EXAMINER ADJUSTED SURVEY

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

D. General Cost Report Year Information 7/1/2016 - 10/31/2016

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: **EFFINGHAM HOSPITAL**

	7/1/2016 through 10/31/2016	11/1/2016 through 6/30/2017	
2. Select Cost Report Year Covered by this Survey:	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 5 - Amended

3a. Date CMS processed the HCRIS file into the HCRIS database: 3/19/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	EFFINGHAM HOSPITAL	-	
5. Medicaid Provider Number:	000000657A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	111306	-	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	-	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	-	

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		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2016 - 10/31/2016)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 852	$ 88,544	$89,396
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 19,172	$ 802,653	$821,825
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$20,024	$891,197	$911,221
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	4.25%	9.94%	9.81%

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

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2016 - 10/31/2016)

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)	519

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	538,212
8.	Outpatient Hospital Charity Care Charges	5,199,642
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 5,737,854

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 1,332,558	$ -	$ -	$ 893,256	$ -	$ -	$ 439,302
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 531,102			$ 356,015	
15.	Swing Bed - NF			$ 679,004			$ 455,158	
16.	Skilled Nursing Facility			$ 2,761,583			$ 1,851,177	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 1,455,243	$ 22,519,129	$ -	$ 975,496	$ 15,095,290	$ -	$ 7,903,586
20.	Outpatient Services		$ 7,006,955	$ -		$ 4,696,985	$ -	$ 2,309,970
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 6,272	$ 831,879	$ 1,284,762	$ 4,204	$ 557,635	$ 861,217	$ 276,312
27.	Total	$ 2,794,073	$ 30,357,963	$ 5,256,451	$ 1,872,956	$ 20,349,911	$ 3,523,567	$ 10,929,169
28.	Total Hospital and Non Hospital		Total from Above	$ 38,408,487		Total from Above	$ 25,746,434	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 38,408,487	Total Contractual Adj. (G-3 Line 2)	$ 25,746,434
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+ $ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+ $ -
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)"				- $ -
35.	Adjusted Contractual Adjustments				25,746,434
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM HOSPITAL

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 1,104,206	$ -	$ -	$ 302,941	**$ 801,265**	704	$ 1,919,872		**$ 1,138.16**
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		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17		0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18		Total Routine	$ 1,104,206	$ -	$ -	$ 302,941	$ 801,265	704	$ 1,919,872		
19		Weighted Average									$ 1,138.16

Line #		Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)		185	-	-	**$ 210,560**	$ 2,310	$ 454,597	$ 456,907	**0.460838**

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*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*
21	5000	OPERATING ROOM	$ 1,323,352	$ -	$ -		**$ 1,323,352**	$ 194,491	$ 2,463,575	$ 2,658,066	**0.497863**
22	5300	ANESTHESIOLOGY	$ 264,200	$ -	$ -		**$ 264,200**	$ 26,003	$ 296,480	$ 322,483	**0.819268**
23	5400	RADIOLOGY-DIAGNOSTIC	$ 1,638,898	$ -	$ -		**$ 1,638,898**	$ 222,907	$ 11,122,613	$ 11,345,520	**0.144453**
24	6000	LABORATORY	$ 798,947	$ -	$ -		**$ 798,947**	$ 290,537	$ 3,439,590	$ 3,730,127	**0.214188**
25	6500	RESPIRATORY THERAPY	$ 313,593	$ -	$ -		**$ 313,593**	$ 232,752	$ 724,026	$ 956,778	**0.327759**
26	6600	PHYSICAL THERAPY	$ 409,655	$ -	$ -		**$ 409,655**	$ 281,390	$ 1,124,861	$ 1,406,251	**0.291310**
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 212,873	$ -	$ -		**$ 212,873**	$ 302,685	$ 647,765	$ 950,450	**0.223971**
28	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 214,588	$ -	$ -		**$ 214,588**	$ 97,992	$ 207,910	$ 305,902	**0.701493**
29	7300	DRUGS CHARGED TO PATIENTS	$ 478,298	$ -	$ -		**$ 478,298**	$ 622,568	$ 3,106,810	$ 3,729,378	**0.128251**
30	9100	EMERGENCY	$ 1,699,716	$ -	$ -		**$ 1,699,716**	$ 8,940	$ 5,631,025	$ 5,639,965	**0.301370**
31			$ -	$ -	$ -		**$ -**	$ -	$ -	$ -	**$ -**
32			$ -	$ -	$ -		**$ -**	$ -	$ -	$ -	**$ -**

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
34		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
35		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
36		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
37		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
38		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
39		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
40		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
41		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
42		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
43		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
44		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
45		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
46		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
47		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
48		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
49		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
50		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
51		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
52		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
53		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
54		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
55		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
56		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
57		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
58		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
59		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
60		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
61		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
62		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
63		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
64		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
65		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
66		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
67		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
68		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
69		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
70		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
71		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
72		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
73		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
74		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
75		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
76		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
77		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
78		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
79		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
80		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
81		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
82		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
83		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
84		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
90		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
91		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
92		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
93		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
94		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126	**Total Ancillary**	$ 7,354,120	$ -	$ -		$ 7,354,120	$ 2,282,575	$ 29,219,252	$ 31,501,827	
127	**Weighted Average**									0.240135
128	**Sub Totals**	$ 8,458,326	$ -	$ -		$ 8,155,385	$ 4,202,447	$ 29,219,252	$ 33,421,699	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ 86,962				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01	Other Cost Adjustments (support must be submitted)					$ -				
132	**Grand Total**					**$ 8,068,423**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

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

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

Cost Report Year (07/01/2016-10/31/2016 | EFFINGHAM 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-Overs (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 Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,138.16		24		11		47		8		36		90		24.28%
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	0	$ -		-		-		-		-		-		-		
12	0	$ -		-		-		-		-		-		-		
13	0	$ -		-		-		-		-		-		-		
14	0	$ -		-		-		-		-		-		-		
15	0	$ -		-		-		-		-		-		-		
16	0	$ -		-		-		-		-		-		-		
17	0	$ -		-		-		-		-		-		-		
18			**Total Days**	24		11		47		8		36		90		24.28%
19	Total Days per PS&R or Exhibit Detail			24		11		47		8		36				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 24,192		$ 27,720		$ 131,183		$ 20,215		$ 81,100		$ 203,310		14.81%
21.01	Calculated Routine Charge Per Dien			$ 1,008.00		$ 2,520.00		$ 2,791.13		$ 2,526.88		$ 2,252.78		$ 2,259.00		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct		0.460838	$ 2,310	$ 15,960	$ 5,985	$ 22,498	$ 4,095	$ 28,207	$ -	$ 4,305	$ -	$ 69,777	$ 12,390	$ 70,970	33.52%
23	5000 OPERATING ROOM		0.497863	$ 15,339	$ 83,721	$ -	$ 125,501	$ 8,107	$ 126,808	$ -	$ 7,921	$ 22,468	$ 2,933	$ 23,446	$ 343,951	14.78%
24	5300 ANESTHESIOLOGY		0.819268	$ 1,527	$ 11,281	$ -	$ 22,021	$ 891	$ 9,223	$ -	$ -	$ 2,888	$ 318	$ 2,418	$ 42,525	14.93%
25	5400 RADIOLOGY-DIAGNOSTIC		0.144453	$ 6,612	$ 310,407	$ 12,662	$ 753,956	$ 20,115	$ 583,631	$ -	$ 157,956	$ 3,626	$ 1,099,795	$ 39,389	$ 1,805,950	25.99%
26	6000 LABORATORY		0.214188	$ 17,050	$ 191,637	$ 9,723	$ 316,026	$ 30,631	$ 188,735	$ 2,409	$ 40,320	$ 13,378	$ 406,475	$ 59,813	$ 736,718	32.61%
27	6500 RESPIRATORY THERAPY		0.327759	$ 2,924	$ 65,410	$ 5,871	$ 117,852	$ 42,407	$ 111,196	$ 10,043	$ 8,696	$ 21,670	$ 284,858	$ 61,245	$ 303,154	70.12%
28	6600 PHYSICAL THERAPY		0.291310	$ 966	$ 7,165	$ -	$ 13,827	$ 18,366	$ 51,097	$ 2,008	$ 14,602	$ -	$ 30,739	$ 21,340	$ 86,691	9.87%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.223971	$ 1,497	$ 34,728	$ 327	$ 66,148	$ 10,930	$ 20,127	$ 1,916	$ 2,249	$ 10,922	$ 37,420	$ 14,670	$ 123,252	19.60%
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.701493	$ -	$ -	$ -	$ -	$ -	$ 2,800	$ -	$ -	$ -	$ -	$ -	$ 2,800	0.92%
31	7300 DRUGS CHARGED TO PATIENTS		0.128251	$ 36,250	$ 61,252	$ 16,546	$ 100,847	$ 56,031	$ 78,999	$ 7,280	$ 21,245	$ 52,631	$ 261,164	$ 116,107	$ 262,343	18.56%
32	9100 EMERGENCY		0.301370	$ 5,271	$ 290,527	$ 4,009	$ 997,837	$ 1,351	$ 279,282	$ -	$ 59,464	$ 2,541	$ 1,263,450	$ 10,631	$ 1,627,110	51.48%
33			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
34			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
35			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
36			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
37			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
38			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
39			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
40			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
41			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
42			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

Cost Report Year (07/01/2016-10/31/2016 | EFFINGHAM 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		%
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			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				89,746	1,072,088	55,123	2,536,513	192,924	1,480,105	23,656	316,758	130,124	3,456,929			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			**$ 113,938**	**$ 1,072,088**	**$ 82,843**	**$ 2,536,513**	**$ 324,107**	**$ 1,480,105**	**$ 43,871**	**$ 316,758**	**$ 211,224** (Agrees to Exhibit A)	**$ 3,456,929** (Agrees to Exhibit A)	**$ 564,759**	**$ 5,405,464**	28.84%
129	Total Charges per PS&R or Exhibit Detail			$ 113,938	$ 1,072,088	$ 82,843	$ 2,536,513	$ 324,107	$ 1,480,105	$ 43,871	$ 316,758	$ 211,224	$ 3,456,929			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 49,688**	**$ 270,880**	**$ 24,517**	**$ 638,614**	**$ 98,904**	**$ 360,522**	**$ 14,861**	**$ 65,634**	**$ 74,979**	**$ 804,768**	$ 187,970	$ 1,335,650	29.79%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 32,851	$ 292,050	$ -	$ -	$ 13,003	$ 160,801	$ -	$ 11,125			$ 45,854	$ 463,976	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 27,614	$ 547,688	$ -	$ -	$ -	$ -			$ 27,614	$ 547,688	
134	Private Insurance (including primary and third party liability)			$ -	$ 15,127	$ -	$ 6,659	$ -	$ 650	$ -	$ 20,756			$ -	$ 43,192	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 457	$ -	$ 821	$ -	$ -	$ -	$ -			$ -	$ 1,278	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 32,851	$ 307,634	$ 27,614	$ 555,168									
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)							$ 73,353	$ 239,892	$ -	$ -			$ 73,353	$ 239,892	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 16,677	$ 75,047			$ 16,677	$ 75,047	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)							$ 11,491	$ (45,587)	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 11,491	$ (45,587)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 852	$ 88,544			
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)**			$ 16,837	$ (36,754)	$ (3,097)	$ 83,446	$ 1,057	$ 4,766	$ (1,816)	$ (41,294)	$ 74,127	$ 716,224	$ 12,981	$ 10,164	
146	**Calculated Payments as a Percentage of Cost**			66%	114%	113%	87%	99%	99%	112%	163%	1%	11%	93%	99%	
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**							316								
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 s
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pa

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM 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 Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,138.16		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
11		$ -		-		-		-		-		-	
12		$ -		-		-		-		-		-	
13		$ -		-		-		-		-		-	
14		$ -		-		-		-		-		-	
15		$ -		-		-		-		-		-	
16		$ -		-		-		-		-		-	
17		$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				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**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.460838	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.497863	-	-	-	-	-	-	-	-	$ -	$ -
24	5300 ANESTHESIOLOGY		0.819268	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.144453	-	-	-	-	-	-	-	-	$ -	$ -
26	6000 LABORATORY		0.214188	-	-	-	-	-	-	-	-	$ -	$ -
27	6500 RESPIRATORY THERAPY		0.327759	-	-	-	-	-	-	-	-	$ -	$ -
28	6600 PHYSICAL THERAPY		0.291310	-	-	-	-	-	-	-	-	$ -	$ -
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.223971	-	-	-	-	-	-	-	-	$ -	$ -
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.701493	-	-	-	-	-	-	-	-	$ -	$ -
31	7300 DRUGS CHARGED TO PATIENTS		0.128251	-	-	-	-	-	-	-	-	$ -	$ -
32	9100 EMERGENCY		0.301370	-	-	-	-	-	-	-	-	$ -	$ -
33			-	-	-	-	-	-	-	-	-	$ -	$ -
34			-	-	-	-	-	-	-	-	-	$ -	$ -
35			-	-	-	-	-	-	-	-	-	$ -	$ -
36			-	-	-	-	-	-	-	-	-	$ -	$ -
37			-	-	-	-	-	-	-	-	-	$ -	$ -
38			-	-	-	-	-	-	-	-	-	$ -	$ -
39			-	-	-	-	-	-	-	-	-	$ -	$ -
40			-	-	-	-	-	-	-	-	-	$ -	$ -
41			-	-	-	-	-	-	-	-	-	$ -	$ -
42			-	-	-	-	-	-	-	-	-	$ -	$ -
43			-	-	-	-	-	-	-	-	-	$ -	$ -
44			-	-	-	-	-	-	-	-	-	$ -	$ -
45			-	-	-	-	-	-	-	-	-	$ -	$ -
46			-	-	-	-	-	-	-	-	-	$ -	$ -
47			-	-	-	-	-	-	-	-	-	$ -	$ -
48			-	-	-	-	-	-	-	-	-	$ -	$ -
49			-	-	-	-	-	-	-	-	-	$ -	$ -
50			-	-	-	-	-	-	-	-	-	$ -	$ -
51			-	-	-	-	-	-	-	-	-	$ -	$ -
52			-	-	-	-	-	-	-	-	-	$ -	$ -
53			-	-	-	-	-	-	-	-	-	$ -	$ -
54			-	-	-	-	-	-	-	-	-	$ -	$ -
55			-	-	-	-	-	-	-	-	-	$ -	$ -
56			-	-	-	-	-	-	-	-	-	$ -	$ -
57			-	-	-	-	-	-	-	-	-	$ -	$ -
58			-	-	-	-	-	-	-	-	-	$ -	$ -
59			-	-	-	-	-	-	-	-	-	$ -	$ -
60			-	-	-	-	-	-	-	-	-	$ -	$ -
61			-	-	-	-	-	-	-	-	-	$ -	$ -
62			-	-	-	-	-	-	-	-	-	$ -	$ -
63			-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM 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	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
73			-	-	-	-	-	-	-	-	-	$ -	$ -
74			-	-	-	-	-	-	-	-	-	$ -	$ -
75			-	-	-	-	-	-	-	-	-	$ -	$ -
76			-	-	-	-	-	-	-	-	-	$ -	$ -
77			-	-	-	-	-	-	-	-	-	$ -	$ -
78			-	-	-	-	-	-	-	-	-	$ -	$ -
79			-	-	-	-	-	-	-	-	-	$ -	$ -
80			-	-	-	-	-	-	-	-	-	$ -	$ -
81			-	-	-	-	-	-	-	-	-	$ -	$ -
82			-	-	-	-	-	-	-	-	-	$ -	$ -
83			-	-	-	-	-	-	-	-	-	$ -	$ -
84			-	-	-	-	-	-	-	-	-	$ -	$ -
85			-	-	-	-	-	-	-	-	-	$ -	$ -
86			-	-	-	-	-	-	-	-	-	$ -	$ -
87			-	-	-	-	-	-	-	-	-	$ -	$ -
88			-	-	-	-	-	-	-	-	-	$ -	$ -
89			-	-	-	-	-	-	-	-	-	$ -	$ -
90			-	-	-	-	-	-	-	-	-	$ -	$ -
91			-	-	-	-	-	-	-	-	-	$ -	$ -
92			-	-	-	-	-	-	-	-	-	$ -	$ -
93			-	-	-	-	-	-	-	-	-	$ -	$ -
94			-	-	-	-	-	-	-	-	-	$ -	$ -
95			-	-	-	-	-	-	-	-	-	$ -	$ -
96			-	-	-	-	-	-	-	-	-	$ -	$ -
97			-	-	-	-	-	-	-	-	-	$ -	$ -
98			-	-	-	-	-	-	-	-	-	$ -	$ -
99			-	-	-	-	-	-	-	-	-	$ -	$ -
100			-	-	-	-	-	-	-	-	-	$ -	$ -
101			-	-	-	-	-	-	-	-	-	$ -	$ -
102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
104			-	-	-	-	-	-	-	-	-	$ -	$ -
105			-	-	-	-	-	-	-	-	-	$ -	$ -
106			-	-	-	-	-	-	-	-	-	$ -	$ -
107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM 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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM 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 Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2016-10/31/2016) EFFINGHAM HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(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 ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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

DSH Examination Eligibility Summary

Hospital Name	**EFFINGHAM HOSPITAL**
Hospital Medicaid Number	**000000657A**
Cost Report Period	From **7/1/2016** To **10/31/2016**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 1,108,196	$ -	$ 1,108,196
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 1,108,196	$ -	$ 1,108,196
4	Net Hospital Patient Revenue	Survey F-3	$ 10,929,169	$ -	$ 10,929,169
5	Medicaid Fraction		10.14%	0.00%	10.14%
6	Inpatient Charity Care Charges	Survey F-2	$ 538,212	$ -	$ 538,212
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 538,212	$ -	$ 538,212
10	Inpatient Hospital Charges	Survey F-3	$ 2,794,073	$ -	$ 2,794,073
11	Inpatient Charity Fraction		19.26%	0.00%	19.26%
12	LIUR		29.40%	0.00%	29.40%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	90	-	90
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		90	-	90
16	Total Hospital Days (excludes swing-bed)	Survey F-1	519	-	519
17	MIUR		17.34%	0.00%	17.34%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **EFFINGHAM HOSPITAL**
Hospital Medicaid Number: **00000657A**
Cost Report Period: From **7/1/2016** To **10/31/2016**

As-Reported:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	49,688	32,851	-	-	-	-	-	-	-	-	-			32,851	16,837	66.11%
2	Medicaid Fee for Service	Outpatient	270,880	292,050	-	15,127	457	-	-	-	-	-	-			307,634	(36,754)	113.57%
3	Medicaid Managed Care	Inpatient	24,517	-	27,614	-	-	-	-							27,614	(3,097)	112.63%
4	Medicaid Managed Care	Outpatient	638,614	-	547,688	6,659	821	-	-							555,168	83,446	86.93%
5	Medicare Cross-over (FFS)	Inpatient	98,904	13,003	-	-	-		-	73,353	-	-	-			86,356	12,548	87.31%
6	Medicare Cross-over (FFS)	Outpatient	360,522	160,801	-	650	-		-	239,892	-	-	-			401,343	(40,821)	111.32%
7	Other Medicaid Eligibles	Inpatient	14,861	-	-	-	-			-	16,677	-	-			16,677	(1,816)	112.22%
8	Other Medicaid Eligibles	Outpatient	65,634	11,125	-	20,756	-			-	75,047	-	-			106,928	(41,294)	162.92%
9	Uninsured	Inpatient	74,979	-	-	-	-	-	-	-	-	-	-	852	-	852	74,127	1.14%
10	Uninsured	Outpatient	804,768	-	-	-	-	-	-	-	-	-	-	88,544	-	88,544	716,224	11.00%
11	In-State Sub-total	Inpatient	262,949	45,854	27,614	-	-	-	-	73,353	16,677	-	-	852	-	164,350	98,599	62.50%
12	In-State Sub-total	Outpatient	2,140,418	463,976	547,688	43,192	1,278	-	-	239,892	75,047	-	-	88,544	-	1,459,617	680,801	68.19%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	2,403,367	509,830	575,302	43,192	1,278	-	-	313,245	91,724	-	-	89,396	-	1,623,967	779,400	67.57%

Adjustments:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	11,491			11,491	(11,491)	11.62%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	(45,587)			(45,587)	45,587	-12.64%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	11,491	-	-	11,491	(11,491)	4.37%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	(45,587)	-	-	(45,587)	45,587	-2.13%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	(34,096)	-	-	(34,096)	34,096	-1.42%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **EFFINGHAM HOSPITAL**
Hospital Medicaid Number: **00000657A**
Cost Report Period: From **7/1/2016** To **10/31/2016**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	49,688	32,851	-	-	-	-	-	-	-	-	-			32,851	16,837	66.11%
2	Medicaid Fee for Service	Outpatient	270,880	292,050	-	15,127	457	-	-	-	-	-	-			307,634	(36,754)	113.57%
3	Medicaid Managed Care	Inpatient	24,517	-	27,614	-	-	-	-							27,614	(3,097)	112.63%
4	Medicaid Managed Care	Outpatient	638,614	-	547,688	6,659	821	-	-							555,168	83,446	86.93%
5	Medicare Cross-over (FFS)	Inpatient	98,904	13,003	-	-	-		-	73,353	-	-	11,491			97,847	1,057	98.93%
6	Medicare Cross-over (FFS)	Outpatient	360,522	160,801	-	650	-		-	239,892	-	-	(45,587)			355,756	4,766	98.68%
7	Other Medicaid Eligibles	Inpatient	14,861	-	-	-	-			-	16,677	-	-			16,677	(1,816)	112.22%
8	Other Medicaid Eligibles	Outpatient	65,634	11,125	-	20,756	-			-	75,047	-	-			106,928	(41,294)	162.92%
9	Uninsured	Inpatient	74,979	-	-	-	-	-	-	-	-	-	-	852	-	852	74,127	1.14%
10	Uninsured	Outpatient	804,768	-	-	-	-	-	-	-	-	-	-	88,544	-	88,544	716,224	11.00%
11	In-State Sub-total	Inpatient	262,949	45,854	27,614	-	-	-	-	73,353	16,677	-	11,491	852	-	175,841	87,108	66.87%
12	In-State Sub-total	Outpatient	2,140,418	463,976	547,688	43,192	1,278	-	-	239,892	75,047	-	(45,587)	88,544	-	1,414,030	726,388	66.06%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	2,403,367	509,830	575,302	43,192	1,278	-	-	313,245	91,724	-	(34,096)	89,396	-	1,589,871	813,496	66.15%

16 Less: Out of State DSH Payments from Adjusted Survey -

17 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments 813,496

Medicaid DSH Survey Adjustments

PROVIDER: EFFINGHAM HOSPITAL
FROM: 7/1/2016 TO: 10/31/2016
Mcaid Number: 000000657A
Mcare Number: 111306

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 11,491	$ 11,491	
	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ (45,587)	$ (45,587)	

Medicaid DSH Report Notes

PROVIDER: EFFINGHAM HOSPITAL Mcaid Number: 000000657A
FROM: 7/1/2016 TO: 10/31/2016 Mcare Number: 111306

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
1		
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EXAMINER ADJUSTED SURVEY

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

D. General Cost Report Year Information 11/1/2016 - 6/30/2017

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: **EFFINGHAM HOSPITAL**

	7/1/2016 through 10/31/2016	11/1/2016 through 6/30/2017	
2. Select Cost Report Year Covered by this Survey:		X	

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 1/18/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	EFFINGHAM HOSPITAL	-	
5. Medicaid Provider Number:	000000657A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	111306	-	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	-	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	-	

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		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (11/01/2016 - 06/30/2017)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 737	$ 160,860	$161,597
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 42,950	$ 1,822,691	$1,865,641
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$43,687	$1,983,551	$2,027,238
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	1.69%	8.11%	7.97%

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

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (11/01/2016 - 06/30/2017)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	816

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	265,401
8.	Outpatient Hospital Charity Care Charges	4,405,961
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 4,671,362

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 2,274,388	$ -	$ -	$ 1,478,141	$ -	$ -	$ 796,247
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 1,351,355			$ 878,255	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ 5,579,111			$ 3,625,903	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 3,989,993	$ 51,125,782	$ -	$ 2,593,124	$ 33,227,002	$ -	$ 19,295,649
20.	Outpatient Services		$ 12,742,046	$ -		$ 8,281,144	$ -	$ 4,460,902
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ 25,019	$ 1,960,156	$ 2,544,155	$ 16,260	$ 1,273,919	$ 1,653,464	$ 694,996
27.	Total	$ 6,289,400	$ 65,827,984	$ 9,474,621	$ 4,087,525	$ 42,782,065	$ 6,157,622	$ 25,247,794
28.	Total Hospital and Non Hospital		Total from Above	$ 81,592,005		Total from Above	$ 53,027,212	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 81,592,005	Total Contractual Adj. (G-3 Line 2)		$ 53,027,212
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
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)"				-	$ -
35.	Adjusted Contractual Adjustments					53,027,212
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 2,426,277	$ -	$ -	$ 794,180	**$ 1,632,097**	1,369	$ 3,625,742		**$ 1,192.18**
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	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
12	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
13	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
14	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
15	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
16	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
17	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 2,426,277	$ -	$ -	$ 794,180	$ 1,632,097	1,369	$ 3,625,742		
19	Weighted Average									$ 1,192.18

Line #			*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*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	553	-	-	**$ 659,276**	$ 11,971	$ 1,374,884	$ 1,386,855	**0.475375**

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$ 2,684,351	$ -	$ -		**$ 2,684,351**	$ 250,895	$ 5,304,139	$ 5,555,034	**0.483229**
22	5300 ANESTHESIOLOGY	$ 386,998	$ -	$ -		**$ 386,998**	$ 31,890	$ 745,471	$ 777,361	**0.497836**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 3,374,489	$ -	$ -		**$ 3,374,489**	$ 418,264	$ 23,725,120	$ 24,143,384	**0.139769**
24	6000 LABORATORY	$ 1,935,025	$ -	$ -		**$ 1,935,025**	$ 507,865	$ 7,249,910	$ 7,757,775	**0.249430**
25	6400 INTRAVENOUS THERAPY	$ 70,682	$ -	$ -		**$ 70,682**	$ -	$ 32,038	$ 32,038	**2.206193**
26	6500 RESPIRATORY THERAPY	$ 848,048	$ -	$ -		**$ 848,048**	$ 509,976	$ 1,884,492	$ 2,394,468	**0.354170**
27	6600 PHYSICAL THERAPY	$ 861,707	$ -	$ -		**$ 861,707**	$ 601,416	$ 2,296,122	$ 2,897,538	**0.297393**
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 536,624	$ -	$ -		**$ 536,624**	$ 326,867	$ 1,526,739	$ 1,853,606	**0.289503**
29	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 568,302	$ -	$ -		**$ 568,302**	$ 386,073	$ 1,166,099	$ 1,552,172	**0.366133**
30	7300 DRUGS CHARGED TO PATIENTS	$ 1,185,539	$ -	$ -		**$ 1,185,539**	$ 946,253	$ 7,191,651	$ 8,137,904	**0.145681**
31	9100 EMERGENCY	$ 3,491,124	$ -	$ -		**$ 3,491,124**	$ 14,493	$ 11,367,162	$ 11,381,655	**0.306733**
32		$ -	$ -	$ -		**$ -**	$ -	$ -	$ -	**-**

G. Cost Report - Cost / Days / Charges

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
33		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
34		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
35		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
36		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
37		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
38		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
39		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
40		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
41		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
42		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
43		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
44		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
45		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
46		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
47		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
48		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
49		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
50		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
51		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
52		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
53		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
54		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
55		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
56		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
57		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
58		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
59		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
60		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
61		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
62		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
63		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
64		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
65		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
66		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
67		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
68		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
69		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
70		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
71		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
72		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
73		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
74		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
75		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
76		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
77		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
78		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
79		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
80		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
81		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
82		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
83		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
84		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
85		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
86		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
87		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
88		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
89		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
90		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
91		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
92		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-
93		$ -	$ -	$ -	$ -	$ -	$ -	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
94		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
95		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
96		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
97		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
98		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
99		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
100		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
101		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
102		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
103		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
104		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
105		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
106		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
107		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
108		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
109		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
110		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
111		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
112		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
113		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
114		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
115		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
116		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
117		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
118		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
119		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
120		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
121		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
122		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
123		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
124		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
125		$ -	$ -	$ -		$ -	$ -	$ -	$ -	-
126	**Total Ancillary**	$ 15,942,889	$ -	$ -		$ 15,942,889	$ 4,005,963	$ 63,863,827	$ 67,869,790	
127	**Weighted Average**									0.244618
128	**Sub Totals**	$ 18,369,166	$ -	$ -		$ 17,574,986	$ 7,631,705	$ 63,863,827	$ 71,495,532	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ 240,735				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01	Other Cost Adjustments (support must be submitted)					$ -				
132	**Grand Total**					**$ 17,334,251**				
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 (11/01/2016-06/30/2017 | EFFINGHAM 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-Overs (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 Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,192.18		50		9		76		14		61		**149**		25.74%
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	0	$ -		-		-		-		-		-		-		
12	0	$ -		-		-		-		-		-		-		
13	0	$ -		-		-		-		-		-		-		
14	0	$ -		-		-		-		-		-		-		
15	0	$ -		-		-		-		-		-		-		
16	0	$ -		-		-		-		-		-		-		
17	0	$ -		-		-		-		-		-		-		
18			**Total Days**	50		9		76		14		61		149		25.74%
19	Total Days per PS&R or Exhibit Detail			50		9		76		14		61				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 50,400		$ 22,680		$ 194,051		$ 35,280		$ 151,461		$ 302,411		12.52%
21.01	Calculated Routine Charge Per Dien			$ 1,008.00		$ 2,520.00		$ 2,553.30		$ 2,520.00		$ 2,482.97		$ 2,029.60		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct		0.475375	$ 3,255	$ 21,676	$ -	$ 12,845	$ 4,410	$ 107,545	$ -	$ 2,918	$ -	$ 184,437	$ 7,665	$ 144,984	24.31%
23	5000 OPERATING ROOM		0.483229	$ 7,797	$ 94,936	$ -	$ 226,766	$ 17,286	$ 314,967	$ -	$ 47,740	$ 21,633	$ 87,052	$ 25,083	$ 684,409	14.73%
24	5300 ANESTHESIOLOGY		0.497836	$ 891	$ 13,987	$ -	$ 34,854	$ 1,961	$ 29,449	$ -	$ 3,328	$ 2,891	$ 15,374	$ 2,852	$ 81,618	13.22%
25	5400 RADIOLOGY-DIAGNOSTIC		0.139769	$ 40,785	$ 667,234	$ 15,308	$ 1,241,350	$ 56,896	$ 1,278,417	$ 875	$ 269,689	$ 21,787	$ 2,396,597	$ 113,864	$ 3,456,690	24.81%
26	6000 LABORATORY		0.249430	$ 30,205	$ 295,622	$ 7,344	$ 517,480	$ 35,291	$ 412,041	$ 6,309	$ 68,285	$ 36,414	$ 948,979	$ 79,149	$ 1,293,428	30.39%
27	6400 INTRAVENOUS THERAPY		2.206193	$ -	$ 8,051	$ -	$ -	$ -	$ 3,502	$ -	$ 840	$ -	$ 726	$ -	$ 12,393	40.95%
28	6500 RESPIRATORY THERAPY		0.354170	$ 59,127	$ 130,564	$ 3,180	$ 187,924	$ 73,851	$ 248,313	$ 9,765	$ 11,622	$ 44,211	$ 621,480	$ 145,923	$ 578,423	58.05%
29	6600 PHYSICAL THERAPY		0.297393	$ 6,951	$ 16,349	$ -	$ 11,580	$ 13,530	$ 102,563	$ 6,720	$ 26,350	$ 327	$ 43,352	$ 27,201	$ 156,842	7.86%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.289503	$ 12,008	$ 47,313	$ 387	$ 139,338	$ 27,904	$ 59,156	$ 1,094	$ 51,128	$ 8,487	$ 107,927	$ 41,393	$ 296,935	24.53%
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.366133	$ -	$ -	$ -	$ -	$ 62,204	$ 56,675	$ -	$ 1,200	$ -	$ 145	$ 62,204	$ 57,875	7.75%
32	7300 DRUGS CHARGED TO PATIENTS		0.145681	$ 83,938	$ 150,271	$ 14,935	$ 164,229	$ 95,350	$ 451,568	$ 11,715	$ 71,725	$ 97,524	$ 557,006	$ 205,938	$ 837,793	20.87%
33	9100 EMERGENCY		0.306733	$ 6,757	$ 494,295	$ 4,054	$ 1,412,965	$ 1,351	$ 483,281	$ -	$ 82,682	$ -	$ 2,536,522	$ 12,162	$ 2,473,223	44.12%
34			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
35			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
36			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
37			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
38			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
39			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
40			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
41			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
42			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
43			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
44			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
45			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
46			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
47			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
48			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
49			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
50			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
51			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
52			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
53			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
54			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
55			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
56			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
57			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
58			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
59			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
60			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
61			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
62			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
63			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
64			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
65			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
66			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
67			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
68			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
69			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
70			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
71			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
72			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
73			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
74			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
75			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
76			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
77			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
78			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
79			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
80			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
81			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
82			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
83			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
84			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	

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

Cost Report Year (11/01/2016-06/30/2017 | EFFINGHAM 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		%
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			-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
				251,714	1,940,298	45,208	3,949,331	390,034	3,547,477	36,478	637,507	233,274	7,499,597			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			**$ 302,114**	**$ 1,940,298**	**$ 67,888**	**$ 3,949,331**	**$ 584,085**	**$ 3,547,477**	**$ 71,758**	**$ 637,507**	**$ 384,735** (Agrees to Exhibit A)	**$ 7,499,597** (Agrees to Exhibit A)	**$ 1,025,845**	**$ 10,074,613**	26.55%
129	Total Charges per PS&R or Exhibit Detail			$ 302,114	$ 1,940,298	$ 67,888	$ 3,949,331	$ 584,085	$ 3,547,477	$ 71,758	$ 637,507	$ 384,735	$ 7,499,597			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 119,387**	**$ 486,210**	**$ 19,359**	**$ 1,003,283**	**$ 194,124**	**$ 877,517**	**$ 25,867**	**$ 145,697**	**$ 129,164**	**$ 1,834,153**	$ 358,737	$ 2,512,707	27.89%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 91,761	$ 512,139	$ -	$ -	$ 16,351	$ 295,901	$ 2,855	$ 15,702			$ 110,967	$ 823,742	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 18,503	$ 797,929	$ -	$ -	$ -	$ -			$ 18,503	$ 797,929	
134	Private Insurance (including primary and third party liability)			$ 8,674	$ 14,918	$ -	$ 21,836	$ -	$ 1,230	$ -	$ 23,568			$ 8,674	$ 61,552	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 1,014	$ -	$ 1,250	$ -	$ -	$ -	$ -			$ -	$ 2,264	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 100,435	$ 528,071	$ 18,503	$ 821,015									
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)							$ 108,852	$ 516,542	$ -	$ -			$ 108,852	$ 516,542	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 11,657	$ 131,506			$ 11,657	$ 131,506	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)							$ 65,784	$ 43,552	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 65,784	$ 43,552	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 737	$ 160,860			
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)**			$ 18,952	$ (41,861)	$ 856	$ 182,268	$ 3,137	$ 20,292	$ 11,355	$ (25,079)	$ 128,427	$ 1,673,293	$ 34,300	$ 135,620	
146	**Calculated Payments as a Percentage of Cost**			84%	109%	96%	82%	98%	98%	56%	117%	1%	9%	90%	95%	
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**							373								
148	**Percent of cross-over days to total Medicare days from the cost report**							20%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with s
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation pa

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

I. Out-of-State Medicaid Data:

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM 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 Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,192.18		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
11		$ -		-		-		-		-		-	
12		$ -		-		-		-		-		-	
13		$ -		-		-		-		-		-	
14		$ -		-		-		-		-		-	
15		$ -		-		-		-		-		-	
16		$ -		-		-		-		-		-	
17		$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				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**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.475375	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.483229	-	-	-	-	-	-	-	-	$ -	$ -
24	5300 ANESTHESIOLOGY		0.497836	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.139769	-	-	-	-	-	-	-	-	$ -	$ -
26	6000 LABORATORY		0.249430	-	-	-	-	-	-	-	-	$ -	$ -
27	6400 INTRAVENOUS THERAPY		2.206193	-	-	-	-	-	-	-	-	$ -	$ -
28	6500 RESPIRATORY THERAPY		0.354170	-	-	-	-	-	-	-	-	$ -	$ -
29	6600 PHYSICAL THERAPY		0.297393	-	-	-	-	-	-	-	-	$ -	$ -
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.289503	-	-	-	-	-	-	-	-	$ -	$ -
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.366133	-	-	-	-	-	-	-	-	$ -	$ -
32	7300 DRUGS CHARGED TO PATIENTS		0.145681	-	-	-	-	-	-	-	-	$ -	$ -
33	9100 EMERGENCY		0.306733	-	-	-	-	-	-	-	-	$ -	$ -
34			-	-	-	-	-	-	-	-	-	$ -	$ -
35			-	-	-	-	-	-	-	-	-	$ -	$ -
36			-	-	-	-	-	-	-	-	-	$ -	$ -
37			-	-	-	-	-	-	-	-	-	$ -	$ -
38			-	-	-	-	-	-	-	-	-	$ -	$ -
39			-	-	-	-	-	-	-	-	-	$ -	$ -
40			-	-	-	-	-	-	-	-	-	$ -	$ -
41			-	-	-	-	-	-	-	-	-	$ -	$ -
42			-	-	-	-	-	-	-	-	-	$ -	$ -
43			-	-	-	-	-	-	-	-	-	$ -	$ -
44			-	-	-	-	-	-	-	-	-	$ -	$ -
45			-	-	-	-	-	-	-	-	-	$ -	$ -
46			-	-	-	-	-	-	-	-	-	$ -	$ -
47			-	-	-	-	-	-	-	-	-	$ -	$ -
48			-	-	-	-	-	-	-	-	-	$ -	$ -
49			-	-	-	-	-	-	-	-	-	$ -	$ -
50			-	-	-	-	-	-	-	-	-	$ -	$ -
51			-	-	-	-	-	-	-	-	-	$ -	$ -
52			-	-	-	-	-	-	-	-	-	$ -	$ -
53			-	-	-	-	-	-	-	-	-	$ -	$ -
54			-	-	-	-	-	-	-	-	-	$ -	$ -
55			-	-	-	-	-	-	-	-	-	$ -	$ -
56			-	-	-	-	-	-	-	-	-	$ -	$ -
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58			-	-	-	-	-	-	-	-	-	$ -	$ -
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60			-	-	-	-	-	-	-	-	-	$ -	$ -
61			-	-	-	-	-	-	-	-	-	$ -	$ -
62			-	-	-	-	-	-	-	-	-	$ -	$ -
63			-	-	-	-	-	-	-	-	-	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM 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	
64			-	-	-	-	-	-	-	-	-	$ -	$ -
65			-	-	-	-	-	-	-	-	-	$ -	$ -
66			-	-	-	-	-	-	-	-	-	$ -	$ -
67			-	-	-	-	-	-	-	-	-	$ -	$ -
68			-	-	-	-	-	-	-	-	-	$ -	$ -
69			-	-	-	-	-	-	-	-	-	$ -	$ -
70			-	-	-	-	-	-	-	-	-	$ -	$ -
71			-	-	-	-	-	-	-	-	-	$ -	$ -
72			-	-	-	-	-	-	-	-	-	$ -	$ -
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102			-	-	-	-	-	-	-	-	-	$ -	$ -
103			-	-	-	-	-	-	-	-	-	$ -	$ -
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107			-	-	-	-	-	-	-	-	-	$ -	$ -
108			-	-	-	-	-	-	-	-	-	$ -	$ -
109			-	-	-	-	-	-	-	-	-	$ -	$ -
110			-	-	-	-	-	-	-	-	-	$ -	$ -
111			-	-	-	-	-	-	-	-	-	$ -	$ -
112			-	-	-	-	-	-	-	-	-	$ -	$ -
113			-	-	-	-	-	-	-	-	-	$ -	$ -
114			-	-	-	-	-	-	-	-	-	$ -	$ -
115			-	-	-	-	-	-	-	-	-	$ -	$ -
116			-	-	-	-	-	-	-	-	-	$ -	$ -
117			-	-	-	-	-	-	-	-	-	$ -	$ -
118			-	-	-	-	-	-	-	-	-	$ -	$ -
119			-	-	-	-	-	-	-	-	-	$ -	$ -
120			-	-	-	-	-	-	-	-	-	$ -	$ -
121			-	-	-	-	-	-	-	-	-	$ -	$ -
122			-	-	-	-	-	-	-	-	-	$ -	$ -
123			-	-	-	-	-	-	-	-	-	$ -	$ -
124			-	-	-	-	-	-	-	-	-	$ -	$ -
125			-	-	-	-	-	-	-	-	-	$ -	$ -
126			-	-	-	-	-	-	-	-	-	$ -	$ -
127			-	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						

I. Out-of-State Medicaid Data:

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143.02	**Calculated Payment Shortfall / (Longfall)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM 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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM 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 Primar		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquistion Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (11/01/2016-06/30/2017) EFFINGHAM HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(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 ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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

DSH Examination Eligibility Summary

Hospital Name	**EFFINGHAM HOSPITAL**
Hospital Medicaid Number	**000000657A**
Cost Report Period	From **11/1/2016** To **6/30/2017**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 1,798,833	$ -	$ 1,798,833
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 1,798,833	$ -	$ 1,798,833
4	Net Hospital Patient Revenue	Survey F-3	$ 25,247,794	$ -	$ 25,247,794
5	Medicaid Fraction		7.12%	0.00%	7.12%
6	Inpatient Charity Care Charges	Survey F-2	$ 265,401	$ -	$ 265,401
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 265,401	$ -	$ 265,401
10	Inpatient Hospital Charges	Survey F-3	$ 6,289,400	$ -	$ 6,289,400
11	Inpatient Charity Fraction		4.22%	0.00%	4.22%
12	LIUR		11.34%	0.00%	11.34%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	149	-	149
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		149	-	149
16	Total Hospital Days (excludes swing-bed)	Survey F-1	816	-	816
17	MIUR		18.26%	0.00%	18.26%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **EFFINGHAM HOSPITAL**
Hospital Medicaid Number: **00000657A**
Cost Report Period: From **11/1/2016** To **6/30/2017**

As-Reported:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1 Medicaid Fee for Service	Inpatient	119,387	91,761	-	8,674	-	-	-	-	-	-	-			100,435	18,952	84.13%
2 Medicaid Fee for Service	Outpatient	486,210	512,139	-	14,918	1,014	-	-	-	-	-	-			528,071	(41,861)	108.61%
3 Medicaid Managed Care	Inpatient	19,359	-	18,503	-	-	-	-							18,503	856	95.58%
4 Medicaid Managed Care	Outpatient	1,003,283	-	797,929	21,836	1,250	-	-							821,015	182,268	81.83%
5 Medicare Cross-over (FFS)	Inpatient	194,124	16,351	-	-	-		-	108,852	-	-	-			125,203	68,921	64.50%
6 Medicare Cross-over (FFS)	Outpatient	877,517	295,901	-	1,230	-		-	516,542	-	-	-			813,673	63,844	92.72%
7 Other Medicaid Eligibles	Inpatient	25,867	2,855	-	-	-			-	11,657	-	-			14,512	11,355	56.10%
8 Other Medicaid Eligibles	Outpatient	145,697	15,702	-	23,568	-			-	131,506	-	-			170,776	(25,079)	117.21%
9 Uninsured	Inpatient	129,164											737	-	737	128,427	0.57%
10 Uninsured	Outpatient	1,834,153											160,860	-	160,860	1,673,293	8.77%
11 In-State Sub-total	Inpatient	487,901	110,967	18,503	8,674	-	-	-	108,852	11,657	-	-	737	-	259,390	228,511	53.16%
12 In-State Sub-total	Outpatient	4,346,860	823,742	797,929	61,552	2,264	-	-	516,542	131,506	-	-	160,860	-	2,494,395	1,852,465	57.38%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15 Sub-Total	I/P and O/P	4,834,761	934,709	816,432	70,226	2,264	-	-	625,394	143,163	-	-	161,597	-	2,753,785	2,080,976	56.96%

Adjustments:

Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
1 Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	65,784			65,784	(65,784)	33.89%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	43,552			43,552	(43,552)	4.96%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9 Uninsured	Inpatient	-											-	-	-	-	0.00%
10 Uninsured	Outpatient	-											-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	65,784	-	-	65,784	(65,784)	13.48%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	43,552	-	-	43,552	(43,552)	1.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	109,336	-	-	109,336	(109,336)	2.26%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **EFFINGHAM HOSPITAL**
Hospital Medicaid Number: **000000657A**
Cost Report Period: From **11/1/2016** To **6/30/2017**

As-Adjusted:

	Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc..) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc..)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments	Uncomp. Care Costs	Payment to Cost Ratio
			Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E			
1	Medicaid Fee for Service	Inpatient	119,387	91,761	-	8,674	-	-	-	-	-	-	-			100,435	18,952	84.13%
2	Medicaid Fee for Service	Outpatient	486,210	512,139	-	14,918	1,014	-	-	-	-	-	-			528,071	(41,861)	108.61%
3	Medicaid Managed Care	Inpatient	19,359	-	18,503	-	-	-	-							18,503	856	95.58%
4	Medicaid Managed Care	Outpatient	1,003,283	-	797,929	21,836	1,250	-	-							821,015	182,268	81.83%
5	Medicare Cross-over (FFS)	Inpatient	194,124	16,351	-	-	-		-	108,852	-	-	65,784			190,987	3,137	98.38%
6	Medicare Cross-over (FFS)	Outpatient	877,517	295,901	-	1,230	-		-	516,542	-	-	43,552			857,225	20,292	97.69%
7	Other Medicaid Eligibles	Inpatient	25,867	2,855	-	-	-			-	11,657	-	-			14,512	11,355	56.10%
8	Other Medicaid Eligibles	Outpatient	145,697	15,702	-	23,568	-			-	131,506	-	-			170,776	(25,079)	117.21%
9	Uninsured	Inpatient	129,164	-	-	-	-	-	-	-	-	-	-	737	-	737	128,427	0.57%
10	Uninsured	Outpatient	1,834,153	-	-	-	-	-	-	-	-	-	-	160,860	-	160,860	1,673,293	8.77%
11	In-State Sub-total	Inpatient	487,901	110,967	18,503	8,674	-	-	-	108,852	11,657	-	65,784	737	-	325,174	162,727	66.65%
12	In-State Sub-total	Outpatient	4,346,860	823,742	797,929	61,552	2,264	-	-	516,542	131,506	-	43,552	160,860	-	2,537,947	1,808,913	58.39%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	4,834,761	934,709	816,432	70,226	2,264	-	-	625,394	143,163	-	109,336	161,597	-	2,863,121	1,971,640	59.22%

16 Less: Out of State DSH Payments from Adjusted Survey -
17 Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments 1,971,640

Medicaid DSH Survey Adjustments

PROVIDER: EFFINGHAM HOSPITAL
FROM: 11/1/2016 TO: 6/30/2017
Mcaid Number: 000000657A
Mcare Number: 111306

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 65,784	$ 65,784	
	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 43,552	$ 43,552	

Medicaid DSH Report Notes

PROVIDER: EFFINGHAM HOSPITAL Mcaid Number: 000000657A
FROM: 11/1/2016 TO: 6/30/2017 Mcare Number: 111306

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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