State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2023	09/30/2024
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000002021A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110105

B. DSH Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/25 - 06/30/26)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1939

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** — $ 4,573,984
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026** — $ 17,822,846
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2025 - 06/30/2026** — $ 22,396,830

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers:

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

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

Julie Bhavnani (Mar 19, 2026 09:35:35 EDT)	CFO	03/19/2026
Hospital CEO or CFO Signature	Title	Date
Julie Bhavnani	229-891-9244	jbhavnani@colquittregional.com
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:		Outside Preparer:	
Name	Julie Bhavnani	Name	Bert Bennett
Title	CFO	Title	Partner
Telephone Number	(229) 891-9244	Firm Name	Draffin & Tucker, LLP
E-Mail Address	jbhavnani@colquittregional.com	Telephone Number	(229) 883-7878
Mailing Street Address	PO Box 40	E-Mail Address	bbennett@draffin-tucker.com
Mailing City, State, Zip	Moultrie, GA 31776		

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D. General Cost Report Year Information 10/1/2023 - 9/30/2024

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

1. Select Your Facility from the Drop-Down Menu Provided:	COLQUITT REGIONAL MEDICAL CENTER		
2. Select Cost Report Year Covered by this Survey (enter "X"):	10/1/2023 through 9/30/2024: X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/4/2025		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	COLQUITT REGIONAL MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000002021A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110105	Yes	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	Yes	
11. Rural Referral Center (Yes or No)	Yes	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.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2023 - 09/30/2024)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 189,194	$ 1,625,791	$1,814,985
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 614,140	$ 4,848,910	$5,463,050
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B less physician and non-hospital portion of payments)	$803,334	$6,474,701	$7,278,035
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	23.55%	25.11%	24.94%

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

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ 17,822,846	*<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.*
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services		
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$17,822,846	

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2023 - 09/30/2024)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	30,487 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	3,131,665
8.	Outpatient Hospital Charity Care Charges	5,225,222
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 8,356,887

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$36,274,169.00			$ 25,085,846	$ -	$ -	$ 11,188,323
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$456,099.00			$ 315,421	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$5,566,914.00			$ 3,849,868	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$172,860,794.00	$373,874,179.00		$ 119,543,999	$ 258,557,266	$ -	$ 168,633,708
20.	Outpatient Services		$59,758,789.00			$ 41,326,922	$ -	$ 18,431,867
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 8,594,851	-	-	$ 5,943,874	$ -
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$2,273,908.00			$ 1,572,549	
26.	Other	$13,802,804.00	$0.00	$56,213,154.00	$ 9,545,498	$ -	$ 38,874,895	$ 4,257,306
27.	Total	$ 222,937,767	$ 433,632,968	$ 73,104,926	$ 154,175,343	$ 299,884,189	$ 50,556,607	$ 202,511,204
28.	Total Hospital and Non Hospital		Total from Above	$ 729,675,661		Total from Above	$ 504,616,138	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	729,675,661	Total Contractual Adj. (G-3 Line 2)	504,616,138
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36.	Adjusted Contractual Adjustments				504,616,138
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 37,760,453	$ 2,009,171	$ -	$140,335.00	$ 39,629,289	28,280	$31,359,132.00		$ 1,401.32
2	03100 INTENSIVE CARE UNIT	$ 5,501,808	$ 77,276	$ -		$ 5,579,084	2,742	$5,371,138.00		$ 2,034.68
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,129,625	$ -	$ -		$ 1,129,625	1,407	$1,194,323.00		$ 802.86
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 44,391,886	$ 2,086,447	$ -	$ 140,335	$ 46,337,998	32,429	$ 37,924,593		
19	Weighted Average									$ 1,428.91

Line #	Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	1,942	-	-	$ 2,721,363	$871,908.00	$5,038,453.00	$ 5,910,361	0.460439

Line #			*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000	OPERATING ROOM	$12,954,683.00	$ 96,594	$ -	$ 13,051,277	$13,834,854.00	$49,814,840.00	$ 63,649,694	0.205049
22	5100	RECOVERY ROOM	$1,267,923.00	$ -	$ -	$ 1,267,923	$1,084,822.00	$5,030,392.00	$ 6,115,214	0.207339
23	5200	DELIVERY ROOM & LABOR ROOM	$1,640,434.00	$ 135,232	$ -	$ 1,775,666	$1,663,136.00	$684.00	$ 1,663,820	1.067222
24	5300	ANESTHESIOLOGY	$3,256,146.00	$ -	$ -	$ 3,256,146	$2,131,358.00	$6,638,288.00	$ 8,769,646	0.371297
25	5400	RADIOLOGY-DIAGNOSTIC	$10,059,864.00	$ 67,617	$ -	$ 10,127,481	$11,151,148.00	$19,947,216.00	$ 31,098,364	0.325660
26	5401	NUCLEAR MEDICINE-DIAG	$1,110,641.00	$ -	$ -	$ 1,110,641	$1,943,609.00	$9,081,077.00	$ 11,024,686	0.100741
27	5700	CT SCAN	$2,195,729.00	$ -	$ -	$ 2,195,729	$19,940,794.00	$56,292,499.00	$ 76,233,293	0.028803
28	6000	LABORATORY	$7,670,547.00	$ -	$ -	$ 7,670,547	$42,884,500.00	$50,047,698.00	$ 92,932,198	0.082539
29	6500	RESPIRATORY THERAPY	$2,307,723.00	$ -	$ -	$ 2,307,723	$8,891,166.00	$3,739,604.00	$ 12,630,770	0.182706

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
6600	PHYSICAL THERAPY	$5,530,246.00	$ -	$ -	$ 5,530,246	$3,288,650.00	$9,595,092.00	$ 12,883,742	0.429242
6900	ELECTROCARDIOLOGY	$3,631,509.00	$ -	$ -	$ 3,631,509	$12,693,856.00	$29,492,917.00	$ 42,186,773	0.086082
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$24,428,935.00	$ -	$ -	$ 24,428,935	$14,850,753.00	$17,028,702.00	$ 31,879,455	0.766291
7200	IMPL. DEV. CHARGED TO PATIENTS	$4,243,791.00	$ -	$ -	$ 4,243,791	$6,477,922.00	$19,148,876.00	$ 25,626,798	0.165600
7300	DRUGS CHARGED TO PATIENTS	$17,726,158.00	$ -	$ -	$ 17,726,158	$28,765,786.00	$57,533,612.00	$ 86,299,398	0.205403
7400	RENAL DIALYSIS	$5,871,502.00	$ 38,638	$ -	$ 5,910,140	$3,258,440.00	$40,482,682.00	$ 43,741,122	0.135116
9000	CLINIC	$2,266,071.00	$ 135,232	$ -	$ 2,401,303	$41,158.00	$2,387,296.00	$ 2,428,454	0.988820
9001	RESIDENCY CLINIC	$3,359,366.00	$ 270,466	$ -	$ 3,629,832	$0.00	$3,038,347.00	$ 3,038,347	1.194673
9100	EMERGENCY	$8,988,367.00	$ 183,530	$ -	$ 9,171,897	$12,739,537.00	$35,642,090.00	$ 48,381,627	0.189574
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
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		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
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		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
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**	$ 118,509,635	$ 927,309	$ -	$ 119,436,944	$ 186,513,397	$ 419,980,365	$ 606,493,762	
127		**Weighted Average**								0.201417
128		**Sub Totals**	$ 162,901,521	$ 3,013,756	$ -	$ 165,774,942	$ 224,437,990	$ 419,980,365	$ 644,418,355	
129		NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*				$0.00				
130		NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*				$136,453.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*								
131.01		Other Cost Adjustments (support must be submitted)								
132		**Grand Total**				$ 165,638,489				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost				1.85%				

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

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

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicare Secondary)		In-State Other Medicaid Eligibles (not included Elsewhere; i.e. with Medicare Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be included Elsewhere)		Uninsured		Total In-State Medicaid (Days include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (excludes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	02000 ADULTS & PEDIATRICS	$ 1,401.32		2,045		1,393		1,125		2,490		31		1,497		8,291		39.25%
2	03100 INTENSIVE CARE UNIT	$ 2,834.68		469		31		345		893		0		324		1,649		71.99%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 602.86		226		726		5		544		13		22		3,125		62.37%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
	Total Days			2,780		2,155		1,480		3,945		44		1,895		11,065		34.56%
19	Total Days per FS&R or Exhibit Detail			2,780		2,155		1,480		3,945		44		1,895				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
24	Routine Charges			$ 3,471,041		$ 1,777,286		$ 1,824,151		$ 9,247,312		$ 42,921		$ 1,894,956		$ 12,919,448		36.46%
21 BI	Calculated Routine Charge Per Diem			$ 1,155.18		$ 809.85		$ 1,232.55		$ 1,126.81		$ 955.02		$ 1,129.09		$ 1,065.55		
	Ancillary Cost Centers (from WS C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	02000 Observation (Non-Distinct)		0.440439	187,206	177,605	126,511	166,291	42,940	63,952	119,871	442,177	5,042		41,889	343,830	$ 470,484	$ 1,660,227	41.09%
23	5000 OPERATING ROOM		0.205949	772,333	1,460,739	1,345,629	2,360,664	536,233	936,101	3,792,327	3,792,347	28,886	18,558	770,301	1,875,559	$ 4,347,306	$ 9,351,877	45.91%
24	5100 RECOVERY ROOM		0.207338	61,130	167,351	149,085	475,488	26,709	26,331	130,707	333,839	3,265	2,642	67,749	165,253	$ 369,796	$ 963,455	40.63%
25	5200 DELIVERY ROOM & LABOR ROOM		1.061222	258,130		791,304	487	5,162		227,894		3,179	212	22,245		$ 1,286,690	$ 487	75.96%
26	5300 ANESTHESIOLOGY		0.371297	102,931	142,342	122,115	530,518	69,956	89,856	585,559	385,552	2,044	2,294	111,600	294,962	$ 537,699	$ 1,195,630	31.02%
27	5400 RADIOLOGY-DIAGNOSTIC		0.322400	352,601	857,405	340,223	1,541,879	301,601	455,060	825,455	2,477,297	196	4,399	157,801	1,512,471	$ 1,426,457	$ 6,847,511	24.21%
28	5401 NUCLEAR MEDICINE (Dx)		0.160321	316,562	491,777	41,957	430,001	25,181	110,118	226,802	769,801		17,662	126,343	264,669	$ 709,045	$ 1,961,408	28.93%
29	5700 CT SCAN		0.628883	3,327,516	1,831,258	512,769	4,418,715	761,503	984,744	2,496,945	4,963,965	11,879	87,657	1,491,111	1,951,412	$ 5,099,195	$ 12,392,682	35.55%
30	4000 LABORATORY		0.683539	3,495,342	2,282,923	1,954,631	5,769,305	1,961,377	921,012	6,175,193	4,958,150	44,127	93,299	2,916,711	6,213,395	$ 12,166,231	$ 19,942,045	39.84%
31	4500 RESPIRATORY THERAPY		0.182706	356,213	155,847	129,973	325,272	361,357	73,805	1,017,694	560,806	5,684	2,910	289,212	321,954	$ 2,948,267	$ 1,113,230	30.95%
32	4600 PHYSICAL THERAPY		0.429745	149,836	141,115	66,835	2,600,129	179,150	111,825	369,977	789,260	11,910	11,595	84,958	162,209	$ 782,663	$ 3,904,361	31.36%
33	4900 ELECTROCARDIOLOGY		0.666963	856,164	434,717	153,930	818,135	437,435	796,264	1,436,839	3,534,993	2,810	80,245	790,812	1,157,257	$ 3,196,938	$ 5,574,243	24.42%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.760291	1,119,290	424,557	659,435	1,087,410	727,999	209,004	2,508,781	1,247,392	13,695	7,042	692,563	561,384	$ 4,920,455	$ 2,801,414	29.13%
35	7200 MPL. DEV. CHARGED TO PATIENTS		0.145680	461,837		46,961	283,589	105,604	325,270	814,463	1,733,665	5,174		77,431	246,469	$ 1,507,965	$ 2,588,647	36.38%
36	7300 DRUGS CHARGED TO PATIENTS		0.205483	2,545,910	2,453,980	1,437,153	3,426,249	1,503,867	2,442,316	5,306,390	3,646,369	35,157	51,379	2,160,244	4,155,123	$ 10,670,328	$ 17,175,557	40.66%
37	7400 RENAL DIALYSIS		0.135116	261,249		9,428		286,560		969,970		230		24,872		$ 1,547,507	$ -	5.19%
38	9000 CLINIC		0.160339	378	268,532	1,078	95,978	10,595	82,348	30,750	437,291	230	5,515	4,269	401,731	$ 42,499	$ 1,196,195	85.49%
39	9001 RESIDENCY CLINIC		1.192473													$ -	$ -	0.00%
40	9100 EMERGENCY		0.189928	669,892	1,408,566	265,018	5,914,439	508,192	934,125	1,355,029	5,229,806	9,410	29,248	648,931	5,823,881	$ 2,831,851	$ 19,560,265	36.27%
41			-													$ -	$ -	
42			-													$ -	$ -	
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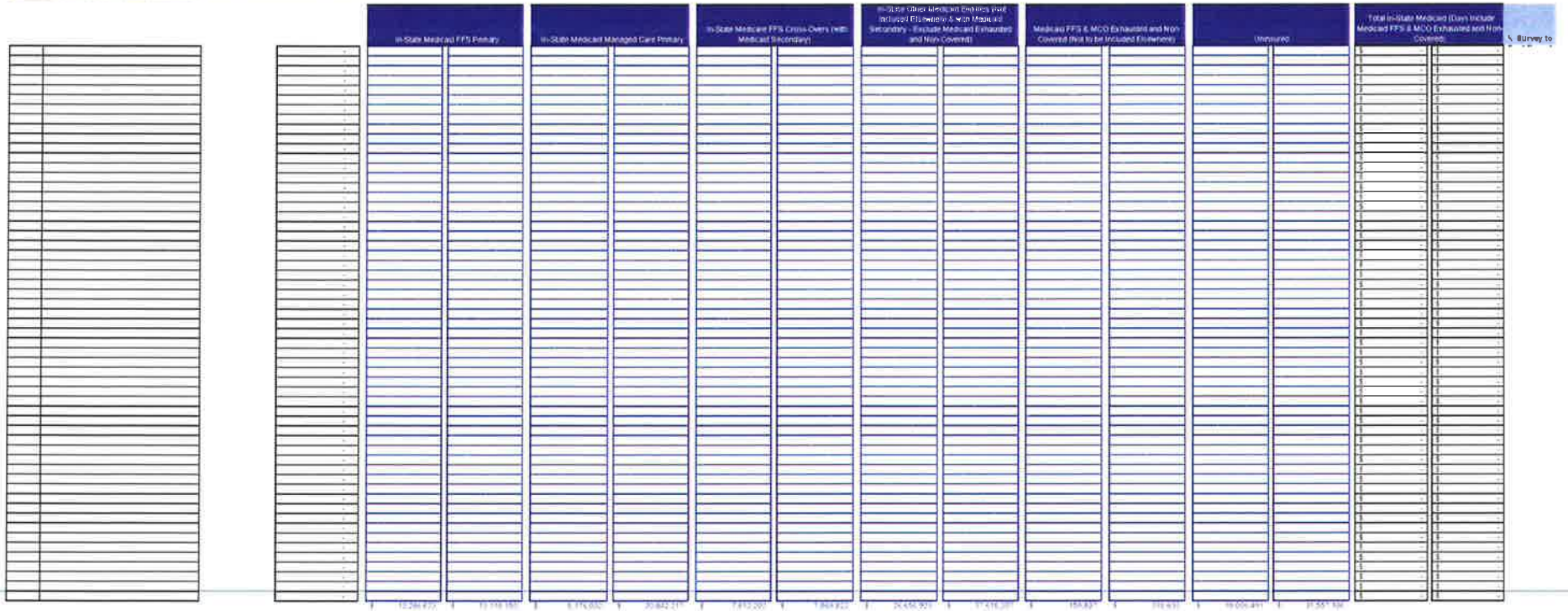
70			-													$ -	$ -	

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

Cost Report Year (10/1/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER



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

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare (FFS Cross-Overs with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicare Secondary - Exclude Medicaid Exhausted and Non-Covered)	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	Survey to
	Totals / Payments								
128	**Total Charges** ***(Includes organ acquisition from Section J)***	$ 16,457,914	$ 13,110,150 / $ 9,953,770 / $ 30,842,217	$ 9,636,353 / $ 7,869,822	$ 31,900,036 / $ 37,618,207	$ 201,858	$ 370,633	$ 67,948,273	$ 89,446,396
129	Total Charges per PS&P or Exhibit Detail	$ 16,457,914	$ 13,110,150 / $ 9,953,770 / $ 30,842,217	$ 9,636,353 / $ 7,869,822	$ 31,900,036 / $ 37,618,207	$ 201,858	$ 370,633		
130	Unreconciled Charges (Explain Variance)	-	- / - / -	- / -	- / -	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 6,806,213	$ 2,625,431 / $ 5,157,568 / $ 6,154,637	$ 3,924,877 / $ 1,490,606	$ 12,253,915 / $ 7,467,496	$ 90,042	$ 57,172	$ 28,442,577	$ 17,736,170
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,820,917	$ 2,425,444 / $ - / $ 5,152,538	$ 459,264 / $ 151,987 / $ 39 / $ 93	$ 239,439 / $ 181,789 / $ 1,625,284 / $ 1,881	$ 589,023 / $ 186,800 / $ 2,644,053 / $ 6,449	[redacted]	$ 4,544,231 / $ 3,371,550 / $ 1,991,835 / $ 2,221	$ 3,412,516 / $ 5,326,196 / $ 2,849,897 / $ 15,823
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	-	- / - / - / -	-	-	-	$ 181	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ 44,579	$ 9,824 / $ 3,265,761 / $ 5,152,538	$ 2,357,125 / $ 1,652,941	$ 183,939 / $ 1,867,247	$ 204,365 / $ 4,436,861	[redacted]	$ 2,441,823 / $ 7,078,241 / $ 169,392 / $ 21,537	$ 1,847,806 / $ 6,621,108 / $ 88,333 / $ 12,870,408
135	Self-Pay (including Co-Pay and Spend-Down)	265	3,925 / 304 / 9,448	11,614 / 42,737 / 89,333 / 891,867	- / - / - / (530,355)	- / - / - / (2,442,814)	[redacted]	-	-
136	Total Allowed Amount from Medicaid PS&P or RA Detail (All Payments)	$ 3,865,761	$ 2,439,193 / $ 3,269,065 / $ 5,161,986	$ 2,827,998 / $ 1,737,665 / $ 189,372 / $ 893,960	$ 423,378 / $ 2,049,036 / $ 1,625,284 / $ 1,881	$ 793,388 / $ 4,623,661 / $ - / $ (2,436,365)	[redacted]	$ 6,986,054 / $ 10,449,791 / $ 2,161,227 / $ 2,243	$ 5,260,322 / $ 11,947,304 / $ 2,938,230 / $ 2,870,231
137	Medicaid Cost Settlement Payments (See Note B)	-	- / - / - / -						
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	-	26,406 / - / - / -					$ - / $ - / $ 2,441,823 / $ 7,078,241 / $ 169,392 / $ 21,537	$ 26,406 / $ - / $ 1,847,806 / $ 6,621,108 / $ 88,333 / $ 12,870,408
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)								
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								
141	Medicare Cross-Over Bad Debt Payments								
142	Other Medicare Cross-Over Payments (See Note D)								
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)						$ 889,164 / $ -	$ 1,425,791 / $ -	
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)								
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 3,012,914	$ (35,858) / $ 1,887,709 / $ 1,007,651	$ 396,107	$ 167,128 / $ 3,594,893 / $ (283,109)	$ 90,042	$ 56,991	$ 4,983,527 / $ 3,288,599	$ 6,882,827 / $ 608,947
146	**Calculated Payments as a Percentage of Cost**	56%	101% / 63% / 84%	90%	105% / 52% / 104%	0%	0%	21% / 23%	69% / 97%
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**			17,725					
148	**Percent of cross-over days to total Medicare days from the cost report**			8%					

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&P summaries are not available (submit logs with surve
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 (PA summary or PS&P).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits due to no coverage or exhausted benefits.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 1,401.32				7						7	
2	03100 INTENSIVE CARE UNIT	$ 2,034.68										-	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 602.86										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-		7		-		-		7	
19	Total Days per PS&R or Exhibit Detail			-		7		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges					$ 5,642						$ 5,642	
21.01	Calculated Routine Charge Per Diem			$ -		$ 806.00		$ -		$ -		$ 806.00	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.460439		-	-	5,598		-		-	$ -	$ 5,598
23	5000 OPERATING ROOM		0.205049		-	8,864	6,474		448		-	$ 8,864	$ 6,922
24	5100 RECOVERY ROOM		0.207339		-	787	787		-		-	$ 787	$ 787
25	5200 DELIVERY ROOM & LABOR ROOM		1.067222		-	-	-		-		-	$ -	$ -
26	5300 ANESTHESIOLOGY		0.371297		-	1,244	1,244		-		-	$ 1,244	$ 1,244
27	5400 RADIOLOGY-DIAGNOSTIC		0.325660		-	1,310	4,694		470		1,174	$ 1,310	$ 6,338
28	5401 NUCLEAR MEDICINE-DIAG		0.100741		-	-	-		-		-	$ -	$ -
29	5700 CT SCAN		0.028803		-	732	36,492		5,787		-	$ 732	$ 42,279
30	6000 LABORATORY		0.082539		559	10,433	32,100		720		3,164	$ 10,433	$ 36,543
31	6500 RESPIRATORY THERAPY		0.182706		-	-	4,221		618		1,394	$ -	$ 6,233
32	6600 PHYSICAL THERAPY		0.429242		-	-	-		-		-	$ -	$ -
33	6900 ELECTROCARDIOLOGY		0.086082		-	-	2,002		286		-	$ -	$ 2,288
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.766291		-	2,865	2,442		171		121	$ 2,865	$ 2,734
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.165600		-	-	-		-		-	$ -	$ -
36	7300 DRUGS CHARGED TO PATIENTS		0.205403		45	11,677	20,058		1,040		636	$ 11,677	$ 21,779
37	7400 RENAL DIALYSIS		0.135116		-	-	-		-		-	$ -	$ -
38	9000 CLINIC		0.988820		-	231	-		-		-	$ 231	$ -
39	9001 RESIDENCY CLINIC		1.194673									$ -	$ -
40	9100 EMERGENCY		0.169574		1,805	1,057	41,566		2,756		2,864	$ 1,057	$ 46,991
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) COLQUITT 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
48		-									$ -	$ -
49		-									$ -	$ -
50		-									$ -	$ -
51		-									$ -	$ -
52		-									$ -	$ -
53		-									$ -	$ -
54		-									$ -	$ -
55		-									$ -	$ -
56		-									$ -	$ -
57		-									$ -	$ -
58		-									$ -	$ -
59		-									$ -	$ -
60		-									$ -	$ -
61		-									$ -	$ -
62		-									$ -	$ -
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70		-									$ -	$ -
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106		-									$ -	$ -
107		-									$ -	$ -
108		-									$ -	$ -
109		-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2023-09/30/2024) COLQUITT 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
110		-									$ -	$ -
111		-									$ -	$ -
112		-									$ -	$ -
113		-									$ -	$ -
114		-									$ -	$ -
115		-									$ -	$ -
116		-									$ -	$ -
117		-									$ -	$ -
118		-									$ -	$ -
119		-									$ -	$ -
120		-									$ -	$ -
121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ -	$ 2,409	$ 39,200	$ 157,678	$ -	$ 12,296	$ -	$ 9,353		

Totals / Payments

128	**Total Charges (Includes organ acquisition from Section K)**	$ -	$ 2,409	$ 44,842	$ 157,678	$ -	$ 12,296	$ -	$ 9,353	$ 44,842	$ 181,736
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 2,409	$ 44,842	$ 157,678	$ -	$ 12,296	$ -	$ 9,353		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (Includes organ acquisition from Section K)**	$ -	$ 398	$ 18,584	$ 24,574	$ -	$ 1,476	$ -	$ 1,664	$ 18,584	$ 28,112
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 256				$ 54			$ -	$ 310
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 5,298					$ -	$ 5,298
134	Private Insurance (including primary and third party liability)								$ 3,085	$ -	$ 3,085
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 256	$ -	$ 5,298						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)						$ 1,398			$ -	$ 1,398
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ 82	$ -	$ 82
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ 142	$ 18,584	$ 19,276	$ -	$ 24	$ -	$ (1,503)	$ 18,584	$ 17,939
144	**Calculated Payments as a Percentage of Cost**	0%	64%	0%	22%	0%	98%	0%	190%	0%	36%

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

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 (10/01/2023-09/30/2024) COLQUITT REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,876,386		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	10.7350.6734	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,876,386	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,876,386		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	Charges Sec. G	158,187,739
19	Uninsured Hospital	Charges Sec. G	43,367,755
20	Total Hospital	Charges Sec. G	644,418,355
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		24.55%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.73%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	**Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles*** **		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	Charges Sec. G	70,568,980
27	Uninsured Hospital	Charges Sec. G	43,940,246
28	Total Hospital	Charges Sec. G	644,418,355
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		10.95%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.82%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	**Medicaid Primary Tax Assessment Adjustment to DSH UCC*** **		$ -

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

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

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized*