

**A. General DSH Year Information**

1. DSH Year: 

Begin	End
07/01/2025	06/30/2026

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

**Identification of cost reports needed to cover the DSH Year:**

3. Cost Report Year 1 

Cost Report Begin Date(s)	Cost Report End Date(s)
04/01/2023	03/31/2024

4. Cost Report Year 2 (if applicable)

5. Cost Report Year 3 (if applicable)

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

Data	
6. Medicaid Provider Number:	000248069A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	112003

**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:**

<p>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.)</p> <p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p> <p>3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?</p> <p>3a. Was the hospital open as of December 22, 1987?</p> <p>3b. What date did the hospital open?</p>	<table border="1" style="background-color: #d9e1f2;"> <tr> <th>DSH Examination Year (07/01/25 - 06/30/26)</th> </tr> <tr> <td>No</td> </tr> <tr> <td>No</td> </tr> <tr> <td>Yes</td> </tr> <tr> <td>Yes</td> </tr> <tr> <td>8/1/1975</td> </tr> </table>	DSH Examination Year (07/01/25 - 06/30/26)	No	No	Yes	Yes	8/1/1975
DSH Examination Year (07/01/25 - 06/30/26)							
No							
No							
Yes							
Yes							
8/1/1975							

**C. Disclosure of Other Medicaid Payments Received:**

- |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| 1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026<br><i>(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)</i>                                                                                                                                                                                                                                                                                                                   | \$ 967,600 |
| 2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026<br><i>(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.<br/>NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.</i> | \$         |
| 3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2025 - 06/30/2026                                                                                                                                                                                                                                                                                                                                                                                                                                                | \$ 967,600 |

**Certification:**

- |                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                   |        |     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----|
| 1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?<br>Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments. | <table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td style="text-align: center;">Answer</td></tr> <tr><td style="text-align: center;">Yes</td></tr> </table> | Answer | Yes |
| Answer                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                   |        |     |
| Yes                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                   |        |     |

Explanation for "No" answers:

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

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

  
 Hospital CEO or CFO Signature  
 Beth Boatwright  
 Hospital CEO or CFO Printed Name

Chief Financial Officer  
 Title  
 404-350-7776  
 Hospital CEO or CFO Telephone Number

11/10/2025  
 Date  
 Beth Boatwright@shepherd.org  
 Hospital CEO or CFO E-Mail

**Contact information for individuals authorized to respond to inquiries related to this survey:**

**Hospital Contact:**

Name	John McDaniel
Title	Director of Finance
Telephone Number	404 350 7329
E-Mail Address	john.mcdaniel@shepherd.org
Mailing Street Address	2020 Peachtree Road NW
Mailing City, State, Zip	Atlanta, GA 30309

**Outside Preparer:**

Name	Ramzi Fadayer
Title	Consulting Manager
Firm Name	PYA, P.C.
Telephone Number	865-474-7363
E-Mail Address	rfadayer@pyapc.com

**D. General Cost Report Year Information** 4/1/2023 - 3/31/2024

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:

SHEPHERD CENTER

4/1/2023 through 3/31/2024		
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2. Select Cost Report Year Covered by this Survey (enter "X"):

X

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

1 - As Submitted

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

8/27/2024

4. Hospital Name:

SHEPHERD CENTER

5. Medicaid Provider Number:

000248069A

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

0

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

0

8. Medicare Provider Number:

112003

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

Private

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

Pool 2

11. Rural Referral Center (Yes or No)

No

Data	Correct?	If Incorrect, Proper Information
SHEPHERD CENTER		
000248069A		
0		
0		
112003		
Private		
Pool 2		
No		

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

State Name	Provider No.

(List additional states on a separate attachment)

**E. Disclosure of Medicaid / Uninsured Payments Received: (04/01/2023 - 03/31/2024)**

- 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)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)
- 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
	\$ 909,918	\$ 176,350	\$1,086,267
	\$ 472,547	\$ 1,389,631	\$1,862,178
	\$1,382,465	\$1,565,981	\$2,948,446
	65.82%	11.26%	36.84%

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 payments received by the hospital (not by the MCO), or other incentive payments

No

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

\$-

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

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

**F. MIUR / LIUR Qualifying Data from the Cost Report (04/01/2023 - 03/31/2024)**

**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. 1, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)

49,317 (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

	6,593,287
	6,359,204
\$	12,952,491

**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	\$135,966,199.00			\$ 78,839,642	\$ -	\$ -	\$ 57,126,557
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00				
15. Swing Bed - NF			\$0.00				
16. Skilled Nursing Facility			\$0.00				
17. Nursing Facility			\$0.00				
18. Other Long-Term Care			\$0.00				
19. Ancillary Services	\$230,910,208.00	\$241,657,761.00		\$ 133,892,676	\$ 140,124,616	\$ -	\$ 198,550,678
20. Outpatient Services		\$39,098,066.00			\$ 22,670,911	\$ -	\$ 16,427,155
21. Home Health Agency			\$0.00				
22. Ambulance			\$ -				
23. Outpatient Rehab Providers			\$0.00				
24. ASC	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00				
26. Other	\$0.00	\$0.00	\$0.00				
27. Total	\$ 366,876,407	\$ 280,755,827	\$ -	\$ 212,732,318	\$ 162,795,526	\$ -	\$ 272,104,390
28. Total Hospital and Non Hospital		Total from Above	\$ 647,632,234		Total from Above	\$ 375,527,844	

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)

Total Patient Revenues (G-3 Line 1) 647,632,234

Total Contractual Adj. (G-3 Line 2) 375,527,844

- 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) \$ -

Unreconciled Difference (Should be \$0) \$ -

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Curve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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.

**Routine Cost Centers (list below):**

1	03000 ADULTS & PEDIATRICS	\$ 70,236,291	\$ -	\$ 135,065	\$ 0.00	\$ 70,371,356	49,317	\$ 133,220,335.00	\$ 1,426.92
2	03100 INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
3	03200 CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
10	04300 NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
11		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
12		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
13		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
14		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
15		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
16		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
17		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
18	Total Routine	\$ 70,236,291	\$ -	\$ 135,065	\$ -	\$ 70,371,356	49,317	\$ 133,220,335	\$ 1,426.92
19	Weighted Average								\$ 1,426.92

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	-	-	-	\$ -	\$ 0.00	\$ 0.00	\$ -	-

Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

21	5000 OPERATING ROOM	\$ 5,986,640.00	\$ -	\$ -	\$ 5,986,640	\$ 10,908,889.00	\$ 782,254.00	\$ 11,691,143	0.512066
22	5400 RADIOLOGY-DIAGNOSTIC	\$ 2,327,290.00	\$ -	\$ -	\$ 2,327,290	\$ 5,855,974.00	\$ 957,766.00	\$ 6,813,740	0.341558
23	5700 CT SCAN	\$ 624,334.00	\$ -	\$ -	\$ 624,334	\$ 5,553,754.00	\$ 617,107.00	\$ 6,170,861	0.101175
24	5800 MRI	\$ 1,666,134.00	\$ -	\$ -	\$ 1,666,134	\$ 930,468.00	\$ 16,272,134.00	\$ 17,202,602	0.096854
25	6000 LABORATORY	\$ 3,059,842.00	\$ -	\$ -	\$ 3,059,842	\$ 12,639,534.00	\$ 7,812,841.00	\$ 20,452,375	0.149608
26	6500 RESPIRATORY THERAPY	\$ 6,360,337.00	\$ -	\$ -	\$ 6,360,337	\$ 68,434,956.00	\$ 77,324.00	\$ 68,512,280	0.092835
27	6600 PHYSICAL THERAPY	\$ 16,465,801.00	\$ -	\$ -	\$ 16,465,801	\$ 26,690,594.00	\$ 15,487,988.00	\$ 42,178,582	0.390383
28	6700 OCCUPATIONAL THERAPY	\$ 13,037,603.00	\$ -	\$ -	\$ 13,037,603	\$ 25,120,870.00	\$ 13,713,241.00	\$ 38,834,111	0.335726
29	6800 SPEECH PATHOLOGY	\$ 5,251,472.00	\$ -	\$ -	\$ 5,251,472	\$ 12,126,262.00	\$ 4,613,824.00	\$ 16,740,086	0.313706
30	6900 ELECTROCARDIOLOGY	\$ 151,976.00	\$ -	\$ -	\$ 151,976	\$ 518,095.00	\$ 8,274.00	\$ 526,369	0.288725
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 5,578,925.00	\$ -	\$ -	\$ 5,578,925	\$ 8,215,038.00	\$ 119,090.00	\$ 8,334,128	0.669407

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7300 DRUGS CHARGED TO PATIENTS	\$73,597,952.00	\$ -	\$ -	\$ 73,597,952	\$48,414,287.00	\$175,775,235.00	\$ 224,189,522	0.328285
33	7503 OTHER PATIENT SERVICES	\$7,090,421.00	\$ -	\$ -	\$ 7,090,421	\$3,880,452.00	\$5,194,363.00	\$ 9,074,815	0.781330
34	9000 CLINIC	\$25,596,934.00	\$ -	\$ 1,199,433	\$ 26,796,367	\$4,818.00	\$20,981,956.00	\$ 20,986,774	1.276822
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	\$ -	-
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	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	<b>Total Ancillary</b>	\$ 166,795,661	\$ -	\$ 1,199,433	\$ 167,995,094	\$ 229,293,991	\$ 262,413,397	\$ 491,707,388	
127	<b>Weighted Average</b>								0.341657
128	<b>Sub Totals</b>	\$ 237,031,952	\$ -	\$ 1,334,498	\$ 238,366,450	\$ 362,514,326	\$ 262,413,397	\$ 624,927,723	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	<b>Grand Total</b>				\$ 238,366,450				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicaid FFS Cross-Overs (with Medicaid Secondary)		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)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From PSAR Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
<b>Routine Cost Centers (from Section G):</b>																
1	03000 ADULTS & PEDIATRICS	\$ 1,426.92		Days	970	Days	-	Days	63	Days	3,659	Days	442	Days	4,692	10.4%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03300 CORPORARY 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	04000 NURSERY	\$ -														
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18		\$ -														
19	Total Days per PSAR or Exhibit Detail			970				63		3,659			442		4,692	10.4%
20	Unreconciled Days (Explain Variance)															
21	Routine Charges															
21 01	Calculated Routine Charge Per Diem	\$ 2,448,785	\$ 2,524,521					\$ 158,716	\$ 2,520,25	\$ 9,472,126	\$ 2,500,09		\$ 1,052,550	\$ 2,471,54	\$ 12,084,688	13.6%
<b>Ancillary Cost Centers (from WIS C) (from Section G):</b>																
22	09200 Observation (Non-Distinct)			Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges
23	6000 OPERATING ROOM	0.512048	320.683	5,859				42,363	10,242	3,182,713	87,840	74,187	240	1,758,759	\$ 83,941	18.1%
24	5400 RADIOLOGIC DIAGNOSTIC	0.341558	60,952	98,553			1,298	44,914	43,043	3,154,411	43,043	23,814	24,469	379,158	\$ 192,408	10.0%
25	5700 DTC SCAN	0.101175	113,837	6,335				26,340	19,813	475,034	19,813	16,503	8,332	588,871	\$ 52,528	10.8%
26	5800 MRI	0.096554	3,589	187,511			24,172	870,568	63,313	430,430	430,430		540,057	66,502	\$ 1,317,190	11.1%
27	6000 LABORATORY	0.149505	278,276	8,740			7,541	22,100	357,666	1,778,388	206,311	71,924	187,265	312,717	\$ 1,477,970	11.9%
28	6500 RESPIRATORY THERAPY	0.092335	1,173,494	6,940			360	7,770	10,303,912	2,531				11,485,765	\$ 17,591	0.1%
29	6600 PHYSICAL THERAPY	0.350383	443,462	113,958			9,235	24,183	547,797	1,749,647	407,358	260,479	279,065	2,217,302	\$ 1,078,348	11.2%
30	6700 OCCUPATIONAL THERAPY	0.330725	497,440	32,040			6,587	20,731	387,449	1,801,219	379,855	233,721	217,053	2,313,390	\$ 805,941	11.2%
31	6800 SPEECH PATHOLOGY	0.313308	215,192	1,932			2,819	10,097	89,272	94,259	88,135	69,227	121,785	1,186,548	\$ 178,354	1.7%
32	6900 ELECTROCARDIOLOGY	0.288725	14,736	394			394	1,182	81,552	3,152			4,766	96,655	\$ 4,723	0.0%
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.669407	245,472				11,360	19,448	987,682	36,464			41,188	3,603	\$ 1,244,515	10.1%
34	7300 DRUGS CHARGED TO PATIENTS	0.323255	907,580	14,282			89,202	38,313	14,100,000	4,897,983	6,914,614	358,494	654,854	5,637,878	\$ 21,118,078	21.6%
35	7503 OTHER PATIENT SERVICES	0.781330	23,627				320	2,441	43,806	442,912	43,306		469,182	53,754	\$ 89,635	0.8%
36	9000 CLINIC	1.276822	4,818	404,046			3,896		764,795	147			277,130	4,365	\$ 1,868,077	15.2%
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**H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:**

Cost Report Year (04/01/2022-03/31/2024) SHEPHERD CENTER

	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere & 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)	% Surplus (g)							
<b>Totals / Payments</b>															
128 Total Charges (includes organ acquisition from Section J)	\$ 6,738,047	\$ 877,810	\$ -	\$ 145,495	\$ 342,643	\$ 17,080,689	\$ 33,908,925	\$ 9,333,175	\$ -	\$ -	\$ 2,497,650	\$ 2,515,224	\$ 40,989,815	\$ 27,436,969	67%
129 Total Charges per PSAR or Exhibit Detail	\$ 6,738,047	\$ 877,810	\$ -	\$ 145,495	\$ 342,643	\$ 17,080,689	\$ 33,908,925	\$ 9,333,175	\$ -	\$ -	\$ 2,497,650	\$ 2,515,224	\$ 40,989,815	\$ 27,436,969	67%
130 Uncontrolled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 2,829,859	\$ 633,520	\$ -	\$ 45,269	\$ 158,835	\$ 6,190,570	\$ 11,385,425	\$ 3,633,996	\$ -	\$ -	\$ 1,097,583	\$ 953,100	\$ 14,170,110	\$ 10,503,355	74%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 2,028,169	\$ 503,071	\$ -	\$ 17,888	\$ 4,451	\$ 975,687	\$ 1,074,304	\$ 81,368					\$ 3,107,014	\$ 1,278,114	41%
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 4,212									\$ -	\$ 4,212	0%
134 Private Insurance (including primary and third party liability)			\$ 2,568	\$ 231		\$ 2,103	\$ 11,954,656	\$ 3,039,565					\$ 11,967,264	\$ 3,041,899	25%
135 Self-Pay (including Co-Pay and Spend-Down)							\$ 5,501	\$ 6,362					\$ 5,501	\$ 6,362	100%
136 Total Allowed Amount from Medicaid PSAR or RA Detail (All Payments)	\$ 2,028,169	\$ 503,071	\$ 2,568	\$ 22,431									\$ -	\$ -	0%
137 Medicaid Cost Settlement Payments (See Note B)													\$ -	\$ -	0%
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													\$ -	\$ -	0%
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					\$ 84,891	\$ 3,965,597							\$ 84,891	\$ 3,965,597	100%
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													\$ -	\$ -	0%
141 Medicare Cross-Over Bad Debt Payments													\$ -	\$ -	0%
142 Other Medicare Cross-Over Payments (See Note D)													\$ -	\$ -	0%
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 909,918	\$ 176,350	\$ -	\$ -	0%
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											\$ -	\$ -	\$ -	\$ -	0%
145 Calculated Payment Shortfall (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 597,690	\$ 130,440	\$ (2,568)	\$ 22,838	\$ 69,403	\$ 1,547,182	\$ (1,659,186)	\$ 506,701	\$ -	\$ -	\$ 188,065	\$ 778,816	\$ (994,551)	\$ 2,207,170	100%
146 Calculated Payments as a Percentage of Cost	77%	79%	0%	50%	56%	75%	115%	86%	0%	0%	83%	19%	107%	79%	
147 Total Medicare Days from WIS 5-3 of the Cost Report Excluding Swing-Bed (CPL WIS 5-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)						3,728									
148 Percent of cross-over days to total Medicare days from the cost report						2%									

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 PSAR 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 PSAR).  
 Note C - Other Medicaid Payments such as Outliers and Non-Cases 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 - Medicare 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 payer buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

**I. Out-of-State Medicaid Data:**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers From Section G	Medicaid Cost to Charge Ratio for Ancillary Cost Centers From Section G	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
<b>Routine Cost Centers (list below):</b>				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,426.62											
2	03100 INTENSIVE CARE UNIT	\$ -											
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										
19	Total Days per PS&R or Exhibit Detail												
20	Unreconciled Days (Explain Variance)												
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Ancillary Cost Centers (from W/S C) (list below):</b>				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
22	09200 Observation (Non-Distinct)		-										
23	5000 OPERATING ROOM		0.512066										
24	5400 RADIOLOGY-DIAGNOSTIC		0.341558										
25	5700 CT SCAN		0.101175										
26	5800 MRI		0.096854										
27	6000 LABORATORY		0.149608										
28	6500 RESPIRATORY THERAPY		0.092835										
29	6600 PHYSICAL THERAPY		0.390383										
30	6700 OCCUPATIONAL THERAPY		0.335726										
31	6800 SPEECH PATHOLOGY		0.313706										
32	6900 ELECTROCARDIOLOGY		0.288725										
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.669407										
34	7300 DRUGS CHARGED TO PATIENTS		0.328285										
35	7503 OTHER PATIENT SERVICES		0.781330										
36	9000 CLINIC		1.276822										
37			-										
38			-										
39			-										
40			-										
41			-										
42			-										
43			-										
44			-										
45			-										
46			-										
47			-										
48			-										

**I. Out-of-State Medicaid Data:**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
											\$	\$
49												
50												
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**I. Out-of-State Medicaid Data:**

Cost Report Year (04/01/2023-03/31/2024) SHEPHERD CENTER

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
111										\$ -	\$ -
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
<b>Totals / Payments</b>		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)										
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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) (See Note F)									\$ -	\$ -
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	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
144	<b>Calculated Payments as a Percentage of Cost</b>	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 Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.  
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).  
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (04/01/2023-03/31/2024): SHEPHERD CENTER

	Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Eligible and Non-Covered)		Medicaid FFS & MCO Eligible and Non-Covered (Not to be Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. II, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 123 * Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WFS D-4 Pt. II, Col. 1, Ln 64 (substitute Medicare with Medicaid Cross-Over & uninsured). See Note C below	Cost Report Worksheet D-4, Pt. II, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	
<b>Organ Acquisition Cost Centers (list below)</b>																	
1	Lung Acquisition	\$0.00	\$-	\$-	\$-	0											
2	Kidney Acquisition	\$0.00	\$-	\$-	\$-	0											
3	Liver Acquisition	\$0.00	\$-	\$-	\$-	0											
4	Heart Acquisition	\$0.00	\$-	\$-	\$-	0											
5	Pancreas Acquisition	\$0.00	\$-	\$-	\$-	0											
6	Intestinal Acquisition	\$0.00	\$-	\$-	\$-	0											
7	Islet Acquisition	\$0.00	\$-	\$-	\$-	0											
8		\$0.00	\$-	\$-	\$-	0											
9	<b>Totals</b>	\$-	\$-	\$-	\$-	0									\$-		0
10	<b>Total Cost</b>																

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).  
 Note B - Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.  
 Note C - Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (04/01/2023-03/31/2024): SHEPHERD CENTER

	Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. II, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 123 * Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report WFS D-4 Pt. II, Col. 1, Ln 64 (substitute Medicare with Medicaid Cross-Over & uninsured). See Note C below	Cost Report Worksheet D-4, Pt. II, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	
<b>Organ Acquisition Cost Centers (list below)</b>													
11	Lung Acquisition	\$-	\$-	\$-	\$-	0							
12	Kidney Acquisition	\$-	\$-	\$-	\$-	0							
13	Liver Acquisition	\$-	\$-	\$-	\$-	0							
14	Heart Acquisition	\$-	\$-	\$-	\$-	0							
15	Pancreas Acquisition	\$-	\$-	\$-	\$-	0							
16	Intestinal Acquisition	\$-	\$-	\$-	\$-	0							
17	Islet Acquisition	\$-	\$-	\$-	\$-	0							
18		\$-	\$-	\$-	\$-	0							
19	<b>Totals</b>	\$-	\$-	\$-	\$-	0							
20	<b>Total Cost</b>												

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

## L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year: (04/01/2023-03/31/2024) SHEPHERD CENTER

### Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)**	\$ 3,823,053	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	18206.00 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 3,823,053	(Where is the cost included on w/s A?)
3 Difference (Explain Here ->)	\$ -	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 3,823,053	

### DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	68,426,584
19 Uninsured Hospital Charges Sec. G	5,012,875
20 Total Hospital Charges Sec. G	624,927,723
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	10.95%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	0.80%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC**	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ -
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	7,761,152
27 Uninsured Hospital Charges Sec. G	5,012,875
28 Total Hospital Charges Sec. G	624,927,723
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	1.24%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	0.80%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC**	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

\*\* 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 diem's used in the survey

\*\*\*\*For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.