GA DSH Payment Results for SFY 2024 - Pool 2 **4/8/2024 7:48**

DSH Uncompensated Care Cost & Allocation Factor Summary

Preliminary Results

Provider Name	FLOYD MEDICAL CENTER
Mcaid Provider Number	000000756A
Mcare Provider Number	110054

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2023 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2023 - 6/30/2024

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	1/1/2022	-	12/31/2022	$ 56,413,857	$ -	$ 56,413,857

Less: 2022 Net UPL Payments	$ 4,544,758
Less: 2024 Net DPP Payments	$ 39,438,542
Plus: 2023 Net DPP Recoupments	$ -
Less: GME Payments	$ 1,072,639
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 413,373
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 1,167,212
Uncompensated Care Allocation Factor	$ 12,938,502
Hospital Specific DSH Limit	$ (11,843,089)
2024 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	17.91%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	36.51%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail:	gadsh@mslc.com
Fax:	816-945-5301
Web Portal Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.11	2/10/2023

D. General Cost Report Year Information 1/1/2022 - 12/31/2022

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: **FLOYD MEDICAL CENTER**

	1/1/2022 through 12/31/2022		
2. Select Cost Report Year Covered by this Survey:	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:	6/9/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	FLOYD MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000756A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110054	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

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

	State Name	Provider No.
9. State Name & Number	Alabama	FLOO54P
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: (01/01/2022 - 12/31/2022)

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)	$ 535,434	$ 1,004,720	$1,540,154
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,377,368	$ 6,576,435	$7,953,803
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$1,912,802	$7,581,155	$9,493,957
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	27.99%	13.25%	16.22%

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 (01/01/2022 - 12/31/2022)

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)	99,251

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	7,200
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 7,200
7.	Inpatient Hospital Charity Care Charges	43,083,692
8.	Outpatient Hospital Charity Care Charges	65,875,554
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 108,959,246

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 131,078,719	$ -	$ -	$ 99,968,141	$ -	$ -	$ 31,110,578
12.	Psych Subprovider	$ 9,461,419	$ -	$ -	$ 7,215,820	$ -	$ -	$ 2,245,599
13.	Rehab. Subprovider	$ 3,837,260	$ -	$ -	$ 2,926,514	$ -	$ -	$ 910,746
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 701,706,719	$ 904,197,283	$ -	$ 535,161,748	$ 689,592,654	$ -	$ 381,149,600
20.	Outpatient Services		$ 250,736,601	$ -		$ 191,226,098	$ -	$ 59,510,503
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 12,631,096			$ 9,633,198	
26.	Other	$ -	$ 16,014	$ -	$ -	$ 12,213	$ -	$ 3,801
27.	Total	$ 846,084,117	$ 1,154,949,898	$ 12,631,096	$ 645,272,224	$ 880,830,965	$ 9,633,198	$ 474,930,826
28.	Total Hospital and Non Hospital		Total from Above	$ 2,013,665,111		Total from Above	$ 1,535,736,386	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 2,013,665,111	Total Contractual Adj. (G-3 Line 2)	$ 1,531,944,119
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)			+	$ 3,792,267
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.	Adjusted Contractual Adjustments				1,535,736,386
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) | FLOYD MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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	$ 94,335,434	$ 2,722,333	$ -	-	**$ 97,057,767**	94,184	$ 78,894,843		**$ 1,030.51**
2	03100 INTENSIVE CARE UNIT	$ 31,888,583	$ 355,190	$ -		**$ 32,243,773**	9,722	$ 23,598,268		**$ 3,316.58**
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	$ 12,015,401	$ 32,182	$ -		**$ 12,047,583**	7,420	$ 11,231,234		**$ 1,623.66**
18	Total Routine	$ 138,239,418	$ 3,109,705	$ -	$ -	$ 141,349,123	111,326	$ 113,724,345		
19	Weighted Average									$ 1,269.68

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)	12,075	-	-	**$ 12,443,408**	1,572,155	18,940,595	$ 20,512,750	**0.606618**

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	$ 27,433,955	$ 281,292	$ -		**$ 27,715,247**	$ 121,450,939	$ 257,160,259	$ 378,611,198	**0.073202**
22	5001 LITHOTRIPSY	$ 418,304	$ -	$ -		**$ 418,304**	$ 3,132	$ 2,486,163	$ 2,489,295	**0.168041**
23	5100 RECOVERY ROOM	$ 6,933,039	$ -	$ -		**$ 6,933,039**	$ 9,641,209	$ 28,904,904	$ 38,546,113	**0.179864**
24	5200 DELIVERY ROOM & LABOR ROOM	$ 7,892,474	$ -	$ -		**$ 7,892,474**	$ 19,268,903	$ 5,046,327	$ 24,315,230	**0.324590**
25	5300 ANESTHESIOLOGY	$ 504,594	$ -	$ -		**$ 504,594**	$ 17,335,960	$ 26,153,391	$ 43,489,351	**0.011603**
26	5400 RADIOLOGY-DIAGNOSTIC	$ 20,592,707	$ 96,545	$ -		**$ 20,689,252**	$ 69,743,046	$ 146,813,246	$ 216,556,292	**0.095538**
27	6000 LABORATORY	$ 20,404,218	$ -	$ -		**$ 20,404,218**	$ 173,671,180	$ 130,673,469	$ 304,344,649	**0.067043**
28	6500 RESPIRATORY THERAPY	$ 10,717,773	$ -	$ -		**$ 10,717,773**	$ 44,166,829	$ 9,072,600	$ 53,239,429	**0.201313**
29	6600 PHYSICAL THERAPY	$ 21,593,170	$ 70,323	$ -		**$ 21,663,493**	$ 12,242,379	$ 20,319,603	$ 32,561,982	**0.665300**
30	6900 ELECTROCARDIOLOGY	$ 8,819,652	$ 156,141	$ -		**$ 8,975,793**	$ 47,149,404	$ 46,984,843	$ 94,134,247	**0.095351**
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 31,584,842	$ -	$ -		**$ 31,584,842**	$ 69,879,259	$ 29,790,305	$ 99,669,564	**0.316896**
32	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 18,757,439	$ -	$ -		**$ 18,757,439**	$ 14,161,763	$ 72,137,610	$ 86,299,373	**0.217353**
33	7300 DRUGS CHARGED TO PATIENTS	$ 38,071,596	$ -	$ -		**$ 38,071,596**	$ 129,208,506	$ 120,631,760	$ 249,840,266	**0.152384**
34	7400 RENAL DIALYSIS	$ 2,112,377	$ -	$ -		**$ 2,112,377**	$ 3,787,200	$ 3,062,637	$ 6,849,837	**0.308384**
35	7601 CHEMICAL DEPENDENCY	$ 671,480	$ 169,252	$ -		**$ 840,732**	$ 2,240	$ 1,907,034	$ 1,909,274	**0.440341**
36	9000 CLINIC	$ 8,218,029	$ 5,220,588	$ -		**$ 13,438,617**	$ 1,125,340	$ 17,742,048	$ 18,867,388	**0.712267**

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) FLOYD MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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
37	9003	OTHER OP SERVICE COST CENTER	$ 120,644	$ -	$ -		**$ 120,644**	$ 2,436	$ 190,457	$ 192,893	**0.625445**
38	9100	EMERGENCY	$ 31,691,567	$ 693,695	$ -		**$ 32,385,262**	$ 65,365,734	$ 149,498,789	$ 214,864,523	**0.150724**
126		**Total Ancillary**	$ 256,537,860	$ 6,687,836	$ -		$ 263,225,696	$ 799,777,614	$ 1,087,516,040	$ 1,887,293,654	
127		**Weighted Average**									**0.146066**
128		**Sub Totals**	$ 394,777,278	$ 9,797,541	$ -		$ 404,574,819	$ 913,501,959	$ 1,087,516,040	$ 2,001,017,999	
129		NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130		NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ -				
131		NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01		Other Cost Adjustments (support must be submitted)					$ -				
132		**Grand Total**					**$ 404,574,819**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					**2.48%**				

* 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 (01/01/2022-12/31/2022) FLOYD 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 Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000	ADULTS & PEDIATRICS	$ 1,030.51		5,573		4,659		4,976		6,712		5,289		**21,920**		35.51%
2	03100	INTENSIVE CARE UNIT	$ 3,316.58		3,396		334		1,001		1,267		1,289		**5,998**		80.83%
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	$ 1,623.66		616		4,170		13		941		205		**5,740**		80.97%
18				**Total Days**	9,585		9,163		5,990		8,920		6,783		33,658		43.35%
19		Total Days per PS&R or Exhibit Detail			9,585		9,163		5,990		8,920		6,783				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 9,663,213		$ 9,071,792		$ 6,123,568		$ 9,017,499		$ 6,959,119		$ 33,876,072		38.36%
21.01		Calculated Routine Charge Per Diem			$ 1,008.16		$ 990.05		$ 1,022.30		$ 1,010.93		$ 1,025.96		$ 1,006.48		
		Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200	Observation (Non-Distinct)		0.606618	$ 311,965	$ 861,280	$ 630,861	$ 2,218,358	$ 329,994	$ 414,123	$ 598,914	$ 1,706,256	$ 307,850	$ 1,509,458	$ 1,871,734	$ 5,200,017	45.54%
23	5000	OPERATING ROOM		0.073202	$ 7,042,623	$ 6,786,774	$ 11,461,217	$ 30,943,122	$ 6,261,053	$ 5,974,716	$ 12,640,623	$ 15,635,330	$ 10,261,749	$ 10,561,057	$ 37,405,516	$ 59,339,942	32.18%
24	5001	LITHOTRIPSY		0.168041	$ -	$ 38,743	$ -	$ 78,431	$ -	$ 38,743	$ -	$ 58,587	$ -	$ 134,183	$ -	$ 214,504	16.36%
25	5100	RECOVERY ROOM		0.179864	$ 842,950	$ 1,022,108	$ 1,650,274	$ 3,684,430	$ 538,009	$ 664,145	$ 1,254,891	$ 1,980,614	$ 1,013,072	$ 1,364,789	$ 4,286,123	$ 7,351,297	37.51%
26	5200	DELIVERY ROOM & LABOR ROOM		0.324590	$ 858,650	$ 110,590	$ 8,304,105	$ 4,173,573	$ 73,932	$ 316,987	$ 2,855,274	$ 1,643,593	$ 374,225	$ 1,054,512	$ 12,091,961	$ 6,244,743	82.51%
27	5300	ANESTHESIOLOGY		0.011603	$ 1,169,575	$ 964,230	$ 2,726,882	$ 3,813,708	$ 803,390	$ 646,341	$ 1,974,275	$ 1,917,323	$ 1,431,204	$ 1,307,525	$ 6,674,123	$ 7,341,602	39.84%
28	5400	RADIOLOGY-DIAGNOSTIC		0.095538	$ 4,870,969	$ 5,733,058	$ 2,753,010	$ 15,105,256	$ 4,983,501	$ 3,314,033	$ 6,665,142	$ 9,720,143	$ 7,453,391	$ 18,385,577	$ 19,272,622	$ 33,872,490	38.32%
29	6000	LABORATORY		0.067043	$ 15,326,793	$ 7,728,181	$ 9,297,824	$ 16,938,287	$ 13,287,700	$ 3,555,504	$ 16,802,469	$ 10,280,879	$ 15,307,588	$ 20,085,822	$ 54,714,786	$ 38,502,852	44.80%
30	6500	RESPIRATORY THERAPY		0.201313	$ 4,284,378	$ 597,329	$ 1,813,986	$ 1,158,953	$ 3,614,492	$ 222,078	$ 5,059,696	$ 836,933	$ 2,370,274	$ 484,116	$ 14,772,552	$ 2,815,293	42.67%
31	6600	PHYSICAL THERAPY		0.665300	$ 572,939	$ 454,754	$ 308,440	$ 1,145,245	$ 722,627	$ 326,306	$ 825,113	$ 1,110,349	$ 629,399	$ 592,485	$ 2,429,119	$ 3,036,654	21.61%
32	6900	ELECTROCARDIOLOGY		0.095351	$ 3,667,187	$ 1,664,267	$ 1,510,491	$ 1,449,760	$ 3,351,500	$ 1,536,663	$ 4,410,494	$ 3,034,541	$ 4,262,990	$ 3,011,912	$ 12,939,672	$ 7,685,231	31.81%
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.316896	$ 1,536,653	$ 1,195,842	$ 1,640,422	$ 2,725,307	$ 1,444,017	$ 650,088	$ 2,218,602	$ 1,757,739	$ 1,894,078	$ 1,580,588	$ 6,839,694	$ 6,328,976	17.69%
34	7200	IMPL. DEV. CHARGED TO PATIENTS		0.217353	$ 2,103,099	$ 3,650,577	$ 782,328	$ 1,619,177	$ 1,072,700	$ 1,741,245	$ 1,774,989	$ 3,214,201	$ 1,888,098	$ 1,240,199	$ 5,733,116	$ 10,225,200	23.99%
35	7300	DRUGS CHARGED TO PATIENTS		0.152384	$ 10,901,584	$ 6,352,017	$ 6,135,154	$ 5,924,850	$ 8,503,027	$ 2,475,932	$ 11,576,040	$ 10,826,370	$ 10,346,589	$ 6,272,006	$ 37,115,805	$ 25,579,169	33.84%
36	7400	RENAL DIALYSIS		0.308384	$ 277,835	$ 9,219	$ 16,736	$ -	$ 508,260	$ 53,145	$ 519,522	$ 143,560	$ 215,668	$ 2,078,641	$ 1,322,353	$ 205,924	58.01%
37	7601	CHEMICAL DEPENDENCY		0.440341	$ -	$ 12,878	$ 7,795	$ 231,089	$ 8,580	$ 86,851	$ 3,120	$ 205,405	$ 780	$ 21,337	$ 19,495	$ 536,223	30.31%
38	9000	CLINIC		0.712267	$ 10,856	$ 1,047,268	$ 239,521	$ 988,598	$ 28,418	$ 651,309	$ 153,072	$ 1,417,807	$ 37,126	$ 1,373,339	$ 431,867	$ 4,104,981	32.43%
39	9003	OTHER OP SERVICE COST CENTER		0.625445	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,612	$ -	$ -	1.87%
40	9100	EMERGENCY		0.150724	$ 4,809,282	$ 8,302,338	$ 2,470,639	$ 29,884,540	$ 5,266,387	$ 3,856,276	$ 6,428,260	$ 11,623,152	$ 7,406,560	$ 31,856,772	$ 18,974,567	$ 53,666,307	54.33%
					58,587,337	46,531,455	51,749,687	122,082,684	50,797,587	26,524,486	75,760,495	77,112,780	65,200,639	102,917,928			

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

Cost Report Year (01/01/2022-12/31/2022) FLOYD 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)		Uninsured		Total In-State Medicaid		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	**$ 68,250,550**	**$ 46,531,455**	**$ 60,821,479**	**$ 122,082,684**	**$ 56,921,155**	**$ 26,524,486**	**$ 84,777,994**	**$ 77,112,780**	**$ 72,159,758** (Agrees to Exhibit A)	**$ 102,917,928** (Agrees to Exhibit A)	**$ 270,771,178**	**$ 272,251,405**	**37.80%**
129	Total Charges per PS&R or Exhibit Detail	$ 68,250,550	$ 46,531,455	$ 60,821,479	$ 122,082,684	$ 56,921,155	$ 26,524,486	$ 84,777,994	$ 77,112,780	$ 72,159,758	$ 102,917,928			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 25,664,837**	**$ 7,050,219**	**$ 20,702,263**	**$ 16,826,465**	**$ 15,113,362**	**$ 3,949,781**	**$ 22,954,509**	**$ 11,717,727**	**$ 18,154,149**	**$ 14,354,833**	$ 84,434,971	$ 39,544,192	40.89%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 11,530,077	$ 5,136,051	$ -	$ -	$ 710,545	$ 259,304	$ 439,058	$ 591,020			$ 12,679,680	$ 5,986,375	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 13,606,629	$ 16,432,605	$ -	$ 1,452	$ 328,266	$ 307,622			$ 13,934,895	$ 16,741,679	
134	Private Insurance (including primary and third party liability)	$ 108,625	$ 17,660	$ -	$ 52,094	$ 4,512	$ 10,898	$ 4,729,535	$ 7,052,814			$ 4,842,672	$ 7,133,466	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 59	$ 1,845	$ 2,959	$ 9,060	$ 13,808	$ 27,539			$ 16,826	$ 38,444	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 11,638,702	$ 5,153,711	$ 13,606,688	$ 16,486,544									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 411,239	$ -	$ -							$ -	$ 411,239	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 9,923,132	$ 2,150,656	$ -	$ -			$ 9,923,132	$ 2,150,656	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 10,024,412	$ 4,637,881			$ 10,024,412	$ 4,637,881	
141	Medicare Cross-Over Bad Debt Payments					$ 338,053	$ 53,854	$ -	$ -			$ 338,053	$ 53,854	
142	Other Medicare Cross-Over Payments (See Note D)					$ 289,688	$ 78,412	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 289,688	$ 78,412	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 535,434	$ 1,004,720			
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)**	$ 14,026,135	$ 1,485,269	$ 7,095,575	$ 339,921	$ 3,844,473	$ 1,386,145	$ 7,419,430	$ (899,149)	$ 17,618,715	$ 13,350,113	$ 32,385,613	$ 2,312,186	
146	**Calculated Payments as a Percentage of Cost**	45%	79%	66%	98%	75%	65%	68%	108%	3%	7%	62%	94%	
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)**					44,143								
148	**Percent of cross-over days to total Medicare days from the cost report**					15%								

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.

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) FLOYD 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 Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 1,030.51		722		-		622		602		1,946	
2	03100 INTENSIVE CARE UNIT	$ 3,316.58		267		-		112		192		571	
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	$ 1,623.66		46		-		4		13		63	
18			**Total Days**	1,035		-		738		807		2,580	
19	Total Days per PS&R or Exhibit Detail			1,035		-		738		807			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 1,095,679		$ -		$ 751,158		$ 947,746		$ 2,794,583	
21.01	Calculated Routine Charge Per Diem			$ 1,058.63		$ -		$ 1,017.83		$ 1,174.41		$ 1,083.17	
	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)		0.606618	55,829	127,872	-	-	53,144	50,746	31,068	133,279	$ 140,041	$ 311,897
23	5000 OPERATING ROOM		0.073202	1,182,385	790,643	-	-	658,541	227,417	976,090	452,534	$ 2,817,017	$ 1,470,594
24	5001 LITHOTRIPSY		0.168041	-	-	-	-	-	58,587	-	-	$ -	$ 58,587
25	5100 RECOVERY ROOM		0.179864	95,264	98,197	-	-	85,009	37,134	72,893	53,904	$ 253,166	$ 189,235
26	5200 DELIVERY ROOM & LABOR ROOM		0.324590	61,866	90,294	-	-	1,005	35,340	40,334	68,279	$ 103,205	$ 193,913
27	5300 ANESTHESIOLOGY		0.011603	162,517	108,486	-	-	88,243	42,449	128,634	43,483	$ 379,395	$ 194,419
28	5400 RADIOLOGY-DIAGNOSTIC		0.095538	897,116	1,124,573	-	-	635,842	245,432	650,032	451,476	$ 2,182,989	$ 1,821,482
29	6000 LABORATORY		0.067043	2,181,642	1,140,699	-	-	1,751,108	327,443	1,752,454	574,151	$ 5,685,204	$ 2,042,292
30	6500 RESPIRATORY THERAPY		0.201313	802,268	102,495	-	-	547,497	18,705	760,917	42,416	$ 2,110,681	$ 163,616
31	6600 PHYSICAL THERAPY		0.665300	92,435	2,559	-	-	96,545	17,559	97,514	41,123	$ 286,494	$ 61,241
32	6900 ELECTROCARDIOLOGY		0.095351	651,371	243,636	-	-	516,226	121,352	330,292	181,508	$ 1,497,889	$ 546,496
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.316896	389,387	94,499	-	-	173,419	56,870	193,340	83,090	$ 756,146	$ 234,459
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.217353	481,442	621,157	-	-	86,642	17,575	398,660	13,072	$ 966,745	$ 651,804
35	7300 DRUGS CHARGED TO PATIENTS		0.152384	2,067,187	559,675	-	-	1,101,673	86,075	1,175,270	240,093	$ 4,344,129	$ 885,843
36	7400 RENAL DIALYSIS		0.308384	25,270	-	-	-	81,664	9,814	33,333	1,062	$ 140,267	$ 10,876
37	7601 CHEMICAL DEPENDENCY		0.440341	390	-	-	-	-	-	390	-	$ 780	$ -
38	9000 CLINIC		0.712267	22,761	63,641	-	-	3,295	33,017	18,325	29,636	$ 44,380	$ 126,295
39	9003 OTHER OP SERVICE COST CENTER		0.625445	-	-	-	-	-	-	-	-	$ -	$ -
40	9100 EMERGENCY		0.150724	753,734	1,834,231	-	-	667,948	308,892	588,629	670,094	$ 2,010,311	$ 2,813,217
				9,922,864	7,002,657	-	-	6,547,801	1,694,407	7,248,175	3,079,202		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 11,018,543**	**$ 7,002,657**	**$ -**	**$ -**	**$ 7,298,959**	**$ 1,694,407**	**$ 8,195,921**	**$ 3,079,202**	**$ 26,513,423**	**$ 11,776,266**
129	Total Charges per PS&R or Exhibit Detail			$ 11,018,543	$ 7,002,657	$ -	$ -	$ 7,298,959	$ 1,694,407	$ 8,195,921	$ 3,079,202		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 3,061,676**	**$ 985,192**	**$ -**	**$ -**	**$ 1,887,704**	**$ 256,397**	**$ 2,264,631**	**$ 469,364**	**$ 7,214,011**	**$ 1,710,953**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,318,909	$ 221,074	$ -	$ -	$ 82,785	$ 268	$ 18,142	$ 3,568	$ 1,419,836	$ 224,910
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)			$ -	$ 7,801	$ -	$ -	$ 4,668	$ 23	$ 174,703	$ 386,830	$ 179,371	$ 394,654
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 955	$ -	$ -	$ -	$ 224	$ 250	$ 401	$ 250	$ 1,580
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,318,909	$ 229,830	$ -	$ -						
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)							$ 1,407,096	$ 132,517	$ -	$ -	$ 1,407,096	$ 132,517
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 1,260,165	$ 157,949	$ 1,260,165	$ 157,949

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) FLOYD MEDICAL CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
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)**	$ 1,742,767	$ 755,362	$ -	$ -	$ 393,155	$ 123,365	$ 811,371	$ (79,384)	$ 2,947,293	$ 799,343
144	**Calculated Payments as a Percentage of Cost**	43%	23%	0%	0%	79%	52%	64%	117%	59%	53%

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 (01/01/2022-12/31/2022) FLOYD MEDICAL CENTER

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 D 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 (01/01/2022-12/31/2022) FLOYD MEDICAL CENTER

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

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (01/01/2022-12/31/2022) FLOYD 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)*		$ 5,256,695		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	1112540502	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 5,256,695	5.02	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ (0)		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	A-8 Adjustment 33.15	$ (4,758,930)	5.02	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 497,765		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 4,758,930
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	581,312,271
19	Uninsured Hospital	**Charges Sec. G**	175,077,686
20	Total Hospital	**Charges Sec. G**	2,001,017,999
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.05%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.75%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,382,508
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 416,379
25	Provider Tax Assessment Adjustment to DSH UCC		$ 1,798,887

** 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.*

DSH Examination Eligibility Summary

Hospital Name	**FLOYD MEDICAL CENTER**
Hospital Medicaid Number	**000000756A**
Cost Report Period	From **1/1/2022** To **12/31/2022**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 51,587,653	$ -	$ 51,587,653
2	Hospital Cash Subsidies	Survey F-2	$ 7,200	$ -	$ 7,200
3	Total		$ 51,594,853	$ -	$ 51,594,853
4	Net Hospital Patient Revenue	Survey F-3	$ 474,930,826	$ -	$ 474,930,826
5	Medicaid Fraction		10.86%	0.00%	10.86%
6	Inpatient Charity Care Charges	Survey F-2	$ 43,083,692	$ -	$ 43,083,692
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ 7,200	$ -	$ 7,200
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 43,076,492	$ -	$ 43,076,492
10	Inpatient Hospital Charges	Survey F-3	$ 846,084,117	$ -	$ 846,084,117
11	Inpatient Charity Fraction		5.09%	0.00%	5.09%
12	LIUR		15.95%	0.00%	15.95%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	33,658	-	33,658
14	Out-of-State Medicaid Eligible Days	Survey I	2,580	-	2,580
15	Total Medicaid Eligible Days		36,238	-	36,238
16	Total Hospital Days (excludes swing-bed)	Survey F-1	99,251	-	99,251
17	MIUR		36.51%	0.00%	36.51%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **FLOYD MEDICAL CENTER**
Hospital Medicaid Number: **000000756A**
Cost Report Period: From **1/1/2022** To **12/31/2022**

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	25,664,837	11,530,077	-	108,625	-	-	-	-	-	-	-			11,638,702	14,026,135	45.35%
2	Medicaid Fee for Service	Outpatient	7,050,219	5,136,051	-	17,660	-	411,239	-	-	-	-	-			5,564,950	1,485,269	78.93%
3	Medicaid Managed Care	Inpatient	20,702,263	-	13,606,629	-	59	-	-							13,606,688	7,095,575	65.73%
4	Medicaid Managed Care	Outpatient	16,826,465	-	16,432,605	52,094	1,845	-	-							16,486,544	339,921	97.98%
5	Medicare Cross-over (FFS)	Inpatient	15,113,362	710,545	-	4,512	2,959		-	9,923,132	-	338,053	289,688			11,268,889	3,844,473	74.56%
6	Medicare Cross-over (FFS)	Outpatient	3,949,781	259,304	1,452	10,898	9,060		-	2,150,656	-	53,854	78,412			2,563,636	1,386,145	64.91%
7	Other Medicaid Eligibles	Inpatient	22,954,509	439,058	328,266	4,729,535	13,808			-	10,024,412	-	-			15,535,079	7,419,430	67.68%
8	Other Medicaid Eligibles	Outpatient	11,717,727	591,020	307,622	7,052,814	27,539			-	4,637,881	-	-			12,616,876	(899,149)	107.67%
9	Uninsured	Inpatient	18,154,149	-	-	-	-	-	-	-	-	-	-	535,434	-	535,434	17,618,715	2.95%
10	Uninsured	Outpatient	14,354,833	-	-	-	-	-	-	-	-	-	-	1,004,720	-	1,004,720	13,350,113	7.00%
11	In-State Sub-total	Inpatient	102,589,120	12,679,680	13,934,895	4,842,672	16,826	-	-	9,923,132	10,024,412	338,053	289,688	535,434	-	52,584,792	50,004,328	51.26%
12	In-State Sub-total	Outpatient	53,899,025	5,986,375	16,741,679	7,133,466	38,444	411,239	-	2,150,656	4,637,881	53,854	78,412	1,004,720	-	38,236,726	15,662,299	70.94%
13	Out-of-State Medicaid	Inpatient	7,214,011	1,419,836	-	179,371	250	-	-	1,407,096	1,260,165	-	-			4,266,718	2,947,293	59.14%
14	Out-of-State Medicaid	Outpatient	1,710,953	224,910	-	394,654	1,580	-	-	132,517	157,949	-	-			911,610	799,343	53.28%
15	Sub-Total	I/P and O/P	165,413,109	20,310,801	30,676,574	12,550,163	57,100	411,239	-	13,613,401	16,080,407	391,907	368,100	1,540,154	-	95,999,846	69,413,263	58.04%
15.01	Provider Tax Assessment Adjustment to UCC																1,798,887	

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01	Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **FLOYD MEDICAL CENTER**
Hospital Medicaid Number: **000000756A**
Cost Report Period: From **1/1/2022** To **12/31/2022**
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	25,664,837	11,530,077	-	108,625	-	-	-	-	-	-	-			11,638,702	14,026,135	45.35%
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4	Medicaid Managed Care	Outpatient	16,826,465	-	16,432,605	52,094	1,845	-	-							16,486,544	339,921	97.98%
5	Medicare Cross-over (FFS)	Inpatient	15,113,362	710,545	-	4,512	2,959		-	9,923,132	-	338,053	289,688			11,268,889	3,844,473	74.56%
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9	Uninsured	Inpatient	18,154,149	-	-	-	-	-	-	-	-	-	-	535,434	-	535,434	17,618,715	2.95%
10	Uninsured	Outpatient	14,354,833	-	-	-	-	-	-	-	-	-	-	1,004,720	-	1,004,720	13,350,113	7.00%
11	In-State Sub-total	Inpatient	102,589,120	12,679,680	13,934,895	4,842,672	16,826	-	-	9,923,132	10,024,412	338,053	289,688	535,434	-	52,584,792	50,004,328	51.26%
12	In-State Sub-total	Outpatient	53,899,025	5,986,375	16,741,679	7,133,466	38,444	411,239	-	2,150,656	4,637,881	53,854	78,412	1,004,720	-	38,236,726	15,662,299	70.94%
13	Out-of-State Medicaid	Inpatient	7,214,011	1,419,836	-	179,371	250	-	-	1,407,096	1,260,165	-	-			4,266,718	2,947,293	59.14%
14	Out-of-State Medicaid	Outpatient	1,710,953	224,910	-	394,654	1,580	-	-	132,517	157,949	-	-			911,610	799,343	53.28%
15	Cost Report Year Sub-Total	I/P and O/P	165,413,109	20,310,801	30,676,574	12,550,163	57,100	411,239	-	13,613,401	16,080,407	391,907	368,100	1,540,154	-	95,999,846	69,413,263	58.04%
15.01															Provider Tax Assessment Adjustment		1,798,887	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		71,212,150	

Medicaid DSH Survey Adjustments

PROVIDER: FLOYD MEDICAL CENTER
FROM: 1/1/2022 TO: 12/31/2022
Mcaid Number: 000000756A
Mcare Number: 110054

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.

Medicaid DSH Report Notes

PROVIDER: FLOYD MEDICAL CENTER Mcaid Number: 000000756A
FROM: 1/1/2022 TO: 12/31/2022 Mcare Number: 110054

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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