

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

COMBINED FINANCIAL STATEMENTS

for the years ended September 30, 2023 and 2022



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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, 2023 and 2022, 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, based on our audits and the report of the other auditors, the accompanying combined financial statements present fairly, in all material respects, the financial position of the Authority as of September 30, 2023 and 2022, 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.

We did not audit the financial statements of Colquitt Regional Medical Center Insurance Segregated Portfolio (Segregated Portfolio), a blended component unit, which statements reflect total assets constituting 1% of combined total assets as of September 30, 2023 and 2022, and total revenues constituting less than 1% of combined total revenues for the years then ended. Those statements were audited by other auditors in accordance with International Standards on Auditing, whose report has been furnished to us, and our opinion, insofar as it relates to the amounts included for the Segregated Portfolio, is based solely on the report of the other auditors. We have applied additional audit procedures to meet the relevant requirements of auditing standards generally accepted in the United States of America.

Continued

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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. The financial statements of the Segregated Portfolio were not audited in accordance with *Governmental Auditing Standards*.

Change in Accounting Principle

As described in Note 1 to the combined financial statements, in 2023 the Authority adopted new accounting guidance, Governmental Accounting Standards Board Statement No. 96, *Subscription-Based Information Technology Arrangements*. Our opinion is not modified with respect to this matter.

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 judgment 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.

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 8 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 22, 2024, 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 22, 2024

PRESIDENT:

James L. Matney

TRUSTEES:

Richard E. Turner, Jr.

John Mark Mobley, Jr.

Howard L. Melton, M.D.

Johnny Brown, III

John W. Griffin

Richard T. Bass

Justin Baker, M.D.

Maureen A. Yearata, Ed.D.

Joe P. Baker

**Management's Discussion and Analysis
For The Year Ended September 30, 2023**

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, 2023, 2022, and 2021. 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

Continued

**Management's Discussion and Analysis
For The Year Ended September 30, 2023**

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

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.

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, 2023, 2022, and 2021:

Combined Balance Sheet

	Dollars in Thousands		
	<u>2023</u>	Restated <u>2022</u>	<u>2021</u> *
Current assets	\$ 52,454	\$ 46,473	\$ 59,998
Capital assets	130,782	120,670	110,648
Other noncurrent assets	97,745	85,849	95,228
Deferred outflows of resources	<u>3,218</u>	<u>3,393</u>	<u>-</u>
Total assets and deferred outflows of resources	<u>\$ 284,199</u>	<u>\$ 256,385</u>	<u>\$ 265,874</u>
Current liabilities	\$ 37,267	\$ 37,184	\$ 50,614
Noncurrent liabilities	51,111	53,337	49,882
Deferred inflows of resources	<u>6</u>	<u>11</u>	<u>-</u>
Total liabilities and deferred inflows of resources	<u>88,384</u>	<u>90,532</u>	<u>100,496</u>
Net position:			
Net investment in capital assets	71,739	59,930	56,457
Restricted	3,620	3,004	4,261
Unrestricted	<u>120,456</u>	<u>102,919</u>	<u>104,660</u>
Total net position	<u>195,815</u>	<u>165,853</u>	<u>165,378</u>
Total liabilities, deferred inflows of resources and net position	<u>\$ 284,199</u>	<u>\$ 256,385</u>	<u>\$ 265,874</u>

* The information presented for the fiscal year ending September 30, 2021 was not restated for the effect of GASB 96.

Continued

**Management's Discussion and Analysis
For The Year Ended September 30, 2023**

Financial Analysis of the Authority, Continued

The Authority's total assets increased by \$28,000,000 in year 2023. This increase is related to the increase in noncurrent cash and investments, 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 \$2,142,000 which is mainly related to the repayment of the Medicare advance payment and other long-term debt agreements.

Long-term debt decreased by \$1,696,00 compared to fiscal year 2022. Debt to capitalization for the year was 23.2% for 2023 compared to 26.8% for 2022.

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

The Authority established Colquitt Regional Medical Center Insurance Segregated Portfolio (Segregated Portfolio) on March 1, 2022 as a segregated portfolio plan in the Georgia Health Care Insurance Company, SPC. See Note 22 to the combined financial statements for additional information. The Segregated Portfolio is a blended component unit of the Authority.

The following table summarizes the statement of revenues, expenses and changes in net position as of September 30, 2023, 2022, and 2021:

Combined Statements of Revenues, Expenses and Changes in Net Position

	Dollars in Thousands		
	<u>2023</u>	<u>Restated 2022</u>	<u>2021</u>
Net patient service revenue	\$ 231,568	\$ 200,782	\$ 198,983
Other revenue	<u>9,168</u>	<u>5,620</u>	<u>4,634</u>
Total operating revenues	<u>240,736</u>	<u>206,402</u>	<u>203,617</u>
Salaries and employee benefits	108,416	99,239	87,964
Other operating expenses	103,894	88,386	87,490
Depreciation and amortization	<u>15,516</u>	<u>14,249</u>	<u>11,217</u>
Total operating expenses	<u>227,826</u>	<u>201,874</u>	<u>186,671</u>
Net operating income	<u>12,910</u>	<u>4,528</u>	<u>16,946</u>

Continued

**Management's Discussion and Analysis
For The Year Ended September 30, 2023**

Financial Analysis of the Authority, Continued

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

	Dollars in Thousands		
	<u>2023</u>	Restated <u>2022</u>	<u>2021</u>
Nonoperating revenues (expenses):			
Investment income	\$ 11,667	\$(15,918)	\$ 14,238
Interest expense	(1,537)	(1,538)	(1,325)
Grant stimulus funding	3,000	8,850	7,060
Other	<u>3,647</u>	<u>4,168</u>	<u>4,232</u>
Total nonoperating revenues (expenses)	<u>16,777</u>	<u>(4,438)</u>	<u>24,205</u>
Excess of revenues before contributions	29,687	90	41,151
Contributions for property acquisitions	<u>275</u>	<u>385</u>	<u>985</u>
Increase in net position	29,962	475	42,136
Net position, beginning of year	<u>165,853</u>	<u>165,378</u>	<u>123,242</u>
Net position, end of year	\$ <u>195,815</u>	\$ <u>165,853</u>	\$ <u>165,378</u>

Fiscal year 2023 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.

Total operating revenue grew by \$34,300,000 compared to prior year. This increase is related to volume and the addition of the skilled nursing facility.

Total operating expenses increased by \$26,000,000. The major portion was related to salaries, yearly incentives, health insurance claims, and supplies.

Overall, the operating income increased by \$8,400,000 compared to the 2022 financial statements.

Operating income in 2023 was \$12,900,000 operating margin of 5.3%. This compares to operating income of \$4,500,000 in 2022, and an operating margin of 2.2%.

Continued

**Management's Discussion and Analysis
For The Year Ended September 30, 2023**

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

In 2023, the Authority recorded a total non-operating gain of \$16,700,000 which was an increase of \$21,200,000 compared to 2022. This increase is attributed to an increase of investment income.

At the end of 2023, the Authority had \$130,800,000 invested in capital assets, net of accumulated depreciation. In 2023, the Authority's capital spending was related to construction of medical education building and other capital equipment.

As of September 30, 2023, the Authority had \$49,100,000 in revenue certificates, \$9,900,000 in other long-term debt, which is a total debt decrease of \$1,700,000 compared to 2022.

Master Plan and Construction

In 2023, the Authority finished 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, 2023 and 2022

	<u>2023</u>	Restated <u>2022</u>
ASSETS AND DEFERRED OUTFLOWS OF RESOURCES		
Current assets:		
Cash and cash equivalents	\$ 9,281,907	\$ 7,953,773
Current portion of designated funds	4,459,115	4,985,475
Patient accounts receivable, net of estimated uncollectibles of \$67,233,137 in 2023 and \$56,162,077 in 2022	25,168,902	23,743,643
Supplies	5,704,254	4,661,481
Notes receivable, current portion	454,099	480,610
Other current assets	<u>7,385,301</u>	<u>4,648,275</u>
Total current assets	<u>52,453,578</u>	<u>46,473,257</u>
Noncurrent cash and investments:		
Internally designated for:		
Capital acquisition	88,871,067	78,275,552
Employee benefits	635,000	635,000
Malpractice funding arrangement	2,289,786	1,300,580
Restricted by:		
Revenue Certificates - debt service reserve fund	<u>3,620,181</u>	<u>3,508,101</u>
Total noncurrent cash and investments	<u>95,416,034</u>	<u>83,719,233</u>
Capital assets:		
Nondepreciable capital assets	18,917,746	5,909,744
Depreciable capital assets, net of accumulated depreciation	107,958,424	109,647,283
Intangible right-to-use lease assets, net of accumulated amortization	214,663	236,932
Intangible right-to-use subscription IT assets, net of accumulated amortization	<u>3,691,344</u>	<u>4,876,042</u>
Total capital assets, net	<u>130,782,177</u>	<u>120,670,001</u>
Other assets:		
Notes receivable, excluding current portion	268,779	458,780
Other assets	<u>2,060,948</u>	<u>1,671,152</u>
Total other assets	<u>2,329,727</u>	<u>2,129,932</u>
Total assets	280,981,516	252,992,423
Deferred outflows of resources:		
Goodwill	<u>3,217,975</u>	<u>3,392,706</u>
Total assets and deferred outflows of resources	<u>\$ 284,199,491</u>	<u>\$ 256,385,129</u>

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

COMBINED BALANCE SHEETS, Continued
September 30, 2023 and 2022

	<u>2023</u>	Restated <u>2022</u>
LIABILITIES, DEFERRED INFLOWS OF RESOURCES AND NET POSITION		
Current liabilities:		
Current installments of long-term debt	\$ 7,931,911	\$ 7,402,799
Current portion of Medicare advance payments	-	179,435
Accounts payable	9,628,980	7,188,450
Accrued expenses	18,263,972	18,562,987
Estimated third-party payor settlements	1,159,868	805,215
Grant stimulus unearned revenue	<u>282,739</u>	<u>3,044,939</u>
Total current liabilities	37,267,470	37,183,825
Long-term debt, excluding current installments	<u>51,111,529</u>	<u>53,336,955</u>
Total liabilities	88,378,999	90,520,780
Deferred inflows of resources	<u>5,608</u>	<u>11,215</u>
Total liabilities and deferred inflows of resources	<u>88,384,607</u>	<u>90,531,995</u>
Net position:		
Net investment in capital assets	71,738,737	59,930,247
Restricted	3,620,181	3,004,156
Unrestricted	<u>120,455,966</u>	<u>102,918,731</u>
Total net position	<u>195,814,884</u>	<u>165,853,134</u>
 Total liabilities, deferred inflows of resources, and net position	 \$ <u>284,199,491</u>	 \$ <u>256,385,129</u>

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, 2023 and 2022

	<u>2023</u>	Restated <u>2022</u>
Operating revenues:		
Net patient service revenue (net of provision for bad debts of approximately \$44,513,000 in 2023 and \$36,296,000 in 2022)	\$ 231,567,879	\$ 200,782,330
Other revenue	<u>9,168,449</u>	<u>5,619,598</u>
Total operating revenues	<u>240,736,328</u>	<u>206,401,928</u>
Operating expenses:		
Salaries and wages	86,942,670	80,487,917
Employee health and welfare	21,473,591	18,751,306
Medical supplies and other expense	74,769,117	63,460,143
Professional fees	21,620,630	18,029,123
Purchased services	7,503,810	6,896,659
Depreciation and amortization	<u>15,516,248</u>	<u>14,248,718</u>
Total operating expenses	<u>227,826,066</u>	<u>201,873,866</u>
Operating income	<u>12,910,262</u>	<u>4,528,062</u>
Nonoperating revenues (expenses):		
Investment income (loss)	11,667,180	(15,918,356)
Interest expense	(1,537,169)	(1,537,708)
Grant stimulus funding	3,000,000	8,850,223
Rural hospital tax credit and other	<u>3,647,157</u>	<u>4,167,728</u>
Total nonoperating revenues (expenses)	<u>16,777,168</u>	(4,438,113)
Excess revenues	29,687,430	89,949
Contributions for property acquisitions	<u>274,320</u>	<u>384,745</u>
Increase in net position	29,961,750	474,694
Net position, beginning of year, originally reported	166,011,581	165,378,440
Implementation of GASB No. 96	(158,447)	-
Net position, end of year, restated	<u>\$ 195,814,884</u>	<u>\$ 165,853,134</u>

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, 2023 and 2022

	<u>2023</u>	Restated <u>2022</u>
Cash flows from operating activities:		
Received from patients and payors	\$ 239,665,722	\$ 206,492,257
Repayments of Medicare advance payments	(179,435)	(10,715,647)
Payments to vendors and other suppliers	(106,200,127)	(91,230,722)
Payments to employees and physicians	(108,050,411)	(98,180,827)
Net cash provided by operating activities	<u>25,235,749</u>	<u>6,365,061</u>
Cash flows from noncapital financing activities:		
Grant stimulus funding	237,800	6,111,156
Rural hospital tax credit	<u>4,061,568</u>	<u>4,158,470</u>
Net cash provided by noncapital financing activities	<u>4,299,368</u>	<u>10,269,626</u>
Cash flows from capital and related financing activities:		
Proceeds from issuance of long-term debt	5,574,135	6,500,000
Principal paid on long-term debt, lease and subscription IT liabilities	(7,353,869)	(6,405,724)
Interest paid on long-term debt, lease and subscription IT liabilities	(1,537,169)	(1,537,708)
Purchase of capital assets	(25,661,139)	(18,048,066)
Capital contributions	<u>274,320</u>	<u>384,745</u>
Net cash used by capital and related financing activities	<u>(28,703,722)</u>	<u>(19,106,753)</u>
Cash flows from investing activities:		
Interest and dividends	1,154,978	1,673,300
Purchase of CRSC	-	(3,494,633)
Purchase of investments	(35,599,495)	(49,030,312)
Sale of investments	<u>34,418,324</u>	<u>40,025,261</u>
Net cash used by investing activities	<u>(26,193)</u>	<u>(10,826,384)</u>
Net increase (decrease) in cash and cash equivalents	805,202	(13,298,450)
Cash and cash equivalents, beginning of year	<u>12,389,901</u>	<u>25,688,351</u>
Cash and cash equivalents, end of year	\$ <u>13,195,103</u>	\$ <u>12,389,901</u>

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, 2023 and 2022

	<u>2023</u>	Restated <u>2022</u>
Reconciliation of cash and cash equivalents to the balance sheets:		
Cash and cash equivalents in current assets	\$ 9,281,907	\$ 7,953,773
Cash and cash equivalents in designated cash and investments:		
Internally designated for capital acquisition	2,899,531	3,746,602
Internally designated for employee benefits	883,061	451,694
Internally designated for malpractice funding	126,777	197,065
Restricted by debt	<u>3,827</u>	<u>40,767</u>
Total cash and cash equivalents	\$ <u>13,195,103</u>	\$ <u>12,389,901</u>
Reconciliation of operating income to net cash flows from operating activities:		
Operating income	\$ 12,910,262	\$ 4,528,062
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation and amortization	15,516,248	14,248,718
Provision for bad debts	44,513,106	36,295,683
Changes in:		
Patient accounts receivable	(45,938,365)	(36,367,452)
Estimated third-party payor settlements	354,653	162,098
Supplies	(1,042,773)	29,018
Other assets	(3,255,974)	757,774
Notes receivable	216,512	(145,622)
Accounts payable	2,440,530	(3,296,829)
Other accrued expenses	(299,015)	869,258
Medicare advance payments	<u>(179,435)</u>	<u>(10,715,647)</u>
Net cash provided by operating activities	\$ <u>25,235,749</u>	\$ <u>6,365,061</u>
Noncash investing activities (nearest thousand):		
Change in fair value of investments	\$ <u>10,630,000</u>	\$(<u>17,592,000</u>)

During 2022, the Authority purchased a skilled nursing facility. See Note 20 for more information.

The Authority entered into subscription-based information technology arrangements of \$1,570,913 in 2022.

The Authority entered into lease obligations of \$83,421 and \$338,660 in 2023 and 2022, respectively.

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

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

NOTES TO COMBINED FINANCIAL STATEMENTS
September 30, 2023 and 2022

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, and has a December 31st year end. The name of the plan is Colquitt Regional Medical Center 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. The combined financial statements present the Segregated Portfolio's audited financial statements as of December 31, 2022 and for the 10 month period from March 1, 2022 (date of commencement of operations) to December 31, 2022.

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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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. Amounts required to meet current liabilities of the Authority have been reclassified in the balance sheet at September 30, 2023 and 2022.

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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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 and subscription IT 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
Right-to-use subscription IT assets	3 to 9 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 18 for additional information.

Subscription-Based Information Technology Arrangements

The Authority has subscription-based information technology arrangements (SBITAs). The Authority recognizes a subscription IT liability and an intangible right-to-use subscription asset (subscription IT asset) in its financial statements. At the commencement of the subscription term, which is when the subscription IT asset is placed into service, the Authority initially measures the subscription IT liability at the present value of subscription payments expected to be made during the subscription term. Subsequently, the subscription IT liability is reduced by the principal portion of subscription payments made. The subscription IT asset is initially measured as the initial amount of the subscription IT liability, adjusted for payments made at or before commencement of the subscription term, plus capitalizable implementation costs,

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

Subscription-Based Information Technology Arrangements, Continued

less any incentives received from the SBITA vendor at or before the commencement of the subscription term. Subsequently, the subscription IT asset is amortized on a straight-line basis over its useful life.

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

- The Authority uses the implicit interest rate charged by the SBITA vendor as the discount rate. When the interest rate charged by the SBITA vendor is not readily determinable, the Authority generally uses its estimated incremental borrowing rate as the discount rate. Amortization of the discount on the subscription IT liability is included in interest expense in the financial statements.
- The subscription term includes the noncancellable period. Subscription payments included in the measurement of the subscription IT liability are composed of fixed payments and other payments that are reasonably certain of being required.

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

Activities associated with a SBITA, other than making subscription payments, should be grouped into the following stages:

- Preliminary Project Stage - Outlays are expensed as incurred.
- Initial Implementation Stage - Outlays are generally capitalized as an addition to the subscription IT asset.
- Operation and Additional Implementation Stage - Outlays are expensed as incurred unless specific capitalization criteria is met.

Subscription IT assets are reported with capital assets and subscription IT liabilities are reported with long-term debt on the balance sheets.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

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*.

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.

Estimated Self-Insurance Costs

The provision for estimated malpractice claims and other claims under self-insurance plans include estimates of the ultimate costs for both reported claims and claims incurred but not reported.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

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.

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.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

Income Taxes, Continued

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, 2023 and 2022 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 22.

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, 2023 and 2022.

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

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, 2023 and 2022. See Note 19 for additional information. Deferred inflows of resources relate to lessor leases that is amortized to lease income over the lease terms.

Recently Adopted Accounting Pronouncement

In June 2020, the GASB issued Statement No. 96, *Subscription-Based Information Technology Arrangements* (GASB 96). GASB 96 provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs). Under this Statement, a government generally should recognize a right-to-use subscription asset, an intangible asset, and a corresponding subscription liability at the commencement of the subscription term, which is when the subscription asset is placed into service. GASB 96 is effective for fiscal years beginning after June 15, 2022. The Authority adopted GASB 96 on October 1, 2022 and retroactively implemented the statement effective October 1, 2021. The adoption of this statement resulted in an increase in subscription obligations and related right-to-use subscription assets of approximately \$3,741,117 as of October 1, 2021. The adoption resulted in a decrease in net position of \$158,447.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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

Prior Year Reclassifications

Certain reclassifications have been made to the fiscal year 2022 financial statements to conform to the fiscal year 2023 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 49% and 15%, respectively, of the Authority's net patient service revenue for the year ended 2023 and 52% and 9%, respectively, of the Authority's net patient service revenue for the year ended 2022. 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.

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.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

2. Net Patient Service Revenue, Continued

- Medicare, Continued

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, 2019.

- 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.

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 \$1,662,000 and \$1,609,000 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, 2023 and 2022, respectively.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

2. Net Patient Service Revenue, Continued

- Medicaid, Continued

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 2023 and 2022 combined financial statements include payment adjustments of approximately \$224,000 and \$1,306,000, 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 \$4,569,000 and \$3,599,000 for 2023 and 2022, 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 2023 and 2022 combined financial statements include payment adjustments of approximately \$4,494,000 and \$820,000, respectively, which are reflected in net patient service revenue.

During 2022, the Georgia Department of Community Health announced final approval of a new state directed payment program - Strengthening the Reinvestment Of a Necessary workforce in Georgia (GA-STRONG). This is a supplemental payment program intended to support the retention of Georgia's existing workforce and development of the next generation of healthcare providers. As a result of participation in the GA-STRONG program, the Authority recognized revenue of approximately \$11,297,000 for the year ended September 30, 2023.

- 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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

3. Uncompensated Services

The Authority was compensated for services at amounts less than its established rates. Charges for uncompensated services for 2023 and 2022 were approximately \$525,621,000 and \$475,365,000, respectively.

Uncompensated services include charity and indigent care services of approximately \$6,099,000 and \$8,180,000 in 2023 and 2022, respectively. The cost of charity and indigent care services provided during 2023 and 2022 was approximately \$1,840,000 and \$2,442,000, 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 2023 and 2022:

	<u>2023</u>	<u>2022</u>
Gross patient charges	\$ <u>757,188,891</u>	\$ <u>676,147,312</u>
Uncompensated services:		
Charity and indigent care	6,099,042	8,180,082
Medicare	220,652,205	185,413,488
Medicaid	54,516,258	55,758,247
Other allowances	199,840,401	189,717,482
Provision for bad debts	<u>44,513,106</u>	<u>36,295,683</u>
Total uncompensated care	<u>525,621,012</u>	<u>475,364,982</u>
Net patient service revenue	\$ <u>231,567,879</u>	\$ <u>200,782,330</u>

4. Designated Net Position

Of the approximately \$114,577,000 and \$96,334,000 of unrestricted net position reported in 2023 and 2022, approximately \$96,255,000 and \$85,197,000, 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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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, 2023 and 2022, is set forth in the following table:

	<u>2023</u>	<u>2022</u>
Internally designated for capital acquisition:		
Cash and cash equivalents	\$ 2,899,531	\$ 3,746,602
U.S. Treasury obligations	3,178,116	2,557,314
U.S. Government Agency securities	2,788,641	1,266,668
Other fixed income	10,945,986	11,284,087
Equity securities	62,232,293	52,788,121
Mutual fund - commodities	587,588	751,576
Public hedge funds	<u>6,238,912</u>	<u>5,881,184</u>
	<u>\$ 88,871,067</u>	<u>\$ 78,275,552</u>
Internally designated for employee benefits:		
Cash and cash equivalents	\$ 883,061	\$ 451,694
Certificates of deposit	635,000	635,000
Equity securities	<u>1,454,656</u>	<u>1,886,023</u>
	2,972,717	2,972,717
Less current portion	<u>2,337,717</u>	<u>2,337,717</u>
	<u>\$ 635,000</u>	<u>\$ 635,000</u>
Internally designated for malpractice funding arrangement:		
Cash and cash equivalents	\$ 126,777	\$ 197,065
Other fixed income	818,325	628,660
Equity securities	2,938,803	2,581,413
Mutual fund - commodities	48,158	55,704
Public hedge funds	<u>479,121</u>	<u>485,496</u>
	4,411,184	3,948,338
Less current portion	<u>2,121,398</u>	<u>2,647,758</u>
	<u>\$ 2,289,786</u>	<u>\$ 1,300,580</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

5. Deposits and Investments, Continued

	<u>2023</u>	<u>2022</u>
Restricted by 2016 and 2020 Revenue		
Certificates - debt service reserve fund:		
Cash and cash equivalents	\$ 3,827	\$ 40,767
Other fixed income	<u>3,616,354</u>	<u>3,467,334</u>
	<u>\$ 3,620,181</u>	<u>\$ 3,508,101</u>
 Total designated cash and investments	 \$ 99,875,149	 \$ 88,704,708
Less current portion of designated funds	(<u>4,459,115</u>)	(<u>4,985,475</u>)
 Noncurrent cash and investments reported as long-term	 <u>\$ 95,416,034</u>	 <u>\$ 83,719,233</u>
 Carrying amount:		
Deposits	\$ 9,916,907	\$ 8,588,773
Investments	<u>99,240,149</u>	<u>88,069,708</u>
 Total cash and investments	 <u>\$ 109,157,056</u>	 <u>\$ 96,658,481</u>
 Included in the following balance sheet options:		
Cash and cash equivalents	\$ 9,281,907	\$ 7,953,773
Current portion of designated funds	4,459,115	4,985,475
Noncurrent cash and investments	<u>95,416,034</u>	<u>83,719,233</u>
 Total cash and investments	 <u>\$ 109,157,056</u>	 <u>\$ 96,658,481</u>

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, 2023, 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, 2023, the Authority has no investments exposed to custodial credit risk.

Concentration of credit risk. As of September 30, 2023, the Authority has no investment in any one issuer that is in excess of 5% of the Authority's total investments.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

5. Deposits and Investments, Continued

As of September 30, 2023 and 2022, the Authority had the following debt securities:

September 30, 2023

<u>Investment Type</u>	<u>Fair Value</u>	<u>Maturity</u>
U.S. Treasury obligations	\$ 3,178,116	March 31, 2025 - May 15, 2053 rating quality AA+
U.S. Government Agency securities	2,788,641	March 1, 2031 - May 1, 2052 rating quality AA+ to AAA
Other fixed income	<u>15,380,665</u>	Average maturity of 12 years, rating quality BBB- to AAA
Total	<u>\$ 21,347,422</u>	

September 30, 2022

<u>Investment Type</u>	<u>Fair Value</u>	<u>Maturity</u>
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	<u>15,380,081</u>	Average maturity of 12 years, rating quality BBB- to AAA
Total	<u>\$ 19,204,063</u>	

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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, 2023 and 2022 consisted of these amounts:

	<u>2023</u>	<u>2022</u>
Patient accounts receivable:		
Receivable from patients and their insurance carriers	\$ 48,011,773	\$ 39,868,083
Receivable from Medicare	35,810,424	30,383,249
Receivable from Medicaid	<u>8,579,842</u>	<u>9,654,388</u>
Total patient accounts receivable	92,402,039	79,905,720
Less allowance for uncollectible amounts and contractual adjustments	<u>67,233,137</u>	<u>56,162,077</u>
Patient accounts receivable, net	\$ <u>25,168,902</u>	\$ <u>23,743,643</u>
Accounts payable and accrued expenses:		
Payable to employees (including payroll taxes)	\$ 16,142,574	\$ 15,915,229
Payable to suppliers	9,628,980	7,188,450
Other accrued expenses	<u>2,121,398</u>	<u>2,647,758</u>
Total accounts payable and accrued expenses	\$ <u>27,892,952</u>	\$ <u>25,751,437</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

7. Capital Assets

A summary of capital assets at September 30, 2023 and 2022 follows:

	Restated Balance September 30, <u>2022</u>	<u>Increase</u>	<u>Decrease</u>	Balance September 30, <u>2023</u>
Capital assets not being depreciated:				
Land	\$ 1,629,639	\$ -	\$ -	\$ 1,629,639
Projects-in-progress	<u>4,280,105</u>	<u>26,188,031</u>	<u>13,180,029</u>	<u>17,288,107</u>
Total capital assets not being depreciated	<u>5,909,744</u>	<u>26,188,031</u>	<u>13,180,029</u>	<u>18,917,746</u>
Capital assets being depreciated:				
Land improvements	5,461,554	943,852	-	6,405,406
Buildings	124,851,101	3,864,842	-	128,715,943
Equipment	<u>126,648,252</u>	<u>8,046,092</u>	<u>2,283,502</u>	<u>132,410,842</u>
Total capital assets being depreciated	<u>256,960,907</u>	<u>12,854,786</u>	<u>2,283,502</u>	<u>267,532,191</u>
Less accumulated depreciation:				
Land improvements	3,205,801	416,917	-	3,622,718
Buildings	51,375,280	5,095,384	1,321	56,469,343
Equipment	<u>92,732,543</u>	<u>8,531,549</u>	<u>1,782,386</u>	<u>99,481,706</u>
Total depreciation	<u>147,313,624</u>	<u>14,043,850</u>	<u>1,783,707</u>	<u>159,573,767</u>
Leased buildings, equipment and subscription IT assets	6,111,842	99,238	56,183	6,154,897
Less: accumulated amortization for leased buildings, equipment and subscription IT assets	<u>998,868</u>	<u>1,306,205</u>	<u>56,183</u>	<u>2,248,890</u>
Intangible right-to-use lease, and subscription IT assets, net	<u>5,112,974</u>	(1,206,967)	-	<u>3,906,007</u>
Net capital assets	\$ <u>120,670,001</u>	\$ <u>23,792,000</u>	\$ <u>13,679,824</u>	\$ <u>130,782,177</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

7. Capital Assets, Continued

	Restated Balance September 30, <u>2021</u>	<u>Increase</u>	<u>Decrease</u>	Restated Balance September 30, <u>2022</u>
Capital assets not being depreciated:				
Land	\$ 1,616,040	\$ 13,599	\$ -	\$ 1,629,639
Projects-in-progress	<u>8,152,147</u>	<u>18,289,910</u>	<u>22,161,952</u>	<u>4,280,105</u>
Total capital assets not being depreciated	<u>9,768,187</u>	<u>18,303,509</u>	<u>22,161,952</u>	<u>5,909,744</u>
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	<u>116,577,347</u>	<u>10,498,600</u>	<u>427,695</u>	<u>126,648,252</u>
Total capital assets being depreciated	<u>235,449,637</u>	<u>21,938,965</u>	<u>427,695</u>	<u>256,960,907</u>
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	<u>85,134,178</u>	<u>8,009,067</u>	<u>410,702</u>	<u>92,732,543</u>
Total depreciation	<u>134,570,198</u>	<u>13,157,210</u>	<u>413,784</u>	<u>147,313,624</u>
Leased buildings, equipment and subscription IT assets	3,741,117	2,370,725	-	6,111,842
Less: accumulated amortization for leased buildings, equipment and subscription IT assets	<u>-</u>	<u>998,868</u>	<u>-</u>	<u>998,868</u>
Intangible right-to-use lease, and subscription IT assets, net	<u>3,741,117</u>	<u>1,371,857</u>	<u>-</u>	<u>5,112,974</u>
Net capital assets	\$ <u>114,388,743</u>	\$ <u>28,457,121</u>	\$ <u>22,175,863</u>	\$ <u>120,670,001</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

8. Long-Term Debt

A schedule of changes in the Authority's noncurrent liabilities for 2023 and 2022 follows:

	<u>Restated 2022 Balance</u>	<u>Additions</u>	<u>Reductions</u>	<u>2023 Balance</u>	<u>Amounts Due Within One Year</u>
Direct placement:					
Revenue					
Certificates					
2016	\$ 23,153,381	\$ -	\$ 3,582,151	\$ 19,571,230	\$ 3,661,087
Revenue					
Certificates					
2020	25,300,355	5,574,135	1,327,009	29,547,481	1,864,529
Direct borrowings:					
Notes payable	7,329,833	-	1,249,800	6,080,033	1,220,520
Lease liabilities	239,527	83,421	103,477	219,471	85,217
Subscription IT liabilities	<u>4,716,658</u>	<u>-</u>	<u>1,091,433</u>	<u>3,625,225</u>	<u>1,100,558</u>
Total noncurrent liabilities	<u>\$ 60,739,754</u>	<u>\$ 5,657,556</u>	<u>\$ 7,353,870</u>	<u>\$ 59,043,440</u>	<u>\$ 7,931,911</u>
	<u>Restated 2021 Balance</u>	<u>Additions</u>	<u>Reductions</u>	<u>Restated 2022 Balance</u>	<u>Amounts Due Within One Year</u>
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
Subscription IT liabilities	<u>3,741,117</u>	<u>1,570,913</u>	<u>595,372</u>	<u>4,716,658</u>	<u>1,091,433</u>
Total noncurrent liabilities	<u>\$ 58,735,904</u>	<u>\$ 8,409,573</u>	<u>\$ 6,405,723</u>	<u>\$ 60,739,754</u>	<u>\$ 7,402,799</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

8. Long-Term Debt, Continued

The terms and due dates of the Authority's long-term debt at September 30, 2023 and 2022 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, 2023, the Authority has drawn all proceeds from Series 2020A. 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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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%.
- Subscription IT liabilities with imputed interest ranging from 3.25% to 7.00%, payable in annual installments for various software licenses and remote hosting arrangements subscriptions ranging from approximately \$1,000 to \$102,000, and payable in monthly installments for certain subscriptions ranging from approximately \$14,000 to \$2,828,000. Secured by subscription IT assets. None of the subscription-based information technology arrangements contain provisions for variable payments. Additionally, there are no other payments, such as termination penalties, not previously included in the measurement of the subscription liability.

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		Subscription Liabilities	
	Principal	Interest	Principal	Interest	Principal	Interest
2024	\$ 6,746,136	\$ 1,256,235	\$ 85,217	\$ 5,360	\$ 1,100,558	\$ 117,637
2025	6,865,858	1,104,519	66,866	3,077	695,107	73,872
2026	6,836,851	944,428	39,440	1,405	483,930	51,946
2027	4,930,830	804,824	27,948	386	434,067	37,305
2028	5,058,019	8,033,670	-	-	448,386	22,986
2029-2033	17,763,446	1,841,508	-	-	463,177	8,194
2034-2037	4,787,354	568,247	-	-	-	-
2038-2041	<u>2,210,250</u>	<u>65,046</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Total	\$ <u>55,198,744</u>	\$ <u>14,618,477</u>	\$ <u>219,471</u>	\$ <u>10,228</u>	\$ <u>3,625,225</u>	\$ <u>311,940</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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, 2023 and 2022 are as follows:

	<u>2023</u>	<u>2022</u>
Short-term lease expense	\$ -	\$ 739,360
Right-to-use lease asset amortization	107,727	103,478
Lease liability interest expense	<u>7,857</u>	<u>7,788</u>
Total lease cost	\$ <u>115,584</u>	\$ <u>850,626</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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 \$3,498,000 and \$3,368,000 in 2023 and 2022, respectively. As of September 30, 2023 and 2022, the Authority accrued approximately \$2,791,000 and \$2,625,000, 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

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

10. Defined Contribution Retirement Plan, 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.

For Employees Hired After December 31, 2022

Colquitt Regional Medical Center provides an employer matching contribution for each eligible employee beginning with the payroll following the first month following thirty (30) days of employment.

The employer match is 50%, up to 6% of the employee's deferral amount.

If an employee leaves Colquitt Regional Medical Center and remains absent for six (6) months or longer, upon retirement they are considered a new employee for purposes of eligibility and vesting.

Vesting

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

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

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

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:

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

The matching employer contributions for eligible employees hired after December 31, 2022, are subject to the following vesting schedule:

<u>Years of Service</u>	<u>Vesting Percent</u>
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:

	<u>2023</u>	<u>2022</u>
Assets, principally cash, investments, unconditional promises to give, and property	\$ <u>11,123,379</u>	\$ <u>9,732,888</u>
Liabilities, principally accounts payable, amounts due to related party, and use obligation subject to life estate	\$ 149,613	\$ 272,383
Net assets	<u>10,973,766</u>	<u>9,460,505</u>
Total liabilities and net assets	\$ <u>11,123,379</u>	\$ <u>9,732,888</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

11. Related Party, Continued

	<u>2023</u>	<u>2022</u>
Revenues and investment income (losses)	\$ 2,084,998	\$(923,503)
Expenses	<u>571,737</u>	<u>505,488</u>
Increase (decrease) in net assets	1,513,261	(1,428,991)
Net assets, beginning of year	<u>9,460,505</u>	<u>10,889,496</u>
Net assets, end of year	\$ <u>10,973,766</u>	\$ <u>9,460,505</u>

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 \$8,359,000 and \$6,454,000 for 2023 and 2022, 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 \$480,000 and \$402,000 for 2023 and 2022, 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, 2023 and 2022, the Authority had investments of approximately \$635,000 designated for worker's compensation claims. At September 30, 2023 and 2022, 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, 2023 and 2022.

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

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

12. Commitments and Contingencies, Continued

Regulatory Compliance, Continued

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.

13. 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, 2023 and 2022.

14. 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.

15. 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 16 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.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

15. Fair Value of Financial Instruments, Continued

The carrying amounts and fair values of the Authority's long-term debt at September 30, 2023 and 2022, are as follows:

	2023		2022	
	<u>Carrying Amount</u>	<u>Fair Value</u>	<u>Carrying Amount</u>	<u>Fair Value</u>
Long-term debt	\$ <u>55,198,744</u>	\$ <u>52,930,427</u>	\$ <u>55,783,569</u>	\$ <u>53,854,504</u>

16. Fair Value Measurement

Fair value of assets and liabilities measured on a recurring basis at September 30, 2023 and 2022 is as follows:

		Fair Value Measurements at Reporting Date Using		
		Quoted Prices In Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
	<u>Fair Value</u>			
<u>September 30, 2023</u>				
Assets:				
Cash equivalents	\$ 3,913,196	\$ 3,913,196	\$ -	\$ -
U.S. Treasury obligations	3,178,116	3,178,116	-	-
U.S. Government Agency securities	2,788,641	-	2,788,641	-
Other fixed income	15,380,665	1,338,455	14,042,210	-
Equity securities	66,625,752	66,625,752	-	-
Mutual funds - commodities	635,746	635,746	-	-
Public hedge funds	<u>6,718,033</u>	<u>6,718,033</u>	<u>-</u>	<u>-</u>
Total assets	\$ <u>99,240,149</u>	\$ <u>82,409,298</u>	\$ <u>16,830,851</u>	\$ <u>-</u>
<u>September 30, 2022</u>				
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	<u>6,366,680</u>	<u>6,366,680</u>	<u>-</u>	<u>-</u>
Total assets	\$ <u>88,069,708</u>	\$ <u>76,749,317</u>	\$ <u>11,320,391</u>	\$ <u>-</u>

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

16. Fair Value Measurement, Continued

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.

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.

17. 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 2023 and 2022. Contributions received under the program approximated \$4,062,000 and \$4,158,000 during the Authority's fiscal year 2023 and 2022, respectively.

18. 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. The federal Public Health Emergency for COVID-19 expired on May 11, 2023.

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

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

18. Coronavirus (COVID-19), Continued

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 \$26.3 million in grant stimulus funding in FY 2020 through FY 2023. The CARES and ARP Act funding may be subject to audits. While the Authority currently believes 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 \$3.0 million, \$8.9 million, \$7.1 million, and \$7.1 million as revenue in FY 2023, 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 repaid all MAAP payments within the 29-month payment period with no interest incurred.

19. Deferred Outflows of Resources

Deferred outflows of resources consisted of the following:

	<u>2023</u>	<u>2022</u>
Goodwill, net of amortization	\$ <u>3,217,975</u>	\$ <u>3,392,706</u>

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 \$175,000 and \$102,000 for 2023 and 2022, respectively.

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

20. 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 19 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	<u>3,494,633</u>
Total	<u>\$ 5,900,000</u>

21. 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 2023 and 2022 were approximately \$448,000 and \$335,000, 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.

22. Self-Insurance

Colquitt Regional Medical Center Insurance Segregated Portfolio (Segregated Portfolio), was incorporated on March 1, 2022 as a segregated portfolio of Georgia Health Care Insurance Company SPC (the SPC). The SPC is an exempted company under the Companies Law of the Cayman Islands. The Segregated Portfolio is a blended component unit of Hospital Authority of Colquitt County (Authority) established to provide general liability, professional liability and employee benefit plan administration liability coverage to the Authority and its affiliated entities.

The Segregated Portfolio issues a claims-made policy with a per occurrence limit of \$2,000,000 and \$1,000,000 for 2023 and 2022, respectively, and an annual aggregate of \$6,000,000 and \$3,000,000 for 2023 and 2022, respectively. The Authority has also purchased excess liability coverage which covers \$10,000,000 per occurrence and in aggregate in excess of the Segregated Portfolio coverage of \$6,000,000. At September 30, 2023, there are known claims and incidents that may result in additional claims, as well as claims from unknown incidents that may be asserted arising from services provided to

Continued

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

NOTES TO COMBINED FINANCIAL STATEMENTS, Continued
September 30, 2023 and 2022

22. Self-Insurance, Continued

patients. 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 Segregated Portfolio reports accrued claims in accrued expenses as a liability.

At September 30, 2023 and 2022, the Authority had investments of approximately \$4,411,000 and \$3,948,000 which are designated by the Board of Directors for potential malpractice claims.

A summary of the Segregated Portfolio's assets, liabilities, equity, and net income is as follows:

	Unaudited <u>September 30, 2023</u>	<u>December 31, 2022</u>
Assets:		
Cash and cash equivalents	\$ 1,263,412	\$ 1,173,242
Investments	2,842,057	-
Premium receivable	80,986	2,799,005
Other assets	<u>7,292</u>	<u>54,167</u>
Total assets	<u>\$ 4,193,747</u>	<u>\$ 4,026,414</u>
Liabilities:		
Accounts payable and accrued expenses	\$ 2,866,591	\$ 696,708
Unearned premium reserve	<u>311,001</u>	<u>3,110,005</u>
Total liabilities	3,177,592	3,806,713
Equity	<u>1,016,155</u>	<u>219,701</u>
Total liabilities and equity	<u>\$ 4,193,747</u>	<u>\$ 4,026,414</u>
	Unaudited	
	Nine Months Ended	Ten Months Ended
	<u>September 30, 2023</u>	<u>December 31, 2022</u>
Premium income	\$ 3,084,360	\$ 945,001
Insurance expenses	<u>2,287,906</u>	<u>825,300</u>
Net income	<u>\$ 796,454</u>	<u>\$ 119,701</u>

After January 1, 2023, the Authority contributed approximately \$2,900,000 in premium payments to the Segregated Portfolio which is expensed on the books of the Authority at September 30, 2023 and is not eliminated because of the difference in fiscal year ends. The Segregated Portfolio used these funds to purchase marketable securities. After January 1, 2023, the Segregated Portfolio recorded additional malpractice liabilities of approximately \$2,100,000.



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, 2023 and 2022, and our report thereon dated January 22, 2024, 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 47 to 52, 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, which insofar as it relates to Colquitt Regional Medical Center Insurance Segregated Portfolio is based on the report of other auditors, is fairly stated in all material respects in relation to the combined financial statements as a whole.

Draffin & Tucker, LLP

Albany, Georgia
January 22, 2024

Let's Think Together.®

Continued

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, 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	<u>4,649,137</u>	<u>-</u>	<u>(6,290)</u>	<u>5,428</u>	<u>4,648,275</u>	<u>-</u>	<u>4,648,275</u>
Total current assets	<u>43,822,562</u>	<u>564,887</u>	<u>3,070,460</u>	<u>366,338</u>	<u>47,824,247</u>	<u>(1,350,990)</u>	<u>46,473,257</u>
Noncurrent cash and investments	<u>83,719,233</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>83,719,233</u>	<u>-</u>	<u>83,719,233</u>
Capital assets, net	<u>120,498,742</u>	<u>171,259</u>	<u>-</u>	<u>-</u>	<u>120,670,001</u>	<u>-</u>	<u>120,670,001</u>
Other assets	<u>2,200,866</u>	<u>23,066</u>	<u>6,000</u>	<u>-</u>	<u>2,229,932</u>	<u>(100,000)</u>	<u>2,129,932</u>
Total assets	250,241,403	759,212	3,076,460	366,338	254,443,413	(1,450,990)	252,992,423
Deferred outflows of resources:							
Goodwill	<u>3,392,706</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>3,392,706</u>	<u>-</u>	<u>3,392,706</u>
Total assets and deferred outflows of resources	<u>\$ 253,634,109</u>	<u>\$ 759,212</u>	<u>\$ 3,076,460</u>	<u>\$ 366,338</u>	<u>\$ 257,836,119</u>	<u>\$(1,450,990)</u>	<u>\$ 256,385,129</u>

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	\$ 7,402,799	\$ -	\$ -	\$ -	\$ 7,402,799	\$ -	\$ 7,402,799
Current portion of Medicare advance payments	121,915	-	57,520	-	179,435	-	179,435
Accounts payable	6,123,531	2,419	1,014,225	48,275	7,188,450	-	7,188,450
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	<u>3,034,826</u>	<u>-</u>	<u>10,113</u>	<u>-</u>	<u>3,044,939</u>	<u>-</u>	<u>3,044,939</u>
Total current liabilities	34,908,268	495,631	2,939,373	231,918	38,575,190	(1,391,365)	37,183,825
Long-term debt, excluding current installments	<u>53,336,955</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>53,336,955</u>	<u>-</u>	<u>53,336,955</u>
Total liabilities	88,245,223	495,631	2,939,373	231,918	91,912,145	(1,391,365)	90,520,780
Deferred inflows of resources	<u>11,215</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>11,215</u>	<u>-</u>	<u>11,215</u>
Total liabilities and deferred inflows of resources	88,256,438	495,631	2,939,373	231,918	91,923,360	(1,391,365)	90,531,995
Net position	<u>165,377,671</u>	<u>263,581</u>	<u>137,087</u>	<u>134,420</u>	<u>165,912,759</u>	<u>(59,625)</u>	<u>165,853,134</u>
Total liabilities, deferred inflows of resources, and net position	<u>\$ 253,634,109</u>	<u>\$ 759,212</u>	<u>\$ 3,076,460</u>	<u>\$ 366,338</u>	<u>\$ 257,836,119</u>	<u>\$(1,450,990)</u>	<u>\$ 256,385,129</u>

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, 2023

	December 31, 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	\$ 201,577,151	\$ 3,003,398	\$ 27,511,361	\$ -	\$ 232,091,910	\$ (524,031)	\$ 231,567,879
Other revenue	<u>11,381,989</u>	<u>423,208</u>	<u>-</u>	<u>945,001</u>	<u>12,750,198</u>	<u>(3,581,749)</u>	<u>9,168,449</u>
Total operating revenues	<u>212,959,140</u>	<u>3,426,606</u>	<u>27,511,361</u>	<u>945,001</u>	<u>244,842,108</u>	<u>(4,105,780)</u>	<u>240,736,328</u>
Operating expenses:							
Salaries and wages	76,220,696	2,185,872	8,536,102	-	86,942,670	-	86,942,670
Employee health and welfare	18,484,088	559,408	2,430,095	-	21,473,591	-	21,473,591
Medical supplies and other expense	72,681,269	436,426	4,930,261	825,300	78,873,256	(4,104,139)	74,769,117
Professional fees	6,615,950	-	15,317,321	-	21,933,271	(312,641)	21,620,630
Purchased services	6,847,671	80,380	575,759	-	7,503,810	-	7,503,810
Depreciation and amortization	<u>15,297,627</u>	<u>30,806</u>	<u>187,815</u>	<u>-</u>	<u>15,516,248</u>	<u>-</u>	<u>15,516,248</u>
Total operating expenses	<u>196,147,301</u>	<u>3,292,892</u>	<u>31,977,353</u>	<u>825,300</u>	<u>232,242,846</u>	<u>(4,416,780)</u>	<u>227,826,066</u>
Operating income (loss)	<u>16,811,839</u>	<u>133,714</u>	<u>(4,465,992)</u>	<u>119,701</u>	<u>12,599,262</u>	<u>311,000</u>	<u>12,910,262</u>
Nonoperating revenues (expenses):							
Investment income (loss)	11,667,180	-	-	-	11,667,180	-	11,667,180
Interest expense	(1,537,169)	-	-	-	(1,537,169)	-	(1,537,169)
Grant stimulus funding	3,000,000	-	-	-	3,000,000	-	3,000,000
Rural hospital tax credit and other	<u>3,647,157</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>3,647,157</u>	<u>-</u>	<u>3,647,157</u>
Total nonoperating revenues (expenses)	<u>16,777,168</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>16,777,168</u>	<u>-</u>	<u>16,777,168</u>
Excess revenues (expenses)	<u>\$ 33,589,007</u>	<u>\$ 133,714</u>	<u>\$ (4,465,992)</u>	<u>\$ 119,701</u>	<u>\$ 29,376,430</u>	<u>\$ 311,000</u>	<u>\$ 29,687,430</u>

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	<u>7,167,250</u>	<u>739,538</u>	<u>-</u>	<u>282,625</u>	<u>8,189,413</u>	<u>(2,569,815)</u>	<u>5,619,598</u>
Total operating revenues	<u>181,166,662</u>	<u>3,284,308</u>	<u>24,712,902</u>	<u>282,625</u>	<u>209,446,497</u>	<u>(3,044,569)</u>	<u>206,401,928</u>
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	60,175,035	411,528	5,446,223	248,205	66,280,991	(2,820,848)	63,460,143
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	<u>14,020,685</u>	<u>31,466</u>	<u>196,567</u>	<u>-</u>	<u>14,248,718</u>	<u>-</u>	<u>14,248,718</u>
Total operating expenses	<u>173,253,543</u>	<u>3,150,811</u>	<u>28,306,251</u>	<u>248,205</u>	<u>204,958,810</u>	<u>(3,084,944)</u>	<u>201,873,866</u>
Operating income (loss)	<u>7,913,119</u>	<u>133,497</u>	<u>(3,593,349)</u>	<u>34,420</u>	<u>4,487,687</u>	<u>40,375</u>	<u>4,528,062</u>
Nonoperating revenues (expenses):							
Investment income (loss)	(15,918,356)	-	-	-	(15,918,356)	-	(15,918,356)
Interest expense	(1,537,708)	-	-	-	(1,537,708)	-	(1,537,708)
Grant stimulus funding	8,750,223	-	100,000	-	8,850,223	-	8,850,223
Rural hospital tax credit and other	<u>4,167,728</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>4,167,728</u>	<u>-</u>	<u>4,167,728</u>
Total nonoperating revenues (expenses)	<u>(4,538,113)</u>	<u>-</u>	<u>100,000</u>	<u>-</u>	<u>(4,438,113)</u>	<u>-</u>	<u>(4,438,113)</u>
Excess revenues (expenses)	<u>\$ 3,375,006</u>	<u>\$ 133,497</u>	<u>\$ (3,493,349)</u>	<u>\$ 34,420</u>	<u>\$ 49,574</u>	<u>\$ 40,375</u>	<u>\$ 89,949</u>

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*



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 Hospital Authority of Colquitt County (Authority), a component unit of Colquitt County, Georgia which comprise the combined balance sheet as of September 30, 2023, 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 22, 2024.

Our report includes a reference to other auditors who audited the financial statements of Colquitt Regional Medical Center Insurance Segregated Portfolio, a blended component unit, as described in our report on the Authority's combined financial statements. The financial statements of Colquitt Regional Medical Center Insurance Segregated Portfolio, were not audited in accordance with *Government Auditing Standards*, and accordingly, this report does not include reporting on internal control over financial reporting or instances of reportable noncompliance associated with Colquitt Regional Medical Center Insurance Segregated Portfolio.

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.

Continued

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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 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.

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 from 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 22, 2024

2023 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	42,365,287.00	46,166,018.00
b. Savings and Temporary Cash Investments	53,408,014.00	60,064,638.00
c. Pledges and Grants Receivable, Net		
d. Accounts Receivable, Net	18,279,850.00	19,974,947.00
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	4,661,481.00	5,704,254.00
h. Prepaid expenses and deferred charges	5,021,232.00	6,011,441.00
i. Land, buildings, and equipment: cost or other basis. Less Accumulated Depreciation	113,138,735.00	126,162,836.00
j. Investments- Publicly Traded Securities		
k. Investments- Other Securities		
l. Investments- Program-Related		
m. Intangible Assets		
n. Other Assets	13,002,052.00	18,752,769.00
o. Total a - n above	\$249,876,651.00	282,836,903.00

2. Total Liabilities	Beginning of Current Year	End of Year
a. Accounts Payable and Accrued Expenses	24,431,959.00	26,167,859.00
b. Grants Payable		
c. Deferred Revenue	3,046,042.00	278,234.00
d. Tax-Exempt Bond Liabilities	48,453,736.00	49,118,711.00
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).	7,569,361.00	9,924,729.00
h. Total a - i above	\$83,501,098.00	\$85,489,533.00

	Beginning of Current Year	End of Year
3. Net Assets or Fund Balances. Subtract line 2h from line 1o.	\$166,375,553.00	\$197,347,370.00



GEORGIA DEPARTMENT OF
COMMUNITY HEALTH

2023 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

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, 2023 through December 31, 2023.

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: Caleb Morris

Contact Title: Controller

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
Not Applicable		

C. Facility Operator

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

D. Operator's Parent Organization

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

E. Management Contractor

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

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
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. Do not include newborn and neonatal services. Do not include long-term care units, 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)	10	752	1,728	754	1,734
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	69	5,186	22,056	5,331	22,703
Intensive Care	10	422	2,670	285	1,804
Psychiatry	10	206	2,058	204	2,038
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	6,566	28,512	6,574	28,279

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	8	49
Asian	23	94
Black/African American	1,792	8,119
Hispanic/Latino	589	2,117
Pacific Islander/Hawaiian	7	15
White	4,118	17,957
Multi-Racial	29	161
Total	6,566	28,512

3. Gender

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

Gender	Admissions	Inpatient Days
Male	2,742	12,605
Female	3,824	15,907
Total	6,566	28,512

4. Payment Source

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

Primary Payment Source	Admissions	Inpatient Days
Medicare	3,576	17,829
Medicaid	1,213	4,212
Peachare	0	0
Third-Party	1,318	4,793
Self-Pay	459	1,678
Other	0	0

5. Discharges to Death

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

138

6. Charges for Selected Services

Please report the hospital's average charges as of 12-31-2023 (to the nearest whole dollar).

Service	Charge
Private Room Rate	806
Semi-Private Room Rate	777
Operating Room: Average Charge for the First Hour	4,342
Average Total Charge for an Inpatient Day	7,050

Part E : Emergency Department and Outpatient Services

1. Emergency Visits

Please report the number of emergency visits only.

37,280

2. Inpatient Admissions from ER

Please report inpatient admissions to the Hospital from the ER for emergency cases ONLY.

6,310

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	901
General Beds	20	36,379
	0	0
	0	0
	0	0
	0	0

5. Transfers

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

1,033

6. Non-Emergency Visits

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

199,447

7. Observation Visits/Cases

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

2,543

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.

983

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
Podiatric Services	1	1
Renal Dialysis	1	1
ESWL	1	1
Biliary Lithotripter	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, Diagnostic	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	202
Number of Dialysis Treatments	12,292
Number of ESWL Patients	68
Number of ESWL Procedures	68
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	34,066
Number of CTS Units (machines)	2
Number of CTS Procedures	24,969
Number of Diagnostic Radioisotope Procedures	711
Number of PET Units (machines)	1
Number of PET Procedures	245
Number of Therapeutic Radioisotope Procedures	2
Number of Number of MRI Units	1
Number of Number of MRI Procedures	3,146
Number of Chemotherapy Treatments	1,746
Number of Respiratory Therapy Treatments	134,901
Number of Occupational Therapy Treatments	16,982
Number of Physical Therapy Treatments	70,491
Number of Speech Pathology Patients	30,400
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	8,400
Number of Hospice Patients	202
Number of Respite care Patients	8
Number of Ultrasound/Medical Sonography Units	4
Number of Ultrasound/Medical Sonography Procedures	10,558
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)
5	612	XI Robot X 4, Mako X1

Part G : Facility Workforce Information

1. Budgeted Staff

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2023. Also, include the number of contract or temporary staff (eg. agency nurses) filling budgeted vacancies as of 12-31-2023.

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)	7.00	1.00	0.00
Registered Nurses (RNs-Advanced Practice*)	366.00	5.00	0.00
Licensed Practical Nurses (LPNs)	55.00	0.00	0.00
Pharmacists	9.00	0.00	0.00
Other Health Services Professionals*	233.00	7.00	0.00
Administration and Support	471.00	28.00	0.00
All Other Hospital Personnel (not included above)	365.00	13.00	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	15
Hispanic/Latino	0
Pacific Islander/Hawaiian	1
White	72
Multi-Racial	11

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 Plan 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	12	☐	0	0
General Internal Medicine	3	☐	0	0
Pediatricians	6	☐	0	0
Other Medical Specialties	35	☐	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	5	☐	0	0
Non-OB Physicians Providing OB Services	0	☐	0	0
Gynecology	1	☐	0	0
Ophthalmology Surgery	1	☐	0	0
Orthopedic Surgery	3	☐	0	0
Plastic Surgery	1	☐	0	0
General Surgery	4	☐	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	7	☐	0	0
Nuclear Medicine	0	☐	0	0
Pathology	2	☐	0	0
Psychiatry	6	☐	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 Privileges	0
Podiatrists	2
Certified Nurse Midwives with Clinical Privileges in the Hospital	0
All Other Staff Affiliates with Clinical Privileges in the Hospital	12

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	15	1	0	1	0	0	0	0	0	0	0	0	0
Atkinson	0	4	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	0	1	0	0	0	0	0	0	0	0	0	0
Barrow	1	0	0	0	0	0	0	0	0	0	0	0	0
Ben Hill	15	48	0	0	0	0	0	0	0	0	0	0	0
Berrien	62	60	7	4	0	0	0	0	0	0	0	0	0
Bibb	2	2	0	0	0	0	0	0	0	0	0	0	0
Bleckley	1	0	0	0	0	0	0	0	0	0	0	0	0
Brooks	73	51	10	2	0	0	0	0	0	0	0	0	0
Calhoun	0	2	0	0	0	0	0	0	0	0	0	0	0
Camden	0	0	0	1	0	0	0	0	0	0	0	0	0
Candler	1	0	0	0	0	0	0	0	0	0	0	0	0
Carroll	1	1	0	0	0	0	0	0	0	0	0	0	0
Charlton	0	1	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
Clinch	2	7	0	0	0	0	0	0	0	0	0	0	0
Cobb	2	0	0	0	0	0	0	0	0	0	0	0	0
Coffee	9	22	1	2	0	0	0	0	0	0	0	0	0
Colquitt	4,799	3,614	520	120	0	0	0	0	0	0	0	0	0
Columbia	2	0	0	0	0	0	0	0	0	0	0	0	0
Cook	167	105	29	10	0	0	0	0	0	0	0	0	0
Coweta	0	1	0	0	0	0	0	0	0	0	0	0	0
Crisp	2	8	0	0	0	0	0	0	0	0	0	0	0
Dade	1	0	0	0	0	0	0	0	0	0	0	0	0
Decatur	12	21	3	7	0	0	0	0	0	0	0	0	0
DeKalb	2	0	0	1	0	0	0	0	0	0	0	0	0

Dodge	0	0	0	1	0	0	0	0	0	0	0	0	0
Dougherty	113	65	13	4	0	0	0	0	0	0	0	0	0
Early	1	4	0	0	0	0	0	0	0	0	0	0	0
Echols	1	1	0	0	0	0	0	0	0	0	0	0	0
Florida	42	25	1	2	0	0	0	0	0	0	0	0	0
Forsyth	0	1	0	0	0	0	0	0	0	0	0	0	0
Fulton	13	1	0	1	0	0	0	0	0	0	0	0	0
Glynn	1	0	0	0	0	0	0	0	0	0	0	0	0
Grady	41	54	4	5	0	0	0	0	0	0	0	0	0
Gwinnett	0	0	0	1	0	0	0	0	0	0	0	0	0
Hall	1	0	0	0	0	0	0	0	0	0	0	0	0
Hart	0	0	0	1	0	0	0	0	0	0	0	0	0
Henry	0	3	0	0	0	0	0	0	0	0	0	0	0
Houston	2	7	0	0	0	0	0	0	0	0	0	0	0
Irwin	6	9	1	0	0	0	0	0	0	0	0	0	0
Jasper	0	0	0	1	0	0	0	0	0	0	0	0	0
Jeff Davis	0	4	0	0	0	0	0	0	0	0	0	0	0
Jenkins	1	0	0	0	0	0	0	0	0	0	0	0	0
Lanier	1	15	0	0	0	0	0	0	0	0	0	0	0
Laurens	4	1	0	0	0	0	0	0	0	0	0	0	0
Lee	12	17	1	0	0	0	0	0	0	0	0	0	0
Liberty	1	1	0	0	0	0	0	0	0	0	0	0	0
Lowndes	130	160	20	16	0	0	0	0	0	0	0	0	0
Macon	1	1	0	0	0	0	0	0	0	0	0	0	0
Miller	1	3	1	1	0	0	0	0	0	0	0	0	0
Mitchell	165	110	38	2	0	0	0	0	0	0	0	0	0
Monroe	1	0	0	0	0	0	0	0	0	0	0	0	0
Montgomery	1	0	0	0	0	0	0	0	0	0	0	0	0
Muscogee	4	0	0	0	0	0	0	0	0	0	0	0	0
North Carolina	3	2	0	0	0	0	0	0	0	0	0	0	0
Oconee	0	3	0	0	0	0	0	0	0	0	0	0	0
Other Out of State	25	5	0	1	0	0	0	0	0	0	0	0	0
Peach	2	3	0	0	0	0	0	0	0	0	0	0	0
Pierce	1	10	0	0	0	0	0	0	0	0	0	0	0
Pulaski	0	2	0	0	0	0	0	0	0	0	0	0	0
Randolph	0	1	0	0	0	0	0	0	0	0	0	0	0
Schley	0	1	0	0	0	0	0	0	0	0	0	0	0
Seminole	2	5	0	1	0	0	0	0	0	0	0	0	0
South Carolina	4	1	1	0	0	0	0	0	0	0	0	0	0
Spalding	0	1	0	0	0	0	0	0	0	0	0	0	0
Sumter	1	2	0	2	0	0	0	0	0	0	0	0	0
Telfair	0	2	0	0	0	0	0	0	0	0	0	0	0
Tennessee	2	0	0	0	0	0	0	0	0	0	0	0	0
Thomas	478	415	56	6	0	0	0	0	0	0	0	0	0

Tift	236	193	35	3	0	0	0	0	0	0	0	0	0
Troup	0	0	1	0	0	0	0	0	0	0	0	0	0
Turner	14	36	0	2	0	0	0	0	0	0	0	0	0
Walker	2	0	0	0	0	0	0	0	0	0	0	0	0
Walton	2	0	0	1	0	0	0	0	0	0	0	0	0
Ware	2	8	0	0	0	0	0	0	0	0	0	0	0
Wheeler	0	1	0	0	0	0	0	0	0	0	0	0	0
Whitfield	0	0	0	1	0	0	0	0	0	0	0	0	0
Wilcox	0	6	0	0	0	0	0	0	0	0	0	0	0
Worth	78	58	9	6	0	0	0	0	0	0	0	0	0
Total	6,566	5,186	752	206	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	4,657
Cystoscopy	0	0	0	490
Endoscopy	0	0	0	2,575
	0	0	0	0
Total	0	0	0	7,722

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	4,657
Cystoscopy	0	0	0	490
Endoscopy	0	0	0	2,575
	0	0	0	0
Total	0	0	0	7,722

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	9
Asian	25
Black/African American	979
Hispanic/Latino	300
Pacific Islander/Hawaiian	7
White	3,825
Multi-Racial	41
Total	5,186

2. Age Grouping

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

Age of Patient	Number of Ambulatory Patients
Ages 0-14	319
Ages 15-64	3,339
Ages 65-74	1,077
Ages 75-85	401
Ages 85 and Up	50
Total	5,186

3. Gender

Please report the total number of ambulatory patients by gender.

Gender	Number of Ambulatory Patients
Male	1,858
Female	3,328
Total	5,186

4. Payment Source

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

Primary Payment Source	Number of Patients
Medicare	1,941
Medicaid	657
Third-Party	2,462
Self-Pay	126

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 the 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: 253
6. Total Live Births: 697
7. Total Births (Live and Late Fetal Deaths): 704
8. Total Deliveries (Births + Early Fetal Deaths and Induced Terminations): 709

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	669	1,246	0
Specialty Care (Intermediate Neonatal Care)	2	28	32	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	0	0
Asian	4	8
Black/African American	178	419
Hispanic/Latino	234	533
Pacific Islander/Hawaiian	3	5
White	331	759
Multi-Racial	2	4
Total	752	1,728

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	4	10
Ages 15-44	738	1,694
Ages 45 and Up	10	24
Total	752	1,728

3. Average Charge for an Uncomplicated Delivery

Please report the average hospital charge for an uncomplicated delivery(CPT 59400)

\$8,100.00

4. Average Charge for a Premature Delivery

Please report the average hospital charge for a premature delivery.

\$11,621.00

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	206	2,058	204	2,038	1,529	☐
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	64	650
Hispanic/Latino	3	23
Pacific Islander/Hawaiian	0	0
White	139	1,385
Multi-Racial	0	0
Total	206	2,058

2. Gender

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

Gender of Patient	Admissions	Inpatient Days
Male	107	1,028
Female	99	1,030
Total	206	2,058

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	149	1,544
Medicaid	27	297
Third Party	17	103
Self-Pay	13	114
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? 2 (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 Interpreter ☐

Telephone Interpreter Service ☒

Refer Patient to Outside Agency ☐

Other (please describe): ☒

Video Remote Interpretation

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
Vietnamese		0	0	0
Hakha Chin		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?

Policy on how to contact inhouse interpreters, how to activate telephone or video remote

interpretation. Portable camera enabled computer on wheels accessible by all floors of the hospital.

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?

n/a

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

1. English

2. Spanish

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 inpatient 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 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 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: Caleb Morris

Date: 2/29/2024

Title: Controller

Comments:

Thursday, July 13, 2023

AHA Annual Survey - 2022

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)
P O Box 40
Moultrie, Georgia 31768
Colquitt County

Survey Status
Submitted

<u>Date Started</u>	<u>Date Last Edited</u>	<u>Date Submitted</u>
JUN-19-23	JUL-13-23	JUL-13-23

Survey Administrators
James Matney

AHA Annual Survey - 2022

Colquitt Regional Medical Center (6380890)

<u>Section Title</u>	<u>Status</u>	<u>Last Edit Date</u>	<u>Last Edit By</u>
Reporting Period	Completed	07/13/2023	James L Matney

Section A: Question

<u>Section A: Question</u>	<u>Description</u>	<u>Answer</u>
1. Reporting Period used (beginning and ending date):	From (mm/dd/yyyy)	10/01/2021
	To (mm/dd/yyyy)	09/30/2022
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	10/01/2022

AHA Annual Survey - 2022

Colquitt Regional Medical Center (6380890)

<u>Section Title</u>	<u>Status</u>	<u>Last Edit Date</u>	<u>Last Edit By</u>
Organizational Structure	Completed	07/13/2023	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

AHA Annual Survey - 2022

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
- ☒ 5. None

AHA Annual Survey - 2022

Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Facilities and Services	Completed	07/13/2023	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	☒ (#Beds: 63)	☐	☐
2. Pediatric medical - surgical care	☒ (#Beds: 6)	☐	☐
3. Obstetrics [Hospital level of unit (1-3)] (Please specify the level of unit provided by the hospital if applicable.)	☒ (#Beds: 11) Level: 1	☐	☐
4. Medical-surgical intensive care	☒ (#Beds: 5)	☐	☐
5. Cardiac intensive care	☒ (#Beds: 5)	☐	☐
6. Neonatal intensive care	☐ (#Beds: ____)	☐	☒
7. Neonatal intermediate care	☐ (#Beds: ____)	☐	☒
8. Pediatric intensive care	☐ (#Beds: ____)	☐	☒
9. Burn care	☐ (#Beds: ____)	☐	☒
10. Other special care (Please specify the type of other special care provided by the hospital if applicable.)	☐ (#Beds: ____) (Specify: ____)	☐	☒
11. Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)	☒ (#Beds: 9) Desc: PCU	☐	☐
12. Physical rehabilitation	☐ (#Beds: ____)	☐	☒
13. Substance use disorder	☐ (#Beds: ____)	☐	☒
14. Psychiatric care	☒ (#Beds: 10)	☐	☐
15. Skilled nursing care	☐ (#Beds: ____)	☐	☒
16. Intermediate nursing care	☐ (#Beds: ____)	☐	☒
17. Acute long-term care	☐ (#Beds: ____)	☐	☒
18. Other long-term care	☐ (#Beds: ____)	☐	☒
19. Biocontainment patient care unit	☐ (#Beds: ____)	☐	☒
20. Other care (Please specify the type of other care provided by the hospital if applicable.)	☐ (#Beds: ____) (Specify: ____)	☐	☒
21. Adult day care program	☐	☐	☒
22. Airborne infection isolation room (Please specify the number of rooms)	☒ # Rooms: 18	☐	☐
23. Alzheimer Center	☐	☐	☒

AHA Annual Survey - 2022

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	☒	☐	☐	☐
25. Air Ambulance services	☐	☐	☐	☒
26. Ambulatory surgery center	☐	☐	☐	☒
27. Arthritis treatment center	☐	☐	☐	☒
28. Auxiliary	☒	☐	☐	☐
29. Bariatric/weight control services	☒	☐	☐	☐
30. Birthing room - LDR room - LDRP room	☒	☐	☐	☐
31. Blood Donor Center	☐	☐	☐	☒
32. Breast cancer screening / mammograms	☒	☐	☐	☐
33. Cardiology and cardiac surgery services:				
33a. Adult cardiology services	☒	☐	☐	☐
33b. Pediatric cardiology services	☐	☐	☐	☒
33c. Adult diagnostic catheterization	☒	☐	☐	☐
33d. Pediatric diagnostic catheterization	☐	☐	☐	☒
33e. Adult interventional cardiac catheterization	☐	☐	☐	☒
33f. Pediatric interventional cardiac catheterization	☐	☐	☐	☒
33g. Adult cardiac surgery	☐	☐	☐	☒
33h. Pediatric cardiac surgery	☐	☐	☐	☒
33i. Adult cardiac electrophysiology	☐	☐	☐	☒
33j. Pediatric cardiac electrophysiology	☐	☐	☐	☒
33k. Cardiac rehabilitation	☐	☐	☐	☒
34. Case management	☒	☐	☐	☐
35. Chaplaincy/pastoral care services	☒	☐	☐	☐
36. Chemotherapy	☒	☐	☐	☐
37. Children's wellness program	☐	☐	☐	☒
38. Chiropractic services	☐	☐	☐	☒
39. Community outreach	☒	☐	☐	☐
40. Complementary and alternative medicine services	☐	☐	☐	☒

AHA Annual Survey - 2022

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).				
45.e If column (1) is checked for 45d (Trauma center) does your hospital own the trauma certification?	☐ (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	☐	☐	☐	☒

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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
58. Health screenings	☒	☐	☐	☐
59. Health research	☐	☐	☐	☒
60. Hemodialysis	☒	☐	☐	☐
61. HIV - AIDS services	☒	☐	☐	☐
62. Home health services	☒	☐	☐	☐
63. Hospice program	☒	☐	☐	☐
64. Hospital - based outpatient care center - services	☐	☐	☐	☒
65. Housing services:				
65a. Assisted living	☐	☐	☐	☒
65b. Retirement housing	☐	☐	☐	☒
65c. Supportive housing services	☐	☐	☐	☒
66. Immunization program	☒	☐	☐	☐
67. Indigent care clinic	☐	☐	☐	☒
68. Linguistic/translation services	☒	☐	☐	☐
69. Meal delivery services	☐	☐	☐	☒
70. Mobile health services	☐	☐	☐	☒
71. Neurological services	☒	☐	☐	☐
72. Nutrition programs	☒	☐	☐	☐
73. Occupational health services	☒	☐	☐	☐
74. Oncology services	☒	☐	☐	☐
75. Orthopedic services	☒	☐	☐	☐
76. Outpatient surgery	☒	☐	☐	☐
77. Pain management program	☒	☐	☐	☐
78. Palliative care program	☐	☐	☐	☒
79. Palliative care inpatient unit	☐	☐	☐	☒
80. Patient Controlled Analgesia (PCA)	☒	☐	☐	☐
81. Patient education center	☒	☐	☐	☐
82. Patient representative services	☐	☐	☐	☒

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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
83. Physical rehabilitation services:				
83a. Assistive technology center	☒	☐	☐	☐
83b. Electrodiagnostic services	☐	☐	☐	☒
83c. Physical rehabilitation outpatient services	☒	☐	☐	☐
83d. Prosthetic and orthotic services	☐	☐	☐	☒
83e. Robot-assisted walking therapy	☐	☐	☐	☒
83f. Simulated rehabilitation environment	☐	☐	☐	☒
84. Primary care department	☒	☐	☐	☐
85. Psychiatric services:				
85a. Psychiatric consultation - liaison services	☒	☐	☐	☐
85b. Psychiatric pediatric care	☐ (#Beds: ____)	☐	☐	☒
85c. Psychiatric geriatric services	☒ (#Beds: 10)	☐	☐	☐
85d. Psychiatric education services	☐	☐	☐	☒
85e. Psychiatric emergency services	☐	☐	☐	☒
85f. Psychiatric outpatient services	☒	☐	☐	☐
85g. Psychiatric intensive outpatient services	☐	☐	☐	☒
85h. Social and Community psychiatry	☐	☐	☐	☒
85i. Forensic psychiatry	☐	☐	☐	☒
85j. Prenatal psychiatry and Postpartum psychiatry	☐	☐	☐	☒
85k. Psychiatric partial hospitalization services - adult	☐	☐	☐	☒
85l. Psychiatric partial hospitalization services - pediatric	☐	☐	☐	☒
85m. Psychiatric residential treatment - adult	☐	☐	☐	☒
85n. Psychiatric residential treatment - pediatric	☐	☐	☐	☒
85o. Suicide prevention services	☐	☐	☐	☒
86. Radiology, diagnostic:				
86a. CT scanner	☒	☐	☐	☐
86b. Diagnostic radioisotope facility	☒	☐	☐	☐
86c. Electron beam computed tomography (EBCT)	☐	☐	☐	☒
86d. Full-field digital mammography(FFDM)	☒	☐	☐	☐

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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
86e. Magnetic resonance imaging (MRI)	☒	☐	☐	☐
86f. Intraoperative magnetic resonance imaging	☒	☐	☐	☐
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	☐	☐	☐	☒

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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
94. Support groups	☒	☐	☐	☐
95. Swing bed services	☒	☐	☐	☐
96. Teen outreach services	☐	☐	☐	☒
97. Tobacco treatment / cessation program	☒	☐	☐	☐
98. Telehealth	☐	☐	☐	☒
98a. Consultation and office visits	☐	☐	☐	☒
98b. eICU	☐	☐	☐	☒
98c. Stroke care	☒	☐	☐	☐
98d. Psychiatric and addiction treatment	☐	☐	☐	☒
98e. Remote patient monitoring:	☒	☐	☐	☐
1. Post-discharge.	☒	☐	☐	☐
2. Ongoing chronic care management	☒	☐	☐	☐
3. Other remote patient monitoring	☐	☐	☐	☒
98f. Other telehealth	☐	☐	☐	☒
99. Transplant services:	☐	☐	☐	☒
99a. Bone marrow	☐	☐	☐	☒
99b. Heart	☐	☐	☐	☒
99c. Kidney	☐	☐	☐	☒
99d. Liver	☐	☐	☐	☒
99e. Lung	☐	☐	☐	☒
99f. Tissue	☐	☐	☐	☒
99g. Other	☐	☐	☐	☒
100. Transportation to health facilities (non-emergency)	☒	☐	☐	☐
101. Urgent care center	☐	☐	☐	☒
102. Violence Prevention Programs:	☒	☐	☐	☐
102a. For the workplace	☐	☐	☐	☒
102b. For the community	☐	☐	☐	☒
103. Virtual Colonoscopy	☐	☐	☐	☒
104. Volunteer services department	☒	☐	☐	☐
105. Women's health center / services	☒	☐	☐	☐
106. Wound management services	☒	☐	☐	☐

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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	Yes	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	No
2. Primary Care Services	No	No
3. Acute inpatient care	No	No
4. Extended care	No	No

107d. Does your organization routinely screen for substance use disorders 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

108a. For each of the physician-organization arrangements, please report the number of involved physicians in these arrangements.

	Number of Physicians	My Hospital	My Health System	Do Not Provide
1. Independent Practice Association (IPA)		☐	☐	☒
2. Group practice without walls		☐	☐	☒
3. Open Physician - Hospital Organization (PHO)		☐	☐	☒
4. Closed Physician - Hospital Organization (PHO)		☐	☐	☒
5. Management Service Organization (MSO)		☐	☐	☒
6. Integrated Salary Model		☐	☐	☒
7. Equity Model		☐	☐	☒
8. Foundation		☐	☐	☒
9. Other, please specify:		☐	☐	☒

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108b. For those arrangements reported in 108a., please report the approximate ownership share.

	Hospital ownership share %	Physician ownership share %	Parent corporation ownership share %	Insurance ownership share %
1. Independent Practice Association (IPA)				
2. Group practice without walls				
3. Open Physician-Hospital Organization (PHO)				
4. Closed Physician-Hospital Organization (PHO)				
5. Management Service Organization (MSO)				
6. Integrated Salary Model				
7. Equity Model				
8. Foundation				
9. Other, specified above:				

108c. If the hospital owns physician practices, how are they organized?

	<u>Percent %</u>	<u>Number of Physicians</u>
108c.1 Solo practice	35	8
108c.2 Single specialty group	30	10
108c.3 Multi-specialty group	35	11

	<u>Answer</u>	<u>Answer (History)</u>
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 payers 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

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	<u>Answer</u>	<u>Answer (History)</u>
110d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?	No	No
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:		
a. Please indicate the total number of airborne infection isolation rooms set up at the start of the reporting period?	18	
b. Please indicate the total number of airborne infection isolation rooms set up at the end of the reporting period?	18	
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?	0	
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?	15	
b. How many adult (in use and not in use) mechanical ventilators were there in your facility at the end of the reporting period?	15	
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??	15	
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?	15	
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	No

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<u>Section Title</u>	<u>Status</u>	<u>Last Edit Date</u>	<u>Last Edit By</u>
Insurance and Alternative Payment Models	Completed	07/13/2023	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 (check all that apply)

<u>Insurance Product</u>	<u>Hospital</u>	<u>System</u>	<u>JV</u>	<u>No</u>	<u>Do Not Know</u>
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?

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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 patients do you serve under capitated contracts?

10. Does your hospital participate in any bundled payment arrangements?

No

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

	(a) Traditional Medicare	(b) Medicare Advantage Plan	(c) Commercial Insurance Plan	(d) Medicaid
1. Cardiovascular	☐	☐	☐	☐
2. Orthopedic	☐	☐	☐	☐
3. Oncologic	☐	☐	☐	☐
4. Neurology	☐	☐	☐	☐
5. Hematology	☐	☐	☐	☐
6. Gastrointestinal	☐	☐	☐	☐
7. Pulmonary	☐	☐	☐	☐
8. Infectious Disease	☐	☐	☐	☐
9. Hospitalist	☐	☐	☐	☐
10. Nephrology	☐	☐	☐	☐
11. Obstetrics	☐	☐	☐	☐
12. Endocrinology	☐	☐	☐	☐
13. Psychiatric Disorders	☐	☐	☐	☐
14. Substance Use Disorders	☐	☐	☐	☐
15. Other:	☐	☐	☐	☐

Answer

10b.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)?

11a.If yes, does your hospital share upside or downside risk with any of those outside providers?

12. What percentage of your hospital's patient revenue is paid on a shared risk basis (other than capitated or bundled payment)?

13. Does your hospital contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis?

14.Does your hospital have contracts with commercial payers where payment is tied to performance on quality/safety metrics?

15a. Has your hospital or health care system established an accountable care organization (ACO)?

- ☐ 1. My hospital/system currently leads an ACO
- ☐ 2. My hospital/system currently participates in an ACO (but is not its leader)
- ☐ 3. My hospital/system previously led or participated in an ACO but is no longer doing so
- ☒ 4. My hospital/system has never participated or led an ACO

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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

Answer

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 2022?

16. Has your hospital/system ever considered participating in an ACO?

- ☐ a. Yes, and we are planning to join one
- ☐ b. Yes, but we are not planning to join one
- ☐ c. No, we have not even considered it

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:
- ☒ j. None

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

Answer

a. Hospital

b. System

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<u>Section Title</u>	<u>Status</u>	<u>Last Edit Date</u>	<u>Last Edit By</u>
Total Facility Beds, Utilization, Finances & Staffing	Completed	07/13/2023	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.	158	99	59	
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds)	109	99	59	
c. Bassinets set up and staffed for use at the end of the reporting period	12	12		
d. Births (exclude fetal deaths)	606	599		
e. Admissions (exclude newborns, include neonatal & swing admissions)	6,082	5,914	104	
f. Inpatient days (exclude newborns, include neonatal & swing days)	37,866	25,441	10,602	
g. Emergency department visits	33,025	32,038		
h. Total outpatient visits (include emergency department visits & outpatient surgeries)	182,167	187,861		
i. Inpatient surgical operations	884	735		
j. Number of operating rooms	6	6		
k. Outpatient surgical operations	3,369	3,090		

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Section E: Question (continued)

	<u>Total Facility</u>	<u>Total Facility</u> <u>(History)</u>	<u>Nursing Home</u> <u>Unit/Facility</u>	<u>Nursing Home</u> <u>Unit/Facility</u> <u>(History)</u>
2. UTILIZATION BY PAYER (exclude newborns, Include neonatal & swing days & deaths)				
a. 1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	3,893	3,690	0	
a. 2. How many Medicare inpatient discharges were Medicare Managed Care?	1,480	1,324		
b. 1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	17,404	16,353		
b. 2. How many Medicare inpatient days were Medicare Managed Care?	6,617	5,869		
c. 1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	824	1,026	0	
c. 2. How many Medicaid inpatient discharges were Medicaid Managed Care?	441	528		
d. 1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	3,685	4,546	0	
d. 2. How many Medicaid inpatient days were Medicaid Managed Care?	1,971	2,339		
e. 1. Total self-pay inpatient discharges	504		0	
e. 2. Total self-pay inpatient days	2,253			
f. 1. Total third-party (non-Medicare, non-Medicaid) inpatient discharges	79		0	
f. 2. Total third-party (non-Medicare, non-Medicaid) inpatient days	351			
g. 1. Other payer (government and non-government inpatient discharges)	585		0	
g. 2. Other payer (government and non-government inpatient days)	2,618			
h. Total inpatient discharges (all payers)(add a1,c1,e1,f1,g1)	5,885		0	

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Section E: Question (continued)

3. FINANCIAL

*a. Net patient revenue (treat bad debt as a deduction from revenue)

*b. Tax appropriations

*c. Other operating revenue

*d. Nonoperating revenue

*e. TOTAL REVENUE (add 3a thru 3d)

f. Payroll expenses (only)

g. Employee benefits

h. Depreciation expense (for reporting period only)

i. Interest expense

j. Pharmacy Expense

k. Supply expense (other than pharmacy)

l. All other expenses

m. TOTAL EXPENSES (Add 3f thru 3l. Exclude bad debt)

Total Facility	Total Facility (History)	Nursing Home Unit/Facility	Nursing Home Unit/Facility (History)

173,165,921	173,026,773	2,789,643	
0	0		
6,507,473	5,881,056		
-1,878,587	25,386,365		
177,794,807	204,294,194	2,789,643	
71,340,858	64,326,414	1,752,919	
17,652,580	14,006,286	298,186	
13,125,295	10,973,724		
1,378,036	1,324,899		
3,759,181	4,008,540		
29,499,557	30,942,121		
37,207,239	32,910,844		
173,962,746	158,492,828	2,051,105	

n. Do your total expenses (E3.m) reflect full allocation from your corporate office?

*4. Revenue By Type

a. Total gross inpatient revenue

b. Total gross outpatient revenue

c. Total gross patient revenue

*5. Uncompensated Care & Provider Taxes

a. Bad debt (Revenue forgone at full established rates. Include in gross revenue)

1. Are you able to distinguish bad debt derived from patients with or without insurance?

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.)

c. Is your bad debt (5a.) reported on the basis of full charges?

d. Does your state have a provider Medicaid tax/assessment program?

e. If yes, please report the total gross amount paid into the program

f. Due to differing accounting standards please indicate whether the provider tax/assessment amount is included in:

Deductions from net Patient Revenue.....

Total Expenses.....

Answer

Answer (History)

Yes	Yes
200511954	196181876
388992435	355965580
589504389	552147456
35094275	37821961
No	No
8173734	9462360
No	No
Yes	Yes
1608808	1569946
No	No
Yes	Yes

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Colquitt Regional Medical Center (6380890)

Section E: Question (continued)

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

	<u>(1)</u> <u>Gross</u>	<u>(1)</u> <u>Gross (History)</u>	<u>(2)</u> <u>Net</u>	<u>(2)</u> <u>Net (History)</u>
*6a. GOVERNMENT				
6a1. Medicare				
6a1a. Fee for service patient revenue	225,790,177	210,134,685	34,821,114	31,243,192
6a1b. Managed care revenue	138,505,484	117,639,000	37,652,326	34,393,743
6a1c. Total (a + b)	364,295,661	327,773,685	72,473,440	65,636,935
6a2. Medicaid:				
6a2a. Fee for service patient revenue	34,086,518	32,401,460	10,890,256	17,147,431
6a2b. Managed care revenue	39,215,943	34,346,570	4,120,437	3,721,449
6a2c. Medicaid Graduate Medical Education (GME) payments			1,510,741	2,048,730
6a2d. Medicaid Disproportionate Share Hospital Payments (DSH)			1,306,441	6,693,808
6a2e. Medicaid supplemental payments: not including Medicaid Disproportionate Share Hospital Payments			3,208,640	4,005,810
6a2f. Other Medicaid			0	0
6a2g. Total (a-f)	73,302,461	66,748,030	21,036,515	33,617,228
6a3. Other Government:	11,527,830	8,867,756	3,254,751	2,090,498
*6b. NONGOVERNMENT				
6b1. Self-pay	38,326,772	44,748,505	7,331,060	5,940,351
6b2. Third-party payers:				
6b2a. Managed care (includes HMO and PPO)	75,951,367	78,828,473	52,699,351	59,189,016
6b2b. Other third - party payers	15,351,486	14,833,726	4,500,558	3,348,617
6b2c. Total Third - party payers (a+b)	91,302,853	93,662,199	57,199,909	62,537,633
6b3. All Other nongovernment	10,748,812	10,347,281	9,080,603	3,204,128
*6c. TOTAL	589,504,389	552,147,456	170,376,278	173,026,773

*6d. If you reported receiving Medicaid Supplemental Payments on line 6.a(2)e, please break the payment total into inpatient and outpatient care.

	<u>Inpatient</u>	<u>Inpatient</u> <u>(History)</u>	<u>Outpatient</u>	<u>Outpatient</u> <u>(History)</u>
Medicaid supplemental payments				

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Section E: Question (continued)

*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.

Answer

Answer (History)

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

Gross

Net

*6g. Are the financial data reported from your audited financial statement?

Answer

Answer (History)

6h. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER?

Yes

Yes

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.

*7a. Provider/COVID Relief Funds recognized as revenue in 2022

8,750,223

6,917,825

*7b. On which survey line did you report this revenue?

1. Net patient revenue

No

No

2. Other operating revenue

No

3. Nonoperating revenue

Yes

*7c. Provider/COVID Relief Funds recognized as revenue in 2021 (please do not include these dollars in 7a)

6,917,825

6,217,615

*7d. Did you include these funds as revenue on the 2021 survey?

Yes

*7e. If yes, on which survey line did you report this revenue?

1. Net patient revenue

No

No

2. Other operating revenue

No

3. Nonoperating revenue

Yes

*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

258,874,766

243,623,874

9b. Accumulated depreciation

145,907,290

133,164,047

9c. Net property, plant and equipment (a - b)

112,967,476

110,459,827

9d. Total gross square feet of your physical plant used for or in support of your healthcare activities

307,171

307,171

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	<u>Answer</u>	<u>Answer</u> <u>(History)</u>
10. Total Capital Expenses		
Include all expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.	18,289,912	27,886,959
11. Information Technology and Cybersecurity		
a. *Overall IT Budget	4,412,544	4,144,357
b. *Number of internal IT staff (in FTEs)	22	18
c. *What percent of your IT budget is spent on cybersecurity?	20	20
d. *Number of internal staff devoted to cybersecurity (in FTEs)		
e. *Number of outsourced staff devoted to cybersecurity (in FTEs)		0
f. *What position does your cybersecurity lead report to?		
g. *Does your organization rank cybersecurity as an enterprise risk issue?		
h. *If yes, what priority number to rank it as?		
i. *How often is the board briefed on cybersecurity?		
j. *What do you view as your biggest cybersecurity threat? (Please rank the choices 1-9, with 1 being the biggest threat)		
1. Ransomware which may disrupt and delay patient care delivery		
2. Ransomware which may disrupt business operations		
3. Theft of sensitive patient data such as Protected Health Information (PHI) or Personally Identifiable Information (PII)		
4. Theft of medical research or intellectual property		
5. Cyber risk exposure through business associates. Business associate as conduit for cyber attacks or theft of your data stored by third parties		
6. Software and supply chain cyber risk		
7. Medical device cyber risk		
8. Phishing emails or other social engineering attacks which may result in the delivery of malware or ransomware into the organization		
9. Phishing emails or other social engineering attacks which may result in the theft of funds		

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	<u>Answer</u>	<u>Answer</u> <u>(History)</u>
k. *Does your organization use any of the following cybersecurity techniques? (Check yes or no)		
1. Enterprise wide multi-factor authentication for all remote access to networks, data and applications	Yes	
2. Network segmentation	Yes	
3. Off line, network segmented, redundant network and data back ups	Yes	
4. Immutable backups	Yes	
5. Intrusion detection systems	Yes	
6. Employee cybersecurity education including phishing email simulations	Yes	
7. 24/7 Security Operations Center (SOC) monitoring all cyber incidents and events	No	
8. Highly efficient and effective patch management program	Yes	
9. Forced password change every 90 days or less	Yes	
10. Integration of cyber incident response plans with emergency management plans	No	
11. Cross function cyber incident response exercise for all leaders	Yes	
12. Relationship with local FBI and CISA offices	No	
13. Third Party Risk Management Program which assesses business associate access to networks and bulk sensitive data; mission criticality and life criticality of third party	Yes	
l. *How confident are you in the organization's ability to sustain care delivery through manual downtime procedures for up to four weeks, without the benefit of network and internet connected technology?		
☐ 1. Confident		
☐ 2. Somewhat confident		
☒ 3. Uncertain		
☐ 4. Somewhat not confident		
☐ 5. Not confident		
m. *What do you view as your biggest challenges in improving your organization's cybersecurity posture? Please rank choices 1-6, with 1 being the biggest challenge		
1. Funding	5	
2. Staffing	2	
3. Legacy insecure technology	3	
4. Leadership support	6	
5. Organizational culture	4	
6. Non-compliant third parties/business associates	1	
*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.		
*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.		

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12. STAFFING

	<u>Full-Time (35 hr/wk or more) On Payroll</u>	<u>Full-Time (History)</u>	<u>Part-Time (<35 hr/wk) On Payroll</u>	<u>Part-Time (History)</u>	<u>FTE</u>	<u>Vacancies</u>	<u>Vacancies (History)</u>
a. Physicians	51	28	0	0	51	0	0
b. Dentists	0	0	0	0	0	0	0
c. Medical residents/interns	17	18	0	0	17	0	0
d. Dental residents/interns	0	0	0	0	0	0	0
e. Other trainees	15	0	0	0	15	0	7
f. Registered nurses	185	153	81	95	226	15	16
g. Licensed practical (vocational) nurses	57	35	6	4	60	5	7
h. Nursing assistive personnel	127	84	13	60	134	8	5
i. Radiology technicians	29	30	16	4	37	1	0
j. Laboratory technicians	35	34	0	7	35	5	2
k. Pharmacists, licensed	7	6	2	2	8	0	0
l. Pharmacy technicians	10	10	0	0	10	0	0
m. Respiratory therapists	19	14	5	4	22	1	1
n. All other personnel	706	710	20	114	715	12	60
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)	1258	1122	143	290	1330	47	98
p. Nursing home type unit/facility Registered Nurses	5	0	2	0	0	0	0
q. Nursing home type unit/facility personnel	67	0	4	0	0	2	0
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.					<u>Answer</u>	<u>Answer (History)</u>	
					217	198	
s. For your medical residents/interns reported above (E.12c. column 1) please indicate the number of full-time on payroll by specialty.					<u>Answer</u>	<u>Answer (History)</u>	
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)						18	
2. Other Specialties						0	

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Please report the number of contracted FTEs for each occupational category. Personnel that are on the hospitals payroll and reported in E(12) should not be reported here.

13. CONTRACTED STAFF

	<u>CONTRACTED FTEs</u>	<u>CONTRACTED FTEs</u> <u>(History)</u>
a. Registered nurses	0	
b. Radiology technicians	0	
c. Laboratory technicians	0	
d. Pharmacists licensed	0	
e. Pharmacy technicians	0	
f. Respiratory therapists	0	
g. All other contracted staff	0	

14. PRIVILEGED PHYSICIANS

	<u>(1)</u> <u>Total Employed</u>	<u>(2)</u> <u>Total Individual</u>	<u>(3)</u> <u>Total Group</u> <u>Contract</u>	<u>(4)</u> <u>Not Employed</u> <u>or Under</u> <u>Contract</u>	<u>(5)</u> <u>Total Privileged</u>
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	18	0	0	2	20
b. Obstetrics/gynecology	3	0	0	0	3
c. Emergency medicine	0	0	4	0	4
d. Hospitalist	13	0	0	0	13
e. Intensivist	0	0	0	0	0
f. Radiologist/pathologist/anesthesiologist	0	4	4	0	8
g. Other specialist	0	16	8	1	25
h. Total (add 14a-14g)	34	20	16	3	73

15. HOSPITALISTS

	<u>Answer</u>	<u>Answer (History)</u>
15a. Do hospitalists provide care for patients in your hospital? (if yes, please report in E.14d.)	Yes	Yes
15b. If yes, please report the total number of full-time equivalents (FTE) hospitalists. FTE	13	13

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16. INTENSIVISTS

	<u>Answer</u>	<u>Answer (History)</u>		
a. Do intensivists provide care for patients in your hospital. (If no, please skip to question 17) (if yes, please report in E.14e.)	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 authorized to care for ICU patients.)				
	<u>FTE</u>	<u>Closed</u>	<u>FTE (History)</u>	<u>Closed (History)</u>
1. Medical-surgical intensive care				
2. Cardiac intensive care				
3. Neonatal intensive care				
4. Pediatric intensive care				
5. Other intensive care				
6. Total				

17. ADVANCED PRACTICE REGISTERED NURSES / PHYSICIAN ASSISTANTS

	<u>Answer</u>	<u>Answer (History)</u>
a. Do advanced practice nurses/physician assistants provide care for patients in your hospital?(if no, please skip to 18)	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	20	18
Advanced Practice Registered Nurses Part-time	0	0
Advanced Practice Registered Nurses FTE	20	18
Physician Assistants Full-time		8
Physician Assistants Part-time		0
Physician Assistants FTE		8

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
- ☐ 5. Patient education
- ☐ 6. Case management
- ☐ 7. Other

18. FOREIGN EDUCATED NURSES

- a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2022 vs. 2021?
- ☐ Did not hire foreign nurses
 - ☐ Less
 - ☐ More
 - ☒ Same

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b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)

- ☐ Africa
- ☐ Canada
- ☐ China
- ☐ India
- ☐ Other
- ☐ Philippines
- ☐ South Korea

19. WORKFORCE

19a. 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
- ☐ 6. None of the above

19b. How is your hospital incorporating workforce as part of the strategic planning process (Check all that apply):

- ☒ 1. Conduct needs assessment
- ☒ 2. Leadership succession planning
- ☒ 3. Talent development plan
- ☒ 4. Recruitment and retention planning
- ☒ 5. Partnerships with elementary/HS to develop interest in health care careers
- ☒ 6. Training program partnership with community colleges, vocational training programs
- ☐ 7. None of the above

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<u>Section Title</u>	<u>Status</u>	<u>Last Edit Date</u>	<u>Last Edit By</u>
Addressing Patient Social Needs and Community Social Determinants of Health	Completed	07/13/2023	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
- ☒ 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

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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):

- ☐ 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
- ☐ e. None of the above

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
- ☐ g. None of the above

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
- ☐ g. None of the above

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
- ☐ f. None of the above

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
- ☐ h. None of the above

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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)

	<u>Not involved</u>	<u>Work together to meet patient social needs</u>	<u>Participates in our Community</u>	<u>Work together to implement community-level initiatives</u>
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)	☐	☐	☐	☐

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Colquitt Regional Medical Center (6380890)

Section Title	Status	Last Edit Date	Last Edit By
Supplemental Information	Completed	07/13/2023	James L Matney

Section G: Supplemental Information

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:

Answer
Yes

Name	City	State
Healthtrust	Brentwood	TN

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

Answer
Yes

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

Name:

Name:

Name:

3. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?

Answer
23

4. Does your hospital have an established patient and family advisory council that meets regularly to actively engage the perspectives of patients and families?

Answer
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

b. Certified Community Behavioral Health Center

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Decarbonization Goals

7. Which of the following describe(s) your organizations decarbonization efforts?

Answer

If yes to, have your hospital set a decarbonization percentage reduction.

% Reduction goal (e.g. xxx.xx)

Target year to meet goal

Baseline year

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.

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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@colquittre

Your Phone Number

(229)890-3513

Your Fax Number

(229)891-9335



2023 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: Moultrie

Zip: 31776

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, 2023 - December 31, 2023 (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: Gary Mackie

Contact Title: Director of Cardiology

Phone: 229-891-9060

Fax: 229-891-9368

E-mail: gmackie@colquittergional.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	365	Diagnostic 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.

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	359	359
Right Heart Diagnostic Cardiac Catheterizations	0	6	6
Total Diagnostic Cardiac Catheterization Procedures	0	365	365
Grand Total (All Cardiac Catheterization Procedures)	0	365	365

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	359	359
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	36	36

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	174	174
Outpatient Diagnostic Cardiac Catheterizations	0	191	191
Inpatient Therapeutic Cardiac Catheterizations	0	0	0
Outpatient Therapeutic Cardiac Catheterizations	0	0	0
Total	0	365	365

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	31	31
Angiograms/Venograms	0	0	0
Angioplasty	0	31	31
Stents	0	14	14
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	76	76

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 equipped 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.

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	127
Hispanic/Latino	13
Pacific Islander/Hawaiian	0
White	225
Multi-Racial	0
Total	365

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	195
Female	170
Total	365

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)	92,905	7	0	28,568
Cds w/AMI and CV Complication, Discharged Alive (MS-DRG 280)	42,177	33	0	10,814
Cds w/AMI w/o CV Complication, Discharged Alive (MS-DRG 281 & 282)	27,439	30	0	8,111
Cds except AMI w/Cardiac Cath and Complex Diagnosis (MS-DRG 286)	49,762	25	0	14,949
Cds except AMI w/Cardiac Cath and Complex Diagnosis (MS-DRG 287)	36,400	36	0	9,079
Heart Failure and Shock (MS-DRG 291, 292, 293)	28,378	317	0	8,967
Peripheral Vascular Disorders w/CC (MS-DRG 299)	32,394	6	0	9,563
Cardiac arrhythmia and conduction disorders w/CC (MS-DRG 308)	31,982	35	0	11,181
Angina Pectoris (MS-DRG 311)	26,492	11	0	5,456

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
\$10,356,085	\$2,272,662

4. Total Uncompensated Charges for Cardiac Catheterization Services

Please report the total uncompensated charges 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
\$125,919	4

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
\$10,230,166

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				I/C Care Account
	Medicare	Medicaid	3rd Party (Including Peachcare)	Individual Self-Pay	
Number of Cardiac Catheterization Patients (unduplicated)	210	31	94	30	0
Number of Procedures Billed	210	31	94	30	0
Number of Procedures Not Billed or Written Off	0	0	0	0	0
Total Charges	\$6,550,059	\$784,256	\$2,308,181	\$713,590	\$0
Actual Reimbursement	\$1,205,870	\$146,435	\$895,143	\$25,214	\$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 accredited. ☒

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-of-state 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	365	0	0	0
Total	365	0	0	0

Part F : Patient Origin 2023

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	365	365
Total Patients	0	365	365

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 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 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 original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: JULIE BHAVNANI

Title: CFO

Date: 7/12/2024

Comments:



2023 Hospital Financial Survey

Part A : General Information

1. Identification

UID:HOSP524

Facility Name: Colquitt Regional Medical Center

County: Colquitt

Street Address: 3131 SOUTH MAIN STREET

City: MOULTRIE

Zip: 31768

Mailing Address: 2028 OAKDALE DRIVE

Mailing City: VALDOSTA

Mailing Zip: 31602

Medicaid Provider Number: 110105

Medicare Provider Number: 000002021A

2. Report Period

Please report data for the hospital fiscal year ending during calendar year 2023 only.

Do not use a different report period.

Please indicate your hospital fiscal year.

From: 10/1/2022 To:9/30/2023

Please indicate your cost report year.

From: 10/01/2022 To:09/30/2023

☐

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	210,028,033
Total Inpatient Admissions accounting for Inpatient Revenue	6,471
Outpatient Gross Patient Revenue	324,623,362
Total Outpatient Visits accounting for Outpatient Revenue	194,430
Medicare Contractual Adjustments	188,483,130
Medicaid Contractual Adjustments	48,365,909
Other Contractual Adjustments:	97,258,880
Hill Burton Obligations:	0
Bad Debt (net of recoveries):	35,377,126
Gross Indigent Care:	5,119,868
Gross Charity Care:	717,286
Uncompensated Indigent Care (net):	5,119,868
Uncompensated Charity Care (net):	717,286
Other Free Care:	1,329,049
Other Revenue/Gains:	21,971,097
Total Expenses:	144,208,131

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	1,329,049
Employee Discounts	0
	0
Total	1,329,049

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 2023? (Check box if yes.) ☒

2. Effective Date

What was the effective date of the policy or policies in effect during 2023?

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.?

DIRECTOR 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 2023? (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	1,865,888	156,952	2,022,840
Outpatient	3,253,980	560,334	3,814,314
Total	5,119,868	717,286	5,837,154

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	1,865,888	156,952	2,022,840
Outpatient	3,253,980	560,334	3,814,314
Total	5,119,868	717,286	5,837,154

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
Appling	1	1,750	1	90	0	0	0	0
Ben Hill	0	0	4	1,516	1	545	4	665
Berrien	0	0	6	11,179	0	0	0	0
Brooks	16	189,210	113	93,256	1	570	24	3,505
Coffee	0	0	3	799	0	0	0	0
Colquitt	232	1,534,591	2,921	2,689,338	66	148,265	1,079	386,481
Cook	3	2,917	53	29,337	0	0	15	41,618
Dougherty	0	0	6	2,069	0	0	3	1,323
Houston	0	0	0	0	0	0	16	441
Lowndes	1	1,580	42	13,636	0	0	9	37,450
Macon	1	4,950	0	0	0	0	0	0
Mitchell	6	6,525	98	28,387	0	0	61	57,088
Other Out of State	1	1,480	42	93,299	2	1,556	35	16,939
Sumter	0	0	0	0	0	0	3	639
Thomas	10	107,676	136	130,232	2	6,016	22	7,810
Tift	1	1,125	104	125,700	0	0	25	6,375
Turner	0	0	1	3,817	0	0	0	0
Wilcox	0	0	16	22,927	0	0	0	0
Worth	4	14,084	11	8,398	0	0	0	0
Total	276	1,865,888	3,557	3,253,980	72	156,952	1,296	560,334

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 2023?
(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 2023.

Patient Category		SFY 2022 7/1/21-6/30/22	SFY2023 7/1/22-6/30/23	SFY2024 7/1/23-6/30/24
A.	Qualified Medically Indigent Patients with incomes up to 125% of the Federal Poverty Level Guidelines and served without charge.	0	5,119,868	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	717,286	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.

SFY2022 7/1/21-6/30/22	SFY2023 7/1/22-6/30/23	SFY2024 7/1/23-6/30/24
0	5,201	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 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 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: JIM MATNEY

Date: 7/1/2024

Title: CHIEF EXECUTIVE OFFICER

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: 7/1/2024

Title: CFO

Comments:

2023 Hospital Financial Survey Hospital Financial Statements Reconciliation Addendum HOSP524- Colquitt Regional Medical Center

Section 1: Hospital Only Data from Hospital Financial Survey (HFS):											
HFS Source:	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part C, 1	Part E, 1	Part C, 1	Total Deductions of All Types (Sum Col 2-9)	Net Patient Revenue (Col 1 - 10)
	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		
Inpatient Gross Patient Revenue	1	2	3	4	5	6	7	8	9	10	11
	210,028,033										
Outpatient Gross Patient Revenue	324,623,362										
Per Part C, 1. Financial Table		188,483,130	48,365,909	97,258,880	0	35,377,126			1,329,049		
Per Part E, 1. Indigent and Charity Care							5,119,868	717,286			
Totals per HFS	534,651,395	188,483,130	48,365,909	97,258,880	0	35,377,126	5,119,868	717,286	1,329,049	376,651,248	158,000,147
Section 2: Reconciling Items to Financial Statements:											
Non-Hospital Services:											
> Professional Fees	93,103,420									65,592,059	
> Home Health Agency	3,898,082									894,684	
> SNF/NF Swing Bed Services	1,893,687									1,329,357	
> Nursing Home	4,743,884									290,388	
> Hospice	2,410,270									219,614	
> Freestanding Ambulatory Surg. Centers	0									0	
> RHC	5,084,664									3,688,145	
> AMBULANCE	7,769,277									5,231,042	
> PRIVATE DUTY	233,185									2,120	
> HOSPITAL PRO FEES	15,757,767									10,420,950	
> DIALYSIS	87,643,260									61,525,063	
> NA	0									0	
Bad Debt (Expense per Financials) (A)										0	
Indigent Care Trust Fund Income										-223,658	
Other Reconciling Items:											
> NA	0									0	
> NA	0									0	
> NA	0									0	
> NA	0									0	
Total Reconciling Items	222,537,496									148,969,764	73,567,732
Total Per Form	757,188,891									525,621,012	231,567,879
Total Per Financial Statements	757,188,891										231,567,879
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	(i) Base Compensation	(ii) Bonus & Incentive Comp.	(iii) Taxable Deferred Comp. Accrued in Prior Years	(iv) Other Reportable Compensation	(B) Retirement and other Deferred Compensation	(C) Non taxable Benefits
President	\$1,331,013	\$420,333	\$0	\$220,978	\$132,000	\$15,000
Vice President	\$578,212	\$55,493	\$0	\$0	\$51,427	
Vice President	\$360,587	\$51,205	\$0	\$0	\$35,191	
Vice President	\$284,104	\$40,344	\$0	\$0	\$27,727	
Vice President	\$361,504	\$51,335	\$0	\$0	\$35,146	
Vice President	\$224,984	\$28,575	\$0	\$0	\$20,380	
Vice President	\$328,967	\$46,717	\$0	\$0	\$31,107	
Vice President	\$196,908	\$27,961	\$0	\$0	\$19,217	
Vice President	\$257,088	\$33,842	\$0	\$0	\$23,957	
Vice President	\$231,658	\$32,895	\$0	\$0	\$11,304	

****Calendar year 2023

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 10/01/2022 To 09/30/2023	Worksheet S Parts I-III Date/Time Prepared: 2/29/2024 12:04 pm

PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 2/29/2024	Time: 12:04 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☒ Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. ☒ 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. ☒ Initial Report for this Provider CCN 9. ☒ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ 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 10/01/2022 and ending 09/30/2023 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	<i>Julie Bhavnani</i>	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		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	1,066,225	113,795	0	3,106,672
2.00	SUBPROVIDER - IPF	0	0	0	0	0
3.00	SUBPROVIDER - IRF	0	0	0	0	0
5.00	SWING BED - SNF	0	0	0	0	0
6.00	SWING BED - NF	0	0	0	0	0
7.00	SKILLED NURSING FACILITY	0	0	0	0	0
10.00	RURAL HEALTH CLINIC I	0	0	25,444	0	0
200.00	TOTAL	0	1,066,225	139,239	0	3,106,672

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023		Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 12:04 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			
		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		COLQUITT REGIONAL MEDICAL CENTER	11S105	99911	4	10/01/2022	N	P	O	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)						10/01/2022	09/30/2023		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.									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	

Worksheet S-2
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

MCRIF32 - 21.3.178.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet S-2
Part I
Date/Time Prepared:
2/29/2024 12:04 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	
		1.00	2.00	3.00	
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	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
61.20	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
					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
62.01	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
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 10/01/2022
To 09/30/2023Worksheet S-2
Part I
Date/Time Prepared:
2/29/2024 12:04 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 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 12:04 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)?				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.				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)				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.				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)				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.				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.				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.				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.				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)		N	0	88.00
Column 2: Enter the number of approved permanent adjustments.					
			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 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 12:04 pm	
			V 1.00	XIX 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 1.00	Occupational 2.00	Speech 3.00	Respiratory 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
				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	
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
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			0115.00
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 10/01/2022 To 09/30/2023	Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 12:04 pm
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	1,707,637	75,642	1,213,015
		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.	Y	N	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 10/01/2022 To 09/30/2023		Worksheet S-2 Part I Date/Time Prepared: 2/29/2024 12:04 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	
						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 10/01/2022 To 09/30/2023		Worksheet S-2 Part II Date/Time Prepared: 2/29/2024 12:04 pm	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE 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	01/22/2024			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	12/18/2023	Y	12/18/2023		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 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/29/2024 12:04 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
		Y/N	Date	Y/N
		1.00	2.00	3.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	N	
				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 10/01/2022 To 09/30/2023	Worksheet S-2 Part II Date/Time Prepared: 2/29/2024 12:04 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 10/01/2022
To 09/30/2023Worksheet S-3
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips		
					Title V		
					1.00		2.00
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	90	32,850	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)		90	32,850	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)		100	36,500	0.00	0	14.00
15.00	CAH visits					0	15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	40.00	10	3,650		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	59	21,535		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)		204				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 10/01/2022
To 09/30/2023Worksheet S-3
Part I
Date/Time Prepared:
2/29/2024 12:04 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)	4,606	2,175	25,411			1.00
2.00	HMO and other (see instructions)	9,412	2,873				2.00
3.00	HMO IPF Subprovider	724	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	123	0	123			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	647			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	4,729	2,175	26,181			7.00
8.00	INTENSIVE CARE UNIT	1,422	488	2,754			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		196	1,216			13.00
14.00	Total (see instructions)	6,151	2,859	30,151	21.21	1,238.88	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits						15.10
16.00	SUBPROVIDER - IPF	429	0	1,751	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	2,225	12,310	17,978	0.00	44.34	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	11,636	856	13,052	0.00	11.60	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,601	8,090	19,728	0.00	20.01	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)				21.21	1,314.83	27.00
28.00	Observation Bed Days		105	1,816			28.00
29.00	Ambulance Trips	1,274					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	183	225			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 10/01/2022
To 09/30/2023Worksheet S-3
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	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	1,237	677	6,219	1.00
2.00 HMO and other (see instructions)			1,981	971		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	1,237	677	6,219	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	52	0	189	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 10/01/2022
To 09/30/2023Worksheet S-3
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on 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	86,942,670	0	86,942,670	2,647,652.00	32.84
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	377,872	377,872	2,717.00	139.08
5.00	Physician and Non Physician-Part B		0	220,791	220,791	2,096.00	105.34
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		357,415	0	357,415	39,532.00	9.04
7.00	Interns & residents (in an approved program)	21.00	2,331,157	-1,030,758	1,300,399	44,111.00	29.48
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,238,088	0	2,238,088	92,224.00	24.27
10.00	Excluded area salaries (see instructions)		15,914,410	-1,757,910	14,156,500	499,273.00	28.35
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		302,564	0	302,564	913.00	331.40
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		0	0	0	0.00	0.00
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		17,358,641	0	17,358,641		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		3,421,095	0	3,421,095		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		91,317	0	91,317		
23.00	Physician Part B		53,357	0	53,357		
24.00	Wage-related costs (RHC/FQHC)		86,374	0	86,374		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet S-3
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on 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	905,667	0	905,667	20,279.00	44.66	26.00
27.00	Administrative & General	5.00	18,799,746	435,481	19,235,227	459,550.00	41.86	27.00
28.00	Administrative & General under contract (see inst.)		388,011	0	388,011	2,037.00	190.48	28.00
29.00	Maintenance & Repairs	6.00	1,553,364	420	1,553,784	70,751.00	21.96	29.00
30.00	Operation of Plant	7.00	420	-420	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	47,949	0	47,949	2,770.00	17.31	31.00
32.00	Housekeeping	9.00	1,227,730	0	1,227,730	72,428.00	16.95	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,367,006	-975,613	391,393	30,635.00	12.78	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	975,613	975,613	45,649.00	21.37	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	819,255	559,331	1,378,586	25,482.00	54.10	38.00
39.00	Central Services and Supply	14.00	804,990	-288,931	516,059	25,217.00	20.46	39.00
40.00	Pharmacy	15.00	1,188,064	0	1,188,064	38,676.00	30.72	40.00
41.00	Medical Records & Medical Records Library	16.00	333,680	0	333,680	17,246.00	19.35	41.00
42.00	Social Service	17.00	132,931	0	132,931	7,440.00	17.87	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 10/01/2022
To 09/30/2023Worksheet S-3
Part III
Date/Time Prepared:
2/29/2024 12:04 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on 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)	84,642,109	432,095	85,074,204	2,561,233.00	33.22	1.00
2.00	Excluded area salaries (see instructions)	18,152,498	-1,757,910	16,394,588	591,497.00	27.72	2.00
3.00	Subtotal salaries (line 1 minus line 2)	66,489,611	2,190,005	68,679,616	1,969,736.00	34.87	3.00
4.00	Subtotal other wages & related costs (see inst.)	302,564	0	302,564	913.00	331.40	4.00
5.00	Subtotal wage-related costs (see inst.)	17,358,641	0	17,358,641	0.00	25.27	5.00
6.00	Total (sum of lines 3 thru 5)	84,150,816	2,190,005	86,340,821	1,970,649.00	43.81	6.00
7.00	Total overhead cost (see instructions)	27,568,813	705,881	28,274,694	818,160.00	34.56	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet S-3
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,498,470	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)	10,601,753	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)	108,467	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)	71,049	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	480,460	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	5,976,605	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	13,139	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	179,242	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,010,785	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 10/01/2022
To 09/30/2023Worksheet S-3
Part V
Date/Time Prepared:
2/29/2024 12:04 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	21,010,785	1.00
2.00	Hospital	0	17,489,132	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	466,290	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	157,468	13.00
14.00	Hospital-Based Health Clinic RHC	0	139,731	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	2,758,164	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet S-5

Date/Time Prepared:
2/29/2024 12:04 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						1		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	383,756	0	93,706,000	0		22.00	

Health Financial Systems

COLQUITT REGIONAL MEDICAL CENTER

In Lieu of Form CMS-2552-10

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet S-5 Date/Time Prepared: 2/29/2024 12:04 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

Health Financial Systems		COLQUITT REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider CCN: 11-0105 Component CCN: 11-3422		Period: From 10/01/2022 To 09/30/2023 Worksheet S-8 Date/Time Prepared: 2/29/2024 12:04 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
		1.00	2.00	3.00	4.00
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
		1.00	2.00	3.00	4.00
		Total Visits			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

Period:

Worksheet S-8

Component CCN: 11-3422

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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

Period:

Worksheet S-9

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023PARTS I THROUGH IV
Date/Time Prepared:
2/29/2024 12:04 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	11,581	853	560	12,994	11.00
12.00	Hospice Inpatient Respite Care	55	3	0	58	12.00
13.00	Hospice General Inpatient Care	0	0	0	0	13.00
14.00	Total Hospice Days	11,636	856	560	13,052	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 10/01/2022 To 09/30/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 2/29/2024 12:04 pm
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.265239	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		15,426,165	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		14,647,402	5.00
6.00	Medicaid charges		72,864,883	6.00
7.00	Medicaid cost (line 1 times line 6)		19,326,609	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		264,838	9.00
10.00	Stand-alone CHIP charges		1,531,846	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		406,305	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		141,467	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 (see instructions)		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)		141,467	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	4,369,255	1,758,444	6,127,699
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,158,897	1,758,444	2,917,341
22.00	Payments received from patients for amounts previously written off as charity care	0	177,556	177,556
23.00	Cost of charity care (see instructions)	1,158,897	1,580,888	2,739,785
				1.00
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		26,844,498	26.00
27.00	Medicare reimbursable bad debts (see instructions)		642,901	27.00
27.01	Medicare allowable bad debts (see instructions)		989,078	27.01
28.00	Non-Medicare bad debt amount (see instructions)		25,855,420	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		7,204,043	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		9,943,828	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,085,295	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet S-10
Parts I & II
Date/Time Prepared:
2/29/2024 12:04 pm

			1.00	
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.244034	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			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)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			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			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	4,369,255	1,758,444	6,127,699
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,066,247	1,758,444	2,824,691
22.00	Payments received from patients for amounts previously written off as charity care	0	177,556	177,556
23.00	Cost of charity care (see instructions)	1,066,247	1,580,888	2,647,135
				1.00
24.00	Does the amount on line 20 col. 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
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		26,844,498	26.00
27.00	Medicare reimbursable bad debts (see instructions)		550,888	27.00
27.01	Medicare allowable bad debts (see instructions)		847,519	27.01
28.00	Non-Medicare bad debt amount (see instructions)		25,996,979	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		6,640,778	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		9,287,913	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		9,287,913	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (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		5,711,088	5,711,088	2,202,431	7,913,519
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		7,790,431	7,790,431	3,367,112	11,157,543
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	905,667	12,243,877	13,149,544	1,263,845	14,413,389
5.00	00500	ADMINISTRATIVE & GENERAL	18,799,746	19,389,975	38,189,721	-1,870,769	36,318,952
6.00	00600	MAINTENANCE & REPAIRS	1,553,364	4,623,747	6,177,111	420	6,177,531
7.00	00700	OPERATION OF PLANT	420	1,664,279	1,664,699	-18,455	1,646,244
8.00	00800	LAUNDRY & LINEN SERVICE	47,949	708,034	755,983	0	755,983
9.00	00900	HOUSEKEEPING	1,227,730	467,883	1,695,613	-34,668	1,660,945
10.00	01000	DIETARY	1,367,006	1,382,687	2,749,693	-1,962,828	786,865
11.00	01100	CAFETERIA	0	0	0	1,962,417	1,962,417
13.00	01300	NURSING ADMINISTRATION	819,255	445,601	1,264,856	559,331	1,824,187
14.00	01400	CENTRAL SERVICES & SUPPLY	804,990	325,456	1,130,446	-333,669	796,777
15.00	01500	PHARMACY	1,188,064	8,591,363	9,779,427	-291,120	9,488,307
16.00	01600	MEDICAL RECORDS & LIBRARY	333,680	98,062	431,742	-3,562	428,180
17.00	01700	SOCIAL SERVICE	132,931	11,455	144,386	0	144,386
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,331,157	0	2,331,157	-1,030,758	1,300,399
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	452,093	452,093	826,190	1,278,283
23.00	02300	PARAMED ED PRGM	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	14,701,575	3,733,410	18,434,985	-64,284	18,370,701
31.00	03100	INTENSIVE CARE UNIT	2,378,502	276,685	2,655,187	149	2,655,336
40.00	04000	SUBPROVIDER - IPF	1,154,835	248,746	1,403,581	-1,403,582	-1
43.00	04300	NURSERY	103,428	44,690	148,118	399,412	547,530
44.00	04400	SKILLED NURSING FACILITY	2,238,088	1,591,326	3,829,414	0	3,829,414
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,351,249	4,739,878	8,091,127	-1,985,933	6,105,194
51.00	05100	RECOVERY ROOM	609,761	60,552	670,313	0	670,313
52.00	05200	DELIVERY ROOM & LABOR ROOM	173,746	64,648	238,394	560,845	799,239
53.00	05300	ANESTHESIOLOGY	-366,875	3,261,692	2,894,817	13,300	2,908,117
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,445,819	2,587,818	6,033,637	-667,524	5,366,113
54.01	05401	NUCLEAR MEDICINE-DIAG	277,982	339,007	616,989	0	616,989
57.00	05700	CT SCAN	908,346	324,378	1,232,724	0	1,232,724
60.00	06000	LABORATORY	2,440,145	2,405,274	4,845,419	-13,566	4,831,853
65.00	06500	RESPIRATORY THERAPY	1,232,090	166,800	1,398,890	-42,091	1,356,799
66.00	06600	PHYSICAL THERAPY	2,324,536	406,029	2,730,565	-26,929	2,703,636
69.00	06900	ELECTROCARDIOLOGY	1,107,425	1,174,994	2,282,419	-434,029	1,848,390
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,262,299	17,262,299	0	17,262,299
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,652,258	2,652,258
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,726,417	4,726,417	-499,910	4,226,507
74.00	07400	RENAL DIALYSIS	1,227,013	414,630	1,641,643	498,661	2,140,304
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	851,260	1,629,016	2,480,276	112,491	2,592,767
90.00	09000	CLINIC	782,119	1,208,139	1,990,258	460,044	2,450,302
90.01	09001	URGENT CARE	0	2,794	2,794	-2,794	0
90.02	09002	FAMILY RESIDENCY CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	3,730,092	1,276,077	5,006,169	500	5,006,669
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,725,360	554,254	2,279,614	-30,257	2,249,357
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		2,843,375	2,843,375	-2,843,375	0
116.00	11600	HOSPICE	755,814	614,958	1,370,772	-139,475	1,231,297
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74,664,269	115,863,917	190,528,186	1,179,828	191,708,014
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,132	361,312	366,444	-201	366,243
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,501,451	20,058,119	27,559,570	-1,113,336	26,446,234
194.00	07950	CRH	256,775	449,040	705,815	-705,815	0
194.01	07951	HOME HEALTH	1,493,988	443,424	1,937,412	1,530	1,938,942
194.02	07952	COMM CARE	140,970	48,219	189,189	0	189,189
194.03	07953	FOUNDATION	181,352	145,131	326,483	0	326,483
194.04	07954	TRANSPORT	294,139	166,338	460,477	0	460,477
194.05	07955	PRIVATE DUTY NURSING	193,074	36,084	229,158	0	229,158
194.06	07956	PUBLIC RELATIONS	0	0	0	859,308	859,308
194.07	07957	KIRK CLINIC	1,734,241	2,967,316	4,701,557	-344,988	4,356,569
194.08	07958	NORMAN PARK FM CLINIC	246,996	139,002	385,998	123,674	509,672
194.09	07959	RETAIL PHARMACY	230,283	1,742,664	1,972,947	0	1,972,947
200.00		TOTAL (SUM OF LINES 118 through 199)	86,942,670	142,420,566	229,363,236	0	229,363,236

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A

Date/Time Prepared:
2/29/2024 12:04 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	-643,598	7,269,921	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-33,760	11,123,783	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-115,339	14,298,050	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-322,135	35,996,817	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	6,177,531	6.00
7.00	00700	OPERATION OF PLANT	-48,165	1,598,079	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	755,983	8.00
9.00	00900	HOUSEKEEPING	0	1,660,945	9.00
10.00	01000	DIETARY	0	786,865	10.00
11.00	01100	CAFETERIA	-1,087,942	874,475	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,824,187	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	796,777	14.00
15.00	01500	PHARMACY	0	9,488,307	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-229	427,951	16.00
17.00	01700	SOCIAL SERVICE	0	144,386	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	1,300,399	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	-322,717	955,566	22.00
23.00	02300	PARAMED ED PRGM	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,440,022	16,930,679	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,655,336	31.00
40.00	04000	SUBPROVIDER - IPF	0	-1	40.00
43.00	04300	NURSERY	0	547,530	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,829,414	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,105,194	50.00
51.00	05100	RECOVERY ROOM	0	670,313	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	799,239	52.00
53.00	05300	ANESTHESIOLOGY	-3,067,118	-159,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,366,113	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	616,989	54.01
57.00	05700	CT SCAN	0	1,232,724	57.00
60.00	06000	LABORATORY	0	4,831,853	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,356,799	65.00
66.00	06600	PHYSICAL THERAPY	-1,374,848	1,328,788	66.00
69.00	06900	ELECTROCARDIOLOGY	-187,121	1,661,269	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,262,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,652,258	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,226,507	73.00
74.00	07400	RENAL DIALYSIS	0	2,140,304	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,592,767	88.00
90.00	09000	CLINIC	-913,682	1,536,620	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	-770,756	4,235,913	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	2,249,357	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	1,231,297	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-10,327,432	181,380,582	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	366,243	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	26,446,234	192.00
194.00	07950	CRH	0	0	194.00
194.01	07951	HOME HEALTH	0	1,938,942	194.01
194.02	07952	COMM CARE	0	189,189	194.02
194.03	07953	FOUNDATION	0	326,483	194.03
194.04	07954	TRANSPORT	0	460,477	194.04
194.05	07955	PRIVATE DUTY NURSING	0	229,158	194.05
194.06	07956	PUBLIC RELATIONS	0	859,308	194.06
194.07	07957	KIRK CLINIC	0	4,356,569	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	509,672	194.08
194.09	07959	RETAIL PHARMACY	0	1,972,947	194.09
200.00		TOTAL (SUM OF LINES 118 through 199)	-10,327,432	219,035,804	200.00

RECLASSIFICATIONS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A-6

Date/Time Prepared:
2/29/2024 12:04 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	975,613	986,804		1.00
	0		975,613	986,804		
	B - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	687,602		1.00
2.00	MAINTENANCE & REPAIRS	6.00	420	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
	0		420	687,602		
	C - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,338,303		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	44,096		2.00
3.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,460,976		3.00
	0		0	2,843,375		
	D - CENTRAL STERILE					
1.00	INTENSIVE CARE UNIT	31.00	149	0		1.00
2.00	OPERATING ROOM	50.00	238,814	0		2.00
3.00	ANESTHESIOLOGY	53.00	25,598	0		3.00
4.00	ELECTROCARDIOLOGY	69.00	1,141	0		4.00
5.00	CLINIC	90.00	22,010	0		5.00
6.00	EMERGENCY	91.00	500	0		6.00
7.00	PHYSICIANS' PRIVATE OFFICES	192.00	703	0		7.00
8.00	PHYSICAL THERAPY	66.00	16	0		8.00
	0		288,931	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	15,420		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	372,274		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	35,984	32,816		4.00
5.00	RURAL HEALTH CLINIC	88.00	220,791	14,066		5.00
	0		256,775	449,040		
	F - NURSING ADMIN					
1.00	NURSING ADMINISTRATION	13.00	559,331	0		1.00
	0		559,331	0		
	G - LABOR AND DELIVERY AND NURSERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	501,940	58,905		1.00
2.00	NURSERY	43.00	357,462	41,950		2.00
	0		859,402	100,855		
	H - URGENT CARE					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2,794		1.00
	TOTALS		0	2,794		
	I - PUBLIC RELATIONS					
1.00	PUBLIC RELATIONS	194.06	219,792	639,516		1.00
	0		219,792	639,516		
	J - EPOETIN					
1.00	RENAL DIALYSIS	74.00	0	499,910		1.00
	0		0	499,910		
	K - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	849,664		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	1,159,018		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00

RECLASSIFICATIONS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A-6

Date/Time Prepared:
2/29/2024 12:04 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
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
0			0	2,008,682	
L - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,652,258	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	2,652,258	
M - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	891,571	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	891,571	
N - EDUCATION AND TRAINING					
1.00	ADMINISTRATIVE & GENERAL	5.00	405,727	251,355	1.00
0			405,727	251,355	
O - INTERNS AND RESIDENTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	772,893	0	1.00
2.00	I&R SERVICES-OTHER PRGM. COSTS APPRVD	22.00	826,190	0	2.00
0			1,599,083	0	
P - SPEECH THERAPY					
1.00	HOME HEALTH	194.01	1,530	0	1.00
0			1,530	0	
Q - RHC PHYSICIANS					
1.00	NORMAN PARK FM CLINIC	194.08	0	145,085	1.00
0			0	145,085	
S - PSYCH SUBPROVIDER					
1.00	ADULTS & PEDIATRICS	30.00	1,154,835	248,747	1.00
	TOTALS		1,154,835	248,747	
T - JAIL					
1.00	CLINIC	90.00	0	497,677	1.00
	TOTALS		0	497,677	
500.00	Grand Total: Increases		6,321,439	12,905,271	500.00

RECLASSIFICATIONS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A-6

Date/Time Prepared:
2/29/2024 12:04 pm

	Decreases						2/29/2024 12:04 pm
	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	975,613	986,804	0		1.00
	0		975,613	986,804			
	B - RENTAL EXPENSE						
1.00	OPERATION OF PLANT	7.00	420	1,628	10		1.00
2.00	HOUSEKEEPING	9.00	0	34,668	0		2.00
3.00	DIETARY	10.00	0	411	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	38,439	0		4.00
5.00	PHARMACY	15.00	0	291,120	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,562	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	9,541	0		7.00
8.00	OPERATING ROOM	50.00	0	3,654	0		8.00
9.00	ANESTHESIOLOGY	53.00	0	12,298	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,420	0		10.00
11.00	RESPIRATORY THERAPY	65.00	0	42,091	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	22,928	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	0	7,805	0		13.00
14.00	RENAL DIALYSIS	74.00	0	1,227	0		14.00
15.00	RURAL HEALTH CLINIC	88.00	0	34,830	0		15.00
16.00	CLINIC	90.00	0	33,304	0		16.00
17.00	HOSPICE	116.00	0	139,475	0		17.00
18.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	201	0		18.00
	0		420	687,602			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,843,375	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
	0		0	2,843,375			
	D - CENTRAL STERILE						
1.00	CENTRAL SERVICES & SUPPLY	14.00	288,931	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
	0		288,931	0			
	E - CLINIC						
1.00	CRH	194.00	256,775	449,040	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		256,775	449,040			
	F - NURSING ADMIN						
1.00	ADMINISTRATIVE & GENERAL	5.00	559,331	0	0		1.00
	0		559,331	0			
	G - LABOR AND DELIVERY AND NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	859,402	100,855	0		1.00
2.00		0.00	0	0	0		2.00
	0		859,402	100,855			
	H - URGENT CARE						
1.00	URGENT CARE	90.01	0	2,794	0		1.00
	TOTALS		0	2,794			
	I - PUBLIC RELATIONS						
1.00	ADMINISTRATIVE & GENERAL	5.00	219,792	639,516	0		1.00
	0		219,792	639,516			
	J - EPOETIN						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	499,910	0		1.00
	0		0	499,910			
	K - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,950,905	12		1.00
2.00	OPERATION OF PLANT	7.00	0	16,407	12		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,299	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22	0		4.00
5.00	LABORATORY	60.00	0	2,235	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	2,487	0		6.00
7.00	RENAL DIALYSIS	74.00	0	22	0		7.00
8.00	AMBULANCE SERVICES	95.00	0	29,491	0		8.00
9.00	AMBULANCE SERVICES	95.00	0	766	0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	48	0		10.00
	0		0	2,008,682			

RECLASSIFICATIONS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A-6

Date/Time Prepared:
2/29/2024 12:04 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00		
	L - IMPLANTABLE DEVICES					
1.00	OPERATING ROOM	50.00	0	2,221,093	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	0	427,365	0	2.00
3.00	CLINIC	90.00	0	3,800	0	3.00
	0		0	2,652,258		
	M - EMPLOYEE BENEFITS					
1.00	ADULTS & PEDIATRICS	30.00	0	391	0	1.00
2.00	LABORATORY	60.00	0	11,331	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	87,536	0	3.00
4.00	CLINIC	90.00	0	22,539	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	548,460	0	5.00
6.00	KIRK CLINIC	194.07	0	199,903	0	6.00
7.00	NORMAN PARK FM CLINIC	194.08	0	21,411	0	7.00
	0		0	891,571		
	N - EDUCATION AND TRAINING					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	405,727	251,355	0	1.00
	0		405,727	251,355		
	O - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	1,030,758	0	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	568,325	0	0	2.00
	0		1,599,083	0		
	P - SPEECH THERAPY					
1.00	PHYSICAL THERAPY	66.00	1,530	0	0	1.00
	0		1,530	0		
	Q - RHC PHYSICIANS					
1.00	KIRK CLINIC	194.07	0	145,085	0	1.00
	0		0	145,085		
	S - PSYCH SUBPROVIDER					
1.00	SUBPROVIDER - IPF	40.00	1,154,835	248,747	0	1.00
	TOTALS		1,154,835	248,747		
	T - JAIL					
1.00	ADULTS & PEDIATRICS	30.00	0	497,677	0	1.00
	TOTALS		0	497,677		
500.00	Grand Total: Decreases		6,321,439	12,905,271		500.00

500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part I
Date/Time Prepared:
2/29/2024 12:04 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	2,035,006	0	0	0	0	1.00
2.00	Land Improvements	5,056,186	943,853	0	943,853	0	2.00
3.00	Buildings and Fixtures	123,436,465	3,864,843	0	3,864,843	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	20,357,217	275,134	0	275,134	0	5.00
6.00	Movable Equipment	110,302,953	20,778,961	0	20,778,961	2,283,503	6.00
7.00	HIT designated Assets	88,874	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	261,276,701	25,862,791	0	25,862,791	2,283,503	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	261,276,701	25,862,791	0	25,862,791	2,283,503	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	6,000,039	0				2.00
3.00	Buildings and Fixtures	127,301,308	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	20,632,351	0				5.00
6.00	Movable Equipment	128,798,411	0				6.00
7.00	HIT designated Assets	88,874	0				7.00
8.00	Subtotal (sum of lines 1-7)	284,855,989	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	284,855,989	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part II
Date/Time Prepared:
2/29/2024 12:04 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	5,711,088	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,790,431	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	13,501,519	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	5,711,088				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	7,790,431				2.00
3.00	Total (sum of lines 1-2)	0	13,501,519				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet A-7
Part III
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	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	155,968,703	0	155,968,703	0.547535	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	128,887,285	0	128,887,285	0.452465	0	2.00
3.00	Total (sum of lines 1-2)	284,855,988	0	284,855,988	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	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	5,690,396	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,792,139	687,602	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,482,535	687,602	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	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	729,861	849,664	0	0	7,269,921	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,485,024	1,159,018	0	0	11,123,783	2.00
3.00	Total (sum of lines 1-2)	2,214,885	2,008,682	0	0	18,393,704	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet A-8

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-608,442	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-20,048	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	-5,549	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	-154,728	ADMINISTRATIVE & GENERAL	5.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-25,182	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-48,165	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	-6,654,420			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	-1,087,942	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	-229	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 10/01/2022
To 09/30/2023

Worksheet A-8

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		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	-2,455	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	PHYSICIAN OFFICE BILLING COSTS	A	0	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	SWITCHBOARD SALARIES	A	-10,721	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	-6,147	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
36.01	PHYSICIAN RECRUITMENT	A	-98,688	ADMINISTRATIVE & GENERAL	5.00	0	36.01
36.02	PHYSICIAN RECRUITMENT	A	-1,374,848	PHYSICAL THERAPY	66.00	0	36.02
36.03	PHYSICIAN RECRUITMENT	A	-14,994	ADMINISTRATIVE & GENERAL	5.00	0	36.03
37.00	AHA DUES - LOBBYING EXPENSE	A	-6,887	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	GHA DUES - LOBBYING EXPENSE	A	-13,652	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	0	ADULTS & PEDIATRICS	30.00	0	42.00
44.00	LIFE INSURANCE PROCEEDS	A	-109,192	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.00
45.00	HOSPICE PAYMENTS TO NF	A	-46,996	ADULTS & PEDIATRICS	30.00	0	45.00
46.00	DONATED ASSET DEPRECIATION	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.)		-10,327,432				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 10/01/2022
To 09/30/2023

Worksheet A-8-2

Date/Time Prepared:
2/29/2024 12:04 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	738,204	0	738,204	179,000	4,828	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,393,026	1,393,026	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	3,067,118	3,067,118	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	187,121	187,121	0	0	0	5.00
6.00	90.00	CLINIC	913,682	913,682	0	0	0	6.00
7.00	91.00	EMERGENCY	770,756	770,756	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			7,069,907	6,331,703	738,204		4,828	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	415,487	20,774	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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	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			415,487	20,774	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	415,487	322,717	322,717		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,393,026		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	3,067,118		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	187,121		5.00
6.00	90.00	CLINIC	0	0	0	913,682		6.00
7.00	91.00	EMERGENCY	0	0	0	770,756		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	415,487	322,717	6,654,420		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	7,269,921	7,269,921			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	11,123,783	11,123,783			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,298,050	58,999	88,928	14,445,977	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,996,817	567,786	855,812	3,189,344	5.00
6.00	00600	MAINTENANCE & REPAIRS	6,177,531	0	0	259,855	6.00
7.00	00700	OPERATION OF PLANT	1,598,079	1,157,564	1,744,770	70	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	755,983	12,862	19,387	8,019	8.00
9.00	00900	HOUSEKEEPING	1,660,945	65,078	98,091	205,326	9.00
10.00	01000	DIETARY	786,865	103,280	155,672	65,457	10.00
11.00	01100	CAFETERIA	874,475	5,098	7,684	163,162	11.00
13.00	01300	NURSING ADMINISTRATION	1,824,187	18,472	27,842	230,555	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	796,777	164,946	248,619	86,306	14.00
15.00	01500	PHARMACY	9,488,307	54,733	82,498	198,692	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	427,951	40,079	60,411	55,805	16.00
17.00	01700	SOCIAL SERVICE	144,386	8,511	12,828	22,231	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	1,300,399	0	0	339,169	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	955,566	58,167	87,674	63,195	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,930,679	906,722	1,366,682	2,508,100	30.00
31.00	03100	INTENSIVE CARE UNIT	2,655,336	197,794	298,131	397,806	31.00
40.00	04000	SUBPROVIDER - IPF	-1	0	0	0	40.00
43.00	04300	NURSERY	547,530	36,794	55,459	77,079	43.00
44.00	04400	SKILLED NURSING FACILITY	3,829,414	339,063	511,063	374,298	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,105,194	438,504	660,948	600,402	50.00
51.00	05100	RECOVERY ROOM	670,313	23,911	36,041	101,976	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	799,239	48,675	73,367	113,002	52.00
53.00	05300	ANESTHESIOLOGY	-159,001	19,986	30,125	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,366,113	228,765	344,813	508,425	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	616,989	25,127	37,873	46,490	54.01
57.00	05700	CT SCAN	1,232,724	18,067	27,231	151,912	57.00
60.00	06000	LABORATORY	4,831,853	111,407	167,922	408,090	60.00
65.00	06500	RESPIRATORY THERAPY	1,356,799	25,703	38,741	206,055	65.00
66.00	06600	PHYSICAL THERAPY	1,328,788	278,059	419,113	388,127	66.00
69.00	06900	ELECTROCARDIOLOGY	1,661,269	144,938	218,462	185,397	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	17,262,299	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,652,258	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,226,507	3,925	5,916	0	73.00
74.00	07400	RENAL DIALYSIS	2,140,304	233,927	352,593	205,206	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	2,592,767	264,003	397,926	179,290	88.00
90.00	09000	CLINIC	1,536,620	18,856	28,421	134,483	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	4,235,913	253,338	381,850	623,904	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	2,249,357	20,328	30,639	288,549	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,231,297	32,571	49,094	126,402	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	181,380,582	5,986,038	9,022,626	12,512,179	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	366,243	16,872	25,431	858	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,446,234	1,239,005	1,867,520	1,140,455	192.00
194.00	07950	CRH	0	0	0	0	194.00
194.01	07951	HOME HEALTH	1,938,942	0	165,993	250,485	194.01
194.02	07952	COMM CARE	189,189	0	0	23,576	194.02
194.03	07953	FOUNDATION	326,483	0	0	30,329	194.03
194.04	07954	TRANSPORT	460,477	0	0	49,192	194.04
194.05	07955	PRIVATE DUTY NURSING	229,158	28,006	42,213	32,290	194.05
194.06	07956	PUBLIC RELATIONS	859,308	0	0	36,758	194.06
194.07	07957	KIRK CLINIC	4,356,569	0	0	290,034	194.07
194.08	07958	NORMAN PARK FM CLINIC	509,672	0	0	41,308	194.08

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
194.09	07959	RETAIL PHARMACY	0	1.00	2.00	4.00	4A	
194.09			1,972,947	0	0	38,513	2,011,460	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)	219,035,804	7,269,921	11,123,783	14,445,977	219,035,804	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
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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	40,609,759					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,464,254	7,901,640				6.00
7.00	00700	OPERATION OF PLANT	1,023,684	1,369,304	6,893,471			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	181,116	15,215	19,786	1,012,368		8.00
9.00	00900	HOUSEKEEPING	461,618	76,982	100,109	31,508	2,699,657	9.00
10.00	01000	DIETARY	252,771	122,172	158,875	0	83,479	10.00
11.00	01100	CAFETERIA	238,929	6,030	7,842	0	4,121	11.00
13.00	01300	NURSING ADMINISTRATION	477,908	21,851	28,415	0	14,930	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	294,937	195,117	253,734	0	133,322	14.00
15.00	01500	PHARMACY	2,234,629	64,745	84,195	0	44,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132,893	47,411	61,653	0	32,395	16.00
17.00	01700	SOCIAL SERVICE	42,753	10,067	13,092	0	6,879	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	372,938	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	264,902	68,807	89,478	0	47,015	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,938,675	1,072,578	1,394,799	369,685	732,881	30.00
31.00	03100	INTENSIVE CARE UNIT	807,274	233,974	304,264	59,591	159,872	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	163,058	43,525	56,600	0	29,740	43.00
44.00	04400	SKILLED NURSING FACILITY	1,149,551	401,085	521,577	0	274,057	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,775,344	518,715	674,546	68,350	0	50.00
51.00	05100	RECOVERY ROOM	189,302	28,285	36,782	0	19,327	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	235,259	57,579	74,877	0	39,343	52.00
53.00	05300	ANESTHESIOLOGY	0	23,642	30,745	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,466,695	270,611	351,907	27,053	184,906	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	165,246	29,723	38,652	42,034	20,309	54.01
57.00	05700	CT SCAN	325,254	21,371	27,792	23,255	14,603	57.00
60.00	06000	LABORATORY	1,255,419	131,786	171,376	0	90,048	60.00
65.00	06500	RESPIRATORY THERAPY	370,147	30,404	39,538	0	20,775	65.00
66.00	06600	PHYSICAL THERAPY	549,111	328,922	427,735	28,468	224,749	66.00
69.00	06900	ELECTROCARDIOLOGY	502,704	171,450	222,956	1,188	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,926,500	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	603,285	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	963,604	4,643	6,037	0	0	73.00
74.00	07400	RENAL DIALYSIS	666,922	276,717	359,847	116,372	189,078	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	781,098	312,294	406,112	0	0	88.00
90.00	09000	CLINIC	390,864	22,305	29,006	66,868	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	1,249,899	299,678	389,706	124,793	204,767	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	588,868	24,046	31,270	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	327,399	38,529	50,104	70	26,326	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	30,834,810	6,339,563	6,463,407	959,235	2,597,161	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	93,123	19,958	25,954	0	13,637	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,981,536	1,378,718	136,300	52,528	71,618	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	535,766	130,272	169,407	0	0	194.01
194.02	07952	COMM CARE	48,396	0	0	0	0	194.02
194.03	07953	FOUNDATION	81,161	0	32,812	0	17,241	194.03
194.04	07954	TRANSPORT	115,930	0	22,509	236	0	194.04
194.05	07955	PRIVATE DUTY NURSING	75,441	33,129	43,082	0	0	194.05
194.06	07956	PUBLIC RELATIONS	203,820	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	1,056,921	0	0	369	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	125,326	0	0	0	0	194.08
194.09	07959	RETAIL PHARMACY	457,529	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)	40,609,759	7,901,640	6,893,471	1,012,368	2,699,657	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
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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	1,728,571					10.00
11.00	01100	CAFETERIA	0	1,307,341				11.00
13.00	01300	NURSING ADMINISTRATION	0	22,426	2,666,586			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	22,188	0	2,195,946		14.00
15.00	01500	PHARMACY	0	34,033	0	199,983	12,486,054	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,177	0	954	0	16.00
17.00	01700	SOCIAL SERVICE	0	6,554	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	38,830	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	2,398	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	602,007	340,756	1,448,764	384,421	5,845	30.00
31.00	03100	INTENSIVE CARE UNIT	337,346	55,929	237,789	59,282	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	9,685	41,175	14,005	0	43.00
44.00	04400	SKILLED NURSING FACILITY	788,818	81,174	345,125	0	676,718	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	101,294	0	190,794	0	50.00
51.00	05100	RECOVERY ROOM	0	10,032	42,654	37,054	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	400	13,840	58,844	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	18,216	0	89,412	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	67,407	0	27,304	8,546	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	7,158	0	2,766	349	54.01
57.00	05700	CT SCAN	0	21,914	0	21,710	386	57.00
60.00	06000	LABORATORY	0	84,525	0	63,639	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	31,214	0	32,909	0	65.00
66.00	06600	PHYSICAL THERAPY	0	44,267	0	1,047	3,503	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,124	0	179,182	855	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	6	10,120,522	73.00
74.00	07400	RENAL DIALYSIS	0	32,019	0	368,387	1,484,412	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	8,306	0	88.00
90.00	09000	CLINIC	0	22,811	0	46,568	4,932	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	94,539	401,945	348,659	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	54,281	0	45,502	24,144	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	21,236	90,290	27,708	152,373	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,728,571	1,280,027	2,666,586	2,149,598	12,482,585	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,176	0	1,038	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	40,117	68	194.01
194.02	07952	COMM CARE	0	0	0	321	0	194.02
194.03	07953	FOUNDATION	0	0	0	3,898	0	194.03
194.04	07954	TRANSPORT	0	13,895	0	974	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	6,243	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	3,401	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)	1,728,571	1,307,341	2,666,586	2,195,946	12,486,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00	21.00	22.00	23.00	
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	874,729					16.00
17.00	01700	SOCIAL SERVICE	0	267,301				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,051,336			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		1,637,202		22.00
23.00	02300	PARAMED ED PRGM	0	0			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	44,463	239,253	600,125	478,969	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,319	25,930	65,468	52,251	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,638	0	0	0	0	40.00
43.00	04300	NURSERY	7,704	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	96,861	0	114,569	91,439	0	50.00
51.00	05100	RECOVERY ROOM	8,848	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,300	2,118	76,380	60,960	0	52.00
53.00	05300	ANESTHESIOLOGY	13,112	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,832	0	10,911	8,709	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	18,250	0	0	0	0	54.01
57.00	05700	CT SCAN	110,723	0	0	0	0	57.00
60.00	06000	LABORATORY	137,550	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	30,785	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,358	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	62,689	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,094	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	28,837	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	143,151	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	10,911	8,709	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	87,291	69,668	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	50,301	0	81,835	65,314	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	3,914	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	874,729	267,301	1,047,490	836,019	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,003,846	801,183	0	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	0	0	0	0	0	194.01
194.02	07952	COMM CARE	0	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	0	194.03
194.04	07954	TRANSPORT	0	0	0	0	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	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	0	0	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/29/2024 12:04 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00	21.00	22.00	23.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	874,729	267,301	2,051,336	1,637,202	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	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
23.00	02300	PARAMED ED PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,365,404	-1,079,094	33,286,310	30.00
31.00	03100	INTENSIVE CARE UNIT	5,956,356	-117,719	5,838,637	31.00
40.00	04000	SUBPROVIDER - IPF	1,637	0	1,637	40.00
43.00	04300	NURSERY	1,082,354	0	1,082,354	43.00
44.00	04400	SKILLED NURSING FACILITY	9,291,943	0	9,291,943	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,436,960	-206,008	11,230,952	50.00
51.00	05100	RECOVERY ROOM	1,204,525	0	1,204,525	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,656,183	-137,340	1,518,843	52.00
53.00	05300	ANESTHESIOLOGY	66,237	0	66,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,914,997	-19,620	8,895,377	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,050,966	0	1,050,966	54.01
57.00	05700	CT SCAN	1,996,942	0	1,996,942	57.00
60.00	06000	LABORATORY	7,453,615	0	7,453,615	60.00
65.00	06500	RESPIRATORY THERAPY	2,183,070	0	2,183,070	65.00
66.00	06600	PHYSICAL THERAPY	4,042,247	0	4,042,247	66.00
69.00	06900	ELECTROCARDIOLOGY	3,377,214	0	3,377,214	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,230,893	0	21,230,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,284,380	0	3,284,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,474,311	0	15,474,311	73.00
74.00	07400	RENAL DIALYSIS	6,445,404	-403,376	6,042,028	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,941,796	0	4,941,796	88.00
90.00	09000	CLINIC	2,458,693	-156,959	2,301,734	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	8,806,441	-147,149	8,659,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,356,984	0	3,356,984	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	2,177,313	0	2,177,313	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	162,256,865	-2,267,265	159,989,600	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	570,290	0	570,290	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	41,118,943	-1,805,029	39,313,914	192.00
194.00	07950	CRH	0	0	0	194.00
194.01	07951	HOME HEALTH	3,231,050	0	3,231,050	194.01
194.02	07952	COMM CARE	261,482	0	261,482	194.02
194.03	07953	FOUNDATION	491,924	0	491,924	194.03
194.04	07954	TRANSPORT	663,213	0	663,213	194.04
194.05	07955	PRIVATE DUTY NURSING	483,319	0	483,319	194.05
194.06	07956	PUBLIC RELATIONS	1,106,129	0	1,106,129	194.06
194.07	07957	KIRK CLINIC	5,707,294	0	5,707,294	194.07
194.08	07958	NORMAN PARK FM CLINIC	676,306	0	676,306	194.08
194.09	07959	RETAIL PHARMACY	2,468,989	0	2,468,989	194.09
200.00		Cross Foot Adjustments	0	0	0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part I Date/Time Prepared: 2/29/2024 12:04 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	219,035,804	-4,072,294	214,963,510		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		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	58,999	88,928	147,927	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	567,786	855,812	1,423,598	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	2,662	6.00
7.00	00700	OPERATION OF PLANT	0	1,157,564	1,744,770	2,902,334	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	12,862	19,387	32,249	8.00
9.00	00900	HOUSEKEEPING	0	65,078	98,091	163,169	9.00
10.00	01000	DIETARY	0	103,280	155,672	258,952	10.00
11.00	01100	CAFETERIA	0	5,098	7,684	12,782	11.00
13.00	01300	NURSING ADMINISTRATION	0	18,472	27,842	46,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	164,946	248,619	413,565	14.00
15.00	01500	PHARMACY	0	54,733	82,498	137,231	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,079	60,411	100,490	16.00
17.00	01700	SOCIAL SERVICE	0	8,511	12,828	21,339	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	3,474	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	58,167	87,674	145,841	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	906,722	1,366,682	2,273,404	30.00
31.00	03100	INTENSIVE CARE UNIT	0	197,794	298,131	495,925	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
43.00	04300	NURSERY	0	36,794	55,459	92,253	43.00
44.00	04400	SKILLED NURSING FACILITY	242,100	339,063	511,063	1,092,226	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	438,504	660,948	1,099,452	50.00
51.00	05100	RECOVERY ROOM	0	23,911	36,041	59,952	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	48,675	73,367	122,042	52.00
53.00	05300	ANESTHESIOLOGY	0	19,986	30,125	50,111	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	228,765	344,813	573,578	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	25,127	37,873	63,000	54.01
57.00	05700	CT SCAN	0	18,067	27,231	45,298	57.00
60.00	06000	LABORATORY	0	111,407	167,922	279,329	60.00
65.00	06500	RESPIRATORY THERAPY	0	25,703	38,741	64,444	65.00
66.00	06600	PHYSICAL THERAPY	0	278,059	419,113	697,172	66.00
69.00	06900	ELECTROCARDIOLOGY	0	144,938	218,462	363,400	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,925	5,916	9,841	73.00
74.00	07400	RENAL DIALYSIS	0	233,927	352,593	586,520	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	264,003	397,926	661,929	88.00
90.00	09000	CLINIC	0	18,856	28,421	47,277	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	0	253,338	381,850	635,188	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	20,328	30,639	50,967	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	32,571	49,094	81,665	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	242,100	5,986,038	9,022,626	15,250,764	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16,872	25,431	42,303	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	167,566	1,239,005	1,867,520	3,274,091	192.00
194.00	07950	CRH	0	0	0	0	194.00
194.01	07951	HOME HEALTH	57,034	0	165,993	223,027	194.01
194.02	07952	COMM CARE	0	0	0	0	194.02
194.03	07953	FOUNDATION	0	0	0	0	194.03
194.04	07954	TRANSPORT	75,981	0	0	75,981	194.04
194.05	07955	PRIVATE DUTY NURSING	0	28,006	42,213	70,219	194.05
194.06	07956	PUBLIC RELATIONS	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	99,753	0	0	99,753	194.07
194.08	07958	NORMAN PARK FM CLINIC	1,601	0	0	1,601	194.08
194.09	07959	RETAIL PHARMACY	-1,600	0	0	-1,600	194.09

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/29/2024 12:04 pm	
Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				NEW BLDG & FIXT	NEW MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
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)	642,435	7,269,921	11,123,783	19,036,139	147,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/29/2024 12:04 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	1,456,223					5.00
6.00	00600	MAINTENANCE & REPAIRS	52,510	55,172				6.00
7.00	00700	OPERATION OF PLANT	36,710	9,561	2,948,606			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,495	106	8,463	47,395		8.00
9.00	00900	HOUSEKEEPING	16,554	538	42,820	1,475	226,659	9.00
10.00	01000	DIETARY	9,065	853	67,957	0	7,009	10.00
11.00	01100	CAFETERIA	8,568	42	3,354	0	346	11.00
13.00	01300	NURSING ADMINISTRATION	17,138	153	12,154	0	1,254	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	10,577	1,362	108,532	0	11,193	14.00
15.00	01500	PHARMACY	80,136	452	36,014	0	3,714	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,766	331	26,372	0	2,720	16.00
17.00	01700	SOCIAL SERVICE	1,533	70	5,600	0	578	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	13,374	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	9,500	480	38,273	0	3,947	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	177,106	7,489	596,610	17,307	61,532	30.00
31.00	03100	INTENSIVE CARE UNIT	28,950	1,634	130,146	2,790	13,423	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	5,847	304	24,210	0	2,497	43.00
44.00	04400	SKILLED NURSING FACILITY	41,224	2,801	223,099	0	23,009	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	63,666	3,622	288,529	3,200	0	50.00
51.00	05100	RECOVERY ROOM	6,789	197	15,733	0	1,623	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,437	402	32,028	0	3,303	52.00
53.00	05300	ANESTHESIOLOGY	0	165	13,151	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,597	1,889	150,524	1,267	15,524	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	5,926	208	16,533	1,968	1,705	54.01
57.00	05700	CT SCAN	11,664	149	11,888	1,089	1,226	57.00
60.00	06000	LABORATORY	45,021	920	73,304	0	7,560	60.00
65.00	06500	RESPIRATORY THERAPY	13,274	212	16,912	0	1,744	65.00
66.00	06600	PHYSICAL THERAPY	19,692	2,297	182,959	1,333	18,870	66.00
69.00	06900	ELECTROCARDIOLOGY	18,028	1,197	95,367	56	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	140,809	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	21,634	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,556	32	2,582	0	0	73.00
74.00	07400	RENAL DIALYSIS	23,917	1,932	153,921	5,448	15,875	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	28,011	2,181	173,710	0	0	88.00
90.00	09000	CLINIC	14,017	156	12,407	3,130	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	44,823	2,092	166,692	5,842	17,192	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	21,117	168	13,375	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	11,741	269	21,431	3	2,210	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,105,772	44,264	2,764,650	44,908	218,054	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,340	139	11,102	0	1,145	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	250,277	9,628	58,301	2,459	6,013	192.00
194.00	07950	CRH	0	0	0	0	0	194.00
194.01	07951	HOME HEALTH	19,213	910	72,462	0	0	194.01
194.02	07952	COMM CARE	1,736	0	0	0	0	194.02
194.03	07953	FOUNDATION	2,911	0	14,035	0	1,447	194.03
194.04	07954	TRANSPORT	4,157	0	9,628	11	0	194.04
194.05	07955	PRIVATE DUTY NURSING	2,705	231	18,428	0	0	194.05
194.06	07956	PUBLIC RELATIONS	7,309	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	37,902	0	0	17	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	4,494	0	0	0	0	194.08
194.09	07959	RETAIL PHARMACY	16,407	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)	1,456,223	55,172	2,948,606	47,395	226,659	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/29/2024 12:04 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	344,506					10.00
11.00	01100	CAFETERIA	0	26,763				11.00
13.00	01300	NURSING ADMINISTRATION	0	459	79,834			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	454	0	546,567		14.00
15.00	01500	PHARMACY	0	697	0	49,775	310,054	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	311	0	237	0	16.00
17.00	01700	SOCIAL SERVICE	0	134	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	795	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	49	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	119,981	6,976	43,373	95,682	145	30.00
31.00	03100	INTENSIVE CARE UNIT	67,234	1,145	7,119	14,755	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	198	1,233	3,486	0	43.00
44.00	04400	SKILLED NURSING FACILITY	157,211	1,662	10,333	0	16,804	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,074	0	47,488	0	50.00
51.00	05100	RECOVERY ROOM	0	205	1,277	9,223	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	80	283	1,762	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	373	0	22,254	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,380	0	6,796	212	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	147	0	688	9	54.01
57.00	05700	CT SCAN	0	449	0	5,404	10	57.00
60.00	06000	LABORATORY	0	1,730	0	15,840	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	639	0	8,191	0	65.00
66.00	06600	PHYSICAL THERAPY	0	906	0	261	87	66.00
69.00	06900	ELECTROCARDIOLOGY	0	535	0	44,598	21	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	2	251,313	73.00
74.00	07400	RENAL DIALYSIS	0	655	0	91,691	36,861	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,067	0	88.00
90.00	09000	CLINIC	0	467	0	11,591	122	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	1,935	12,034	86,781	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	1,111	0	11,325	600	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	435	2,703	6,897	3,784	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	344,506	26,204	79,834	535,032	309,968	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	147	0	258	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	9,985	2	194.01
194.02	07952	COMM CARE	0	0	0	80	0	194.02
194.03	07953	FOUNDATION	0	0	0	970	0	194.03
194.04	07954	TRANSPORT	0	284	0	242	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	0	128	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	0	84	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)	344,506	26,763	79,834	546,567	310,054	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS		
			16.00	17.00	21.00	22.00	23.00	
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	135,799					16.00
17.00	01700	SOCIAL SERVICE	0	29,482				17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	17,643			21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		198,737		22.00
23.00	02300	PARAMED ED PRGM	0	0			0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	6,899	26,388				30.00
31.00	03100	INTENSIVE CARE UNIT	1,291	2,860				31.00
40.00	04000	SUBPROVIDER - IPF	254	0				40.00
43.00	04300	NURSERY	1,195	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	15,030	0				50.00
51.00	05100	RECOVERY ROOM	1,373	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	357	234				52.00
53.00	05300	ANESTHESIOLOGY	2,035	0				53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,646	0				54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	2,832	0				54.01
57.00	05700	CT SCAN	17,181	0				57.00
60.00	06000	LABORATORY	21,344	0				60.00
65.00	06500	RESPIRATORY THERAPY	4,777	0				65.00
66.00	06600	PHYSICAL THERAPY	3,159	0				66.00
69.00	06900	ELECTROCARDIOLOGY	9,728	0				69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,532	0				71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	4,475	0				72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,279	0				73.00
74.00	07400	RENAL DIALYSIS	0	0				74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0				77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0				78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0				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	7,805	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	0				95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0				102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	607	0				116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	135,799	29,482	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0				192.00
194.00	07950	CRH	0	0				194.00
194.01	07951	HOME HEALTH	0	0				194.01
194.02	07952	COMM CARE	0	0				194.02
194.03	07953	FOUNDATION	0	0				194.03
194.04	07954	TRANSPORT	0	0				194.04
194.05	07955	PRIVATE DUTY NURSING	0	0				194.05
194.06	07956	PUBLIC RELATIONS	0	0				194.06
194.07	07957	KIRK CLINIC	0	0				194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0				194.08
194.09	07959	RETAIL PHARMACY	0	0				194.09
200.00		Cross Foot Adjustments			17,643	198,737	0	200.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/29/2024 12:04 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		PARAMED ED PRGM	
					SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS		
					16.00	17.00	21.00	22.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	135,799	29,482	17,643	198,737	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet B
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	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
23.00	02300	PARAMED ED PRGM				23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,458,582	0	3,458,582	30.00
31.00	03100	INTENSIVE CARE UNIT	771,347	0	771,347	31.00
40.00	04000	SUBPROVIDER - IPF	254	0	254	40.00
43.00	04300	NURSERY	132,013	0	132,013	43.00
44.00	04400	SKILLED NURSING FACILITY	1,572,203	0	1,572,203	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,529,211	0	1,529,211	50.00
51.00	05100	RECOVERY ROOM	97,417	0	97,417	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	170,085	0	170,085	52.00
53.00	05300	ANESTHESIOLOGY	88,089	0	88,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,621	0	815,621	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	93,492	0	93,492	54.01
57.00	05700	CT SCAN	95,914	0	95,914	57.00
60.00	06000	LABORATORY	449,228	0	449,228	60.00
65.00	06500	RESPIRATORY THERAPY	112,304	0	112,304	65.00
66.00	06600	PHYSICAL THERAPY	930,711	0	930,711	66.00
69.00	06900	ELECTROCARDIOLOGY	534,829	0	534,829	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,341	0	147,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,109	0	26,109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	320,605	0	320,605	73.00
74.00	07400	RENAL DIALYSIS	918,922	0	918,922	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	869,734	0	869,734	88.00
90.00	09000	CLINIC	90,544	0	90,544	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	986,775	0	986,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	101,619	0	101,619	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	133,040	0	133,040	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,445,989	0	14,445,989	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	58,443	0	58,443	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,612,450	0	3,612,450	192.00
194.00	07950	CRH	0	0	0	194.00
194.01	07951	HOME HEALTH	328,165	0	328,165	194.01
194.02	07952	COMM CARE	2,057	0	2,057	194.02
194.03	07953	FOUNDATION	19,674	0	19,674	194.03
194.04	07954	TRANSPORT	90,807	0	90,807	194.04
194.05	07955	PRIVATE DUTY NURSING	91,914	0	91,914	194.05
194.06	07956	PUBLIC RELATIONS	7,814	0	7,814	194.06
194.07	07957	KIRK CLINIC	140,727	0	140,727	194.07
194.08	07958	NORMAN PARK FM CLINIC	6,518	0	6,518	194.08
194.09	07959	RETAIL PHARMACY	15,201	0	15,201	194.09
200.00		Cross Foot Adjustments	216,380	0	216,380	200.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023	Worksheet B Part II Date/Time Prepared: 2/29/2024 12:04 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	19,036,139	0	19,036,139		202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	340,829				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		345,992			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,766	2,766	86,378,701		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,619	26,619	19,070,464	-40,609,759	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	1,553,784	0	6.00
7.00	00700	OPERATION OF PLANT	54,269	54,269	420	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	603	603	47,949	0	8.00
9.00	00900	HOUSEKEEPING	3,051	3,051	1,227,730	0	9.00
10.00	01000	DIETARY	4,842	4,842	391,393	0	10.00
11.00	01100	CAFETERIA	239	239	975,613	0	11.00
13.00	01300	NURSING ADMINISTRATION	866	866	1,378,586	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,733	7,733	516,059	0	14.00
15.00	01500	PHARMACY	2,566	2,566	1,188,064	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,879	1,879	333,680	0	16.00
17.00	01700	SOCIAL SERVICE	399	399	132,931	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,028,037	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	2,727	2,727	377,872	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,509	42,509	14,997,008	0	30.00
31.00	03100	INTENSIVE CARE UNIT	9,273	9,273	2,378,651	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	1	40.00
43.00	04300	NURSERY	1,725	1,725	460,890	0	43.00
44.00	04400	SKILLED NURSING FACILITY	15,896	15,896	2,238,088	0	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,558	20,558	3,590,063	0	50.00
51.00	05100	RECOVERY ROOM	1,121	1,121	609,761	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,282	2,282	675,686	0	52.00
53.00	05300	ANESTHESIOLOGY	937	937	0	108,890	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,725	10,725	3,040,092	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,178	1,178	277,982	0	54.01
57.00	05700	CT SCAN	847	847	908,346	0	57.00
60.00	06000	LABORATORY	5,223	5,223	2,440,145	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,205	1,205	1,232,090	0	65.00
66.00	06600	PHYSICAL THERAPY	13,036	13,036	2,320,780	0	66.00
69.00	06900	ELECTROCARDIOLOGY	6,795	6,795	1,108,566	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	184	184	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,967	10,967	1,227,013	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	12,377	12,377	1,072,051	0	88.00
90.00	09000	CLINIC	884	884	804,129	0	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	11,877	11,877	3,730,592	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	953	953	1,725,360	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,527	1,527	755,814	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	280,638	280,638	74,815,689	-40,500,868	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	791	791	5,132	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	58,087	58,087	6,819,273	0	192.00
194.00	07950	CRH	0	0	0	0	194.00
194.01	07951	HOME HEALTH	0	5,163	1,497,760	0	194.01
194.02	07952	COMM CARE	0	0	140,970	0	194.02
194.03	07953	FOUNDATION	0	0	181,352	0	194.03
194.04	07954	TRANSPORT	0	0	294,139	0	194.04
194.05	07955	PRIVATE DUTY NURSING	1,313	1,313	193,074	0	194.05
194.06	07956	PUBLIC RELATIONS	0	0	219,792	0	194.06
194.07	07957	KIRK CLINIC	0	0	1,734,241	0	194.07
194.08	07958	NORMAN PARK FM CLINIC	0	0	246,996	0	194.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.09	07959	RETAIL PHARMACY	0	0	230,283	0	2,011,460	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)	7,269,921	11,123,783	14,445,977		40,609,759	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.330113	32.150405	0.167240		0.227461	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			147,927		1,456,223	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001713		0.008157	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 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 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	210,091			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	603	603	929,913		8.00
9.00	00900	HOUSEKEEPING	3,051	3,051	28,942	156,587	9.00
10.00	01000	DIETARY	4,842	4,842	0	4,842	125,185 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
23.00	02300	PARAMED ED PRGM	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,509	42,509	339,575	42,509	43,598 30.00
31.00	03100	INTENSIVE CARE UNIT	9,273	9,273	54,737	9,273	24,431 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	15,896	0	15,896	57,127 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	20,558	20,558	62,783	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	29 52.00
53.00	05300	ANESTHESIOLOGY	937	937	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,725	10,725	24,850	10,725	0 54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,178	1,178	38,610	1,178	0 54.01
57.00	05700	CT SCAN	847	847	21,361	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	26,149	13,036	0 66.00
69.00	06900	ELECTROCARDIOLOGY	6,795	6,795	1,091	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	106,894	10,967	0 74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0 78.00
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	61,422	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	114,629	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
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0 102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	1,527	1,527	64	1,527	0 116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	251,253	196,984	881,107	150,642	125,185 118.00
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	48,250	4,154	0 192.00
194.00	07950	CRH	0	0	0	0	0 194.00
194.01	07951	HOME HEALTH	5,163	5,163	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	217	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	339	0	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 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	
202.00		Cost to be allocated (per Wkst. B, Part I)	7,901,640	6,893,471	1,012,368	2,699,657	1,728,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.231797	32.811834	1.088670	17.240620	13.808132	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	55,172	2,948,606	47,395	226,659	344,506	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.176177	14.034899	0.050967	1.447496	2.751975	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 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 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	71,411					11.00
13.00	01300	NURSING ADMINISTRATION	1,225	34,259				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,212	0	2,774,304			14.00
15.00	01500	PHARMACY	1,859	0	252,654	4,045,670		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	829	0	1,205	0	538,758,880	16.00
17.00	01700	SOCIAL SERVICE	358	0	0	0	0	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,121	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	131	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,613	18,613	485,666	1,894	27,378,453	30.00
31.00	03100	INTENSIVE CARE UNIT	3,055	3,055	74,896	0	5,122,241	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	1,008,674	40.00
43.00	04300	NURSERY	529	529	17,693	0	4,743,884	43.00
44.00	04400	SKILLED NURSING FACILITY	4,434	4,434	0	219,267	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,533	0	241,045	0	59,643,275	50.00
51.00	05100	RECOVERY ROOM	548	548	46,813	0	5,448,274	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	756	756	0	0	1,416,358	52.00
53.00	05300	ANESTHESIOLOGY	995	0	112,961	0	8,073,936	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,682	0	34,495	2,769	26,374,261	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	391	0	3,494	113	11,237,644	54.01
57.00	05700	CT SCAN	1,197	0	27,428	125	68,179,115	57.00
60.00	06000	LABORATORY	4,617	0	80,400	0	84,698,091	60.00
65.00	06500	RESPIRATORY THERAPY	1,705	0	41,577	0	18,956,478	65.00
66.00	06600	PHYSICAL THERAPY	2,418	0	1,323	1,135	12,535,514	66.00
69.00	06900	ELECTROCARDIOLOGY	1,427	0	226,374	277	38,601,594	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	25,920,143	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	17,756,636	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8	3,279,202	88,280,363	73.00
74.00	07400	RENAL DIALYSIS	1,749	0	465,411	480,972	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	10,493	0	0	88.00
90.00	09000	CLINIC	1,246	0	58,833	1,598	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	5,164	5,164	440,488	0	30,973,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	2,965	0	57,486	7,823	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE	0	0	0	0	0	113.00
116.00	11600	HOSPICE	1,160	1,160	35,006	49,371	2,410,270	116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,919	34,259	2,715,749	4,044,546	538,758,880	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	392	0	1,312	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	50,683	22	0	194.01
194.02	07952	COMM CARE	0	0	405	0	0	194.02
194.03	07953	FOUNDATION	0	0	4,925	0	0	194.03
194.04	07954	TRANSPORT	759	0	1,230	0	0	194.04
194.05	07955	PRIVATE DUTY NURSING	0	0	0	0	0	194.05
194.06	07956	PUBLIC RELATIONS	341	0	0	0	0	194.06
194.07	07957	KIRK CLINIC	0	0	0	1,102	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 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	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,307,341	2,666,586	2,195,946	12,486,054	874,729	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.307278	77.836072	0.791530	3.086276	0.001624	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	26,763	79,834	546,567	310,054	135,799	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.374774	2.330307	0.197010	0.076638	0.000252	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 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		INTERNS & RESIDENTS			PARAMED ED PRGM (ASSIGNED TIME)	
		SOCIAL SERVICE (PATIENT DAYS)	SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)		
		17.00	21.00	22.00	23.00	
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	28,390			17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	752		21.00
22.00	02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0		752	22.00
23.00	02300	PARAMED ED PRGM	0		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,411	220	220	30.00
31.00	03100	INTENSIVE CARE UNIT	2,754	24	24	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	42	42	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	225	28	28	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4	4	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	4	4	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	78.00
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	30	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	102.00
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)	28,390	384	384	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	368	368	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet B-1

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		SOCIAL SERVICE (PATIENT DAYS)	INTERNS & RESIDENTS		PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-SALAR Y & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM. COSTS (ASSIGNED TIME)			
			17.00	21.00	22.00	23.00	
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)	267,301	2,051,336	1,637,202	0		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.415322	2,727.840426	2,177.130319	0.000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	29,482	17,643	198,737	0		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.038464	23.461436	264.277926	0.000000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

		Description	Worksheet		Amount	
			CODE	Line No.		
			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	-383,756	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 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	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	33,286,310		33,286,310	0	33,286,310	30.00
31.00	03100	INTENSIVE CARE UNIT	5,838,637		5,838,637	0	5,838,637	31.00
40.00	04000	SUBPROVIDER - IPF	1,637		1,637	0	1,637	40.00
43.00	04300	NURSERY	1,082,354		1,082,354	0	1,082,354	43.00
44.00	04400	SKILLED NURSING FACILITY	9,291,943		9,291,943	0	9,291,943	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,230,952		11,230,952	0	11,230,952	50.00
51.00	05100	RECOVERY ROOM	1,204,525		1,204,525	0	1,204,525	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,518,843		1,518,843	0	1,518,843	52.00
53.00	05300	ANESTHESIOLOGY	66,237		66,237	0	66,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,895,377		8,895,377	0	8,895,377	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,050,966		1,050,966	0	1,050,966	54.01
57.00	05700	CT SCAN	1,996,942		1,996,942	0	1,996,942	57.00
60.00	06000	LABORATORY	7,453,615		7,453,615	0	7,453,615	60.00
65.00	06500	RESPIRATORY THERAPY	2,183,070	0	2,183,070	0	2,183,070	65.00
66.00	06600	PHYSICAL THERAPY	4,042,247	0	4,042,247	0	4,042,247	66.00
69.00	06900	ELECTROCARDIOLOGY	3,377,214		3,377,214	0	3,377,214	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,230,893		21,230,893	0	21,230,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,284,380		3,284,380	0	3,284,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,474,311		15,474,311	0	15,474,311	73.00
74.00	07400	RENAL DIALYSIS	6,042,028		6,042,028	0	6,042,028	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	4,941,796		4,941,796	0	4,941,796	88.00
90.00	09000	CLINIC	2,301,734		2,301,734	0	2,301,734	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	8,659,292		8,659,292	0	8,659,292	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,209,001		2,209,001	0	2,209,001	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	3,356,984		3,356,984	0	3,356,984	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,177,313		2,177,313	0	2,177,313	116.00
200.00		Subtotal (see instructions)	162,198,601	0	162,198,601	0	162,198,601	200.00
201.00		Less Observation Beds	2,209,001		2,209,001	0	2,209,001	201.00
202.00		Total (see instructions)	159,989,600	0	159,989,600	0	159,989,600	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	20,333,827		20,333,827			30.00
31.00	03100	INTENSIVE CARE UNIT	5,122,241		5,122,241			31.00
40.00	04000	SUBPROVIDER - IPF	2,603,426		2,603,426			40.00
43.00	04300	NURSERY	1,008,674		1,008,674			43.00
44.00	04400	SKILLED NURSING FACILITY	4,743,884		4,743,884			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	13,951,330	45,691,945	59,643,275	0.188302	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,011,823	4,436,451	5,448,274	0.221084	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,402,568	13,790	1,416,358	1.072358	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,227,879	5,846,057	8,073,936	0.008204	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,050,566	17,323,695	26,374,261	0.337275	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	2,324,803	8,912,841	11,237,644	0.093522	0.000000	54.01
57.00	05700	CT SCAN	18,087,236	50,091,879	68,179,115	0.029290	0.000000	57.00
60.00	06000	LABORATORY	38,581,872	46,116,219	84,698,091	0.088002	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	14,483,127	4,473,351	18,956,478	0.115162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,202,444	9,333,070	12,535,514	0.322464	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,716,558	25,885,036	38,601,594	0.087489	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,294,496	15,625,647	25,920,143	0.819089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,208,875	12,547,761	17,756,636	0.184966	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,462,157	56,818,206	88,280,363	0.175286	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,477,346	42,310,744	45,788,090	0.131956	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	5,084,664	5,084,664			88.00
90.00	09000	CLINIC	51,104	5,737,251	5,788,355	0.397649	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	7,559,311	23,414,365	30,973,676	0.279569	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	566,829	3,874,371	4,441,200	0.497388	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	7,769,277	7,769,277	0.432084	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
	SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,410,270	2,410,270			116.00
200.00		Subtotal (see instructions)	209,472,376	393,716,890	603,189,266			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	209,472,376	393,716,890	603,189,266			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		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	0.188302		50.00
51.00	05100	RECOVERY ROOM	0.221084		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.072358		52.00
53.00	05300	ANESTHESIOLOGY	0.008204		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337275		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.093522		54.01
57.00	05700	CT SCAN	0.029290		57.00
60.00	06000	LABORATORY	0.088002		60.00
65.00	06500	RESPIRATORY THERAPY	0.115162		65.00
66.00	06600	PHYSICAL THERAPY	0.322464		66.00
69.00	06900	ELECTROCARDIOLOGY	0.087489		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.184966		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175286		73.00
74.00	07400	RENAL DIALYSIS	0.131956		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.397649		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	0.279569		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497388		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.432084		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	34,365,404		34,365,404	30.00
31.00	03100	INTENSIVE CARE UNIT	5,956,356		5,956,356	31.00
40.00	04000	SUBPROVIDER - IPF	1,637		1,637	40.00
43.00	04300	NURSERY	1,082,354		1,082,354	43.00
44.00	04400	SKILLED NURSING FACILITY	9,291,943		9,291,943	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,436,960		11,436,960	50.00
51.00	05100	RECOVERY ROOM	1,204,525		1,204,525	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,656,183		1,656,183	52.00
53.00	05300	ANESTHESIOLOGY	66,237		66,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,914,997		8,914,997	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	1,050,966		1,050,966	54.01
57.00	05700	CT SCAN	1,996,942		1,996,942	57.00
60.00	06000	LABORATORY	7,453,615		7,453,615	60.00
65.00	06500	RESPIRATORY THERAPY	2,183,070	0	2,183,070	65.00
66.00	06600	PHYSICAL THERAPY	4,042,247	0	4,042,247	66.00
69.00	06900	ELECTROCARDIOLOGY	3,377,214		3,377,214	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,230,893		21,230,893	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,284,380		3,284,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,474,311		15,474,311	73.00
74.00	07400	RENAL DIALYSIS	6,061,648		6,061,648	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,941,796		4,941,796	88.00
90.00	09000	CLINIC	2,458,693		2,458,693	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	8,806,441		8,806,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2,209,001		2,209,001	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,356,984		3,356,984	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE	2,177,313		2,177,313	116.00
200.00		Subtotal (see instructions)	164,082,110	0	164,082,110	200.00
201.00		Less Observation Beds	2,209,001		2,209,001	201.00
202.00		Total (see instructions)	161,873,109	0	161,873,109	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,333,827		20,333,827			30.00
31.00	03100	INTENSIVE CARE UNIT	5,122,241		5,122,241			31.00
40.00	04000	SUBPROVIDER - IPF	2,603,426		2,603,426			40.00
43.00	04300	NURSERY	1,008,674		1,008,674			43.00
44.00	04400	SKILLED NURSING FACILITY	4,743,884		4,743,884			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,951,330	45,691,945	59,643,275	0.191756	0.000000	50.00
51.00	05100	RECOVERY ROOM	1,011,823	4,436,451	5,448,274	0.221084	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,402,568	13,790	1,416,358	1.169325	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,227,879	5,846,057	8,073,936	0.008204	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,050,566	17,323,695	26,374,261	0.338019	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	2,324,803	8,912,841	11,237,644	0.093522	0.000000	54.01
57.00	05700	CT SCAN	18,087,236	50,091,879	68,179,115	0.029290	0.000000	57.00
60.00	06000	LABORATORY	38,581,872	46,116,219	84,698,091	0.088002	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	14,483,127	4,473,351	18,956,478	0.115162	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,202,444	9,333,070	12,535,514	0.322464	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	12,716,558	25,885,036	38,601,594	0.087489	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	10,294,496	15,625,647	25,920,143	0.819089	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	5,208,875	12,547,761	17,756,636	0.184966	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,462,157	56,818,206	88,280,363	0.175286	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,477,346	42,310,744	45,788,090	0.132385	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,084,664	5,084,664	0.971902	0.000000	88.00
90.00	09000	CLINIC	51,104	5,737,251	5,788,355	0.424765	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	7,559,311	23,414,365	30,973,676	0.284320	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	566,829	3,874,371	4,441,200	0.497388	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	7,769,277	7,769,277	0.432084	0.000000	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	2,410,270	2,410,270			116.00
200.00		Subtotal (see instructions)	209,472,376	393,716,890	603,189,266			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	209,472,376	393,716,890	603,189,266			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet C
Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000		78.00
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
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
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 10/01/2022
To 09/30/2023Worksheet D
Part I
Date/Time Prepared:
2/29/2024 12:04 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	3,458,582	17,359	3,441,223	27,227	126.39	30.00	
31.00	INTENSIVE CARE UNIT	771,347		771,347	2,754	280.08	31.00	
40.00	SUBPROVIDER - IPF	254	0	254	1,751	0.15	40.00	
43.00	NURSERY	132,013		132,013	1,216	108.56	43.00	
44.00	SKILLED NURSING FACILITY	1,572,203		1,572,203	17,978	87.45	44.00	
200.00	Total (lines 30 through 199)	5,934,399		5,917,040	50,926		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	4,606	582,152					30.00
31.00	INTENSIVE CARE UNIT	1,422	398,274					31.00
40.00	SUBPROVIDER - IPF	429	64					40.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	2,225	194,576					44.00
200.00	Total (lines 30 through 199)	8,682	1,175,066					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part II
Date/Time Prepared:
2/29/2024 12:04 pm

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	PPS	
						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	1,529,211	59,643,275	0.025639	2,728,356	69,952	50.00
51.00	05100 RECOVERY ROOM	97,417	5,448,274	0.017880	171,035	3,058	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	170,085	1,416,358	0.120086	0	0	52.00
53.00	05300 ANESTHESIOLOGY	88,089	8,073,936	0.010910	397,808	4,340	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	815,621	26,374,261	0.030925	1,464,775	45,298	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	93,492	11,237,644	0.008320	471,541	3,923	54.01
57.00	05700 CT SCAN	95,914	68,179,115	0.001407	4,337,130	6,102	57.00
60.00	06000 LABORATORY	449,228	84,698,091	0.005304	9,379,523	49,749	60.00
65.00	06500 RESPIRATORY THERAPY	112,304	18,956,478	0.005924	1,327,082	7,862	65.00
66.00	06600 PHYSICAL THERAPY	930,711	12,535,514	0.074246	719,666	53,432	66.00
69.00	06900 ELECTROCARDIOLOGY	534,829	38,601,594	0.013855	2,329,155	32,270	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	147,341	25,920,143	0.005684	3,673,459	20,880	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	26,109	17,756,636	0.001470	1,380,346	2,029	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	320,605	88,280,363	0.003632	6,753,689	24,529	73.00
74.00	07400 RENAL DIALYSIS	918,922	45,788,090	0.020069	916,823	18,400	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	869,734	5,084,664	0.171050	0	0	88.00
90.00	09000 CLINIC	90,544	5,788,355	0.015642	48,006	751	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	986,775	30,973,676	0.031859	1,592,442	50,734	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	229,524	4,441,200	0.051681	267,693	13,835	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	8,506,455	559,197,667		37,958,529	407,144	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS						Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023		Worksheet D Part III Date/Time Prepared: 2/29/2024 12:04 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	30.00	
31.00	03100	INTENSIVE CARE UNIT		0		0		0		0	31.00	
40.00	04000	SUBPROVIDER - IPF		0		0		0		0	40.00	
43.00	04300	NURSERY		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	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	27,227	0.00		4,606	30.00	
31.00	03100	INTENSIVE CARE UNIT		0		0	2,754	0.00		1,422	31.00	
40.00	04000	SUBPROVIDER - IPF	0			0	1,751	0.00		429	40.00	
43.00	04300	NURSERY		0		0	1,216	0.00		0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0		0	17,978	0.00		2,225	44.00	
200.00		Total (lines 30 through 199)		0		0	50,926			8,682	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 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
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	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 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 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	59,643,275	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,448,274	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,358	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,073,936	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,374,261	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	11,237,644	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	68,179,115	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	84,698,091	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,956,478	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,535,514	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,601,594	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,920,143	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	17,756,636	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,280,363	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	45,788,090	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,084,664	0.000000	88.00
90.00	09000	CLINIC	0	0	0	5,788,355	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	30,973,676	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,441,200	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	0	0	559,197,667		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		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	2,728,356	0	6,419,333	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	171,035	0	528,873	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	397,808	0	615,456	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,464,775	0	3,335,394	0	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.000000	471,541	0	1,450,319	0	54.01
57.00	05700	CT SCAN	0.000000	4,337,130	0	7,054,260	0	57.00
60.00	06000	LABORATORY	0.000000	9,379,523	0	3,555,909	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,327,082	0	560,508	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	719,666	0	10,899	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,329,155	0	4,888,819	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	3,673,459	0	2,274,225	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	1,380,346	0	2,721,142	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	6,753,689	0	13,402,639	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	916,823	0	80,676	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000	CLINIC	0.000000	48,006	0	674,436	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	1,592,442	0	2,029,495	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	267,693	0	413,878	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		37,958,529	0	50,016,261	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part V
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XVIII	Hospital	PPS		
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.188302	6,419,333	0	0	1,208,773	50.00
51.00	05100 RECOVERY ROOM	0.221084	528,873	0	0	116,925	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.072358	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.008204	615,456	0	0	5,049	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337275	3,335,394	0	0	1,124,945	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	0.093522	1,450,319	0	0	135,637	54.01
57.00	05700 CT SCAN	0.029290	7,054,260	0	0	206,619	57.00
60.00	06000 LABORATORY	0.088002	3,555,909	0	0	312,927	60.00
65.00	06500 RESPIRATORY THERAPY	0.115162	560,508	0	0	64,549	65.00
66.00	06600 PHYSICAL THERAPY	0.322464	10,899	0	0	3,515	66.00
69.00	06900 ELECTROCARDIOLOGY	0.087489	4,888,819	0	0	427,718	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	2,274,225	0	0	1,862,793	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.184966	2,721,142	0	0	503,319	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175286	13,402,639	0	1,642	2,349,295	73.00
74.00	07400 RENAL DIALYSIS	0.131956	80,676	0	0	10,646	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC						88.00
90.00	09000 CLINIC	0.397649	674,436	0	0	268,189	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	0.279569	2,029,495	0	0	567,384	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	413,878	0	0	205,858	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.432084		0			95.00
200.00	Subtotal (see instructions)		50,016,261	0	1,642	9,374,141	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 - line 201)		50,016,261	0	1,642	9,374,141	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part V
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XVIII		Hospital	PPS
Cost Center Description	Costs					
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	288		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
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	288		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	288		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023		Worksheet D Part II Date/Time Prepared: 2/29/2024 12:04 pm	
				Component CCN: 11-S105					
				Title XVIII		Subprovider - IPF		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	1,529,211	59,643,275	0.025639	0	0	50.00	
51.00	05100	RECOVERY ROOM	97,417	5,448,274	0.017880	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	170,085	1,416,358	0.120086	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	88,089	8,073,936	0.010910	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	815,621	26,374,261	0.030925	6,998	216	54.00	
54.01	05401	NUCLEAR MEDICINE-DIAG	93,492	11,237,644	0.008320	6,043	50	54.01	
57.00	05700	CT SCAN	95,914	68,179,115	0.001407	58,809	83	57.00	
60.00	06000	LABORATORY	449,228	84,698,091	0.005304	128,875	684	60.00	
65.00	06500	RESPIRATORY THERAPY	112,304	18,956,478	0.005924	9,812	58	65.00	
66.00	06600	PHYSICAL THERAPY	930,711	12,535,514	0.074246	25,943	1,926	66.00	
69.00	06900	ELECTROCARDIOLOGY	534,829	38,601,594	0.013855	8,991	125	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,341	25,920,143	0.005684	5,390	31	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	26,109	17,756,636	0.001470	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	320,605	88,280,363	0.003632	82,299	299	73.00	
74.00	07400	RENAL DIALYSIS	918,922	45,788,090	0.020069	0	0	74.00	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	869,734	5,084,664	0.171050	0	0	88.00	
90.00	09000	CLINIC	90,544	5,788,355	0.015642	2,912	46	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	986,775	30,973,676	0.031859	34,727	1,106	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	4,441,200	0.000000	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	8,276,931	559,197,667		370,799	4,624	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 11-0105
Component CCN: 11-S105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

		Title XVIII		Subprovider - IPF		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
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78.00
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	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	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-S105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

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	59,643,275	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,448,274	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,358	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,073,936	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,374,261	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	11,237,644	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	68,179,115	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	84,698,091	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,956,478	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,535,514	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,601,594	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,920,143	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	17,756,636	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,280,363	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	45,788,090	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,084,664	0.000000	88.00
90.00	09000	CLINIC	0	0	0	5,788,355	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	30,973,676	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,441,200	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	559,197,667		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

Component CCN: 11-S105

Title XVIII

Subprovider -

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	6,998	0	0	0	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	0.000000	6,043	0	0	0	54.01
57.00	05700 CT SCAN	0.000000	58,809	0	2,466	0	57.00
60.00	06000 LABORATORY	0.000000	128,875	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.000000	9,812	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	25,943	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	8,991	0	556	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5,390	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	82,299	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00	09000 CLINIC	0.000000	2,912	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	34,727	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)		370,799	0	3,022	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:

Worksheet D

Component CCN: 11-S105

From 10/01/2022
To 09/30/2023Part V
Date/Time Prepared:
2/29/2024 12:04 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.188302	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.221084	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.072358	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.008204	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337275	0	0	0	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	0.093522	0	0	0	54.01
57.00	05700 CT SCAN	0.029290	2,466	0	0	72 57.00
60.00	06000 LABORATORY	0.088002	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.115162	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.322464	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.087489	556	0	0	49 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.184966	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175286	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0.131956	0	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC					88.00
90.00	09000 CLINIC	0.397649	0	0	0	90.00
90.01	09001 URGENT CARE	0.000000	0	0	0	90.01
90.02	09002 FAMILY RESIDENCY CLINIC	0.000000	0	0	0	90.02
91.00	09100 EMERGENCY	0.279569	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0.432084		0		95.00
200.00	Subtotal (see instructions)		3,022	0	0	121 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 - line 201)		3,022	0	0	121 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:

Worksheet D

Component CCN: 11-S105

From 10/01/2022
To 09/30/2023Part V
Date/Time Prepared:
2/29/2024 12:04 pm

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost	Cost		
		Reimbursed	Reimbursed		
		Services Subject To Ded. & Coins. (see inst.)	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	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
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	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part V
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XIX		Hospital		Cost	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.191756	0	1,226,291	0	0	50.00	
51.00	05100 RECOVERY ROOM	0.221084	0	112,025	0	0	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.169325	0	206	0	0	52.00	
53.00	05300 ANESTHESIOLOGY	0.008204	0	107,369	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.338019	0	850,679	0	0	54.00	
54.01	05401 NUCLEAR MEDICINE-DIAG	0.093522	0	644,738	0	0	54.01	
57.00	05700 CT SCAN	0.029290	0	1,796,288	0	0	57.00	
60.00	06000 LABORATORY	0.088002	0	114,902	0	0	60.00	
65.00	06500 RESPIRATORY THERAPY	0.115162	0	171,053	0	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.322464	0	235,961	0	0	66.00	
69.00	06900 ELECTROCARDIOLOGY	0.087489	0	555,740	0	0	69.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	0	469,442	0	0	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.184966	0	0	0	0	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175286	0	735,906	0	0	73.00	
74.00	07400 RENAL DIALYSIS	0.132385	0	0	0	0	74.00	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00	
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC						88.00	
90.00	09000 CLINIC	0.424765	0	289,280	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	0.284320	0	1,290,891	0	0	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	0	148,940	0	0	92.00	
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0.432084	0	0			95.00	
200.00	Subtotal (see instructions)		0	8,749,711	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	8,749,711	0	0	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet D
Part V
Date/Time Prepared:
2/29/2024 12:04 pm

			Title XIX		Hospital	Cost
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	235,149	0		50.00
51.00	05100	RECOVERY ROOM	24,767	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	241	0		52.00
53.00	05300	ANESTHESIOLOGY	881	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	287,546	0		54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	60,297	0		54.01
57.00	05700	CT SCAN	52,613	0		57.00
60.00	06000	LABORATORY	10,112	0		60.00
65.00	06500	RESPIRATORY THERAPY	19,699	0		65.00
66.00	06600	PHYSICAL THERAPY	76,089	0		66.00
69.00	06900	ELECTROCARDIOLOGY	48,621	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	384,515	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,994	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				88.00
90.00	09000	CLINIC	122,876	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	367,026	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	74,081	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,893,507	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,893,507	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 11-0105 Component CCN: 11-5667		Period: From 10/01/2022 To 09/30/2023		Worksheet D Part IV Date/Time Prepared: 2/29/2024 12:04 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0	78.00
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	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 10/01/2022
To 09/30/2023

Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 pm

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	59,643,275	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	5,448,274	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,416,358	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	8,073,936	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	26,374,261	0.000000	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0	0	0	11,237,644	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	68,179,115	0.000000	57.00
60.00	06000	LABORATORY	0	0	0	84,698,091	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	18,956,478	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	12,535,514	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	38,601,594	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	25,920,143	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	17,756,636	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	88,280,363	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	45,788,090	0.000000	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	5,084,664	0.000000	88.00
90.00	09000	CLINIC	0	0	0	5,788,355	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	30,973,676	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	4,441,200	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	559,197,667		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 11-0105
Component CCN: 11-5667

Period:
From 10/01/2022
To 09/30/2023

Worksheet D
Part IV
Date/Time Prepared:
2/29/2024 12:04 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
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	78.00
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

Health Financial Systems		COLQUITT REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 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)		27,997	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		27,227	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)		25,411	4.00	
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		3	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)		120	6.00	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		361	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)		286	8.00	
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,606	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)		3	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)		120	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		254.70	17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		263.50	18.00	
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		208.16	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		208.16	20.00	
21.00	Total general inpatient routine service cost (see instructions)		33,286,310	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)		764	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)		31,620	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)		75,146	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)		59,534	25.00	
26.00	Total swing-bed cost (see instructions)		167,064	26.00	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		33,119,246	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)		33,119,246	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)		1,216.41	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		5,602,784	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)		5,602,784	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D-1

Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		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	5,838,637	2,754	2,120.06	1,422	3,014,725	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)					7,800,533	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)					16,418,042	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)					980,426	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					407,144	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,387,570	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					15,030,472	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)					764	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					31,620	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					32,384	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)					1,816	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,216.41	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,209,001	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D-1

Date/Time Prepared:
2/29/2024 12:04 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	3,458,582	33,286,310	0.103904	2,209,001	229,524	90.00
91.00 Nursing Program cost	0	33,286,310	0.000000	2,209,001	0	91.00
92.00 Allied health cost	0	33,286,310	0.000000	2,209,001	0	92.00
93.00 All other Medical Education	0	33,286,310	0.000000	2,209,001	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 11-0105 Component CCN: 11-S105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 pm
		Title XVIII	Subprovider - IPF	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)		1,751	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,751	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)		1,751	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)		429	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		254.70	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		263.50	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		208.16	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		208.16	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,637	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)		1,637	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)		1,637	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)		0.93	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		399	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)		399	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1	
				Component CCN: 11-S105		Date/Time Prepared: 2/29/2024 12:04 pm	
				Title XVIII	Subprovider - IPF	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	0	0	0.00	0	0	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)					55,980	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)					56,379	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)					64	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,624	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,688	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					51,691	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)					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-S105		Period: From 10/01/2022 To 09/30/2023		Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 pm	
				Title XVIII		Subprovider - IPF		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				254	1,637	0.155162	0	0 90.00
91.00	Nursing Program cost				0	1,637	0.000000	0	0 91.00
92.00	Allied health cost				0	1,637	0.000000	0	0 92.00
93.00	All other Medical Education				0	1,637	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 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)	17,978	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	17,978	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)	17,978	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)	2,225	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	254.70	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	263.50	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	208.16	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	208.16	20.00
21.00	Total general inpatient routine service cost (see instructions)	9,291,943	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)	9,291,943	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)	9,291,943	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	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1	
				Component CCN: 11-5667		Date/Time Prepared: 2/29/2024 12:04 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)					9,291,943	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					516.85	71.00
72.00	Program routine service cost (line 9 x line 71)					1,149,991	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)					1,149,991	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)					1,149,991	83.00
84.00	Program inpatient ancillary services (see instructions)					115,218	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)					1,265,209	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 10/01/2022 To 09/30/2023		Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 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 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			27,997 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			27,227 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)			25,411 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			3 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)			120 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			361 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)			286 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)			2,175 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)			3 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)			1,216 15.00
16.00	Nursery days (title V or XIX only)			196 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			254.70 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			263.50 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			208.16 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			208.16 20.00
21.00	Total general inpatient routine service cost (see instructions)			34,365,404 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)			764 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)			31,620 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)			75,146 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)			59,534 25.00
26.00	Total swing-bed cost (see instructions)			167,064 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			34,198,340 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)			34,198,340 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)			1,256.05 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			2,731,909 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)			2,731,909 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D-1

Date/Time Prepared:
2/29/2024 12:04 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)	1,082,354	1,216	890.09	196	174,458	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,956,356	2,754	2,162.80	488	1,055,446	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)					3,320,778	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)					7,282,591	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)					764	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					764	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)					1,816	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,256.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,280,987	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet D-1

Date/Time Prepared:
2/29/2024 12:04 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	3,458,582	34,365,404	0.100641	2,280,987	229,561
91.00	Nursing Program cost	0	34,365,404	0.000000	2,280,987	0
92.00	Allied health cost	0	34,365,404	0.000000	2,280,987	0
93.00	All other Medical Education	0	34,365,404	0.000000	2,280,987	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 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)		17,978	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		17,978	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)		17,978	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)		12,310	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)		1,216	15.00
16.00	Nursery days (title V or XIX only)		196	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		254.70	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		263.50	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		208.16	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		208.16	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,291,943	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)		9,291,943	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)		9,291,943	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	Period: From 10/01/2022 To 09/30/2023	Worksheet D-1	
				Component CCN: 11-5667		Date/Time Prepared: 2/29/2024 12:04 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)					9,291,943	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					516.85	71.00
72.00	Program routine service cost (line 9 x line 71)					6,362,424	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)					6,362,424	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					1,572,203	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					87.45	76.00
77.00	Program capital-related costs (line 9 x line 76)					1,076,510	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					5,285,914	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)					5,285,914	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)					1,076,510	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)					1,076,510	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 10/01/2022 To 09/30/2023		Worksheet D-1 Date/Time Prepared: 2/29/2024 12:04 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			
91.00	Nursing Program cost	0	0	0.000000	0	0			
92.00	Allied health cost	0	0	0.000000	0	0			
93.00	All other Medical Education	0	0	0.000000	0	0			

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/29/2024 12:04 pm	
Cost Center Description		Title XVIII	Hospital	PPS	
		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		4,457,084	30.00
31.00	03100	INTENSIVE CARE UNIT		2,103,432	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	0.188302	2,728,356	50.00
51.00	05100	RECOVERY ROOM	0.221084	171,035	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.072358	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008204	397,808	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337275	1,464,775	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.093522	471,541	54.01
57.00	05700	CT SCAN	0.029290	4,337,130	57.00
60.00	06000	LABORATORY	0.088002	9,379,523	60.00
65.00	06500	RESPIRATORY THERAPY	0.115162	1,327,082	65.00
66.00	06600	PHYSICAL THERAPY	0.322464	719,666	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087489	2,329,155	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	3,673,459	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.184966	1,380,346	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175286	6,753,689	73.00
74.00	07400	RENAL DIALYSIS	0.131956	916,823	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.397649	48,006	90.00
90.01	09001	URGENT CARE	0.000000	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	90.02
91.00	09100	EMERGENCY	0.279569	1,592,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	267,693	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)		37,958,529	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)		37,958,529	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 11-0105 Component CCN: 11-S105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/29/2024 12:04 pm	
		Title XVIII	Subprovider - IPF	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		503,341		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.188302	0	0	50.00
51.00	05100 RECOVERY ROOM	0.221084	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.072358	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.008204	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337275	6,998	2,360	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	0.093522	6,043	565	54.01
57.00	05700 CT SCAN	0.029290	58,809	1,723	57.00
60.00	06000 LABORATORY	0.088002	128,875	11,341	60.00
65.00	06500 RESPIRATORY THERAPY	0.115162	9,812	1,130	65.00
66.00	06600 PHYSICAL THERAPY	0.322464	25,943	8,366	66.00
69.00	06900 ELECTROCARDIOLOGY	0.087489	8,991	787	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	5,390	4,415	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.184966	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175286	82,299	14,426	73.00
74.00	07400 RENAL DIALYSIS	0.131956	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.397649	2,912	1,158	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	0.279569	34,727	9,709	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	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)		370,799	55,980	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)		370,799		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 11-0105 Component CCN: 11-U105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/29/2024 12:04 pm	
Cost Center Description		Title XVIII	Swing Beds - SNF	PPS	
		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	0.188302	0	50.00
51.00	05100	RECOVERY ROOM	0.221084	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.072358	0	52.00
53.00	05300	ANESTHESIOLOGY	0.008204	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.337275	1,656	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.093522	0	54.01
57.00	05700	CT SCAN	0.029290	8,644	57.00
60.00	06000	LABORATORY	0.088002	37,853	60.00
65.00	06500	RESPIRATORY THERAPY	0.115162	8,412	65.00
66.00	06600	PHYSICAL THERAPY	0.322464	31,688	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087489	834	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	9,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.184966	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175286	107,563	73.00
74.00	07400	RENAL DIALYSIS	0.131956	0	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.397649	0	90.00
90.01	09001	URGENT CARE	0.000000	0	90.01
90.02	09002	FAMILY RESIDENCY CLINIC	0.000000	0	90.02
91.00	09100	EMERGENCY	0.279569	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	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)		206,629	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)		206,629	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/29/2024 12:04 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	0.188302	0	0	50.00
51.00	05100 RECOVERY ROOM	0.221084	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1.072358	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.008204	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.337275	732	247	54.00
54.01	05401 NUCLEAR MEDICINE-DIAG	0.093522	0	0	54.01
57.00	05700 CT SCAN	0.029290	0	0	57.00
60.00	06000 LABORATORY	0.088002	6,131	540	60.00
65.00	06500 RESPIRATORY THERAPY	0.115162	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.322464	287,686	92,768	66.00
69.00	06900 ELECTROCARDIOLOGY	0.087489	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.184966	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.175286	123,584	21,663	73.00
74.00	07400 RENAL DIALYSIS	0.131956	0	0	74.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.397649	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	0.279569	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	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)		418,133	115,218	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)		418,133		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet D-3 Date/Time Prepared: 2/29/2024 12:04 pm	
Cost Center Description			Title XIX	Hospital	Cost	
			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		2,434,433		30.00
31.00	03100	INTENSIVE CARE UNIT		718,974		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		123,500		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.191756	1,016,245	194,871	50.00
51.00	05100	RECOVERY ROOM	0.221084	90,105	19,921	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.169325	219,845	257,070	52.00
53.00	05300	ANESTHESIOLOGY	0.008204	126,898	1,041	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.338019	364,705	123,277	54.00
54.01	05401	NUCLEAR MEDICINE-DIAG	0.093522	1,109,213	103,736	54.01
57.00	05700	CT SCAN	0.029290	363,365	10,643	57.00
60.00	06000	LABORATORY	0.088002	3,985,247	350,710	60.00
65.00	06500	RESPIRATORY THERAPY	0.115162	594,645	68,481	65.00
66.00	06600	PHYSICAL THERAPY	0.322464	168,780	54,425	66.00
69.00	06900	ELECTROCARDIOLOGY	0.087489	651,311	56,983	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.819089	1,414,143	1,158,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.184966	476,879	88,206	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.175286	3,011,338	527,845	73.00
74.00	07400	RENAL DIALYSIS	0.132385	558,948	73,996	74.00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.971902	0	0	88.00
90.00	09000	CLINIC	0.424765	186	79	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	0.284320	615,423	174,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.497388	113,007	56,208	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)		14,880,283	3,320,778	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)		14,880,283		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/29/2024 12:04 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)		9,838,160	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)		194,990	2.04
3.00	Managed Care Simulated Payments		15,675,087	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		96.92	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)		11.75	5.00
5.01	FTE cap adjustment for qualifying 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)		11.75	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		11.22	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)		11.22	12.00
13.00	Total allowable FTE count for the prior year.		11.75	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.		11.84	14.00
15.00	Sum of lines 12 through 14 divided by 3.		11.60	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		3.69	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		15.29	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.157759	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.158815	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.157759	21.00
22.00	IME payment adjustment (see instructions)		811,796	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		1,293,430	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)		-0.53	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)		811,796	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1,293,430	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)		19.98	31.00
32.00	Sum of lines 30 and 31		33.58	32.00
33.00	Allowable disproportionate share percentage (see instructions)		16.92	33.00
34.00	Disproportionate share adjustment (see instructions)		416,154	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/29/2024 12:04 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	6,874,403,459	35.00
35.01	Factor 3 (see instructions)	0.000000000	0	0.000342256	35.01
35.02	Hospital UCP, including supplemental UCP (If line 34 is zero, enter zero on this line) (see instructions)		0	2,352,809	35.02
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		0	2,352,809	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		2,352,809		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)		13,613,909		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		11,406,632		48.00
			Amount		
			1.00		
49.00	Total payment for inpatient operating costs (see instructions)			14,907,339	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			794,458	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).			639,079	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	Special add-on payments for new technologies			46,759	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 instructions)			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)			16,387,635	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			16,387,635	61.00
62.00	Deductibles billed to program beneficiaries			1,290,504	62.00
63.00	Coinsurance billed to program beneficiaries			37,002	63.00
64.00	Allowable bad debts (see instructions)			503,312	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			327,153	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			276,769	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15,387,282	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
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
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)			0	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)			-71,171	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part A Date/Time Prepared: 2/29/2024 12:04 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	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)		15,316,111	71.00
71.01	Sequestration adjustment (see instructions)		306,322	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		13,943,564	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		1,066,225	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,345,412	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
Comparison 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 10/01/2022
To 09/30/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/29/2024 12:04 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
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	9,838,160	0	0	9,838,160	9,838,160
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	194,990	0	0	194,990	194,990
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	15,675,087	0	0	15,675,087	15,675,087
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.157759	0.157759	0.157759	0.157759	0.157759
6.00	IME payment adjustment (see instructions)	22.00	811,796	0	0	811,796	811,796
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,293,430	0	0	1,293,430	1,293,430
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	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	811,796	0	0	811,796	811,796
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,293,430	0	0	1,293,430	1,293,430
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1692	0.1692	0.1692	0.1692	0.1692
11.00	Disproportionate share adjustment (see instructions)	34.00	416,154	0	0	416,154	416,154
11.01	Uncompensated care payments	36.00	2,352,809	0	0	2,352,809	2,352,809
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	13,613,909	0	0	13,613,909	13,613,909
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	14,907,339	0	0	14,907,339	14,907,339
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	794,458	0	0	794,458	794,458

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/29/2024 12:04 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	46,759	0	0	46,759	46,759	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	15,748,556	15,748,556	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	728,399	0	0	728,399	728,399	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	24,467	0	0	24,467	24,467	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	0.0571	0.0571	0.0571	0.0571		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	41,592	0	0	41,592	41,592	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	794,458	0	0	794,458	794,458	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 10/01/2022
To 09/30/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/29/2024 12:04 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	9,838,160		9,838,160	9,838,160	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	194,990		194,990	194,990	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,675,087	0	15,675,087	15,675,087	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.157759	0.157759	0.157759		5.00
6.00	IME payment adjustment (see instructions)	22.00	811,796	0	811,796	811,796	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,293,430	0	1,293,430	1,293,430	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	811,796	0	811,796	811,796	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,293,430	0	1,293,430	1,293,430	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1692	0.1692	0.1692		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	416,154	0	416,154	416,154	11.00
11.01	Uncompensated care payments	36.00	2,352,809	0	2,352,809	2,352,809	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	13,613,909	0	13,613,909	13,613,909	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	14,907,339	0	14,907,339	14,907,339	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	794,458	0	794,458	794,458	16.00
17.00	Special add-on payments for new technologies	54.00	46,759	0	46,759	46,759	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	15,748,556	15,748,556	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/29/2024 12:04 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	728,399	0	728,399	728,399	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	24,467	0	24,467	24,467	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	0.0571	0.0571	0.0571		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	41,592	0	41,592	41,592	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	794,458	0	794,458	794,458	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	-71,171	0	-71,171	-71,171	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 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 12:04 pm
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		288	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		9,374,141	2.00
3.00	OPPS or REH payments		11,026,689	3.00
4.00	Outlier payment (see instructions)		0	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		8,249,244	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)		288	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		1,642	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)		1,642	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 charge basis 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)		1,642	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		1,354	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)		288	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)		11,026,689	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		30	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,962,740	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)		9,064,207	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		322,101	28.00
28.50	REH facility payment amount		0	28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		9,386,308	30.00
31.00	Primary payer payments		2,309	31.00
32.00	Subtotal (line 30 minus line 31)		9,383,999	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		89,218	33.00
34.00	Allowable bad debts (see instructions)		344,207	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		223,735	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		119,200	36.00
37.00	Subtotal (see instructions)		9,696,952	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)		0	39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
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)		9,696,952	40.00
40.01	Sequestration adjustment (see instructions)		193,939	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		9,389,218	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		113,795	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	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

Health Financial Systems		COLQUITT REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 12:04 pm	
		Title XVIII	Hospital	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00	Part B Combined Billed Days				0 200.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105 Component CCN: 11-S105	Period: From 10/01/2022 To 09/30/2023	Worksheet E Part B Date/Time Prepared: 2/29/2024 12:04 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		121	2.00
3.00	OPPS or REH payments		92	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	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)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	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)		0	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 charge basis 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)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	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)		0	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)		92	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)		18	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)		74	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
28.50	REH facility payment amount			28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)		74	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		74	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		74	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS		-1	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39.75	N95 respirator payment adjustment amount (see instructions)		0	39.75
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)		73	40.00
40.01	Sequestration adjustment (see instructions)		1	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments		72	41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)		0	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

Health Financial Systems			COLQUITT REGIONAL MEDICAL CENTER			In Lieu of Form CMS-2552-10				
CALCULATION OF REIMBURSEMENT SETTLEMENT					Provider CCN: 11-0105		Period: From 10/01/2022		Worksheet E	
					Component CCN:11-S105		To 09/30/2023		Part B Date/Time Prepared: 2/29/2024 12:04 pm	
					Title XVIII		Subprovider - IPF		PPS	
									1.00	
94.00	Total (sum of lines 91 and 93)								0	94.00
									1.00	
MEDICARE PART B ANCILLARY COSTS										
200.00	Part B Combined Billed Days									200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet E-1
Part I
Date/Time Prepared:
2/29/2024 12:04 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		14,333,991		9,659,646	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	01/24/2023	264,565	01/24/2023	148,946	3.50	
3.51		07/07/2023	108,072	07/07/2023	121,482	3.51	
3.52		06/21/2023	17,790		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)		-390,427		-270,428	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)		13,943,564		9,389,218	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		1,066,225		113,795	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		15,009,789		9,503,013	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

Period:

Worksheet E-1

Component CCN: 11-S105

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Title XVIII

Subprovider -
IPF

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		380,511		72	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)		380,511		72	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)		380,511		72	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

Period:

Worksheet E-1

Component CCN: 11-U105

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 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		59,131		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)		59,131		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)		59,131		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 10/01/2022
 To 09/30/2023

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/29/2024 12:04 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		1,129,221		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	07/07/2023	28,458		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)		-28,458		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)		1,100,763		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)		1,100,763		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 10/01/2022
To 09/30/2023Worksheet E-1
Part II
Date/Time Prepared:
2/29/2024 12:04 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

Health Financial Systems		COLQUITT REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet E-2	
		Component CCN: 11-U105		Date/Time Prepared: 2/29/2024 12:04 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)		68,721	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 (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		123	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)		68,721	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		68,721	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)		68,721	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		8,384	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		60,337	0	15.00
16.00	OTHER ADJUSTMENT		1	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)		60,338	0	19.00
19.01	Sequestration adjustment (see instructions)		1,207	0	19.01
19.02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19.03	Sequestration adjustment-PARHM pass-throughs				19.03
19.25	Sequestration for non-claims based amounts (see instructions)		0	0	19.25
20.00	Interim payments		59,131	0	20.00
20.01	Interim payments-PARHM				20.01
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21.01	Tentative settlement-PARHM (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 (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
Comparison 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-S105	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part II Date/Time Prepared: 2/29/2024 12:04 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		420,813	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		4.797260	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		420,813	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		420,813	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		420,813	18.00
19.00	Deductibles		28,624	19.00
20.00	Subtotal (line 18 minus line 19)		392,189	20.00
21.00	Coinsurance		3,912	21.00
22.00	Subtotal (line 20 minus line 21)		388,277	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		388,277	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.98	Recovery of accelerated depreciation.		0	30.98
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		388,277	31.00
31.01	Sequestration adjustment (see instructions)		7,766	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		380,511	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.		0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VI Date/Time Prepared: 2/29/2024 12:04 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		1,292,302	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)		1,292,302	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		169,075	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)		1,123,227	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENT		1	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)		1,123,228	15.00
15.01	Sequestration adjustment (see instructions)		22,465	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		1,100,763	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)		0	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 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/29/2024 12:04 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		7,282,591		1.00
2.00	Medical and other services			1,893,507	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,282,591	1,893,507	4.00
5.00	Inpatient primary payer payments		58,092		5.00
6.00	Outpatient primary payer payments			5,609	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7,224,499	1,887,898	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		3,276,907		8.00
9.00	Ancillary service charges		14,880,283	8,749,711	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)		18,157,190	8,749,711	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)		18,157,190	8,749,711	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		10,874,599	6,856,204	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)		7,282,591	1,893,507	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	0	24.00
25.00	Capital exception payments (see instructions)		0	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)		7,282,591	1,893,507	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)		7,224,499	1,887,898	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		7,224,499	1,887,898	36.00
37.00	4.23% MEDICAID NET OP REDUCATION		0	-80,095	37.00
38.00	Subtotal (line 36 ± line 37)		7,224,499	1,807,803	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		7,224,499	1,807,803	40.00
41.00	Interim payments		4,015,253	1,910,377	41.00
42.00	Balance due provider/program (line 40 minus line 41)		3,209,246	-102,574	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-S105	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/29/2024 12:04 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 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	0		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)	0	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)	0	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)	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)	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)	0	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		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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 11-0105 Component CCN: 11-5667	Period: From 10/01/2022 To 09/30/2023	Worksheet E-3 Part VII Date/Time Prepared: 2/29/2024 12:04 pm
		Title XIX	Skilled Nursing Facility	PPS
		Inpatient 1.00	Outpatient 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	1,076,510		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)	1,076,510	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)	1,076,510	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)	1,076,510	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	0	24.00
25.00	Capital exception payments (see instructions)	0	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)	1,076,510	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	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	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	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 10/01/2022 To 09/30/2023	Worksheet E-4 Date/Time Prepared: 2/29/2024 12:04 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)			0.00	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)			0.00	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)			0.00	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)			11.22	6.00
7.00	Enter the lesser of line 5 or line 6			11.22	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.	11.22	0.00	11.22	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.	11.22	0.00	11.22	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	11.22	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	11.75	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.84	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	11.60	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	3.69		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	11.22	0.00		16.01
17.00	Adjusted rolling average FTE count	11.60	3.69		17.00
18.00	Per resident amount	116,518.11	116,518.11		18.00
18.01	Per resident amount under §131 of the CAA 2021	0.00	0.00		18.01
19.00	Approved amount for resident costs	1,351,610	429,952	1,781,562	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)			1,781,562	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS			Provider CCN: 11-0105		Period: From 10/01/2022 To 09/30/2023		Worksheet E-4 Date/Time Prepared: 2/29/2024 12:04 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)		6,457	2,184	7,952			26.00
27.00	Total Inpatient Days (see instructions)		30,141	30,141	30,141			27.00
28.00	Ratio of inpatient days to total inpatient days		0.214226	0.072459	0.263827			28.00
29.00	Program direct GME amount		381,657	129,090	470,024	980,771		29.00
29.01	Percent reduction for MA DGME			3.27	3.27			29.01
30.00	Reduction for direct GME payments for Medicare Advantage			4,221	15,370	19,591		30.00
31.00	Net Program direct GME amount					961,180		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)					45,788,090		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)					18,985,435		37.00
38.00	Organ acquisition and HSCT 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)					0		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)					18,985,435		41.00
Part B Reasonable Cost								
42.00	Reasonable cost (see instructions)					9,571,219		42.00
43.00	Primary payer payments (see instructions)					2,384		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)					9,568,835		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)					28,554,270		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)					0.664890		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)					0.335110		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B								
48.00	Total program GME payment (line 31)					961,180		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)					639,079		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)					322,101		50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet E-5

Date/Time Prepared:
2/29/2024 12:04 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 10/01/2022
To 09/30/2023

Worksheet G

Date/Time Prepared:
2/29/2024 12:04 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	9,281,907	0	0	0	1.00
2.00	Temporary investments	4,459,115	0	0	0	2.00
3.00	Notes receivable	454,099	0	0	0	3.00
4.00	Accounts receivable	92,402,039	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	-67,233,137	0	0	0	7.00
8.00	Prepaid expenses	5,704,254	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	7,385,300	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	52,453,577	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,629,639	0	0	0	12.00
13.00	Land improvements	6,405,406	0	0	0	13.00
14.00	Accumulated depreciation	-3,622,718	0	0	0	14.00
15.00	Buildings	146,004,050	0	0	0	15.00
16.00	Accumulated depreciation	-56,469,343	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	132,410,842	0	0	0	23.00
24.00	Accumulated depreciation	-99,481,706	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	3,906,007	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	130,782,177	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	95,416,034	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	5,547,702	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	100,963,736	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	284,199,490	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,628,980	0	0	0	37.00
38.00	Salaries, wages, and fees payable	18,263,972	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,931,911	0	0	0	40.00
41.00	Deferred income	282,739	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,159,868	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	37,267,470	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	51,111,529	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,608	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	51,117,137	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	88,384,607	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	195,814,883				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)	195,814,883	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	284,199,490	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet G-1

Date/Time Prepared:
2/29/2024 12:04 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		166,011,581		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		29,687,430				2.00
3.00	Total (sum of line 1 and line 2)		195,699,011		0		3.00
4.00	CAPITAL CONTRIBUTIONS	317,811		0		0	4.00
5.00		0		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)		317,811		0		10.00
11.00	Subtotal (line 3 plus line 10)		196,016,822		0		11.00
12.00	GASB NO.96 IMPLEMENTATION	158,447		0		0	12.00
13.00	CAPITAL CONTRIBUTIONS	43,491		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)		201,938		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		195,814,884		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			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	GASB NO.96 IMPLEMENTATION		0				12.00
13.00	CAPITAL CONTRIBUTIONS		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 10/01/2022
To 09/30/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	19,753,247		19,753,247	1.00
2.00	SUBPROVIDER - IPF	2,603,426		2,603,426	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	580,580		580,580	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	4,743,884		4,743,884	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)	27,681,137		27,681,137	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	5,122,241		5,122,241	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)	5,122,241		5,122,241	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	32,803,378		32,803,378	17.00
18.00	Ancillary services	167,483,080	385,460,303	552,943,383	18.00
19.00	Outpatient services	8,126,140	36,286,990	44,413,130	19.00
20.00	RURAL HEALTH CLINIC	0	5,084,664	5,084,664	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	7,769,277	7,769,277	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	2,410,270	2,410,270	26.00
27.00	MISC OTHER SERVICES	7,606,728	8,004,558	15,611,286	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	216,019,326	445,016,062	661,035,388	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		229,363,236		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	DEDUCT (SPECIFY)	0			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)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		229,363,236		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023

Worksheet G-3

Date/Time Prepared:
2/29/2024 12:04 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	661,035,388	1.00
2.00	Less contractual allowances and discounts on patients' accounts	459,134,269	2.00
3.00	Net patient revenues (line 1 minus line 2)	201,901,119	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	229,363,236	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-27,462,117	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	11,667,180	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	5,549	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	1,087,942	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	474,222	17.00
18.00	Revenue from sale of medical records and abstracts	229	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	372,369	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	154,206	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS OTHER	10,191,529	24.00
24.01	CRH NET PATIENT REV	2,690,757	24.01
24.02	CRM NET PATIENT REV	27,511,361	24.02
24.03	SALE OF ASSETS	-414,411	24.03
24.50	COVID-19 PHE Funding	3,408,614	24.50
25.00	Total other income (sum of lines 6-24)	57,149,547	25.00
26.00	Total (line 5 plus line 25)	29,687,430	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)	29,687,430	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 11-0105

Period:

Worksheet I-1

Component CCN: 11-2314

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 pm

		Renal Dialysis			
		Total Costs	Basis	Statistics	FTEs per 2080 Hours
		1.00	2.00	3.00	4.00
1.00	REGISTERED NURSES	607,637	HOURS OF SERVICE	14,924.00	7.18
2.00	LICENSED PRACTICAL NURSES	255,562	HOURS OF SERVICE	10,004.00	4.81
3.00	NURSES AIDES	11,325	HOURS OF SERVICE	1,118.00	0.54
4.00	TECHNICIANS	31,107	HOURS OF SERVICE	1,920.00	0.92
5.00	SOCIAL WORKERS	57,217	HOURS OF SERVICE	1,786.00	0.86
6.00	DIETICIANS	37,577	HOURS OF SERVICE	1,215.00	0.58
7.00	PHYSICIANS	33,511	ACCUMULATED COST		
8.00	NON-PATIENT CARE SALARY	193,079	ACCUMULATED COST		
9.00	SUBTOTAL (SUM OF LINES 1-8)	1,227,015			
10.00	EMPLOYEE BENEFITS	100,324	SALARY		
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0	SQUARE FEET		
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	0	PERCENTAGE OF TIME		
13.00	MACHINE COSTS & REPAIRS	27,907	PERCENTAGE OF TIME		
14.00	SUPPLIES	23,538	REQUISITIONS		
15.00	DRUGS	499,910	REQUISITIONS		
16.00	OTHER	261,610	ACCUMULATED COST		
17.00	SUBTOTAL (SUM OF LINES 9-16)*	2,140,304			
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	233,927	SQUARE FEET		
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	352,593	PERCENTAGE OF TIME		
20.00	EMPLOYEE BENEFITS DEPARTMENT	205,206	SALARY		
21.00	ADMINISTRATIVE & GENERAL	666,922	ACCUMULATED COST		
22.00	MAINT./REPAIRS-OPER-HOUSEKEEPING	825,642	SQUARE FEET		
23.00	MEDICAL EDUCATION PROGRAM COSTS	0			
24.00	CENTRAL SERVICE & SUPPLIES	368,387	REQUISITIONS		
25.00	PHARMACY	1,484,412	REQUISITIONS		
26.00	OTHER ALLOCATED COSTS	148,391	ACCUMULATED COST		
27.00	SUBTOTAL (SUM OF LINES 17-26)*	6,425,784			
28.00	LABORATORY (SEE INSTRUCTIONS)	0	CHARGES	0	
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	0	CHARGES	0	
30.00	OTHER ANCILLARY SERVICE COST CENTERS	0	CHARGES	0	
31.00	TOTAL COSTS (SUM OF LINES 27-30)	6,425,784			

* 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

Period:

Worksheet I-2

Component CCN: 11-2314

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		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	1,059,569	380,500	607,637	392,788	305,530	1,600,566	1.00
MAINTENANCE								
2.00	Hemodialysis	947,979	340,427	543,634	351,412	273,343	1,424,504	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	111,590	40,073	64,003	41,376	32,187	176,062	12.00
13.00	Method II Home Patient	0	0	0	0	0	0	13.00
14.00	ESAs (included in Renal Department)						383,756	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)	1,059,569	380,500	607,637	392,788	305,530	1,600,566	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	391,925	0	4,738,515	1,303,513	6,042,028		1.00
MAINTENANCE								
2.00	Hemodialysis	348,813	0	4,230,112	1,163,657	5,393,769		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	43,112	0	508,403	139,856	648,259		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)	391,925	0	4,738,515	1,303,513	6,042,028		17.00
18.00	Medical Educational Program Costs					0		18.00
19.00	Total Renal Costs (line 17 + line 18)					6,042,028		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 11-0105

Period:

Worksheet I-3

Component CCN: 11-2314

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 pm

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		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	1,059,569	380,500	607,637	392,788	305,530		1.00
MAINTENANCE								
2.00	Hemodialysis	9,812	9,812.00	13,327.00	18,804.00	1,097,749		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	1,292	1,155	1,155.00	1,569.00	2,214.00	129,265	12.00
13.00	Method II Home Patient		0	0.00	0.00	0	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	14,896.00	21,018.00	1,227,014		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	96.614297	34.694994	40.791958	18.688172	0.249003		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	1,600,566	391,925	0	4,738,515	1,303,513		1.00
MAINTENANCE								
2.00	Hemodialysis	89	89	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	11	11	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		4,738,515		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	16,005.660000	3,919.250000	0.000000		0.275089		18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 11-0105

Period:

From 10/01/2022

Worksheet I-4

Component CCN: 11-2314

To 09/30/2023

Date/Time Prepared:
2/29/2024 12:04 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	12,264	5,393,769	439.81	2,520	1,108,321
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		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
10.00	Home Program - CCPD	0	0	0.00	0	0
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)	12,264	5,393,769		2,520	1,108,321
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	12,264				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	1,051,455	417.24			
2.00	Maintenance - Peritoneal Dialysis	0	0.00			
3.00	Training - Hemodialysis	0	0.00			
4.00	Training - Peritoneal Dialysis	0	0.00			
5.00	Training - CAPD	0	0.00			
6.00	Training - CCPD	0	0.00			
7.00	Home Program - Hemodialysis	0	0.00			
8.00	Home Program - Peritoneal Dialysis	0	0.00			
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			
10.00	Home Program - CCPD	0	0.00			
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)	1,051,455				
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet I-5 Date/Time Prepared: 2/29/2024 12:04 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)		1,108,321		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)		1,051,455	981,615	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)		1,051,455	981,615	2.03
2.04	Outlier payments		405,823		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)		1,499	1,399	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)		1,499	1,399	3.03
4.00	Coinsurance billed to Medicare (Part B) patients		210,243	196,278	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)		210,243	196,278	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		147,025	137,259	5.04
5.05	Allowable bad debts (sum of lines 5 through line 5.04)		147,025	137,259	5.05
6.00	Adjusted reimbursable bad debts (see instructions)		89,218		6.00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		94,298		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)		0	60,418	8.00
9.00	Program payment (see instructions)		0	784,173	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)		89,218		11.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE					
12.00	Total allowable expenses (see instructions)		5,777,525		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)		5,393,769		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)		0.933578		14.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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*		139,475	139,475	-139,475	0
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	43,314	43,314	0	43,314
4.00	ADMINISTRATIVE & GENERAL*	144,842	97,654	242,496	0	242,496
5.00	PLANT OPERATION & MAINTENANCE*	0	27,616	27,616	0	27,616
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0
7.00	HOUSEKEEPING*	0	0	0	0	0
8.00	DIETARY*	0	0	0	0	0
9.00	NURSING ADMINISTRATION*	0	0	0	0	0
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0
11.00	MEDICAL RECORDS*	0	0	0	0	0
12.00	STAFF TRANSPORTATION*	0	0	0	0	0
13.00	VOLUNTEER SERVICE COORDINATION*	134,711	2,477	137,188	0	137,188
14.00	PHARMACY*	0	47,533	47,533	0	47,533
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	0
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0
17.00	PATIENT/RESIDENTIAL CARE SERVICES					
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		51,956	51,956	0	51,956
26.00	PHYSICIAN SERVICES**	0	0	0	0	0
27.00	NURSE PRACTITIONER**	0	0	0	0	0
28.00	REGISTERED NURSE**	222,272	6,807	229,079	0	229,079
29.00	LPN/LVN**	0	0	0	0	0
30.00	PHYSICAL THERAPY**	0	0	0	0	0
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0
33.00	MEDICAL SOCIAL SERVICES**	116,590	1,255	117,845	0	117,845
34.00	SPIRITUAL COUNSELING**	39,108	0	39,108	0	39,108
35.00	DIETARY COUNSELING**	0	0	0	0	0
36.00	COUNSELING - OTHER**	0	0	0	0	0
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	69,862	11,576	81,438	0	81,438
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	0
39.00	PATIENT TRANSPORTATION**	0	0	0	0	0
40.00	IMAGING SERVICES**	0	0	0	0	0
41.00	LABS & DIAGNOSTICS**	0	0	0	0	0
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	0	0	0	0
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0
43.00	OUTPATIENT SERVICES**	0	0	0	0	0
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	0
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	28,429	4,626	33,055	0	33,055
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0
61.00	VOLUNTEER PROGRAM *	0	0	0	0	0
62.00	FUNDRAISING*	0	0	0	0	0
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0
66.00	RESIDENTIAL CARE*	0	0	0	0	0
67.00	ADVERTISING*	0	0	0	0	0
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	0
69.00	THRIFT STORE*	0	0	0	0	0
70.00	NURSING FACILITY ROOM & BOARD*	0	180,669	180,669	0	180,669
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0
100.00	TOTAL	755,814	614,958	1,370,772	-139,475	1,231,297

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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	43,314	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	242,496	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	27,616	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	137,188	13.00
14.00	PHARMACY*	0	47,533	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	51,956	25.00
26.00	PHYSICIAN SERVICES**	0	0	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	229,079	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	117,845	33.00
34.00	SPIRITUAL COUNSELING**	0	39,108	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	81,438	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	33,055	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	0	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	180,669	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	1,231,297	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME CARE

Provider CCN: 11-0105

Period:

Worksheet 0-2

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 pm

				Hospice I		2/26/2024 12:10 PM	
		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	221,284	6,807	228,091	0	228,091	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	116,072	1,255	117,327	0	117,327	33.00
34.00	SPIRITUAL COUNSELING	38,934	0	38,934	0	38,934	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	69,552	11,576	81,128	0	81,128	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)	28,303	4,626	32,929	0	32,929	46.00
100.00	TOTAL *	474,145	24,264	498,409	0	498,409	100.00

* Transfer the amount in column 7 to Wkst. 0-5, 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	228,091	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	117,327	33.00
34.00	SPIRITUAL COUNSELING	0	38,934	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	81,128	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	32,929	46.00
100.00	TOTAL *	0	498,409	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 11-0105

Period:

Worksheet 0-3

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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		51,956	51,956	0	51,956	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	988	0	988	0	988	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	518	0	518	0	518	33.00
34.00	SPIRITUAL COUNSELING	174	0	174	0	174	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	310	0	310	0	310	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)	126	0	126	0	126	46.00
100.00	TOTAL *	2,116	51,956	54,072	0	54,072	100.00

* Transfer the amount in column 7 to Wkst. 0-5, 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	51,956	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	988	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	518	33.00
34.00	SPIRITUAL COUNSELING	0	174	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	310	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	126	46.00
100.00	TOTAL *	0	54,072	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 11-0105

Period:

Worksheet 0-5

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 pm

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	32,571	32,571	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	49,094	49,094	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	43,314	126,402	169,716	3.00
4.00	ADMINISTRATIVE & GENERAL	242,496	348,635	591,131	4.00
5.00	PLANT OPERATION & MAINTENANCE	27,616	88,633	116,249	5.00
6.00	LAUNDRY & LINEN SERVICE	0	70	70	6.00
7.00	HOUSEKEEPING	0	26,326	26,326	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	90,290	90,290	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	27,708	27,708	10.00
11.00	MEDICAL RECORDS	0	3,914	3,914	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	137,188		137,188	13.00
14.00	PHARMACY	47,533	152,373	199,906	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	498,409		498,409	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	54,072		54,072	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	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0	68.00
69.00	THRIFT STORE	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	180,669		180,669	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0	71.00
99.00	NEGATIVE COST CENTER	0		0	99.00
100.00	TOTAL	1,231,297	946,016	2,177,313	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 pm

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	32,571		32,571							1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,094				49,094					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	169,716		0		0		169,716			3.00
4.00	ADMINISTRATIVE & GENERAL	591,131		32,571		49,094		32,524		705,320	4.00
5.00	PLANT OPERATION & MAINTENANCE	116,249		0		0		0		116,249	5.00
6.00	LAUNDRY & LINEN SERVICE	70		0		0		0		70	6.00
7.00	HOUSEKEEPING	26,326		0		0		0		26,326	7.00
8.00	DIETARY	0		0		0		0		0	8.00
9.00	NURSING ADMINISTRATION	90,290		0		0		0		90,290	9.00
10.00	ROUTINE MEDICAL SUPPLIES	27,708		0		0		0		27,708	10.00
11.00	MEDICAL RECORDS	3,914		0		0		0		3,914	11.00
12.00	STAFF TRANSPORTATION	0		0		0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	137,188		0		0		30,249		167,437	13.00
14.00	PHARMACY	199,906		0		0		0		199,906	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		0	17.00
LEVEL OF CARE											
50.00	HOSPICE CONTINUOUS HOME CARE	0						0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	498,409						106,468		604,877	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	54,072		0		0		475		54,547	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		0		0		0	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	180,669								180,669	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0		0		0		0		0	71.00
99.00	NEGATIVE COST CENTER	0		0		0		0		0	99.00
100.00	TOTAL	2,177,313		32,571		49,094		169,716		2,177,313	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I 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	705,320						4.00
5.00	PLANT OPERATION & MAINTENANCE	63,495	179,744					5.00
6.00	LAUNDRY & LINEN SERVICE	38	0		108			6.00
7.00	HOUSEKEEPING	14,379	0			40,705		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	49,316	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	15,134	0			0		10.00
11.00	MEDICAL RECORDS	2,138	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	91,454	179,744			40,705		13.00
14.00	PHARMACY	109,188	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	330,384						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	29,794	0		108	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	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	0	0		0	0	0	99.00
100.00	TOTAL	705,320	179,744		108	40,705	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Descriptions		Hospice I				
		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	139,606				9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	42,842			10.00
11.00	MEDICAL RECORDS	0		6,052		11.00
12.00	STAFF TRANSPORTATION	0			0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	479,340 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	139,004	42,652	6,025	0	477,210 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	602	190	27	0	2,130 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	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	0	0	0	0	0 99.00
100.00	TOTAL	139,606	42,842	6,052	0	479,340 100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part I
Date/Time Prepared:
2/29/2024 12:04 pm

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		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	309,094					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	307,723	0	0		1,907,875	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1,371	0	0	0	88,769	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					180,669	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	309,094	0	0	0	2,177,313	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I 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	755,815			3.00
4.00	ADMINISTRATIVE & GENERAL	1,527	1,527	144,842	-705,320	1,291,324	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	116,249	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	70	6.00
7.00	HOUSEKEEPING	0	0	0	0	26,326	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	90,290	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	27,708	10.00
11.00	MEDICAL RECORDS	0	0	0	0	3,914	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	134,711	0	167,437	13.00
14.00	PHARMACY	0	0	0	0	199,906	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	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			474,146	0	604,877	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	2,116	0	54,547	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	0	0	0	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				-180,669		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. 0-6, Part I)	32,571	49,094	169,716		705,320	100.00
101.00	UNIT COST MULTIPLIER	21.330059	32.150622	0.224547		0.546199	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Descriptions		Hospice I					
		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	58				6.00
7.00	HOUSEKEEPING	0		1,527			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		1,160	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		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					1,155	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	58	0	0	5	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. 0-6, Part I)	179,744	108	40,705	0	139,606	100.00
101.00	UNIT COST MULTIPLIER	117.710544	1.862069	26.656843	0.000000	120.350000	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105

Period:

From 10/01/2022

Worksheet 0-6

Part II

Hospice CCN: 11-1542

To 09/30/2023

Date/Time Prepared:
2/29/2024 12:04 pm

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	13,052						10.00
11.00	MEDICAL RECORDS		13,052					11.00
12.00	STAFF TRANSPORTATION				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION				0	476,262		13.00
14.00	PHARMACY				0	0	49,371	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	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	12,994	12,994	0	0	474,146	49,152	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	58	58	0	0	2,116	219	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	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	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				0	0	0	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. 0-6, Part I)	42,842	6,052	0	0	479,340	309,094	100.00
101.00	UNIT COST MULTIPLIER	3.282409	0.463684	0.000000	0.000000	1.006463	6.260639	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 11-0105

Period:

Worksheet 0-6

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Part II
Date/Time Prepared:
2/29/2024 12:04 pm

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		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		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0			99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, 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

Period:

Worksheet 0-7

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023

Date/Time Prepared:
2/29/2024 12:04 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	
				2.00	3.00	4.00	
		0	1.00	2.00	3.00	4.00	
ANCILLARY SERVICE COST CENTERS							
1.00	PHYSICAL THERAPY	66.00	0.322464	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	0.175286	0	4,779	21	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00					5.00
6.00	LABORATORY	60.00	0.088002	0	1,192	5	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.819089	0	6,430	29	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)	Shared Service Costs by LOC				
		HGIP	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	838	4	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED						5.00
6.00	LABORATORY	0	0	105	0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,267	24	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	6,210	28	0	11.00

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 11-0105

Period:

Worksheet 0-8

Hospice CCN: 11-1542

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, 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. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			1,914,085	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			12,994	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			147.31	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	11,581	853		9.00
10.00	Program cost (line 8 times line 9)	1,705,997	125,655		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			88,797	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			58	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			1,530.98	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	55	3		14.00
15.00	Program cost (line 13 times line 14)	84,204	4,593		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, 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)			2,002,882	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			13,052	22.00
23.00	Average cost per diem (line 21 divided by line 22)			153.45	23.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 11-0105

Period:
From 10/01/2022
To 09/30/2023Worksheet L
Parts I-III
Date/Time Prepared:
2/29/2024 12:04 pm

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	728,399	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	24,467	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)	77.78	3.00
4.00	Number of interns & residents (see instructions)	15.29	4.00
5.00	Indirect medical education percentage (see instructions)	5.71	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)	41,592	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)	794,458	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

Period:

Worksheet M-1

Component CCN: 11-3422

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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	103,648	0	103,648	75,766	179,414 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	249,313	0	249,313	0	249,313 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)	352,961	0	352,961	75,766	428,727 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	38,158	38,158	0	38,158 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	2,074	2,074	0	2,074 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,232	40,232	0	40,232 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	352,961	40,232	393,193	75,766	468,959 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	0	0	0	0	0 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	-37	-37 29.00
30.00	Administrative Costs	498,299	1,629,016	2,127,315	-3,470	2,123,845 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	498,299	1,629,016	2,127,315	-3,507	2,123,808 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	851,260	1,669,248	2,520,508	72,259	2,592,767 32.00

ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS

Provider CCN: 11-0105

Period:

Worksheet M-1

Component CCN: 11-3422

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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	179,414	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	249,313	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	428,727	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	38,158	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	2,074	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	40,232	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	468,959	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	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	-37	29.00
30.00	Administrative Costs	0	2,123,845	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	2,123,808	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,592,767	32.00

ALLOCATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC SERVICES

Provider CCN: 11-0105

Period:

Worksheet M-2

Component CCN: 11-3422

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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	2.00	17,614	4,200	8,400		1.00
2.00	Physician Assistant	1.00	1,057	2,100	2,100		2.00
3.00	Nurse Practitioner	1.00	1,057	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.00	19,728		12,600	19,728	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	19,728			19,728	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)					468,959	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)					468,959	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)					2,123,808	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,349,029	15.00
16.00	Total overhead (sum of lines 14 and 15)					4,472,837	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Enter the amount from line 16					4,472,837	18.00
19.00	Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)					4,472,837	19.00
20.00	Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)					4,941,796	20.00

Health Financial Systems		COLQUITT REGIONAL MEDICAL CENTER		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC SERVICES		Provider CCN: 11-0105	Period: From 10/01/2022 To 09/30/2023	Worksheet M-3	
		Component CCN: 11-3422		Date/Time Prepared: 2/29/2024 12:04 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)			4,941,796	1.00
2.00	Cost of injections/infusions and their administration (from Wkst. M-4, line 15)			20,440	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 minus line 2)			4,921,356	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			19,728	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)			19,728	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)			249.46	7.00
			Calculation of Limit (1)		
			Rate Period 1 (10/01/2022 through 12/31/2022)	Rate Period 2 (01/01/2023 through 09/30/2023)	
			1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)		113.00	126.00	8.00
9.00	Rate for Program covered visits (see instructions)		113.00	126.00	9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)		389	1,212	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)		43,957	152,712	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	196,669	16.00
16.01	Total program charges (see instructions)(from contractor's records)			460,690	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.)			129,166	16.04
16.05	Total program cost (see instructions)		0	129,166	16.05
17.00	Primary payer amounts			75	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)			35,212	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)			85,095	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)			129,091	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			20,440	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)			149,531	22.00
23.00	Allowable bad debts (see instructions)			4,300	23.00
23.01	Adjusted reimbursable bad debts (see instructions)			2,795	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)			152,326	26.00
26.01	Sequestration adjustment (see instructions)			3,047	26.01
26.02	Demonstration payment adjustment amount after sequestration			0	26.02
27.00	Interim payments			123,835	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)			25,444	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

Period:

Worksheet M-4

Component CCN: 11-3422

From 10/01/2022
To 09/30/2023Date/Time Prepared:
2/29/2024 12:04 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)	428,727	428,727	428,727	428,727	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0.000023	0.000938	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	10	402	0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	205	1,323	0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	215	1,725	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	468,959	468,959	468,959	468,959	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	4,472,837	4,472,837	4,472,837	4,472,837	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0.000458	0.003678	0.000000	0.000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	2,049	16,451	0	0	9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	2,264	18,176	0	0	10.00
11.00	Total number of injections/infusions (from your records)	2	128	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	1,132.00	142.00	0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	2	128	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)	2,264	18,176	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
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)				20,440	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)				20,440	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 10/01/2022 To 09/30/2023	Worksheet M-5 Date/Time Prepared: 2/29/2024 12:04 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		123,835	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			0	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)		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		123,835	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		25,444	6.01	
6.02	SETTLEMENT TO PROGRAM		0	6.02	
7.00	Total Medicare program liability (see instructions)		149,279	7.00	
		Contractor Number	NPR Date (Mo/Day/Yr)		
		0	1.00	2.00	
8.00	Name of Contractor				8.00

General Instructions and Identification of Cost Reports that Cover the DSH Year:

1. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.
2. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 3 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 [Psychiatric or Rehab] Line 7 - Medicaid Provider Number 2 [Psychiatric or Rehab] and Line 8 - Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.
3. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

NOTE: For the 2022 DSH Survey, if your hospital completed the DSH survey for 2022, the first cost report year should follow the last cost report year reported on the 2022 DSH survey. The last cost report year on the 2022 survey must end on or after the end of the 2022 DSH year. If your hospital did not complete the 2022 survey, you must report data for each cost report year that covers the 2022 DSH year.

- Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Exhibit A Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.
 2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology. If your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data.
 3. Exhibit A population should include all uninsured patients whose dates of service [see above] fall within the cost report period.
- The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 12 of the DSH survey.

Exhibit B ☐ Support for Self Pay I/P and O/P ☐ Hospital Payments Received:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments received from patients during the cost report year regardless of dates of service and insurance status.
3. Only the payments received from uninsured patients should be included on Section H of the DSH survey, line 1 ☐ 3. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 1 ☐ 3 should reconcile to Section E, line 9.

Section D General Cost Report Year Information

1. For Lines 1 through of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.
2. For Lines 9 through 15, provide the name and Medicaid provider number for each state other than your home state where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through . After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.
2. Please read "Note 2" located at the bottom of Section E before entering information for Line . After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.
3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.
- Line 13 is a drop-down menu. Please answer 'Yes' or 'No' to the question.
5. Lines 1 and 15 should be completed if you answered 'Yes' to line 13. Please provide the amount of lump sum non-claims-based payments received from Medicaid Managed Care plans. Please also provide supporting documentation for the amounts reported in the form of cancelled checks, general ledger records, or some other financial records.

Section IUR / LIUR Qualifying Data from the Cost Report

Section Total Hospital Days Used in Medicaid Inpatient Utilization Ratio IUR

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate IUR. The IUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section 2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

2. For Lines 2 through 6 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate cell. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified cell. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental PL Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

- ☐ Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.
- 5. For Lines ☐ through 10 report the applicable charity care charges. Charity care charges are used in the calculation of the low-income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. Any charity care charges related to non-hospital services should be reported on the non-hospital charity care charges line. Total charity care charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

Section ☐3 Calculation of Net ☐ospital Revenue from Patient Services ☐Used for LIUR☐

- 6. For purposes of the low-income utilization rate ☐LIUR☐calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.
- ☐ A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS 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. Formulas can be overwritten as needed with actual data.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State".
 2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.
 3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.
- ☐ Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.
2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.
3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

In-State Medicaid Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement PSR report, or your state version generated from the MMIS. Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)" the total gross payments, prior to reductions for third party liability (TPL) your hospital received for these services. Reconcile your responses on the survey with the PSR total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Same requirements as above, except payments received from the Medicaid Managed Care entity should be reported on the line titled "Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)". If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). NOTE: 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.

In-State Medicare Cross-Overs with Medicaid Secondary

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

In-State Other Medicaid Eligibles Not Included Elsewhere

In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number. This would include Medicare Part C cross-overs not reported elsewhere on the survey.

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Uninsured

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage ☐ insurance ☐ or third party liability for the specific service provided. See "Uninsured Definitions" tab for additional details.

- ☐ Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I Out of State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PSR or equivalent schedule produced by the Medicaid program or managed care entity.

Out of State Medicaid Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out of State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out of State Medicare Cross Overs with Medicaid Secondary

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Out of State Other Medicaid Eligibles Not Included Elsewhere

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Section II Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section I.
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section I. Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.**
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
3. The following columns will **NO** need to be entered by the provider as they will automatically populate after Section I has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs Count".

Section L. Provider Tax Assessment Reconciliation / Adjustment:

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**
The objective of this form is to determine the state assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.
2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on Worksheet A-1 to remove the non-hospital expense.
3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.
- ☐ If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided or attach separate explanation if it won't fit.
5. Lines 3-4 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.
6. Lines 5-11 should identify any amount of the hospital allowable Provider Tax expense assessed by the state that was adjusted on Worksheet A-1 of the cost report.

Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.
- ☐ Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-1 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangements outside of the state's assessed tax).

Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.
- ☐ Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.
9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH CCC.
10. The amount on Line 25 may NOT be the final amount added into your DSH CCC. The examination will review the various adjustments and reconciliations and make a final determination.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be uploaded to the secure web portal at <https://dsh.mslc.com> or sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit to:

Myers and Stauffer LC
Attention: DSH Examinations
1000 W. 4th Street, Suite 1000
Kansas City, Missouri 64112
Web Portal: <https://dsh.mslc.com>
Phone: 800341-1111
Email: ADS@mslc.com

Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who have no source of third party coverage for a specific inpatient hospital or outpatient hospital service reported based on date of service 42 CFR 447.295 (b))

- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. 3 FR dated 12/19/01, page 916 / 2 CFR 299.13
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments provided for hospital patients that met the uninsured definition for the specific inpatient or outpatient hospital service provided. The payments must be reported on a cash basis report in the year provided, regardless of the year of service 3 FR dated 12/19/01, pages 913 92

- Include uninsured liens and uninsured accounts sold, when the cash is collected. 3 FR dated 12/19/01, pages 92 92
- Include Section 1011 payments for hospital services without insurance or other third party coverage undocumented aliens 2 CFR 299.13
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. 3 FR dated 12/19/01, pages 92 92

Do NO Include In Hospital Uninsured Charges:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage for the specific inpatient or outpatient hospital service provided. Exclude charges for all non-hospital services. 42 CFR 447.295 (b)

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. 42 CFR 447.299 (f)(5) / 73 FR dated 12/19/08, pages 77912-77926
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage for the specific inpatient or outpatient hospital service provided. 42 CFR 447.299 (f)(5) and 42 CFR 447.295 (b)
- Exclude claims denied by an active health insurance carrier unless the entire claim was denied due to exhaustion of benefits or due to the benefit package not covering the specific inpatient or outpatient hospital service provided. (73 FR dated 12/19/08, pages 77910-77911, 77913 and 42 CFR 447.295 (b))
- Exclude uninsured charges for services that are not medically necessary (including elective procedures) under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan) (42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)
- Exclude charges for services to prisoners (wards of the state) (73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied) (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured) (45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured) (42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured) (73 FR dated 12/19/08, page 77916)
- Exclude charges related to accounts with unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage) (42 CFR 447.299 (15))

- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA) (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan) (42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan) (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude non-Title I charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP)
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

Do NO Include In Hospital Uninsured Payments:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. (42 CFR 447.299 (12))
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment) (42 CFR 447.299 (15))
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

December 3, 2014 Final Rule Highlights:

- **Medicaid Eligible Individuals:**
 - If an individual is Medicaid eligible for any day during a single inpatient stay for a particular service, states must classify the individual as Medicaid eligible.
 - If an individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, states cannot include any costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

- If an individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, states should classify the individual as uninsured and include all costs and revenues associated with the particular service when calculating the hospital-specific DSH limit.

■ **Uninsured and Underinsured:**

- Individuals who have exhausted benefits before obtaining services will be considered uninsured.
- Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for the particular service. If the individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, the costs and revenues of the service cannot be included in the hospital-specific DSH limit.
- Individuals with high deductible or catastrophic plans are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims cannot be included in the hospital-specific DSH limit.
- The costs and revenues, including the payments from private insurance for Medicaid eligible individuals, should be included in the calculation of the hospital-specific DSH limit.

■ **Scope of Inpatient and Outpatient Hospital Services:**

- To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, the service must meet the federal and state definitions of inpatient or outpatient hospital services and must be included in the state's definition of an inpatient or outpatient hospital service under the approved state plan.
- FQHC services are not inpatient or outpatient hospital services and cannot be included in the hospital-specific DSH limit.
- Example: If transplant services are not covered under the approved state plan, costs associated with transplants cannot be included in calculating the hospital-specific DSH limit.
- Example: NF, HHA, employed physicians or other licensed practitioners are not recognized as inpatient or outpatient hospital services and are not covered under the inpatient or outpatient hospital Medicaid benefit service categories and cannot be included in the hospital-specific DSH limit.
- Administratively necessary days (days awaiting placement) are recognized as inpatient hospital services and should be included in the hospital-specific DSH limit.

■ **Timing of Service Specific Determination:**

- The determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire claim's services.

- When benefits have been exhausted for individuals with a source of third party coverage, only costs associated with separate services provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific limit. These services must be a separate service based on the definition of a service for Medicaid [e.g., separate inpatient stay or separate outpatient billing period]

- Uncompensated care costs incurred by hospitals due to unpaid co-pays, co-insurance, or deductibles associated with a non-Medicaid eligible individual cannot be included in the calculation of the hospital-specific DSH limit.

- **Physician Services:**

- Services that are not inpatient or outpatient hospital services, including physician services, must be excluded when calculating the hospital-specific DSH limit.

- Exception: Costs where insurance pays an all inclusive rate are allowable.

- Physician costs under Section 1115 waivers are still excluded from the DSH limit calculation.

- **Prisoners:**

- Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage.

- **Indian Health Services:**

- For Medicaid DSH purposes, American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs [direct health care services] and for services specifically authorized under CHS.

- Determining factor in deciding whether an American Indian or Alaska Native has health insurance for I/P or O/P hospital service is if the providing entity is an IHS facility or tribal health program.

- Contract Services (Non-IHS provider): if the service is specifically authorized via a purchase order or equivalent document, it is considered to be insured. If it does not have an authorization, it is considered an uninsured service.

Example of Exhibit A - Uninsured Charges

DSH Reporting Instructions A-R														
Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider (D)	Patient Identifier Code (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (L) Inpatient / Outpatient / Ambulatory	Revenue Code (M)	Total Charges for Services Provided (N)	Routine Days of Care (O)
Uninsured Charges	Charity	Self-Pay	123.5	222222	1/1/1900	999-99-9999	Female	Doe, Jane	3/1/2010	3/1/2010	Inpatient	200	\$ 500.00	3
Uninsured Charges	Charity	Self-Pay	123.5	222222	1/1/1900	999-99-9999	Female	Doe, Jane	3/1/2010	3/1/2010	Inpatient	250	\$ 5,200.25	
Uninsured Charges	Charity	Self-Pay	123.5	222222	1/1/1900	999-99-9999	Female	Doe, Jane	3/1/2010	3/1/2010	Inpatient	300	\$ 2,000.00	
Uninsured Charges	Charity	Self-Pay	123.5	222222	1/1/1900	999-99-9999	Female	Doe, Jane	3/1/2010	3/1/2010	Inpatient	360	\$ 15,000.15	
Uninsured Charges	Charity	Self-Pay	123.5	222222	1/1/2000	999-99-9999	Female	Doe, Jane	6/15/2010	6/15/2010	Outpatient	250	\$ 150.00	
Uninsured Charges	Medicaid	Medicaid	123.5	111111	7/12/19.5	999-99-9999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	\$ 500.00	
Uninsured Charges	Medicaid	Medicaid	123.5	111111	7/12/19.5	999-99-9999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	\$ 500.00	
Uninsured Charges	Blue Cross	Blue Cross	123.5	111111	3/5/2000	999-99-9999	Male	Smith, Mike	7/10/2010	7/10/2010	Outpatient	250	\$ 1,100.00	

Notes for Completing Exhibit A:

- All charges for non-hospital services should be excluded.
- Payments reported in Columns P-Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.
- Report services not covered under the patient's insurance package as a "Non-Covered Service". Note: the service must be covered under the state Medicaid plan.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel .xls or .xlsx. If this is not possible, the data must be submitted as a CSV .csv file using either the TAB or PIPE symbol above the ENTER key. The data may not be accepted if not in one of these formats. Please do not alter column headings: these column headings will be used to input patient detail into a database from which MYERS and STAUFFER will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payer (B)	Secondary Payer Plan (C)	Transaction Code (D)	Hospital's Patient ID (E)	Patient Identifier (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Name (I)	Admit Date (J)	Discharge Date (K)	Date of Cash Collections (L)	Amount of Cash Collections (M)	Indicate if Collection is a 0 = Payment (N)	Service Indicator (O) Inpatient / Outpatient	total Hospital Charges for Services Provided (P)	Physician Charges for Services Provided (Q)	total Outpatient Hospital Charges for Services Provided (R)	Insurance Status (S) Insured or Uninsured If Uninsured, provide explanation of status (T)	Calculated Hospital Collections if Uninsured (U) If Uninsured, provide explanation of status (V)
Self Pay Payments	Medicare	Medicaid	500	123.5	3333333	2/7/2025	999-99-999	Cornes, Anthony	7/12/1995	7/11/1995	11/10/2010	\$ 10,000	No	Inpatient	\$ 10,000	\$ 900	\$ 900	Insured	\$ 0.00
Self Pay Payments	Medicare	Medicaid	500	123.5	3333333	2/7/2025	999-99-999	Cornes, Anthony	7/12/1995	7/11/1995	3/1/2010	\$ 10,000	No	Inpatient	\$ 10,000	\$ 900	\$ 900	Insured	\$ 0.00
Self Pay Payments	Medicare	Medicaid	500	123.5	3333333	2/7/2025	999-99-999	Cornes, Anthony	7/12/1995	7/11/1995	5/1/2010	\$ 10,000	No	Inpatient	\$ 10,000	\$ 900	\$ 900	Insured	\$ 0.00
Self Pay Payments	Medicare	Medicaid	150	123.5	9999999	9/25/19	999-99-999	Smith, John	9/21/2000	9/21/2000	10/31/2009	\$ 2,000	No	Outpatient	\$ 2,000	\$ -	\$ -	Insured	\$ 0.00
Self Pay Payments	Blue Cross	Blue Cross	150	123.5	9999999	9/25/19	999-99-999	Smith, John	9/21/2000	9/21/2000	11/30/2009	\$ 2,000	No	Outpatient	\$ 2,000	\$ -	\$ -	Insured	\$ 0.00
Self Pay Payments	Self Pay	Self Pay	500	123.5	5555555	7/9/2000	999-99-999	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	\$ 15,000	No	Inpatient	\$ 15,000	\$ 1,000	\$ 1,000	Insured	\$ 126
Self Pay Payments	United Healthcare	United Healthcare	500	123.5	5555555	2/15/1960	999-99-999	Johnson, Joe	9/1/2005	9/3/2005	11/1/2010	\$ 1,000	No	Inpatient	\$ 1,000	\$ 100	\$ 100	Insured	\$ 0.00

Notes for Completing Exhibit B:

- Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.
- Other Non-Hospital Charges should include RHC, FHC, Pharmacy, etc..
- If Section 1011 Uninsured payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.
- Report services not covered under the patient's insurance package as a "Non-Covered Service". Note: the service must be covered under the state medical plan.
- The total Calculated Hospital Uninsured Collections should tie to the total Inpatient and Outpatient payments reported in Section H, Line 1-3 of the DSH Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel .xls or .xlsx. If this is not possible, the data must be submitted as a CSV .csv file using either the .AB or .pipe symbol above the ENTER key. The data may not be accepted if not in one of these formats. Please do not alter column headings or these column headings will be used to input patient detail into a database from which years and Stauffer will generate reports.

Example of Exhibit C (Other Medicaid Eligible example)

Claim Type A	Primary Payer B	Secondary Payer C	Medicaid Provider ID	Medicaid ID	Patients' Social Security Number	Patients' Birth Date	Patients' Gender	Name	Admit Date	Discharge Date	Service Indicator	Revenue Code	Total Charges for Services	Routine Care P	Payments for Routine Care	Payments for Private Insurance Services	Payments for Private Insurance Services	Sum of All Payments Received on Claim	any coverage other than Medicaid assigned Care
Other Medicaid Eligible	Blue Cross	Medicaid	123.56	123.56	999-99-9999	11/19/90	Male	James, Samuel	9/12/2019	9/12/2019	Inpatient	150	\$ 1,500	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Blue Cross	Medicaid	123.56	123.56	999-99-9999	11/19/90	Male	James, Samuel	9/12/2019	9/12/2019	Inpatient	250	\$ 2,500	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Blue Cross	Medicaid	123.56	123.56	999-99-9999	11/19/90	Male	James, Samuel	9/12/2019	9/12/2019	Inpatient	300	\$ 3,000	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Blue Cross	Medicaid	123.56	123.56	999-99-9999	11/19/90	Male	James, Samuel	9/12/2019	9/12/2019	Inpatient	300	\$ 3,000	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Aetna	Medicaid	123.56	123.56	999-99-9999	7/12/19	Female	Jamison, Sandy	6/30/2010	6/30/2010	Outpatient	250	\$ 2,500	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Cigna	Medicaid	123.56	123.56	999-99-9999	7/12/19	Female	Jamison, Sandy	6/30/2010	6/30/2010	Outpatient	300	\$ 3,000	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Cigna	Medicaid	123.56	123.56	999-99-9999	3/5/2000	Female	Jaffery, Susan	2/2/2010	2/2/2010	Outpatient	300	\$ 3,000	\$	\$	\$	\$	\$	Y
Other Medicaid Eligible	Cigna	Medicaid	123.56	123.56	999-99-9999	3/5/2000	Female	Jaffery, Susan	2/2/2010	2/2/2010	Outpatient	350	\$ 3,500	\$	\$	\$	\$	\$	Y

Notes for Completing Exhibit C:

- All charges for non-hospital services should be excluded.
- A separate Exhibit C file should be submitted for each claim type reported (e.g., Medicaid, Managed Care, Other Medicaid Eligibles, Out of State Medicaid, etc.). The format above should be used for each Exhibit C.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel, .xls or .xlsx. If this is not possible, the data must be submitted as a CSV file using either the .AB or .pipe symbol above the EN, ER, or . The data may not be accepted if not in one of these formats. Please do not alter column headings. These column headings will be used to input patient detail into a database from which .yers and Statdtr will generate reports.

D. General Cost Report Year Information

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.

2/10/2023

DSH Version 11

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

COLLETT REGIONAL MEDICAL CENTER

2. Select Cost Report Year Covered by this Survey Enter "1" through "30"

01/2022 through 03/2022

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

1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database:

01/2023

Hospital Name:

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab)

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab)

8. Medicare Provider Number:

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal)

Data	Correct	If Incorrect, Proper Information
COLLETT REGIONAL MEDICAL CENTER	Yes	
000002021A	Yes	
0	Yes	
0	Yes	
110105	Yes	
Non-State Govt.	Yes	

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

State Name	Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: 01/2022 03/2022

- Section 1011 Payment Related to Hospital Services Included in Exhibits B B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B B-1 (See Note 1)

Out of State DSH Payments (See Note 2)

- Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column N on Exhibit B, less physician and non-hospital portion of payments)
- Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

Inpatient	Outpatient	Total
\$ 10,012	\$ 1,231,06	\$1,611,07
\$ 1,092,50	\$ 1,612,22	\$5,553,22
\$1,502,592	\$5,699,0	\$201,6
229	21,2	22,2

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

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

No

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

1. ☐ LIUR / LIUR ☐ Qualifying Data from the Cost Report ☐ 0/0/2022 ☐ 0/30/2022 ☐

☐ ☐ ☐ Total Hospital Days Used in Medicaid Inpatient Utilization Ratio ☐ LIUR ☐

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 ☐

2,216

See Note in Section 3, below ☐

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

\$ -

3,052,65
5,121,05
\$ 1,3,523

3. Calculation of Net Hospital Revenue from Patient Services Used for LIUR, S, 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. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues / Charges		
	Inpatient	Outpatient	Non
11. Hospital	\$23,532,30.00		
12. Subprovider I Psych or Rehab	\$0.00		
13. Subprovider II Psych or Rehab	\$0.00		
14. Swing Bed - SNF		\$3,12.00	
15. Swing Bed - NF		\$0.00	
16. Skilled Nursing Facility		\$5,91,000	
17. Nursing Facility		\$0.00	
18. Other Long-Term Care		\$0.00	
19. Ancillary Services	\$153,50,929.00	\$335,19,09.00	
20. Outpatient Services		\$2,255,039.00	
21. Home Health Agency		\$0.00	
22. Ambulance		\$,9,391	
23. Outpatient Rehab Providers		\$0.00	
24. ASC	\$0.00		
25. Hospice		\$2,312,02.00	
26. Other	\$9,15,626.00	\$11,26,112.00	\$,020,65.00
27. Total	\$ 1,6,213,35	\$ 3,00,00,030	\$ 20,10,03
28. Total Hospital and Non Hospital	Total from Above \$ 595,201,153		

Contractual Adjustments Formulas below can be overwritten if amounts are known		
Inpatient	Outpatient	Non
\$ 16,13,292		
\$ -		
\$ -		
	26,255	
		202,953
\$ 109,021,001	\$ 23,062,16	
	\$ 30,010,02	
		5,311,951
		1,62,061
		2,55,531
\$ 6,516,63	\$ 11,959	
\$ 132,250,930	\$ 2,6,1,159	\$ 1,2,0,51
Total from Above \$ 122,1,1		

\$ 6,19,53
\$ -
\$ -
\$ 1,1,620,631
\$ 12,25,015
\$ -
\$ -
\$ -
\$ 5,9,0,12
\$ 166,655,325

29. Total Per Cost Report
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLDED on worksheet G-3, Line 2 impact is a decrease in net patient revenue ☐

Total Contractual Adj. G-3 Line 2 ☐

31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLDED on worksheet G-3, Line 2 impact is a decrease in net patient revenue ☐
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLDED on worksheet G-3, Line 2 impact is a decrease in net patient revenue ☐
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLDED on worksheet G-3, Line 2 impact is a decrease in net patient revenue ☐
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLDED on worksheet G-3, Line 2 impact is an increase in net patient revenue ☐
35. Adjusted Contractual Adjustments
36. Unreconciled Difference ☐

1,306,12
\$ 22,1,1
\$ -

Unreconciled Difference Should be \$0 ☐

Cost Report Cost / Days / Charges

Cost Report Year 10/01/2021-09/30/2022

COLLETT REGIONAL MEDICAL CENTER

Line	Cost Center Description	Total Allowable Cost		Intern Resident Costs Removed on Cost Report		RCE and Therapy Add Back if Applicable	Swing-Bed Care Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Total Cost		I/P Days and I/P Ancillary Charges		I/P Routine Charges and O/P Ancillary Charges		Total Charges		Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4						Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others		Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)				Calculated Per Diem

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Routine Cost Centers list below:

1	03000 ADULTS PEDIATRICS	\$ 29,000.05	\$ 5,235.5	\$ 93,100.00	\$ 30,362.030	\$ 10,000.00	\$ 5,500.51	\$ 25,610.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00
2	03100 INTENSIVE CARE UNIT	\$ 5,055.00	\$ 93,100.00	\$ 30,362.030	\$ 10,000.00	\$ 5,500.51	\$ 25,610.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00
3	03200 CORONARY CARE UNIT																
4	03300 BURN INTENSIVE CARE UNIT																
5	03400 SURGICAL INTENSIVE CARE UNIT																
6	03500 OTHER SPECIAL CARE UNIT																
7	04000 SUBPROSIDER I																
8	04100 SUBPROSIDER II																
9	04200 OTHER SUBPROSIDER																
10	04300 NURSERY	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511	\$ 1,020.511
11																	
12																	
13																	
14																	
15																	
16																	
17																	
18																	
19	Total Routine Weighted Average	\$ 36,300.000	\$ 61,532.00	\$ 10,000.00	\$ 36,930.122	\$ 10,000.00	\$ 5,500.51	\$ 25,610.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00	\$ 1,000.00

Observation Data Non-Distinct

20	09200 Observation Non-Distinct																

Ancillary Cost Centers from I/S C excluding Observation list below:

21	5000 OPERATING ROOM	\$ 665,291.00	\$ 291,100.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00	\$ 916,220.00
22	5100 RECOVERY ROOM																
23	5200 DELIVERY ROOM LABOR ROOM	\$ 1,112,119.00	\$ 209,600.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00	\$ 3,330,000.00
24	5300 ANESTHESIOLOGY																
25	5400 RADIOLOGY/DIAGNOSTIC	\$ 1,050,516.00	\$ 1,530.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00	\$ 1,050,516.00
26	5500 CLEAR MEDICINE/DIAG	\$ 91,201.00	\$ 1,530.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00	\$ 91,201.00
27	5600 CT SCAN	\$ 1,163,105.00	\$ 1,530.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00	\$ 1,163,105.00
28	6000 LABORATORY	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00	\$ 1,000.560.00
29	6500 RESPIRATORY THERAPY	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00	\$ 2,061,000.00
30	6600 PHYSICAL THERAPY	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00	\$ 1,500,333.00

1. Cost Report Cost / Days / Charges

Cost Report Year 10/01/2021-09/30/2022 COL ITT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Intern Resident		RCE and Therapy Add Back if Applicable	IP Routine		Total Charges	Medical Per Diem / Cost or Other Ratios
		Total Allowable Cost	Costs Removed on Cost Report		IP Days and IP Ancillary Charges	Charges and OIP Ancillary Charges		
31	6900 ELECTROCARDIOLOGY	\$3,126,601.00	\$ -	-	\$12,115,311.00	\$21,916,106.00	\$1,161,120	0.02052
32	100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$19,623,512.00	\$ -	-	\$16,119,661.00	\$13,391,160.00	\$30,211,121	0.61916
33	200 IMPL. DE. CHARGED TO PATIENTS	\$28,503.00	\$ -	-	\$2,121,119.00	\$9,206,116.00	\$13,111,995	0.199616
34	300 DRUGS CHARGED TO PATIENTS	\$12,111,013.00	\$ -	-	\$29,191,019.00	\$39,110,626.00	\$69,311,615	0.111151
35	000 RENAL DIALYSIS	\$5,621,121.00	\$16,519	-	\$3,091,211.00	\$11,615,531.00	\$9,111,113	0.061111
36	9000 CLINIC	\$1,116,602.00	\$116,353	-	\$16,361.00	\$9,121,155.00	\$9,111,523	0.20916
37	9100 EMERGENCY	\$1,102,011.00	\$163,059	-	\$15,591.00	\$11,192,261.00	\$26,031,252	0.302060
38		\$ -	\$ -	-	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
49		\$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	\$ -	-
54		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
58		\$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	\$ -	-
64		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	-	\$0.00	\$0.00	\$ -	-

1. Cost Report Cost / Days / Charges

Cost Report Year 10/01/2021-09/30/2022 COL ITT REGIONAL MEDICAL CENTER

Line	Cost Center Description	Total Allowable Cost	Intern Resident Costs Removed on Cost Report	RCE and Therapy Acid Bac If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
92		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
93		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
94		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
95		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
96		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
97		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
98		\$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	\$	-
104		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
105		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
106		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
107		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
108		\$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	\$	-
114		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
115		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
116		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
117		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
118		\$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	\$	-
124		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
125		\$0.00	\$	-	\$	\$0.00	\$0.00	\$	-
126	Total Ancillary	\$	91,992.29	\$	9,350	\$	161,663.220	\$	366,612.112
127	Weighted Average								0.19556

128	Sub Totals	\$	121,362.29	\$	1,653,119	\$	1,650,002	\$	366,612.112	\$	553,110.112
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)										
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)										
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)										
131.01	Other Cost Adjustments (support must be submitted)										
132	Grand Total	\$	129,161.12								
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost										

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 ☐ Medicaid and All Uninsured Inpatient and Outpatient ☐ Hospital Data:

Cost Report Year 10/01/2021-09/30/2022

[illegible]

Cost Report Year 10/01/2021-09/30/2022

61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 10

Cost Report Year 10/01/2021-09/30/2022

Total Days per PS ☐ or Exhibit Detail ☐reconciled Days ☐Explain ☐ariance ☐

I. Out of State Medicaid Data:

Cost Report Year: 1001/2021-09/30/2022 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	-							\$ -	\$ -
54	-							\$ -	\$ -
55	-							\$ -	\$ -
56	-							\$ -	\$ -
57	-							\$ -	\$ -
58	-							\$ -	\$ -
59	-							\$ -	\$ -
60	-							\$ -	\$ -
61	-							\$ -	\$ -
62	-							\$ -	\$ -
63	-							\$ -	\$ -
64	-							\$ -	\$ -
65	-							\$ -	\$ -
66	-							\$ -	\$ -
67	-							\$ -	\$ -
68	-							\$ -	\$ -
69	-							\$ -	\$ -
70	-							\$ -	\$ -
71	-							\$ -	\$ -
72	-							\$ -	\$ -
73	-							\$ -	\$ -
74	-							\$ -	\$ -
75	-							\$ -	\$ -
76	-							\$ -	\$ -
77	-							\$ -	\$ -
78	-							\$ -	\$ -
79	-							\$ -	\$ -
80	-							\$ -	\$ -
91	-							\$ -	\$ -
92	-							\$ -	\$ -
93	-							\$ -	\$ -
94	-							\$ -	\$ -
95	-							\$ -	\$ -
96	-							\$ -	\$ -
97	-							\$ -	\$ -
98	-							\$ -	\$ -
99	-							\$ -	\$ -
100	-							\$ -	\$ -
101	-							\$ -	\$ -
102	-							\$ -	\$ -
103	-							\$ -	\$ -
104	-							\$ -	\$ -
105	-							\$ -	\$ -
106	-							\$ -	\$ -
107	-							\$ -	\$ -
108	-							\$ -	\$ -
109	-							\$ -	\$ -
110	-							\$ -	\$ -
111	-							\$ -	\$ -

I. Out of State ☐ Medicaid Data:

Cost Report Year 10/01/2021-09/30/2022 COLCUTT REGIONAL MEDICAL CENTER

112		
113		
114		
115		
116		
117		
118		
119		
120		
121		
122		
123		
124		
125		
126		
127		

[illegible]**Totals / Payments**[illegible]

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 PSQR 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 summary). These amounts are assigned to your inpatient and outpatient insurance plans (including Medicare) and managed care contracts. For more information, see the Medicaid program manual.

Note C - Other Medicaid Payments such as Quilters 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, graduate medical education payments, payments for Medicare cost report settlement, etc.).

Note E - Medicaid managed care payments are included in the point estimate of the Medicaid cost report. Managed care payments are reported separately in the Medicaid cost report.

Note 2 – **Intentional marriage** Carc payments should include an individual marriage car payment, but not interest, depreciation and sub-depreciation payments.

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☐ Transplant facilities only: Organ Acquisition Cost In State ☐ Medicaid and Uninsured

Cost Report Year 10/01/2021-09/30/2022 COLCUTT REGIONAL MEDICAL CENTER

Organ Acquisition Cost Centers - list below :													
Organ Acquisition	Total Organ Acquisition Cost	Additional Add In Intero/Resident Cost	Total Add Used Organ Acquisition Cost	Revenue for Medicaid Cross-Over / Uninsured Organs Sold	Total Usable Organs Count	In-State Medicaid FFS Primary		In-State Medicare FFS Cross-Overs with Medicaid Secondary		In-State Other Medicaid Eligibles - Not Included Elsewhere		Uninsured	
						Charges	Usable Organs Count	Charges	Usable Organs Count	Charges	Usable Organs Count	Charges	Usable Organs Count
Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 X Total Cost Acquisition Cost	Sum of Cost Report on Section G, Line 133 X Total Cost Acquisition Cost and the Add-On Cost	Cost Report Worksheet D-4, Pt. II, Line 62	Similar to Instructions from Cost Report W/S D-4 Pt. II, Col. 1, Ln 66 (Substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. II, Line 62	From Paid Claims Data of Provider Logs (Note A)	From Paid Claims Data of Provider Logs (Note A)	From Paid Claims Data of Provider Logs (Note A)	From Paid Claims Data of Provider Logs (Note A)	From Paid Claims Data of Provider Logs (Note A)	From Hospital's Own Internal Analysis		
Lung Acquisition	\$0.00	\$ -	\$ -		0								
Trachea Acquisition	\$0.00	\$ -	\$ -		0								
Liver Acquisition	\$0.00	\$ -	\$ -		0								
Heart Acquisition	\$0.00	\$ -	\$ -		0								
Pancreas Acquisition	\$0.00	\$ -	\$ -		0								
Intestinal Acquisition	\$0.00	\$ -	\$ -		0								
Islet Acquisition	\$0.00	\$ -	\$ -		0								
Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
Total Cost													

☐ total Cost

Note A ☐ these amounts must agree to your inpatient and outpatient ☐ edicaid paid claims summary, if available. If not, use hospital's logs and submit with survey.

Note B: Enter Organ Acquisition Payments in Section 8 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.

☐. ☐transplant ☐activities Only: Organ Acquisition Cost Out of State ☐ Medicaid

Cost Report Year	10/01/2021-09/30/2022	COLCUTT REGIONAL MEDICAL CENTER

Total Organ Acquisition Cost		Additional Add In Interim/Pre-empt Cost		Revenue for Medicaid/ Cross-Over/ Uninsured Organs Sold		Total Usable Organs Count		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over with Medicaid Secondary		Out-of-State Other Medicaid Eligibles Not Included Elsewhere	
Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 133 x Total Cost Report Organ Acquisition Cost	Sum of Organ Acquisition On Cost and Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	66 substitute Medicaid/ Cross-Over & uninsured. See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From 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)
Lung Acquisition	\$ -	\$ -	\$ -	\$ 0											
Other Acquisition	\$ -	\$ -	\$ -	\$ 0											
Liver Acquisition	\$ -	\$ -	\$ -	\$ 0											
Heart Acquisition	\$ -	\$ -	\$ -	\$ 0											
Pancreas Acquisition	\$ -	\$ -	\$ -	\$ 0											
Intestinal Acquisition	\$ -	\$ -	\$ -	\$ 0											
Kidney Acquisition	\$ -	\$ -	\$ -	\$ 0											
Islet Acquisition	\$ -	\$ -	\$ -	\$ 0											
TOTALS	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Cost															
Note A: These amounts must be reported to your implant and equipment utilization paid claims summary, if available, if not, use hospital's logs and submit with survey.															
Note B: Enter Organ Acquisition Payments in Section A as part of your Out-of-State Medicaid total payments.															

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: 10/01/2021-09/30/2022 COLLETT REGIONAL MEDICAL CENTER

or sheet A Provider Tax Assessment Reconciliation:

- 1 Hospital Gross Provider Tax Assessment from general ledger
- 1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment
- 2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report W/S A, Col. 2
- 3 Difference Explain Here

Provider Tax Assessment Reclassifications from w/s A of the Medicare cost report

- Reclassification Code
- 5 Reclassification Code
- 6 Reclassification Code
- Reclassification Code

DS UCC ALLOABLE Provider Tax Assessment Adjustments from w/s A of the Medicare cost report

- Reason for adjustment
- 9 Reason for adjustment
- 10 Reason for adjustment
- 11 Reason for adjustment

DS UCC NON ALLOABLE Provider Tax Assessment Adjustments from w/s A of the Medicare cost report

- Reason for adjustment
- 13 Reason for adjustment
- 1 Reason for adjustment
- 15 Reason for adjustment

16 Total Net Provider Tax Assessment Expense Included in the Cost Report

DS UCC Provider Tax Assessment Adjustment:

1 Gross Allowable Assessment Not Included in the Cost Report

Apportionment of Provider Tax Assessment Adjustment to Medicaid Uninsured:

- Medicaid Hospital Charges Sec.
- 19 Uninsured Hospital Charges Sec.
- 20 Total Hospital Charges Sec.
- Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid
- 21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid
- 22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured
- 23 Medicaid Provider Tax Assessment Adjustment to DSH
- 2 Uninsured Provider Tax Assessment Adjustment to DSH
- 25 Provider Tax Assessment Adjustment to DSH

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

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

Dollar Amount	/ S A Cost Center Line
\$ 1,600.00	
Expense	10..350.6..33 (WTB Account #)
\$ 1,600.00	(Where is the cost included on w/s A?)

	(Reclassified to / (from))
	(Reclassified to / (from))
	(Reclassified to / (from))

	(Adjusted to / (from))
	(Adjusted to / (from))
	(Adjusted to / (from))

\$ -

\$ 1,600.00

1..33..19
3..565.0..
553.10..
2..0..
6.9..
\$..35..69
\$ 112.15
4..2



Origination: 11/2003
Last Approved: 02/2019
Last Revised: 02/2019
Next Review: 02/2021
Owner: Samantha Allen: Director of
Patient Financial Services
Policy Area: PFS
References:

Accounts Receivable Discounts, 340.07

ELIGIBILITY:

- A. RFT AND RPT medical center employees and their dependents after three (3) months of continuous employment.
- B. Hospital Authority Members and their dependents.
- C. Medical Staff Member and their dependents.
- D. Retired Medical Staff Members and their dependents.
- E. Employees of Colquitt Regional owned physician clinics.
- F. Prompt payment discounts to payers and patients not to exceed the current discount provided to the hospital managed care contracts. Payment should be made to the hospital within ten (10) days of the discount contract.
- G. Hospital Administration reserves the right to offer a special, one time, or promotional discount to the patient population of Colquitt Regional Medical Center.
- H. Discounts for extenuating circumstances may be approved by the Director of Patient Financial Services, AVP of Revenue Cycle, Vice President of Finance or Hospital Administration.

APPLICATION:

- A. Medical Center Employees and their dependents, Hospital Authority Members and their dependents, Medical Staff Members and their dependents and Retired Medical Staff and their dependents are eligible for a 50% discount of their patient responsibility if paid in full or processed through payroll deduction. The discount is calculated on patient responsibility after third party payment or total charges of self pay balances.
- B. Discounts do not apply to any AMBULANCE SERVICE ACCOUNTS OR PRIVATE DUTY SERVICES.
- C. Prompt pay discounts can be offered up to the discounted amount of Preferred Provider Contracts without director approval. The current discount is 10 percent.
- D. Any other discount requires prior approval from the PFS Director, AVP Revenue Cycle or Vice President of Finance.

Attachments:

No Attachments

Approval Signatures

Approver	Date
Shamb Purohit: CFO	02/2019
Samantha Allen: Director of Patient Financial Services	02/2019

COPY



Origination 11/2003
Last 07/2023
Approved
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
		



Origination: 01/2007
Last Approved: 09/2019
Last Revised: 11/2017
Next Review: 09/2021
Owner: Samantha Allen: Director of
Patient Financial Services
Policy Area: PFS
References:

Collection/Bad Debt Policy, 340.23

PURPOSE:

To collect any outstanding patient liability due Colquitt Regional Medical Center through the use of an Extended Business Office "Early Out" efforts and/or Bad Debt Collection Agencies.

PROCEDURE:

- A. Colquitt Regional Medical Center sends bills for all services after Final Bill status has been established in Meditech Accounts Receivables. The bills are either submitted to a third party payer for services or to the Extended Business Office. A summary bill of all inpatient accounts are sent to patients for information only.
- B. The Extended Business Office receives all accounts that are due from the patient. This liability can either be "True Self Pay"-no third party coverage or "Balance After Insurance"-patient liability after third party payment.
- C. The Extended Business Office will actively attempt to collection through the use of statements and phone calls. A total of three statements will be mailed given a payment plan in not set up. In addition to statements, three phone calls will go out to client. All collections efforts will continue for 120 days from date of placement.
- D. For accounts that are not resolved, paid in full, or on an active payment plan are returned to the facility for Bad Debt Collection efforts.
- E. Our Bad Debt Collection agencies will attempt to collect owed debt for 365 days from placement through the use of letters, statements, phone calls, and legal actions unless certain circumstances warrant an earlier close such as patient is confirmed deceased, patient files bankruptcy, balance is less than \$15.00, patient moves to no collect state, client request close, and agency attorney advises to close account.
- F. If after 365 days of placement with our Bad Debt Agencies, the accounts that are still unresolved are deemed uncollectible and returned to the facility. These accounts are adjusted to a zero balance and written off as Bad Debt uncollectible.
- G. Medicare accounts that are deemed uncollectible are reviewed for possible submission on the Medicare Cost Report Medicare Bad Debt Log. To be included on the report, the amount deemed uncollectible must be a covered service by CMS guidelines which include the patient's deductibles and coinsurance.
- H. Once deemed allowable for the Medicare Bad Debt Log, the following information is obtained and logged:
Patient Name

HIC Number
Date of Service
Whether patient has been deemed Indigent
Date of First Bill
Date of Bad Debt Write Off
Remittance Date
Deductible and/or Coinsurance Amounts
Total Recoveries.

Attachments

No Attachments

Approval Signatures

Approver	Date
Shamb Purohit: CFO	09/2019
Samantha Allen: Director of Patient Financial Services	09/2019

COPY

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:

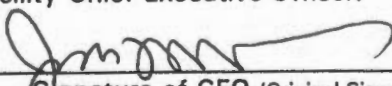
Julie Bhavnani

Colquitt Regional Medical Center

P.O Box 40, Moultrie, GA

For the Period October 1, 2022 through September 30 2023 (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, GA 31768
4. County in which Facility or Hospital is located: Colquitt County
5. Governing Body (or Bodies) of Hospital Authority's Participating Units: _____
6. Person Authorized to respond to inquiries about this report:
 - a. Name: Julie Bhavnani
 - b. Title: CFO
 - c. Phone Number: (229) 1891-9244
7. Report data for the full preceding 12-month period, either calendar or 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 10/1/2022 Ending Date 9/30/2023
 - b. Was the hospital operational for the entire year? ☒ 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: 7/17/24
James L. Matney- President & CEO
(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: Julie Bhavnani
Colquitt Regional Medical Center
P. o Box 40, Moultrie GA

For the Period October 1st, 2022 through September 30th, 2023.

PART A. GENERAL INFORMATION

1. Name of Hospital Authority or Nonprofit: Hospital Authority of Colquitt County
2. Street Address: 3131 South Main Street, Moultrie GA 31768
3. Mailing Address (if different from Street Address): _____
4. County in which Hospital is located: Colquitt
5. Governing Body (or Bodies) of Hospital Authority's Participating Units: _____
6. Person Authorized to respond to inquiries about this report:
 - a. Name: Julie Bhavnani
 - b. Title: CFO
 - 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)

<u>Name of Hospital Authority Member (or Family Member)</u>	<u>Name of Entity</u>	<u>Type of Ownership Interest</u>	<u>Percentage Ownership Interest</u>	<u>Nature of Business Transaction</u>
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.

<u>Name of Nonprofit Board Member (or Family Member)</u>	<u>Name of Entity</u>	<u>Type of Ownership Interest</u>	<u>Percentage Ownership Interest</u>	<u>Nature of Business Transaction</u>
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.

Julie
Signature

7/17/24
Date

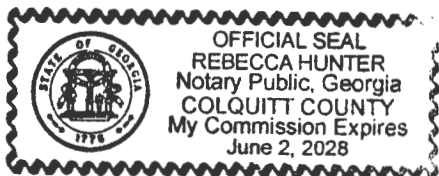
Julie Bhavnani
Name (please print or type)

CFO
Title

Sworn to and subscribed before me this 17 day of July, 2024.

Rebecca Hunter
Notary Public

My Commission expires: June 2, 2028
[Notarial Seal]



HOSPITAL AUTHORITY OF COULQUITT COUNTY
INDIGENT/CHARITY CARE WRITE-OFFS
FISCAL YEAR ENDED SEPTEMBER 2023

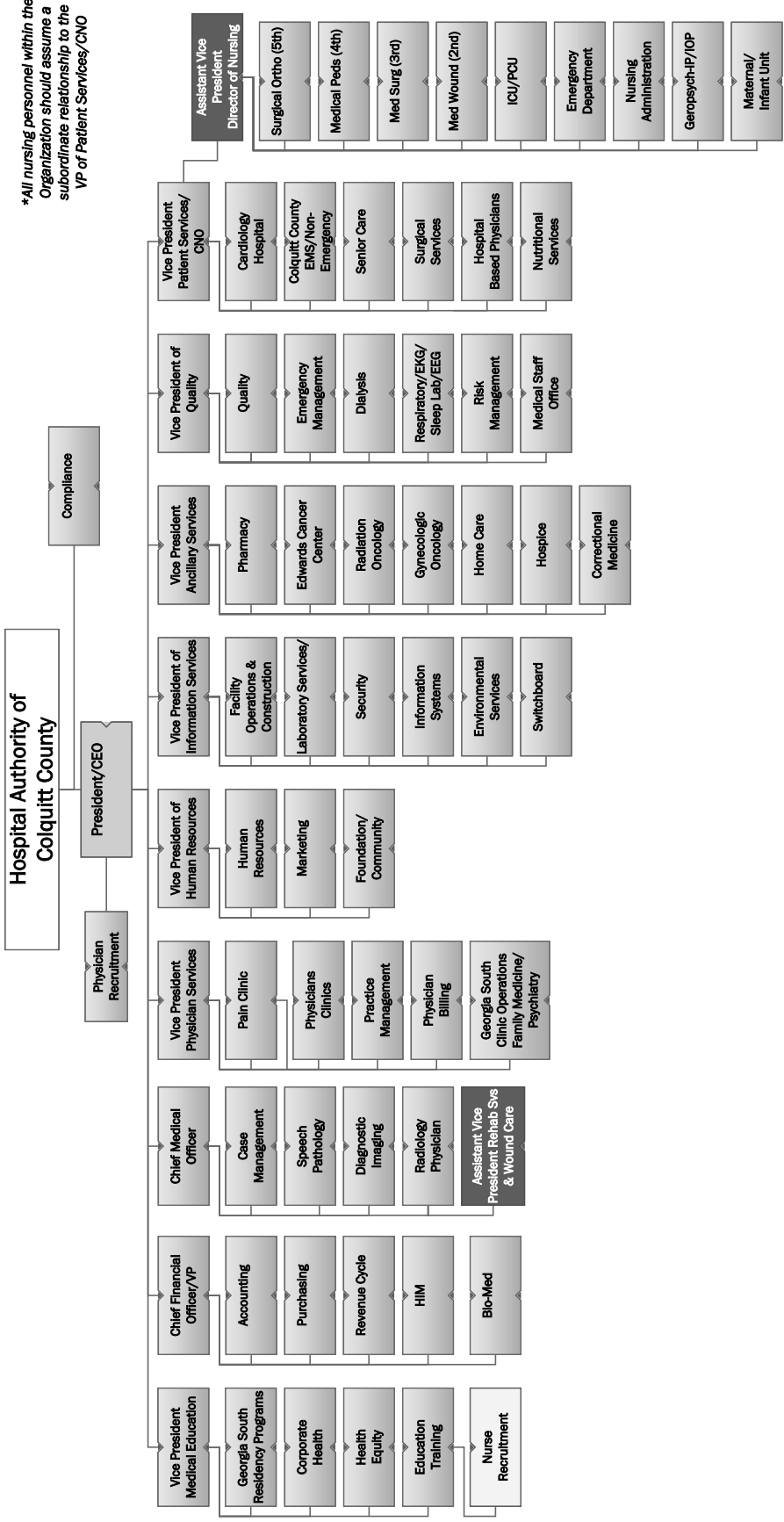
County	Inpatient			
	Indigent		Charity	
	# Patients	Adjustments	# Patients	Adjustments
	0	-	0	-
Ada	1	1,750	0	-
Ben Hill	0	-	1	545.16
Brooks	16	189,210	1	569.50
Colquitt	232	1,534,591	66	148,265.44
Cook	3	2,917	0	-
Lowndes	1	1,580	0	-
Macon	1	4,950	0	-
Mitchell	6	6,525	0	-
Out of State	1	1,480	2	1,556.15
Thomas	10	107,676	2	6,015.81
Tift	1	1,125	0	-
Worth	4	14,084	0	-
Sub-total	276	1,865,888	72	156,952.06

County	Outpatient			
	Indigent		Charity	
	# Patients	Adjustments	# Patients	Adjustments
Ada	1	90	-	-
Ben Hill	4	1,516	4	665
Berrien	6	11,179	0	0
Brooks	113	93,256	24	3,505
Coffee	3	799	0	-
Colquitt	2921	2,689,338	1079	386,481
Cook	53	29,337	15	41,618
Dougherty	6	2,069	3	1,323
Houston	0	-	16	441
Lowndes	42	13,636	9	37,450
Mitchell	98	28,387	61	57,088
Out of State	42	93,299	35	16,939
Sumter	0	-	3	639
Thomas	136	130,232	22	7,810
Tift	104	125,700	25	6,375
Turner	1	3,817	0	-
Wilcox	11	8,398		
Worth	10	22,927		
Sub-total	3,557	3,253,978	1,296	560,332

Grand Total	3,833	5,119,866	1,368	717,284

Total write offs: 5,837,151

Colquitt Regional Medical Center Organizational Chart



HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

YEAR 2023

List of Hospital Joint Ventures and Ownership Interest

Entity Name	Domicile	Nature of Ownership or Interest	Book Value of Ownership or Interest	Notes
Not Applicable				

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

Fiscal Year Ending: September 30th 2023

List of Hospital Indebtedness- (HB 321)

Lender Name	Origination Date	Due Date	Outstanding Balance	In Default ?		In Forbearance?	
				Yes	No	Yes	No
Ameris Bank- Revenue Certificate 2016A	9/1/2016	9/5/2031	6,295,453.83		x		x
Ameris Bank- Revenue Certificate 2016B	9/1/2016	9/5/2026	13,275,776.33		x		x
Ameris Bank- Revenue Certificate 2020A	10/1/2020	12/5/1940	14,000,000.00		x		x
Ameris Bank- Revenue Certificate 2020B	12/15/2021	12/5/2040	15,547,480.75		X		X
N/P Senior Care	2/28/2022	3/5/2029	5,216,450.25		x		x
Mako Robot	9/1/2021	9/1/2028	643,778.74		x		x
South west GA Bank	5/26/2019	4/26/2024	219,804.49		x		x

HOSPITAL AUTHORITY OF COLQUITT COUNTY- DBA COLQUITT REGIONAL MEDICAL CENTER

Real Property Holdings Owned by the Hospital

Location	Parcel ID Number	Estimated Size (Acres)	Purchase Price	Current Healthcare Purpose ?		Improvements		Notes
				Yes	No	Yes	No	
3026 South Main Street, Moultrie, GA	C039D080	1	95,000.00					LAND ACROSS FROM THE STREET
Peachtree Court, S Main, Moultrie, GA	C039C010	1.16	15,000.00					LAND ACROSS FROM THE STREET
912, 2nd Street SE, Moultrie, GA	M026101	0.34	149,246.76	x			x	Deboach
209 13th Ave. SW Moultrie, GA	M027013	1 lot	75,000.00				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	land next to Primary Care
Unit 11 Hospital Park, Moultrie, GA	M042023	0.13	35,000.00				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				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				Lab Building
13 Hospital Park, Moultrie GA	M042035	0.12	227,500.00	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	cordista 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 2023

	Unrestricted Net Assets (\$)	Restricted- Expendable Net Assets (\$)*	Restricted-Non- Expendable Net Assets (\$)*	Total Net Assets (\$)	Notes
Hospital Authority (Hospital, CRH & Clinics)	120,456,000	3,620,000	71,739,000	195,815,000	
Hospital Owned or Controlled Foundation	9,330,507.00	1,643,259.00	-	10,973,766.00	

Colquitt Regional Medical Center

Moultrie, GA

has been Accredited by



The Joint Commission

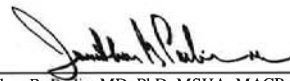
Which has surveyed this organization and found it to meet the requirements for the
Hospital Accreditation Program

January 27, 2024

Accreditation is customarily valid for up to 36 months.


Jane Englebright, PhD, RN, CENP, FAAN
Chair, Board of Commissioners

ID #6714
Print/Reprint Date: 03/28/2024


Jonathan B. Berlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer

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.

