

DSH Version 9.02

4/22/2025

D. General Cost Report Year Information 9/1/2023 - 8/31/2024

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

1. Select Your Facility from the Drop-Down Menu Provided:

APPLING HOSPITAL

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

9/1/2023
through
8/31/2024
X

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

5 - Amended

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

3/21/2025

4. Hospital Name:

APPLING HOSPITAL

5. Medicaid Provider Number:

00000052A

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

0

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

0

8. Medicare Provider Number:

110071

9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):

Non-State Govt.

10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)

Pool 1

11. Rural Referral Center (Yes or No)

No

Data	Correct?	If Incorrect, Proper Information
APPLING HOSPITAL	Yes	
00000052A	Yes	
0	Yes	
0	Yes	
110071	Yes	
Non-State Govt.	Yes	
Pool 1	Yes	
No	Yes	

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

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

16. State Name & Number

17. State Name & Number

18. State Name & Number

(List additional states on a separate attachment)

State Name	Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: (09/01/2023 - 08/31/2024)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)

\$ -

2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

\$ -

3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

\$ -

4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**

\$-

5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)

\$ -

6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)

\$ -

7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**

\$-

8. **Out-of-State DSH Payments (See Note 2)**

\$ -

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

Inpatient	Outpatient	Total
\$ 669	\$ 103,138	\$103,807
\$ 20,601	\$ 271,335	\$291,936
\$21,270	\$374,473	\$395,743
3.15%	27.54%	26.23%

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

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

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

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

Yes

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

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

\$ 103,782

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

\$103,782

<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.

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 (09/01/2023 - 08/31/2024)**F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)**

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

7,693

(See Note in Section F-3, below)

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

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified I/P and O/P Hospital Subsidies
5. Non-Hospital Subsidies
6. Total Hospital Subsidies

-
-
-
-
\$ -

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

40,085
350,159
\$ 390,244

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

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

Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$8,364,055.00		\$ 4,602,723	\$ -	\$ -	\$ 3,761,332
12. Subprovider I (Psych or Rehab)	\$4,032,011.00		\$ 2,218,808	\$ -	\$ -	\$ 1,813,203
13. Subprovider II (Psych or Rehab)	\$0.00		\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF		\$0.00			\$ -	
15. Swing Bed - NF		\$0.00			\$ -	
16. Skilled Nursing Facility		\$7,578,200.00			\$ 4,170,268	
17. Nursing Facility		\$0.00			\$ -	
18. Other Long-Term Care		\$0.00			\$ -	
19. Ancillary Services	\$4,459,166.00	\$27,216,472.00	\$ 2,453,870	\$ 14,977,170	\$ -	\$ 14,244,598
20. Outpatient Services		\$6,036,774.00		\$ 3,322,025	\$ -	\$ 2,714,749
21. Home Health Agency		\$0.00			\$ -	
22. Ambulance		\$ 2,527,122			\$ 1,390,670	
23. Outpatient Rehab Providers		\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
25. Hospice		\$0.00			\$ -	
26. Other	\$0.00	\$3,067,209.00	\$ -	\$ -	\$ 1,687,879	\$ -
27. Total	\$ 16,855,232	\$ 33,253,246	\$ 9,275,401	\$ 18,299,195	\$ 7,248,818	\$ 22,533,883
28. Total Hospital and Non Hospital		Total from Above		Total from Above		
		\$ 63,281,009			\$ 34,823,413	

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

Unreconciled Difference (Should be \$0)

\$ -

Total Contractual Adj. (G-3 Line 2)

34,823,413

Unreconciled Difference (Should be \$0)

\$ -

Cost Report Year (09/01/2023-08/31/2024)	APPLING HOSPITAL
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NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

[illegible]

Observation Data (Non-Distinct)

Ancillary Cost Centers (from W/S C excluding Observation) (list below):

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2023-08/31/2024) APPLING HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	9100 EMERGENCY	\$2,672,364.00	\$ -	\$ 330,186	\$ 3,002,550	\$238,248.00	\$3,697,823.00	\$ 3,936,071	0.762829
32		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2023-08/31/2024) APPLING HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 12,170,245	\$ -	\$ 330,186	\$ 12,500,431	\$ 8,971,632	\$ 36,311,066	\$ 45,282,698	
127	Weighted Average								0.287047
128	Sub Totals	\$ 19,119,342	\$ -	\$ 330,186	\$ 19,434,600	\$ 12,490,265	\$ 36,311,066	\$ 48,801,331	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$107,326.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 19,327,274				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				0.00%				

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

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

Cost Report Year (09/01/2023-08/31/2024) APPLING HOSPITAL

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)		
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	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)		Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days			
1	03000 ADULTS & PEDIATRICS	\$ 833.93		1,135	8	3,178	897			2		208		5,220		70.69%		
2	03100 INTENSIVE CARE UNIT	\$ 2,328.07										6			8	100.00%		
3	03200 CORONARY CARE UNIT	\$ -																
4	03300 BURN INTENSIVE CARE UNIT	\$ -																
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -																
6	03500 OTHER SPECIAL CARE UNIT	\$ -																
7	04000 SUBPROVIDER I	\$ -																
8	04100 SUBPROVIDER II	\$ -																
9	04200 OTHER SUBPROVIDER	\$ -																
10	04300 NURSERY	\$ -																
11		\$ -																
12		\$ -																
13		\$ -																
14		\$ -																
15		\$ -																
16		\$ -																
17		\$ -																
18		\$ -																
Total Days				1,135	8	3,186	897			2		214		5,228		65.65%		
Total Days per PS&R or Exhibit Detail				1,135	8	3,186	897			2		214						
Unreconciled Days (Explain Variance)				-	-	-	-			-		-		-				
Routine Charges				Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges			
21		\$ 472,946		\$ 3,751	\$ 1,363,850	\$ 382,838	\$ 938	\$ 469.00	\$ 161,990	\$ 2,223,385	\$ 425.28					67.79%		
21.01	Calculated Routine Charge Per Diem	\$ 416.69		\$ 468.88	\$ 428.08	\$ 426.80	\$ 469.00		\$ 756.96	\$ 425.28								
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges			
22	09200 Observation (Non-Distinct)	0.103595		33,055	170,464	-	333,304	2,654	872,396	3,688	741,919	-	59,182	335	831,379	\$ 39,397	\$ 2,118,083	63.43%
23	5000 OPERATING ROOM	0.417175		-	14,195	-	13,008	403	89,149	-	84,251	-	3,398	-	403	6,795	\$ 200,603	37.11%
24	5300 ANESTHESIOLOGY	0.012159		-	1,947	-	1,010	-	7,876	-	12,221	-	-	-	1,010	-	\$ 23,056	39.49%
25	5400 RADIOLOGY-DIAGNOSTIC	0.115923		47,842	473,645	1,376	1,365,403	93,574	1,599,350	87,633	1,692,502	3,184	89,912	88,563	2,527,128	\$ 240,425	\$ 5,130,900	98.21%
26	6000 LABORATORY	0.362761		154,376	186,571	2,589	421,962	266,212	340,132	122,070	419,326	356	14,161	72,461	659,237	\$ 545,247	\$ 1,367,991	55.18%
27	6500 RESPIRATORY THERAPY	0.449797		42,030	80,986	6,741	61,797	61,797	419,734	35,942	447,946	3,100	4,543	30,623	158,318	\$ 146,511	\$ 1,009,653	66.20%
28	6600 PHYSICAL THERAPY	0.602020		3,574	124,004	828	154,740	13,537	180,296	8,141	164,859	-	47,548	1,150	127,793	\$ 26,080	\$ 623,900	27.58%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.345683		30,879	24,314	1,911	40,405	32,462	64,159	23,124	61,952	768	2,701	19,128	84,047	\$ 88,375	\$ 190,630	57.59%
30	7200 IMPL. DEV. CHARGED TO PATIENTS	0.284444		-	-	-	-	1,604	2,008	-	-	-	1,638	-	806	\$ -	\$ 3,612	107.66%
31	7300 DRUGS CHARGED TO PATIENTS	0.188607		378,800	388,171	9,897	489,747	912,777	793,319	304,471	783,153	39,495	56,495	256,469	1,217,740	\$ 1,605,945	\$ 2,454,390	64.06%
32	7600 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.755428		-	13,260	-	-	213,249	-	68,220	17,496	-	3,038	-	-	\$ 294,729	68.60%	
33	9100 EMERGENCY	0.762629		36,099	185,366	2,098	675,735	70,537	315,447	30,553	356,603	443	6,526	20,831	889,383	\$ 139,286	\$ 1,533,152	65.79%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (09/01/2023-08/31/2024) APPLING HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													\$	-	-
72				-													\$	-	-
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					\$ 726,655	\$ 1,662,923	\$ 25,440	\$ 3,556,302	\$ 1,453,952	\$ 4,896,713	\$ 625,621	\$ 4,834,961	\$ 47,346	\$ 303,601	\$ 489,962	\$ 6,506,673			

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

Cost Report Year (09/01/2023-08/31/2024) APPLING HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 1,199,601	\$ 1,662,923	\$ 29,191	\$ 3,556,302	\$ 2,817,802	\$ 4,896,713	\$ 1,008,459	\$ 4,834,961	\$ 48,284	\$ 303,601	\$ 651,952	\$ 6,506,673	\$ 5,055,053	\$ 14,950,899	55.66%
129 Total Charges per PS&R or Exhibit Detail	\$ 1,199,601	\$ 1,662,923	\$ 29,191	\$ 3,556,302	\$ 2,817,802	\$ 4,896,713	\$ 1,008,459	\$ 4,834,961	\$ 48,284	\$ 303,601	\$ 651,952	\$ 6,506,673			
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 1,173,074	\$ 514,622	\$ 17,339	\$ 1,134,122	\$ 3,082,308	\$ 1,371,933	\$ 936,934	\$ 1,316,414	\$ 12,380	\$ 86,728	\$ 328,651	\$ 1,792,962	\$ 5,209,655	\$ 4,337,091	60.37%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 810,760	\$ 501,587		\$ 112	\$ 65,539	\$ 105,708	\$ 39,132	\$ 79,024					\$ 915,431	\$ 686,431	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 12,713	\$ 745,599				\$ 29,154					\$ 12,713	\$ 774,753	
134 Private Insurance (including primary and third party liability)				\$ 1,511	\$ 11	\$ 3,095	\$ 283,793	\$ 506,418					\$ 283,804	\$ 511,024	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 5,898	\$ 1,025		\$ 79	\$ 50	\$ 704	\$ 1,694	\$ 489					\$ 7,642	\$ 2,297	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 816,658	\$ 502,612	\$ 12,713	\$ 747,301											
137 Medicaid Cost Settlement Payments (See Note B)		\$ (45,000)											\$ -	\$ (45,000)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	\$ 5,099				\$ 3,007,769	\$ 793,429	\$ -	\$ 372					\$ 3,012,868	\$ 793,801	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 313,894	\$ 264,041					\$ 313,894	\$ 264,041	
141 Medicare Cross-Over Bad Debt Payments					\$ 25,442								\$ 25,442	\$ -	
142 Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 669	\$ 103,138			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											\$ -	\$ -			
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 351,317	\$ 57,010	\$ 4,626	\$ 386,821	\$ (16,503)	\$ 468,997	\$ 208,421	\$ 436,916	\$ 12,380	\$ 86,728	\$ 327,982	\$ 1,689,824	\$ 637,861	\$ 1,349,744	
146 Calculated Payments as a Percentage of Cost	70%	89%	73%	66%	101%	66%	68%	67%	0%	0%	0%	6%	88%	69%	
147 Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)						5,015									
148 Percent of cross-over days to total Medicare days from the cost report						64%									

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

Cost Report Year (09/01/2023-08/31/2024)	APPLING HOSPITAL
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Page 9

Cost Report Year (09/01/2023-08/31/2024)	APPLING HOSPITAL
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Page 10

Cost Report Year (09/01/2023-08/31/2024)	APPLING HOSPITAL
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Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.