915	43.00
44.00	04400	SKILLED NURSING FACILITY	1,325,949	1,318,361	2,644,310	0	2,644,310	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,720,016	2,958,096	5,678,112	-1,552,715	4,125,397	50.00
51.00	05100	RECOVERY ROOM	450,883	39,902	490,785	0	490,785	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	218,586	71,848	290,434	476,975	767,409	52.00
53.00	05300	ANESTHESIOLOGY	1,661,369	2,582,054	4,243,423	22,003	4,265,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,880,159	1,624,415	4,504,574	-491,970	4,012,604	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	225,990	305,271	531,261	0	531,261	54.01
57.00	05700	CT SCAN	811,500	245,833	1,057,333	0	1,057,333	57.00
60.00	06000	LABORATORY	2,278,236	2,815,377	5,093,613	-11,333	5,082,280	60.00
65.00	06500	RESPIRATORY THERAPY	1,151,343	174,553	1,325,896	-40,977	1,284,919	65.00
66.00	06600	PHYSICAL THERAPY	2,171,230	394,497	2,565,727	-42,166	2,523,561	66.00
69.00	06900	ELECTROCARDIOLOGY	1,144,093	1,204,956	2,349,049	-419,532	1,929,517	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,723,841	15,723,841	0	15,723,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,136,763	2,136,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,033,752	4,033,752	-158,559	3,875,193	73.00
74.00	07400	RENAL DIALYSIS	1,100,889	414,482	1,515,371	157,356	1,672,727	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	694,152	1,030,702	1,724,854	199,630	1,924,484	88.00
90.00	09000	CLINIC	701,755	1,640,752	2,342,507	-770	2,341,737	90.00
90.01	09001	URGENT CARE	0	2,811	2,811	-2,811	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,271,808	1,043,670	4,315,478	657	4,316,135	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,631,782	448,970	2,080,752	-31,322	2,049,430	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,481,514	1,481,514	-1,481,514	0	113.00
116.00	11600	HOSPICE	752,355	635,158	1,387,513	-156,388	1,231,125	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,942,978	100,907,440	170,850,418	-44,157	170,806,261	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288,291	288,291	-195	288,096	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,578,961	18,003,526	24,582,487	-1,022,486	23,560,001	192.00
194.00	07950	CRH	264,091	475,202	739,293	-739,292	1	194.00
194.01	07951	HOME HEALTH	1,319,205	378,083	1,697,288	3,772	1,701,060	194.01
194.02	07952	COMM CARE	199,518	55,745	255,263	0	255,263	194.02
194.03	07953	FOUNDATION	170,054	114,312	284,366	0	284,366	194.03
194.04	07954	TRANSPORT	277,972	180,995	458,967	0	458,967	194.04
194.05	07955	PRIVATE DUTY NURSING	319,230	44,545	363,775	-553	363,222	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	770,124	770,124	194.06
194.07	07957	KIRK CLINIC	1,207,944	2,208,833	3,416,777	-150,521	3,266,256	194.07
194.08	07958	NORMAN PARK FM CLINIC	207,973	108,235	316,208	22,429	338,637	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	1,160,879	1,160,879	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	80,487,926	122,765,207	203,253,133	0	203,253,133	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-662,893	6,793,909		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-25,831	9,024,417		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-81,481	12,646,824		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-416,354	33,792,102		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	4,724,094		6.00
7.00	00700	OPERATION OF PLANT	-43,403	1,712,717		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	700,880		8.00
9.00	00900	HOUSEKEEPING	0	1,477,429		9.00
10.00	01000	DIETARY	0	910,987		10.00
11.00	01100	CAFETERIA	-779,668	754,807		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,245,543		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	702,390		14.00
15.00	01500	PHARMACY	0	7,172,666		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-301	457,935		16.00
17.00	01700	SOCIAL SERVICE	0	188,467		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,823,244		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-144,053	602,710		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,207,671	14,616,128		30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,563,205		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	547,915		43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,644,310		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,125,397		50.00
51.00	05100	RECOVERY ROOM	0	490,785		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	767,409		52.00
53.00	05300	ANESTHESIOLOGY	-2,023,199	2,242,227		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,012,604		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	531,261		54.01
57.00	05700	CT SCAN	0	1,057,333		57.00
60.00	06000	LABORATORY	0	5,082,280		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,284,919		65.00
66.00	06600	PHYSICAL THERAPY	-733,990	1,789,571		66.00
69.00	06900	ELECTROCARDIOLOGY	-185,157	1,744,360		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15,723,841		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,136,763		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,875,193		73.00
74.00	07400	RENAL DIALYSIS	0	1,672,727		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,924,484		88.00
90.00	09000	CLINIC	-1,172,124	1,169,613		90.00
90.01	09001	URGENT CARE	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	-619,300	3,696,835		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	2,049,430		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	1,231,125		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-9,095,425	161,710,836		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288,096		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	23,560,001		192.00
194.00	07950	CRH	0	1		194.00
194.01	07951	HOME HEALTH	0	1,701,060		194.01
194.02	07952	COMM CARE	0	255,263		194.02
194.03	07953	FOUNDATION	0	284,366		194.03
194.04	07954	TRANSPORT	0	458,967		194.04
194.05	07955	PRIVATE DUTY NURSING	0	363,222		194.05
194.06	07956	PUBLIC RELATIONS	0	770,124		194.06
194.07	07957	KIRK CLINIC	0	3,266,256		194.07
194.08	07958	NORMAN PARK FM CLINIC	0	338,637		194.08
194.09	07959	RETAIL PHARMACY	0	1,160,879		194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-9,095,425	194,157,708		200.00

RECLASSIFICATIONS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 3/31/2023 2:25 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	748,483	785,992		1.00
	0		748,483	785,992		
	B - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	820,985		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
	0		0	820,985		
	C - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,342,320		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	35,716		2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	103,478		3.00
	0		0	1,481,514		
	D - CENTRAL STERILE					
1.00	ADULTS & PEDIATRICS	30.00	4,304	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	86	0		2.00
3.00	NURSERY	43.00	35	0		3.00
4.00	OPERATING ROOM	50.00	215,746	0		4.00
5.00	ANESTHESIOLOGY	53.00	24,277	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	925	0		6.00
7.00	CLINIC	90.00	23,110	0		7.00
8.00	EMERGENCY	91.00	657	0		8.00
9.00	AMBULANCE SERVICES	95.00	173	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	709	0		10.00
	0		270,022	0		
	E - CLINIC					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	14,464		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	16,043		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	391,369		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	14,183	39,957		4.00
5.00	RURAL HEALTH CLINIC	88.00	249,908	13,368		5.00
	0		264,091	475,201		
	F - NURSING ADMIN					
1.00	NURSING ADMINISTRATION	13.00	386,954			1.00
	0		386,954	0		
	G - LABOR AND DELIVERY AND NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	432,474	44,501		1.00
2.00	NURSERY	43.00	316,173	32,534		2.00
	0		748,647	77,035		
	H - URGENT CARE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,811		1.00
	TOTALS		0	2,811		
	I - PUBLIC RELATIONS					
1.00	PUBLIC RELATIONS	194.06	178,817	591,307		1.00
	0		178,817	591,307		
	J - EPOETIN					
1.00	RENAL DIALYSIS	74.00		158,559		1.00
	0		0	158,559		

RECLASSIFICATIONS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 3/31/2023 2:25 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	K - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00		613,768		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00		812,387		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	0		0	1,426,155		
	L - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00		2,136,763		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		0	2,136,763		
	M - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	542,257		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	542,257		
	N - EDUCATION AND TRAINING					
1.00	ADMINISTRATIVE & GENERAL	5.00	280,885	210,655		1.00
	0		280,885	210,655		
	O - INTERNS AND RESIDENTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	608,129	0		1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	377,872	0		2.00
	0		986,001	0		
	P - SPEECH THERAPY					
1.00	HOME HEALTH	194.01	3,772			1.00
	0		3,772	0		
	Q - RHC PHYSICIANS					
1.00	NORMAN PARK FM CLINIC	194.08		29,006		1.00
	0		0	29,006		
	R - RETAIL PHARMACY					
1.00	RETAIL PHARMACY	194.09	202,907	957,972		1.00
	TOTALS		202,907	957,972		
	S - PSYCH SUBPROVIDER					
1.00	ADULTS & PEDIATRICS	30.00	439,106	155,958		1.00
	TOTALS		439,106	155,958		
500.00	Grand Total: Increases		4,509,685	9,852,170		500.00

RECLASSIFICATIONS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 3/31/2023 2:25 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA						
1.00	DIETARY	10.00	748,483	785,992	0		1.00
	0		748,483	785,992			
	B - RENTAL EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	66,502	10		1.00
2.00	OPERATION OF PLANT	7.00	0	37	0		2.00
3.00	HOUSEKEEPING	9.00	0	34,637	0		3.00
4.00	DIETARY	10.00	0	278	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	28,254	0		5.00
6.00	PHARMACY	15.00	0	361,511	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	8,926	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	367	0		8.00
9.00	OPERATING ROOM	50.00	0	22,876	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	2,274	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	420	0		11.00
12.00	LABORATORY	60.00	0	210	0		12.00
13.00	RESPIRATORY THERAPY	65.00	0	40,977	0		13.00
14.00	PHYSICAL THERAPY	66.00	0	36,202	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	31,429	0		15.00
16.00	RENAL DIALYSIS	74.00	0	1,193	0		16.00
17.00	RURAL HEALTH CLINIC	88.00	0	6,026	0		17.00
18.00	CLINIC	90.00	0	21,730	0		18.00
19.00	HOSPICE	116.00	0	156,388	0		19.00
20.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	195	0		20.00
21.00	PRIVATE DUTY NURSING	194.05	0	553	0		21.00
	0		0	820,985			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	1,378,036	11		1.00
2.00	INTEREST EXPENSE	113.00	0	103,478	11		2.00
3.00		0.00	0	0	11		3.00
	0		0	1,481,514			
	D - CENTRAL STERILE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	270,022	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
	0		270,022	0			
	E - CLINIC						
1.00	CRH	194.00	264,091	475,201	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	0		264,091	475,201			
	F - NURSING ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00	386,954	0	0		1.00
	0		386,954	0			
	G - LABOR AND DELIVERY AND NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	748,647	77,035	0		1.00
2.00		0.00	0	0	0		2.00
	0		748,647	77,035			
	H - URGENT CARE						
1.00	URGENT CARE	90.01	0	2,811	0		1.00
	TOTALS		0	2,811			
	I - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	178,817	591,307	0		1.00
	0		178,817	591,307			
	J - EPOETIN						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	158,559	0		1.00
	0		0	158,559			
	K - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00		1,370,807	12		1.00
2.00	OPERATION OF PLANT	7.00		15,024	12		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00		4,598			3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00		10			4.00
5.00	LABORATORY	60.00		2,019			5.00
6.00	PHYSICAL THERAPY	66.00		2,192			6.00

RECLASSIFICATIONS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-6 | Date/Time Prepared: 3/31/2023 2:25 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
7.00	RENAL DIALYSIS	74.00		10			7.00
8.00	AMBULANCE SERVICES	95.00		31,495	0		8.00
	0		0	1,426,155			
	L - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00		1,745,585	0		1.00
2.00	ELECTROCARDIOLOGY	69.00		389,028	0		2.00
3.00	CLINIC	90.00		2,150	0		3.00
	0		0	2,136,763			
	M - EMPLOYEE BENEFITS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,316	0		1.00
2.00	LABORATORY	60.00	0	9,104	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	57,620	0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14,193	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	328,932	0		5.00
6.00	KIRK CLINIC	194.07	0	121,515	0		6.00
7.00	NORMAN PARK FM CLINIC	194.08	0	6,577	0		7.00
	0		0	542,257			
	N - EDUCATION AND TRAINING						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	280,885	210,655	0		1.00
	0		280,885	210,655			
	O - INTERNS AND RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	303,120	0	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	682,881	0	0		2.00
	0		986,001	0			
	P - SPEECH THERAPY						
1.00	PHYSICAL THERAPY	66.00	3,772	0	0		1.00
	0		3,772	0			
	Q - RHC PHYSICIANS						
1.00	KIRK CLINIC	194.07		29,006	0		1.00
	0		0	29,006			
	R - RETAIL PHARMACY						
1.00	PHARMACY	15.00	202,907	957,972	0		1.00
	TOTALS		202,907	957,972			
	S - PSYCH SUBPROVIDER						
1.00	SUBPROVIDER - IPF	40.00	439,106	155,958	0		1.00
	TOTALS		439,106	155,958			
500.00	Grand Total: Decreases		4,509,685	9,852,170			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,616,040	418,966	0	418,966	0	1.00
2.00	Land Improvements	3,784,337	1,271,850	0	1,271,850	0	2.00
3.00	Buildings and Fixtures	113,673,318	9,763,147	0	9,763,147	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	19,860,857	496,360	0	496,360	0	5.00
6.00	Movable Equipment	104,600,449	6,130,198	0	6,130,198	427,695	6.00
7.00	HIT designated Assets	88,874	0	0	0	88,874	7.00
8.00	Subtotal (sum of lines 1-7)	243,623,875	18,080,521	0	18,080,521	516,569	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	243,623,875	18,080,521	0	18,080,521	516,569	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,035,006	0	1.00
2.00	Land Improvements	5,056,187	0	2.00
3.00	Buildings and Fixtures	123,436,465	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	20,357,217	0	5.00
6.00	Movable Equipment	110,302,952	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	261,187,827	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	261,187,827	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part II | Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	5,486,250	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,261,639	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,747,889	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	5,486,250		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	7,261,639		2.00
3.00	Total (sum of lines 1-2)	0	12,747,889		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-7 Part III Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	150,884,875	0	150,884,875	0.577687	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	110,302,953	0	110,302,953	0.422313	0	2.00
3.00	Total (sum of lines 1-2)	261,187,828	0	261,187,828	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	5,526,852	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,270,185	820,985	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,797,037	820,985	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	653,289	613,768	0	0	6,793,909	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	120,860	812,387	0	0	9,024,417	2.00
3.00	Total (sum of lines 1-2)	774,149	1,426,155	0	0	15,818,326	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-689,031	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-18,334	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-4,588	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-86,997	ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-20,968	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-43,403	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-5,790,867			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-779,668	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	0	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-301	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8 | Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MISCELLANEOUS REVENUE	B	-1,691	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN OFFICE BILLING COSTS	A	-18,585	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	SWITCHBOARD SALARIES	A	-4,506	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	34.01
35.00	PATIENT TELEPHONE DEPRECIATION	A	-2,991	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	35.00
36.00	TV DEPRECIATION	A	-9,135	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PHYSICIAN RECRUITMENT	A	-233,246	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	PHYSICIAN RECRUITMENT	A	-733,990	PHYSICAL THERAPY	66.00	0	36.02
36.03	PHYSICIAN RECRUITMENT	A	-32,463	ADMINISTRATIVE & GENERAL	5.00	0	36.03
37.00	AHA DUES - LOBBYING EXPENSE	A	-6,680	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	GHA DUES - LOBBYING EXPENSE	A	-11,136	ADMINISTRATIVE & GENERAL	5.00	0	38.00
40.00	BOND ISSUANCE COSTS	A	30,647	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	40.00
42.00	JAIL REVENUE	A	-516,979	ADULTS & PEDIATRICS	30.00	0	42.00
44.00	LIFE INSURANCE PROCEEDS	A	-72,346	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	HOSPICE PAYMENTS TO NF	A	-43,658	ADULTS & PEDIATRICS	30.00	0	45.00
46.00	DONATED ASSET DEPRECATION	A	-4,509	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-9,095,425				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet A-8-2 | Date/Time Prepared: 3/31/2023 2:25 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	377,872	0	377,872	179,000	2,717	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,647,034	1,647,034	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	2,023,199	2,023,199	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	185,157	185,157	0	0	0	4.00
5.00	90.00	CLINIC	1,172,124	1,172,124	0	0	0	5.00
6.00	91.00	EMERGENCY	619,300	619,300	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,024,686	5,646,814	377,872		2,717	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	233,819	11,691	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			233,819	11,691	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	233,819	144,053	144,053		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,647,034		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	2,023,199		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	185,157		4.00
5.00	90.00	CLINIC	0	0	0	1,172,124		5.00
6.00	91.00	EMERGENCY	0	0	0	619,300		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	233,819	144,053	5,790,867		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	6,793,909	6,793,909				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	9,024,417		9,024,417			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,646,824	23,841	31,165	12,701,830		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	33,792,102	568,807	743,557	3,006,402	38,110,868	5.00
6.00	00600	MAINTENANCE & REPAIRS	4,724,094	0	0	216,348	4,940,442	6.00
7.00	00700	OPERATION OF PLANT	1,712,717	1,152,115	1,506,068	0	4,370,900	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	700,880	12,802	16,734	11,029	741,445	8.00
9.00	00900	HOUSEKEEPING	1,477,429	64,772	84,671	181,958	1,808,830	9.00
10.00	01000	DIETARY	910,987	102,794	134,375	70,870	1,219,026	10.00
11.00	01100	CAFETERIA	754,807	5,074	6,633	119,338	885,852	11.00
13.00	01300	NURSING ADMINISTRATION	1,245,543	18,385	24,033	169,414	1,457,375	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	702,390	164,169	214,605	86,530	1,167,694	14.00
15.00	01500	PHARMACY	7,172,666	54,475	71,211	181,128	7,479,480	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	457,935	39,891	52,146	50,117	600,089	16.00
17.00	01700	SOCIAL SERVICE	188,467	8,471	11,073	27,690	235,701	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,823,244	0	0	290,698	2,113,942	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	602,710	57,893	75,679	60,248	796,530	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,616,128	902,454	1,179,705	2,071,897	18,770,184	30.00
31.00	03100	INTENSIVE CARE UNIT	2,563,205	196,863	257,343	368,615	3,386,026	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	547,915	36,621	47,872	75,424	707,832	43.00
44.00	04400	SKILLED NURSING FACILITY	2,644,310	0	0	211,409	2,855,719	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,125,397	436,440	570,523	468,078	5,600,438	50.00
51.00	05100	RECOVERY ROOM	490,785	23,798	31,110	71,889	617,582	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	767,409	48,446	63,330	103,805	982,990	52.00
53.00	05300	ANESTHESIOLOGY	2,242,227	19,892	26,004	268,759	2,556,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,012,604	227,689	297,639	414,428	4,952,360	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	531,261	25,009	32,692	36,032	624,994	54.01
57.00	05700	CT SCAN	1,057,333	17,982	23,506	129,386	1,228,207	57.00
60.00	06000	LABORATORY	5,082,280	110,883	144,948	363,242	5,701,353	60.00
65.00	06500	RESPIRATORY THERAPY	1,284,919	25,582	33,441	183,570	1,527,512	65.00
66.00	06600	PHYSICAL THERAPY	1,789,571	276,750	361,774	345,580	2,773,675	66.00
69.00	06900	ELECTROCARDIOLOGY	1,744,360	144,256	188,574	182,562	2,259,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	15,723,841	0	0	0	15,723,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,136,763	0	0	0	2,136,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,875,193	3,906	5,106	0	3,884,205	73.00
74.00	07400	RENAL DIALYSIS	1,672,727	232,826	304,355	175,526	2,385,434	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,924,484	262,760	343,485	150,521	2,681,250	88.00
90.00	09000	CLINIC	1,169,613	18,767	24,533	115,572	1,328,485	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,696,835	252,145	329,609	521,762	4,800,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,049,430	20,232	26,448	260,171	2,356,281	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,231,125	32,418	42,377	119,955	1,425,875	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,710,836	5,589,208	7,306,324	11,109,953	157,196,165	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	288,096	16,793	21,952	0	326,841	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,560,001	1,160,033	1,516,420	940,184	27,176,638	192.00
194.00	07950	CRH	1	0	0	0	1	194.00
194.01	07951	HOME HEALTH	1,701,060	0	143,283	210,935	2,055,278	194.01
194.02	07952	COMM CARE	255,263	0	0	31,811	287,074	194.02
194.03	07953	FOUNDATION	284,366	0	0	27,113	311,479	194.03
194.04	07954	TRANSPORT	458,967	0	0	44,320	503,287	194.04
194.05	07955	PRIVATE DUTY NURSING	363,222	27,875	36,438	50,898	478,433	194.05
194.06	07956	PUBLIC RELATIONS	770,124	0	0	28,511	798,635	194.06
194.07	07957	KIRK CLINIC	3,266,256	0	0	192,595	3,458,851	194.07
194.08	07958	NORMAN PARK FM CLINIC	338,637	0	0	33,159	371,796	194.08
194.09	07959	RETAIL PHARMACY	1,160,879	0	0	32,351	1,193,230	194.09
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	194,157,708	6,793,909	9,024,417	12,701,830	194,157,708	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	38,110,868					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,206,589	6,147,031				6.00
7.00	00700	OPERATION OF PLANT	1,067,492	1,065,242	6,503,634			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	181,081	11,836	20,746	955,108		8.00
9.00	00900	HOUSEKEEPING	441,765	59,888	104,969	25,214	2,440,666	9.00
10.00	01000	DIETARY	297,719	95,043	166,589	0	75,471	10.00
11.00	01100	CAFETERIA	216,349	4,691	8,223	0	3,725	11.00
13.00	01300	NURSING ADMINISTRATION	355,930	16,999	29,795	0	13,498	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	285,182	151,790	266,053	0	120,532	14.00
15.00	01500	PHARMACY	1,826,691	50,368	88,283	0	39,995	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,558	36,883	64,647	0	29,287	16.00
17.00	01700	SOCIAL SERVICE	57,565	7,832	13,728	0	6,219	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	516,282	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	194,534	53,528	93,822	0	42,505	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,584,186	834,406	1,462,518	337,477	662,570	30.00
31.00	03100	INTENSIVE CARE UNIT	826,959	182,019	319,037	57,286	144,535	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	172,872	33,860	59,349	0	26,887	43.00
44.00	04400	SKILLED NURSING FACILITY	697,444	312,021	0	0	247,765	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,367,778	403,531	707,297	70,268	0	50.00
51.00	05100	RECOVERY ROOM	150,830	22,004	38,568	0	17,473	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	240,073	44,793	78,512	0	35,569	52.00
53.00	05300	ANESTHESIOLOGY	624,460	18,392	32,237	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,209,500	210,520	368,993	22,310	167,167	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	152,640	23,123	40,529	19,177	18,361	54.01
57.00	05700	CT SCAN	299,961	16,626	29,141	34,664	13,202	57.00
60.00	06000	LABORATORY	1,392,424	102,522	179,697	0	81,409	60.00
65.00	06500	RESPIRATORY THERAPY	373,060	23,653	41,458	0	18,782	65.00
66.00	06600	PHYSICAL THERAPY	677,406	255,883	448,503	27,520	203,188	66.00
69.00	06900	ELECTROCARDIOLOGY	551,892	133,378	233,782	3,839	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,840,187	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	521,855	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	948,628	3,612	6,331	0	0	73.00
74.00	07400	RENAL DIALYSIS	582,587	215,270	377,319	103,742	170,939	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	654,834	242,947	425,830	0	0	88.00
90.00	09000	CLINIC	324,452	17,352	30,414	70,419	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,172,375	233,133	408,627	129,919	185,123	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	575,467	18,706	32,788	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	348,237	29,973	52,536	307	23,801	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	29,083,844	4,931,824	6,230,321	902,142	2,348,003	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	79,823	15,526	27,214	0	12,329	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,637,287	1,072,564	142,918	52,154	64,747	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	501,954	101,344	0	0	0	194.01
194.02	07952	COMM CARE	70,111	0	0	0	0	194.02
194.03	07953	FOUNDATION	76,072	0	34,405	0	15,587	194.03
194.04	07954	TRANSPORT	122,916	0	23,602	424	0	194.04
194.05	07955	PRIVATE DUTY NURSING	116,846	25,773	45,174	0	0	194.05
194.06	07956	PUBLIC RELATIONS	195,048	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	844,745	0	0	356	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	90,803	0	0	32	0	194.08
194.09	07959	RETAIL PHARMACY	291,419	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,110,868	6,147,031	6,503,634	955,108	2,440,666	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,853,848					10.00
11.00	01100	CAFETERIA	0	1,118,840				11.00
13.00	01300	NURSING ADMINISTRATION	0	16,821	1,890,418			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,875	0	2,013,126		14.00
15.00	01500	PHARMACY	0	26,068	0	140,077	9,650,962	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,681	0	736	0	16.00
17.00	01700	SOCIAL SERVICE	0	9,195	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	30,139	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	2,260	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,228,665	290,539	1,058,014	322,407	0	30.00
31.00	03100	INTENSIVE CARE UNIT	153,834	54,154	213,247	69,725	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	9,661	7,745	9,305	0	43.00
44.00	04400	SKILLED NURSING FACILITY	460,873	45,821	180,434	0	49,140	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	78,479	0	332,752	332	50.00
51.00	05100	RECOVERY ROOM	0	8,902	35,054	18,577	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,476	11,921	5,571	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	18,856	0	70,932	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54,620	0	15,898	12,100	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	5,503	0	2,278	171	54.01
57.00	05700	CT SCAN	0	19,581	0	18,098	0	57.00
60.00	06000	LABORATORY	0	74,994	0	53,551	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	28,862	0	26,444	0	65.00
66.00	06600	PHYSICAL THERAPY	0	44,217	0	1,591	4,624	66.00
69.00	06900	ELECTROCARDIOLOGY	0	27,155	0	134,157	627	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	7,838,015	73.00
74.00	07400	RENAL DIALYSIS	0	31,278	0	294,381	1,625,737	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	19,874	0	1,504	0	88.00
90.00	09000	CLINIC	0	0	0	36,112	9,368	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	78,238	307,948	335,191	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	51,773	0	33,279	27,240	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	20,927	82,405	26,653	69,346	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,853,848	1,095,394	1,890,418	1,943,648	9,636,700	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,728	0	99	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	0	0	0	61,909	226	194.01
194.02	07952	COMM CARE	0	0	0	963	0	194.02
194.03	07953	FOUNDATION	0	0	0	4,484	0	194.03
194.04	07954	TRANSPORT	0	12,542	0	2,023	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	5,176	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	14,036	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	0	0	0	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,853,848	1,118,840	1,890,418	2,013,126	9,650,962	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	891,881					16.00
17.00	01700	SOCIAL SERVICE	0	330,240				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,660,363			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		1,183,179		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,350	293,769	403,085	179,270	30,469,440	30.00
31.00	03100	INTENSIVE CARE UNIT	12,111	36,471	64,494	28,683	5,548,581	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	1,027,511	43.00
44.00	04400	SKILLED NURSING FACILITY	1,835	0	0	0	4,851,052	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	94,416	0	201,543	89,635	8,946,469	50.00
51.00	05100	RECOVERY ROOM	7,230	0	0	0	916,220	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,514	0	145,111	64,537	1,622,067	52.00
53.00	05300	ANESTHESIOLOGY	13,118	0	0	0	3,334,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,048	0	56,432	25,098	7,140,046	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	11,425	0	0	0	898,201	54.01
57.00	05700	CT SCAN	104,325	0	0	0	1,763,805	57.00
60.00	06000	LABORATORY	154,618	0	0	0	7,740,568	60.00
65.00	06500	RESPIRATORY THERAPY	21,316	0	0	0	2,061,087	65.00
66.00	06600	PHYSICAL THERAPY	21,726	0	0	0	4,458,333	66.00
69.00	06900	ELECTROCARDIOLOGY	82,019	0	0	0	3,426,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	59,484	0	0	0	19,623,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,414	0	0	0	2,685,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	136,252	0	0	0	12,817,043	73.00
74.00	07400	RENAL DIALYSIS	0	0	32,247	14,342	5,833,276	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	4,026,239	88.00
90.00	09000	CLINIC	0	0	128,987	57,366	2,002,955	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	51,139	0	112,864	50,195	7,865,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	3,095,534	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	4,541	0			2,084,601	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	891,881	330,240	1,144,763	509,126	144,238,153	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	467,560	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,515,600	674,053	37,335,961	192.00
194.00	07950	CRH	0	0	0	0	1	194.00
194.01	07951	HOME HEALTH	0	0	0	0	2,720,711	194.01
194.02	07952	COMM CARE	0	0	0	0	358,148	194.02
194.03	07953	FOUNDATION	0	0	0	0	442,027	194.03
194.04	07954	TRANSPORT	0	0	0	0	664,794	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	666,226	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	0	998,859	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	4,317,988	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	0	0	462,631	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	0	1,484,649	194.09
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	891,881	330,240	2,660,363	1,183,179	194,157,708	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part I | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-582,355	29,887,085		30.00
31.00	03100	INTENSIVE CARE UNIT	-93,177	5,455,404		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	1,027,511		43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,851,052		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-291,178	8,655,291		50.00
51.00	05100	RECOVERY ROOM	0	916,220		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-209,648	1,412,419		52.00
53.00	05300	ANESTHESIOLOGY	0	3,334,877		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-81,530	7,058,516		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	898,201		54.01
57.00	05700	CT SCAN	0	1,763,805		57.00
60.00	06000	LABORATORY	0	7,740,568		60.00
65.00	06500	RESPIRATORY THERAPY	0	2,061,087		65.00
66.00	06600	PHYSICAL THERAPY	0	4,458,333		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,426,601		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,623,512		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,685,032		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,817,043		73.00
74.00	07400	RENAL DIALYSIS	-205,148	5,628,128		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,026,239		88.00
90.00	09000	CLINIC	-186,353	1,816,602		90.00
90.01	09001	URGENT CARE	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	-163,059	7,702,044		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,095,534		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	2,084,601		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-1,812,448	142,425,705		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	467,560		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-2,189,653	35,146,308		192.00
194.00	07950	CRH	0	1		194.00
194.01	07951	HOME HEALTH	0	2,720,711		194.01
194.02	07952	COMM CARE	0	358,148		194.02
194.03	07953	FOUNDATION	0	442,027		194.03
194.04	07954	TRANSPORT	0	664,794		194.04
194.05	07955	PRIVATE DUTY NURSING	0	666,226		194.05
194.06	07956	PUBLIC RELATIONS	0	998,859		194.06
194.07	07957	KIRK CLINIC	0	4,317,988		194.07
194.08	07958	NORMAN PARK FM CLINIC	0	462,631		194.08
194.09	07959	RETAIL PHARMACY	0	1,484,649		194.09
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	-4,002,101	190,155,607		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	23,841	31,165	55,006	55,006	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	568,807	743,557	1,312,364	13,050	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	936	6.00
7.00	00700	OPERATION OF PLANT	0	1,152,115	1,506,068	2,658,183	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,802	16,734	29,536	48	8.00
9.00	00900	HOUSEKEEPING	0	64,772	84,671	149,443	787	9.00
10.00	01000	DIETARY	0	102,794	134,375	237,169	307	10.00
11.00	01100	CAFETERIA	0	5,074	6,633	11,707	516	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,385	24,033	42,418	733	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,169	214,605	378,774	374	14.00
15.00	01500	PHARMACY	0	54,475	71,211	125,686	784	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	39,891	52,146	92,037	217	16.00
17.00	01700	SOCIAL SERVICE	0	8,471	11,073	19,544	120	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	1,258	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	57,893	75,679	133,572	261	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	902,454	1,179,705	2,082,159	8,966	30.00
31.00	03100	INTENSIVE CARE UNIT	0	196,863	257,343	454,206	1,595	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	36,621	47,872	84,493	326	43.00
44.00	04400	SKILLED NURSING FACILITY	79,252	0	0	79,252	915	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	436,440	570,523	1,006,963	2,026	50.00
51.00	05100	RECOVERY ROOM	0	23,798	31,110	54,908	311	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	48,446	63,330	111,776	449	52.00
53.00	05300	ANESTHESIOLOGY	0	19,892	26,004	45,896	1,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	227,689	297,639	525,328	1,793	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	25,009	32,692	57,701	156	54.01
57.00	05700	CT SCAN	0	17,982	23,506	41,488	560	57.00
60.00	06000	LABORATORY	0	110,883	144,948	255,831	1,572	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,582	33,441	59,023	794	65.00
66.00	06600	PHYSICAL THERAPY	0	276,750	361,774	638,524	1,496	66.00
69.00	06900	ELECTROCARDIOLOGY	0	144,256	188,574	332,830	790	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,906	5,106	9,012	0	73.00
74.00	07400	RENAL DIALYSIS	0	232,826	304,355	537,181	760	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	262,760	343,485	606,245	651	88.00
90.00	09000	CLINIC	0	18,767	24,533	43,300	500	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	252,145	329,609	581,754	2,258	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	20,232	26,448	46,680	1,126	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	32,418	42,377	74,795	519	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	79,252	5,589,208	7,306,324	12,974,784	48,117	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,793	21,952	38,745	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	193,576	1,160,033	1,516,420	2,870,029	4,069	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	52,205	0	143,283	195,488	913	194.01
194.02	07952	COMM CARE	552	0	0	552	138	194.02
194.03	07953	FOUNDATION	0	0	0	0	117	194.03
194.04	07954	TRANSPORT	76,647	0	0	76,647	192	194.04
194.05	07955	PRIVATE DUTY NURSING	0	27,875	36,438	64,313	220	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	0	123	194.06
194.07	07957	KIRK CLINIC	101,426	0	0	101,426	833	194.07
194.08	07958	NORMAN PARK FM CLINIC	1,550	0	0	1,550	144	194.08
194.09	07959	RETAIL PHARMACY	1,600	0	0	1,600	140	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	506,808	6,793,909	9,024,417	16,325,134	55,006	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,325,414					5.00
6.00	00600	MAINTENANCE & REPAIRS	41,964	42,900				6.00
7.00	00700	OPERATION OF PLANT	37,126	7,434	2,702,743			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,298	83	8,622	44,587		8.00
9.00	00900	HOUSEKEEPING	15,364	418	43,623	1,177	210,812	9.00
10.00	01000	DIETARY	10,354	663	69,230	0	6,519	10.00
11.00	01100	CAFETERIA	7,524	33	3,417	0	322	11.00
13.00	01300	NURSING ADMINISTRATION	12,379	119	12,382	0	1,166	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,918	1,059	110,565	0	10,411	14.00
15.00	01500	PHARMACY	63,531	352	36,688	0	3,455	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,097	257	26,866	0	2,530	16.00
17.00	01700	SOCIAL SERVICE	2,002	55	5,705	0	537	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	17,956	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	6,766	374	38,990	0	3,671	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	159,434	5,823	607,783	15,756	57,229	30.00
31.00	03100	INTENSIVE CARE UNIT	28,761	1,270	132,584	2,674	12,484	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	6,012	236	24,664	0	2,322	43.00
44.00	04400	SKILLED NURSING FACILITY	24,256	2,178	0	0	21,401	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	47,570	2,816	293,934	3,280	0	50.00
51.00	05100	RECOVERY ROOM	5,246	154	16,028	0	1,509	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,350	313	32,628	0	3,072	52.00
53.00	05300	ANESTHESIOLOGY	21,718	128	13,397	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,065	1,469	153,344	1,041	14,439	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	5,309	161	16,843	895	1,586	54.01
57.00	05700	CT SCAN	10,432	116	12,110	1,618	1,140	57.00
60.00	06000	LABORATORY	48,427	715	74,677	0	7,032	60.00
65.00	06500	RESPIRATORY THERAPY	12,975	165	17,229	0	1,622	65.00
66.00	06600	PHYSICAL THERAPY	23,560	1,786	186,386	1,285	17,550	66.00
69.00	06900	ELECTROCARDIOLOGY	19,194	931	97,154	179	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	133,558	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	18,150	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	32,992	25	2,631	0	0	73.00
74.00	07400	RENAL DIALYSIS	20,262	1,502	156,804	4,843	14,765	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	22,775	1,696	176,964	0	0	88.00
90.00	09000	CLINIC	11,284	121	12,639	3,287	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	40,774	1,627	169,815	6,065	15,990	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	20,014	131	13,626	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	12,111	209	21,833	14	2,056	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,011,508	34,419	2,589,161	42,114	202,808	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,776	108	11,310	0	1,065	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	230,793	7,486	59,393	2,435	5,593	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	17,458	707	0	0	0	194.01
194.02	07952	COMM CARE	2,438	0	0	0	0	194.02
194.03	07953	FOUNDATION	2,646	0	14,298	0	1,346	194.03
194.04	07954	TRANSPORT	4,275	0	9,808	20	0	194.04
194.05	07955	PRIVATE DUTY NURSING	4,064	180	18,773	0	0	194.05
194.06	07956	PUBLIC RELATIONS	6,784	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	29,379	0	0	17	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	3,158	0	0	1	0	194.08
194.09	07959	RETAIL PHARMACY	10,135	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,325,414	42,900	2,702,743	44,587	210,812	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	324,242					10.00
11.00	01100	CAFETERIA	0	23,519				11.00
13.00	01300	NURSING ADMINISTRATION	0	354	69,551			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	460	0	511,561		14.00
15.00	01500	PHARMACY	0	548	0	35,595	266,639	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	288	0	187	0	16.00
17.00	01700	SOCIAL SERVICE	0	193	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	634	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	48	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	214,896	6,106	38,925	81,928	0	30.00
31.00	03100	INTENSIVE CARE UNIT	26,906	1,138	7,846	17,718	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	203	285	2,365	0	43.00
44.00	04400	SKILLED NURSING FACILITY	80,608	963	6,638	0	1,358	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,650	0	84,556	9	50.00
51.00	05100	RECOVERY ROOM	0	187	1,290	4,721	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,832	251	205	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	396	0	18,025	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,148	0	4,040	334	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	116	0	579	5	54.01
57.00	05700	CT SCAN	0	412	0	4,599	0	57.00
60.00	06000	LABORATORY	0	1,576	0	13,608	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	607	0	6,720	0	65.00
66.00	06600	PHYSICAL THERAPY	0	929	0	404	128	66.00
69.00	06900	ELECTROCARDIOLOGY	0	571	0	34,091	17	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	216,550	73.00
74.00	07400	RENAL DIALYSIS	0	657	0	74,806	44,916	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	418	0	382	0	88.00
90.00	09000	CLINIC	0	0	0	9,176	259	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	1,645	11,330	85,176	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,088	0	8,457	753	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	440	3,032	6,773	1,916	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	324,242	23,026	69,551	493,906	266,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	120	0	25	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	0	0	0	15,732	6	194.01
194.02	07952	COMM CARE	0	0	0	245	0	194.02
194.03	07953	FOUNDATION	0	0	0	1,139	0	194.03
194.04	07954	TRANSPORT	0	264	0	514	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	109	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	388	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	0	0	0	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	324,242	23,519	69,551	511,561	266,639	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS	Subtotal	
			16.00	17.00	21.00	22.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	127,479					16.00
17.00	01700	SOCIAL SERVICE	0	28,156				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	19,848			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		183,682		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,059	25,046			3,310,110	30.00
31.00	03100	INTENSIVE CARE UNIT	1,733	3,110			692,025	31.00
40.00	04000	SUBPROVIDER - IPF	0	0			0	40.00
43.00	04300	NURSERY	0	0			120,906	43.00
44.00	04400	SKILLED NURSING FACILITY	263	0			217,832	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,509	0			1,456,313	50.00
51.00	05100	RECOVERY ROOM	1,034	0			85,388	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	360	0			159,236	52.00
53.00	05300	ANESTHESIOLOGY	1,877	0			102,600	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,445	0			751,446	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,635	0			84,986	54.01
57.00	05700	CT SCAN	14,926	0			87,401	57.00
60.00	06000	LABORATORY	21,994	0			425,432	60.00
65.00	06500	RESPIRATORY THERAPY	3,050	0			102,185	65.00
66.00	06600	PHYSICAL THERAPY	3,108	0			875,156	66.00
69.00	06900	ELECTROCARDIOLOGY	11,735	0			497,492	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,511	0			142,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,779	0			21,929	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,494	0			280,704	73.00
74.00	07400	RENAL DIALYSIS	0	0			856,496	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0			809,131	88.00
90.00	09000	CLINIC	0	0			80,566	90.00
90.01	09001	URGENT CARE	0	0			0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0			0	90.02
91.00	09100	EMERGENCY	7,317	0			923,751	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0			91,875	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	650	0			124,348	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,479	28,156	0	0	12,299,377	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			54,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0			3,179,798	192.00
194.00	07950	CRH	0	0			0	194.00
194.01	07951	HOME HEALTH	0	0			230,304	194.01
194.02	07952	COMM CARE	0	0			3,373	194.02
194.03	07953	FOUNDATION	0	0			19,546	194.03
194.04	07954	TRANSPORT	0	0			91,720	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0			87,550	194.05
194.06	07956	PUBLIC RELATIONS	0	0			7,016	194.06
194.07	07957	KIRK CLINIC	0	0			132,043	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0			4,853	194.08
194.09	07959	RETAIL PHARMACY	0	0			11,875	194.09
200.00		Cross Foot Adjustments			19,848	183,682	203,530	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	127,479	28,156	19,848	183,682	16,325,134	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B Part II | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD				22.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,310,110		30.00
31.00	03100	INTENSIVE CARE UNIT	0	692,025		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
43.00	04300	NURSERY	0	120,906		43.00
44.00	04400	SKILLED NURSING FACILITY	0	217,832		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,456,313		50.00
51.00	05100	RECOVERY ROOM	0	85,388		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	159,236		52.00
53.00	05300	ANESTHESIOLOGY	0	102,600		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	751,446		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	84,986		54.01
57.00	05700	CT SCAN	0	87,401		57.00
60.00	06000	LABORATORY	0	425,432		60.00
65.00	06500	RESPIRATORY THERAPY	0	102,185		65.00
66.00	06600	PHYSICAL THERAPY	0	875,156		66.00
69.00	06900	ELECTROCARDIOLOGY	0	497,492		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	142,069		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	21,929		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	280,704		73.00
74.00	07400	RENAL DIALYSIS	0	856,496		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	809,131		88.00
90.00	09000	CLINIC	0	80,566		90.00
90.01	09001	URGENT CARE	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	923,751		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	91,875		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	0	124,348		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,299,377		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54,149		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,179,798		192.00
194.00	07950	CRH	0	0		194.00
194.01	07951	HOME HEALTH	0	230,304		194.01
194.02	07952	COMM CARE	0	3,373		194.02
194.03	07953	FOUNDATION	0	19,546		194.03
194.04	07954	TRANSPORT	0	91,720		194.04
194.05	07955	PRIVATE DUTY NURSING	0	87,550		194.05
194.06	07956	PUBLIC RELATIONS	0	7,016		194.06
194.07	07957	KIRK CLINIC	0	132,043		194.07
194.08	07958	NORMAN PARK FM CLINIC	0	4,853		194.08
194.09	07959	RETAIL PHARMACY	0	11,875		194.09
200.00		Cross Foot Adjustments	0	203,530		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	0	16,325,134		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	320,019					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		325,182				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,123	1,123	79,665,237			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,793	26,793	18,855,980	-38,110,868	156,046,840	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,356,922	0	4,940,442	6.00
7.00	00700	OPERATION OF PLANT	54,269	54,269	0	0	4,370,900	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	603	603	69,172	0	741,445	8.00
9.00	00900	HOUSEKEEPING	3,051	3,051	1,141,229	0	1,808,830	9.00
10.00	01000	DIETARY	4,842	4,842	444,495	0	1,219,026	10.00
11.00	01100	CAFETERIA	239	239	748,483	0	885,852	11.00
13.00	01300	NURSING ADMINISTRATION	866	866	1,062,555	0	1,457,375	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,733	7,733	542,709	0	1,167,694	14.00
15.00	01500	PHARMACY	2,566	2,566	1,136,026	0	7,479,480	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,879	1,879	314,334	0	600,089	16.00
17.00	01700	SOCIAL SERVICE	399	399	173,673	0	235,701	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,823,244	0	2,113,942	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,727	2,727	377,872	0	796,530	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,509	42,509	12,994,838	0	18,770,184	30.00
31.00	03100	INTENSIVE CARE UNIT	9,273	9,273	2,311,936	0	3,386,026	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,725	1,725	473,053	0	707,832	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,325,949	0	2,855,719	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,558	20,558	2,935,762	0	5,600,438	50.00
51.00	05100	RECOVERY ROOM	1,121	1,121	450,883	0	617,582	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,282	2,282	651,060	0	982,990	52.00
53.00	05300	ANESTHESIOLOGY	937	937	1,685,646	0	2,556,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,725	10,725	2,599,274	0	4,952,360	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,178	1,178	225,990	0	624,994	54.01
57.00	05700	CT SCAN	847	847	811,500	0	1,228,207	57.00
60.00	06000	LABORATORY	5,223	5,223	2,278,236	0	5,701,353	60.00
65.00	06500	RESPIRATORY THERAPY	1,205	1,205	1,151,343	0	1,527,512	65.00
66.00	06600	PHYSICAL THERAPY	13,036	13,036	2,167,458	0	2,773,675	66.00
69.00	06900	ELECTROCARDIOLOGY	6,795	6,795	1,145,018	0	2,259,752	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	15,723,841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,136,763	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184	184	0	0	3,884,205	73.00
74.00	07400	RENAL DIALYSIS	10,967	10,967	1,100,889	0	2,385,434	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,377	12,377	944,060	0	2,681,250	88.00
90.00	09000	CLINIC	884	884	724,865	0	1,328,485	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	11,877	11,877	3,272,465	0	4,800,351	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	953	953	1,631,782	0	2,356,281	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,527	1,527	752,355	0	1,425,875	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	263,273	263,273	69,681,056	-38,110,868	119,085,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	791	791	0	0	326,841	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	54,642	54,642	5,896,789	0	27,176,638	192.00
194.00	07950	CRH	0	0	0	0	1	194.00
194.01	07951	HOME HEALTH	0	5,163	1,322,977	0	2,055,278	194.01
194.02	07952	COMM CARE	0	0	199,518	0	287,074	194.02
194.03	07953	FOUNDATION	0	0	170,054	0	311,479	194.03
194.04	07954	TRANSPORT	0	0	277,972	0	503,287	194.04
194.05	07955	PRIVATE DUTY NURSING	1,313	1,313	319,230	0	478,433	194.05
194.06	07956	PUBLIC RELATIONS	0	0	178,817	0	798,635	194.06
194.07	07957	KIRK CLINIC	0	0	1,207,944	0	3,458,851	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	207,973	0	371,796	194.08
194.09	07959	RETAIL PHARMACY	0	0	202,907	0	1,193,230	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	6,793,909	9,024,417	12,701,830		38,110,868	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.229705	27.751896	0.159440		0.244227	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			55,006		1,325,414	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000690		0.008494	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	313,162					6.00
7.00	00700	OPERATION OF PLANT	54,269	189,032				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	603	603	901,352			8.00
9.00	00900	HOUSEKEEPING	3,051	3,051	23,795	156,587		9.00
10.00	01000	DIETARY	4,842	4,842	0	4,842	138,743	10.00
11.00	01100	CAFETERIA	239	239	0	239	0	11.00
13.00	01300	NURSING ADMINISTRATION	866	866	0	866	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,733	7,733	0	7,733	0	14.00
15.00	01500	PHARMACY	2,566	2,566	0	2,566	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,879	1,879	0	1,879	0	16.00
17.00	01700	SOCIAL SERVICE	399	399	0	399	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,727	2,727	0	2,727	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	42,509	42,509	318,482	42,509	91,954	30.00
31.00	03100	INTENSIVE CARE UNIT	9,273	9,273	54,062	9,273	11,513	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	1,725	1,725	0	1,725	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,896	0	0	15,896	34,492	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	20,558	20,558	66,313	0	0	50.00
51.00	05100	RECOVERY ROOM	1,121	1,121	0	1,121	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,282	2,282	0	2,282	784	52.00
53.00	05300	ANESTHESIOLOGY	937	937	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,725	10,725	21,054	10,725	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,178	1,178	18,098	1,178	0	54.01
57.00	05700	CT SCAN	847	847	32,713	847	0	57.00
60.00	06000	LABORATORY	5,223	5,223	0	5,223	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,205	1,205	0	1,205	0	65.00
66.00	06600	PHYSICAL THERAPY	13,036	13,036	25,971	13,036	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,795	6,795	3,623	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184	184	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,967	10,967	97,903	10,967	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,377	12,377	0	0	0	88.00
90.00	09000	CLINIC	884	884	66,456	0	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	11,877	11,877	122,607	11,877	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	953	953	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,527	1,527	290	1,527	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	251,253	181,088	851,367	150,642	138,743	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	791	791	0	791	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	54,642	4,154	49,219	4,154	0	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	5,163	0	0	0	0	194.01
194.02	07952	COMM CARE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	1,000	0	1,000	0	194.03
194.04	07954	TRANSPORT	0	686	400	0	0	194.04
194.05	07955	PRIVATE DUTY NURSING	1,313	1,313	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	336	0	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	30	0	0	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,147,031	6,503,634	955,108	2,440,666	1,853,848	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.628917	34.404937	1.059639	15.586645	13.361741	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	42,900	2,702,743	44,587	210,812	324,242	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.136990	14.297807	0.049467	1.346293	2.336997	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	CAFETERIA (FTEs)	NURSING ADMINISTRATION (FTEs SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	64,853					11.00
13.00	01300	NURSING ADMINISTRATION	975	27,827				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,268	0	3,005,205			14.00
15.00	01500	PHARMACY	1,511	0	209,108	2,815,569		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	793	0	1,099	0	454,004,275	16.00
17.00	01700	SOCIAL SERVICE	533	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,747	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	131	0	0	0	0	22.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,841	15,574	481,290	0	21,563,221	30.00
31.00	03100	INTENSIVE CARE UNIT	3,139	3,139	104,086	0	6,166,430	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	560	114	13,891	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,656	2,656	0	14,336	934,240	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,549	0	496,733	97	48,073,160	50.00
51.00	05100	RECOVERY ROOM	516	516	27,732	0	3,681,012	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	691	82	0	0	1,280,205	52.00
53.00	05300	ANESTHESIOLOGY	1,093	0	105,888	0	6,679,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,166	0	23,732	3,530	22,936,881	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	319	0	3,401	50	5,817,253	54.01
57.00	05700	CT SCAN	1,135	0	27,017	0	53,118,795	57.00
60.00	06000	LABORATORY	4,347	0	79,941	0	78,615,971	60.00
65.00	06500	RESPIRATORY THERAPY	1,673	0	39,476	0	10,853,158	65.00
66.00	06600	PHYSICAL THERAPY	2,563	0	2,375	1,349	11,062,126	66.00
69.00	06900	ELECTROCARDIOLOGY	1,574	0	200,270	183	41,761,420	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	30,287,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	13,448,995	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,286,660	69,374,645	73.00
74.00	07400	RENAL DIALYSIS	1,813	0	439,453	474,292	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,152	0	2,245	0	0	88.00
90.00	09000	CLINIC	0	0	53,908	2,733	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	4,535	4,533	500,376	0	26,038,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,001	0	49,679	7,947	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,213	1,213	39,788	20,231	2,312,072	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,494	27,827	2,901,488	2,811,408	454,004,275	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	332	0	148	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	0	0	92,418	66	0	194.01
194.02	07952	COMM CARE	0	0	1,437	0	0	194.02
194.03	07953	FOUNDATION	0	0	6,694	0	0	194.03
194.04	07954	TRANSPORT	727	0	3,020	0	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	300	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	4,095	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	0	0	0	194.08
194.09	07959	RETAIL PHARMACY	0	0	0	0	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,118,840	1,890,418	2,013,126	9,650,962	891,881	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.251939	67.934668	0.669880	3.427713	0.001964	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	CAFETERIA (FTEs)	NURSING ADMINISTRATION (FTEs SUPERVISED)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	23,519	69,551	511,561	266,639	127,479	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.362651	2.499407	0.170225	0.094702	0.000281	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	21.00	22.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	27,264				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	660			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		660		22.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	24,253	100	100		30.00
31.00	03100	INTENSIVE CARE UNIT	3,011	16	16		31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
43.00	04300	NURSERY	0	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	50	50		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36	36		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14	14		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0		54.01
57.00	05700	CT SCAN	0	0	0		57.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	8	8		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	32	32		90.00
90.01	09001	URGENT CARE	0	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	0	28	28		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0				116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,264	284	284		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	376	376		192.00
194.00	07950	CRH	0	0	0		194.00
194.01	07951	HOME HEALTH	0	0	0		194.01
194.02	07952	COMM CARE	0	0	0		194.02
194.03	07953	FOUNDATION	0	0	0		194.03
194.04	07954	TRANSPORT	0	0	0		194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0		194.05
194.06	07956	PUBLIC RELATIONS	0	0	0		194.06
194.07	07957	KIRK CLINIC	0	0	0		194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	0		194.08
194.09	07959	RETAIL PHARMACY	0	0	0		194.09
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	330,240	2,660,363	1,183,179		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
			17.00	21.00	22.00		
203.00		Unit cost multiplier (Wkst. B, Part I)	12.112676	4,030.853030	1,792.695455		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	28,156	19,848	183,682		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.032717	30.072727	278.306061		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet B-2 | Date/Time Prepared: 3/31/2023 2:25 pm

		Description	Worksheet CODE	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	-158,559	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,887,085		29,887,085	0	29,887,085	30.00
31.00	03100	INTENSIVE CARE UNIT	5,455,404		5,455,404	0	5,455,404	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	1,027,511		1,027,511	0	1,027,511	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851,052		4,851,052	0	4,851,052	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,655,291		8,655,291	0	8,655,291	50.00
51.00	05100	RECOVERY ROOM	916,220		916,220	0	916,220	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,412,419		1,412,419	0	1,412,419	52.00
53.00	05300	ANESTHESIOLOGY	3,334,877		3,334,877	0	3,334,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,058,516		7,058,516	0	7,058,516	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	898,201		898,201	0	898,201	54.01
57.00	05700	CT SCAN	1,763,805		1,763,805	0	1,763,805	57.00
60.00	06000	LABORATORY	7,740,568		7,740,568	0	7,740,568	60.00
65.00	06500	RESPIRATORY THERAPY	2,061,087	0	2,061,087	0	2,061,087	65.00
66.00	06600	PHYSICAL THERAPY	4,458,333	0	4,458,333	0	4,458,333	66.00
69.00	06900	ELECTROCARDIOLOGY	3,426,601		3,426,601	0	3,426,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,623,512		19,623,512	0	19,623,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,685,032		2,685,032	0	2,685,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,817,043		12,817,043	0	12,817,043	73.00
74.00	07400	RENAL DIALYSIS	5,628,128		5,628,128	0	5,628,128	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,026,239		4,026,239	0	4,026,239	88.00
90.00	09000	CLINIC	1,816,602		1,816,602	0	1,816,602	90.00
90.01	09001	URGENT CARE	0		0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	7,702,044		7,702,044	0	7,702,044	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,852,945		1,852,945		1,852,945	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,095,534		3,095,534	0	3,095,534	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,084,601		2,084,601		2,084,601	116.00
200.00		Subtotal (see instructions)	144,278,650	0	144,278,650	0	144,278,650	200.00
201.00		Less Observation Beds	1,852,945		1,852,945		1,852,945	201.00
202.00		Total (see instructions)	142,425,705	0	142,425,705	0	142,425,705	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,744,112		17,744,112			30.00
31.00	03100	INTENSIVE CARE UNIT	6,166,430		6,166,430			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	934,240		934,240			43.00
44.00	04400	SKILLED NURSING FACILITY	5,917,887		5,917,887			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,721,474	35,351,686	48,073,160	0.180044	0.000000	50.00
51.00	05100	RECOVERY ROOM	958,714	2,722,298	3,681,012	0.248904	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,277,890	2,315	1,280,205	1.103276	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,995,007	4,684,308	6,679,315	0.499284	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,836,519	16,100,362	22,936,881	0.307737	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,490,108	4,327,145	5,817,253	0.154403	0.000000	54.01
57.00	05700	CT SCAN	14,632,938	38,485,857	53,118,795	0.033205	0.000000	57.00
60.00	06000	LABORATORY	35,652,641	42,963,330	78,615,971	0.098461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,091,554	1,761,604	10,853,158	0.189907	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,356,861	8,705,265	11,062,126	0.403027	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,775,314	28,986,106	41,761,420	0.082052	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,889,664	13,397,460	30,287,124	0.647916	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,242,119	9,206,876	13,448,995	0.199646	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,494,019	39,880,626	69,374,645	0.184751	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,098,217	88,615,531	91,713,748	0.061366	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,020,675	4,020,675			88.00
90.00	09000	CLINIC	46,368	9,728,155	9,774,523	0.185851	0.000000	90.00
90.01	09001	URGENT CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	7,545,984	18,492,268	26,038,252	0.295797	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,829	3,261,280	3,819,109	0.485177	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,479,391	7,479,391	0.413875	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,312,072	2,312,072			116.00
200.00		Subtotal (see instructions)	192,425,889	380,484,610	572,910,499			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	192,425,889	380,484,610	572,910,499			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.180044		50.00
51.00	05100	RECOVERY ROOM	0.248904		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.103276		52.00
53.00	05300	ANESTHESIOLOGY	0.499284		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307737		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403		54.01
57.00	05700	CT SCAN	0.033205		57.00
60.00	06000	LABORATORY	0.098461		60.00
65.00	06500	RESPIRATORY THERAPY	0.189907		65.00
66.00	06600	PHYSICAL THERAPY	0.403027		66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751		73.00
74.00	07400	RENAL DIALYSIS	0.061366		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.185851		90.00
90.01	09001	URGENT CARE	0.000000		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.295797		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.413875		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,469,440		30,469,440	0	30,469,440	30.00
31.00	03100	INTENSIVE CARE UNIT	5,548,581		5,548,581	0	5,548,581	31.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
43.00	04300	NURSERY	1,027,511		1,027,511	0	1,027,511	43.00
44.00	04400	SKILLED NURSING FACILITY	4,851,052		4,851,052	0	4,851,052	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,946,469		8,946,469	0	8,946,469	50.00
51.00	05100	RECOVERY ROOM	916,220		916,220	0	916,220	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,622,067		1,622,067	0	1,622,067	52.00
53.00	05300	ANESTHESIOLOGY	3,334,877		3,334,877	0	3,334,877	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,140,046		7,140,046	0	7,140,046	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	898,201		898,201	0	898,201	54.01
57.00	05700	CT SCAN	1,763,805		1,763,805	0	1,763,805	57.00
60.00	06000	LABORATORY	7,740,568		7,740,568	0	7,740,568	60.00
65.00	06500	RESPIRATORY THERAPY	2,061,087	0	2,061,087	0	2,061,087	65.00
66.00	06600	PHYSICAL THERAPY	4,458,333	0	4,458,333	0	4,458,333	66.00
69.00	06900	ELECTROCARDIOLOGY	3,426,601		3,426,601	0	3,426,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	19,623,512		19,623,512	0	19,623,512	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,685,032		2,685,032	0	2,685,032	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,817,043		12,817,043	0	12,817,043	73.00
74.00	07400	RENAL DIALYSIS	5,674,717		5,674,717	0	5,674,717	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,026,239		4,026,239	0	4,026,239	88.00
90.00	09000	CLINIC	2,002,955		2,002,955	0	2,002,955	90.00
90.01	09001	URGENT CARE	0		0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	7,865,103		7,865,103	0	7,865,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,852,945		1,852,945		1,852,945	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,095,534		3,095,534	0	3,095,534	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,084,601		2,084,601		2,084,601	116.00
200.00		Subtotal (see instructions)	145,932,539	0	145,932,539	0	145,932,539	200.00
201.00		Less Observation Beds	1,852,945		1,852,945		1,852,945	201.00
202.00		Total (see instructions)	144,079,594	0	144,079,594	0	144,079,594	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,744,112		17,744,112			30.00
31.00	03100	INTENSIVE CARE UNIT	6,166,430		6,166,430			31.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	934,240		934,240			43.00
44.00	04400	SKILLED NURSING FACILITY	5,917,887		5,917,887			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,721,474	35,351,686	48,073,160	0.186101	0.000000	50.00
51.00	05100	RECOVERY ROOM	958,714	2,722,298	3,681,012	0.248904	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,277,890	2,315	1,280,205	1.267037	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	1,995,007	4,684,308	6,679,315	0.499284	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,836,519	16,100,362	22,936,881	0.311291	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,490,108	4,327,145	5,817,253	0.154403	0.000000	54.01
57.00	05700	CT SCAN	14,632,938	38,485,857	53,118,795	0.033205	0.000000	57.00
60.00	06000	LABORATORY	35,652,641	42,963,330	78,615,971	0.098461	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	9,091,554	1,761,604	10,853,158	0.189907	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	2,356,861	8,705,265	11,062,126	0.403027	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,775,314	28,986,106	41,761,420	0.082052	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	16,889,664	13,397,460	30,287,124	0.647916	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,242,119	9,206,876	13,448,995	0.199646	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,494,019	39,880,626	69,374,645	0.184751	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,098,217	88,615,531	91,713,748	0.061874	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,020,675	4,020,675	1.001384	0.000000	88.00
90.00	09000	CLINIC	46,368	9,728,155	9,774,523	0.204916	0.000000	90.00
90.01	09001	URGENT CARE	0	0	0	0.000000	0.000000	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	7,545,984	18,492,268	26,038,252	0.302060	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	557,829	3,261,280	3,819,109	0.485177	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	7,479,391	7,479,391	0.413875	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,312,072	2,312,072			116.00
200.00		Subtotal (see instructions)	192,425,889	380,484,610	572,910,499			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	192,425,889	380,484,610	572,910,499			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet C Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.000000		54.01
57.00	05700	CT SCAN	0.000000		57.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	URGENT CARE	0.000000		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000		90.02
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part I Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,310,110	11,897	3,298,213	25,618	128.75	30.00
31.00	INTENSIVE CARE UNIT	692,025		692,025	3,011	229.83	31.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
43.00	NURSERY	120,906		120,906	1,181	102.38	43.00
44.00	SKILLED NURSING FACILITY	217,832		217,832	11,078	19.66	44.00
200.00	Total (lines 30 through 199)	4,340,873		4,328,976	40,888		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,725	737,094	30.00
31.00	INTENSIVE CARE UNIT	1,004	230,749	31.00
40.00	SUBPROVIDER - IPF	0	0	40.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	257	5,053	44.00
200.00	Total (lines 30 through 199)	6,986	972,896	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part II Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,456,313	48,073,160	0.030294	2,316,628	70,180	50.00
51.00	05100	RECOVERY ROOM	85,388	3,681,012	0.023197	158,023	3,666	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	159,236	1,280,205	0.124383	4,912	611	52.00
53.00	05300	ANESTHESIOLOGY	102,600	6,679,315	0.015361	354,264	5,442	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	751,446	22,936,881	0.032761	1,273,925	41,735	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	84,986	5,817,253	0.014609	522,817	7,638	54.01
57.00	05700	CT SCAN	87,401	53,118,795	0.001645	3,663,520	6,026	57.00
60.00	06000	LABORATORY	425,432	78,615,971	0.005412	9,529,400	51,573	60.00
65.00	06500	RESPIRATORY THERAPY	102,185	10,853,158	0.009415	1,483,127	13,964	65.00
66.00	06600	PHYSICAL THERAPY	875,156	11,062,126	0.079113	703,515	55,657	66.00
69.00	06900	ELECTROCARDIOLOGY	497,492	41,761,420	0.011913	2,274,372	27,095	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	142,069	30,287,124	0.004691	4,147,512	19,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,929	13,448,995	0.001631	1,458,150	2,378	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	280,704	69,374,645	0.004046	6,946,450	28,105	73.00
74.00	07400	RENAL DIALYSIS	856,496	91,713,748	0.009339	1,122,214	10,480	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	809,131	4,020,675	0.201243	0	0	88.00
90.00	09000	CLINIC	80,566	9,774,523	0.008242	45,297	373	90.00
90.01	09001	URGENT CARE	0	0	0.000000	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	923,751	26,038,252	0.035477	1,582,068	56,127	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	205,221	3,819,109	0.053735	244,452	13,136	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	7,947,502	532,356,367		37,830,646	413,642	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part III Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	25,618	0.00	5,725	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,011	0.00	1,004	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00
43.00	04300	NURSERY		0	1,181	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	11,078	0.00	257	44.00
200.00		Total (lines 30 through 199)		0	40,888		6,986	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	48,073,160	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,681,012	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,280,205	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,679,315	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,936,881	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	5,817,253	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	53,118,795	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	78,615,971	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,853,158	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,062,126	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,761,420	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	30,287,124	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,448,995	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,374,645	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	91,713,748	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,020,675	0.000000	88.00
90.00	09000	CLINIC	0	0	0	9,774,523	0.000000	90.00
90.01	09001	URGENT CARE	0	0	0	0	0.000000	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,038,252	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,819,109	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	532,356,367		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	2,316,628	0	6,499,081	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	158,023	0	449,536	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	4,912	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	354,264	0	512,680	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,273,925	0	2,504,452	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.000000	522,817	0	1,313,225	0	54.01
57.00	05700	CT SCAN	0.000000	3,663,520	0	6,253,170	0	57.00
60.00	06000	LABORATORY	0.000000	9,529,400	0	3,497,829	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,483,127	0	634,808	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	703,515	0	4,840	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,274,372	0	4,730,645	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	4,147,512	0	2,066,302	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,458,150	0	2,670,419	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,946,450	0	9,064,629	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	1,122,214	0	58,600	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	45,297	0	604,727	0	90.00
90.01	09001	URGENT CARE	0.000000	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	1,582,068	0	1,980,658	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	244,452	0	374,167	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		37,830,646	0	43,219,768	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.180044	6,499,081	0	0	1,170,121	50.00
51.00	05100	RECOVERY ROOM	0.248904	449,536	0	0	111,891	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.103276	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	512,680	0	0	255,973	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307737	2,504,452	0	0	770,713	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	1,313,225	0	0	202,766	54.01
57.00	05700	CT SCAN	0.033205	6,253,170	0	0	207,637	57.00
60.00	06000	LABORATORY	0.098461	3,497,829	0	0	344,400	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	634,808	0	0	120,554	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	4,840	0	0	1,951	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	4,730,645	0	0	388,159	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	2,066,302	0	0	1,338,790	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	2,670,419	0	0	533,138	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	9,064,629	0	3,519	1,674,699	73.00
74.00	07400	RENAL DIALYSIS	0.061366	58,600	0	0	3,596	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.185851	604,727	0	0	112,389	90.00
90.01	09001	URGENT CARE	0.000000	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.295797	1,980,658	0	0	585,873	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	374,167	0	0	181,537	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.413875		0			95.00
200.00		Subtotal (see instructions)		43,219,768	0	3,519	8,004,187	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		43,219,768	0	3,519	8,004,187	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	650		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	URGENT CARE	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	650		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	650		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.186101	0	1,132,324	0	0	50.00
51.00	05100	RECOVERY ROOM	0.248904	0	121,545	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.267037	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	0	110,618	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.311291	0	693,356	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	0	686,745	0	0	54.01
57.00	05700	CT SCAN	0.033205	0	1,437,544	0	0	57.00
60.00	06000	LABORATORY	0.098461	0	85,927	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	0	150,034	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	0	177,752	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	0	549,965	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	0	450,942	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	0	4,064	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	0	557,965	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.061874	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC						88.00
90.00	09000	CLINIC	0.204916	0	204,766	0	0	90.00
90.01	09001	URGENT CARE	0.000000	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.302060	0	983,959	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	0	140,105	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.413875	0	0			95.00
200.00		Subtotal (see instructions)		0	7,487,611	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	7,487,611	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part V Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	210,727	0		50.00
51.00	05100	RECOVERY ROOM	30,253	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	55,230	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	215,835	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	106,035	0		54.01
57.00	05700	CT SCAN	47,734	0		57.00
60.00	06000	LABORATORY	8,460	0		60.00
65.00	06500	RESPIRATORY THERAPY	28,493	0		65.00
66.00	06600	PHYSICAL THERAPY	71,639	0		66.00
69.00	06900	ELECTROCARDIOLOGY	45,126	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	292,173	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	811	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	103,085	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	41,960	0		90.00
90.01	09001	URGENT CARE	0	0		90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0		90.02
91.00	09100	EMERGENCY	297,215	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	67,976	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,622,752	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,622,752	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	URGENT CARE	0	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	48,073,160	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	3,681,012	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,280,205	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,679,315	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,936,881	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	5,817,253	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	53,118,795	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	78,615,971	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,853,158	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,062,126	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	41,761,420	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	30,287,124	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	13,448,995	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,374,645	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	91,713,748	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	4,020,675	0.000000	88.00
90.00	09000	CLINIC	0	0	0	9,774,523	0.000000	90.00
90.01	09001	URGENT CARE	0	0	0	0	0.000000	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	0	0	0	26,038,252	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	3,819,109	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	0	0	532,356,367		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D Part IV | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	URGENT CARE	0.000000	0	0	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	26,134	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,618	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	24,024	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	23	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	69	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	106	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	318	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	5,725	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	23	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	69	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	247.54	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	254.70	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	198.45	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	198.45	20.00
21.00	Total general inpatient routine service cost (see instructions)	29,887,085	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5,693	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	17,574	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	21,036	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	63,107	25.00
26.00	Total swing-bed cost (see instructions)	107,410	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	29,779,675	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	29,779,675	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,162.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,655,026	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	6,655,026	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,455,404	3,011	1,811.82	1,004	1,819,067	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	7,848,788	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	16,322,881	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	967,843	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	413,642	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,381,485	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	14,941,396	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	5,693	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	17,574	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	23,267	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,162.45	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,852,945	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,310,110	29,887,085	0.110754	1,852,945	205,221	90.00
91.00	Nursing Program cost	0	29,887,085	0.000000	1,852,945	0	91.00
92.00	Allied health cost	0	29,887,085	0.000000	1,852,945	0	92.00
93.00	All other Medical Education	0	29,887,085	0.000000	1,852,945	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet D-1 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,078	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,078	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,078	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	257	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	247.54	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	254.70	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	219.78	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,851,052	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,851,052	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,851,052	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	4,851,052	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	437.90	71.00
72.00	Program routine service cost (line 9 x line 71)	112,540	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	112,540	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	112,540	83.00
84.00	Program inpatient ancillary services (see instructions)	20,271	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	132,811	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet D-1 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	26,134	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	25,618	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	24,024	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	23	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	69	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	106	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	318	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,932	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,181	15.00
16.00	Nursery days (title V or XIX only)	182	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	247.54	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	254.70	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	198.45	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	198.45	20.00
21.00	Total general inpatient routine service cost (see instructions)	30,469,440	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	5,693	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	17,574	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	21,036	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	63,107	25.00
26.00	Total swing-bed cost (see instructions)	107,410	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	30,362,030	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	30,362,030	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,185.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,289,768	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,289,768	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	1,027,511	1,181	870.03	182	158,345	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,548,581	3,011	1,842.77	424	781,334	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,388,839	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)	0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)	6,618,286	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,594	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,185.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,889,177	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	3,310,110	30,469,440	0.108637	1,889,177	205,235	90.00
91.00	Nursing Program cost	0	30,469,440	0.000000	1,889,177	0	91.00
92.00	Allied health cost	0	30,469,440	0.000000	1,889,177	0	92.00
93.00	All other Medical Education	0	30,469,440	0.000000	1,889,177	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet D-1 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	11,078	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	11,078	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	11,078	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	8,293	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	1,181	15.00
16.00	Nursery days (title V or XIX only)	182	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	247.54	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	254.70	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	216.53	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	219.78	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,851,052	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,851,052	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,851,052	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-1 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)		48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
55.01	Permanent adjustment amount per discharge		55.01
55.02	Adjustment amount per discharge (contractor use only)		55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)		59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)		60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	4,851,052	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	437.90	71.00
72.00	Program routine service cost (line 9 x line 71)	3,631,505	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	3,631,505	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	217,832	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	19.66	76.00
77.00	Program capital-related costs (line 9 x line 76)	163,040	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	3,468,465	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	3,468,465	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	163,040	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	163,040	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet D-1 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XIX	Skilled Nursing Facility	PPS

	Cost Center Description						
						1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		6,051,190		30.00
31.00	03100	INTENSIVE CARE UNIT		1,628,359		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.180044	2,316,628	417,095	50.00
51.00	05100	RECOVERY ROOM	0.248904	158,023	39,333	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.103276	4,912	5,419	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	354,264	176,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307737	1,273,925	392,034	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	522,817	80,725	54.01
57.00	05700	CT SCAN	0.033205	3,663,520	121,647	57.00
60.00	06000	LABORATORY	0.098461	9,529,400	938,274	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	1,483,127	281,656	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	703,515	283,536	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	2,274,372	186,617	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	4,147,512	2,687,239	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	1,458,150	291,114	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	6,946,450	1,283,364	73.00
74.00	07400	RENAL DIALYSIS	0.061366	1,122,214	68,866	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.185851	45,297	8,418	90.00
90.01	09001	URGENT CARE	0.000000	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.295797	1,582,068	467,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	244,452	118,602	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		37,830,646	7,848,788	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		37,830,646		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 11-0105 | Component CCN: 11-U105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.180044	0	0	50.00
51.00	05100	RECOVERY ROOM	0.248904	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.103276	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307737	930	286	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	0	0	54.01
57.00	05700	CT SCAN	0.033205	1,380	46	57.00
60.00	06000	LABORATORY	0.098461	19,215	1,892	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	2,114	401	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	13,665	5,507	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	538	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	12,180	7,892	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	60,876	11,247	73.00
74.00	07400	RENAL DIALYSIS	0.061366	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.185851	0	0	90.00
90.01	09001	URGENT CARE	0.000000	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.295797	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		110,898	27,315	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		110,898		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.180044	0	0	50.00
51.00	05100	RECOVERY ROOM	0.248904	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.103276	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.307737	61	19	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	0	0	54.01
57.00	05700	CT SCAN	0.033205	0	0	57.00
60.00	06000	LABORATORY	0.098461	573	56	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	44,952	18,117	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	11,251	2,079	73.00
74.00	07400	RENAL DIALYSIS	0.061366	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.185851	0	0	90.00
90.01	09001	URGENT CARE	0.000000	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.295797	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		56,837	20,271	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		56,837		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet D-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,153,274		30.00
31.00	03100	INTENSIVE CARE UNIT		754,598		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		124,170		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186101	966,488	179,864	50.00
51.00	05100	RECOVERY ROOM	0.248904	74,874	18,636	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.267037	208,613	264,320	52.00
53.00	05300	ANESTHESIOLOGY	0.499284	117,547	58,689	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.311291	437,986	136,341	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.154403	967,291	149,353	54.01
57.00	05700	CT SCAN	0.033205	227,844	7,566	57.00
60.00	06000	LABORATORY	0.098461	3,763,799	370,587	60.00
65.00	06500	RESPIRATORY THERAPY	0.189907	689,230	130,890	65.00
66.00	06600	PHYSICAL THERAPY	0.403027	148,422	59,818	66.00
69.00	06900	ELECTROCARDIOLOGY	0.082052	621,368	50,984	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.647916	1,601,869	1,037,877	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.199646	341,476	68,174	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.184751	3,343,262	617,671	73.00
74.00	07400	RENAL DIALYSIS	0.061874	293,528	18,162	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.001384	0	0	88.00
90.00	09000	CLINIC	0.204916	1,071	219	90.00
90.01	09001	URGENT CARE	0.000000	0	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.302060	641,193	193,679	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.485177	53,607	26,009	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		14,499,468	3,388,839	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		14,499,468		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part A Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,489,650	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)		2.00
2.01	Outlier reconciliation amount	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	279,537	2.04
3.00	Managed Care Simulated Payments	15,400,538	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	97.22	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	11.84	5.00
5.01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)	0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7.02
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	11.84	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	11.75	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	11.75	12.00
13.00	Total allowable FTE count for the prior year.	11.84	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	11.12	14.00
15.00	Sum of lines 12 through 14 divided by 3.	11.57	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)	0.69	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	12.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.126106	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.115018	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.115018	21.00
22.00	IME payment adjustment (see instructions)	638,369	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	937,231	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	-0.09	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	638,369	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	937,231	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	13.60	30.00
31.00	Percentage of Medicaid patient days (see instructions)	18.57	31.00
32.00	Sum of lines 30 and 31	32.17	32.00
33.00	Allowable disproportionate share percentage (see instructions)	15.76	33.00
34.00	Disproportionate share adjustment (see instructions)	413,292	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part A Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Payment Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	7,192,008,710	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000428752	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)	0	3,083,589	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)	0	3,083,589	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	3,083,589		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges (see instructions)	0		40.00

		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	14,904,437		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	12,087,580		48.00

		Amount	
		1.00	
49.00	Total payment for inpatient operating costs (see instructions)	15,841,668	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	853,389	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	799,578	52.00
53.00	Nursing and Allied Health Managed Care payment	0	53.00
54.00	Special add-on payments for new technologies	153,922	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
55.01	Cellular therapy acquisition cost (see instructions)	0	55.01
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	0	58.00
59.00	Total (sum of amounts on lines 49 through 58)	17,648,557	59.00
60.00	Primary payer payments	10,699	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	17,637,858	61.00
62.00	Deductibles billed to program beneficiaries	1,257,760	62.00
63.00	Coinsurance billed to program beneficiaries	23,585	63.00
64.00	Allowable bad debts (see instructions)	419,551	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	272,708	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	223,384	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	16,629,221	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)	0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)	0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)	0	70.50
70.87	Demonstration payment adjustment amount before sequestration	0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)	0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)	0	70.91
70.92	Bundled Model 1 discount amount (see instructions)	0	70.92
70.93	HVBP payment adjustment amount (see instructions)	0	70.93
70.94	HRR adjustment amount (see instructions)	-70,248	70.94
70.95	Recovery of accelerated depreciation	0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part A Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		16,558,973	71.00
71.01	Sequestration adjustment (see instructions)		124,192	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM or CHART pass-throughs			71.03
72.00	Interim payments		16,781,373	72.00
72.01	Interim payments-PARHM or CHART			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM or CHART (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-346,592	74.00
74.01	Balance due provider/program-PARHM or CHART (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,525,827	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,489,650	0		10,489,650	10,489,650	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00						2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	279,537	0		279,537	279,537	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,400,538	0	0	15,400,538	15,400,538	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.115018	0.115018	0.115018	0.115018		5.00
6.00	IME payment adjustment (see instructions)	22.00	638,369	0	0	638,369	638,369	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	937,231	0	0	937,231	937,231	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	638,369	0	0	638,369	638,369	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	937,231	0	0	937,231	937,231	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1576	0.1576	0.1576	0.1576		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	413,292	0	0	413,292	413,292	11.00
11.01	Uncompensated care payments	36.00	3,083,589	0	0	3,083,589	3,083,589	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,904,437	0	0	14,904,437	14,904,437	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,841,668	0	0	15,841,668	15,841,668	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	853,389	0	0	853,389	853,389	16.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	153,922	0	0	153,922	153,922	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	16,848,979	16,848,979	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	774,569	0	0	774,569	774,569	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	42,105	0	0	42,105	42,105	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0474	0.0474	0.0474	0.0474		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,715	0	0	36,715	36,715	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	853,389	0	0	853,389	853,389	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	10,489,650		10,489,650	10,489,650	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	279,537		279,537	279,537	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,400,538	0	15,400,538	15,400,538	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.115018	0.115018	0.115018		5.00
6.00	IME payment adjustment (see instructions)	22.00	638,369	0	638,369	638,369	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	937,231	0	937,231	937,231	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	638,369	0	638,369	638,369	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	937,231	0	937,231	937,231	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1576	0.1576	0.1576		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	413,292	0	413,292	413,292	11.00
11.01	Uncompensated care payments	36.00	3,083,589	0	3,083,589	3,083,589	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	14,904,437	0	14,904,437	14,904,437	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	15,841,668	0	15,841,668	15,841,668	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	853,389	0	853,389	853,389	16.00
17.00	Special add-on payments for new technologies	54.00	153,922	0	153,922	153,922	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	16,848,979	16,848,979	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	774,569	0	774,569	774,569	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	42,105	0	42,105	42,105	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0474	0.0474	0.0474		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	36,715	0	36,715	36,715	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	853,389	0	853,389	853,389	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	0	0	0	0	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-70,248	0	-70,248	-70,248	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E Part B Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	650	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,004,187	2.00
3.00	OPPS payments	9,159,732	3.00
4.00	Outlier payment (see instructions)	5,731	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.880	5.00
6.00	Line 2 times line 5	7,043,685	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	650	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	3,519	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	3,519	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	3,519	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	2,869	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	650	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,165,463	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1,644,533	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,521,580	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	393,669	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	7,915,249	30.00
31.00	Primary payer payments	878	31.00
32.00	Subtotal (line 30 minus line 31)	7,914,371	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	154,265	33.00
34.00	Allowable bad debts (see instructions)	377,062	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	245,090	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	68,857	36.00
37.00	Subtotal (see instructions)	8,313,726	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	8,313,726	40.00
40.01	Sequestration adjustment (see instructions)	62,353	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM or CHART pass-throughs		40.03
41.00	Interim payments	8,716,312	41.00
41.01	Interim payments-PARHM or CHART		41.01
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM or CHART (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	-464,939	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E Part B Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	MEDICARE PART B ANCILLARY COSTS		
200.00	Part B Combined Billed Days	0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16,849,113		8,633,618	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	01/27/2022	78,564	09/29/2022	46,015	3.01
3.02			0	01/27/2022	36,679	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	09/29/2022	137,399		0	3.50
3.51		01/27/2022	8,728		0	3.51
3.52		01/27/2022	169		0	3.52
3.53		01/27/2022	8		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-67,740		82,694	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16,781,373		8,716,312	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		346,592		464,939	6.02
7.00	Total Medicare program liability (see instructions)		16,434,781		8,251,373	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 11-0105 | Component CCN: 11-U105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		20,505		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		20,505		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		20,505		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 11-0105 | Component CCN: 11-5667 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-1 Part I | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		155,240		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/11/2022	7,421		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-7,421		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		147,819		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		21,617		0	6.02
7.00	Total Medicare program liability (see instructions)		126,202		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E-1 Part II Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days (see instructions)		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days (see instructions)		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 11-0105 | Component CCN: 11-U105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-2 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	29,549	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions)	0	0	3.00
3.01	Nursing and allied health payment-PARHM or CHART (see instructions)			3.01
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	92	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	29,549	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	29,549	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	29,549	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,558	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (see instructions)	20,991	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
16.55	Rural community hospital demonstration project (§410A Demonstration) payment adjustment (see instructions)	0		16.55
16.99	Demonstration payment adjustment amount before sequestration	0	0	16.99
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	20,991	0	19.00
19.01	Sequestration adjustment (see instructions)	486	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)	0	0	19.02
19.03	Sequestration adjustment-PARHM or CHART pass-throughs			19.03
19.25	Sequestration for non-claims based amounts (see instructions)	0	0	19.25
20.00	Interim payments	20,505	0	20.00
20.01	Interim payments-PARHM or CHART			20.01
21.00	Tentative settlement (for contractor use only)	0	0	21.00
21.01	Tentative settlement-PARHM or CHART (for contractor use only)			21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21)	0	0	22.00
22.01	Balance due provider/program-PARHM or CHART (see instructions)			22.01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 66 (title XVIII hospital))			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 200 (title XVIII swing-bed SNF))			202.00
203.00	Total (sum of lines 201 and 202)			203.00
204.00	Medicare swing-bed SNF discharges (see instructions)			204.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
205.00	Medicare swing-bed SNF target amount			205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)			208.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
	Comparision of PPS versus Cost Reimbursement			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see instructions)			215.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part VI Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	144,598	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	144,598	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	17,894	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	126,704	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	126,704	15.00
15.01	Sequestration adjustment (see instructions)	502	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	0	15.75
16.00	Interim payments	147,819	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	-21,617	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-3 Part VII Date/Time Prepared: 3/31/2023 2:25 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	6,618,286		1.00
2.00	Medical and other services		1,622,752	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	6,618,286	1,622,752	4.00
5.00	Inpatient primary payer payments	69,137		5.00
6.00	Outpatient primary payer payments		517	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	6,549,149	1,622,235	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	3,032,042		8.00
9.00	Ancillary service charges	14,499,468	7,487,611	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	17,531,510	7,487,611	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	17,531,510	7,487,611	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	10,913,224	5,864,859	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	6,618,286	1,622,752	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	6,618,286	1,622,752	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6,549,149	1,622,235	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	6,549,149	1,622,235	36.00
37.00	4.23% MEDICAID NET OP REDUCATION	0	-68,642	37.00
38.00	Subtotal (line 36 ± line 37)	6,549,149	1,553,593	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	6,549,149	1,553,593	40.00
41.00	Interim payments	4,157,744	1,647,902	41.00
42.00	Balance due provider/program (line 40 minus line 41)	2,391,405	-94,309	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2021 To 09/30/2022	Worksheet E-3 Part VII Date/Time Prepared: 3/31/2023 2:25 pm
	Title XIX	Skilled Nursing Facility	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	163,040		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	163,040	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	163,040	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	163,040	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	163,040	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-4 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			11.84	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)				2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)				3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)				4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27			11.84	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			11.75	6.00
7.00	Enter the lesser of line 5 or line 6			11.75	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	11.75	0.00	11.75	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	11.75	0.00	11.75	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	11.75	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	11.84	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.12	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.57	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.69		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	11.57	0.69		17.00
18.00	Per resident amount	163,615.95	163,615.95		18.00
18.01	Per resident amount under §131 of the CAA 2021				18.01
19.00	Approved amount for resident costs	1,893,037	112,895	2,005,932	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			107,812.30	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			2,005,932	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS

Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet E-4 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | Hospital | PPS

		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	6,729	2,081	7,728		26.00
27.00	Total Inpatient Days (see instructions)	27,264	27,264	27,264		27.00
28.00	Ratio of inpatient days to total inpatient days	0.246809	0.076328	0.283451		28.00
29.00	Program direct GME amount	495,082	153,109	568,583	1,216,774	29.00
29.01	Percent reduction for MA DGME		3.26	3.26		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		4,991	18,536	23,527	30.00
31.00	Net Program direct GME amount				1,193,247	31.00

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	91,713,748	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	16,609,568	37.00
38.00	Organ acquisition costs (see instructions)	0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00	Primary payer payments (see instructions)	10,699	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)	16,598,869	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	8,173,409	42.00
43.00	Primary payer payments (see instructions)	1,034	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	8,172,375	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	24,771,244	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.670086	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.329914	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	1,193,247	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	799,578	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	393,669	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet E-5 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII		PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR		
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2	0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instructions)	0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instructions)	0	4.00
5.00	The rate used to calculate the time value of money (see instructions)	0.00	5.00
6.00	Time value of money for operating expenses (see instructions)	0	6.00
7.00	Time value of money for capital related expenses (see instructions)	0	7.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G | Date/Time Prepared: 3/31/2023 2:25 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	7,953,773	0	0	0	1.00
2.00	Temporary investments	4,985,475	0	0	0	2.00
3.00	Notes receivable	480,610	0	0	0	3.00
4.00	Accounts receivable	79,905,720	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	-56,162,077	0	0	0	7.00
8.00	Prepaid expenses	4,661,481	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	4,941,840	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	46,766,822	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,629,639	0	0	0	12.00
13.00	Land improvements	5,461,554	0	0	0	13.00
14.00	Accumulated depreciation	-3,205,801	0	0	0	14.00
15.00	Buildings	129,131,206	0	0	0	15.00
16.00	Accumulated depreciation	-51,375,280	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	126,648,252	0	0	0	23.00
24.00	Accumulated depreciation	-92,732,543	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	236,932	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	115,793,959	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	83,719,233	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5,522,638	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	89,241,871	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	251,802,652	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	7,164,184	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,562,987	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,311,366	0	0	0	40.00
41.00	Deferred income	3,044,939	0	0	0	41.00
42.00	Accelerated payments	179,435				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	805,215	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	36,068,126	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	49,711,730	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	11,215	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,722,945	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	85,791,071	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	166,011,581				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	166,011,581	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	251,802,652	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-1 | Date/Time Prepared: 3/31/2023 2:25 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		165,378,440		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		248,396				2.00
3.00	Total (sum of line 1 and line 2)		165,626,836		0		3.00
4.00	CAPITAL CONTRIBUTIONS	330,500		0		0	4.00
5.00	CAPITAL CONTRIBUTIONS	54,245		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		384,745		0		10.00
11.00	Subtotal (line 3 plus line 10)		166,011,581		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		166,011,581		0		19.00

		Endowment Fund	Plant Fund			
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	CAPITAL CONTRIBUTIONS		0			4.00
5.00	CAPITAL CONTRIBUTIONS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-2 Parts I & II | Date/Time Prepared: 3/31/2023 2:25 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	17,366,400		17,366,400	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	377,712		377,712	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	5,917,888		5,917,888	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	23,662,000		23,662,000	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,166,430		6,166,430	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	6,166,430		6,166,430	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	29,828,430		29,828,430	17.00
18.00	Ancillary services	153,504,929	335,198,879	488,703,808	18.00
19.00	Outpatient services	8,103,813	34,151,226	42,255,039	19.00
20.00	RURAL HEALTH CLINIC	0	4,020,675	4,020,675	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	7,479,391	7,479,391	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,312,072	2,312,072	26.00
27.00	MISC OTHER SERVICES	9,175,626	11,426,112	20,601,738	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	200,612,798	394,588,355	595,201,153	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		203,253,133		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	ROUNDING	1			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		1		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		203,253,132		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet G-3 | Date/Time Prepared: 3/31/2023 2:25 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	595,201,153	1.00
2.00	Less contractual allowances and discounts on patients' accounts	421,412,399	2.00
3.00	Net patient revenues (line 1 minus line 2)	173,788,754	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	203,253,132	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-29,464,378	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	-15,918,356	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	4,588	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	782,189	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	301	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	320,105	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	108,100	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS OTHER	7,901,400	24.00
24.01	CRH NET PATIENT REV	2,280,673	24.01
24.02	CRM NET PATIENT REV	24,712,902	24.02
24.03	SALE OF ASSETS	9,263	24.03
24.50	COVID-19 PHE Funding	9,511,609	24.50
25.00	Total other income (sum of lines 6-24)	29,712,774	25.00
26.00	Total (line 5 plus line 25)	248,396	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	248,396	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 11-0105
Component CCN: 11-2314

Period: From 10/01/2021 To 09/30/2022

Worksheet I-1

Date/Time Prepared: 3/31/2023 2:25 pm

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	521,470	HOURS OF SERVICE	12,228.00	5.88	1.00
2.00	LICENSED PRACTICAL NURSES	267,914	HOURS OF SERVICE	9,945.00	4.78	2.00
3.00	NURSES AIDES	9,400	HOURS OF SERVICE	914.00	0.44	3.00
4.00	TECHNICIANS	49,110	HOURS OF SERVICE	3,068.00	1.48	4.00
5.00	SOCIAL WORKERS	54,452	HOURS OF SERVICE	1,608.00	0.77	5.00
6.00	DIETICIANS	43,468	HOURS OF SERVICE	1,387.00	0.67	6.00
7.00	PHYSICIANS	32,195	ACCUMULATED COST			7.00
8.00	NON-PATIENT CARE SALARY	122,880	ACCUMULATED COST			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	1,100,889				9.00
10.00	EMPLOYEE BENEFITS	93,319	SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS	57,089	PERCENTAGE OF TIME			13.00
14.00	SUPPLIES	30,600	REQUISITIONS			14.00
15.00	DRUGS	158,559	REQUISITIONS			15.00
16.00	OTHER	232,271	ACCUMULATED COST			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	1,672,727				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	232,826	SQUARE FEET			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	304,355	PERCENTAGE OF TIME			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	175,526	SALARY			20.00
21.00	ADMINISTRATIVE & GENERAL	582,587	ACCUMULATED COST			21.00
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	763,528	SQUARE FEET			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	294,381	REQUISITIONS			24.00
25.00	PHARMACY	1,625,737	REQUISITIONS			25.00
26.00	OTHER ALLOCATED COSTS	135,020	ACCUMULATED COST			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	5,786,687				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0		29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0		30.00
31.00	TOTAL COSTS (SUM OF LINES 27-30)	5,786,687				31.00

* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 11-0105 | Component CCN: 11-2314 | Period: From 10/01/2021 To 09/30/2022 | Worksheet I-2 | Date/Time Prepared: 3/31/2023 2:25 pm

Renal Dialysis

		Capital Related Costs		Direct Patient Care Salary				
		Building	Equipment	RNs	Other	Employee Benefits Department	Drugs	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Total Renal Department Costs	996,354	361,444	521,470	424,344	268,845	1,625,737	1.00
	MAINTENANCE							
2.00	Hemodialysis	912,772	331,123	477,743	388,750	246,293	1,495,678	2.00
2.01	AKI-Hemodialysis	0	0	0	0	0	0	2.01
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0	0	3.01
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	0	6.00
7.00	CCPD	0	0	0	0	0	0	7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	0	10.00
11.00	CCPD	0	0	0	0	0	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	83,582	30,321	43,727	35,594	22,552	130,059	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						158,559	14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	996,354	361,444	521,470	424,344	268,845	1,625,737	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00

		Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
		7.00	8.00	9.00	10.00	11.00		
1.00	Total Renal Department Costs	324,981	0	4,523,175	1,104,953	5,628,128		1.00
	MAINTENANCE							
2.00	Hemodialysis	298,983	0	4,151,342	1,014,119	5,165,461		2.00
2.01	AKI-Hemodialysis	0	0	0	0	0		2.01
3.00	Intermittent Peritoneal	0	0	0	0	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0	0		3.01
	TRAINING							
4.00	Hemodialysis	0	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0	0		5.00
6.00	CAPD	0	0	0	0	0		6.00
7.00	CCPD	0	0	0	0	0		7.00
	HOME							
8.00	Hemodialysis	0	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0	0		9.00
10.00	CAPD	0	0	0	0	0		10.00
11.00	CCPD	0	0	0	0	0		11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	25,998	0	371,833	90,834	462,667		12.00
13.00	Method II Home Patient	0	0	0	0	0		13.00
14.00	ESAs (included in Renal Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0		16.00
17.00	Total (sum of lines 2 through 16)	324,981	0	4,523,175	1,104,953	5,628,128		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					5,628,128		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105 | Component CCN: 11-2314 | Period: From 10/01/2021 To 09/30/2022 | Worksheet I-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Renal Dialysis

			Capital Related Costs		Direct Patient Care Salary			
			Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	Total Renal Department Costs		996,354	361,444	521,470	424,344	268,845	1.00
	MAINTENANCE							
2.00	Hemodialysis		10,047	10,047.00	10,882.00	19,146.00	892,732	2.00
2.01	AKI-Hemodialysis		0	0.00	0.00	0.00	0	2.01
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.00
3.01	AKI-Intermittent Peritoneal		0	0.00	0.00	0.00	0	3.01
	TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	0	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	5.00
6.00	CAPD		0	0.00	0.00	0.00	0	6.00
7.00	CCPD		0	0.00	0.00	0.00	0	7.00
	HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	0	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	0	9.00
10.00	CAPD		0	0.00	0.00	0.00	0	10.00
11.00	CCPD		0	0.00	0.00	0.00	0	11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	1,056	920	920.00	996.00	1,753.00	81,742	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	0	13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other		0	0.00	0.00	0.00	0	16.00
17.00	Total Statistical Basis		10,967	10,967.00	11,878.00	20,899.00	974,474	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		90.850187	32.957418	43.902172	20.304512	0.275887	18.00

		Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)		
		6.00	7.00	8.00	9.00	10.00		
1.00	Total Renal Department Costs	1,625,737	324,981	0	4,523,175	1,104,953		1.00
	MAINTENANCE							
2.00	Hemodialysis	92	92	0				2.00
2.01	AKI-Hemodialysis	0	0	0				2.01
3.00	Intermittent Peritoneal	0	0	0				3.00
3.01	AKI-Intermittent Peritoneal	0	0	0				3.01
	TRAINING							
4.00	Hemodialysis	0	0	0				4.00
5.00	Intermittent Peritoneal	0	0	0				5.00
6.00	CAPD	0	0	0				6.00
7.00	CCPD	0	0	0				7.00
	HOME							
8.00	Hemodialysis	0	0	0				8.00
9.00	Intermittent Peritoneal	0	0	0				9.00
10.00	CAPD	0	0	0				10.00
11.00	CCPD	0	0	0				11.00
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	8	8	0				12.00
13.00	Method II Home Patient	0	0	0				13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other	0	0	0				16.00
17.00	Total Statistical Basis	100	100	0		4,523,175		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	16,257.370000	3,249.810000	0.000000		0.244287		18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 11-0105 | Component CCN: 11-2314 | Period: From 10/01/2021 To 09/30/2022 | Worksheet I-4 | Date/Time Prepared: 3/31/2023 2:25 pm

Rate 0 | Renal Dialysis

		Number of Total Treatments	Total Cost (from Wkst. I-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	12,589	5,165,461	410.32	4,131	1,695,032	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - CAPD	0	0	0.00	0	0	5.00
6.00	Training - CCPD	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - CAPD	0	0	0.00	0	0	9.00
10.00	Home Program - CCPD	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	12,589	5,165,461		4,131	1,695,032	11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	12,589					12.00

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
		6.00	7.00	
1.00	Maintenance - Hemodialysis	1,491,782	361.12	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00	2.00
3.00	Training - Hemodialysis	0	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0.00	4.00
5.00	Training - CAPD	0	0.00	5.00
6.00	Training - CCPD	0	0.00	6.00
7.00	Home Program - Hemodialysis	0	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00	8.00
		6.00	7.00	
9.00	Home Program - CAPD	0	0.00	9.00
10.00	Home Program - CCPD	0	0.00	10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	1,491,782		11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)			12.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 11-0105 | Period: From 10/01/2021 To 09/30/2022 | Worksheet I-5 | Date/Time Prepared: 3/31/2023 2:25 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	1,695,032		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	1,491,782	1,447,354	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)	1,491,782	1,447,354	2.03
2.04	Outlier payments	459,274		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	1,925	1,868	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	1,925	1,868	3.03
4.00	Coinsurance billed to Medicare (Part B) patients	298,384	289,498	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	298,384	289,498	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	244,615	237,330	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	244,615	237,330	5.05
6.00	Adjusted reimbursable bad debts (see instructions)	154,265		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	148,218		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	54,036	8.00
9.00	Program payment (see instructions)	0	1,156,389	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	154,265		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	5,324,020		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	5,165,461		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.970218		14.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 11-0105 | Hospice CCN: 11-1542 | Period: From 10/01/2021 To 09/30/2022 | Worksheet O | Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		156,388	156,388	-156,388	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	42,029	42,029	0	42,029	3.00
4.00	ADMINISTRATIVE & GENERAL*	171,355	96,102	267,457	0	267,457	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	29,840	29,840	0	29,840	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	143,474	2,715	146,189	0	146,189	13.00
14.00	PHARMACY*	0	2,498	2,498	0	2,498	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		50,341	50,341	0	50,341	25.00
26.00	PHYSICIAN SERVICES**	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27.00
28.00	REGISTERED NURSE**	197,753	8,631	206,384	0	206,384	28.00
29.00	LPN/LVN**	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	104,756	2,364	107,120	0	107,120	33.00
34.00	SPIRITUAL COUNSELING**	35,298	0	35,298	0	35,298	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	68,493	8,829	77,322	0	77,322	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	16,077	2,429	18,506	0	18,506	46.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	0	66.00
67.00	ADVERTISING*	15,149	0	15,149	0	15,149	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	232,988	232,988	0	232,988	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	4	4	0	4	71.00
100.00	TOTAL	752,355	635,158	1,387,513	-156,388	1,231,125	100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 11-0105 | Hospice CCN: 11-1542 | Period: From 10/01/2021 To 09/30/2022 | Worksheet O | Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0		1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	42,029		3.00
4.00	ADMINISTRATIVE & GENERAL*	0	267,457		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	29,840		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7.00	HOUSEKEEPING*	0	0		7.00
8.00	DIETARY*	0	0		8.00
9.00	NURSING ADMINISTRATION*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0		10.00
11.00	MEDICAL RECORDS*	0	0		11.00
12.00	STAFF TRANSPORTATION*	0	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	146,189		13.00
14.00	PHARMACY*	0	2,498		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0		15.00
16.00	OTHER GENERAL SERVICE*	0	0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				17.00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	50,341		25.00
26.00	PHYSICIAN SERVICES**	0	0		26.00
27.00	NURSE PRACTITIONER**	0	0		27.00
28.00	REGISTERED NURSE**	0	206,384		28.00
29.00	LPN/LVN**	0	0		29.00
30.00	PHYSICAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	107,120		33.00
34.00	SPIRITUAL COUNSELING**	0	35,298		34.00
35.00	DIETARY COUNSELING**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	77,322		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATIENT TRANSPORTATION**	0	0		39.00
40.00	IMAGING SERVICES**	0	0		40.00
41.00	LABS & DIAGNOSTICS**	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42.50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	18,506		46.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAISING*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESIDENTIAL CARE*	0	0		66.00
67.00	ADVERTISING*	0	15,149		67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	232,988		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	4		71.00
100.00	TOTAL	0	1,231,125		100.00

* Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. O-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 11-0105 | Hospice CCN: 11-1542 | Period: From 10/01/2021 To 09/30/2022 | Worksheet O-2 | Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	197,446	8,631	206,077	0	206,077	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	104,594	2,364	106,958	0	106,958	33.00
34.00	SPIRITUAL COUNSELING	35,243	0	35,243	0	35,243	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	68,387	8,829	77,216	0	77,216	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	16,052	2,429	18,481	0	18,481	46.00
100.00	TOTAL *	421,722	22,253	443,975	0	443,975	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED				25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	206,077		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	106,958		33.00
34.00	SPIRITUAL COUNSELING	0	35,243		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	77,216		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	18,481		46.00
100.00	TOTAL *	0	443,975		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Provider CCN: 11-0105 | Hospice CCN: 11-1542 | Period: From 10/01/2021 To 09/30/2022 | Worksheet O-3 | Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		50,341	50,341	0	50,341	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	307	0	307	0	307	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	162	0	162	0	162	33.00
34.00	SPIRITUAL COUNSELING	55	0	55	0	55	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	106	0	106	0	106	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	25	0	25	0	25	46.00
100.00	TOTAL *	655	50,341	50,996	0	50,996	100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		
		6.00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	50,341		25.00
26.00	PHYSICIAN SERVICES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGISTERED NURSE	0	307		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSICAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	162		33.00
34.00	SPIRITUAL COUNSELING	0	55		34.00
35.00	DIETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	106		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	IMAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	25		46.00
100.00	TOTAL *	0	50,996		100.00

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET EXPENSES FOR ALLOCATION

Provider CCN: 11-0105 Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-5

Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Descriptions	HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)	TOTAL EXPENSES (sum of cols. 1 + 2)	
		1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	32,418	32,418	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	42,377	42,377	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	42,029	119,955	161,984	3.00
4.00	ADMINISTRATIVE & GENERAL	267,457	369,164	636,621	4.00
5.00	PLANT OPERATION & MAINTENANCE	29,840	82,509	112,349	5.00
6.00	LAUNDRY & LINEN SERVICE	0	307	307	6.00
7.00	HOUSEKEEPING	0	23,801	23,801	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	82,405	82,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	26,653	26,653	10.00
11.00	MEDICAL RECORDS	0	4,541	4,541	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	146,189		146,189	13.00
14.00	PHARMACY	2,498	69,346	71,844	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0	17.00
	LEVEL OF CARE				
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	443,975		443,975	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	50,996		50,996	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0		0	53.00
	NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0	61.00
62.00	FUNDRAISING	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0	65.00
66.00	RESIDENTIAL CARE	0		0	66.00
67.00	ADVERTISING	15,149		15,149	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	232,988		232,988	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	4		4	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,231,125	853,476	2,084,601	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6 Part I
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Descriptions	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	32,418	32,418				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,377		42,377			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	161,984	0	0	161,984		3.00
4.00	ADMINISTRATIVE & GENERAL	636,621	32,418	42,377	36,893	748,309	4.00
5.00	PLANT OPERATION & MAINTENANCE	112,349	0	0	0	112,349	5.00
6.00	LAUNDRY & LINEN SERVICE	307	0	0	0	307	6.00
7.00	HOUSEKEEPING	23,801	0	0	0	23,801	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	82,405	0	0	0	82,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	26,653	0	0	0	26,653	10.00
11.00	MEDICAL RECORDS	4,541	0	0	0	4,541	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	146,189	0	0	30,890	177,079	13.00
14.00	PHARMACY	71,844	0	0	0	71,844	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0	0		0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	443,975			90,798	534,773	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	50,996	0	0	141	51,137	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	15,149	0	0	3,262	18,411	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	232,988				232,988	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	4	0	0	0	4	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		99.00
100.00	TOTAL	2,084,601	32,418	42,377	161,984	2,084,601	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6 Part I
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Descriptions	ADMINISTRATIVE & GENERAL	PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	748,309					4.00
5.00	PLANT OPERATION & MAINTENANCE	76,200	188,549				5.00
6.00	LAUNDRY & LINEN SERVICE	208	0	515			6.00
7.00	HOUSEKEEPING	16,143	0		39,944		7.00
8.00	DIETARY	0	0		0	0	8.00
9.00	NURSING ADMINISTRATION	55,891	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	18,077	0		0		10.00
11.00	MEDICAL RECORDS	3,080	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0		0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	120,103	188,549		39,944		13.00
14.00	PHARMACY	48,728	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0		15.00
16.00	OTHER GENERAL SERVICE	0	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	362,706					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	34,683	0	515	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61.00
62.00	FUNDRAISING	0	0		0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	12,487	0		0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0		0		68.00
69.00	THRIFT STORE	0	0		0		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	3	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	748,309	188,549	515	39,944	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6 Part I
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Descriptions	NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	138,296					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	44,730				10.00
11.00	MEDICAL RECORDS	0		7,621			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	525,675	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	138,068	44,657	7,609	0	524,672	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	228	73	12	0	815	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	188	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	138,296	44,730	7,621	0	525,675	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6 Part I
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Descriptions	PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES	TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	120,572					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	120,387	0	0		1,732,872	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	185	0	0	0	87,648	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		31,086	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					232,988	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	7	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	120,572	0	0	0	2,084,601	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6 Part II
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,527					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		1,527				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	752,356			3.00
4.00	ADMINISTRATIVE & GENERAL	1,527	1,527	171,355	-748,309	1,103,304	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	112,349	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	307	6.00
7.00	HOUSEKEEPING	0	0	0	0	23,801	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	82,405	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	26,653	10.00
11.00	MEDICAL RECORDS	0	0	0	0	4,541	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	143,474	0	177,079	13.00
14.00	PHARMACY	0	0	0	0	71,844	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			421,721	0	534,773	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	655	0	51,137	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	15,151	0	18,411	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				-232,988		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	4	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	32,418	42,377	161,984		748,309	100.00
101.00	UNIT COST MULTIPLIER	21.229862	27.751801	0.215302		0.678244	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period:
From 10/01/2021
To 09/30/2022

Worksheet O-6
Part II
Date/Time Prepared:
3/31/2023 2:25 pm

Hospice I

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	1,527					5.00
6.00	LAUNDRY & LINEN SERVICE	0	20				6.00
7.00	HOUSEKEEPING	0		1,527			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		1,213	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	1,527		1,527		0	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					1,211	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	20	0	0	2	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	188,549	515	39,944	0	138,296	100.00
101.00	UNIT COST MULTIPLIER	123.476752	25.750000	26.158481	0.000000	114.011542	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-6
Part II
Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	12,254					10.00
11.00	MEDICAL RECORDS		12,254				11.00
12.00	STAFF TRANSPORTATION			0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	42,252,781		13.00
14.00	PHARMACY			0	0	20,231	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	12,234	12,234	0	42,172,135	20,200	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	20	20	0	65,495	31	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0	60.00
61.00	VOLUNTEER PROGRAM			0	0	0	61.00
62.00	FUNDRAISING			0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0	65.00
66.00	RESIDENTIAL CARE			0	0	0	66.00
67.00	ADVERTISING			0	15,151	0	67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0	68.00
69.00	THRIFT STORE			0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	44,730	7,621	0	525,675	120,572	100.00
101.00	UNIT COST MULTIPLIER	3.650237	0.621919	0.000000	0.012441	5.959765	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105
Hospice CCN: 11-1542

Period:
From 10/01/2021
To 09/30/2022

Worksheet O-6
Part II
Date/Time Prepared:
3/31/2023 2:25 pm

Hospice I

	Cost Center Descriptions	PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)		
		15.00	16.00	17.00		
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
	LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
	NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD					70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. O-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

Provider CCN: 11-0105 Hospice CCN: 11-1542 | Period: From 10/01/2021 To 09/30/2022 | Worksheet O-7 | Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

	Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	66.00	0.403027	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68.00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.184751	0	4,793	7	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.098461	0	1,195	2	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.647916	0	6,449	10	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00					9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00					10.00
11.00	Totals (sum of lines 1-11)						11.00

	Cost Center Descriptions	Charges by LOC (from Provider Records) HGIP	Shared Service Costs by LOC HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSICAL THERAPY	0	0	0	0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0	886	1	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	118	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	4,178	6	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADIOLOGY-THERAPEUTIC						9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS						10.00
11.00	Totals (sum of lines 1-11)		0	5,182	7	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 11-0105 Hospice CCN: 11-1542

Period: From 10/01/2021 To 09/30/2022

Worksheet O-8

Date/Time Prepared: 3/31/2023 2:25 pm

Hospice I

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE				
1.00	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 6, line 11)			0	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	0	0		4.00
5.00	Program cost (line 3 times line 4)	0	0		5.00
	HOSPICE ROUTINE HOME CARE				
6.00	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 7, line 11)			1,738,054	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,234	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			142.07	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,464	438		9.00
10.00	Program cost (line 8 times line 9)	1,628,690	62,227		10.00
	HOSPICE INPATIENT RESPITE CARE				
11.00	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11)			87,655	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			20	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			4,382.75	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	20	0		14.00
15.00	Program cost (line 13 times line 14)	87,655	0		15.00
	HOSPICE GENERAL INPATIENT CARE				
16.00	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11)			0	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			0	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			0.00	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	0	0		19.00
20.00	Program cost (line 18 times line 19)	0	0		20.00
	TOTAL HOSPICE CARE				
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,825,709	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			12,254	22.00
23.00	Average cost per diem (line 21 divided by line 22)			148.99	23.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 11-0105	Period: From 10/01/2021 To 09/30/2022	Worksheet L Parts I-III Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	774,569	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	42,105	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	74.70	3.00
4.00	Number of interns & residents (see instructions)	12.26	4.00
5.00	Indirect medical education percentage (see instructions)	4.74	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	36,715	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	853,389	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 11-0105 | Component CCN: 11-3422 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 3/31/2023 2:25 pm

RHC I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	138,944	0	138,944	263,276	402,220	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	170,184	0	170,184	0	170,184	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	309,128	0	309,128	263,276	572,404	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	37,791	20,837	58,628	0	58,628	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	37,791	20,837	58,628	0	58,628	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	346,919	20,837	367,756	263,276	631,032	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
25.01	Telehealth	0	0	0	0	0	25.01
25.02	Chronic Care Management	0	0	0	0	0	25.02
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	347,233	1,009,865	1,357,098	-63,646	1,293,452	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	347,233	1,009,865	1,357,098	-63,646	1,293,452	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	694,152	1,030,702	1,724,854	199,630	1,924,484	32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 11-0105 | Component CCN: 11-3422 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-1 | Date/Time Prepared: 3/31/2023 2:25 pm

RHC I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	402,220		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	170,184		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	572,404		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	58,628		19.00
20.00	Allowable GME Costs				20.00
21.00	Subtotal (sum of lines 15 through 20)	0	58,628		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	631,032		22.00
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
25.01	Telehealth	0	0		25.01
25.02	Chronic Care Management	0	0		25.02
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs				27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	1,293,452		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	1,293,452		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	1,924,484		32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 11-0105 | Component CCN: 11-3422 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-2 | Date/Time Prepared: 3/31/2023 2:25 pm

RHC I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	3.00	16,096	4,200	12,600		1.00
2.00	Physician Assistant	1.00	1,057	2,100	2,100		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.00	17,153		14,700	17,153	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	4.00	17,153			17,153	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					631,032	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					631,032	12.00
13.00	Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					1,293,452	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,101,755	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,395,207	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					3,395,207	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					3,395,207	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,026,239	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES	Provider CCN: 11-0105 Component CCN: 11-3422	Period: From 10/01/2021 To 09/30/2022	Worksheet M-3 Date/Time Prepared: 3/31/2023 2:25 pm
	Title XVIII	RHC I	Cost

				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from Wkst. M-2, line 20)			4,026,239	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			24,757	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,001,482	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			17,153	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)			0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			17,153	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			233.28	7.00
		Calculation of Limit (1)			
		Rate Period 1 (10/01/2021 through 12/31/2021)	Rate Period 2 (01/01/2022 through 09/30/2022)		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	100.00	113.00		8.00
9.00	Rate for Program covered visits (see instructions)	100.00	113.00		9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	506	1,044		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	50,600	117,972		11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0		12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0		13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0		14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)				15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *	0	168,572		16.00
16.01	Total program charges (see instructions)(from contractor's records)		350,725		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		107,476		16.04
16.05	Total program cost (see instructions)	0	107,476		16.05
17.00	Primary payer amounts		156		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		34,227		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		63,299		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		107,320		20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,757		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		132,077		22.00
23.00	Allowable bad debts (see instructions)		270		23.00
23.01	Adjusted reimbursable bad debts (see instructions)		176		23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0		24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0		25.50
25.99	Demonstration payment adjustment amount before sequestration		0		25.99
26.00	Net reimbursable amount (see instructions)		132,253		26.00
26.01	Sequestration adjustment (see instructions)		992		26.01
26.02	Demonstration payment adjustment amount after sequestration		0		26.02
27.00	Interim payments		106,283		27.00
28.00	Tentative settlement (for contractor use only)		0		28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)		24,978		29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0		30.00

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST

Provider CCN: 11-0105 | Component CCN: 11-3422 | Period: From 10/01/2021 To 09/30/2022 | Worksheet M-4 | Date/Time Prepared: 3/31/2023 2:25 pm

Title XVIII | RHC I | Cost

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	572,404	572,404	572,404	572,404	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000071	0.002316	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	41	1,326	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	409	2,104	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	450	3,430	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	631,032	631,032	631,032	631,032	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	3,395,207	3,395,207	3,395,207	3,395,207	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000713	0.005436	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,421	18,456	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,871	21,886	0	0	10.00
11.00	Total number of injections/infusions (from your records)	5	131	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	574.20	167.07	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	5	131	0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2,871	21,886	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)		24,757			15.00
16.00	Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		24,757			16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 11-0105 Component CCN: 11-3422	Period: From 10/01/2021 To 09/30/2022	Worksheet M-5 Date/Time Prepared: 3/31/2023 2:25 pm
		RHC I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		104,380	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		09/29/2022	1,903	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,903	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		106,283	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		24,978	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		131,261	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

DSH □ersion □.10 □/5/2022

D. □eneral Cost Report □ear Information □0/□/2020 □ □/30/202□

The following information is provided based on the information we received from the state. Please review this information for items □ through □ 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:	COL□□ITT REGIONAL MEDICAL CENTER		
	□0/□/2020 through □/30/202□		
2. Select Cost Report Year Covered by this Survey □enter "□"□	□		
3. Status of Cost Report □sed for this Survey □Should be audited if available□	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/2/2022		

	Data	Correct□	If Incorrect, Proper Information
□. Hospital Name:	COL□□ITT REGIONAL MEDICAL CENTER	□es	
5. Medicaid Provider Number:	000002021A	□es	
6. Medicaid Subprovider Number 1 □Psychiatric or Rehab□	0	□es	
□. Medicaid Subprovider Number 2 □Psychiatric or Rehab□	0	□es	
□. Medicare Provider Number:	110105	□es	
Owner/Operator □Private State Govt., Non-State Govt., HIS/Tribal□	Non-State Govt.	□es	
DSH Pool Classification □Small Rural, Non-Small Rural, □rban□	Non-Small Rural	□es	

Out□of□State □edicaid Provider Number. List all states where you had a □edicaid 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		
1□. State Name □ Number		
15. State Name □ Number		

□*ist a□□itional states on a se□arate attachment*□

E. Disclosure of □edicaid / Uninsured Payments Received: □□0/0□/2020 □0□/30/202□□

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□	
□. **□otal Section □0□□ Payments Related to □ospital Services □See Note □□**	$-
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□	
□. **□otal Section □0□□ Payments Related to Non□□ospital Services □See Note □□**	$-
□. **Out□of□State DS□ Payments □See Note 2□**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from □ninsured □On Exhibit B□	$ 1,501,309	$ 1,693,522	$3,19□,□31
10. Total Cash Basis Patient Payments from All Other Patients □On Exhibit B□	$ 60,2□3,233	$ □2,3□1,□15	$1□2,65□,6□□
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□	$61,□□□,5□2	$□□,06□,93□	$1□5,□□9,□□9
12. □ninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	2.□3□	2.01□	2.19□

13. **Did your hospital receive any □edicaid <u>managed care</u> payments not paid at the claim level□**	No
Sho□/□incl□□e all non□claim□s□ecific □a□ments s□ch as l□m□s□m □a□ments for f□ll □e□ical□□ricin□□s□□□lementals□□□alit□□a□ments□□on□s □a□ments□ca□itation □a□ments receive□ □□□the <u>hos□ital</u> □not □□the □□□□□or other incentive □a□ments□	
1□. 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.

□. □IUR / LIUR □ualifying Data from the Cost Report □□0/0□/2020 □0□/30/202□□

□□. □otal □ospital Days Used in □edicaid Inpatient Utili□ation Ratio □□IUR□

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed □C/R, W/S S-3, Pt. I, Col. □, Sum of Lns. 1□, 16, 1□, 1□.00-1□.03, 30, 31 less lines 5 □ 6□	26,□30	□See Note in Section □□3, below□

□□2. Cash Subsidies for Patient Services Received from State or Local □overnments and Charity Care Charges □Used in Low□Income Utili□ation Ratio □LIUR□Calculation□:

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
□.	□nspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
□.	Inpatient Hospital Charity Care Charges	3,06□,□1□
□.	Outpatient Hospital Charity Care Charges	6,2□3,□□2
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 9,312,290

□□3. Calculation of Net □ospital Revenue from Patient Services □Used for LIUR□□□ /S □□2 and □□3 of Cost Report□

NO□E: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using C□S □CRIS 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. □ormulas can be overwritten as needed with actual data.

		Total Patient Revenues □Charges□			Contractual Adjustments □formulas below can be overwritten if amounts are known□			
		Inpatient □ospital	Outpatient □ospital	Non□□ospital	Inpatient □ospital	Outpatient □ospital	Non□□ospital	Net Hospital Revenue
11.	Hospital	$33,520,96□.00			$ 23,□21,□□□	$ -	$ -	$ 10,099,□90
12.	Subprovider I □Psych or Rehab□	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II □Psych or Rehab□	$0.00			$ -	$ -	$ -	$ -
1□.	Swing Bed - SNF			$□12,510.00			$ 2□□,225	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
1□.	Nursing Facility			$0.00			$ -	
1□.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$1□5,□55,093.00	$30□,3□□,2□2.00		$ 101,631,10□	$ 212,6□6,□1□	$ -	$ 135,531,551
20.	Outpatient Services		$36,530,0□□.00			$ 25,523,9□3	$ -	$ 11,006,101
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 5,5□□,210			$ 3,901,□50	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
2□.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,2□2,503.00			$ 1,59□,□10	
26.	Other	$0.00	$0.00	$23,1□9,109.00	$ -	$ -	$ 16,195,50□	$ -
2□.	Total	$ 1□□,9□6,05□	$ 3□0,91□,356	$ 31,□5□,332	$ 125,052,5□1	$ 23□,200,690	$ 21,9□0,290	$ 156,63□,1□2
2□.	Total Hospital and Non Hospital		Total from Above	$ 551,3□□,□□5		Total from Above	$ 3□5,233,561	

29.	Total Per Cost Report	Total Patient Revenues □G-3 Line 1□	551,3□□,□□5	Total Contractual Adj. □G-3 Line 2□	3□□,539,□53	
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCL□DED on worksheet G-3, Line 2 □mpact is a decrease in net patient revenue□					□
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCL□DED on worksheet G-3, Line 2 □mpact is a decrease in net patient revenue□					□
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCL□DED on worksheet G-3, Line 2 □mpact is a decrease in net patient revenue□				6,693,□0□	□
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCL□DED on worksheet G-3, Line 2 □mpact is a decrease in net patient revenue□					□
3□.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCL□DED on worksheet G-3, Line 2 □mpact 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 INCL□DED on worksheet G-3, Line 2 □mpact is an increase in net patient revenue□"					-
35.	Adjusted Contractual Adjustments				3□5,233,561	
36.	□nreconciled Difference	□nreconciled Difference □Should be $0□	$ -	□nreconciled Difference □Should be $0□	$ -	

□. Cost Report □Cost / Days / Charges

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

NO□E: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using C□S □CRIS 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. □ormulas can be overwritten as needed with actual data.

Line □	Cost Center Description	□otal Allowable Cost	Intern □ Resident Costs Removed on Cost Report □	RCE and □herapy Add□Bac□ □If Applicable		□otal Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	□otal Charges	□edicaid Per Diem / Cost or Other Ratios
		□ost □e□ort □ or□sheet □□ Part □□□ol□26	*□ost □e□ort □ or□sheet Part □□ol□25 □ntern □ □esi□ent □ffset □ □□□*	*□ost □e□ort □ or□sheet □□ Part □□□ol□2 an□ □ol□□*	*S□in□□□e□ □arve □□t □□ost □e□ort □ or□sheet D□1□ Part □□□ine 26*	*□alc□late□*	*Da□s □□ost □e□ort □ /S D□1□Pt□□□ine 2 for A□□lts □ Pe□s□ □ /S D□1□Pt□2□ □ines □2□□7 for others*	*□n□atient □o□tine □har□es □□ost □e□ort □ or□sheet □e□Pt□□□ □ol□6 □nformational onl□ □nless □se□ in Section □ char□es allocation□*		*□alc□late□ Per Diem*
	Routine Cost Centers □list below□									
1	03000 AD□LTS □ PEDIATRICS	$ 26,163,□□3	$ 31□,29□	$ -	$129,109.00	$ 26,352,031	23,269	$26,9□0,536.00		$ 1,132.50
2	03100 INTENSI□E CARE □NIT	$ □,9□□,195	$ □□,530	$ -		$ 5,065,□25	3,9□□	$6,952,93□.00		$ 1,2□□.□1
3	03200 CORONARY CARE □NIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
□	03300 B□RN INTENSI□E CARE □NIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03□00 S□RGICAL INTENSI□E CARE □NIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE □NIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
□	0□000 S□BPRO□IDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
□	0□100 S□BPRO□IDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	0□200 OTHER S□BPRO□IDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	0□300 N□RSERY	$ □52,5□9	$ -	$ -		$ □52,5□9	1,19□	$926,060.00		$ □1□.03
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
1□		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
1□		$ -	$ -	$ -		$ -	-	$0.00		$ -
1□	Total Routine	$ 31,99□,5□□	$ □0□,□2□	$ -	$ 129,109	$ 32,2□0,305	2□,□0□	$ 3□,□59,53□		
19	Weighted Average									$ 1,136.00

			□os□ital □ □servation Da□s □ □ost □e□ort □ /S S□ □□Pt□□□ine 28□ □ol□8	*S□□□rovi□er □ □servation Da□s □ □ost □e□ort □ /S S□ □□Pt□□□ine 28□01□ □ol□8*	*S□□□rovi□er □□ □servation Da□s □ □ost □e□ort □ /S S□ □□Pt□□□ine 28□02□ □ol□8*	*□alc□late□ □Per Diems A□ove □ □lti□le□ □□Da□s□*	*□n□atient □har□es □ □ost □e□ort □ or□sheet □□Pt□□□ □ol□6*	*□□t□atient □har□es □□ost □e□ort □ or□sheet □□Pt□□□ □ol□7*	*□otal □har□es □ □ost □e□ort □ or□sheet □□Pt□□□ □ol□8*	*□e□ical□ □alc□late□ □ost to□□har□e □atio*
	Observation Data □Non-Distinct□									
20	09200 Observation □Non-Distinct□		1,9□□	-	-	$ 2,23□,953	$5□9,15□.00	$3,□1□,299.00	$ □,□0□,□53	0.50□992

Line □	Cost Center Description	□otal Allowable Cost	*□ost □e□ort □ or□sheet □□ Part □□□ol□26*	*□ost □e□ort □ or□sheet □□ Part □□ol□25 □ntern □ □esi□ent □ffset □ □□□*	*□ost □e□ort □ or□sheet □□ Part □□□ol□2 an□ □ol□□*		*□alc□late□*	*□n□atient □har□es □ □ost □e□ort □ or□sheet □□Pt□□□ □ol□6*	*□□t□atient □har□es □□ost □e□ort □ or□sheet □□Pt□□□ □ol□7*	*□otal □har□es □ □ost □e□ort □ or□sheet □□Pt□□□ □ol□8*	*□e□ical□ □alc□late□ □ost to□□har□e □atio*
	Ancillary Cost Centers □from □ /S C excluding Observation□□list below□										
21	5000 OPERATING ROOM	$□,□0□,361.00	$ 295,□15	$ -		$ 9,002,□□6	$9,69□,1□5.00	$30,□61,□□2.00	$ □0,□55,65□	0.22253□
22	5100 RECO□ERY ROOM	$□51,□91.00	$ -	$ -		$ □51,□91	$□36,132.00	$3,061,2□1.00	$ 3,□9□,3□3	0.22□232
23	5200 DELI□ERY ROOM □ LABOR ROOM	$1,216,□□3.00	$ 20□,□□□	$ -		$ 1,□2□,32□	$1,2□1,□□3.00	$0.00	$ 1,2□1,□□3	1.1199□5
2□	5300 ANESTHESIOLOGY	$3,2□3,□□1.00	$ □3,□65	$ -		$ 3,31□,236	$1,56□,605.00	$3,9□1,51□.00	$ 5,539,122	0.59□□□□
25	5□00 RADIOLOGY-DIAGNOSTIC	$6,150,□56.00	$ □3,□65	$ -		$ 6,19□,621	$□,201,□□□.00	$13,□□5,93□.00	$ 1□,9□□,3□5	0.3□5155
26	5□01 N□CLEAR MEDICINE-DIAG	$□□1,□26.00	$ -	$ -		$ □□1,□26	$1,□9□,090.00	$6,162,□□9.00	$ □,960,□□9	0.109□6□
2□	5□00 CT SCAN	$1,553,23□.00	$ -	$ -		$ 1,553,23□	$12,2□3,□□□.00	$33,9□9,1□2.00	$ □6,262,619	0.0335□□
2□	6000 LABORATORY	$□,□□0,390.00	$ -	$ -		$ □,□□0,390	$36,059,□□□.00	$3□,2□□,□2□.00	$ □3,3□□,5□5	0.1019□6
29	6500 RESPIRATORY THERAPY	$1,□33,395.00	$ -	$ -		$ 1,□33,395	$□,096,29□.00	$1,19□,31□.00	$ □,290,61□	0.2211□1
30	6600 PHYSICAL THERAPY	$□,65□,15□.00	$ -	$ -		$ □,65□,15□	$2,32□,□3□.00	$□,306,1□□.00	$ 9,63□,915	0.□□3051

□. Cost Report □Cost / Days / Charges

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

	Line □	Cost Center Description	□otal Allowable Cost	Intern □ Resident Costs Removed on Cost Report □	RCE and □herapy Add□Bac□ □If Applicable		□otal Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	□otal Charges	□edicaid Per Diem / Cost or Other Ratios
31	6900	ELECTROCARDIOLOGY	$2,9□0,23□.00	$ -	$ -		$ 2,9□0,23□	$9,09□,301.00	$25,□09,□□3.00	$ 3□,906,□□□	0.0□53□□
32	□100	MEDICAL S□PPLIES CHARGED TO PATIENT	$19,356,336.00	$ -	$ -		$ 19,356,336	$1□,0□2,□31.00	$12,□□2,6□□.00	$ 29,□□5,509	0.6□□551
33	□200	IMPL. DE□. CHARGED TO PATIENTS	$2,105,132.00	$ -	$ -		$ 2,105,132	$3,509,960.00	$10,05□,561.00	$ 13,56□,521	0.15519□
3□	□300	DR□GS CHARGED TO PATIENTS	$15,□5□,059.00	$ -	$ -		$ 15,□5□,059	$36,655,□06.00	$□2,□□□,160.00	$ □9,133,966	0.199119
35	□□00	RENAL DIALYSIS	$5,13□,0□1.00	$ 309,□□5	$ -		$ 5,□□□,□56	$2,091,□23.00	$□2,□95,□□9.00	$ □□,□□□,□□2	0.0□2□□□
36	9000	CLINIC	$1,□61,30□.00	$ □□,530	$ -		$ 1,□□□,□3□	$35,3□6.00	$□,560,□23.00	$ □,596,069	0.2□339□
3□	9100	EMERGENCY	$6,905,292.00	$ 9□,□□1	$ -		$ □,003,□63	$6,559,656.00	$16,060,1□□.00	$ 22,619,□□0	0.309629
3□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□0			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□1			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□2			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□3			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□5			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□6			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□9			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
5□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
5□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
5□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
6□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
6□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
6□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□0			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□1			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□2			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□3			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□5			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□6			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□9			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□0			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□1			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□2			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□3			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□5			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□6			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□□			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
□9			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

□. Cost Report □Cost / Days / Charges

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

Line □	Cost Center Description	□otal Allowable Cost	Intern □ Resident Costs Removed on Cost Report □	RCE and □herapy Add□Bac□ □If Applicable		□otal Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	□otal Charges	□edicaid Per Diem / Cost or Other Ratios
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
9□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
9□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
9□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
10□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
10□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
10□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
11□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
11□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
11□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
12□		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**□otal Ancillary**	$ 90,595,663	$ 1,0□6,615	$ -		$ 91,6□2,2□□	$ 152,639,2□9	$ 32□,□30,2□□	$ □□1,□69,□96	
12□	**□eighted Average**									0.1950□2
12□	**Sub □otals**	$ 122,590,250	$ 1,□91,□□2	$ -		$ 123,952,5□3	$ 1□□,□9□,□□3	$ 32□,□30,2□□	$ 516,329,030	
129	NF, SNF, and Swing Bed Cost for Medicaid *□S□m of a□□lica□le □ost □e□ort □ or□sheet D□□□□itle 19□□ol□mn □□□ine 200 an□ □ or□sheet D□Part □□□itle 19□□ol□mn 5□7□□ine 200□*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *□S□m of a□□lica□le □ost □e□ort □ or□sheet D□□□□itle 18□□ol□mn □□□ine 200 an□ □ or□sheet D□Part □□□itle 18□□ol□mn 5□7□□ine 200□*					$6□,23□.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *□os□ital m□st calc□late□S□□mit s□□□ort for calc□lation of cost□□*									
131.01	Other Cost Adjustments □support must be submitted□									
132	**□rand □otal**					$ 123,□□□,3□9				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					1.22□				

□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.

□. In□State □edicaid and All Uninsured Inpatient and Outpatient □ospital Data:

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

Line □	Cost Center Description	□edicaid Per Diem Cost for Routine Cost Centers	□edicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs □with Medicaid Secondary□		In-State Other Medicaid Eligibles □Not Included Elsewhere□		□ninsured		Total In-State Medicaid		□ Survey to Cost Report □otals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient □See Exhibit A□	Outpatient □See Exhibit A□	Inpatient	Outpatient	
		From Section □	*From Section □*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From PS□□ S□mmar□ □□ote A□*	*From □os□ital's □□n □nternal Anal□sis*	*From □os□ital's □□n □nternal Anal□sis*			
	Routine Cost Centers □from Section □□:			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 AD□LTS □ PEDIATRICS	$ 1,132.50		2,1□6		1,□19		1,□53		3,5□5		2,0□□		□,993		51.99□
2	03100 INTENSI□E CARE □NIT	$ 1,2□□.□1		53□		□2		□61		562		505		2,029		6□30□
3	03200 CORONARY CARE □NIT	$ -												-		
□	03300 B□RN INTENSI□E CARE □NIT	$ -												-		
5	03□00 S□RGICAL INTENSI□E CARE □NIT	$ -												-		
6	03500 OTHER SPECIAL CARE □NIT	$ -												-		
□	0□000 S□BPRO□IDER I	$ -												-		
□	0□100 S□BPRO□IDER II	$ -												-		
9	0□200 OTHER S□BPRO□IDER	$ -												-		
10	0□300 N□RSERY	$ □1□.03		230		□31				6□		3□		1,029		□9.20□
11		$ -												-		
12		$ -												-		
13		$ -												-		
1□		$ -												-		
15		$ -												-		
16		$ -												-		
1□		$ -												-		
1□			□otal Days	2,9□0		2,222		2,□1□		□,1□5		2,613		12,051		51.6□□
19	Total Days per PS□R or Exhibit Detail			2,9□0		2,222		2,□1□		□,1□5		2,613				
20	□nreconciled Days □Explain □ariance□			□		□		□		□		□				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 3,321,□15		$ 1,955,922		$ 2,□2□,□20		$ 5,0□□,913		$ 3,□92,□63		$ 13,091,2□0		□□.59□
21.01	Calculated Routine Charge Per Diem			$ 1,129.□□		$ □□.0.25		$ 1,003.95		$ 1,21□.90		$ 1,336.5□		$ 1,0□6.32		
	Ancillary Cost Centers □from □/S C□□from Section □□:			**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□		0.50□992	1□9,660	3□5,□3□	□2,33□	520,22□	□□,62□	110,233	90,506	□11,9□2	□□,520	356,611	$ 361,12□	$ 1,□2□,23□	□9.□□□
23	5000 OPERATING ROOM		0.22253□	960,□□3	9□9,115	1,2□2,669	2,9□9,992	6□□,9□□	902,936	1,□□9,332	2,69□,□03	□□9,956	1,629,9□□	$ □,3□1,□1□	$ □,556,□□6	35.□□□
2□	5100 RECO□ERY ROOM		0.22□232	92,□3□	101,62□	136,□9□	3□3,39□	□3,□16	□1,099	99,992	192,191	62,□□□	16□,50□	$ 3□2,□□0	$ □□□,31□	35.61□
25	5200 DELI□ERY ROOM □ LABOR ROOM		1.1199□5	2□3,□52	-	□2□,1□6	5,□3□	-	-	130,□□0	556	26,□□9	1,529	$ 1,09□,39□	$ 6,39□	□9.11□
26	5300 ANESTHESIOLOGY		0.59□□□	153,615	10□,656	96,136	□□0,9□0	91,55□	□□,□□2	192,193	21□,3□□	100,569	215,062	$ 533,502	$ □51,□22	30.□0□
2□	5□00 RADIOLOGY-DIAGNOSTIC		0.3□5155	□62,2□□	□0□,56□	□6,□53	1,135,□9□	2□□,605	□01,□□□	□11,□55	1,101,□50	26□,5□□	1,31□,000	$ 1,62□,161	$ 3,3□□,659	36.60□
2□	5□01 N□CLEAR MEDICINE-DIAG		0.109□6□	2□□,□□3	592,□5□	61,669	□0□,930	□□,602	161,00□	19□,251	603,606	21□,016	352,□96	$ 61□,305	$ 1,□62,29□	3□.02□
29	5□00 CT SCAN		0.0335□□	965,□25	1,329,310	60□,116	3,611,052	1,00□,025	1,111,959	1,92□,5□5	2,□□□,6□0	1,62□,205	5,50□,□□2	$ □,505,151	$ □,□□1,001	□□.32□
30	6000 LABORATORY		0.1019□6	3,□01,□00	1,933,096	1,□9□,0□2	□,□2,02□	3,130,256	1,2□3,1□0	5,520,0□2	3,255,□□□	□,1□3,992	5,6□9,□62	$ 1□,1□5,□10	$ 11,1□□,151	□□.0□□
31	6500 RESPIRATORY THERAPY		0.2211□1	□□5,□91	125,230	195,□99	212,□21	65,□6□1	2□1,5□9	1,05□,306	292,69□	□3□,□2□	220,□93	$ 2,6□□,2□□	$ 902,19□	5□.□9□
32	6600 PHYSICAL THERAPY		0.□□3051	16□,052	1□9,□12	1□,0□2	1,□6□,19□	192,955	162,962	□13,□01	□3□,219	13□,6□3	3□□,6□0	$ □92,□90	$ 2,213,□90	39.0□□
33	6900 ELECTROCARDIOLOGY		0.0□53□□	□5□,561	525,30□	1□0,395	□02,6□5	6□□,010	□□□,3□□	1,050,6□0	3,216,621	□69,□6□	1,9□□6,6□6	$ 2,363,636	$ 5,□31,9□1	30.□2□
3□	□100 MEDICAL S□PPLIES CHARGED TO PATIENT		0.6□□551	1,6□□,25□	□□3,□□5	□22,23□	1,1□9,□11	1,□2□3□5	362,□0□	2,63□,2□5	93□,0□5	1,52□,9□6	1,05□,535	$ 6,56□,126	$ 2,920,36□	□0.□9□
35	□200 IMPL. DE□. CHARGED TO PATIENTS		0.15519□	3□6,□95	1,032	13,3□1	□5□,21	1□1,201	291,333	6□3,□□□	912,6□2	160,561	3□2,□□□	$ 1,225,261	$ 1,662,□6□	25.22□
36	□300 DR□GS CHARGED TO PATIENTS		0.199119	□,59□,1□0	2,29□,□65	1,□□6,252	2,5□□,□□2	□,05□,□6□	2,95□,1□0	□,900,316	2,□52,6□□	□,1□5,290	□,03□,□6□	$ 15,302,1□6	$ 10,25□,□9□	□2.□1□
3□	□□00 RENAL DIALYSIS		0.0□2□□□	150,□32	-	5,6□□□	-	59□,925	-	560,1□□	-	1□,220	-	$ 1,315,533	$ -	1.□□□
3□	9000 CLINIC		0.2□339□	266	□6□,□□0	1,□0□	90,562	11,5□□	1□□,2□3	19,6□1	□12,□□0	□,3□□	10□,□53	$ 33,1□□	$ 1,119,0□5	16.69□
39	9100 EMERGENCY		0.309629	561,013	□□□,□6□	2□□,2□3	3,130,0□2	521,66□	□6□,530	□□3,2□0	1,166,6□5	69□,522	3,□35,25□	$ 2,1□3,20□	$ 5,6□9,151	5□.31□
□0			-											$ -	$ -	
□1			-											$ -	$ -	
□2			-											$ -	$ -	
□3			-											$ -	$ -	
□□			-											$ -	$ -	
□5			-											$ -	$ -	
□6			-											$ -	$ -	
□□			-											$ -	$ -	
□□			-											$ -	$ -	
□9			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
5□			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
5□			-											$ -	$ -	
5□			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

□. In□State □edicaid and All Uninsured Inpatient and Outpatient □ospital Data:

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs □with Medicaid Secondary□		In-State Other Medicaid Eligibles □Not Included Elsewhere□		□ninsured		Total In-State Medicaid	
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
6□				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
6□				-											$ -	$ -
6□				-											$ -	$ -
69				-											$ -	$ -
□0				-											$ -	$ -
□1				-											$ -	$ -
□2				-											$ -	$ -
□3				-											$ -	$ -
□□				-											$ -	$ -
□5				-											$ -	$ -
□6				-											$ -	$ -
□□				-											$ -	$ -
□□				-											$ -	$ -
□9				-											$ -	$ -
□0				-											$ -	$ -
□1				-											$ -	$ -
□2				-											$ -	$ -
□3				-											$ -	$ -
□□				-											$ -	$ -
□5				-											$ -	$ -
□6				-											$ -	$ -
□□				-											$ -	$ -
□□				-											$ -	$ -
□9				-											$ -	$ -
90				-											$ -	$ -
91				-											$ -	$ -
92				-											$ -	$ -
93				-											$ -	$ -
9□				-											$ -	$ -
95				-											$ -	$ -
96				-											$ -	$ -
9□				-											$ -	$ -
9□				-											$ -	$ -
99				-											$ -	$ -
100				-											$ -	$ -
101				-											$ -	$ -
102				-											$ -	$ -
103				-											$ -	$ -
10□				-											$ -	$ -
105				-											$ -	$ -
106				-											$ -	$ -
10□				-											$ -	$ -
10□				-											$ -	$ -
109				-											$ -	$ -
110				-											$ -	$ -
111				-											$ -	$ -
112				-											$ -	$ -
113				-											$ -	$ -
11□				-											$ -	$ -
115				-											$ -	$ -
116				-											$ -	$ -
11□				-											$ -	$ -
11□				-											$ -	$ -
119				-											$ -	$ -
120				-											$ -	$ -
121				-											$ -	$ -
122				-											$ -	$ -
123				-											$ -	$ -
12□				-											$ -	$ -
125				-											$ -	$ -
126				-											$ -	$ -
12□				-											$ -	$ -
					$ 15,□6,□□2	$ 11,06□,230	$ □,069,□11	$ 2□,0□0,9□3	$ 13,695,900	$ 9,636,20□	$ 22,5□0,□1□	$ 21,0□□,□□2	$ 15,6□6,2□9	$ 2□,102,6□□		

□. In□State □edicaid and All Uninsured Inpatient and Outpatient □ospital Data:

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs □with Medicaid Secondary□		In-State Other Medicaid Eligibles □Not Included Elsewhere□		□ninsured		Total In-State Medicaid		
	□otals / Payments													
12□	□otal Charges *(includes organ acquisition from Section J)*	$ 19,10□,5□□	$ 11,06□,230	$ 10,025,333	$ 2□,0□0,9□3	$ 16,□20,620	$ 9,636,20□	$ 2□,629,630	$ 21,0□□,□□2	$ 19,13□,□52 □Agrees to Exhibit A□	$ 2□,102,6□□ □Agrees to Exhibit A□	$ □3,1□□,1□0	$ 65,□69,□53	35.96□
129	Total Charges per PS□R or Exhibit Detail	$ 19,10□,5□□	$ 11,06□,230	$ 10,025,333	$ 2□,0□0,9□3	$ 16,□20,620	$ 9,636,20□	$ 2□,629,630	$ 21,0□□,□□2	$ 19,13□,□52	$ 2□,102,6□□			
130	□nreconciled Charges □Explain □ariance□	-	-	-	-	-	-	-	-	-	-			
131	**□otal Calculated Cost □ncludes organ ac□uisition from Section □□**	$ □,13□,069	$ 2,350,1□9	$ □,□05,0□□	$ 5,□63,5□□	$ 6,1□0,66□	$ 1,910,205	$ 9,9□0,□□□	$ □,100,96□	$ 6,292,399	$ 5,102,3□□	$ 2□,990,265	$ 13,□2□,□65	□3.0□□
132	Total Medicaid Paid Amount □excludes TPL, Co-Pay and Spend-Down□	$ □,662,29□	$ 2,330,9□□				$ 132,□□5		$ 35,9□□			$ □,662,29□	$ 2,□99,□26	
133	Total Medicaid Managed Care Paid Amount □excludes TPL, Co-Pay and Spend-Down□See Note E□			$ 3,569,0□1	$ 3,□□□,3□2		$ 3,□05		$ 1,613			$ 3,569,0□1	$ 3,□□9,□00	
13□	Private Insurance □ncluding primary and third party liability□	$ 10□,□93	$ 1,20□				$ 9□,26□		$ □,203			$ 10□,□93	$ 1□3,6□□	
135	Self-Pay □ncluding Co-Pay and Spend-Down□				$ 255		$ 1,3□9					$ -	$ 1,63□	
136	Total Allowed Amount from Medicaid PS□R or RA Detail □All Payments□	$ □,□66,□□□	$ 2,332,1□2	$ 3,569,0□1	$ 3,□□□,63□									
13□	Medicaid Cost Settlement Payments □See Note B□		$ □,591□									$ -	$ □,591□	
13□	Other Medicaid Payments Reported on Cost Report Year □See Note C□											$ -	$ -	
139	Medicare Traditional □non-HMO□Paid Amount □excludes coinsurance/deductibles□					$ □,635,0□0	$ 1,□61,92□		$ 10,65□			$ □,635,0□0	$ 1,□□2,5□□	
1□0	Medicare Managed Care □HMO□Paid Amount □excludes coinsurance/deductibles□							$ □,500,322	$ □,553,13□			$ □,500,322	$ □,553,13□	
1□1	Medicare Cross-Over Bad Debt Payments					$ 1□3,□33	$ 93,991					$ 1□3,□33	$ 93,991	
1□2	Other Medicare Cross-Over Payments □See Note D□					$ □115,31□	$ 6□,351					$ □115,31□	$ 6□,351□	
1□3	Payment from Hospital □ninsured During Cost Report Year □Cash Basis□									$ 1,501,309 □Agrees to Exhibit B and B-1□	$ 1,693,522 □Agrees to Exhibit B and B-1□			
1□□	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B □ B-1 □from Section E□									$ -	$ -			
1□5	**Calculated Payment Shortfall / □Longfall□PRIOR □O SUPPLE□EN□AL PA□□EN□S AND DS**□□	$ 2,36□,2□2	$ 23,55□	$ 1,135,96□	$ 1,61□,910	$ 1,□□□,069	$ □116,□□5□	$ 1,□□0,162	$ □5□5,61□□	$ □,□91,090	$ 3,□0□,□25	$ 6,□60,□□0	$ 9□0,366	
1□6	**Calculated Payments as a Percentage of Cost**	6□□	99□	□6□	□0□	□6□	106□	□5□	113□	2□□	33□	□□□	93□	
1□□	**□otal □edicare Days from □/S S□3 of the Cost Report Excluding Swing□Bed □C/R, □/S S□3, Pt. I, Col. □, Sum of Lns. 2, 3, 4, □4, □□, □□, □□less lines** □□ □□					15,2□3								
1□□	**Percent of cross□over days to total □edicare 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 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. □PL 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 □edicaid Data:

Cost Report Year □10/01/2020-09/30/2021□ COL□ □ITT REGIONAL MEDICAL CENTER

Line □	Cost Center Description	□edicaid Per Diem Cost for Routine Cost Centers	□edicaid 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 □	From Section □	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□	From PS□□ S□mmar□ □□ote A□		
	Routine Cost Centers □list below□:			Days		Days		Days		Days		Days	
1	03000 AD□LTS □ PEDIATRICS	$ 1,132.50		2								2	
2	03100 INTENSI□E CARE □NIT	$ 1,2□□.□1		2								2	
3	03200 CORONARY CARE □NIT	$ -										-	
□	03300 B□RN INTENSI□E CARE □NIT	$ -										-	
5	03□00 S□RGICAL INTENSI□E CARE □NIT	$ -										-	
6	03500 OTHER SPECIAL CARE □NIT	$ -										-	
□	0□000 S□BPRO□IDER I	$ -										-	
□	0□100 S□BPRO□IDER II	$ -										-	
9	0□200 OTHER S□BPRO□IDER	$ -										-	
10	0□300 N□RSERY	$ □1□.03		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
1□		$ -										-	
15		$ -										-	
16		$ -										-	
1□		$ -										-	
1□			□otal Days	6		-		-		-		6	
19	Total Days per PS□R or Exhibit Detail			6		-		-		-			
20	□nreconciled Days □Explain □ariance□			□		□		□		□			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 6,062								$ 6,062	
21.01	Calculated Routine Charge Per Diem			$ 1,010.33		$ -		$ -		$ -		$ 1,010.33	
	Ancillary Cost Centers □from □ /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□		0.50□992	-	-							$ -	$ -
23	5000 OPERATING ROOM		0.22253□	5,2□□	-							$ 5,2□□	$ -
2□	5100 RECO□ERY ROOM		0.22□232	□5□	-							$ □5□	$ -
25	5200 DELI□ERY ROOM □ LABOR ROOM		1.1199□5	139	-							$ 139	$ -
26	5300 ANESTHESIOLOGY		0.59□□□□	-	-							$ -	$ -
2□	5□00 RADIOLOGY-DIAGNOSTIC		0.3□5155	2□2	6,96□							$ 2□2	$ 6,96□
2□	5□01 N□CLEAR MEDICINE-DIAG		0.109□6□	-	-							$ -	$ -
29	5□00 CT SCAN		0.0335□□	2,□50	20,□3□							$ 2,□50	$ 20,□3□
30	6000 LABORATORY		0.1019□6	11,9□1	29,6□2							$ 11,9□1	$ 29,6□2
31	6500 RESPIRATORY THERAPY		0.2211□1	3,□□2	2,5□□							$ 3,□□2	$ 2,5□□
32	6600 PHYSICAL THERAPY		0.□□3051	-	23□121							$ -	$ 23□121
33	6900 ELECTROCARDIOLOGY		0.0□53□□	2,569	1,□2□							$ 2,569	$ 1,□2□
3□	□100 MEDICAL S□PPLIES CHARGED TO PATIENT		0.6□□551	5,021	3,93□							$ 5,021	$ 3,93□
35	□200 IMPL. DE□. CHARGED TO PATIENTS		0.15519□	-	-							$ -	$ -
36	□300 DR□GS CHARGED TO PATIENTS		0.199119	□,□3□	1□,□69							$ □,□3□	$ 1□,□69
3□	□□00 RENAL DIALYSIS		0.0□2□□□	-	-							$ -	$ -
3□	9000 CLINIC		0.2□339□	210	-							$ 210	$ -
39	9100 EMERGENCY		0.309629	2,20□	29,60□							$ 2,20□	$ 29,60□
□0			-									$ -	$ -
□1			-									$ -	$ -
□2			-									$ -	$ -
□3			-									$ -	$ -
□□			-									$ -	$ -
□5			-									$ -	$ -
□6			-									$ -	$ -
□□			-									$ -	$ -
□□			-									$ -	$ -

I. Out of State edicaid Data:

Cost Report Year 10/01/2020-09/30/2021 COL ITT REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs with Medicaid Secondary		Out-of-State Other Medicaid Eligibles Not Included Elsewhere		Total Out-Of-State Medicaid	
9			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
5			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
5			-									$ -	$ -
5			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
6			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
6			-									$ -	$ -
6			-									$ -	$ -
69			-									$ -	$ -
0			-									$ -	$ -
1			-									$ -	$ -
2			-									$ -	$ -
3			-									$ -	$ -
			-									$ -	$ -
5			-									$ -	$ -
6			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
9			-									$ -	$ -
0			-									$ -	$ -
1			-									$ -	$ -
2			-									$ -	$ -
3			-									$ -	$ -
			-									$ -	$ -
5			-									$ -	$ -
6			-									$ -	$ -
			-									$ -	$ -
			-									$ -	$ -
9			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
9			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
9			-									$ -	$ -
9			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
10			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
10			-									$ -	$ -
10			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out□of□State □edicaid Data:

Cost Report Year □10/01/2020-09/30/2021□ COL□□ITT REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs □with Medicaid Secondary□		Out-of-State Other Medicaid Eligibles □Not Included Elsewhere□		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
11□			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
11□			-									$ -	$ -
11□			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
12□			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
12□			-									$ -	$ -
				$ □3,961	$ 350,□93	$ -	$ -	$ -	$ -	$ -	$ -		

□otals / Payments

12□	**□otal Charges □ncludes organ ac□uisition from Section □□**	$ 50,023	$ 350,□93	$ -	$ -	$ -	$ -	$ -	$ -	$ 50,023	$ 350,□93
129	Total Charges per PS□R or Exhibit Detail	$ 50,023	$ 350,□93	$ -	$ -	$ -	$ -	$ -	$ -		
130	□nreconciled Charges □Explain □ariance□	-	-	-	-	-	-	-	-		
131	**□otal Calculated Cost □ncludes organ ac□uisition from Section □□**	$ 15,996	$ 136,□36	$ -	$ -	$ -	$ -	$ -	$ -	$ 15,996	$ 136,□36
132	Total Medicaid Paid Amount □excludes TPL, Co-Pay and Spend-Down□	$ 11,26□	$ 51,902							$ 11,26□	$ 51,902
133	Total Medicaid Managed Care Paid Amount □excludes TPL, Co-Pay and Spend-Down□□See Note E□									$ -	$ -
13□	Private Insurance □ncluding primary and third party liability□									$ -	$ -
135	Self-Pay □ncluding Co-Pay and Spend-Down□									$ -	$ -
136	Total Allowed Amount from Medicaid PS□R or RA Detail □All Payments□	$ 11,26□	$ 51,902	$ -	$ -						
13□	Medicaid Cost Settlement Payments □See Note B□									$ -	$ -
13□	Other Medicaid Payments Reported on Cost Report Year □See Note C□									$ -	$ -
139	Medicare Traditional □non-HMO□Paid Amount □excludes coinsurance/deductibles□									$ -	$ -
1□0	Medicare Managed Care □HMO□Paid Amount □excludes coinsurance/deductibles□									$ -	$ -
1□1	Medicare Cross-Over Bad Debt Payments									$ -	$ -
1□2	Other Medicare Cross-Over Payments □See Note D□									$ -	$ -
1□3	**Calculated Payment Shortfall / □Longfall□□PRIOR □O SUPPLE□ EN□AL PA□□ EN□S AND DS□□**	$ □,□32	$ □□93□	$ -	$ -	$ -	$ -	$ -	$ -	$ □,□32	$ □□,93□
1□□	**Calculated Payments as a Percentage of Cost**	□0□	3□□	0□	0□	0□	0□	0□	0□	□0□	3□□

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

Cost Report Year (10/01/2020-09/30/2021) | COLUMBIA REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-On 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 Organ Worksheet D Part II Line 61	Adjustment Cost Factor on Section I Line 1 Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Adjustment Cost	Similar to Instructions from Cost Report D/S Part II Line 66 Substitute Medicare with Medicaid/ Cross-Over Uninsured See Note B Below	Cost Report Organ Worksheet D Part II 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 Hospitals Own Internal Analysis	From Hospitals 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 I 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.**

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

Cost Report Year (10/01/2020-09/30/2021) | COLUMBIA REGIONAL MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-On 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 Organ Worksheet D Part II Line 61	Adjustment Cost Factor on Section I Line 1 Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Adjustment Cost	Similar to Instructions from Cost Report D/S Part II Line 66 Substitute Medicare with Medicaid/ Cross-Over Uninsured See Note B Below	Cost Report Organ Worksheet D Part II Line 62	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A	From Paid Claims Data or Provider Logs Note A
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available. If not, use hospital's logs and submit with survey.

Note B: **Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.**

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2020-09/30/2021) COL(S) (ITT REGIONAL MEDICAL CENTER

(Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)(1)		$ 1,569,9(6		
1a	(Original (Trial (Balance Account (Code and (Account (that includes (Gross Provider (Tax (Assessment		Expense	10.(350.6(3(	(1) (Account ((
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2(		$ 1,569,9(6	5.00	(1) here is the cost incl(de(on (/s A((
3	Difference (Explain Here ----------((		$ -		
	Provider (ax Assessment Reclassifications (from w/s A((of the (edicare cost report(				
(	(eclassification (o(e				((eclassifie(to / (from((
5	(eclassification (o(e				((eclassifie(to / (from((
6	(eclassification (o(e				((eclassifie(to / (from((
(	(eclassification (o(e				((eclassifie(to / (from((
	DS(UCC ALLO(ABLE (Provider (ax Assessment Ad(ustments (from w/s A((of the (edicare cost report(				
(	(eason for a((stment				(A((ste(to / (from((
9	(eason for a((stment				(A((ste(to / (from((
10	(eason for a((stment				(A((ste(to / (from((
11	(eason for a((stment				(A((ste(to / (from((
	DS(UCC NON(ALLO(ABLE Provider (ax Assessment Ad(ustments (from w/s A((of the (edicare cost report(				
12	(eason for a((stment				
13	(eason for a((stment				
1(	(eason for a((stment				
15	(eason for a((stment				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,569,9(6		

DS(UCC Provider (ax Assessment Ad(ustment:

1(	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider (ax Assessment Ad(ustment to (edicaid (Uninsured:		
1(	Medicaid Hospital	**Charges Sec. (**	139,(5(,939
19	(ninsured Hospital	**Charges Sec. (**	(6,2(1,(26
20	Total Hospital	**Charges Sec. (**	516,329,030
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid (CC		2(.01(
22	Percentage of Provider Tax Assessment Adjustment to include in DSH (ninsured (CC		(.96(
23	Medicaid Provider Tax Assessment Adjustment to DSH (CC		$ -
2(	(ninsured Provider Tax Assessment Adjustment to DSH (CC		$ -
25	Provider Tax Assessment Adjustment to DSH (CC		(

(Assessment m(st e(cl(de an(non(hos(ital assessment s(ch as ((rsin(Facilit((

((he (ross Allo(a(le Assessment (ot (incl(de(in the (ost (e(ort (line 17(a(ove((ill (e a((ortione(to (e(ical(an((nins(re((ase(on char(es sec(((nless the hos(ital (rovi(es a revise(cost re(ort to incl(de the amo(nt in the cost to char(e ratios an((er (iems (se(in the s(rve((

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

YEAR 2022

List of Hospital Joint Ventures and Ownership Interest

Entity Name	Domicile	Nature of Ownership or Interst	Book Value of Ownership or Interest	Notes
Not Applicable				

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

Fiscal Year Ending: September 30th 2022

List of Hospital Indebtedness- (HB 321)

				In Default ?		In Forbearance?	
Lender Name	Orgination Date	Due Date	Outstanding Balance	Yes	No	Yes	No
Ameris Bank- Revenue Certificate 2016A	9/1/2016	9/5/2031	8,367,381.54		x		x
Ameris Bank- Revenue Certificate 2016B	9/1/2016	9/5/2026	14,785,999.12		x		x
Ameris Bank- Revenue Certificate 2020A	10/1/2020	12/5/1940	8,425,865.03		x		x
Ameris Bank- Revenue Certificate 2020B	12/15/2021	12/5/2040	16,874,490.09		X		X
N/P Senior Care	2/28/2022	3/5/2029	6,014,147.05		x		x
Mako Robot	9/1/2021	9/1/2028	729,994.87		x		x
South west GA Bank	5/26/2019	4/26/2024	585,691.04		x		x

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

Real Property Holdings Owned by the Hospital

				Current Healthcare Purpose ?		Improvements		
Location	**Parcel ID Number**	**Estimated Size (Acres)**	**Purchase Price**	**Yes**	**No**	**Yes**	**No**	**Notes**
3026 South Main Street, Moultrie, GA	C039B080	1	95,000.00		x		x	LAND ACROSS FROM THE STREET
Peachtree Court, S Main, Moultrie, GA	C039C010	1.16	15,000.00		x		x	LAND ACROSS FROM THE STREET
912, 2nd Street SE, Moultrie, GA	M026101	0.34	149,246.76	x			x	Deloach
209 13th Ave, SW Moultrie, GA	M027013	1 lot	75,000.00		x		x	LAND ACROSS FROM THE STREET
1912 South Main St., Moultrie GA	M029027A	0.6	215,465.99	X		x		PFS Building
Building 316 Sunset Circle, Moultrie GA	M042010	0.5	147,166.00	x			x	
115 31ST Avenue SE, Moultrie GA	M042016	0.59	1,143,617.00	X		x		Trescot building- old womens health
Sunset Circle, Unit 12 Hospital Park, Moultrie, GA	M042022	0.14	42,000.00		x		x	land next to Primary Care
Unit 11 Hospital Park, Moultrie, GA	M042023	0.13	35,000.00		x		x	land next to Primary Care
6 Hospital Park, Moultrie GA	M042024	0.23	1,240,426.21	X		X		PCC Building
31st Avenue SE, Moultrie GA	M042025	0.14	228,600.00	X		x		SLEEP LAB
9 Hospital Park, Moultrie GA	M042028	0.16	375,546.74	X		x		Old GA South, PCOM building
31st Avenue SE, Moultrie GA	M042029	0.05	325,000.00	X			x	Land in between building in hospital park
7 Hospital Park, Moultrie, GA	M042030		389,231.21	X		X		Pulmonology Building
9, Hospital Park, Moultrie GA	M042031	0.1	125,000.00	x		x		Lab Building
13 Hospital Park, Moultrie GA	M042035	0.12	227,500.00	X		x		Education Building
3131 South Main St, Moultrie GA	M043001	29.97	70,755,541.60	X		x		Main Hospital- includes the renovation
3 Magnolia CT, Moultrie	M043011B		620,000.00	X			X	D.W Adcock Building
1, Magnolia CT, Moultrie, GA	M043011D		1,116,714.08	X		x		GA South- includes renovation
8, Laurel Court, Moultrie, GA	M043011G		2,434,976.32	X		X		Kirk Clinic
4 Live oak CT, Moultrie GA	M043011H	0.59	4,573,937.33	x			x	Sterling Center
8 Live oak CT, Moultrie , GA	M043011J	0.31	569,920.00	X			X	coridsta building
1 Sweet Bay CT, Moultrie, GA	M043011K	0.76	1,300,000.00	X			X	Physician Center
Sweet Bay CT, Moultrie, GA	M043011L	0.44	3,230,502.67	X			X	sterling center women building
3100, Veterans Parkway S, Moultrie GA	M047A015	2.7	2,568,211.80	X		x		Rehab Building
31st Avenue SE, Moultrie GA	M047A018	0.14	647,246.01	x		x		Dialysis Building
3300 Freedom Lane SE, Moultrie GA	M047A023B	2.51	10,793.00	x				Parking lot- Accounting building
3300 Freedom Lane SE, Moultrie GA	M047A024	3.00	468,742.00	X			X	Accounting Building- Randy Knights
Rowland Drive,Moultrie, Ga	M048A014	2.00	300,000.00	x			x	Home health parking lot
Rowland Drive,Moultrie, Ga	M048A015	1.4	150,000.00	x			x	Home health parking lot

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

End of Year Listing of Hospital Net Assets (HB 321)- Fiscal Year 2022

	Unrestricted Net Assets ($)	Restricted-Expendable Net Assets ($)*	Restricted-Non-Expendable Net Assets ($)*	Total Net Assets ($)	Notes
Hospital Authority (Hospital, CRH & Clinics)	66,515,004	3,004,156	96,492,421	166,011,581	
Hospital Owned or Controlled Foundation	8,161,892.00	1,185,043.00	113,570.00	9,460,505.00	

Colquitt Regional Medical Center

Moultrie, GA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Hospital Accreditation Program

May 1, 2021

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6714
Print/Reprint Date: 07/21/2021

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

Colquitt Regional Medical Center

Moultrie, GA

has been Accredited by

The Joint Commission

Which has surveyed this organization and found it to meet the requirements for the

Ambulatory Health Care Accreditation Program

April 29, 2021

Accreditation is customarily valid for up to 36 months.

Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6714
Print/Reprint Date: 07/21/2021

Mark R. Chassin, MD, FACP, MPP, MPH
President

The Joint Commission is an independent, not-for-profit national body that oversees the safety and quality of health care and other services provided in accredited organizations. Information about accredited organizations may be provided directly to The Joint Commission at 1-800-994-6610. Information regarding accreditation and the accreditation performance of individual organizations can be obtained through The Joint Commission's web site at www.jointcommission.org.

ANNUAL COMMUNITY BENEFIT REPORT

[As Required Pursuant to O.C.G.A. § 31-7-90.1(a) and O.C.G.A. § 14-3-305 (d)]

To be filed with the Clerk of the Superior Court of the County in which the Authority's Hospital is located and with the governing body (or bodies) of the Authority's participating unit(s).

Clerk: After recording, please return to: Julie Bhavnani
Colquitt Regional Medical Center
P.O Box 40, Moultrie GA 31776

For the Period October 1, 2021 through September 30 2022 (or dates for fiscal year).

PART A. GENERAL INFORMATION

1. Facility Name or Hospital Authority Name: Hospital Authority of Colquitt County, Georgia

2. Street Address: 3131 South Main Street, Moultrie, GA- 31768

3. Mailing Address (if different from Street Address): P.O Box 40
Moultrie, Georgia 31776

4. County in which Facility or Hospital is located: Colquitt County

5. Governing Body (or Bodies) of Hospital Authority's Participating Units: City of Moultrie, Colquitt County

6. Person Authorized to respond to inquiries about this report:
   a. Name: Julie Bhavnani
   b. Title: Vice President and Chief Financial Officer
   c. Phone Number: (229) 891-9244

7. Report data for the full preceding 12-month period, either calendar of fiscal year. Confirm that the correct report period has been used by completing the report period beginning and ending dates below.
   a. Report Period: Beginning Date 10/1/2021 Ending Date 9/30/2022
   b. Was the hospital operational for the entire year? [X]Yes [ ]No
   If No, provide the dates the hospital was operational (*explain*):

8. Verification of Review by Facility Chief Executive Officer:

Reviewed and Approved: _____ Date: 8/17/23
Signature of CEO (Original Signature)

Julie Bhavnani, Vice president and Chief Financial Officer
(Typed/Printed Name and Title of CEO)

ANNUAL REPORT OF CERTAIN TRANSACTIONS

[As Required Pursuant to O.C.G.A. §31-7-90.1 and O.C.G.A. §14-3-305(d)]

To be filed with the Clerk of the Superior Court of the County in which the Authority's Hospital is located and with the governing body (or bodies) of the Authority's participating unit(s).

Note: A separate form should be completed and filed for the Hospital Authority and each nonprofit corporation formed, created or operated by or on behalf of the Hospital Authority (a "Nonprofit") in order to operate the hospital.

Clerk: After recording, please return to: Colquitt Regional Medical Center
James I. Matney, President & CEO
P.O Box 40, Moultrie, GA 31776

For the Period October 1, 2021 through September 30, 2022.

PART A. GENERAL INFORMATION

1. Name of Hospital Authority or Nonprofit: Hospital Authority of Colquitt County, Georgia
2. Street Address: 3131 South Main Street, Moultrie, GA 31768
3. Mailing Address (if different from Street Address): P.O Box 40
Moultrie, GA 31776
4. County in which Hospital is located: Colquitt
5. Governing Body (or Bodies) of Hospital Authority's Participating Units: City Of Moultrie, Colquitt County
6. Person Authorized to respond to inquiries about this report:
   a. Name: Julie Bhavnani
   b. Title: Vice President & Chief Financial Officer
   c. Phone Number: (229) 891-9244

PART B. BUSINESS TRANSACTIONS – HOSPITAL AUTHORITY

If this report is being filed on behalf of a Hospital Authority, please identify below any entity in which a Hospital Authority member (or a Hospital Authority member's spouse, child or sibling) has a direct or indirect ownership of assets or stock constituting between 10% and 25% and which Transacted Business with the Hospital Authority during the year covered by this report. (Attach additional pages, if necessary.) For purposes hereof, the term "Transacted Business" means any sale or lease of any personal property, real property, or services on behalf of oneself or on behalf of any third party as an agent, broker, dealer, or representative.

B. BUSINESS TRANSACTIONS - HOSPITAL AUTHORITY (Continued)

Name of Hospital Authority Member (or Family Member)	Name of Entity	Type of Ownership Interest	Percentage Ownership Interest	Nature of Business Transaction
1.				
2.				
3.				
4.				
5.				

PART C. BUSINESS TRANSACTIONS -- NONPROFIT

If this report is being filed on behalf of a Nonprofit, please identify below any entity in which a member of the board of such Nonprofit (or such board member's spouse, child or sibling) has a direct or indirect ownership of assets or stock constituting between 10% and 25% and which Transacted Business with the Nonprofit during the year covered by this report. (Attach additional pages, if necessary.) For purposes hereof, the term "Transacted Business" means any sale or lease of any personal property, real property, or services on behalf of oneself or on behalf of any third party as an agent, broker, dealer, or representative.

Name of Nonprofit Board Member (or Family Member)	Name of Entity	Type of Ownership Interest	Percentage Ownership Interest	Nature of Business Transaction
1.				
2.				
3.				
4.				
5.				

PART D. CERTIFICATION

By signing below, I certify that, to the best of my knowledge and belief, this report is complete and accurate as of the date of signing.

Signature

8/17/23
Date

Julie Bhavnani
Name (please print or type)

Vice President & CFO
Title

Sworn to and subscribed before me this 17 day of August, 2023.

Rebecca Hunter
Notary Public

My Commission expires: June 2, 2024
[Notarial Seal]

OFFICIAL SEAL
REBECCA HUNTER
NOTARY PUBLIC – GEORGIA
COLQUITT COUNTY
My Commission Expires June 2, 2024

HOSPITAL AUTHORITY OF COULQUITT COUNTY
INDIGENT/CHARITY CARE WRITE-OFFS
FISCAL YEAR ENDED SEPTEMBER 2021

	Inpatient			
	Indigent		Charity	
County	# Patients	Adjustments	# Patients	Adjustments
Colquitt	309	2,140,860	109	661,629.52
Thomas	4	18,452	7	62,697.34
Out of State	1	14,712		-
Brooks	5	5,237	3	6,951.54
Mitchell	8	68,817	2	1,882.60
Tift	6	8,245	3	1,755.00
Lowndes	2	1,301		-
Cook	1	1,580	1	1,630.10
Ben Hill	1	683		-
Worth	4	5,873		-
Dougherty	1	1,800	1	15,858.03
Turner	1	29,455	1	1,557.60
Cobb		-	1	1,488.86
Sub-total	**343**	**2,297,014**	**128**	**755,450.59**

	Outpatient			
	Indigent		Charity	
County	# Patients	Adjustments	# Patients	Adjustments
Colquitt	3,811	3,543,548	1,647	639,255
Thomas	156	167,814	39	27,003
Out of State	34	20,153	29	34,797
Brooks	121	143,803	41	18,151
Mitchell	81	68,680	39	38,238
Webster	1	300		-
Pierce	4	11,789		-
Tift	87	127,989	18	14,419
Lowndes	40	30,146	5	20,579
Cook	34	18,374	34	8,011
Macon	3	161		-
Ben Hill	13	5,231	11	1,393
Franklin	3	3,712		-
Worth	13	9,757	4	915
Lee	2	4,987	5	743
Dougherty	28	41,054		-
Whitfield	9	1,913		-
Turner		-	1	52
Berrien	19	6,572	14	7,947
Twiggs		-	7	(412)
Cobb		-	5	1,931
Sub-total	**4,459**	**4,205,981**	**1,899**	**813,024**

Grand Total	**4,802**	**6,502,996**	**2,027**	**1,568,474**

Total write offs: **8,071,470**

Status **Active** PolicyStat ID **14068058**

COLQUITT REGIONAL MEDICAL CENTER

Origination	11/2003
Last Approved	07/2023
Last Revised	07/2023
Next Review	07/2025
Owner	Megan Ford: Patient Access
Policy Area	Patient Access

Financial Assistance Policy, 340.06

Dept:Patient Access

Subject: Financial Assistance Policy No. 340.06

I. PURPOSE:
To document the method by which medically indigent persons can qualify for medical indigent services under the Indigent Care Trust Fund Program administered by Colquitt Regional Medical Center. Medical indigent services are healthcare services provided to patients at no charge or on a sliding scale. Applicants must meet certain financial criteria of incomes below 200% of the Federal Poverty Level to qualify for free care. Applicants with incomes between 201% - 380% of the Federal Poverty Level will qualify for reduced charges based on a sliding scale.

II. DEFINITIONS:

A. ***Amounts Generally Billed (AGB):*** Means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with §1.501(r)-5(b).

B. ***Federal Poverty Guidelines (FPG):*** At the beginning of each year the federal government issues guidelines that will be used to determine eligibility for Colquitt Regional's Indigent Care Program. The federal guidelines can be found on the US Department of Health and Human Services website at https://aspe.hhs.gov/poverty-guidelines.

C. ***Gross Charges*** Means the hospitals full, established price for medical care that the hospital facility uniformly charges patients before applying any contractual allowances, discounts, or deductions.

D. ***Gross Income:*** Income as defined by the Internal Revenue Service (IRS), which includes but is not limited to: income from wages, salaries, tips; interest and dividend income; unemployment compensation, individual income policy, alimony, all social security income, disability income, self-employment income, rental income, and other taxable income. Examples of other sources of income that are not

included in the definition of Gross Income are food stamps, student loan, and foster care disbursement.

E. ***Medical Necessity***: Any procedure reasonably determined to prevent, diagnose, correct, cure, alleviate, or avert the worsening of conditions that endanger life, cause suffering or pain, result in illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, if there is no other equally effective, more conservative or less costly course of treatment available.

III. PROCEDURE:

A. The Financial Assistance Policy covers all emergency and other medically necessary care provided by Colquitt Regional Medical Center. In addition to care delivered by Colquitt Regional Medical Center emergent and medically necessary care delivered. Physician's covered by Colquitt Regional Medical Center's FAP include Emergency Room Physicians, Anesthesiologists, Radiologists, Hospitalists, Critical Care Physicians, Oncologists, and all Sterling Physician Group specialists who provide emergent and medically-necessary care at the hospital listed at https://colquittregional.com/sterling-physician-group on our website. Physicians not subject to Colquitt's FAP are community physicians and independent specialists who are not Colquitt Regional Medical Center physicians. Procedures exempt from the Indigent Care Program include:

1. Accounts involving services cosmetic in nature.
2. Procedures already discounted or offered at a promotional rate.

B. Colquitt Regional Medical Center will make available to all patients notification of the Financial Assistance Policy adopted by Colquitt Regional Medical Center. Notification will include placing downloadable electronic copies of the Financial Assistance Policy, the Financial Assistance Policy application form, and a plain language summary of the Financial Assistance Policy on the Colquitt Regional Medical Center website and paper copies of the Financial Assistance Policy, the Financial Assistance Policy application form, and a plain language summary of the Financial Assistance Policy in public locations in the hospital facility, including in the emergency room and all admissions areas. The Financial Assistance Policy, the Financial Assistance Policy application form, and a plain language summary of the Financial Assistance Policy will also be made available by mail without charge, if requested. A paper copy of the plain language summary of the Financial Assistance Policy will be offered to patients as part of the intake or discharge process. Conspicuous written notice of the availability of financial assistance under the Financial Assistance Policy, including the telephone number of the hospital facility office or department that can provide information about the Financial Assistance Policy application process and the direct website address where copies of the Financial Assistance Policy, the Financial Assistance Policy application form, and a plain language summary of the Financial Assistance Policy may be obtained, will be included on billing statements. Colquitt Regional Medical Center will also set up conspicuous public displays that notify and inform patients about the Financial Assistance Policy in the emergency room and admissions areas.

C. Patients wishing to apply for financial assistance may pick up a Financial Assistance application from the emergency room or at any admission area at the hospital, request one to be mailed, or download the application from the hospital website. Applications will be available in English and Spanish. The individual will be provided a plain language summary of this

Financial Assistance Policy.

D. Completed applications and required documentation should be turned in to the Financial Counselor's Office located at the Main Entrance of the Hospital. The time limit to apply for financial assistance is 250 days after the first post discharge bill.

E. The Financial Counselors will interview the patient and verify the data included on the application. Verification of gross income will be required and may take the form of, but not limited to, check stubs, income tax return, or written verification from employer. Applications will not be denied based solely upon an incomplete application. When an incomplete application is received, Financial Counselors will contact the patient/guarantor via mail to notify of additional information that is needed. The patient/guarantor will have six months from the date of the letter to return the requested information.

F. The Financial Counselors will then make an initial determination as to whether the individual is eligible for free services, discounted services, or ineligible for either free or discounted services. Determination will be made according to the Federal Poverty Guidelines regardless of race, color, creed, social status, national origin, gender, or religious affiliation. Final approval lies with the Director of Patient Access. Appropriate adjustments will be made at this time to the account(s) to reflect the outcome of the application. All applicants will be notified by mail with the determination of their application. As well, it is the patients' responsibility to reapply monthly for each account to be eligible for the Medical Indigent Care Program to continue.

G. Individuals may not be eligible for assistance if their plan of care is covered under liability or worker's compensation with no proof of denial of coverage or if the claim is still in litigation or where the payment went to the subscriber.

H. The Financial Counselors will maintain a file of recipients. A system generated report will be used for reporting purposes.

I. In the event that the individual disagrees with the original decision, the patient has the right to request reconsideration. All reconsiderations shall be made in writing. The Director of Patient Access will review the application and make a determination. The patient will be notified by mail of the reconsideration decision.

J. For financial purposes, Colquitt Regional Medical Center will utilize a cost to charges ratio of 65%. Over a twelve-month period beginning on July 1, and ending on June 30, Colquitt Regional Medical Center will expend an amount equal to no less than 90% of the hospital's total Trust Fund payment adjustments minus the amount transferred or deposited to the Trust Fund by or on behalf of the hospital.

K. Amounts Generally Billed (AGB) is determined by using the "look-back" method as defined in section 4(b)(2) of the IRS and Treasury's 501(r) final rule. In the method the medical center will divide the sum of claims paid the previous fiscal year by Medicare fee-for-service claims by the sum of the associated gross charges for those claims. Colquitt Regional Medical Center will not charge patients who are eligible for financial assistance more for emergency or medically necessary care than amounts generally billed to insured patients. The current AGB percentage is 76%.

L. Any patient seeking urgent or emergent care shall be treated without discrimination and ability to pay for care. Colquitt Regional Medical Center will operate in accordance with all federal and state requirements under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). Colquitt Regional Medical Center will provide emergency services in accordance

with 24 CFR 482.55 (or any successor regulation). Colquitt Regional Medical Center prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment for emergency medical conditions or permitting debt collection activities that interfere with the provision, without discrimination, or emergency medical care.

M. The collection actions that Colquitt Regional Medical Center may take are defined in a separate policy (No. 340.23 Collection/Bad Debt Policy). Members of the public may obtain a free copy of the Collection/Bad Debt Policy in the emergency room, in any admissions area, online at https://colquittregional.com/patients-visitors/financial-assistance, or, if requested, via mail.

Approval Signatures

Step Description	Approver	Date
CFO	Julie Bhavnani: Director of Accounting	07/2023
AVP	Samantha Allen: AVP of Revenue Cycle	07/2023
Director	Megan Ford: Patient Access	07/2023

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

Real Property Holdings Owned by the Hospital

				Current Healthcare Purpose ?		Improvements		
Location	**Parcel ID Number**	**Estimated Size (Acres)**	**Purchase Price**	**Yes**	**No**	**Yes**	**No**	**Notes**
3026 South Main Street, Moultrie, GA	C039B080	1	95,000.00		x		x	LAND ACROSS FROM THE STREET
Peachtree Court, S Main, Moultrie, GA	C039C010	1.16	15,000.00		x		x	LAND ACROSS FROM THE STREET
912, 2nd Street SE, Moultrie, GA	M026101	0.34	149,246.76	x			x	Deloach
209 13th Ave, SW Moultrie, GA	M027013	1 lot	75,000.00		x		x	LAND ACROSS FROM THE STREET
1912 South Main St., Moultrie GA	M029027A	0.6	215,465.99	X		x		PFS Building
Building 316 Sunset Circle, Moultrie GA	M042010	0.5	147,166.00	x			x	
115 31ST Avenue SE, Moultrie GA	M042016	0.59	1,143,617.00	X		x		Trescot building- old womens health
Sunset Circle, Unit 12 Hospital Park, Moultrie, GA	M042022	0.14	42,000.00		x		x	land next to Primary Care
Unit 11 Hospital Park, Moultrie, GA	M042023	0.13	35,000.00		x		x	land next to Primary Care
6 Hospital Park, Moultrie GA	M042024	0.23	1,240,426.21	X		X		PCC Building
31st Avenue SE, Moultrie GA	M042025	0.14	228,600.00	X		x		SLEEP LAB
9 Hospital Park, Moultrie GA	M042028	0.16	375,546.74	X		x		Old GA South, PCOM building
31st Avenue SE, Moultrie GA	M042029	0.05	325,000.00	X			x	Land in between building in hospital park
7 Hospital Park, Moultrie, GA	M042030		389,231.21	X		X		Pulmonology Building
9, Hospital Park, Moultrie GA	M042031	0.1	125,000.00	x		x		Lab Building
13 Hospital Park, Moultrie GA	M042035	0.12	227,500.00	X		x		Education Building
3131 South Main St, Moultrie GA	M043001	29.97	70,755,541.60	X		x		Main Hospital- includes the renovation
3 Magnolia CT, Moultrie	M043011B		620,000.00	X			X	D.W Adcock Building
1, Magnolia CT, Moultrie, GA	M043011D		1,116,714.08	X		x		GA South- includes renovation
8, Laurel Court, Moultrie, GA	M043011G		2,434,976.32	X		X		Kirk Clinic
4 Live oak CT, Moultrie GA	M043011H	0.59	4,573,937.33	x			x	Sterling Center
8 Live oak CT, Moultrie , GA	M043011J	0.31	569,920.00	X			X	coridsta building
1 Sweet Bay CT, Moultrie, GA	M043011K	0.76	1,300,000.00	X			X	Physician Center
Sweet Bay CT, Moultrie, GA	M043011L	0.44	3,230,502.67	X			X	sterling center women building
3100, Veterans Parkway S, Moultrie GA	M047A015	2.7	2,568,211.80	X		x		Rehab Building
31st Avenue SE, Moultrie GA	M047A018	0.14	647,246.01	x		x		Dialysis Building
3300 Freedom Lane SE, Moultrie GA	M047A023B	2.51	10,793.00	x				Parking lot- Accounting building
3300 Freedom Lane SE, Moultrie GA	M047A024	3.00	468,742.00	X			X	Accounting Building- Randy Knights
Rowland Drive,Moultrie, Ga	M048A014	2.00	300,000.00	x			x	Home health parking lot
Rowland Drive,Moultrie, Ga	M048A015	1.4	150,000.00	x			x	Home health parking lot

Colquitt Regional Medical Center Organizational Chart