

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025
2. Select Your Facility from the Drop-Down Menu Provided:	TAYLOR REGIONAL HOSPITAL	
Identification of cost reports needed to cover the DSH Year:		
	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	04/01/2022	03/31/2023
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:	000001548A	
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	
9. Medicare Provider Number:	110135	

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:

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.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
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?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

DSH Examination
Year (07/01/24 -
06/30/25)

Yes

No

No

Yes

4/1/1936

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025

\$ 239,531

(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 07/01/2024 - 06/30/2025

(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 Services 07/01/2024 - 06/30/2025

\$ 239,531

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?

Answer

Yes

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.

Explanation for "No" answers:

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

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


Hospital CEO or CFO Signature

Tiffany Jolly
Hospital CEO or CFO Printed Name

CFO
Title

478-782-0200
Hospital CEO or CFO Telephone Number

1/31/2025
Date

tiffany.jolly@taylorregional.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name Tiffany Jolly
Title CFO
Telephone Number 478-782-0200 ext. 4292
E-Mail Address Tiffany.jolly@taylorregional.org
Mailing Street Address P.O. Box 1297
Mailing City, State, Zip Hawkinsville, GA 31036

Outside Preparer:

Name Jimmie D. Richter, Jr.
Title Partner
Firm Name Draffin Tucker
Telephone Number 404-719-4059
E-Mail Address jrichter@draffin-tucker.com

DSH Version 9.00

9/11/2024

D. General Cost Report Year Information 4/1/2022 - 3/31/2023

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:

TAYLOR REGIONAL HOSPITAL

2. Select Cost Report Year Covered by this Survey (enter "X"):

X

3. Status of Cost Report Used for this Survey (Should be audited if available):

1 - As Submitted

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

5/9/2024

4. Hospital Name:

TAYLOR REGIONAL HOSPITAL

5. Medicaid Provider Number:

000001548A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110135

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

Private

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

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (04/01/2022 - 03/31/2023)

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)**

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

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)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-

\$-

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 5,578	\$ 137,580	\$143,158
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 45,185	\$ 629,590	\$674,775
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)	\$50,763	\$767,170	\$817,933
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	10.99%	17.93%	17.50%

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

No

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

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

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

16. Total Medicaid managed care non-claims payments (see question 13 above) received

\$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (04/01/2022 - 03/31/2023)

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)

2,999

(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
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

244,861
\$ 244,861

366,632
413,789
\$ 780,421

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)			Net Hospital Revenue
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$2,960,746.00		\$ 1,826,970	\$ -	\$ -	\$ 1,133,776
12. Subprovider I (Psych or Rehab)	\$0.00		\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00		\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF		\$0.00			\$ -	
15. Swing Bed - NF		\$0.00			\$ -	
16. Skilled Nursing Facility		\$4,097,240.00			\$ 2,528,260	
17. Nursing Facility		\$0.00			\$ -	
18. Other Long-Term Care		\$0.00			\$ -	
19. Ancillary Services	\$7,503,205.00	\$30,858,418.00	\$ 4,629,958	\$ 19,041,620	\$ -	\$ 14,690,045
20. Outpatient Services		\$7,894,926.00		\$ 4,871,675	\$ -	\$ 3,023,251
21. Home Health Agency		\$0.00			\$ -	
22. Ambulance		\$ -			\$ -	
23. Outpatient Rehab Providers		\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
25. Hospice		\$0.00			\$ -	
26. Other	\$0.00	\$4,912,226.00	\$ -	\$ 3,031,158	\$ 2,687,628	\$ 1,881,068
27. Total	\$ 10,463,951	\$ 43,665,570	\$ 6,456,928	\$ 26,944,453	\$ 5,215,888	\$ 20,728,140
28. Total Hospital and Non Hospital		Total from Above		Total from Above	\$ 38,617,269	

29. Total Per Cost Report
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
37. Unreconciled Difference

Total Patient Revenues (G-3 Line 1) 62,582,270

Total Contractual Adj. (G-3 Line 2)

38,617,269

Unreconciled Difference (Should be \$0)

\$ -

Unreconciled Difference (Should be \$0)

\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

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
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.		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	\$ 2,277,866	\$ -	\$ -	\$0.00	\$ 2,277,866	2,587	\$1,382,810.00	\$ 880.50
2	03100 INTENSIVE CARE UNIT	\$ 1,115,532	\$ -	\$ -		\$ 1,115,532	1,101	\$1,577,936.00	\$ 1,013.20
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300 NURSERY	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
11		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine	\$ 3,393,398	\$ -	\$ -	\$ -	\$ 3,393,398	3,688	\$ 2,960,746	
19	Weighted Average								\$ 920.12

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		689	-	-	\$ 606,665	\$128,956.00	\$320,450.00	\$ 449,406	1.349926
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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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$2,491,554.00	\$ -	\$ -		\$ 2,491,554	\$551,605.00	\$7,569,276.00	\$ 8,120,881	0.306808
22	5400 RADIOLOGY-DIAGNOSTIC	\$2,349,844.00	\$ -	\$ -		\$ 2,349,844	\$1,295,662.00	\$12,392,033.00	\$ 13,687,695	0.171676
23	6000 LABORATORY	\$1,771,646.00	\$ -	\$ -		\$ 1,771,646	\$1,056,065.00	\$5,183,849.00	\$ 6,239,914	0.283922
24	6500 RESPIRATORY THERAPY	\$777,682.00	\$ -	\$ -		\$ 777,682	\$1,022,427.00	\$397,227.00	\$ 1,419,654	0.547797
25	6600 PHYSICAL THERAPY	\$886,901.00	\$ -	\$ -		\$ 886,901	\$813,052.00	\$1,068,873.00	\$ 1,881,925	0.471273
26	6900 ELECTROCARDIOLOGY	\$229,981.00	\$ -	\$ -		\$ 229,981	\$108,098.00	\$405,796.00	\$ 513,894	0.447526
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$428,863.00	\$ -	\$ -		\$ 428,863	\$681,720.00	\$1,029,471.00	\$ 1,711,191	0.250623
28	7200 IMPL. DEV. CHARGED TO PATIENTS	\$651,729.00	\$ -	\$ -		\$ 651,729	\$260,814.00	\$546,255.00	\$ 807,069	0.807526
29	7300 DRUGS CHARGED TO PATIENTS	\$1,523,413.00	\$ -	\$ -		\$ 1,523,413	\$1,713,763.00	\$2,265,638.00	\$ 3,979,401	0.382825

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

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
30	9000 CLINIC	\$88,898.00	\$ -	\$ -	\$ 88,898	\$1,768.00	\$50,763.00	\$ 52,531	1.692296
31	9100 EMERGENCY	\$2,651,300.00	\$ -	\$ 82,860	\$ 2,734,160	\$1,083,324.00	\$6,309,667.00	\$ 7,392,991	0.369831
32		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$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	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

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	\$ 13,851,811	\$ -	\$ 82,860	\$ 13,934,671	\$ 8,717,254	\$ 37,539,298	\$ 46,256,552	
127	Weighted Average								0.314363
128	Sub Totals	\$ 17,245,209	\$ -	\$ 82,860	\$ 17,328,069	\$ 11,678,000	\$ 37,539,298	\$ 49,217,298	
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)				\$166,281.00				
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				\$ 17,161,788				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

Cost Report Year (04/01/2022-03/31/2023)

TAYLOR REGIONAL HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid 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 (Includes all payers)
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		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):																	
1	03000 ADULTS & PEDIATRICS	\$ 680.50	101		69		239		91				137			500	33.61%
2	03100 INTENSIVE CARE UNIT	\$ 1,013.20	116		18		181		63				76			378	41.42%
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	\$ -														-	
11		\$ -														-	
12		\$ -														-	
13		\$ -														-	
14		\$ -														-	
15		\$ -														-	
16		\$ -														-	
17		\$ -														-	
18		\$ -														-	
Total Days			217		87		420		154		-		213			878	29.66%
Total Days per PS&R or Exhibit Detail			217		87		420		154		-		213				
Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
Routine Charges			\$ 236,235		\$ 75,294		\$ 435,925		\$ 148,212		\$ 211,838		\$ 895,666		\$ 1,020.12		37.53%
Calculated Routine Charge Per Diem			\$ 1,088.64		\$ 865.45		\$ 1,037.92		\$ 962.42		\$ -		\$ 994.54				
Ancillary Cost Centers (from W/S C) (from Section G):																	
22	09200 Observation (Non-Distinct)	1.349926	10,404	9,499	5,321	17,568	15,109	26,955	4,852	23,443			17,812	42,010	35,686	77,465	38.49%
23	5000 OPERATING ROOM	0.306808	35,117	202,259	51,717	347,842	64,934	537,308	56,679	201,136		23,988	38,313	61,071	208,447	1,288,545	
24	5400 RADIOLOGY-DIAGNOSTIC	0.171676	107,398	374,893	28,599	824,371	181,641	1,125,679	88,907	531,024		20,523	105,759	661,840	406,545	2,855,967	
25	6000 LABORATORY	0.283922	90,981	191,629	35,773	419,714	205,073	334,412	88,911	369,071		21,865	8,901	119,378	422,238	1,314,826	
26	6500 RESPIRATORY THERAPY	0.547797	123,168	7,392	59,024	15,062	164,933	15,376	43,057	16,204			87,971	33,042	390,182	54,034	6.96%
27	6600 PHYSICAL THERAPY	0.471273	5,833	11,426	1,171	34,627	20,621	69,849	8,446	36,632			1,019	3,984	7,668	152,534	1.47%
28	6900 ELECTROCARDIOLOGY	0.447526	4,455	11,705	1,683	24,817	12,584	45,586	6,513	13,794		1,386	99	32,484	25,235	95,902	2.40%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.250623	66,234	27,365	11,194	51,302	114,852	63,398	29,014	26,488		54	1,300	43,210	38,607	168,553	33.33%
30	7200 IMPL. DEV. CHARGED TO PATIENTS	0.807526	306	102		15,186	1,204	15,380	30,990	14,108			508	32,500	44,776	4,133	4.13%
31	7300 DRUGS CHARGED TO PATIENTS	0.382825	120,132	102,903	47,746	156,010	276,530	213,084	90,562	81,648		31,790	25,038	148,115	534,970	553,645	287.14%
32	9000 CLINIC	1.692296	1			8,862	367	8,351	4,352					17,119	368	19,565	1.29%
33	9100 EMERGENCY	0.369831	103,328	253,498	44,932	801,319	171,246	561,787	65,540	334,086			462	124,366	929,220	1,950,690	421.25%
34		-															0.00%
35		-															0.00%
36		-															0.00%
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70		-															

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

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

				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 Medicaid 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										
71				-													\$	-	-									
72				-													\$	-	-									
73				-													\$	-	-									
74				-													\$	-	-									
75				-													\$	-	-									
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125				-													\$	-	-									
126				-													\$	-	-									
127				-													\$	-	-									
				\$	667,357	\$	1,192,671	\$	287,160	\$	2,716,680	\$	1,229,094	\$	3,015,165	\$	513,471	\$	1,651,986	\$	55,541	\$	81,885	\$	697,384	\$	2,410,526	

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

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

															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 Medicaid 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)																	\$	903,592	\$	1,192,671	\$	362,454	\$	2,716,680	\$	1,665,019	\$	3,015,165	\$	661,683	\$	1,651,986	\$	55,541	\$	81,885	\$	909,222	\$	2,410,526	\$	3,592,748	\$	8,576,502	31.52%
129	Total Charges per PS&R or Exhibit Detail																	\$	903,592	\$	1,192,671	\$	362,454	\$	2,716,680	\$	1,665,019	\$	3,015,165	\$	661,683	\$	1,651,986	\$	55,541	\$	81,885	\$	909,222	\$	2,410,526					
130	Unreconciled Charges (Explain Variance)																																													
131	Total Calculated Cost (includes organ acquisition from Section J)																	\$	448,815	\$	348,404	\$	188,448	\$	822,998	\$	828,827	\$	879,575	\$	330,090	\$	501,829	\$	19,088	\$	24,746	\$	453,052	\$	770,591	\$	1,796,180	\$	2,552,806	32.52%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)																	\$	428,681	\$	272,547				\$	37,921	\$	55,172													\$	466,602	\$	327,719		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)																					\$	17,240	\$	548,488																\$	17,240	\$	548,488		
134	Private Insurance (including primary and third party liability)																		\$	5,326	\$	22						\$	72			\$	69,596								\$	5,326	\$	69,690		
135	Self-Pay (including Co-Pay and Spend-Down)																																								\$	-	\$	-		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)																	\$	434,007	\$	272,569	\$	17,240	\$	548,488																					
137	Medicaid Cost Settlement Payments (See Note B)																			\$	10,215																				\$	-	\$	10,215		
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)																								\$	724,797	\$	528,925	\$	46,930	\$	174,082									\$	771,727	\$	703,007		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																													\$	9,013									\$	-	\$	9,013			
141	Medicare Cross-Over Bad Debt Payments																								\$	30,615	\$	15,174													\$	30,615	\$	15,174		
142	Other Medicare Cross-Over Payments (See Note D)																								\$	37,294	\$	(13,853)	\$	14,821	\$	(7,590)										\$	52,115	\$	(21,443)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																																													
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)																	\$	14,808	\$	65,620	\$	171,208	\$	274,510	\$	(1,800)	\$	294,085	\$	268,339	\$	256,728	\$	19,088	\$	24,746	\$	447,474	\$	633,011	\$	452,555	\$	890,943	
146	Calculated Payments as a Percentage of Cost																		97%		81%		9%		67%		100%		67%		19%		49%		0%		0%		1%		18%		75%		65%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)																																													
148	Percent of cross-over days to total Medicare days from the cost report																																													

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 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 payment.
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).

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

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 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 Section G	From Section G										
	Routine Cost Centers (list below):			Days	Days	Days	Days	Days	Days	Days	Days		
1	03000 ADULTS & PEDIATRICS	\$ 880.50								1		1	
2	03100 INTENSIVE CARE UNIT	\$ 1,013.20								2		2	
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	\$ -										-	
11		\$ -										-	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
18		\$ -										-	
			Total Days	-		-		-		3		3	
19	Total Days per PS&R or Exhibit Detail			-		-		-		3			
20	Unreconciled Days (Explain Variance)			-		-		-					
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			\$ -		\$ -		\$ -		\$ 3,676		\$ 3,676	
21.01	Calculated Routine Charge Per Diem									\$ 1,225.33		\$ 1,225.33	
	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)	1.349926										\$ -	\$ -
23	5000 OPERATING ROOM	0.306808										\$ -	\$ -
24	5400 RADIOLOGY-DIAGNOSTIC	0.171676			456					228	2,307	\$ 228	\$ 2,763
25	6000 LABORATORY	0.283922			1,154					1,092	2,183	\$ 1,092	\$ 3,337
26	6500 RESPIRATORY THERAPY	0.547797								56		\$ 56	\$ -
27	6600 PHYSICAL THERAPY	0.471273										\$ -	\$ -
28	6900 ELECTROCARDIOLOGY	0.447526								99	198	\$ 99	\$ 198
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.250623								27	136	\$ 27	\$ 136
30	7200 IMPL. DEV. CHARGED TO PATIENTS	0.807526										\$ -	\$ -
31	7300 DRUGS CHARGED TO PATIENTS	0.382825			12					761	646	\$ 761	\$ 658
32	9000 CLINIC	1.692296										\$ -	\$ -
33	9100 EMERGENCY	0.369831			1,470						8,495	\$ -	\$ 9,965
34		-										\$ -	\$ -
35		-										\$ -	\$ -
36		-										\$ -	\$ -
37		-										\$ -	\$ -
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45		-										\$ -	\$ -
46		-										\$ -	\$ -
47		-										\$ -	\$ -

Cost Report Year (04/01/2022-03/31/2023) TAYLOR REGIONAL HOSPITAL

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

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (04/01/2022-03/31/2023)

TAYLOR REGIONAL HOSPITAL

	Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
	Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):																	
1	Lung Acquisition	\$0.00	\$ -	\$ -	0												
2	Kidney Acquisition	\$0.00	\$ -	\$ -	0												
3	Liver Acquisition	\$0.00	\$ -	\$ -	0												
4	Heart Acquisition	\$0.00	\$ -	\$ -	0												
5	Pancreas Acquisition	\$0.00	\$ -	\$ -	0												
6	Intestinal Acquisition	\$0.00	\$ -	\$ -	0												
7	Islet Acquisition	\$0.00	\$ -	\$ -	0												
8		\$0.00	\$ -	\$ -	0												
9	Totals	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost						-		-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B - Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments

Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (04/01/2022-03/31/2023)

TAYLOR REGIONAL HOSPITAL

	Total Organ Acquisition Cost			Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
	Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WS D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	Total Cost						-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey)

Note B - Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments