DSH Version 8.11 2/10/2023

D. General Cost Report Year Information 7/1/2021 - 6/30/2022

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

	7/1/2021 through 6/30/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 11/30/2022

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

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

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2021 - 06/30/2022)

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)	$ 3,529	$ 370,515	$374,044
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 57,231	$ 2,239,252	$2,296,483
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$60,760	$2,609,767	$2,670,527
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.81%	14.20%	14.01%

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 (07/01/2021 - 06/30/2022)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	2,436 **(See Note in Section F-3, below)**

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	188,157
8.	Outpatient Hospital Charity Care Charges	4,844,783
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 5,032,940

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$14,308,048.00			$ 10,148,062	$ -	$ -	$ 4,159,986
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$8,542,968.00			$ 6,059,147	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$9,361,873.00	$125,414,754.00		$ 6,639,960	$ 88,951,105	$ -	$ 39,185,562
20.	Outpatient Services		$32,318,874.00			$ 22,922,339	$ -	$ 9,396,535
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$3,627,751.00	$ -	$ -	$ 2,573,002	$ -
27.	Total	$ 23,669,921	$ 157,733,628	$ 12,170,719	$ 16,788,022	$ 111,873,444	$ 8,632,149	$ 52,742,083
28.	Total Hospital and Non Hospital		Total from Above	$ 193,574,268		Total from Above	$ 137,293,615	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	193,574,268	Total Contractual Adj. (G-3 Line 2)	137,293,615
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				137,293,615
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) EFFINGHAM HOSPITAL

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		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	$ 5,322,432	$ -	$ -	$283,559.00	$ 5,038,873	3,845	$11,239,655.00		$ 1,310.50
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 5,322,432	$ -	$ -	$ 283,559	$ 5,038,873	3,845	$ 11,239,655		
19	Weighted Average									$ 1,310.50

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)	1,409	-	-	$ 1,846,495	$72,395.00	$3,433,710.00	$ 3,506,105	0.526651

Line #		*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	$4,844,585.00	$ -	$ -		$ 4,844,585	$927,540.00	$12,140,815.00	$ 13,068,355	0.370711
22	5300 ANESTHESIOLOGY	$783,188.00	$ -	$ -		$ 783,188	$463,959.00	$4,161,021.00	$ 4,624,980	0.169339
23	5400 RADIOLOGY-DIAGNOSTIC	$4,925,620.00	$ -	$ -		$ 4,925,620	$1,335,317.00	$53,413,538.00	$ 54,748,855	0.089968
24	6000 LABORATORY	$3,897,005.00	$ -	$ -		$ 3,897,005	$1,050,369.00	$10,353,045.00	$ 11,403,414	0.341740
25	6400 INTRAVENOUS THERAPY	$3,813,230.00	$ -	$ -		$ 3,813,230	$6,374.00	$2,759,554.00	$ 2,765,928	1.378644
26	6500 RESPIRATORY THERAPY	$1,949,775.00	$ -	$ -		$ 1,949,775	$595,326.00	$2,611,383.00	$ 3,206,709	0.608030
27	6600 PHYSICAL THERAPY	$546,491.00	$ -	$ -		$ 546,491	$149,394.00	$1,754,341.00	$ 1,903,735	0.287063
28	6700 OCCUPATIONAL THERAPY	$132,700.00	$ -	$ -		$ 132,700	$80,105.00	$140,899.00	$ 221,004	0.600442
29	6800 SPEECH PATHOLOGY	$57,503.00	$ -	$ -		$ 57,503	$18,102.00	$37,062.00	$ 55,164	1.042401

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) EFFINGHAM HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$2,510,246.00	$ -	$ -		$ 2,510,246	$684,597.00	$5,092,446.00	$ 5,777,043	0.434521
31	7200	IMPL. DEV. CHARGED TO PATIENTS	$1,673,688.00	$ -	$ -		$ 1,673,688	$51,459.00	$2,780,232.00	$ 2,831,691	0.591056
32	7300	DRUGS CHARGED TO PATIENTS	$11,036,314.00	$ -	$ -		$ 11,036,314	$3,907,031.00	$29,641,785.00	$ 33,548,816	0.328963
33	9100	EMERGENCY	$4,822,626.00	$ -	$ -		$ 4,822,626	$432,327.00	$31,710,698.00	$ 32,143,025	0.150036
34			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
35			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
36			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) EFFINGHAM HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
91		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 40,992,971	$ -	$ -	$ 40,992,971	$ 9,774,295	$ 160,030,529	$ 169,804,824	
127	**Weighted Average**								0.252287
128	**Sub Totals**	$ 46,315,403	$ -	$ -	$ 46,031,844	$ 21,013,950	$ 160,030,529	$ 181,044,479	

129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$103,928.00
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 45,927,916
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 (07/01/2021-06/30/2022) 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	$ 1,310.50		48		10		126		66		166		250		17.41%
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**	48		10		126		66		166		250		11.03%
19	Total Days per PS&R or Exhibit Detail			48		10		126		66		166				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 121,114		$ 25,200		$ 317,850		$ 146,267		$ 383,742		$ 610,431		9.02%
21.01	Calculated Routine Charge Per Diem			$ 2,523.21		$ 2,520.00		$ 2,522.62		$ 2,216.17		$ 2,311.70		$ 2,441.72		
	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)		0.526651	21,210	46,318	3,990	75,200	4,410	177,908	-	38,535	358,050	3,705	$ 29,610	$ 337,961	21.18%
23	5000 OPERATING ROOM		0.370711	5,417	254,062	-	612,849	21,295	513,728	1,756	110,039	174,414	255,420	$ 28,468	$ 1,490,678	14.92%
24	5300 ANESTHESIOLOGY		0.169339	2,768	94,024	-	275,615	10,916	176,561	-	38,743	78,649	90,475	$ 13,684	$ 584,943	16.60%
25	5400 RADIOLOGY-DIAGNOSTIC		0.089968	109,302	1,182,121	25,155	3,589,880	44,294	2,730,682	34,783	646,047	1,207,907	4,335,103	$ 213,534	$ 8,148,730	25.65%
26	6000 LABORATORY		0.341740	47,713	329,392	11,927	970,875	47,583	344,367	19,710	211,366	337,001	683,133	$ 126,933	$ 1,856,000	26.60%
27	6400 INTRAVENOUS THERAPY		1.378644	-	2,016	5,661	356,839	467	443,794	2,065	54,269	165,964	654,788	$ 8,193	$ 856,918	61.75%
28	6500 RESPIRATORY THERAPY		0.608030	30,850	209,212	612	123,758	40,991	127,285	17,719	26,127	114,775	135,819	$ 90,172	$ 486,382	26.43%
29	6600 PHYSICAL THERAPY		0.287063	1,027	79,009	-	240,468	3,158	169,606	9,677	53,724	11,441	-	$ 13,862	$ 542,807	29.84%
30	6700 OCCUPATIONAL THERAPY		0.600442	-	-	-	28,336	2,711	21,471	7,510	-	1,573	-	$ 10,221	$ 49,807	27.87%
31	6800 SPEECH PATHOLOGY		1.042401	-	-	-	-	4,571	1,242	-	429	1,341	-	$ 4,571	$ 1,671	13.75%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.434521	5,593	105,286	-	328,436	24,357	246,652	5,285	55,177	101,506	140,899	$ 35,235	$ 735,551	17.60%
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.591056	-	163,100	-	104,612	-	205,908	-	25,142	92	81,442	$ -	$ 498,762	20.49%
34	7300 DRUGS CHARGED TO PATIENTS		0.328963	73,009	318,554	17,969	933,474	163,315	2,456,774	68,062	215,925	547,377	845,819	$ 322,355	$ 3,924,727	16.90%
35	9100 EMERGENCY		0.150036	28,938	778,395	10,335	4,225,788	5,189	899,108	2,067	505,101	805,618	3,901,297	$ 46,529	$ 6,408,392	35.25%
36			-											$ -	$ -	
37			-											$ -	$ -	
38			-											$ -	$ -	
39			-											$ -	$ -	
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60			-											$ -	$ -	

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

Cost Report Year (07/01/2021-06/30/2022) 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	%
61			-											$ -	$ -
62			-											$ -	$ -
63			-											$ -	$ -
64			-											$ -	$ -
65			-											$ -	$ -
66			-											$ -	$ -
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124			-											$ -	$ -
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 325,827	$ 3,561,489	$ 75,649	$ 11,866,130	$ 373,257	$ 8,515,086	$ 168,634	$ 1,980,624	$ 3,905,708	$ 11,127,900		

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

Cost Report Year (07/01/2021-06/30/2022) EFFINGHAM HOSPITAL

	Totals / Payments	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		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 446,941	$ 3,561,489	$ 100,849	$ 11,866,130	$ 691,107	$ 8,515,086	$ 314,901	$ 1,980,624	$ 4,289,450 (Agrees to Exhibit A)	$ 11,127,900 (Agrees to Exhibit A)	$ 1,553,798	$ 25,923,329	23.94%
129	Total Charges per PS&R or Exhibit Detail	$ 446,941	$ 3,561,489	$ 100,849	$ 11,866,130	$ 691,107	$ 8,515,086	$ 314,901	$ 1,980,624	$ 4,289,450	$ 11,127,900			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 152,532	$ 869,815	$ 37,184	$ 2,767,116	$ 295,388	$ 2,601,463	$ 142,913	$ 490,227	$ 1,357,244	$ 2,693,674	$ 628,017	$ 6,728,621	25.10%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 209,576	$ 783,512	$ -	$ -	$ 33,251	$ 341,512	$ 4,128	$ 15,377			$ 246,955	$ 1,140,401	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 33,602	$ 1,982,879	$ -	$ -	$ 7,962	$ 54,496			$ 41,564	$ 2,037,375	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ 13,114	$ 43,237	$ 445,328			$ 43,237	$ 458,442	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -			$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 209,576	$ 783,512	$ 33,602	$ 1,982,879									
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)					$ 251,948	$ 1,611,433	$ 84,705	$ 29,607			$ 336,653	$ 1,641,040	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ 106,628	$ -	$ -			$ -	$ 106,628	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 3,529	$ 370,515			
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)**	$ (57,044)	$ 86,303	$ 3,582	$ 784,237	$ 10,189	$ 528,776	$ 2,881	$ (54,581)	$ 1,353,715	$ 2,323,159	$ (40,392)	$ 1,344,735	
146	**Calculated Payments as a Percentage of Cost**	137%	90%	90%	72%	97%	80%	98%	111%	0%	14%	106%	80%	
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)**					1,155								
148	**Percent of cross-over days to total Medicare days from the cost report**					11%								

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.

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) 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	$ 1,310.50		8								8	
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**	8		-		-		-		8	
19	Total Days per PS&R or Exhibit Detail			8		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 20,160								$ 20,160	
21.01	Calculated Routine Charge Per Diem			$ 2,520.00		$ -		$ -		$ -		$ 2,520.00	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.526651	6,930	6,405							$ 6,930	$ 6,405
23	5000 OPERATING ROOM		0.370711	-	1,055							$ -	$ 1,055
24	5300 ANESTHESIOLOGY		0.169339	-	-							$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.089968	3,441	132,171							$ 3,441	$ 132,171
26	6000 LABORATORY		0.341740	5,678	24,693							$ 5,678	$ 24,693
27	6400 INTRAVENOUS THERAPY		1.378644	1,092	20,971							$ 1,092	$ 20,971
28	6500 RESPIRATORY THERAPY		0.608030	11,777	8,683							$ 11,777	$ 8,683
29	6600 PHYSICAL THERAPY		0.287063	-	-							$ -	$ -
30	6700 OCCUPATIONAL THERAPY		0.600442	-	-							$ -	$ -
31	6800 SPEECH PATHOLOGY		1.042401	-	-							$ -	$ -
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.434521	1,954	1,655							$ 1,954	$ 1,655
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.591056	-	-							$ -	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.328963	10,180	19,359							$ 10,180	$ 19,359
35	9100 EMERGENCY		0.150036	6,201	161,589							$ 6,201	$ 161,589
36			-									$ -	$ -
37			-									$ -	$ -
38			-									$ -	$ -
39			-									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) 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	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
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100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 47,253	$ 376,581	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 67,413	$ 376,581	$ -	$ -	$ -	$ -	$ -	$ -	$ 67,413	$ 376,581
129	Total Charges per PS&R or Exhibit Detail			$ 67,413	$ 376,581	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 30,178	$ 89,617	$ -	$ -	$ -	$ -	$ -	$ -	$ 30,178	$ 89,617
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 16,515	$ 21,136							$ 16,515	$ 21,136
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)			$ -	$ 948							$ -	$ 948
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -							$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 16,515	$ 22,084	$ -	$ -						
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	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 13,663	$ 67,533	$ -	$ -	$ -	$ -	$ -	$ -	$ 13,663	$ 67,533
144	**Calculated Payments as a Percentage of Cost**			55%	25%	0%	0%	0%	0%	0%	0%	55%	25%

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 (07/01/2021-06/30/2022) 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 Acquisition 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	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (07/01/2021-06/30/2022) 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 Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition 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								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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