State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2022

			DSH Version	6.02	2/10/2023
A. General DSH Year Information					
1. DSH Year:	Begin 07/01/2021	End 06/30/2022			
2. Select Your Facility from the Drop-Down Menu Provided:	CHILDREN'S HLTHCRE-HUGHES S	PALDING			
Identification of cost reports needed to cover the DSH Year:					
 Cost Report Year 1 Cost Report Year 2 (if applicable) Cost Report Year 3 (if applicable) 		t Report Date(s) 12/31/2022 Must also complete a	separate survey file for each cos	t report period listed - SEE [DSH SURVEY PART II FILES
	Data				
6. Medicaid Provider Number:	0006798	08A			
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0				
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0				
9. Medicare Provider Number:	110079				

B. DSH Qualifying Information

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

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to
provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital
located in a rural area, the term "obstetrician" includes any physician with staff privileges at the
hospital to perform nonemergency obstetric procedures.)

- 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 3. Was the hospital exempt from the requirement listed under #1 above because it did not offer nonemergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

DSH Examination Year (07/01/21 - 06/30/22)
No

	Yes	
_	Ne	
	No	

Yes
1952

State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2022

Disclosure of Other Medicaid Payments Received:		
1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021	06/30/2022	\$ 2,781,519
(Should include UPL and non-claim specific payments paid based on the state fisc	al year. However, DSH payments should NOT be inclu	uded.)
2. Medicaid Managed Care Supplemental Payments for hospital services for DS	3H Year 07/01/2021 - 06/30/2022	\$ -
(Should include all non-claim specific payments for hospital services such as lump	sum payments for full Medicaid pricing (FMP), supple	ementals, quality payments, bonus
payments, capitation payments received by the hospital (not by the MCO), or othe	r incentive payments.	
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part I	l, Section E, Question 14 should be reported here if pa	aid on a SFY basis.
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospi	tal Services07/01/2021 - 06/30/2022	\$ 2,781,519
··· ····· · ···· · ···· · ····		
ification:		
incation:		
		Answer
1. Was your hospital allowed to retain 100% of the DSH payment it received for	this DSH year?	Yes
Matching the federal share with an IGT/CPE is not a basis for answering this		
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.		
Evaluation for "No" analysis		
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 h	pest of our ability, and supported by the financial and other
records of the hospital. All Medicaid eligible patients, including those who have priv		
payment on the claim. I understand that this information will be used to determine		
provisions. Detailed support exists for all amounts reported in the survey. These re		
available for inspection when requested.		
	SVP & CFO	
Hospital CEO or CFO Signature	Title	Date
Ruth Fowler	404-785-7006	ruth.fowler@choa.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Num	
Contact Information for individuals authorized to respond to inquiries related	d to this survey:	
Hospital Contact:	•	Quisida Proparar:
Hospital Contact: Name Sherry Came		Outside Preparer: Name
Title Reimbursem		Title
Telephone Number 404-785-796		Firm Name
E-Mail Address sherry.came		
		Telephone Number
Mailing Street Address <u>1575 NE Exp</u> Mailing City, State, Zip Atlanta, GA	ron@choa.org pressway	

Provider Name	CHILDREN'S HLTHCRE-HUGHES SPALDING
Mcaid Provider Number	000679808A
Mcare Provider Number	110079

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:							6/30/2024
	(A) (B) (C) (D) (E)						
Cost Report Year UCC:	Cost Report Year Begin 1/1/2022 -	Cost Report Year End 12/31/2022	As-Filed DSH Uncompensated Care Cost (UCC) \$ (10,513,802)	Total Adjustments \$-	Adjusted DSH Uncompensated Care Cost (UCC) \$ (10,513,802)		
Less: 2022 Net UPL Payments Less: 2024 Net DPP Payments Plus: 2023 Net DPP Recoupmer Less: GME Payments Add: Net OP Settlement (Differ Add: Provider tax excluded fro Uncompensated Care Allocatio Hospital Specific DSH Limit 2024 Eligibility	ence between pro m the cost report (\$ 262,645 \$ 6,176,785 \$ 2,382,908 \$ 201,094 \$ 14,353 \$ (19,120,693) \$ (22,454,263)		
DSH Year Low Income Utiliza DSH Year Medicaid Inpatient					102.96% 64.66%		

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 receive	ed from the state. Please r	review ti	nis information for it	ems 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:	CHILDREN'S HLTHCRE-HUGHES SPALDING		
2. Select Cost Report Year Covered by this Survey:	1/1/2022 through 12/31/2022 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:	6/13/2023		
	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	Data CHILDREN'S HLTHCRE-HUGHES SPALDING	Correct? Yes	If Incorrect, Proper Information
4. Hospital Name: 5. Medicaid Provider Number:			If Incorrect, Proper Information
	CHILDREN'S HLTHCRE-HUGHES SPALDING	Yes	If Incorrect, Proper Information
5. Medicaid Provider Number:	CHILDREN'S HLTHCRE-HUGHES SPALDING	Yes	If Incorrect, Proper Information
5. Medicaid Provider Number: 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	CHILDREN'S HLTHCRE-HUGHES SPALDING	Yes	If Incorrect, Proper Information

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		
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)

L. Disclosure of medicala / offinisarea r ayments received. (01/01/2022 - 12/01/2022)			
Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Total Section 1011 Payment Related to Hospital Services (See Note 1) Section 1011 Payment Related to Non-Hospital Services (See Note 1) Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1) Section 1011 Payment Related to Non-Hospital Services (See Note 1)	\$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -		
8. Out-of-State DSH Payments (See Note 2)	\$-		
 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B) 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B) 11. Total Cash Basis Patient Payments Reported on Exhibit B(Agrees to Column (N) on Exhibit B) 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments: 	Inpatient	Outpatient \$ 210,329 \$ 627,972 \$838,301 25.09%	Total \$210,929 \$643,379 \$854,308 24.69%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation	No payments received by the ho	nspital (not by the MCO), or othe.	r incentive payments.

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

Version	8.1	1

\$

\$-

7,011,41

7,510,715

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) 2,487

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

- 2. Inpatient Hospital Subsidies
- 3. Outpatient Hospital Subsidies
- 4. Unspecified I/P and O/P Hospital Subsidies
- 5. Non-Hospital Subsidies
- 6. Total Hospital Subsidies
- 7. Inpatient Hospital Charity Care Charges
- 8. Outpatient Hospital Charity Care Charges
- 9. Non-Hospital Charity Care Charges
- 10. Total Charity Care Charges

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

	Tota	I Patient Revenues (Charge	es)		Contractual Adjustments		
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Reve
11. Hospital	\$ 7,286,046	\$-	\$-	\$ 5,589,544	\$-	\$-	\$ 1,696,
12. Psych Subprovider	\$-	\$-	\$-	\$-	\$-	\$-	\$
13. Rehab. Subprovider	\$	\$-	\$-	\$ -	\$ -	\$-	\$
14. Swing Bed - SNF			\$ -			\$ -	
15. Swing Bed - NF			\$ -			\$-	
16. Skilled Nursing Facility			\$ -			\$ -	
17. Nursing Facility			\$ -			\$ -	
18. Other Long-Term Care	40.045.550	£ 50 404 407	\$ -	40.075.405	40,000,500	\$-	\$ 15.674.
19. Ancillary Services 20. Outpatient Services	\$ 13,915,559	\$ 53,404,407 \$ 155,257,311	\$ - \$ -	\$ 10,675,425	\$ 40,969,588 \$ 119,106,802	\$ - \$ -	\$ 15,674, \$ 36,150.
20. Outpatient Services 21. Home Health Agency		\$ 100,207,311	⇒ - \$ -		T19,100,002	ф -	\$ 30,10U,
21. Home Health Agency 22. Ambulance			\$ - \$ -			> -	
23. Outpatient Rehab Providers	¢	¢	s -	¢	¢	9 - C	s
24. ASC	у «	φ - \$ -	\$	\$	\$ -	φ - 2	s s
25. Hospice	•	Ψ	\$ -	Ψ	•	\$ -	, end of the second sec
26. Other	\$-	\$-	\$ 3,394,390	\$-	\$-	\$ 2,604,032	\$
27. Total	\$ 21,201,605	\$ 208.661.718	\$ 3,394,390	\$ 16.264.969	\$ 160.076.390	\$ 2,604,032	\$ 53,521
28. Total Hospital and Non Hospital		Total from Above	\$ 233,257,713		Total from Above	\$ 178,945,391	
29. Total Per Cost Report 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED or		nt Revenues (G-3 Line 1) ct is a decrease in net	\$ 233,257,713	Total Con	tractual Adj. (G-3 Line 2)	\$ 178,945,391	
patient revenue)						+ \$ -	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT IN decrease in net patient revenue)	NCLUDED on worksheet G-3,	Line 2 (impact is a				+ \$ _	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH is a decrease in net patient revenue)	Revenue INCLUDED on work	ksheet G-3, Line 2 (impact				+ \$	
 Increase worksheet G-3, Line 2 to reverse offset of State and Loca worksheet G-3, Line 2 (impact is a decrease in net patient revenue) 		s INCLUDED on				+ \$ _	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Tax increase in net patient revenue)	es INCLUDED on worksheet	G-3, Line 2 (impact is an				s -	
35. Adjusted Contractual Adjustments 36. Unreconciled Difference	Unreconciled [Difference (Should be \$0)	\$ -	Unreconciled E	Difference (Should be \$0)	178,945,391 \$	

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HLTHCRE-HUGHES SPALDING

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 0	Cost Centers (list below):									
	OULTS & PEDIATRICS	\$ 208,987,151	\$ 48,581,618	\$ 1,858,006	-	\$ 259,426,775	170,403	\$ 444,413,039		\$ 1,522.43
03100 INT	TENSIVE CARE UNIT	\$ 117,028,291	\$ 9,337,441	\$ -		\$ 126,365,732	48,211	\$ 283,215,132		\$ 2,621.10
03200 CO	DRONARY CARE UNIT	\$-	\$-	\$-		\$-	-	\$-		\$-
03300 BU	JRN INTENSIVE CARE UNIT	\$-	\$-	\$-		\$-	-	\$-		\$-
	JRGICAL INTENSIVE CARE UNIT	\$ 58,069,626	\$ 3,659,201	\$ 173,566		\$ 61,902,393	15,887	\$ 155,153,994		\$ 3,896.42
	THER SPECIAL CARE UNIT	\$-		\$ -		\$-	-	\$-		\$-
	JBPROVIDER I	\$-	Ŧ	\$ -		\$-	-	\$-		\$-
	JBPROVIDER II	\$-		\$ -		\$-	-	\$-		\$-
	THER SUBPROVIDER	\$-	Ŷ	\$ -		\$-	-	\$-		\$-
	JRSERY	\$ 9,025,372		\$ -		\$ 9,927,709		\$ 6,418,082		\$ 2,059.26
	ONATAL INTENSIVE CARE UNIT	\$ 24,512,092	+ -,,	\$ -		\$ 26,625,854	11,228	\$ 54,139,910		\$ 2,371.38
4400 SK	KILLED NURSING FACILITY	\$ 26,360,785		\$ -		\$ 26,360,785		\$ 24,549,334		\$-
	Total Routine	\$ 443,983,317	\$ 64,594,359	\$ 2,031,572	\$ -	\$ 510,609,248	250,550	\$ 967,889,491		
	Weighted Average									\$ 1,932.74
Observati	ion Data (Non-Distinct)		Observation Days - Cost Report W/S S- 3, Pt. I, Line 28, Col. 8	Observation Days - Cost Report W/S S- 3, Pt. I, Line 28.01, Col. 8	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
09200 Ob	oservation (Non-Distinct)								000	
			6,845	-	-	\$ 10,421,033	3,410,644	18,760,942	\$ 22,171,586	0.470017
		Cost Report Worksheet B, Part I, Col. 26	6,845 Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY	Cost Report Worksheet C, Part I, Col.2 and Col. 4		\$ 10,421,033 Calculated	3,410,644 Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	18,760,942 Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7		0.470017 Medicaid Calculated Cost-to-Charge Ratio
Ancillary	Cost Centers (from W/S C excluding Ot	Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY	Worksheet C, Part I, Col.2 and			Inpatient Charges - Cost Report Worksheet C, Pt. I,	Outpatient Charges - Cost Report Worksheet C, Pt. I,	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I,	Medicaid Calculated
5000 OP	PERATING ROOM	Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY w):	Worksheet C, Part I, Col.2 and	-	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I,	Outpatient Charges - Cost Report Worksheet C, Pt. I,	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684	Medicaid Calculated Cost-to-Charge Ratio 0.060843
5000 OP 5200 DE	PERATING ROOM ELIVERY ROOM & LABOR ROOM	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y w): \$ 6,533,218 \$ 653,072	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ -	-	Calculated \$ 75,651,663 \$ 26,178,054	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697
5000 OP 5200 DE 5300 AN	PERATING ROOM ELIVERY ROOM & LABOR ROOM IESTHESIOLOGY	Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y): \$ 6,533,218 \$ 653,072 \$ 4,449,368	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ - \$ 136,295	-	Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746
5000 OP 5200 DE 5300 AN 5400 RA	PERATING ROOM ELIVERY ROOM & LABOR ROOM IESTHESIOLOGY ADIOLOGY-DIAGNOSTIC	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y): \$ 6,533,218 \$ 653,072 \$ 4,449,368	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ -		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA	PERATING ROOM LIVERY ROOM & LABOR ROOM JESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY w): \$ 6,533,218 \$ 653,072 \$ 4,449,368 \$ 5,541,146 \$ -	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ - \$ 136,295 \$ 34,205 \$ -	-	Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA	PERATING ROOM LIVERY ROOM & LABOR ROOM IESTHESIOLOGY JDIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW JDIOLSOTOPE	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232 \$ 8,892,072	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y): \$ 6,533,218 \$ 653,072 \$ 4,449,368 \$ 5,541,146 \$ - \$ 147,066	Worksheet C, Part I, Col.2 and Col. 4 \$ 803,215 \$	-	Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,582,338	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ \$ 80,997,714	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,580,052	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071 0.077654
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT	PERATING ROOM ELIVERY ROOM & LABOR ROOM IESTHESIOLOGY UDIOLOGY-DIAGNOSTIC UDIOLOGY-DIAGNOSTIC-CRESTVIEW UDIOISOTOPE SCAN	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232 \$ 8,892,072 \$ 8,021,962	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONL Y *): \$ 6,533,218 \$ 653,072 \$ 4,449,368 \$ 5,541,146 \$ - \$ 147,066 \$ 795,153	Worksheet C, Part I, Col.2 and Col. 4 \$ 803,215 \$		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 8,888,221	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,582,338 \$ 342,457,835	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ - \$ 80,997,714 \$ 287,677,338	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,680,052 \$ 630,135,173	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.014105
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR	PERATING ROOM LIVERY ROOM & LABOR ROOM IESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232 \$ 8,892,072 \$ 8,021,962 \$ 4,369,991	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY \$ 6,533,218 \$ 653,072 \$ 4,449,368 \$ 5,541,146 \$\$ \$ 147,066 \$ 795,153 \$ 112,169	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ 136,295 \$ 34,201 \$ - \$ 13,723 \$ 71,106 \$ 9,922	-	Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 8,888,221 \$ 4,492,082 \$ 4,492,082	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,228 \$ 35,582,338 \$ 342,457,835 \$ 48,817,875	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ - \$ 80,997,714 \$ 287,677,338 \$ 39,728,886	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.13083 1.511071 0.077654 0.014105 0.050731
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR 6000 LA	PERATING ROOM LIVERY ROOM & LABOR ROOM JESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN RI BORATORY	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232 \$ 8,892,072 \$ 8,021,962 \$ 4,369,991 \$ 47,390,380	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY w): \$ 6,533,218 \$ 653,072 \$ 4,449,388 \$ 5,541,146 \$ - \$ 147,066 \$ 795,153 \$ 142,106 \$ 2,081,357	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$	-	Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 3,232 \$ 9,052,861 \$ 8,888,221 \$ 4,492,082 \$ 4,492,082 \$ 4,9545,227	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,582,338 \$ 342,457,835 \$ 48,817,878 \$ 420,241,583	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ - \$ 80,997,714 \$ 287,677,338	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774 \$ 791,306,494	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.014105 0.050731 0.062612
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR 6000 LA 6001 LA	PERATING ROOM LIVERY ROOM & LABOR ROOM IESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN RI BORATORY BORATORY	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 30,833,274 \$ 30,833,274 \$ 53,232 \$ 8,862,072 \$ 8,862,072 \$ 8,8021,962 \$ 4,369,991 \$ 47,390,380 \$ 50,210	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY *): \$ 6,533,218 \$ 653,072 \$ 4,449,388 \$ 5,541,146 \$ 5,541,146 \$ 147,066 \$ 795,153 \$ 112,169 \$ 2,081,357 \$ -	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$ - \$ 136,295 \$ 34,201 \$ - \$ 13,723 \$ 71,106 \$ 9,922 \$ 73,490 \$ -		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 8,888,221 \$ 4,492,082 \$ 4,492,082 \$ 4,9545,227 \$ 50,210	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 927,402,958 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 167,753,863 \$ 136,776,626 \$ 35,582,338 \$ 342,457,835 \$ 48,817,876 \$ 420,241,583 \$ 1,154,525	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ \$ 80,997,714 \$ 287,677,338 \$ 39,728,896 \$ 371,064,911 \$ -	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774 \$ 791,306,494 \$ 1,154,525	Medicaid Calculated Cost-to-Charge Ratio 0.423697 0.044746 0.130883 1.511071 0.047654 0.014105 0.050731 0.062612 0.043490
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR 6000 LA 6001 LA 6200 WH	PERATING ROOM LIVERY ROOM & LABOR ROOM JESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN SCAN BORATORY BORATORY BORATORY-CRESTVIEW HOLE BLOOD & PACKED RED BLOOD CELL	Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY *): \$ 6,533,218 \$ 653,072 \$ 4,449,388 \$ 5,541,146 \$ 5,541,146 \$ 147,066 \$ 795,153 \$ 112,169 \$ 2,081,357 \$ -	Worksheet C, Part I, Col.2 and Col. 4 \$ 803,215 \$ 136,295 \$ 34,201 \$ 34,201 \$ 13,723 \$ 71,106 \$ 9,922 \$ 73,490 \$ - \$ -		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 9,888,221 \$ 4,492,082 \$ 4,9545,227 \$ 50,210 \$ 13,969,865	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,582,338 \$ 342,457,835 \$ 48,817,878 \$ 420,241,583 \$ 1,154,525 \$ 79,720,641	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ - \$ 80,997,714 \$ 287,677,338 \$ 39,728,896 \$ 371,064,911 \$ - \$ 24,238,044	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774 \$ 791,306,494 \$ 1,154,525 \$ 103,958,685	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071 0.047416 0.030751 0.050731 0.062612 0.043490 0.134379
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR 6000 LA 6001 LA 6200 WH 6500 RE	PERATING ROOM LIVERY ROOM & LABOR ROOM IESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN R BORATORY BORATORY BORATORY-CRESTVIEW HOLE BLOOD & PACKED RED BLOOD CELL SPIRATORY THERAPY	Worksheet B, Part I, Col. 26 servation) (list belo \$ 68,315,230 \$ 25,524,982 \$ 5,918,809 \$ 30,833,274 \$ 53,232 \$ 8,892,072 \$ 8,892,072 \$ 8,892,072 \$ 8,892,072 \$ 8,892,072 \$ 4,369,991 \$ 47,390,380 \$ 50,210 \$ 47,390,380 \$ 50,210 \$ 40,869,865 \$ 26,863,353	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY \$ 6,533,218 \$ 653,072 \$ 4,449,368 \$ 5,541,146 \$ - \$ 147,066 \$ 795,153 \$ 112,169 \$ 2,081,357 \$ - \$ - \$ - \$ - \$ -	Worksheet C, Part I, Col. 2 and Col. 4 \$ 803,215 \$		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 8,888,221 \$ 49,545,227 \$ 50,210 \$ 13,969,865 \$ 26,863,353	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,582,338 \$ 342,457,835 \$ 448,817,878 \$ 420,241,583 \$ 1,154,525 \$ 79,720,641 \$ 273,624,809	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ \$ 80,997,714 \$ 287,677,338 \$ 39,728,896 \$ 371,064,9111 \$ \$ 24,238,044 \$ 11,858,931	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 234,759,771 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774 \$ 791,306,494 \$ 1,154,525 \$ 103,958,685 \$ 285,483,740	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.13083 1.511071 0.077654 0.014105 0.050731 0.062612 0.043490 0.134379 0.094098
5000 OP 5200 DE 5300 AN 5400 RA 5401 RA 5600 RA 5700 CT 5800 MR 6000 LA 6001 LA 6001 LA 6000 RE 6500 RE	PERATING ROOM LIVERY ROOM & LABOR ROOM JESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOISOTOPE SCAN SCAN BORATORY BORATORY BORATORY-CRESTVIEW HOLE BLOOD & PACKED RED BLOOD CELL	Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY w): \$ 6,533,218 \$ 653,072 \$ 4,449,388 \$ 5,541,146 \$ - \$ 147,066 \$ 795,153 \$ 112,169 \$ 2,081,357 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Worksheet C, Part I, Col.2 and Col. 4 \$ 803,215 \$ 136,295 \$ 34,201 \$ 34,201 \$ 13,723 \$ 71,106 \$ 9,922 \$ 73,490 \$ - \$ -		Calculated \$ 75,651,663 \$ 26,178,054 \$ 10,504,472 \$ 36,408,621 \$ 53,232 \$ 9,052,861 \$ 9,888,221 \$ 4,492,082 \$ 4,9545,227 \$ 50,210 \$ 13,969,865	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6 \$ 53,577,226 \$ 167,753,863 \$ 136,776,626 \$ 35,228 \$ 35,582,338 \$ 342,457,835 \$ 48,817,878 \$ 420,241,583 \$ 1,154,525 \$ 79,720,641	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7 \$ 315,995,726 \$ 8,207,597 \$ 67,005,908 \$ 141,399,849 \$ -9 \$ 80,997,714 \$ 287,677,338 \$ 39,728,896 \$ 371,064,911 \$ - \$ 24,238,044 \$ 11,858,931 \$ -	\$ 22,171,586 Total Charges - Cost Report Worksheet C, Pt. I, Col. 8 \$ 1,243,398,684 \$ 61,784,823 \$ 278,176,475 \$ 35,228 \$ 116,580,052 \$ 630,135,173 \$ 88,546,774 \$ 791,306,494 \$ 1,154,525 \$ 103,958,685	Medicaid Calculated Cost-to-Charge Ratio 0.060843 0.423697 0.044746 0.130883 1.511071 0.047416 0.030751 0.050731 0.062612 0.043490 0.134379

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HLTHCRE-HUGHES SPALDING

		_			rn & Resident		CE and Therapy					I/P Routine			
Line #	Cost Center Description	10	otal Allowable Cost		sts Removed Cost Report *		Add-Back (If Applicable		Net Cost		Days and I/P illary Charges	narges and O/P cillary Charges	-	Total Charges	Medicaid Per Dien Cost or Other Ratio
660	1 PHYSICAL THERAPY-CRESTVIEW	\$	1,187,949	\$	-	\$	-		\$ 1,187,949	\$	6,970,217	\$ -	\$	6,970,217	0.1704
690	0 ELECTROCARDIOLOGY	\$	5.623.189	\$	-	\$	-		\$ 5.623.189	\$	107.638.714	\$ 45.026.788	\$	152,665,502	0.0368
710	0 MEDICAL SUPPLIES CHARGED TO PATIENT	\$	39,908,716	\$	-	\$	-		\$ 39,908,716	\$	75,229,786	\$ 19,439,404	\$	94,669,190	0.4215
710	1 MEDICAL SUPPLIES CHARGED CRESTVIEW	\$	353,375	\$	-	\$	-		\$ 353,375	\$	979,694	\$ -	\$	979,694	0.3606
720	0 IMPL. DEV. CHARGED TO PATIENTS	\$	33,294,446	\$	-	\$	-		\$ 33,294,446	\$	52,313,661	\$ 10,738,349	\$	63,052,010	0.5280
730	0 DRUGS CHARGED TO PATIENTS	\$	76,145,445	\$	-	\$	-		\$ 76,145,445	\$	196,589,337	\$ 167,883,587	\$	364,472,924	0.2089
730	1 DRUGS CHARGED TO PATIENTS-CRESTVIEW	\$	164,669	\$	-	\$	-		\$ 164,669	\$	415,987	\$ -	\$	415,987	0.3958
	2 OUTPATIENT PHARMACY	\$	94,032,769	\$	-	\$	-		\$ 94,032,769	\$	15,384	\$ 178,229,939	\$	178,245,323	0.5275
740	0 RENAL DIALYSIS	\$	9,174,585	\$		\$	-		\$ 9,174,585	\$	23,290,839	\$ 36,386,059	\$	59,676,898	0.1537
760	1 PULMONARY FUNCTION TESTING	\$	1,656,763	\$	-	\$	212,648		\$ 1,869,411	\$	3,686,346	\$ 9,807,296	\$	13,493,642	0.1385
760	2 CARDIOVASCULAR LAB	\$	6,415,817	\$	1,403,359	\$	355,805		\$ 8,174,981	\$	30,907,803	\$ 9,859,145	\$	40,766,948	0.2005
	0 CLINIC	\$	111,087,306	\$	12,592,834	\$	679,624		\$ 124,359,764	\$	32,286,809	\$ 248,325,080	\$	280,611,889	0.4431
	1 SATELLITE CLINICS	\$	33,135,476		-	\$	105,845		\$ 33,241,321	\$	121,390	48,308,961	\$	48,430,351	0.6863
	0 EMERGENCY	\$	103,125,543		12,400,901	\$	781,860		\$ 116,308,304		259,147,701	\$ 510,475,861	\$	769,623,562	0.1511
920	1 OBSERVATION BEDS (DISTINCT PART)	\$	6,554,671	\$	-	\$	-		\$ 6,554,671	\$	2,563,852	\$ 19,096,641	\$	21,660,493	0.3026
	Total Ancillary	\$	778,546,679	\$	47,208,172	\$	3,317,956		\$ 829,072,807	\$	3,370,711,131	\$ 2,697,507,307	\$	6,068,218,438	
	Weighted Average														0.1383
	Sub Totals	\$	1,222,529,996	\$	111,802,531	\$	5,349,528		\$ 1,339,682,055	\$	4,338,600,622	\$ 2,697,507,307	\$	7,036,107,929	
	NF, SNF, and Swing Bed Cost for Medicaid (S	um	of applicable Cos	t Rep	ort Worksheet [D-3,	Title 19, Column	, Line 200 and		1					
	Worksheet D, Part V, Title 19, Column 5-7, Lir	ne 20	00)						\$ -	2002					
	NF, SNF, and Swing Bed Cost for Medicare (S	Sum	of applicable Cos	st Rep	ort Worksheet	D-3.	Title 18. Column	3. Line 200 and							
	Worksheet D, Part V, Title 18, Column 5-7, Lir					- 1	- , -	,	\$ 114,432	2002					
	NF, SNF, and Swing Bed Cost for Other Payer	rs (H	lospital must calc	ulate.	Submit suppor	t for	calculation of cos	t.)	\$ -						
	Other Cost Adjustments (support must be sub	mitte	ed)						\$ -						
	Grand Total								\$ 1,339,567,623	-					
	Total Intern/Resident Cost as a Percent of Oth	^							9.11%						

* 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) CHILDREN'S HLTHCRE-HUGHES SPALDING

		caid Per Medicaid (In-State Medica	aid FFS Primary	In-State Medicaid I	fanaged Care Primary		FFS Cross-Overs (with Secondary)		dicaid Eligibles (Not Elsewhere)	Unir	sured	Total In-S	tate Medicaid	% Surv
Line # Cost Ce	Routi	Cost for Charge Ra tine Cost Ancillary enters Cente	Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	to C Rep Tot
	From S	Section G From Sec	ion 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 (fro		1,522.43	ſ	Days 533		Days		Days		Days 41		Days 33		Days 1,608		
03100 INTENSIVE CARE 03200 CORONARY CAR	E UNIT \$	2,621.10		-		-		-		-		-		-	+	
03300 BURN INTENSIVI	E CARE UNIT \$	-				-		-				-			+	
03400 SURGICAL INTER 03500 OTHER SPECIAL	NSIVE CARE UNIT \$	3,896.42		-		-						-			•	
04000 SUBPROVIDER I 04100 SUBPROVIDER I				-		-				-					ļ	
04200 OTHER SUBPRO		-				-		-		-		-		-	1	
04300 NURSERY 3501 NEONATAL INTE	SENSIVE CARE UNIT	2,059.26 2,371.38	-												ł	
4400 SKILLED NURSIN	NG FACILITY \$	· · ·		-		-		-		-		-		- 1,608		
Total Days per PS&R or E	while it Date it	10	tal Days	533		1,034		-		41		33		1,008	1	
Total Days per PS&R of E	Unreconciled Days (Explain Var	riance)	L	533		1,034				41						
			_	Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
Routine Charges								reduine enargee							T	0000
				\$ 905,170		\$ 1,755,215		\$-		\$ 69,792		\$ 55,896		\$ 2,730,177		
	e Charge Per Diem			\$ 905,170 \$ 1,698.26		\$ 1,755,215 \$ 1,697.50		<u>\$</u> - \$-		\$ 69,792 \$ 1,702.24		\$ 55,896 \$ 1,693.82		\$ 1,697.87	1	
Calculated Routin	rom W/S C) (from Section G):			\$ 1,698.26 Ancillary Charges	Ancillary Charges	\$ 1,697.50 Ancillary Charges	Ancillary Charges	\$ - \$ -	Ancillary Charges	\$ 1,702.24 Ancillary Charges	Ancillary Charges	\$ 1,693.82 Ancillary Charges	Ancillary Charges	\$ 1,697.87 Ancillary Charges		s
Calculated Routin	ne Charge Per Diem			\$ 1,698.26	Ancillary Charges \$ 35,749 \$ 92,082	\$ 1,697.50	Ancillary Charges \$ 640,952 \$ -	\$ - \$ - Ancillary Charges \$ - \$ -	Ancillary Charges	\$ 1,702.24	Ancillary Charges \$ 30,876 \$ 9,746	\$ 1,693.82	Ancillary Charges \$ 16,682 \$ -	\$ 1,697.87		7
Calculated Routin Ancillary Cost Centers (fr 09200 Observation (Non 5000 OPERATING ROU 5200 DELIVERY ROOM	ine Charge Per Diem inom W/S C) (from Section G): in-Distinct) OM M & LABOR ROOM		0.470017 0.060843 0.423697	\$ 1,698.26 Ancillary Charges	\$ 35,749	\$ 1,697.50 Ancillary Charges		S - S - Ancillary Charges S - S - S - S -	Ancillary Charges	\$ 1,702.24 Ancillary Charges	\$ 30,876	\$ 1,693.82 Ancillary Charges		\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ -	\$ 707,577	7
Calculated Routin Ancillary Cost Centers (fr 09200 Observation (Non 5000 OPERATING ROC 5200 DELIVERY ROOM 5300 ANESTHESIOLO 5400 [RADIOLOGY-DIA	rom W/S C) (from Section G): Distinct) OM M & LABOR ROOM GY GNOSTIC		0.470017 0.060843 0.423697 0.044746 0.130883	\$ 1,698.26 Ancillary Charges	\$ 35,749	\$ 1,697.50 Ancillary Charges		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Ancillary Charges	\$ 1,702.24 Ancillary Charges	\$ 30,876	\$ 1,693.82 Ancillary Charges		\$ 1,697.87 Ancillary Charges	\$ 707,577 \$ 101,828 \$ - \$ -	7 8 -
Calculated Routin Ancillary Cost Centers (fr 09200 Observation (Non 5000 OPERATING ROO 5200 DELIVERY ROON 5300 ANESTHESIOLO 5400 RADIOLOGY-DIA 5401 RADIOLOGY-DIA	ree Charge Per Diem rom W/S C) (from Section G): +Distinct) OM M & LABOR ROOM GY GNOSTIC GNOSTIC-CRESTVIEW		0.470017 0.060843 0.423697 0.044746 0.130883 0.511071	\$ 1,698.26 Ancillary Charges \$ 9,333 \$ - \$ - \$ - \$ -	\$ 35,749 \$ 92,082 \$ - \$ -	\$ 1,697.50 Ancillary Charges \$ 86,017 \$ - \$ - \$ - \$ - \$ -	\$ 640,952 \$ - \$ - \$ -	\$ - Ancillary Charges \$ \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Anciliary Charges	\$ 1,702.24 Ancillary Charges \$ 3,394 \$ - \$ - \$ - \$ 32,443 \$ - \$ 32,443 \$ -	\$ 30,876 \$ 9,746 \$ - \$ -	\$ 1,693.82 Ancillary Charges \$ 1,281 \$ - \$ - \$ - \$ -	\$ 16,682 \$ - \$ - \$ -	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ - \$ - \$ 680,216 \$ -	\$ 707,577 \$ 101,828 \$	7 B -
Calculated Routin Ancillary Cost Centers (fl 09200 Observation (Non 5000 OPERATING RO 5200 DELIVERY ROO 5300 ANESTHESIOLO 5400 RADIOLOGY-DIA 5401 RADIOLOGY-DIA 5600 (RADIOLOGY-DIA 5600 (RADIOSTOPE 5700 [CT SCAN	ree Charge Per Diem rom W/S C) (from Section G): +Distinct) OM M & LABOR ROOM GY GNOSTIC GNOSTIC-CRESTVIEW		0.470017 0.060843 0.423697 0.044746 0.130883 0.511071 0.077654 0.014105	\$ 1,698.26 Ancillary Charges \$ 9,333 \$ - \$ - \$ - \$ -	\$ 35,749 \$ 92,082 \$ - \$ -	\$ 1,697.50 Ancillary Charges \$ 86,017 \$ - \$ - \$ - \$ - \$ -	\$ 640,952 \$ - \$ - \$ -	§ - Ancillary Charges 5 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Anciliary Charges	\$ 1,702.24 Ancillary Charges \$ 3,394 \$ - \$ - \$ -	\$ 30,876 \$ 9,746 \$ - \$ -	\$ 1,693.82 Ancillary Charges \$ 1,281 \$ - \$ - \$ - \$ -	\$ 16,682 \$ - \$ - \$ -	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ 680,216 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707,577 \$ 101,828 \$	7 B -
Calculated Routin Ancillary Cost Centers (fr 09200 Observation (Non 5000 OPERATING ROO 5200 DELIVERY ROON 5300 (ANESTHESIOLO 5400 RADIOLOGY-DIA 5401 RADIOLOGY-DIA 5401 RADIOLOGY-DIA	ree Charge Per Diem rom W/S C) (from Section G): +Distinct) OM M & LABOR ROOM GY GNOSTIC GNOSTIC-CRESTVIEW		0.470017 0.060843 0.423697 0.044746 0.130883 0.511071 0.077654	\$ 1,698.26 Ancillary Charges \$ 9,333 \$ - \$ - \$ - \$ -	\$ 35,749 \$ 92,082 \$ - \$ -	\$ 1,697.50 Ancillary Charges \$ 86,017 \$ - \$ - \$ - \$ - \$ -	\$ 640,952 \$ - \$ - \$ -	\$ Anciliary Charges <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u> <u>\$</u>	Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,702.24 Ancillary Charges \$ 3,394 \$ - \$ - \$ - \$ 32,443 \$ - \$ 32,443 \$ -	\$ 30,876 \$ 9,746 \$ - \$ -	\$ 1,693.82 Ancillary Charges \$ 1,281 \$ - \$ - \$ - \$ -	\$ 16,682 \$ - \$ - \$ -	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ 680,216 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707,577 \$ 101,828 \$	7 B - 4 -
Calculated Routin Ancillary Cost Centers (ft 9200 Observation (Non 5000 OPERATING ROC 5000 DELIVERY ROOM 5000 RADIOLOGY DIA 5401 RADIOLOGY DIA 5401 RADIOLOGY DIA 5401 RADIOLOGY DIA 5600 RADIOSTOPE 5700 CT SCAN 5600 MADRATORY-C	the Charge Per Diem trom W/S C) (from Section G): Distinct) OM M & LABOR ROOM (GY VGNOSTIC		0.470017 0.060843 1.423697 0.044746 1.30083 .511071 0.077654 0.014105 0.050731 0.062612 0.043490	\$ 1,698.26 Ancillary Charges \$ \$ 9,333 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 35,749 \$ 92,082 \$ - \$ - \$ 1,011,000 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,697.50 Ancillary Charges \$ \$ 86,017 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 640,952 \$ - \$ - \$ - \$ 8,658,646 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ - Ancillary Charges \$ \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	Ancillary Charges \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 30,876 \$ 9,746 \$ - \$ 433,788 \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,693.82 Ancillary Charges \$ \$ 1,281 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 16,682 \$ - \$ - \$ 330,401 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ 680,216 \$ - \$ 680,216 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707,577 \$ 101,828 \$ \$ \$ 10,103,434 \$ \$ \$ 20,026,515 \$	7 B - 4 - -
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Calculated Routin Anciliary Cost Centers (fr 09200 Observation (Non 5000 OPERATING ROC 5000 DELIVERY ROOD 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 MRI 6001 LABORATORY 6001 LABORATORY 6001 LABORATORY 6001 RESPIRATORY 1 6001 PHYSICAL THER 6001 PHYSICAL THER 6001 PHYSICAL SUPPLI 7101 MEDICAL SUPPLI	te Charge Per Diem rom W/S C) (from Section G): -Distinct) OM M & LABOR ROOM GY IGNOSTIC VGNOSTIC-CRESTVIEW PROXED RED BLOOD CELL THERAPY THERAPY-CRESTVIEW VAY VAY VAY ES CHARGEO TO PATIENT ES CHARGEO TO PATIENT ES CHARGEO TO PATIENT		1470017 1.060843 1.423697 1.044746 1.130883 .511071 1.077654 1.077654 1.014105 1.050731 1.062612 1.043490 1.134379 1.043490 1.132524 1.149975 1.170452 1.128524 1.19975 1.170452 1.170452 1.170452 1.360683 3.360689	\$ 1,698.26 Ancillary Charges \$ 9,333 \$ - \$ - \$ - \$ - \$ \$ - \$ - \$ - \$ \$ - \$ \$ - \$ \$ 1.698.26 \$< \$< \$< \$< \$< \$< \$< \$< \$< <td>\$ 35,749 \$ 92,082 \$ 92,082 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -</td> <td>\$ 1,897.50 Ancillary Charges § 86,017 \$ - - > \$ -</td> <td>\$ 640,952 \$.</td> <td>§ - Ancillary Charges - § - § - \$ -</td> <td>Ancillary Charges</td> <td>\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -</td> <td>\$ 30,876 \$ 9,748 \$ 9,748 \$ \$ 433,788 \$ \$ 433,788 \$</td> <td>\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$. \$</td> <td>\$ 16,682 \$ 10,682 \$</td> <td>\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -</td> <td>\$ 707.577 \$ 101.828 \$ 101.03.434 \$ -</td> <td>s 7 8 - - - - - - - - - - - - - - - - - -</td>	\$ 35,749 \$ 92,082 \$ 92,082 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,897.50 Ancillary Charges § 86,017 \$ - - > \$ -	\$ 640,952 \$.	§ - Ancillary Charges - § - § - \$ -	Ancillary Charges	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30,876 \$ 9,748 \$ 9,748 \$ \$ 433,788 \$ \$ 433,788 \$	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$. \$	\$ 16,682 \$ 10,682 \$	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707.577 \$ 101.828 \$ 101.03.434 \$ -	s 7 8 - - - - - - - - - - - - - - - - - -
Calculated Routin Anciliary Cost Centers (f 08200 Observation (Non 5000 OPERATING ROC 5000 OPERATING ROC 5000 DELIVERY ROOD 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 MRI 6000 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6010 RESPIRATORY I 6601 PHYSICAL THER 6601 PHYSICAL SUPPLI 7000 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7200 DRUGS CHARGE 5000 SCHARGE 5000 SCHARGE 50000 SCHARGE 50000 SCHARGE 5000 SCHARGE 5000 SCHA	In the Charge Per Diem Tom W/S C) (from Section G): Distinct) M & LABOR ROOM GY GY GY GY GY GY GY FX GY GY GY GY GY GY GY GY GY G		1470017 1.060843 1.423697 0.044746 1.130883 .511071 1.077654 0.014105 1.050731 1.062612 1.043490 1.043490 1.043490 1.134379 1.094098 1.134379 1.094098 1.134379 1.094098 1.123524 1.42975 1.170432	\$ 1,698.26 Ancillary Charges \$ 9,333 \$ - \$ - \$ - \$ - \$ \$ - \$ - \$ - \$ \$ - \$ \$ - \$ \$ 1.698.26 \$< \$< \$< \$< \$< \$< \$< \$< \$< <td>\$ 35,749 \$ 92,082 \$ 92,082 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -</td> <td>\$ 1,897.50 Ancillary Charges § 86,017 \$ - - > \$ -</td> <td>\$ 640,952 \$.</td> <td>§ . Ancillary Charges . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . .</td> <td>Ancillary Charges \$</td> <td>\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ - \$ 1,100 \$ - \$ - \$ 1,2666</td> <td>\$ 30,876 \$ 9,748 \$ 9,748 \$ \$ 433,788 \$ \$ 433,788 \$</td> <td>\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$. \$</td> <td>\$ 16,682 \$ 10,682 \$</td> <td>\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -</td> <td>\$ 707.577 \$ 101.828 \$ 101.03.434 \$ -</td> <td>s 7 8 - - 4 - - - 5 - - 5 - - 8 8 - 7 - 8 8 - - - 8 8 - - - - 8 8 - - - -</td>	\$ 35,749 \$ 92,082 \$ 92,082 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 1,897.50 Ancillary Charges § 86,017 \$ - - > \$ -	\$ 640,952 \$.	§ . Ancillary Charges . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . . § . .	Ancillary Charges \$	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ - \$ 1,100 \$ - \$ - \$ 1,2666	\$ 30,876 \$ 9,748 \$ 9,748 \$ \$ 433,788 \$ \$ 433,788 \$	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$. \$	\$ 16,682 \$ 10,682 \$	\$ 1,697.87 Ancillary Charges \$ 98,744 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707.577 \$ 101.828 \$ 101.03.434 \$ -	s 7 8 - - 4 - - - 5 - - 5 - - 8 8 - 7 - 8 8 - - - 8 8 - - - - 8 8 - - - -
Calculated Routin Anciliary Cost Centers (f 08200 Observation (Non 5000 OPERATING ROC 5000 OPERATING ROC 5000 DELIVERY ROOD 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 MRI 6000 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6011 LABORATORY 6010 RESPIRATORY I 6601 PHYSICAL THER 6601 PHYSICAL SUPPLI 7000 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7101 MEDICAL SUPPLI 7200 DRUGS CHARGE 5000 SCHARGE 5000 SCHARGE 50000 SCHARGE 50000 SCHARGE 5000 SCHARGE 5000 SCHA	In the Charge Per Diem Tom W/S C) (from Section G): Distinct) OM M & LABOR ROOM GY		1470017 1.060843 1423697 1.044746 1.130883 .511071 1.0077654 1.014105 1.050731 1.062612 1.043460 1.134379 1.134379 1.134379 1.134375 1.149975 1.149	\$ 1,698.26 Ancillary Charges \$ 9,533 \$ - \$. \$. \$. \$. \$. \$. \$. \$.	\$ 35,749 \$ 92,082 \$ -	\$ 1,697.50 Ancillary Charges \$ \$ 66,077 \$ -	\$ 640,952 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 1.073.21 \$ - \$ - \$ -	§ - S -	Ancillary Charges 5	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30.876 \$ 9.746 \$ 9.746 \$ -	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$ -	\$ 16.822 \$ -	\$ 1,607.87 Ancillary Charges \$ 96,744 \$ - \$ - \$ 680,216 \$ - \$ - \$ 680,216 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707.577 \$ 101.828 \$ -	s 7 8
Calculated Routin Anciliary Cost Centers (f) 09200 Observation Norse 0000 OPERATINION ROU 2000 DELIVERY ROOD 5000 ANDISOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RADIOLOGY-DIA 5000 RESPIRATORY 6001 LABORATORY- 6001 RESPIRATORY 6001 RESPIRATORY 6001 PHYSICAL THEE 6000 PHYSICAL SUPPLI 7101 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 DRUGS CHARGED 7301 DRUGS CHARGED 7301 DRUGS CHARGED 7302 OUTPATIENT PH 7400 RENAL DIALYSIS	In the Charge Per Diem Tom W/S C) (from Section G): Distinct) OM M & LABOR ROOM GV GNOSTIC-CRESTVIEW GNOSTIC-CRESTVIEW GNOSTIC-CRESTVIEW PACKED RED BLOOD CELL THERAPY-CRESTVIEW HERAPY-CRESTVIEW LOLOGY ES CHARGED TO PATIENTT ES CHARGED TO PATIENTS ED TO PATIEN		1470017 1060843 1423697 1044746 130083 511071 1077654 1014105 1050731 10622612 1043490 1134379 1044096 1123524 1149975 1170432 1036833 1421560 1360699 1528047 1208919 1529047 153738 153738	\$ 1,698.26 Ancillary Charges \$ 9,533 \$ - \$. \$. \$. \$. \$. \$. \$. \$.	\$ 35,749 \$ 92,082 \$ -	\$ 1,697.50 Ancillary Charges \$ \$ 66,077 \$ -	\$ 640,952 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 1.073.21 \$ - \$ - \$ -	§ - Ancillary Charges 5 § - S	Ancillary Charges § - <	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30.876 \$ 9.746 \$ 9.746 \$ -	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$ -	\$ 16.822 \$ -	\$ 1,607.87 Ancillary Charges \$ 96,744 \$ - \$ - \$ 680,216 \$ - \$ - \$ 680,216 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707.577 \$ 101.822 \$	s 7 8 - - - - - - - - - - - - - - - - - -
Calculated Routin Anciliary Cost Centers (f) 09200 Observation Nor 2000 DELIVERY ROOD 2000 DELIVERY ROOD 3000 AND RADIOLOGY DIA 4001 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RESPIRATORY 1 6001 LABORATORY 6001 LABORATORY 6001 RESPIRATORY 1 6000 RESPIRATORY 1 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 5001 PHYSICAL THER 5001 PHYSICAL THER 5001 PHYSICAL SUPPLI 7101 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 PHYSICAL THER 6000 CLASCHARGED 7000 CHARLAL LINER 7001 PHYSICAL THER 6000 CLASCHARGED 7000 PHYSICAL THER 6000 LABORATORY 7000 PHYSICAL THER 6000 LABORATORY 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL LINER 7000	Incometer Section 2015 Incometer Section 2015 Income		2.470017 0.600843 1.423697 1.423697 1.044746 1.30883 5.511071 1.02612 1.050731 1.02612 1.043490 1.043490 1.043490 1.043497 1.043497 1.043497 1.043497 1.043493 1.149975 1.17042 1.050833 1.149975 1.17042 1.050833 1.149275 1.17042 1.050833 1.149275 1.17042 1.050833 1.149275 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.170442 1.170444 1.170444 1.170444 1.1	\$ 1,698.26 Ancillary Charges \$ 9,333 \$	\$ 35,749 \$ 92,082 \$ - \$ - <	\$ 1,697.50 Ancillary Charges \$ \$ 66,077 \$ -	\$ 640,952 \$ -	§ . S .	Ancillary Charges 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30.876 \$ 9.746 \$ 9.746 \$ - \$	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$ - \$	\$ 16.822 \$ -	\$ 1,607.87 Ancillary Charges \$ \$ 96,744 \$ -	\$ 707.577 \$ 101.828 \$	s 7 8
Calculated Routin Anciliary Cost Centers (I) 9020 Observation (Non 9020 Observation (Non 9020 Observation (Non 9020 Distribution (Non 902 Distribution (Non	Income and the charge Per Diem from WKS C) (from Section G): Obstituct) MK JLABOR RCOM GY GY GY GY GY GY GY GY GY G		2470017 1060843 1423697 1044746 1130883 511071 1077654 1014105 10577654 1014105 10057651 10057651 10057651 10057651 10057651 10057651 10057651 10057651 10057651 1005765 10057651 1005765 10	\$ 1,698.26 Ancillary Charges \$ 9,533 \$ - \$. \$. \$. \$. \$. \$. \$. \$.	\$ 35,749 \$ 92,082 \$ -	\$ 1,697.50 Ancillary Charges \$ \$ 66,077 \$ -	\$ 640,952 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 1.073.21 \$ - \$ - \$ -	§ . Ancillary Charges . § . § . \$	Ancillary Charges \$ - <	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30,876 \$ 9,746 \$ 9,746 \$ \$ 433,788 \$ \$ 815,236 \$	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$ - \$	\$ 16,682 \$.	\$ 1,697.87 Ancillary Charges \$ \$ 98,744 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ 90,764 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ 707.577 \$ 101.828 \$	s 7 8
Calculated Routin Anciliary Cost Centers (f) 09200 Observation Nor 2000 DELIVERY ROOD 2000 DELIVERY ROOD 3000 AND RADIOLOGY DIA 4001 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RADIOLOGY DIA 5000 RESPIRATORY 1 6001 LABORATORY 6001 LABORATORY 6001 RESPIRATORY 1 6000 RESPIRATORY 1 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 6000 PHYSICAL THER 5001 PHYSICAL THER 5001 PHYSICAL THER 5001 PHYSICAL SUPPLI 7101 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 MEDICAL SUPPLI 7100 PHYSICAL THER 6000 CLASCHARGED 7000 CHARLAL LINER 7001 PHYSICAL THER 6000 CLASCHARGED 7000 PHYSICAL THER 6000 LABORATORY 7000 PHYSICAL THER 6000 LABORATORY 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL THER 7000 PHYSICAL LINER 7000	le Charge Per Diem		2.470017 0.600843 1.423697 1.423697 1.044746 1.30883 5.511071 1.02612 1.050731 1.02612 1.043490 1.043490 1.043490 1.043497 1.043497 1.043497 1.043497 1.043493 1.149975 1.17042 1.050833 1.149975 1.17042 1.050833 1.149275 1.17042 1.050833 1.149275 1.17042 1.050833 1.149275 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.149975 1.17042 1.170442 1.170444 1.170444 1.170444 1.1	\$ 1,698.26 Ancillary Charges \$ 9,333 \$	\$ 35,749 \$ 92,082 \$ - \$ - <	\$ 1,697.50 Ancillary Charges \$ \$ 66,077 \$ -	\$ 640,952 \$ -	S - Ancillary Charges - S	Ancillary Charges \$	\$ 1,702.24 Ancillary Charges \$ \$ 3,394 \$ -	\$ 30.876 \$ 9.746 \$ 9.746 \$ - \$	\$ 1.693.82 Ancillary Charges \$ \$ 1.281 \$ - \$	\$ 16.822 \$ -	\$ 1,607.87 Ancillary Charges \$ \$ 96,744 \$ -	\$ 707.577 \$ 101.828 \$ - \$ <	s 7 8

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HLTHCRE-HUGHES SPALDING

	Totals / Paymonts		In-State Medie	caid FF	S Primary	In-	State Medicaid M	lanage	ed Care Primary		In-State Medicare FF Medicaid S			In	I-State Other Me Included I				Unins	sured		Total In-S	ate Medica	id	%
	· · · ·									_		r								0					
128	Total Charges (includes organ acquisition from Section J)	\$	6,178,498	\$	16,721,670	\$	11,070,528	\$	152,696,106	\$		\$	-	\$	553,374	\$	6,650,978	\$ 4 (Agrees to Ex	124,527	\$ 5,154,592 (Agrees to Exhibit A)	\$	17,802,400	\$ 17	6,068,754	2.83%
																		(Agrees to E)	(nibit A)	(Agrees to Exhibit A)					
129	Total Charges per PS&R or Exhibit Detail	\$	6,178,498	\$	16,721,670	\$	11,070,528	\$	152,696,106	\$; -	\$	-	\$	553,374	\$	6,650,978	\$ 4	424,527	\$ 5,154,592					
130	Unreconciled Charges (Explain Variance)		-		-		-	-	-		-		-		-		-		-	-					
131.01	Sampling Cost Adjustment (if applicable)																				\$	-	\$	-	
131.02	Total Calculated Cost (includes organ acquisition from Section J)	s	1.424.701	\$	3.287.959	s	2.747.365	\$	25.843.568	s	i -	\$	-	s	124,665	s	1.138.277	s	94.636	\$ 767.333	s	4.296.731	\$ 3	0,269,804	2.64%
							1 1										1				,				
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$	966,134	\$	3,199,540	\$	3,469,790	\$	37,017,772	\$; -	\$	-	\$		\$					\$	4,435,924	\$ 4	0,217,312	
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)	\$	-	\$	-	\$	-	\$	-	\$	-	\$	-	\$	143,971	\$	1,698,915				\$	143,971	\$	1,698,915	
135	Self-Pay (including Co-Pay and Spend-Down)	\$	-	\$	6,438	\$	-	\$	-	\$	-	\$	-	\$	-	\$					\$	-	\$	6,438	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$	966,134	\$	3,205,978	\$	3,469,790	\$	37,017,772																
137	Medicaid Cost Settlement Payments (See Note B)	\$	-	\$	(191,239)	\$	-	\$	-												\$		\$	(191,239)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$	-	\$		\$	-	\$	-	_											\$	-	\$	-	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									\$; -	\$	-	\$	-	\$					\$	-	\$	-	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$; -	\$	-	\$	-	\$					\$	-	\$	-	
141	Medicare Cross-Over Bad Debt Payments									\$; -	\$	-	\$	-	\$		(Agrees to E	xhibit B	(Agrees to Exhibit B	\$	-	\$	-	
142	Other Medicare Cross-Over Payments (See Note D)									\$	-	\$	-	\$		\$		and B-		and B-1)	\$	-	\$	-	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																	\$	600	\$ 210,329					
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from	n Section	E)															\$	-	\$ -					
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$	458,567	\$	273,220	\$	(722,425)	\$	(11,174,204)	\$; -	\$	-	\$	(19,306)	\$	(560,638)	\$	94,036	\$ 557,004	\$	(283,164)	\$ (1	1,461,622)	
146	Calculated Payments as a Percentage of Cost		68%		92%		126%		143%		0%		0%		115%		149%		1%	27%	•	107%		138%	
447	Tatal Madiana Davis from W/O O O of the Ocet Depart Fundation Order, Ded (O/D, W/O O O, Dt.)	0-1-0	0		4 40 47 40 1					-	04.400.1														
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Percent of cross-over days to total Medicare days from the cost report	, Col. 6, 9	sum of Lns. 2,	3, 4, 1	4, 16, 17, 18 less	lines 5	& 6)				81,423														
148	Percent of cross-over days to total medicare days from the cost report										0%														

Percent of cross-over days to total Medicare days from the cost report 148

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 sund so Voltes and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a statis should be reported in Section C of the survey. Note D - Should include other Medicaire organization included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medicaire Graduate Medicaire Graduate Medicaire Graduate Medicaire Care payments should Section C of the survey. Note E - Medicaire Managed Care, payments should section payments).

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

Cost Report Y	Year (01/01/2022-12/31/2022)	CHILDREN'S HLTHO											
				Out-of-State Med	dicaid FFS Primary		icaid Managed Care mary		are FFS Cross-Overs aid Secondary)		Medicaid Eligibles (Not Elsewhere)	Total Out-Of-	State Medicaio
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpati
		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 Cos	st Centers (list below):			Days		Days		Days		Days		Days	
	JLTS & PEDIATRICS	\$ 1,522.43						-				-	
	ENSIVE CARE UNIT	\$ 2,621.10		-		-		-		-		-	
	RONARY CARE UNIT	\$ -						-				-	
	RN INTENSIVE CARE UNIT	\$-		-		-		-				-	
	RGICAL INTENSIVE CARE UNIT	\$ 3,896.42		-		-		-		-		-	
	IER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
	BPROVIDER I	\$-		-		-		-		-		-	
	BPROVIDER II	\$ -		-				-				-	
	IER SUBPROVIDER	\$ -		-				-				-	
04300 NUR		\$ 2,059.26		-				-				-	
	DNATAL INTENSIVE CARE UNIT	\$ 2,371.38		-				-				-	
4400 SKIL	LLED NURSING FACILITY	\$-				-		-		-		-	
			Total Days	-		-		-		-		-	
Fotal Davs pe	er PS&R or Exhibit Detail			-		-		-		-			
	Unreconciled Days (E	Explain Variance)						-		-			
	tine Charges sulated Routine Charge Per Diem	ו		Routine Charges \$ -		Routine Charges \$ -		Routine Charges \$- \$-		Routine Charges \$ -		Routine Charges \$ - \$	
Calc	culated Routine Charge Per Diem]		\$ \$	Ancillary Charges	\$ \$	Ancillary Charges	\$ - \$ -	Ancillary Charges	\$ \$	Ancillary Charges	\$- \$-	Ancillary C
Calco Ancillary Co]	0.470017	Routine Charges	Ancillary Charges	Routine Charges S - Ancillary Charges -	Ancillary Charges	Routine Charges S - Ancillary Charges -	Ancillary Charges	Routine Charges \$ - Ancillary Charges -	Ancillary Charges	Routine Charges \$- Ancillary Charges	Ancillary C
Calco Ancillary Co 19200 Obse	culated Routine Charge Per Diem ost Centers (from W/S C) (list below):]	0.470017	\$ \$	Ancillary Charges	\$ \$	Ancillary Charges	\$ - \$ -	Ancillary Charges	\$ \$	Ancillary Charges	\$- \$-	Ancillary C \$ \$
Calco Ancillary Co 09200 Obse 5000 OPE	culated Routine Charge Per Diem ost Centers (from W/S C) (list below): ervation (Non-Distinct) ERATING ROOM		0.060843	\$ \$	Ancillary Charges	\$ \$	Ancillary Charges	\$ - \$ -	Ancillary Charges	\$ \$	Ancillary Charges	\$- \$-	Ancillary C \$ \$ \$
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Calci Ancillary Co 3200 Obsession 5000 OPE 5000 OPE 5000 OPE 5000 CAS 5000 CAS 5000 CAS 5000 CAS 6000 CAS 6000 CAS 6000 CAS 6000 CAS 6000 RES 6000 RES 6000 RES 6000 RES 7100 MED 7100 MED 7100 DRU 7300 DRU	Sulated Routine Charge Per Diem Sott Centers (from W/S C) (list below): ervation (Non-Distinct) ERATING ROOM IVERY ROOM & LABOR ROOM STHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOLOGY-DIAGNOSTIC-CRESTVIEW DIOLOGY-DIAGNOSTIC-CRESTVIEW ORATORY-CRESTVIEW ORATORY-CRESTVIEW ORATORY-CRESTVIEW DICL HIERAPY-CRESTVIEW SICAL THERAPY-CRESTVIEW SICAL THERAPY-CRESTVIEW SICAL THERAPY-CRESTVIEW SICAL THERAPY-CRESTVIEW DICLA SUPPLIES CHARGED TO PATIENTS DICLA SUPPLIES CHARGED TO PATIENTS DIS CHARGED	V	0.060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.050731 0.050731 0.050731 0.050731 0.043490 0.134379 0.043490 0.123524 0.134379 0.123524 0.123524 0.123524 0.360699 0.528047 0.208919 0.3958651 0.527547 0.138540	\$ - \$ - Ancillary Charges - -		\$ - \$ - - -		\$ - \$ - - -		\$ - \$ - - -		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Calci Ancillary Co 39200 Obse 5000 OPE 5200 DEL 5300 ANE 5400 RAD 5400 RAD 5400 RAD 5400 RAD 6001 LAB(6000 LAB 6000 LAB 6000 LAB 6000 LAB 6000 RAD 6001 LAB 6000 PHY 6000 LAB 6000 PHY 6000 ELE 7101 MED 7100 MED 7101 MED 7100 MED 7100 MED 7100 MED 7100 MED 7100 REN 7300 DRU 7300 DRU 7300 DRU 7300 DRU 7300 DRU 7300 DRU 7601 PULI	Sulated Routine Charge Per Diem Set Centers (from W/S C) (list below): ervation (Non-Distinct) ERATING ROOM UTERY ROOM & LABOR ROOM STHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY	V	0 060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.050731 0.050731 0.050731 0.043490 0.123524 0.123524 0.123524 0.120523 0.0360699 0.528047 0.360699 0.528047 0.360699 0.528047 0.360699 0.528547 0.360699 0.528547 0.360699 0.527547 0.527	\$ - \$ - Ancillary Charges - -		\$ - Ancillary Charges - -		\$ - \$ - - -		\$ - \$ - Ancillary Charges - -		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Calci Ancillary Co 39200 Obse 5000 OPE 5200 DEL 5300 ANE 5400 RAD 5400 RAD 5600 RAD 5700 CT S 5800 MRI 6001 LABC 6001 LABC 6001 CABC 6001 RES 6001 PHY 6900 ELEC 7100 MED 7100 MED 7200 IMPL 7300 DRU 7301 DRU 7301 DRU 7301 DRU 7302 CUT 7400 REN 7602 CAR	Sulated Routine Charge Per Diem bat Centers (from W/S C) (list below): ervation (Non-Distinct) IRATING ROOM UTERY ROOM & LABOR ROOM ISTHESIOLOGY DIOLOGY-DIAGNOSTIC SIGAL THERAPY-CRESTVIEW CTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENTS DICAL SUPPLIES CHARGED TO PATIENTS DISCAL SUPPLIES CHARGED TO PATIENTS DISCALSUPPLIES CHARGED TO PATIENTS D	V	0 060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.050731 0.062612 0.043490 0.134379 0.043490 0.123524 0.149975 0.170432 0.036833 0.421560 0.360699 0.528047 0.289849 0.527547 0.153758 0.138540 0.138540 0.280530 0.423174	\$ - \$ - Ancillary Charges - -		\$ - \$ - - -		\$ - \$ - - -		\$ - \$ - - -		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Calci Ancillary Co. 92200 Obses 5000 OPEL 5300 OPEL 5300 ANE 5400 RAD 5400 RAD 5400 RAD 5600 MRI 6000 LAB 6000 LAB 6000 LAB 6000 LAB 6000 LAB 6000 LAB 6000 ELE 7100 MED 7100 MED 7100 MED 7100 MED 7100 MED 7100 REN 7300 DRU 7301 DRU 7301 DRU 7301 DRU 7302 OLT 7400 CEN 7400	Sulated Routine Charge Per Diem Sott Centers (from W/S C) (list below): ervation (Non-Distinct) ERATING ROOM STHESIOLOGY DIOLOGY-DIAGNOSTIC	V	0.060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.014105 0.050731 0.060731 0.062612 0.043490 0.134379 0.043490 0.123524 0.149975 0.170432 0.036839 0.360699 0.360699 0.360699 0.360699 0.360699 0.328547 0.138540 0.3985851 0.138540 0.3985851 0.138540 0.209019 0.395851 0.138540 0.200530 0.443174 0.686374	\$ - \$ - Ancillary Charges - -		\$ - \$ - - -		\$ - \$ - - -		\$ - \$ - - -		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
Calci Ancillary Co 9200 Obse 5000 OPE 5200 DELI 5300 ANE 5400 RAD 5400 RAD 5400 RAD 5400 RAD 5600 RAD 5600 RAD 5600 RAD 6001 LAB 6001 LAB 7101 MED 7101 MED 7100 MED 7101 MED 7200 IMPL 7301 DRU 7301 DRU 7400 REN 7400 REN 74	Sulated Routine Charge Per Diem Sott Centers (from W/S C) (list below): ervation (Non-Distinct) ERATING ROOM STHESIOLOGY DIOLOGY-DIAGNOSTIC	V	0 060843 0.423697 0.044746 0.130883 1.511071 0.077654 0.050731 0.062612 0.043490 0.134379 0.043490 0.123524 0.149975 0.170432 0.036833 0.421560 0.360699 0.528047 0.289849 0.527547 0.153758 0.138540 0.138540 0.280530 0.423174	\$ - \$ - Ancillary Charges - -		\$ - Ancillary Charges - -		\$ - \$ - - -		\$ - \$ - Ancillary Charges - -		\$ - Ancillary Charges - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	\$ \$ <t< td=""></t<>

	Totals / Payments										
128	Total Charges (includes organ acquisition from Section K)	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-
129	Total Charges per PS&R or Exhibit Detail	\$-	\$-	\$-	\$-	\$-	\$-	\$-	\$-		

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HLTHCRE-HUGHES SPALDING

		Out-of-Sta	te Medicaid FFS Primar	у		icaid Managed Care mary		te Medicare FFS Cross-Overs n Medicaid Secondary)		Medicaid Eligibles (Not Elsewhere)	Total Out-Of-	State Medicaid
130	Unreconciled Charges (Explain Variance)				-	-			-	-		
131.01	Sampling Cost Adjustment (if applicable)										\$ -	\$ -
131.02	Total Calculated Cost (includes organ acquisition from Section K)	\$	- \$	- \$	-	\$-	\$	- \$ -	\$-	\$ -	\$ -	\$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$	- \$	- \$	-	\$-	\$	- \$ -	\$-	\$-	\$ -	\$ -
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)	\$	- \$	- \$	-	\$-	\$	- \$ -	\$-	\$-	\$-	\$-
135	Self-Pay (including Co-Pay and Spend-Down)	\$	- \$	- \$	-	\$-	\$	- \$ -	\$-	\$-	\$-	\$-
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$	- \$	- \$	-	\$-						
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)						\$	- \$ -	\$-	\$-	\$-	\$-
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						\$	- \$ -	\$-	\$-	\$-	\$-
141	Medicare Cross-Over Bad Debt Payments						\$	- \$ -	\$-	\$-	\$-	\$-
142	Other Medicare Cross-Over Payments (See Note D)						\$	- \$ -	\$-	\$ -	\$ -	\$-
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$	- \$	- \$	-	\$-	\$	- \$ -	\$-	\$-	\$-	\$-
144	Calculated Payments as a Percentage of Cost		0%	0%	0%	0%	-	0% 0%	0%	0%	0%	0%

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 Medicial Payments such as Outliers and Non-Claim Specific payments. Should and report seturine in an are not released on the data seturine for yours. Note C - Other Medicial Payments such as Outliers and Non-Claim Specific 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 Medicaie are 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) CHILDREN'S HLTHCRE-HUGHES SPALDING

		Total			Revenue for	Total	In-State Medi	caid FFS Primary	In-State Medicaid	Managed Care Primary		FS Cross-Overs (with Secondary)		edicaid Eligibles (Not Elsewhere)	Unin	nsured
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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, In 66 (substitute Medicate 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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis							
0	rgan Acquisition Cost Centers (list below):				·			,		,						
	Lung Acquisition	\$ -	\$-	\$-	\$ -	0	\$ -	0	\$ -	0	\$-	0	\$ -	0	\$ -	0
	Kidney Acquisition	\$ -	\$-	ş -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
	Liver Acquisition	\$ -	\$-	\$-	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$-	0	\$ -	0
	Heart Acquisition	\$ -	\$-	s -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$-	0	\$ -	0
	Pancreas Acquisition	\$ -	\$-	\$-	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$-	0	\$ -	0
	Intestinal Acquisition	\$ -	\$-	\$-	\$ -	0	\$ -	0	\$-	0	\$-	0	\$-	0	\$ -	0
	Islet Acquisition	\$ -	\$-	ş -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
		\$ -	\$-	\$-	\$-	0	\$ -	0	\$-	0	\$-	0	\$-	0	\$ -	0
		1	1		r				1		i	·	i	·	·	
	Totals	\$ -	\$-	\$-	\$-		\$ -	-	\$-	-	\$-	-	\$ -		\$ -	
Not	Total Cost 9 A - These amounts must agree to your inp	atient and outpatie	nt Modicaid naid cla	ime eummary if ava	ilable (if not use bosnita	l'e loge and eubr	ait with survey)	-						-		-

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 accounting. If organs are transplanted into non-Medicaid/on-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

9 10

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HLTHCRE-HUGHES SPALDING

		Total			Revenue for	Total	Out-of-State Med	licaid FFS Primary	Out-of-State Medicaid	Managed Care Primary		are FFS Cross-Overs id Secondary)		ledicaid Eligibles (Not Elsewhere)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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 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)							
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	s -	\$-	s -	\$-	0	\$-	0	\$ -	0	\$ -	0	\$ -	0
12	Kidney Acquisition	ş -	\$ -	s -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
13	Liver Acquisition	ş -	\$ -	s -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
14	Heart Acquisition	s -	\$-	s -	\$-	0	\$-	0	\$ -	0	\$-	0	\$-	0
15	Pancreas Acquisition	s -	\$-	s -	\$-	0	\$-	0	\$ -	0	\$-	0	\$-	0
16	Intestinal Acquisition	s -	\$-	ş -	\$-	0	\$-	0	\$ -	0	\$-	0	\$ -	0
17	Islet Acquisition	s -	\$-	s -	\$-	0	\$-	0	\$ -	0	\$-	0	\$-	0
18		s -	\$-	s -	\$-	0	\$-	0	\$ -	0	\$-	0	\$-	0
19	Totals	s -	\$-	s -	\$ -	-	\$-	-	\$ -	-	\$-	-	\$-	-
		_												
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 limits. 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) CHILDREN'S HLTHCRE-HUGHES SPALDING

Workshoot A	Providor	Tax Assessment	Percenciliation:

				W/S A Cost Center
			Dollar Amount	Line
	al Gross Provider Tax Assessment (from	s s,	\$ 525,318	
		nt # that includes Gross Provider Tax Assessment	Expense	0 (WTB Account #)
2 Hospit	al Gross Provider Tax Assessment Includ	ed in Expense on the Cost Report (W/S A, Col. 2)	\$ -	- (Where is the cost included on w/s A?)
3 Differe	nce (Explain Here>)	0	\$ 525,318	
Provid		(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))
		ssment Adjustments (from w/s A-8 of the Medicare cost report)		
8	Reason for adjustment	0	\$	- (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))
		ssessment 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 N	Net Provider Tax Assessment Expense In	cluded in the Cost Report	\$ -	
DSH UCC Provid	der Tax Assessment Adjustment:			
17 Gross	Allowable Assessment Not Included in the	e Cost Report	\$ 525,318	
	tionment of Provider Tax Assessment			
18	Medicaid Hospital Charges S		193,871,154	
19	Uninsured Hospital Charges S		5,579,119	
20	Total Hospital Charges S	ec. G	7,036,107,929	
21	Percentage of Provider Tax Assess	ment Adjustment to include in DSH Medicaid UCC	2.76%	
22	Percentage of Provider Tax Assess	ment Adjustment to include in DSH Uninsured UCC	0.08%	
23	Medicaid Provider Tax Assessment	Adjustment to DSH UCC	\$ 14,474	
24	Uninsured Provider Tax Assessmer		\$ 417	
25 Provid	er Tax Assessment Adjustment to DSH U	CC	\$ 14,891	
	,			

* 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.

Version 8.11

DSH Examination Eligibility Summary				
Hospital Name	CHILDREN'S HLTHCRE-HUGHES SPALDING			
Hospital Medicaid Number	000679808A			
Cost Report Period	From 1/1/202	2 To	12/31/2022	
		As-Reported	Adjustments	As-Adjusted
		As-inepolied	Aujustments	AS-Aujusieu
LIUR				
1 Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 44,468,435	\$-	\$ 44,468,435
2 Hospital Cash Subsidies	Survey F-2	\$ -	\$-	\$ -
3 Total		\$ 44,468,435	\$ -	\$ 44,468,435
4 Net Hospital Patient Revenue	Survey F-3	\$ 53,521,964	\$ -	\$ 53,521,964
5 Medicaid Fraction		83.08%	0.00%	83.08%
6 Inpatient Charity Care Charges 7 Inpatient Hospital Cash Subsidies	Survey F-2	\$ 499,299 \$ -	\$- \$-	\$ 499,299 \$ -
8 Unspecified Hospital Cash Subsidies	Survey F-2 Survey F-2	\$ - \$ -	⇒ - \$ -	\$ -
9 Adjusted Inpatient Charity Care	Survey I -2	\$ 499,299	\$ -	\$ 499,299
10 Inpatient Hospital Charges	Survey F-3	\$ 21,201,605	\$-	\$ 21,201,605
11 Inpatient Charity Fraction		2.36%	0.00%	2.36%
12 LIUR		85.44%	0.00%	85.44%
MIUR				
13 In-State Medicaid Eligible Days	Survey H	1,608	-	1,608
14 Out-of-State Medicaid Eligible Days 15 Total Medicaid Eligible Days	Survey I	- 1,608	-	- 1,608
16 Total Hospital Days (excludes swing-bed)	Survey F-1	2,487	_	2,487
17 MIUR		64.66%	0.00%	64.66%

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 & P	Payment Summa	ary												Georgia			
Hospital Name Hospital Medicaid Number	CHILDREN'S I 000679808A	HLTHCRE-HUGHE	S SPALDING		-												
Cost Report Period	From	1/1/2022	То	12/31/2022													
As-Reported:		A	В	С	D	E	F	G	н	1	J	к	L	M	N	0	Р
Service Type		Total Costs Survey H & I	Medicaid Basic Rate Payments Survey H & I	Medicaid Managed Care Payments Survey H & I	Private Insurance Payments Survey H & I	Self-Pay Payments (Includes Co- Pay and Spenddown) Survey H & I	Medicaid Cost Settlement Payments Survey H & I	Other Medicaid Payments (Outliers, etc) ** Survey H & I	Medicare Traditional (non-HMO) Payments Survey H & I	Medicare Managed Care (HMO) Payments Survey H & I	Medicare Cross-over Bad Debt Survey H & I	Other Medicare Cross-over Payments (GME, etc.) Survey H & I	Uninsured Payments Survey H & I	Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service 2 Medicaid Fee for Service	Inpatient Outpatient	1,424,701 3,287,959	966,134 3,199,540		-	- 6,438	- (191,239)					:			966,134 3,014,739	458,567 273,220	67.81% 91.69%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	2,747,365 25,843,568	3,469,790 37,017,772	:	:	:									3,469,790 37,017,772	(722,425) (11,174,204)	126.30% 143.24%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient	:	:	:	:	:		:	:	:		:			-	-	n/a n/a
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient	124,665 1,138,277	:	:	143,971 1,698,915	:			:	:	:	:			143,971 1,698,915	(19,306) (560,638)	115.49% 149.25%
9 Uninsured 10 Uninsured	Inpatient Outpatient	94,636 767,333	:	:	:	:	:	:	:	:	:	:	600 210,329		600 210,329	94,036 557,004	0.63% 27.41%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	4,391,367 31,037,137	4,435,924 40,217,312	-	143,971 1,698,915	6,438	(191,239)	-	-	-	-	-	600 210,329	-	4,580,495 41,941,755	(189,128) (10,904,618)	104.31% 135.13%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient	1	:	:	1	1	:	:	:	1	:	:			-	-	n/a n/a
15 Sub-Total 15.01 Provider Tax Assessment Adjustr	I/P and O/P ment to UCC	35,428,504	44,653,236		1,842,886	6,438	(191,239)	-					210,929	-	46,522,250	(11,093,746) 14,891	131.31%
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	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 2 Medicaid Fee for Service	Inpatient Outpatient	:	-	:	:	:	:	:	:	:	:	:			-	-	0.00% 0.00%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	:	-	-	:	:	:	-							:	-	0.00% 0.00%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient	:	-	:	:	:		:	:	:	:	:			:	-	0.00% 0.00%
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient	:	-	-	:	-			-	-	-	:			-	-	0.00% 0.00%
9 Uninsured 10 Uninsured	Inpatient Outpatient	:		:		:			:	:		:	-	-	-	-	0.00% 0.00%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00% 0.00%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient		-	-	-	-	-	-	-	-	-	-			-	-	0.00% 0.00%
15 Sub-Total 15.01 Provider Tax Assessment Adjustr	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-		-	-	0.00%

15 Sub-Total I/P and O 15.01 Provider Tax Assessment Adjustment to UCC

DSH Examination UCC Cost &	Payment Summ	ary												Georgia			
Hospital Name Hospital Medicaid Number	CHILDREN'S 000679808A	HLTHCRE-HUGHE	S SPALDING														
Cost Report Period	From	1/1/2022	То	12/31/2022													
As-Adjusted:		A	В	С	D	E	F	G	н	<u> </u>	J	к	L	м	N	0	Р
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co- Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service 2 Medicaid Fee for Service	Inpatient Outpatient	1,424,701 3,287,959	966,134 3,199,540	•	•	6,438	(191,239)		:	•	-				966,134 3,014,739	458,567 273,220	67.81% 91.69%
3 Medicaid Managed Care 4 Medicaid Managed Care	Inpatient Outpatient	2,747,365 25,843,568	3,469,790 37,017,772	:			:	:							3,469,790 37,017,772	(722,425) (11,174,204)	126.30% 143.24%
5 Medicare Cross-over (FFS) 6 Medicare Cross-over (FFS)	Inpatient Outpatient		1	:	:	:				:	:				:	:	n/a n/a
7 Other Medicaid Eligibles 8 Other Medicaid Eligibles	Inpatient Outpatient	124,665 1,138,277	1	:	143,971 1,698,915	:			1	:	:	1			143,971 1,698,915	(19,306) (560,638)	115.49% 149.25%
9 Uninsured 10 Uninsured	Inpatient Outpatient	94,636 767,333	:		•	-	-		:		-	:	600 210,329		600 210,329	94,036 557,004	0.63% 27.41%
11 In-State Sub-total 12 In-State Sub-total	Inpatient Outpatient	4,391,367 31,037,137	4,435,924 40,217,312		143,971 1,698,915	6,438	(191,239)		:				600 210,329		4,580,495 41,941,755	(189,128) (10,904,618)	104.31% 135.13%
13 Out-of-State Medicaid 14 Out-of-State Medicaid	Inpatient Outpatient		:	:	:		•			:	:	:			-	-	n/a n/a
15 Cost Report Year Sub-Total	I/P and O/P	35,428,504	44,653,236		1,842,886	6,438	(191,239)		<u> </u>				210,929	<u> </u>	46,522,250	(11,093,746)	131.31%

14,891

Provider Tax Assessment Adjustment

(11,078,855)

Less: Out of State DSH Payments from Adjusted Survey Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments

Version 8.11

15.01

16 17

Medicaid DSH Survey Adjustments

PRO	VIDER	र:	CHILDREN'	S HLTHCRE-HUGHES SPALDING				Mcaid Number:	000679808A		
FRO	DM:		1/1/2022		TO:	12/31/2022		Mcare Number:	<u>110079</u>		
				Муе	rs and Stauffe	er DSH Survey Adjustments					_
Adj.	#	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1		G - CR Data		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)		Sum of ancillary cost for Medicaid NF, SNF, and Swing	Adjust to cost report.	\$ 3.462.294.00	\$ (3.462.294)	\$ -	2002
1		G - CR Data		NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D, S, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)-	Sum of ancillary cost for Medicare NF, SNF, and Swing Bed.			\$ (61,273,924)		

Medicaid DSH Report Notes

PROVIDER:	CHILDREN'S HLTHC	RE-HUGH	IES SPALDING
FROM:	1/1/2022	TO:	12/31/2022

Mcaid Number: 000679808A

Mcare Number: 110079

Myers and Stauffer DSH Report Notes

e # Note for Report	Amounts
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