

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

DSH Version 6.02

2/10/2023

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2024	06/30/2025

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

Identification of cost reports needed to cover the DSH Year:

Cost Report Begin Date(s)	Cost Report End Date(s)
10/01/2022	09/30/2023

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

Data	
6. Medicaid Provider Number:	000000734A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110142

B. DSH Qualifying Information

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

During the DSH Examination Year:

- 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.)
- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?

DSH Examination
Year (07/01/24 -
06/30/25)

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

3b. What date did the hospital open?

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)	\$ 186,673
2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025 (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.	\$ 202,040
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025	\$ 388,713

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.	Answer Yes
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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	CFO Title	02/19/2025 Date
John Wiggins Hospital CEO or CFO Printed Name	912-739-5139 Hospital CEO or CFO Telephone Number	jwiggins@evansmemorial.org Hospital CEO or CFO E-Mail

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

Hospital Contact:	Outside Preparer:
Name John Wiggins	Name Bert Bennett
Title CFO	Title Partner
Telephone Number 912-739-5139	Firm Name Draffin & Tucker, LLP
E-Mail Address jwiggins@evansmemorial.org	Telephone Number 229-883-7878
Mailing Street Address 200 N. River Street	E-Mail Address bbennett@draffin-tucker.com
Mailing City, State, Zip Claxton, GA	

DSH Version 9.00

9/11/2024

D. General Cost Report Year Information 10/1/2022 - 9/30/2023

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"):

10/1/2022 through 9/30/2023 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:

3/6/2024

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

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

Non-State Govt.

Correct?

Yes

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

State Name Provider No.

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)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2022 - 09/30/2023)

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
\$ 1,307	\$ 96,218	\$97,525
\$ 56,201	\$ 700,657	\$756,858
\$57,508	\$796,875	\$854,383
2.27%	12.07%	11.41%

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

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

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

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

Yes

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

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

\$ 202,040

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

\$202,040

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (10/01/2022 - 09/30/2023)

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)

1,855

(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

689,521
899,591
1,589,112

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	\$1,830,528.00		\$ 1,566,968	\$ -	\$ -	\$ 263,560
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	\$14,068,704.00	\$70,656,708.00	\$ 12,043,084	\$ 60,483,516	\$ -	\$ 12,198,811
20. Outpatient Services	\$17,364,540.00		\$ 14,864,384	\$ -	\$ -	\$ 2,500,156
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	\$3,106,615.00	\$ -	\$ -	\$ 2,659,323	\$ -
27. Total	\$ 15,899,232	\$ 88,021,248	\$ 13,610,052	\$ 75,347,900	\$ 2,659,323	\$ 14,962,528
28. Total Hospital and Non Hospital		Total from Above		Total from Above	\$ 91,617,275	

29. Total Per Cost Report Total Patient Revenues (G-3 Line 1) 107,027,095
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"
36. Adjusted Contractual Adjustments
37. Unreconciled Difference Unreconciled Difference (Should be \$0) \$ -

Total Contractual Adj. (G-3 Line 2) 90,773,872

+

+

843,403

+

-

91,617,275

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

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
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.		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	\$ 3,413,141	\$ -	\$ -	\$0.00	\$ 3,413,141	2,720	\$1,037,883.00	\$ 1,254.83
2	03100	INTENSIVE CARE UNIT	\$ 217,756	\$ -	\$ -		\$ 217,756	102	\$792,645.00	\$ 2,134.86
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	\$ -	\$ -	\$ -		\$ -	-	\$1.00	\$ -
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		\$ 3,630,897	\$ -	\$ -	\$ -	\$ 3,630,897	2,822	\$ 1,830,529	
19	Weighted Average									\$ 1,286.64

Observation Data (Non-Distinct)

20	09200	Observation (Non-Distinct)								
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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
967	-	-	\$ 1,213,421	\$270,000.00	\$3,783,785.00	\$ 4,053,785	0.299330

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	\$2,118,849.00	\$ -	\$ -	\$ 2,118,849	\$495,015.00	\$12,414,434.00	\$ 12,909,449	0.164132
22	5400	RADIOLOGY-DIAGNOSTIC	\$1,787,902.00	\$ -	\$ -	\$ 1,787,902	\$1,406,250.00	\$29,238,640.00	\$ 30,644,890	0.058343
23	6000	LABORATORY	\$1,744,805.00	\$ -	\$ -	\$ 1,744,805	\$3,547,083.00	\$13,128,312.00	\$ 16,675,395	0.104634
24	6500	RESPIRATORY THERAPY	\$982,106.00	\$ -	\$ -	\$ 982,106	\$1,438,590.00	\$1,119,040.00	\$ 2,557,630	0.383991
25	6600	PHYSICAL THERAPY	\$1,073,847.00	\$ -	\$ -	\$ 1,073,847	\$167,955.00	\$3,976,990.00	\$ 4,144,945	0.259074
26	6900	ELECTROCARDIOLOGY	\$130,278.00	\$ -	\$ -	\$ 130,278	\$308,780.00	\$1,980,615.00	\$ 2,289,395	0.056905
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$574,671.00	\$ -	\$ -	\$ 574,671	\$1,498,587.00	\$3,497,988.00	\$ 4,996,575	0.115013
28	7300	DRUGS CHARGED TO PATIENTS	\$1,325,097.00	\$ -	\$ -	\$ 1,325,097	\$5,206,444.00	\$5,300,689.00	\$ 10,507,133	0.126114
29	9100	EMERGENCY	\$2,936,558.00	\$ -	\$ 468,529	\$ 3,405,087	\$1,259,038.00	\$12,051,717.00	\$ 13,310,755	0.255815
30			\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
31			\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
32		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2022-09/30/2023) 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
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 12,674,113	\$ -	\$ 468,529	\$ 13,142,642	\$ 15,597,742	\$ 86,492,210	\$ 102,089,952	
127	Weighted Average								0.140622
128	Sub Totals	\$ 16,305,010	\$ -	\$ 468,529	\$ 16,773,539	\$ 17,428,271	\$ 86,492,210	\$ 103,920,481	
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				\$ 16,773,539				
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 (10/01/2022-09/30/2023)

EVANS MEMORIAL HOSPITAL

		Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non- Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non- Covered)		% Survey to Cost Report Totals (Includes all payers)
Line #	Cost Center Description			Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal	From Hospital's Own Internal			
Routine Cost Centers (from Section G):				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,254.83		106		73		114		243				180		536		40.84%
2	03100 INTENSIVE CARE UNIT	\$ 2,134.86		27				4		18				21		49		68.63%
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		\$ -																
19			Total Days	133		73		118		261			-	201		585		27.85%
19	Total Days per PS&R or Exhibit Detail			133		73		118		261			-	201				
20	Unreconciled Days (Explain Variance)			-		-		-		-			-	-				
21	Routine Charges	\$ 245,145		Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	78.86%
21.01	Calculated Routine Charge Per Diem	\$ 1,843.20		\$ 1,843.20	\$ 1,455.21	\$ 217.110	\$ 1,839.92	\$ 493.310	\$ 1,890.08	\$ -			\$ 381.795	\$ 1,899.48	\$ 1,815.03			
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	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)	0.299330		35,745	142,090	250,965	103,320	307,575	71,325	474,185	140,670	276,060	22,180	\$ 1,068,470	\$ 457,405	\$ 457,405	45.00%	
23	5000 OPERATING ROOM	0.164132		11,080	132,255	1,181,334	553,010	54,235	114,965	206,680	389,105	342,400	191,380	\$ 1,453,329	\$ 1,189,335	\$ 1,189,335		
24	5400 RADIOLOGY-DIAGNOSTIC	0.058343		211,300	479,390	603,120	1,972,760	583,220	557,635	827,485	1,915,690	761,570	2,157,130	\$ 2,225,125	\$ 4,925,475	\$ 4,925,475		
25	6000 LABORATORY	0.104634		424,205	432,470	525,370	1,207,785	645,865	1,038,170	237,295	941,160	1,100,810		\$ 2,633,610	\$ 2,639,615	\$ 2,639,615		
26	6500 RESPIRATORY THERAPY	0.383991		127,820	19,730	42,225	53,365	108,420	11,415	341,960	61,355	54,970	28,370	\$ 620,425	\$ 145,865	\$ 145,865	6.58%	
27	6600 PHYSICAL THERAPY	0.259074		6,135	197,125	288,525	15,000	47,990	3,500	265,520	15,370	92,405	6,440	\$ 608,170	\$ 230,995	\$ 230,995	3.96%	
28	6900 ELECTROCARDIOLOGY	0.056905		24,495	44,765	35,135	73,260	54,120	51,920	94,590	123,940	54,600	65,815	\$ 208,340	\$ 293,885	\$ 293,885	3.73%	
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.115013		140,643	86,638	316,562	217,742	222,448	60,031	426,938	158,615	246,769	172,476	\$ 1,106,590	\$ 523,026	\$ 523,026	80.11%	
30	7300 DRUGS CHARGED TO PATIENTS	0.126114		299,030	85,911	401,391	381,410	425,214	132,170	704,745	304,764	531,450	382,008	\$ 1,830,380	\$ 904,255	\$ 904,255	88.03%	
31	9100 EMERGENCY	0.255815		114,040	480,885	405,760	2,258,740	243,040	201,220	376,215	713,495	446,480	1,791,820	\$ 1,139,055	\$ 3,654,340	\$ 3,654,340	307.14%	
32		-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	\$ -	0.00%	
33		-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	\$ -	0.00%	
34		-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	\$ -	0.00%	
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		-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	\$ -		

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

Cost Report Year (10/01/2022-09/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report										
74				-												\$	-	-										
75				-												\$	-	-										
76				-												\$	-	-										
77				-												\$	-	-										
78				-												\$	-	-										
79				-												\$	-	-										
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121				-												\$	-	-										
122				-												\$	-	-										
123				-												\$	-	-										
124				-												\$	-	-										
125				-												\$	-	-										
126				-												\$	-	-										
127				-												\$	-	-										
				\$	1,394,493	\$	2,101,259	\$	4,050,386	\$	6,836,392	\$	2,692,127	\$	1,466,446	\$	4,756,488	\$	4,560,298	\$	-	\$	-	\$	3,747,864	\$	5,919,029	

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

Cost Report Year (10/01/2022-09/30/2023) EVANS 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report																				
Totals / Payments																																																	
128	Total Charges (includes organ acquisition from Section J)																	\$	1,639,638	\$	2,101,259	\$	4,156,616	\$	6,836,392	\$	2,909,237	\$	1,466,446	\$	5,249,798	\$	4,560,298	\$	-	\$	-	\$	4,129,659	\$	5,919,029	\$	13,955,288	\$	14,964,395	37.50%			
129	Total Charges per PS&R or Exhibit Detail																	\$	1,639,638	\$	2,101,259	\$	4,156,616	\$	6,836,392	\$	2,909,237	\$	1,466,446	\$	5,249,798	\$	4,560,298	\$	-	\$	-	(Agrees to Exhibit A)		(Agrees to Exhibit A)									
130	Unreconciled Charges (Explain Variance)																		-		-		-		-		-		-		-		-		-		-		-		-		-						
131	Total Calculated Cost (includes organ acquisition from Section J)																	\$	395,011	\$	342,469	\$	734,570	\$	1,042,676		552,692	\$	183,488	\$	1,115,822	\$	568,680	\$	-	\$	-	\$	810,219	\$	821,857	\$	2,798,095	\$	2,137,313	38.15%			
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)																	\$	307,282		292,128																			\$	307,282		292,128						
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)																																							\$	548,035		869,005						
134	Private Insurance (including primary and third party liability)																	\$	9,666		271																			\$	45,750		118,429						
135	Self-Pay (including Co-Pay and Spend-Down)																																								\$	4,701		15,130					
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)																	\$	316,948		292,399																												
137	Medicaid Cost Settlement Payments (See Note B)																				(22,003)																												
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)																																																
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)																																																
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																																																
141	Medicare Cross-Over Bad Debt Payments																																																
142	Other Medicare Cross-Over Payments (See Note D)																																																
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)																																																
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)																	\$	78,063		72,073																				\$	808,912	\$	725,639	\$	617,210	\$	418,994	
146	Calculated Payments as a Percentage of Cost																		80%		79%																												
147	Total Medicare Days from WIS 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																																																

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 payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

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 (10/01/2022-09/30/2023) 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)*	\$ 262,080	
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)	\$ 262,080	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	\$ 262,080	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	28,919,683
19 Uninsured Hospital Charges Sec. G	10,048,688
20 Total Hospital Charges Sec. G	103,920,481
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	27.83%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.67%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	14,733,905
27 Uninsured Hospital Charges Sec. G	10,048,688
28 Total Hospital Charges Sec. G	103,920,481
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	14.18%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.67%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

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

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

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