EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	7.25	5/3/2018

D. General Cost Report Year Information 7/1/2016 - 6/30/2017

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: **ELBERT MEMORIAL HOSPITAL**

	7/1/2016 through 6/30/2017		
2. Select Cost Report Year Covered by this Survey:	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 12/22/2017

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ELBERT MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000668A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110026	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

	State Name	Provider No.
9. State Name & Number	South Carolina - Inpatient	10029A
10. State Name & Number	South Carolina - Outpatient	255142
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2016 - 06/30/2017)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 12,673	$ 93,968	$106,641
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 127,625	$ 479,036	$606,661
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$140,298	$573,004	$713,302
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.03%	16.40%	14.95%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2016 - 06/30/2017)

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)	2,350

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	195,393
8. Outpatient Hospital Charity Care Charges	311,460
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 506,853

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

	Total Patient Revenues (Charges)			Contractual Adjustments			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$ 1,589,857	$ -	$ -	$ 1,120,243	$ -	$ -	$ 469,614
12. Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ 514,375			$ 362,438	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 5,034,308	$ 20,718,731	$ -	$ 3,547,267	$ 14,598,803	$ -	$ 7,606,969
20. Outpatient Services		$ 5,002,368	$ -		$ 3,524,762	$ -	$ 1,477,606
21. Home Health Agency			$ -			$ -	
22. Ambulance			$ -			$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27. Total	$ 6,624,165	$ 25,721,099	$ 514,375	$ 4,667,510	$ 18,123,565	$ 362,438	$ 9,554,189
28. Total Hospital and Non Hospital		Total from Above	$ 32,859,639		Total from Above	$ 23,153,513	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 32,859,639	Total Contractual Adj. (G-3 Line 2)	$ 22,713,442
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)			+	$ -
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)			+	$ 571,379
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)			-	$ (131,308)
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)"			-	$ -
35. Adjusted Contractual Adjustments				23,153,513
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
		Routine Cost Centers (list below):									
1	03000	ADULTS & PEDIATRICS	$ 2,276,643	$ -	$ -	$ -	$ 2,276,643	2,797	$ 2,051,761		$ 813.96
2	03100	INTENSIVE CARE UNIT	$ 401,470	$ -	$ -		$ 401,470	37	$ 55,568		$ 10,850.54
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		0	$ -	$ -	$ -		$ -	-	$ -		$ -
12		0	$ -	$ -	$ -		$ -	-	$ -		$ -
13		0	$ -	$ -	$ -		$ -	-	$ -		$ -
14		0	$ -	$ -	$ -		$ -	-	$ -		$ -
15		0	$ -	$ -	$ -		$ -	-	$ -		$ -
16		0	$ -	$ -	$ -		$ -	-	$ -		$ -
17		0	$ -	$ -	$ -		$ -	-	$ -		$ -
18		Total Routine	$ 2,678,113	$ -	$ -	$ -	$ 2,678,113	2,834	$ 2,107,329		
19		Weighted Average									$ 945.00

Line #		Observation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200	Observation (Non-Distinct)		484	-	-	$ 393,957	$ 29,911	$ 172,162	$ 202,073	1.949578

Line #		Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
		Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000	OPERATING ROOM	$ 1,101,681	$ -	$ -		$ 1,101,681	$ 271,200	$ 2,994,251	$ 3,265,451	0.337375
22	5300	ANESTHESIOLOGY	$ 213,727	$ -	$ -		$ 213,727	$ 121,769	$ 1,065,925	$ 1,187,694	0.179951
23	5400	RADIOLOGY-DIAGNOSTIC	$ 520,609	$ -	$ -		$ 520,609	$ 454,428	$ 2,855,941	$ 3,310,369	0.157266
24	5700	CT SCAN	$ 438,343	$ -	$ -		$ 438,343	$ 409,671	$ 4,651,121	$ 5,060,792	0.086615
25	5800	MRI	$ 201,084	$ -	$ -		$ 201,084	$ 43,625	$ 771,226	$ 814,851	0.246774
26	6000	LABORATORY	$ 1,025,930	$ -	$ -		$ 1,025,930	$ 1,077,990	$ 3,558,223	$ 4,636,213	0.221286
27	6500	RESPIRATORY THERAPY	$ 380,418	$ -	$ -		$ 380,418	$ 510,537	$ 550,805	$ 1,061,342	0.358431
28	6600	PHYSICAL THERAPY	$ 421,188	$ -	$ -		$ 421,188	$ 526,830	$ 653,855	$ 1,180,685	0.356732
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 837,481	$ -	$ -		$ 837,481	$ 397,059	$ 366,323	$ 763,382	1.097067
30	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 87,657	$ -	$ -		$ 87,657	$ 48,754	$ 133,981	$ 182,735	0.479695
31	7300	DRUGS CHARGED TO PATIENTS	$ 702,969	$ -	$ -		$ 702,969	$ 1,172,409	$ 1,186,686	$ 2,359,095	0.297982
32	9100	EMERGENCY	$ 1,741,198	$ -	$ -		$ 1,741,198	$ 404,460	$ 4,597,908	$ 5,002,368	0.348075

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

	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
33			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
34			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
35			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
36			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
37			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
38			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
39			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
40			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
41			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
42			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
43			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
44			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
45			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
46			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
47			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
48			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
49			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
50			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
51			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
52			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
53			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
54			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
55			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
56			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
57			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
58			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
59			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
60			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
61			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
62			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
63			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
64			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
65			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
66			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
67			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
68			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
69			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
70			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
71			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
72			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
73			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
74			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
75			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
76			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
77			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
78			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
79			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
80			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
81			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
82			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
83			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
84			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
85			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
86			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
87			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
88			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
89			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
90			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
91			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
92			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
93			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

	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
94			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125			$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126		**Total Ancillary**	$ 7,672,285	$ -	$ -		$ 7,672,285	$ 5,468,643	$ 23,558,407	$ 29,027,050	
127		**Weighted Average**									0.277887
128		**Sub Totals**	$ 10,350,398	$ -	$ -		$ 10,350,398	$ 7,575,972	$ 23,558,407	$ 31,134,379	

Line	Description	Amount
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)	$ -
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)	$ 164,831
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)	$ -
131.01	Other Cost Adjustments (support must be submitted)	$ -
132	**Grand Total**	**$ 10,185,567**
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 (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):				**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000	ADULTS & PEDIATRICS	$ 813.96		125		68		311		170		132		**674**		34.93%
2	03100	INTENSIVE CARE UNIT	$ 10,850.54		5		2		5		-		1		**12**		35.14%
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		0	$ -		-		-		-		-		-		-		
12		0	$ -		-		-		-		-		-		-		
13		0	$ -		-		-		-		-		-		-		
14		0	$ -		-		-		-		-		-		-		
15		0	$ -		-		-		-		-		-		-		
16		0	$ -		-		-		-		-		-		-		
17		0	$ -		-		-		-		-		-		-		
18				**Total Days**	130		70		316		170		133		686		34.94%
19	Total Days per PS&R or Exhibit Detail				130		70		316		170		133				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 82,025		$ 46,110		$ 240,775		$ 111,450		$ 92,305		$ 480,360		27.23%
21.01		Calculated Routine Charge Per Dier			$ 630.96		$ 658.71		$ 761.95		$ 655.59		$ 694.02		$ 700.23		
	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		1.949578	$ 971	$ 7,632	$ 1,014	$ 29,766	$ 6,198	$ 26,570	$ 4,338	$ 5,906	$ 2,169	$ 21,002	$ 12,521	$ 69,874	52.24%
23	5000	OPERATING ROOM		0.337375	$ 39,975	$ 125,723	$ 32,645	$ 308,831	$ 19,590	$ 227,604	$ 18,565	$ 45,595	$ 12,181	$ 43,283	$ 110,775	$ 707,753	26.84%
24	5300	ANESTHESIOLOGY		0.179951	$ 5,911	$ 9,096	$ 4,185	$ 82,734	$ 4,176	$ 33,616	$ 5,205	$ 12,973	$ 3,175	$ 9,565	$ 19,477	$ 138,419	14.44%
25	5400	RADIOLOGY-DIAGNOSTIC		0.157266	$ 12,229	$ 143,806	$ 9,345	$ 286,839	$ 95,755	$ 284,114	$ 28,278	$ 54,959	$ 29,037	$ 197,159	$ 145,607	$ 769,718	34.62%
26	5700	CT SCAN		0.086615	$ 23,504	$ 218,910	$ 11,312	$ 375,962	$ 103,118	$ 534,458	$ 49,358	$ 70,008	$ 78,912	$ 469,888	$ 187,292	$ 1,199,338	38.49%
27	5800	MRI		0.246774	$ 3,756	$ 54,288	$ -	$ 76,449	$ 1,878	$ 84,914	$ 3,756	$ 15,522	$ 3,991	$ 12,085	$ 9,390	$ 231,173	31.50%
28	6000	LABORATORY		0.221286	$ 63,235	$ 212,774	$ 35,498	$ 320,011	$ 197,033	$ 324,095	$ 90,007	$ 257,790	$ 103,393	$ 423,093	$ 385,773	$ 1,114,670	43.82%
29	6500	RESPIRATORY THERAPY		0.358431	$ 23,912	$ 28,525	$ 8,506	$ 46,363	$ 102,469	$ 67,053	$ 32,149	$ 7,280	$ 12,836	$ 57,155	$ 167,036	$ 149,221	36.44%
30	6600	PHYSICAL THERAPY		0.356732	$ 6,276	$ 9,861	$ -	$ 35,529	$ 5,458	$ 57,515	$ 1,148	$ 14,721	$ 925	$ 1,665	$ 12,882	$ 117,626	11.27%
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.097067	$ 33,771	$ 17,300	$ 9,248	$ 46,891	$ 66,851	$ 24,011	$ 35,080	$ 5,615	$ 8,705	$ 21,367	$ 144,950	$ 93,817	35.24%
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.479695	$ 12,067	$ -	$ -	$ 1,727	$ -	$ 10,452	$ -	$ -	$ -	$ -	$ 12,067	$ 12,179	13.27%
33	7300	DRUGS CHARGED TO PATIENTS		0.297982	$ 80,033	$ 110,146	$ 40,576	$ 194,816	$ 206,534	$ 171,527	$ 89,837	$ 27,889	$ 95,670	$ 264,907	$ 416,980	$ 504,378	54.46%
34	9100	EMERGENCY		0.348075	$ 21,722	$ 298,091	$ 11,848	$ 628,637	$ 64,060	$ 385,684	$ 18,760	$ 62,856	$ 40,482	$ 781,306	$ 116,390	$ 1,375,268	46.45%
35				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
36				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
37				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
38				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
39				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
40				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
41				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
42				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

Line	Description		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
85		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
86		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
87		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
88		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
89		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
90		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
91		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
92		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
93		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
94		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
95		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
96		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
97		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
98		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
99		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
100		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
101		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
102		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
103		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
104		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
105		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
106		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
107		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
108		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
109		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
110		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
111		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
112		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
113		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
114		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
115		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
116		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
117		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
118		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
119		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
120		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
121		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
122		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
123		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
124		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
125		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
126		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
127		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
			327,362	1,236,152	164,177	2,434,555	873,120	2,231,613	376,481	581,114	391,476	2,302,475			
	Totals / Payments														
128	**Total Charges *(includes organ acquisition from Section J)***		**$ 409,387**	**$ 1,236,152**	**$ 210,287**	**$ 2,434,555**	**$ 1,113,895**	**$ 2,231,613**	**$ 487,931**	**$ 581,114**	**$ 483,781** (Agrees to Exhibit A)	**$ 2,302,475** (Agrees to Exhibit A)	**$ 2,221,500**	**$ 6,483,434**	**37.04%**
129	Total Charges per PS&R or Exhibit Detail		$ 409,387	$ 1,236,152	$ 210,287	$ 2,434,555	$ 1,113,895	$ 2,231,613	$ 487,931	$ 581,114	$ 483,781	$ 2,302,475			
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**												$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**		**$ 276,376**	**$ 330,290**	**$ 130,508**	**$ 702,892**	**$ 590,749**	**$ 579,549**	**$ 267,314**	**$ 149,024**	**$ 219,548**	**$ 620,993**	$ 1,264,947	$ 1,761,755	38.07%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 214,893	$ 309,154	$ -	$ -	$ 66,035	$ 55,825	$ 1,288	$ 1,411			$ 282,216	$ 366,390	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ -	$ 117,713	$ 521,236	$ -	$ -	$ 320	$ 5,063			$ 118,033	$ 526,299	
134	Private Insurance (including primary and third party liability)		$ 2,451	$ 199	$ -	$ 3,259	$ 188	$ 1,021	$ 13,771	$ 41,216			$ 16,410	$ 45,695	
135	Self-Pay (including Co-Pay and Spend-Down)		$ -	$ 1,225	$ 3	$ 2,509	$ -	$ -	$ 13	$ 2,857			$ 16	$ 6,591	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 217,344	$ 310,578	$ 117,716	$ 527,004									
137	Medicaid Cost Settlement Payments (See Note B)		$ -	$ (32,508)	$ -	$ -							$ -	$ (32,508)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						$ 525,027	$ 348,993	$ 205,808	$ 44,582			$ 730,835	$ 393,575	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						$ -	$ -	$ 44,120	$ 18,951			$ 44,120	$ 18,951	
141	Medicare Cross-Over Bad Debt Payments						$ 2,211	$ 11,179	$ -	$ -			$ 2,211	$ 11,179	
142	Other Medicare Cross-Over Payments (See Note D)						$ (735)	$ (12,520)	$ (224)	$ (1,632)	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (959)	$ (14,152)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										$ 12,673	$ 93,968			
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)**		$ 59,032	$ 52,220	$ 12,792	$ 175,888	$ (1,977)	$ 175,051	$ 2,218	$ 36,576	$ 206,875	$ 527,025	$ 72,065	$ 439,735	
146	**Calculated Payments as a Percentage of Cost**		79%	84%	90%	75%	100%	70%	99%	75%	6%	15%	94%	75%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & (**						1,586								
148	**Percent of cross-over days to total Medicare days from the cost report**						20%								

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 s
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 pay
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 pa

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
			From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):				**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000	ADULTS & PEDIATRICS	$ 813.96		-		-		-		2		2	
2	03100	INTENSIVE CARE UNIT	$ 10,850.54		-		-		-		-		-	
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**	-		-		-		2		2	
19		Total Days per PS&R or Exhibit Detail			-		-		-		2			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ -		$ -		$ -		$ 1,250		$ 1,250	
21.01		Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 625.00		$ 625.00	
	Ancillary Cost Centers (from W/S C) (list below):				**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200	Observation (Non-Distinct)		1.949578	-	-	-	-	-	-	-	-	$ -	$ -
23	5000	OPERATING ROOM		0.337375	-	-	-	-	-	-	-	2,395	$ -	$ 2,395
24	5300	ANESTHESIOLOGY		0.179951	-	-	-	-	-	-	-	822	$ -	$ 822
25	5400	RADIOLOGY-DIAGNOSTIC		0.157266	-	1,747	-	-	-	-	236	2,576	$ 236	$ 4,323
26	5700	CT SCAN		0.086615	-	9,393	-	-	-	-	-	3,208	$ -	$ 12,601
27	5800	MRI		0.246774	-	-	-	-	-	-	-	-	$ -	$ -
28	6000	LABORATORY		0.221286	-	2,866	-	-	-	-	1,281	722	$ 1,281	$ 3,588
29	6500	RESPIRATORY THERAPY		0.358431	-	164	-	-	-	-	164	164	$ 164	$ 328
30	6600	PHYSICAL THERAPY		0.356732	-	-	-	-	-	-	-	-	$ -	$ -
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.097067	-	-	-	-	-	-	10	197	$ 10	$ 197
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.479695	-	-	-	-	-	-	-	-	$ -	$ -
33	7300	DRUGS CHARGED TO PATIENTS		0.297982	-	1,273	-	-	-	-	587	1,065	$ 587	$ 2,338
34	9100	EMERGENCY		0.348075	-	7,004	-	-	-	-	-	3,008	$ -	$ 10,012
35				-	-	-	-	-	-	-	-	-	$ -	$ -
36				-	-	-	-	-	-	-	-	-	$ -	$ -
37				-	-	-	-	-	-	-	-	-	$ -	$ -
38				-	-	-	-	-	-	-	-	-	$ -	$ -
39				-	-	-	-	-	-	-	-	-	$ -	$ -
40				-	-	-	-	-	-	-	-	-	$ -	$ -
41				-	-	-	-	-	-	-	-	-	$ -	$ -
42				-	-	-	-	-	-	-	-	-	$ -	$ -
43				-	-	-	-	-	-	-	-	-	$ -	$ -
44				-	-	-	-	-	-	-	-	-	$ -	$ -
45				-	-	-	-	-	-	-	-	-	$ -	$ -
46				-	-	-	-	-	-	-	-	-	$ -	$ -
47				-	-	-	-	-	-	-	-	-	$ -	$ -
48				-	-	-	-	-	-	-	-	-	$ -	$ -
49				-	-	-	-	-	-	-	-	-	$ -	$ -
50				-	-	-	-	-	-	-	-	-	$ -	$ -
51				-	-	-	-	-	-	-	-	-	$ -	$ -
52				-	-	-	-	-	-	-	-	-	$ -	$ -
53				-	-	-	-	-	-	-	-	-	$ -	$ -
54				-	-	-	-	-	-	-	-	-	$ -	$ -
55				-	-	-	-	-	-	-	-	-	$ -	$ -
56				-	-	-	-	-	-	-	-	-	$ -	$ -
57				-	-	-	-	-	-	-	-	-	$ -	$ -
58				-	-	-	-	-	-	-	-	-	$ -	$ -
59				-	-	-	-	-	-	-	-	-	$ -	$ -
60				-	-	-	-	-	-	-	-	-	$ -	$ -
61				-	-	-	-	-	-	-	-	-	$ -	$ -
62				-	-	-	-	-	-	-	-	-	$ -	$ -
63				-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

Line					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
64				-	-	-	-	-	-	-	-	-	$ -	$ -
65				-	-	-	-	-	-	-	-	-	$ -	$ -
66				-	-	-	-	-	-	-	-	-	$ -	$ -
67				-	-	-	-	-	-	-	-	-	$ -	$ -
68				-	-	-	-	-	-	-	-	-	$ -	$ -
69				-	-	-	-	-	-	-	-	-	$ -	$ -
70				-	-	-	-	-	-	-	-	-	$ -	$ -
71				-	-	-	-	-	-	-	-	-	$ -	$ -
72				-	-	-	-	-	-	-	-	-	$ -	$ -
73				-	-	-	-	-	-	-	-	-	$ -	$ -
74				-	-	-	-	-	-	-	-	-	$ -	$ -
75				-	-	-	-	-	-	-	-	-	$ -	$ -
76				-	-	-	-	-	-	-	-	-	$ -	$ -
77				-	-	-	-	-	-	-	-	-	$ -	$ -
78				-	-	-	-	-	-	-	-	-	$ -	$ -
79				-	-	-	-	-	-	-	-	-	$ -	$ -
80				-	-	-	-	-	-	-	-	-	$ -	$ -
81				-	-	-	-	-	-	-	-	-	$ -	$ -
82				-	-	-	-	-	-	-	-	-	$ -	$ -
83				-	-	-	-	-	-	-	-	-	$ -	$ -
84				-	-	-	-	-	-	-	-	-	$ -	$ -
85				-	-	-	-	-	-	-	-	-	$ -	$ -
86				-	-	-	-	-	-	-	-	-	$ -	$ -
87				-	-	-	-	-	-	-	-	-	$ -	$ -
88				-	-	-	-	-	-	-	-	-	$ -	$ -
89				-	-	-	-	-	-	-	-	-	$ -	$ -
90				-	-	-	-	-	-	-	-	-	$ -	$ -
91				-	-	-	-	-	-	-	-	-	$ -	$ -
92				-	-	-	-	-	-	-	-	-	$ -	$ -
93				-	-	-	-	-	-	-	-	-	$ -	$ -
94				-	-	-	-	-	-	-	-	-	$ -	$ -
95				-	-	-	-	-	-	-	-	-	$ -	$ -
96				-	-	-	-	-	-	-	-	-	$ -	$ -
97				-	-	-	-	-	-	-	-	-	$ -	$ -
98				-	-	-	-	-	-	-	-	-	$ -	$ -
99				-	-	-	-	-	-	-	-	-	$ -	$ -
100				-	-	-	-	-	-	-	-	-	$ -	$ -
101				-	-	-	-	-	-	-	-	-	$ -	$ -
102				-	-	-	-	-	-	-	-	-	$ -	$ -
103				-	-	-	-	-	-	-	-	-	$ -	$ -
104				-	-	-	-	-	-	-	-	-	$ -	$ -
105				-	-	-	-	-	-	-	-	-	$ -	$ -
106				-	-	-	-	-	-	-	-	-	$ -	$ -
107				-	-	-	-	-	-	-	-	-	$ -	$ -
108				-	-	-	-	-	-	-	-	-	$ -	$ -
109				-	-	-	-	-	-	-	-	-	$ -	$ -
110				-	-	-	-	-	-	-	-	-	$ -	$ -
111				-	-	-	-	-	-	-	-	-	$ -	$ -
112				-	-	-	-	-	-	-	-	-	$ -	$ -
113				-	-	-	-	-	-	-	-	-	$ -	$ -
114				-	-	-	-	-	-	-	-	-	$ -	$ -
115				-	-	-	-	-	-	-	-	-	$ -	$ -
116				-	-	-	-	-	-	-	-	-	$ -	$ -
117				-	-	-	-	-	-	-	-	-	$ -	$ -
118				-	-	-	-	-	-	-	-	-	$ -	$ -
119				-	-	-	-	-	-	-	-	-	$ -	$ -
120				-	-	-	-	-	-	-	-	-	$ -	$ -
121				-	-	-	-	-	-	-	-	-	$ -	$ -
122				-	-	-	-	-	-	-	-	-	$ -	$ -
123				-	-	-	-	-	-	-	-	-	$ -	$ -
124				-	-	-	-	-	-	-	-	-	$ -	$ -
125				-	-	-	-	-	-	-	-	-	$ -	$ -
126				-	-	-	-	-	-	-	-	-	$ -	$ -
127				-	-	-	-	-	-	-	-	-	$ -	$ -
					-	22,447	-	-	-	-	2,278	14,157		

Totals / Payments

Line	Description	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
128	**Total Charges (includes organ acquisition from Section K)**	**$ -**	**$ 22,447**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,528**	**$ 14,157**	**$ 3,528**	**$ 36,604**
129	Total Charges per PS&R or Exhibit Detail	$ -	$ 22,447	$ -	$ -	$ -	$ -	$ 3,528	$ 14,157		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	**$ -**	**$ 4,599**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,193**	**$ 3,438**	**$ 2,193**	**$ 8,037**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ 877	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 877
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)	$ -	$ 307	$ -	$ -	$ -	$ -	$ -	$ 1,371	$ -	$ 1,678
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ 1,184	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
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)					$ -	$ -	$ 3,747	$ 1,891	$ 3,747	$ 1,891
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)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ 3,415	$ -	$ -	$ -	$ -	$ (1,554)	$ 176	$ (1,554)	$ 3,591
144	**Calculated Payments as a Percentage of Cost**	0%	26%	0%	0%	0%	0%	171%	95%	171%	55%

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 (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

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

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

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

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2016-06/30/2017) ELBERT MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 131,308		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Contractual Adjustment	51020009	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	The provider tax is included in Contracutal Adjustments and not reported on W/S A	$ 131,308		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	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))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ 131,308

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

DSH Examination Eligibility Summary

Hospital Name	**ELBERT MEMORIAL HOSPITAL**
Hospital Medicaid Number	**000000668A**
Cost Report Period	From **7/1/2016** To **6/30/2017**

			As-Reported	Adjustments	As-Adjusted
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 1,271,260	$ -	$ 1,271,260
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 1,271,260	$ -	$ 1,271,260
4	Net Hospital Patient Revenue	Survey F-3	$ 9,554,189	$ -	$ 9,554,189
5	Medicaid Fraction		13.31%	0.00%	13.31%
6	Inpatient Charity Care Charges	Survey F-2	$ 195,393	$ -	$ 195,393
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 195,393	$ -	$ 195,393
10	Inpatient Hospital Charges	Survey F-3	$ 6,624,165	$ -	$ 6,624,165
11	Inpatient Charity Fraction		2.95%	0.00%	2.95%
12	LIUR		16.26%	0.00%	16.26%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	686	-	686
14	Out-of-State Medicaid Eligible Days	Survey I	2	-	2
15	Total Medicaid Eligible Days		688	-	688
16	Total Hospital Days (excludes swing-bed)	Survey F-1	2,350	-	2,350
17	MIUR		29.28%	0.00%	29.28%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	ELBERT MEMORIAL HOSPITAL
Hospital Medicaid Number	000000668A
Cost Report Period	From 7/1/2016 To 6/30/2017

As-Reported:

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	Uncomp. Care Costs	Payment to Cost Ratio
		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	Inpatient	276,376	214,893	-	2,451	-	-	-	-	-	-	-			217,344	59,032	78.64%
2 Medicaid Fee for Service	Outpatient	330,290	309,154	-	199	1,225	(32,508)	-	-	-	-	-			278,070	52,220	84.19%
3 Medicaid Managed Care	Inpatient	130,508	-	117,713	-	3	-	-							117,716	12,792	90.20%
4 Medicaid Managed Care	Outpatient	702,892	-	521,236	3,259	2,509	-	-							527,004	175,888	74.98%
5 Medicare Cross-over (FFS)	Inpatient	590,749	66,035	-	188	-		-	525,027	-	2,211	(735)			592,726	(1,977)	100.33%
6 Medicare Cross-over (FFS)	Outpatient	579,549	55,825	-	1,021	-		-	348,993	-	11,179	(12,520)			404,498	175,051	69.80%
7 Other Medicaid Eligibles	Inpatient	267,314	1,288	320	13,771	13			205,808	44,120	-	(224)			265,096	2,218	99.17%
8 Other Medicaid Eligibles	Outpatient	149,024	1,411	5,063	41,216	2,857			44,582	18,951	-	(1,632)			112,448	36,576	75.46%
9 Uninsured	Inpatient	219,548	-	-	-	-	-	-	-	-	-	-	12,673	-	12,673	206,875	5.77%
10 Uninsured	Outpatient	620,993	-	-	-	-	-	-	-	-	-	-	93,968	-	93,968	527,025	15.13%
11 In-State Sub-total	Inpatient	1,484,495	282,216	118,033	16,410	16	-	-	730,835	44,120	2,211	(959)	12,673	-	1,205,555	278,940	81.21%
12 In-State Sub-total	Outpatient	2,382,748	366,390	526,299	45,695	6,591	(32,508)	-	393,575	18,951	11,179	(14,152)	93,968	-	1,415,988	966,760	59.43%
13 Out-of-State Medicaid	Inpatient	2,193	-	-	-	-	-	-	3,747	-	-	-			3,747	(1,554)	170.86%
14 Out-of-State Medicaid	Outpatient	8,037	877	-	1,678	-	-	-	1,891	-	-	-			4,446	3,591	55.32%
15 Sub-Total	I/P and O/P	3,877,473	649,483	644,332	63,783	6,607	(32,508)	-	1,130,048	63,071	13,390	(15,111)	106,641	-	2,629,736	1,247,737	67.82%
15.01 Provider Tax Assessment Adjustment to UCC																48,633	

Adjustments:

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	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01 Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	ELBERT MEMORIAL HOSPITAL
Hospital Medicaid Number	000000668A
Cost Report Period	From 7/1/2016 To 6/30/2017

As-Adjusted:

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	Uncomp. Care Costs	Payment to Cost Ratio
		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	Inpatient	276,376	214,893	-	2,451	-	-	-	-	-	-	-			217,344	59,032	78.64%
2 Medicaid Fee for Service	Outpatient	330,290	309,154	-	199	1,225	(32,508)	-	-	-	-	-			278,070	52,220	84.19%
3 Medicaid Managed Care	Inpatient	130,508	-	117,713	-	3	-	-							117,716	12,792	90.20%
4 Medicaid Managed Care	Outpatient	702,892	-	521,236	3,259	2,509	-	-							527,004	175,888	74.98%
5 Medicare Cross-over (FFS)	Inpatient	590,749	66,035	-	188	-		-	525,027	-	2,211	(735)			592,726	(1,977)	100.33%
6 Medicare Cross-over (FFS)	Outpatient	579,549	55,825	-	1,021	-		-	348,993	-	11,179	(12,520)			404,498	175,051	69.80%
7 Other Medicaid Eligibles	Inpatient	267,314	1,288	320	13,771	13			205,808	44,120	-	(224)			265,096	2,218	99.17%
8 Other Medicaid Eligibles	Outpatient	149,024	1,411	5,063	41,216	2,857			44,582	18,951	-	(1,632)			112,448	36,576	75.46%
9 Uninsured	Inpatient	219,548	-	-	-	-	-	-	-	-	-	-	12,673	-	12,673	206,875	5.77%
10 Uninsured	Outpatient	620,993	-	-	-	-	-	-	-	-	-	-	93,968	-	93,968	527,025	15.13%
11 In-State Sub-total	Inpatient	1,484,495	282,216	118,033	16,410	16	-	-	730,835	44,120	2,211	(959)	12,673	-	1,205,555	278,940	81.21%
12 In-State Sub-total	Outpatient	2,382,748	366,390	526,299	45,695	6,591	(32,508)	-	393,575	18,951	11,179	(14,152)	93,968	-	1,415,988	966,760	59.43%
13 Out-of-State Medicaid	Inpatient	2,193	-	-	-	-	-	-	3,747	-	-	-			3,747	(1,554)	170.86%
14 Out-of-State Medicaid	Outpatient	8,037	877	-	1,678	-	-	-	1,891	-	-	-			4,446	3,591	55.32%
15 Cost Report Year Sub-Total	I/P and O/P	3,877,473	649,483	644,332	63,783	6,607	(32,508)	-	1,130,048	63,071	13,390	(15,111)	106,641	-	2,629,736	1,247,737	67.82%

Line	Description	Amount
15.01	Provider Tax Assessment Adjustment to UCC	48,633
16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	1,296,370

Medicaid DSH Survey Adjustments

PROVIDER: ELBERT MEMORIAL HOSPITAL
Mcaid Number: 000000668A
FROM: 7/1/2016 TO: 6/30/2017
Mcare Number: 110026

Myers and Stauffer DSH Survey Adjustments

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

Medicaid DSH Report Notes

PROVIDER: ELBERT MEMORIAL HOSPITAL   Mcaid Number: 000000668A
FROM: 7/1/2016   TO: 6/30/2017   Mcare Number: 110026

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		