State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	7/1/2019	6/30/2020

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	1/1/2020	12/31/2020	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000448A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110089

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	9/1/1953

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 1,435,252
   (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 07/01/2019 - 06/30/2020** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2019 - 06/30/2020** — $ 1,435,252

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Martin Hutson	912-384-1900	martin.hutson@coffeeregional.org

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

Hospital Contact:	
Name	Deborah Massey
Title	Patient Financial Services Director
Telephone Number	912-383-6982
E-Mail Address	deborah.massey@coffeeregional.org
Mailing Street Address	1101 Ocilla Rd
Mailing City, State, Zip	Douglas, GA 31533

Outside Preparer:	
Name	Hal Guthrie
Title	Partner
Firm Name	Dixon Hughes Goodman
Telephone Number	404-575-8947
E-Mail Address	Hal.Guthrie@dhg.com

DSH Version 8.00 1/28/2021

D. General Cost Report Year Information 1/1/2020 - 12/31/2020

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: COFFEE REGIONAL MEDICAL CENTER

	1/1/2020 through 12/31/2020		
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:			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	COFFEE REGIONAL MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000448A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110089	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	FLORIDA STATE MEDICAID	014116100
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: (01/01/2020 - 12/31/2020)

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)	$ 113,896	$ 1,048,940	$1,162,835
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 485,818	$ 3,124,181	$3,609,999
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)	$599,713	$4,173,121	$4,772,834
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	18.99%	25.14%	24.36%

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 (01/01/2020 - 12/31/2020)

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)	19,139 **(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	7,373,450
8.	Outpatient Hospital Charity Care Charges	11,049,430
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 18,422,880

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$20,507,324.00			$ 15,158,483	$ -	$ -	$ 5,348,841
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			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$153,213,092.00	$234,196,946.00		$ 113,251,152	$ 173,112,321	$ -	$ 101,046,565
20.	Outpatient Services		$51,230,821.00			$ 37,868,497	$ -	$ 13,362,324
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 4,770,846	-	-	$ 3,526,486	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$9,074,699.00	$ -	$ -	$ 6,707,783	$ -
27.	Total	$ 173,720,416	$ 285,427,767	$ 13,845,545	$ 128,409,635	$ 210,980,817	$ 10,234,268	$ 119,757,730
28.	Total Hospital and Non Hospital		Total from Above	$ 472,993,728		Total from Above	$ 349,624,721	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	472,993,728	Total Contractual Adj. (G-3 Line 2)	347,974,889
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)			+	1,649,832
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				349,624,721
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2020-12/31/2020) | COFFEE REGIONAL MEDICAL CENTER

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 17,748,065	$ -	$ -	$0.00	$ 17,748,065	20,774	$15,579,318.00		$ 854.34
2	03100 INTENSIVE CARE UNIT	$ 3,646,204	$ -	$ -		$ 3,646,204	3,274	$3,997,051.00		$ 1,113.68
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,306,903	$ -	$ -		$ 1,306,903	952	$930,955.00		$ 1,372.80
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 22,701,172	$ -	$ -	$ -	$ 22,701,172	25,000	$ 20,507,324		
19	Weighted Average									$ 908.05

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)	5,861	-	-	$ 5,007,287	$1,877,215.00	$3,514,990.00	$ 5,392,205	0.928616

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5000 OPERATING ROOM	$5,108,331.00	$ -	$0.00		$ 5,108,331	$14,801,205.00	$35,550,822.00	$ 50,352,027	0.101452
22	5100 RECOVERY ROOM	$460,996.00	$ -	$0.00		$ 460,996	$585,931.00	$1,355,748.00	$ 1,941,679	0.237421
23	5200 DELIVERY ROOM & LABOR ROOM	$1,559,148.00	$ -	$0.00		$ 1,559,148	$2,061,739.00	$265,511.00	$ 2,327,250	0.669953
24	5300 ANESTHESIOLOGY	$122,519.00	$ -	$0.00		$ 122,519	$2,157,682.00	$6,147,286.00	$ 8,304,968	0.014752
25	5400 RADIOLOGY-DIAGNOSTIC	$2,251,145.00	$ -	$0.00		$ 2,251,145	$6,092,717.00	$21,677,375.00	$ 27,770,092	0.081064
26	5700 CT SCAN	$3,648,903.00	$ -	$0.00		$ 3,648,903	$7,329,231.00	$23,752,403.00	$ 31,081,634	0.117397
27	5800 MRI	$924,963.00	$ -	$0.00		$ 924,963	$1,167,332.00	$5,903,709.00	$ 7,071,041	0.130810
28	5900 CARDIAC CATHETERIZATION	$2,833,699.00	$ -	$0.00		$ 2,833,699	$10,070,919.00	$19,569,358.00	$ 29,640,277	0.095603
29	6000 LABORATORY	$6,149,104.00	$ -	$0.00		$ 6,149,104	$31,247,851.00	$32,156,366.00	$ 63,404,217	0.096983
30	6500 RESPIRATORY THERAPY	$1,841,966.00	$ -	$0.00		$ 1,841,966	$13,491,061.00	$2,305,692.00	$ 15,796,753	0.116604

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6600	PHYSICAL THERAPY	$1,550,867.00	$ -	$0.00		$ 1,550,867	$1,250,254.00	$3,216,157.00	$ 4,466,411	0.347229
32	6800	SPEECH PATHOLOGY	$86,582.00	$ -	$0.00		$ 86,582	$411,326.00	$40,957.00	$ 452,283	0.191433
33	6900	ELECTROCARDIOLOGY	$119,711.00	$ -	$0.00		$ 119,711	$5,722,092.00	$7,178,078.00	$ 12,900,170	0.009280
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$5,722,884.00	$ -	$0.00		$ 5,722,884	$7,308,853.00	$6,618,586.00	$ 13,927,439	0.410907
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$8,335,366.00	$ -	$0.00		$ 8,335,366	$9,670,673.00	$11,944,557.00	$ 21,615,230	0.385625
36	7300	DRUGS CHARGED TO PATIENTS	$14,096,806.00	$ -	$0.00		$ 14,096,806	$32,579,146.00	$56,385,043.00	$ 88,964,189	0.158455
37	7400	RENAL DIALYSIS	$504,332.00	$ -	$0.00		$ 504,332	$1,450,326.00	$129,298.00	$ 1,579,624	0.319273
38	9001	WOUND CARE CLINIC	$411,009.00	$ -	$0.00		$ 411,009	$4,100.00	$1,828,190.00	$ 1,832,290	0.224314
39	9002	INFUSION CLINIC	$612,120.00	$ -	$0.00		$ 612,120	$0.00	$1,271,700.00	$ 1,271,700	0.481340
40	9100	EMERGENCY	$6,100,147.00	$ -	$0.00		$ 6,100,147	$3,933,439.00	$13,010,229.00	$ 16,943,668	0.360025
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 62,440,598	$ -	$ -		$ 62,440,598	$ 153,213,092	$ 253,822,055	$ 407,035,147	
127	**Weighted Average**									0.165705
128	**Sub Totals**	$ 85,141,770	$ -	$ -		$ 85,141,770	$ 173,720,416	$ 253,822,055	$ 427,542,471	
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)*					$0.00				
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**					$ 85,141,770				
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 (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)
1	03000	ADULTS & PEDIATRICS	$ 854.34	1,424	975	1,554
2	03100	INTENSIVE CARE UNIT	$ 1,113.68	484	46	246
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	$ 1,372.80	63	592	-
11			$ -			
12			$ -			
13			$ -			
14			$ -			
15			$ -			
16			$ -			
17			$ -			
18			**Total Days**	1,971	1,613	1,800
19	Total Days per PS&R or Exhibit Detail			1,971	1,613	1,800
20		Unreconciled Days (Explain Variance)		-	-	-
				Routine Charges	**Routine Charges**	**Routine Charges**
21		Routine Charges		$ 2,007,562	$ 1,386,227	$ 1,797,638
21.01		Calculated Routine Charge Per Diem		$ 1,018.55	$ 859.41	$ 998.69

		Ancillary Cost Centers (from W/S C) (from Section G):		**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)	0.928616	282,982	871,464	185,746	392,620	255,431	498,350
23	5000	OPERATING ROOM	0.101452	1,177,690	1,998,450	1,580,111	3,915,827	1,164,861	949,136
24	5100	RECOVERY ROOM	0.237421	38,384	68,085	123,628	203,518	42,005	25,245
25	5200	DELIVERY ROOM & LABOR ROOM	0.669953	48,445	-	879,223	-	2,237	-
26	5300	ANESTHESIOLOGY	0.014752	152,108	303,781	424,810	772,866	147,189	132,993
27	5400	RADIOLOGY-DIAGNOSTIC	0.081064	699,013	1,216,832	212,668	1,562,488	736,799	750,185
28	5700	CT SCAN	0.117397	796,668	1,502,169	136,833	2,041,886	558,877	1,083,672
29	5800	MRI	0.130810	143,220	304,768	27,751	377,379	100,266	305,422
30	5900	CARDIAC CATHETERIZATION	0.095603	1,393,405	846,189	88,111	432,322	1,094,823	799,371
31	6000	LABORATORY	0.096983	3,663,212	2,220,550	1,422,617	3,356,063	3,297,309	1,352,612
32	6500	RESPIRATORY THERAPY	0.116604	1,149,194	125,186	227,671	141,347	945,857	100,986
33	6600	PHYSICAL THERAPY	0.347229	119,832	68,591	9,890	197,958	103,714	35,443
34	6800	SPEECH PATHOLOGY	0.191433	13,139	3,404	125,122	1,585	40,716	4,963
35	6900	ELECTROCARDIOLOGY	0.009280	459,974	198,975	71,032	301,140	662,264	453,665
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.410907	1,073,587	1,091,702	905,517	1,679,198	1,034,149	642,325
37	7200	IMPL. DEV. CHARGED TO PATIENTS	0.385625	1,154,211	606,370	409,268	410,404	1,002,985	553,457
38	7300	DRUGS CHARGED TO PATIENTS	0.158455	2,381,934	1,877,247	807,543	1,390,709	2,582,293	1,176,085
39	7400	RENAL DIALYSIS	0.319273	156,876	-	54,684	3,416	311,530	17,934

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
40	9001	WOUND CARE CLINIC	0.224314	-	-	-	4,480	-	2,980
41	9002	INFUSION CLINIC	0.481340	-	-	-	51,878	-	21,981
42	9100	EMERGENCY	0.360025	439,420	963,705	104,233	2,240,160	345,979	366,891
43			-						
44			-						
45			-						
46			-						
47			-						
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83			-						
84			-						

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
85			-						
86			-						
87			-						
88			-						
89			-						
90			-						
91			-						
92			-						
93			-						
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118			-						
119			-						
120			-						
121			-						
122			-						
123			-						
124			-						
125			-						
126			-						
127			-						
				$ 15,343,294	$ 14,267,468	$ 7,796,459	$ 19,477,243	$ 14,429,283	$ 9,273,697

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	
	Totals / Payments						
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 17,350,856	$ 14,267,468	$ 9,182,686	$ 19,477,243	$ 16,226,921	$ 9,273,697
129	Total Charges per PS&R or Exhibit Detail	$ 17,350,856	$ 14,267,468	$ 9,182,686	$ 19,477,243	$ 16,226,921	$ 9,273,697
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 4,579,918	$ 3,011,509	$ 3,605,129	$ 3,594,650	$ 4,138,692	$ 1,844,637
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 4,003,761	$ 1,940,089	$ -	$ 1,292	$ 233,842	$ 145,930
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 2,842,462	$ 2,629,801	$ 8,850	$ -
134	Private Insurance (including primary and third party liability)	$ 148,922	$ 17,653	$ -	$ 12,342	$ 980	$ 1,650
135	Self-Pay (including Co-Pay and Spend-Down)	$ 138	$ 1,706	$ 51	$ 302	$ -	$ 56
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 4,152,820	$ 1,959,448	$ 2,842,512	$ 2,643,736		
137	Medicaid Cost Settlement Payments (See Note B)		$ 194,738				
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)						
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 3,757,184	$ 1,041,132
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ 113,147	$ 129,737
142	Other Medicare Cross-Over Payments (See Note D)						
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)**	$ 427,098	$ 857,323	$ 762,617	$ 950,914	$ 24,689	$ 526,133
146	**Calculated Payments as a Percentage of Cost**	91%	72%	79%	74%	99%	71%
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)**					10,691	
148	**Percent of cross-over days to total Medicare days from the cost report**					17%	

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

					In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
1	03000	ADULTS & PEDIATRICS	$	854.34	1,471		1,147		5,424		44.06%
2	03100	INTENSIVE CARE UNIT	$	1,113.68	242		251		1,018		38.76%
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	$	1,372.80	123		16		778		83.40%
11			$	-					-		
12			$	-					-		
13			$	-					-		
14			$	-					-		
15			$	-					-		
16			$	-					-		
17			$	-					-		
18					**Total Days**	1,836		1,414		7,220	34.54%
19	Total Days per PS&R or Exhibit Detail					1,836		1,414			
20		Unreconciled Days (Explain Variance)				-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$	1,787,383	$	1,403,526	$	6,978,810	40.87%
21.01		Calculated Routine Charge Per Diem			$	973.52	$	992.59	$	966.59	

Ancillary Cost Centers (from W/S C) (from Section G):

				Ancillary Charges	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200	Observation (Non-Distinct)	0.928616	270,344	1,099,882	228,526	680,583	$ 994,502	$ 2,862,315	88.39%
23	5000	OPERATING ROOM	0.101452	1,288,456	3,459,358	1,104,747	2,612,017	$ 5,211,118	$ 10,322,771	38.26%
24	5100	RECOVERY ROOM	0.237421	65,650	124,695	60,435	121,635	$ 269,667	$ 421,543	45.01%
25	5200	DELIVERY ROOM & LABOR ROOM	0.669953	281,446	-	16,555	-	$ 1,211,351	$ -	52.76%
26	5300	ANESTHESIOLOGY	0.014752	211,879	546,351	216,699	463,911	$ 935,986	$ 1,755,991	40.64%
27	5400	RADIOLOGY-DIAGNOSTIC	0.081064	581,396	2,257,561	610,161	1,802,397	$ 2,229,876	$ 5,787,066	37.56%
28	5700	CT SCAN	0.117397	581,013	2,287,997	641,131	4,502,074	$ 2,073,391	$ 6,915,724	45.51%
29	5800	MRI	0.130810	110,151	519,943	127,795	283,272	$ 381,388	$ 1,507,512	32.53%
30	5900	CARDIAC CATHETERIZATION	0.095603	971,379	3,300,814	1,341,861	1,015,844	$ 3,547,718	$ 5,378,696	38.07%
31	6000	LABORATORY	0.096983	3,017,017	3,056,315	2,961,491	4,778,739	$ 11,400,155	$ 9,985,540	45.94%
32	6500	RESPIRATORY THERAPY	0.116604	809,078	238,336	520,318	163,914	$ 3,131,800	$ 605,855	27.99%
33	6600	PHYSICAL THERAPY	0.347229	123,025	302,658	51,445	132,988	$ 356,461	$ 604,650	25.65%
34	6800	SPEECH PATHOLOGY	0.191433	49,743	4,121	7,503	634	$ 228,720	$ 14,073	55.48%
35	6900	ELECTROCARDIOLOGY	0.009280	565,913	995,116	606,163	792,106	$ 1,759,183	$ 1,948,896	39.58%
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.410907	1,062,458	2,108,723	968,484	2,274,017	$ 4,075,711	$ 5,521,948	92.24%
37	7200	IMPL. DEV. CHARGED TO PATIENTS	0.385625	826,466	1,789,775	342,703	712,850	$ 3,392,930	$ 3,360,006	36.12%
38	7300	DRUGS CHARGED TO PATIENTS	0.158455	1,786,928	3,819,002	1,285,932	1,949,207	$ 7,558,698	$ 8,263,044	21.42%
39	7400	RENAL DIALYSIS	0.319273	72,796	11,102	82,368	44,238	$ 595,886	$ 32,452	47.79%

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
40	9001	WOUND CARE CLINIC	0.224314	-	55,302	-	20,354	$ -	$ 62,762	4.54%
41	9002	INFUSION CLINIC	0.481340	-	145,770	-	70,109	$ -	$ 219,629	22.78%
42	9100	EMERGENCY	0.360025	341,381	1,162,165	466,731	3,280,457	$ 1,231,013	$ 4,732,921	57.34%
43			-					$ -	$ -	
44			-					$ -	$ -	
45			-					$ -	$ -	
46			-					$ -	$ -	
47			-					$ -	$ -	
48			-					$ -	$ -	
49			-					$ -	$ -	
50			-					$ -	$ -	
51			-					$ -	$ -	
52			-					$ -	$ -	
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69			-					$ -	$ -	
70			-					$ -	$ -	
71			-					$ -	$ -	
72			-					$ -	$ -	
73			-					$ -	$ -	
74			-					$ -	$ -	
75			-					$ -	$ -	
76			-					$ -	$ -	
77			-					$ -	$ -	
78			-					$ -	$ -	
79			-					$ -	$ -	
80			-					$ -	$ -	
81			-					$ -	$ -	
82			-					$ -	$ -	
83			-					$ -	$ -	
84			-					$ -	$ -	

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
85			-					$ -	$ -
86			-					$ -	$ -
87			-					$ -	$ -
88			-					$ -	$ -
89			-					$ -	$ -
90			-					$ -	$ -
91			-					$ -	$ -
92			-					$ -	$ -
93			-					$ -	$ -
94			-					$ -	$ -
95			-					$ -	$ -
96			-					$ -	$ -
97			-					$ -	$ -
98			-					$ -	$ -
99			-					$ -	$ -
100			-					$ -	$ -
101			-					$ -	$ -
102			-					$ -	$ -
103			-					$ -	$ -
104			-					$ -	$ -
105			-					$ -	$ -
106			-					$ -	$ -
107			-					$ -	$ -
108			-					$ -	$ -
109			-					$ -	$ -
110			-					$ -	$ -
111			-					$ -	$ -
112			-					$ -	$ -
113			-					$ -	$ -
114			-					$ -	$ -
115			-					$ -	$ -
116			-					$ -	$ -
117			-					$ -	$ -
118			-					$ -	$ -
119			-					$ -	$ -
120			-					$ -	$ -
121			-					$ -	$ -
122			-					$ -	$ -
123			-					$ -	$ -
124			-					$ -	$ -
125			-					$ -	$ -
126			-					$ -	$ -
127			-					$ -	$ -
				$ 13,016,519	$ 27,284,986	$ 11,641,049	$ 25,701,346		

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
	Totals / Payments							
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 14,803,902	$ 27,284,986	$ 13,044,575 (Agrees to Exhibit A)	$ 25,701,346 (Agrees to Exhibit A)	$ 57,564,365	$ 70,303,393	38.98%
129	Total Charges per PS&R or Exhibit Detail	$ 14,803,902	$ 27,284,986	$ 13,044,575	$ 25,701,346			
130	Unreconciled Charges (Explain Variance)	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 4,135,750	$ 5,350,835	$ 3,205,103	$ 5,029,394	$ 16,459,489	$ 13,801,631	45.22%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 257,536	$ 233,878			$ 4,495,138	$ 2,321,188	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 123,035	$ 99,564			$ 2,974,347	$ 2,729,365	
134	Private Insurance (including primary and third party liability)	$ 836,747	$ 776,769			$ 986,648	$ 808,414	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 5,882	$ 16,577			$ 6,070	$ 18,641	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)							
137	Medicaid Cost Settlement Payments (See Note B)					$ -	$ 194,738	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)					$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)	$ 648,073	$ 852,195			$ 4,405,257	$ 1,893,327	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	$ 1,984,820	$ 2,487,788			$ 1,984,820	$ 2,487,788	
141	Medicare Cross-Over Bad Debt Payments			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 113,147	$ 129,737	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)			$ 113,896	$ 1,048,940			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Se			$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 279,658	$ 884,063	$ 3,091,207	$ 3,980,454	$ 1,494,062	$ 3,218,433	
146	**Calculated Payments as a Percentage of Cost**	93%	83%	4%	21%	91%	77%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, C**							
148	**Percent of cross-over days to total Medicare days from the cost report**							

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 854.34		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ 1,113.68		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ 1,372.80		-		-		-		-		-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		0.928616	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.101452	-	-	-	-	-	-	-	11,571	$ -	$ 11,571
24	5100 RECOVERY ROOM		0.237421	-	-	-	-	-	-	-	765	$ -	$ 765
25	5200 DELIVERY ROOM & LABOR ROOM		0.669953	-	-	-	-	-	-	-	-	$ -	$ -
26	5300 ANESTHESIOLOGY		0.014752	-	-	-	-	-	-	-	2,471	$ -	$ 2,471
27	5400 RADIOLOGY-DIAGNOSTIC		0.081064	-	268	-	-	-	-	-	536	$ -	$ 804
28	5700 CT SCAN		0.117397	-	-	-	-	-	-	-	12,132	$ -	$ 12,132
29	5800 MRI		0.130810	-	-	-	-	-	-	-	-	$ -	$ -
30	5900 CARDIAC CATHETERIZATION		0.095603	-	-	-	-	-	-	-	-	$ -	$ -
31	6000 LABORATORY		0.096983	-	-	-	-	-	250	-	3,145	$ -	$ 3,395
32	6500 RESPIRATORY THERAPY		0.116604	-	-	-	-	-	-	-	-	$ -	$ -
33	6600 PHYSICAL THERAPY		0.347229	-	-	-	-	-	-	-	-	$ -	$ -
34	6800 SPEECH PATHOLOGY		0.191433	-	-	-	-	-	-	-	-	$ -	$ -
35	6900 ELECTROCARDIOLOGY		0.009280	-	-	-	-	-	-	-	-	$ -	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.410907	-	-	-	-	-	72	-	6,727	$ -	$ 6,799
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.385625	-	-	-	-	-	-	-	-	$ -	$ -
38	7300 DRUGS CHARGED TO PATIENTS		0.158455	-	64	-	-	-	-	-	1,174	$ -	$ 1,238
39	7400 RENAL DIALYSIS		0.319273	-	-	-	-	-	-	-	-	$ -	$ -
40	9001 WOUND CARE CLINIC		0.224314	-	-	-	-	-	-	-	-	$ -	$ -
41	9002 INFUSION CLINIC		0.481340	-	-	-	-	-	-	-	-	$ -	$ -
42	9100 EMERGENCY		0.360025	-	395	-	-	-	638	-	3,610	$ -	$ 4,643
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ 727	$ -	$ -	$ -	$ 960	$ -	$ 42,131		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ 727	$ -	$ -	$ -	$ 960	$ -	$ 42,131	$ -	$ 43,818
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 727	$ -	$ -	$ -	$ 960	$ -	$ 42,131		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ 174	$ -	$ -	$ -	$ 284	$ -	$ 7,415	$ -	$ 7,873
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ 68	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 68
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)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,270	$ -	$ 2,270
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 68	$ -	$ -						
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)					$ -	$ 168	$ -	$ -	$ -	$ 168
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ 82	$ -	$ 82
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ 106	$ -	$ -	$ -	$ 116	$ -	$ 5,063	$ -	$ 5,285
144	**Calculated Payments as a Percentage of Cost**	0%	39%	0%	0%	0%	59%	0%	32%	0%	33%

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 (01/01/2020-12/31/2020) COFFEE REGIONAL 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	$0.00	$ -	$ -		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 (01/01/2020-12/31/2020) COFFEE REGIONAL 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 Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report 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								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2020-12/31/2020) COFFEE REGIONAL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 1,154,464		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	7701-3514	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,154,464	Administrative and General	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Medicare non allowable expense	$ (1,154,464)		*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 1,154,464
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	127,911,576
19	Uninsured Hospital	**Charges Sec. G**	38,745,921
20	Total Hospital	**Charges Sec. G**	427,542,471
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.92%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.06%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 345,391
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 104,623
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 450,014**

** 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.*