

D. General Cost Report Year Information **7/1/2017 - 6/30/2018**

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:

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

7/1/2017 through 6/30/2018		
	X	

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

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

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
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		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2017 - 06/30/2018)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)			
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)			\$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)			
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)			
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)			\$-
8. Out-of-State DSH Payments (See Note 2)			
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	Inpatient	Outpatient	Total
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 12,161	\$ 83,332	\$95,493
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)	\$ 121,052	\$ 570,738	\$691,790
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	\$133,213 9.13%	\$654,070 12.74%	\$787,283 12.13%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? <i>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.</i>	<input type="text" value="No"/>		
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	<input type="text"/>		
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	<input type="text"/>		
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 (07/01/2017 - 06/30/2018)

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)

2,012

(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

	23,747
	70,877
\$	94,624

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	\$1,659,192.00			\$ 1,023,873	\$ -	\$ -	\$ 635,319
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$398,750.00			\$ 246,065	
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	\$3,967,230.00	\$18,762,432.00		\$ 2,448,144	\$ 11,578,136	\$ -	\$ 8,703,383
20. Outpatient Services		\$4,842,450.00			\$ 2,988,234	\$ -	\$ 1,854,216
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$1,975,766.00	\$ -	\$ -	\$ 1,219,228	\$ -
27. Total	\$ 5,626,422	\$ 23,604,882	\$ 2,374,516	\$ 3,472,017	\$ 14,566,370	\$ 1,465,293	\$ 11,192,917
28. Total Hospital and Non Hospital		Total from Above	\$ 31,605,820	Total from Above	\$ 19,503,680		

- 29. Total Per Cost Report Total Patient Revenues (G-3 Line 1)
- 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)
- 35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"

31,605,820

Total Contractual Adj. (G-3 Line 2)

19,043,994

585,426

(125,740)

19,503,680

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) ELBERT MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve 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 & 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	\$ 2,194,852	\$ -	\$ -	\$ 153,191.00	\$ 2,041,661	2,501	\$ 1,774,456.00	\$ 816.34
2	03100	INTENSIVE CARE UNIT	\$ 245,693	\$ -	\$ -		\$ 245,693	5	\$ 18,901.00	\$ 49,138.60
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	\$ 2,440,545	\$ -	\$ -	\$ 153,191	\$ 2,287,354	2,506	\$ 1,793,357	
19		Weighted Average								\$ 912.75

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)	494	-	-	\$ 403,272	\$ 25,277.00	\$ 165,540.00	\$ 190,817	2.113397

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	\$ 1,287,885.00	\$ -	\$ 0.00	\$ 1,287,885	\$ 198,311.00	\$ 3,573,325.00	\$ 3,771,636	0.341466
22	5300	ANESTHESIOLOGY	\$ 224,972.00	\$ -	\$ 0.00	\$ 224,972	\$ 100,586.00	\$ 1,310,698.00	\$ 1,411,284	0.159409
23	5400	RADIOLOGY-DIAGNOSTIC	\$ 438,439.00	\$ -	\$ 0.00	\$ 438,439	\$ 273,658.00	\$ 2,607,906.00	\$ 2,881,564	0.152153
24	5700	CT SCAN	\$ 455,871.00	\$ -	\$ 0.00	\$ 455,871	\$ 600,356.00	\$ 3,797,283.00	\$ 4,397,639	0.103663
25	5800	MRI	\$ 211,754.00	\$ -	\$ 0.00	\$ 211,754	\$ 25,836.00	\$ 636,702.00	\$ 662,538	0.319610
26	6000	LABORATORY	\$ 1,083,713.00	\$ -	\$ 0.00	\$ 1,083,713	\$ 863,243.00	\$ 3,598,277.00	\$ 4,461,520	0.242902
27	6500	RESPIRATORY THERAPY	\$ 390,841.00	\$ -	\$ 0.00	\$ 390,841	\$ 407,409.00	\$ 449,136.00	\$ 856,545	0.456299
28	6600	PHYSICAL THERAPY	\$ 331,980.00	\$ -	\$ 0.00	\$ 331,980	\$ 340,565.00	\$ 524,681.00	\$ 865,246	0.383683
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 839,163.00	\$ -	\$ 0.00	\$ 839,163	\$ 408,904.00	\$ 429,171.00	\$ 838,075	1.001298

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) ELBERT MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	I/P Routine			Total Charges	Medicaid Per Diem / Cost or Other Ratios
					Total Cost	I/P Days and I/P Ancillary Charges	Charges and O/P Ancillary Charges		
30	7200 IMPL. DEV. CHARGED TO PATIENTS	\$86,813.00	\$ -	\$0.00	\$ 86,813	\$0.00	\$192,203.00	\$ 192,203	0.451673
31	7300 DRUGS CHARGED TO PATIENTS	\$782,115.00	\$ -	\$0.00	\$ 782,115	\$1,175,707.00	\$2,101,362.00	\$ 3,277,069	0.238663
32	9100 EMERGENCY	\$1,901,842.00	\$ -	\$0.00	\$ 1,901,842	\$205,457.00	\$3,767,908.00	\$ 3,973,365	0.478648
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2017-06/30/2018) ELBERT MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 8,035,388	\$ -	\$ -	\$ 8,035,388	\$ 4,625,309	\$ 23,154,192	\$ 27,779,501	
127	Weighted Average								0.303773
128	Sub Totals	\$ 10,475,933	\$ -	\$ -	\$ 10,322,742	\$ 6,418,666	\$ 23,154,192	\$ 29,572,858	
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)				\$161,174.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 10,161,568				
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 (07/01/2017-06/30/2018) ELBERT MEMORIAL HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
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															
	Totals / Payments		\$ 201,894	\$ 1,081,855	\$ 63,053	\$ 1,876,769	\$ 594,755	\$ 2,028,694	\$ 425,665	\$ 663,074	\$ 248,329	\$ 2,566,250			
128	Total Charges (includes organ acquisition from Section J)		\$ 242,358	\$ 1,081,855	\$ 80,328	\$ 1,876,769	\$ 769,755	\$ 2,028,694	\$ 552,365	\$ 663,074	\$ 317,044	\$ 2,566,250	\$ 1,644,806	\$ 5,650,092	34.4%
129	Total Charges per PS&R or Exhibit Detail		\$ 242,358	\$ 1,081,855	\$ 80,328	\$ 1,876,769	\$ 769,755	\$ 2,028,694	\$ 552,365	\$ 663,074	\$ 317,044	\$ 2,566,250			
130	Unreconciled Charges (Explain Variance)														
131	Total Calculated Cost (includes organ acquisition from Section J)		\$ 136,904	\$ 346,152	\$ 40,975	\$ 670,915	\$ 363,753	\$ 616,007	\$ 294,112	\$ 210,651	\$ 303,602	\$ 811,184	\$ 835,744	\$ 1,843,725	37.3%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 148,328	\$ 242,212	\$ 47,512	\$ 476,013	\$ 50,232	\$ 41,177	\$ -	\$ 1,131			\$ 198,560	\$ 284,520	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 47,512	\$ 476,013			\$ -	\$ 5,633			\$ 47,512	\$ 481,646	
134	Private Insurance (including primary and third party liability)					\$ 1,557	\$ 38	\$ 1,522	\$ 15,513	\$ 36,760			\$ 15,551	\$ 39,839	
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 1,215	\$ 38	\$ 38	\$ 387			\$ 150	\$ 4,527			\$ 180	\$ 6,008	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$ 148,328	\$ 243,427	\$ 47,550	\$ 478,437							\$ -	\$ -	
137	Medicaid Cost Settlement Payments (See Note B)			\$ 37,835									\$ -	\$ -37,835	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)												\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						\$ 405,724	\$ 377,748	\$ 249,230	\$ 43,856			\$ 654,954	\$ 421,804	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 60,722	\$ 37,174			\$ 60,722	\$ 37,174	
141	Medicare Cross-Over Bad Debt Payments						\$ 11,033	\$ 20,307					\$ 11,033	\$ 20,307	
142	Other Medicare Cross-Over Payments (See Note D)						\$ (24,209)	\$ (5,157)	\$ (10,736)	\$ (701)			\$ (34,945)	\$ (5,858)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)												\$ 12,161	\$ 83,332	
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)		\$ (11,424)	\$ 64,890	\$ (6,575)	\$ 192,478	\$ (79,065)	\$ 180,410	\$ (20,767)	\$ 82,271	\$ 291,441	\$ 727,862	\$ (117,831)	\$ 520,049	
146	Calculated Payments as a Percentage of Cost		108%	81%	116%	71%	122%	71%	107%	61%	4%	10%	114%	72%	
147	Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CR, WIS S-3, Pl. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)						1,387								
148	Percent of cross-over days to total Medicare days from the cost report						15%								

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. LPL 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.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) 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		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 816.34											
2	03100 INTENSIVE CARE UNIT	\$ 49,138.60											
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)												
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem			\$ -		\$ -		\$ -		\$ -		\$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
22	09200 Observation (Non-Distinct)		2.113397										
23	5000 OPERATING ROOM		0.341466										
24	5300 ANESTHESIOLOGY		0.159409										
25	5400 RADIOLOGY-DIAGNOSTIC		0.152153		452					348		800	
26	5700 CT SCAN		0.103663										
27	5800 MRI		0.319610										
28	6000 LABORATORY		0.242902		758					231		989	
29	6500 RESPIRATORY THERAPY		0.456299		328					164		492	
30	6600 PHYSICAL THERAPY		0.383683										
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.001298		19							19	
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.451673										
33	7300 DRUGS CHARGED TO PATIENTS		0.238663		305					110		415	
34	9100 EMERGENCY		0.478648		2,409					967		3,376	
35			-										
36			-										
37			-										
38			-										
39			-										
40			-										
41			-										
42			-										
43			-										
44			-										
45			-										
46			-										
47			-										

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2017-06/30/2018) 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	
110										\$ -	\$ -
111										\$ -	\$ -
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
Totals / Payments		\$ -	\$ 4,271	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,820	\$ -	\$ -
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 4,271	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,820	\$ -	\$ 6,091
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 4,271	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,820	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 1,647	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 673	\$ -	\$ 2,320
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 710							\$ -	\$ 710
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)	\$ -	\$ 710	\$ -	\$ -					\$ -	\$ -
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)							\$ 343		\$ -	\$ 343
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 41		\$ -	\$ 41
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ 937	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 289	\$ -	\$ 1,226
144	Calculated Payments as a Percentage of Cost	0%	43%	0%	0%	0%	0%	0%	57%	0%	47%

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 (07/01/2017-06/30/2018)

ELBERT MEMORIAL HOSPITAL

	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-Over (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)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Hospital's Own Internal Analysis</i>	<i>From Hospital's Own Internal Analysis</i>
1	Lung Acquisition	\$0.00	\$ -	\$ -	0										
2	Kidney Acquisition	\$0.00	\$ -	\$ -	0										
3	Liver Acquisition	\$0.00	\$ -	\$ -	0										
4	Heart Acquisition	\$0.00	\$ -	\$ -	0										
5	Pancreas Acquisition	\$0.00	\$ -	\$ -	0										
6	Intestinal Acquisition	\$0.00	\$ -	\$ -	0										
7	Islet Acquisition	\$0.00	\$ -	\$ -	0										
8		\$0.00	\$ -	\$ -	0										
9	Totals	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost														

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (07/01/2017-06/30/2018)

ELBERT MEMORIAL HOSPITAL

	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-Over (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)
	<i>Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61</i>	<i>Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost</i>	<i>Sum of Cost Report Organ Acquisition Cost and the Add-On Cost</i>	<i>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.</i>	<i>Cost Report Worksheet D-4, Pt. III, Line 62</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>	<i>From Paid Claims Data or Provider Logs (Note A)</i>
11	Lung Acquisition	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2017-06/30/2018) 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)*	\$ 125,740	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	51020009.00 (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 ----->)	\$ 125,740	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ -	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 125,740
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	7,300,989
19 Uninsured Hospital Charges Sec. G	2,883,294
20 Total Hospital Charges Sec. G	29,572,858
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.69%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.75%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 31,043
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 12,259
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 43,302

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

** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.