

DSH Version 6.00

2/17/2021

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2019	06/30/2020

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

EVANS MEMORIAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
10/01/2019	09/30/2020

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

6. Medicaid Provider Number:

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

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

9. Medicare Provider Number:

Data
000000734A
0
0
110142

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3a. Was the hospital open as of December 22, 1987?

3b. What date did the hospital open?

DSH Examination
Year (07/01/19 -
06/30/20)

Yes

No

No

Yes

7/1/1966

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020

(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 156,217

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020

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

NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2019 - 06/30/2020

\$ 156,217

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?
Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.

Explanation for "No" answers:

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

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



Hospital CEO or CFO Signature

John Wiggins

Hospital CEO or CFO Printed Name

CFO

Title

912-739-5139

Hospital CEO or CFO Telephone Number

11/10/21

Date

jwiggins@evansmemorial.org

Hospital CEO or CFO E-Mail

Contact Information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:
Name John Wiggins
Title CFO
Telephone Number 912-739-5139
E-Mail Address jwiggins@evansmemorial.org
Mailing Street Address 200 N. River Street
Mailing City, State, Zip Claxton, GA

Outside Preparer:
Name Bert Bennett
Title Partner
Firm Name Draffin & Tucker, LLP
Telephone Number 229-883-7878
E-Mail Address bbennett@draffin-tucker.com

DSH Version 8.00

1/28/2021

D. General Cost Report Year Information

10/1/2019 - 9/30/2020

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:

EVANS MEMORIAL HOSPITAL

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

X

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

1 - As Submitted

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

5/20/2021

4. Hospital Name:

EVANS MEMORIAL HOSPITAL

5. Medicaid Provider Number:

000000734A

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

0

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

0

8. Medicare Provider Number:

110142

Correct?

Yes

Yes

Yes

Yes

Yes

If Incorrect, Proper Information

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

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

State Name

Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2019 - 09/30/2020)

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

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

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

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

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

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

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

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

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

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

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

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

Inpatient

Outpatient

Total

\$ 3,503

\$ 101,726

\$105,229

\$ 56,970

\$ 647,796

\$704,766

\$60,473

\$749,522

\$809,995

5.79%

13.57%

12.99%

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

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

No

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

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

16. Total Medicaid managed care non-claims payments (see question 13 above) received

\$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2019 - 09/30/2020)

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)

2,333

(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

307,367
465,025
\$ 772,392

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	\$2,805,661.00		\$ 2,287,349	\$ -	\$ -	\$ 518,312
12. Subprovider I (Psych or Rehab)	\$0.00		\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00		\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF		\$0.00			\$ -	
15. Swing Bed - NF		\$0.00			\$ -	
16. Skilled Nursing Facility		\$0.00			\$ -	
17. Nursing Facility		\$0.00			\$ -	
18. Other Long-Term Care		\$0.00			\$ -	
19. Ancillary Services	\$6,809,814.00	\$35,277,601.00	\$ 5,551,783	\$ 28,760,487	\$ -	\$ 7,775,145
20. Outpatient Services		\$9,309,423.00		\$ 7,589,619	\$ -	\$ 1,719,804
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	\$2,700,355.00	\$ -	\$ -	\$ 2,201,497	\$ -
27. Total	\$ 9,615,475	\$ 44,587,024	\$ 7,839,131	\$ 36,350,106	\$ 2,201,497	\$ 10,013,262
28. Total Hospital and Non Hospital		Total from Above		Total from Above	\$ 46,390,734	

29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) 56,902,854
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. Adjusted Contractual Adjustments
36. Unreconciled Difference Unreconciled Difference (Should be \$0) \$ -

Total Contractual Adj. (G-3 Line 2) 45,840,690

+
+
+ 550,044
+
- 46,390,734

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

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2019-09/30/2020) EVANS 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
30		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
31		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
32		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
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 (10/01/2019-09/30/2020) EVANS 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	\$ 8,796,977	\$ -	\$ 373,794	\$ 9,170,771	\$ 7,856,040	\$ 43,540,798	\$ 51,396,838	
127	Weighted Average								0.187311
128	Sub Totals	\$ 12,100,412	\$ -	\$ 373,794	\$ 12,474,206	\$ 10,661,701	\$ 43,540,798	\$ 54,202,499	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 12,474,206				
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 (10/01/2019-09/30/2020) EVANS 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		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		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		From Section G	From Section G													
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,220.33		173		57		462				100		692		33.95%
2	03100 INTENSIVE CARE UNIT	\$ -														
3	03200 CORONARY CARE UNIT	\$ -														
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ -														
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18		\$ -														
			Total Days	173		57		462		-		100		692		29.26%
19	Total Days per PS&R or Exhibit Detail			173		57		462		-		100				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
Routine Charges				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			\$ 204,004		\$ 74,896		\$ 555,368		\$ -		\$ 146,292		\$ 834,268		34.95%
21.01	Calculated Routine Charge Per Diem			\$ 1,179.21		\$ 1,313.96		\$ 1,202.10		\$ -		\$ 1,462.92		\$ 1,205.59		
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	09200 Observation (Non-Distinct)		0.233467	10,325	38,047	11,245	110,651	61,867	216,504			17,575	182,209	\$ 83,437	\$ 365,202	33.17%
23	5000 OPERATING ROOM		0.179754		128,644	62,855	564,084	67,930	401,473			82,325	153,710	\$ 130,785	\$ 1,094,201	21.11%
24	5400 RADIOLOGY-DIAGNOSTIC		0.081878	108,490	344,449	76,425	1,215,742	319,598	1,389,627		1,298	142,274	1,193,087	\$ 504,513	\$ 2,951,115	30.00%
25	6000 LABORATORY		0.140808	196,937	265,042	119,235	528,795	567,105	852,956			3,255	712,956	\$ 883,277	\$ 1,350,048	37.50%
26	6500 RESPIRATORY THERAPY		0.754045	8,617	21,771	7,905	18,126	57,022	46,378			1,165	14,725	\$ 14,735	\$ 73,544	23.11%
27	6600 PHYSICAL THERAPY		0.411465	2,110	56,498	905	139,927	5,121	61,903			-	1,435	\$ 14,473	\$ 8,136	19.67%
28	6900 ELECTROCARDIOLOGY		0.066499	20,320	23,406	4,045	73,573	39,935	155,012			510	13,668	\$ 74,202	\$ 64,300	25.21%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.193713	52,748	79,374	62,193	172,941	217,155	193,037			985	106,604	\$ 172,427	\$ 332,096	34.28%
30	7300 DRUGS CHARGED TO PATIENTS		0.205164	119,226	66,932	81,610	211,609	413,885	176,125			50	138,092	\$ 230,745	\$ 614,721	37.59%
31	9100 EMERGENCY		0.371492	64,788	356,370	29,235	1,291,531	134,465	569,983			3,845	67,989	\$ 1,457,211	\$ 2,221,729	53.92%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2019-09/30/2020) EVANS MEMORIAL HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											\$ -	\$ -	-
62				-											\$ -	\$ -	-
63				-											\$ -	\$ -	-
64				-											\$ -	\$ -	-
65				-											\$ -	\$ -	-
66				-											\$ -	\$ -	-
67				-											\$ -	\$ -	-
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123				-											\$ -	\$ -	-
124				-											\$ -	\$ -	-
125				-											\$ -	\$ -	-
126				-											\$ -	\$ -	-
127				-	\$ 573,561	\$ 1,380,533	\$ 455,653	\$ 4,326,980	\$ 1,884,083	\$ 3,762,998	\$ -	\$ 11,108	\$ 795,301	\$ 4,205,755	\$ -	\$ -	-

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

Cost Report Year (10/01/2019-09/30/2020) EVANS MEMORIAL HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%	
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)													33.90%
	\$ 777,565	\$ 1,380,533	\$ 530,549	\$ 4,326,980	\$ 2,439,451	\$ 3,762,998	\$ -	\$ 11,108	\$ 941,593 (Agrees to Exhibit A)	\$ 4,205,755 (Agrees to Exhibit A)	\$ 3,747,565	\$ 9,481,618		
129	Total Charges per PS&R or Exhibit Detail													
130	Unreconciled Charges (Explain Variance)													
	\$ 777,565	\$ 1,380,533	\$ 530,549	\$ 4,326,980	\$ 2,439,451	\$ 3,762,998	\$ -	\$ 11,108	\$ 941,593	\$ 4,205,755				
	-	-	-	-	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section J)													35.89%
	\$ 313,890	\$ 300,246	\$ 152,783	\$ 934,075	\$ 921,161	\$ 670,376	\$ -	\$ 3,106	\$ 269,082	\$ 912,332	\$ 1,387,834	\$ 1,907,803		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)													
	\$ 266,124	\$ 218,225		\$ 1,145	\$ 55,055	\$ 59,195					\$ 321,179	\$ 278,992		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)													
			\$ 168,492	\$ 540,070							\$ 168,492	\$ 540,672		
134	Private Insurance (including primary and third party liability)													
	\$ 5,067	\$ 612		\$ 1,046							\$ 5,067	\$ 1,658		
135	Self-Pay (including Co-Pay and Spend-Down)													
		\$ 777			\$ 12	\$ 877					\$ 12	\$ 1,654		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)													
	\$ 271,191	\$ 219,614	\$ 168,492	\$ 542,261										
137	Medicaid Cost Settlement Payments (See Note B)													
		\$ 3,600											\$ 3,600	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													
													\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)													
					\$ 673,726	\$ 356,618					\$ 673,726	\$ 356,618		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													
													\$ -	
141	Medicare Cross-Over Bad Debt Payments													
					\$ 31,611	\$ 10,673					\$ 31,611	\$ 10,673		
142	Other Medicare Cross-Over Payments (See Note D)													
					\$ 42,000	\$ (2,689)					\$ 42,000	\$ (2,689)		
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													
									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)				
									\$ 3,503	\$ 101,726				
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)													
146	\$ 42,699	\$ 77,032	\$ (15,709)	\$ 391,814	\$ 118,757	\$ 245,702	\$ -	\$ 2,077	\$ 265,579	\$ 810,606	\$ 145,747	\$ 716,625		
	86%	74%	110%	58%	87%	63%	0%	33%	1%	11%	89%	62%		
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 & 6)													
148	Percent of cross-over days to total Medicare days from the cost report													
					1,368									
					34%									

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 (10/01/2019-09/30/2020) EVANS 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)*	\$ 201,776	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	40081.07 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 201,776	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
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	\$ 201,776	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	13,229,183
19 Uninsured Hospital Charges Sec. G	5,147,348
20 Total Hospital Charges Sec. G	54,202,499
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.41%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.50%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC	\$ -

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

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