EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.10	7/5/2022

D. General Cost Report Year Information 7/1/2020 - 6/30/2021

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:	CLINCH MEMORIAL HOSPITAL			
	7/1/2020 through 6/30/2021			
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:	12/14/2021			
	Data	**Correct?**	**If Incorrect, Proper Information**	
4. Hospital Name:	CLINCH MEMORIAL HOSPITAL	Yes		
5. Medicaid Provider Number:	000000415A	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:	111308	Yes		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes		
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes		

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

	State Name	Provider No.
9. State Name & Number		
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: (07/01/2020 - 06/30/2021)

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)	$ 2,534	$ 104,072	$106,606
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 24,533	$ 242,424	$266,957
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$27,067	$346,496	$373,563
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	9.36%	30.04%	28.54%

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 (07/01/2020 - 06/30/2021)

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)	688

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	20,443
8.	Outpatient Hospital Charity Care Charges	78,462
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 98,905

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	$ 469,618	$ -	$ -	$ 166,404	$ -	$ -	$ 303,214
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ 2,899,214			$ 1,027,307	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 7,002,316	$ 6,582,286	$ -	$ 2,481,200	$ 2,332,366	$ -	$ 8,771,036
20.	Outpatient Services		$ 1,859,306	$ -		$ 658,826	$ -	$ 1,200,480
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ 110,159			$ 39,034	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 543,136	$ -	$ -	$ 192,455	$ -
27.	Total	$ 7,471,934	$ 8,441,592	$ 3,552,509	$ 2,647,604	$ 2,991,192	$ 1,258,796	$ 10,274,730
28.	Total Hospital and Non Hospital		Total from Above	$ 19,466,035		Total from Above	$ 6,897,592	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 19,466,035	Total Contractual Adj. (G-3 Line 2)	$ 6,497,419
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)			+	$ 400,173
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	$ -
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
35.	Adjusted Contractual Adjustments				6,897,592
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) | CLINCH MEMORIAL 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	$ 5,347,126	$ -	$ -	3,585,111	**$ 1,762,015**	1,274	$ 3,167,108		**$ 1,383.06**
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	$ -	$ -	$ -		$ -	-	$ -		$ -
18	Total Routine	$ 5,347,126	$ -	$ -	$ 3,585,111	$ 1,762,015	1,274	$ 3,167,108		
19	Weighted Average									$ 1,383.06

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)	586	-	-	**$ 810,473**	9,903	267,377	$ 277,280	**2.922941**

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	$ 318,252	$ -	$ -		**$ 318,252**	$ 4,855	$ 100,316	$ 105,171	**3.026043**
22	5400	RADIOLOGY-DIAGNOSTIC	$ 1,372,486	$ -	$ -		**$ 1,372,486**	$ 283,482	$ 2,155,937	$ 2,439,419	**0.562628**
23	6000	LABORATORY	$ 2,188,022	$ -	$ -		**$ 2,188,022**	$ 695,540	$ 2,383,863	$ 3,079,403	**0.710534**
24	6500	RESPIRATORY THERAPY	$ 1,682,020	$ -	$ -		**$ 1,682,020**	$ 1,553,372	$ 533,727	$ 2,087,099	**0.805913**
25	6600	PHYSICAL THERAPY	$ 660,936	$ -	$ -		**$ 660,936**	$ 280,600	$ 355,892	$ 636,492	**1.038404**
26	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 542,700	$ -	$ -		**$ 542,700**	$ 1,532,091	$ 267,480	$ 1,799,571	**0.301572**
27	7300	DRUGS CHARGED TO PATIENTS	$ 1,007,837	$ -	$ -		**$ 1,007,837**	$ 2,646,793	$ 736,780	$ 3,383,573	**0.297862**
28	9100	EMERGENCY	$ 2,014,630	$ -	$ -		**$ 2,014,630**	$ 17,372	$ 1,530,282	$ 1,547,654	**1.301732**
126		**Total Ancillary**	$ 9,786,883	$ -	$ -		$ 9,786,883	$ 7,024,008	$ 8,331,654	$ 15,355,662	
127		**Weighted Average**									**0.690127**
128		**Sub Totals**	$ 15,134,009	$ -	$ -		$ 11,548,898	$ 10,191,116	$ 8,331,654	$ 18,522,770	
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)					$ -				

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) CLINCH MEMORIAL 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
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)				$ 2,060,687				
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**				**$ 9,488,211**				
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 (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
				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	$ 1,383.06		38		7		162		89		66		**296**	
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	$ -		-		-		-		-		-		-	
18			**Total Days**	38		7		162		89		66		296	
19	Total Days per PS&R or Exhibit Detail			38		7		162		89		66			
20	Unreconciled Days (Explain Variance)			-		-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 15,946		$ 2,800		$ 74,475		$ 33,725		$ 26,750		$ 126,946	
21.01	Calculated Routine Charge Per Diem			$ 419.63		$ 400.00		$ 459.72		$ 378.93		$ 405.30		$ 428.87	
	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)		2.922941	$ 1,377	$ 10,030	$ 782	$ 5,756	$ -	$ 48,133	$ 4,097	$ 14,726	$ 1,589	$ 33,861	$ 6,256	$ 78,645
23	5000 OPERATING ROOM		3.026043	$ -	$ 5,249	$ 117	$ 3,000	$ -	$ 20,320	$ -	$ 2,882	$ -	$ 6,152	$ 117	$ 31,452
24	5400 RADIOLOGY-DIAGNOSTIC		0.562628	$ 19,746	$ 102,416	$ 1,089	$ 178,298	$ 14,984	$ 328,591	$ 12,061	$ 101,195	$ 14,026	$ 336,884	$ 47,879	$ 710,499
25	6000 LABORATORY		0.710534	$ 27,450	$ 134,280	$ 1,549	$ 182,747	$ 52,704	$ 239,835	$ 29,021	$ 139,760	$ 31,457	$ 304,322	$ 110,724	$ 696,622
26	6500 RESPIRATORY THERAPY		0.805913	$ 17,210	$ 38,151	$ 329	$ 53,267	$ 54,935	$ 92,122	$ 14,267	$ 20,566	$ 8,654	$ 61,508	$ 86,741	$ 204,106
27	6600 PHYSICAL THERAPY		1.038404	$ 585	$ 3,341	$ 268	$ 11,252	$ 2,826	$ 35,577	$ 1,628	$ 20,197	$ 620	$ 15,978	$ 5,307	$ 70,367
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.301572	$ 9,937	$ 20,236	$ 2,423	$ 19,312	$ 42,492	$ 50,736	$ 16,403	$ 15,299	$ 11,821	$ 31,195	$ 71,256	$ 105,583
29	7300 DRUGS CHARGED TO PATIENTS		0.297862	$ 35,634	$ 50,620	$ 3,985	$ 63,927	$ 116,013	$ 104,013	$ 54,062	$ 40,957	$ 36,168	$ 122,979	$ 209,693	$ 259,516
30	9100 EMERGENCY		1.301732	$ 3,971	$ 98,561	$ 1,850	$ 177,813	$ 2,196	$ 214,275	$ 4,552	$ 65,130	$ 2,657	$ 286,727	$ 12,569	$ 555,779
				115,910	462,883	12,393	695,372	286,150	1,133,602	136,090	420,712	106,992	1,199,606		

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

Cost Report Year (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	
	Totals / Payments												
128	**Total Charges** ***(includes organ acquisition from Section J)***	**$ 131,856**	**$ 462,883**	**$ 15,193**	**$ 695,372**	**$ 360,625**	**$ 1,133,602**	**$ 169,815**	**$ 420,712**	**$ 133,742** (Agrees to Exhibit A)	**$ 1,199,606** (Agrees to Exhibit A)	**$ 677,490**	**$ 2,712,569**
129	Total Charges per PS&R or Exhibit Detail	$ 131,856	$ 462,883	$ 15,193	$ 695,372	$ 360,625	$ 1,133,602	$ 169,815	$ 420,712	$ 133,742	$ 1,199,606		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-		
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 120,452**	**$ 381,928**	**$ 18,905**	**$ 567,009**	**$ 367,371**	**$ 993,862**	**$ 202,637**	**$ 347,147**	**$ 151,584**	**$ 1,008,804**	$ 709,365	$ 2,289,946
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 97,097	$ 264,977	$ -	$ -	$ 19,754	$ 57,957	$ 277	$ 7,857			$ 117,128	$ 330,791
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 18,351	$ 259,176	$ -	$ -	$ -	$ -			$ 18,351	$ 259,176
134	Private Insurance (including primary and third party liability)	$ -	$ 915	$ -	$ 838	$ -	$ -	$ -	$ 57,149			$ -	$ 58,902
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ 39	$ -	$ -	$ -	$ 698			$ -	$ 737
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 97,097	$ 265,892	$ 18,351	$ 260,053								
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 38,775	$ -	$ -							$ -	$ 38,775
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 322,786	$ 724,836	$ 172,183	$ 195,306			$ 494,969	$ 920,142
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ 14,452	$ 41,657	$ -	$ -			$ 14,452	$ 41,657
142	Other Medicare Cross-Over Payments (See Note D)					$ 6,581	$ 152,631	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 6,581	$ 152,631
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 2,534	$ 104,072		
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)**	$ 23,355	$ 77,261	$ 554	$ 306,956	$ 3,798	$ 16,781	$ 30,177	$ 86,137	$ 149,050	$ 904,732	$ 57,884	$ 487,135
146	**Calculated Payments as a Percentage of Cost**	81%	80%	97%	46%	99%	98%	85%	75%	2%	10%	92%	79%
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)**					395							
148	**Percent of cross-over days to total Medicare days from the cost report**					41%							

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.

% Survey to Cost Report Totals
52.62%
52.62%
4.85%
43.40%
35.87%
45.47%
37.12%
17.30%
14.50%
12.22%
18.57%
55.42%


%
25.50%
43.84%

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) | CLINCH MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From 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	$ 1,383.06		-		-		-		-		-	
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	$ -		-		-		-		-		-	
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)		2.922941	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		3.026043	-	-	-	-	-	-	-	-	$ -	$ -
24	5400 RADIOLOGY-DIAGNOSTIC		0.562628	-	-	-	-	-	-	-	-	$ -	$ -
25	6000 LABORATORY		0.710534	-	-	-	-	-	-	-	-	$ -	$ -
26	6500 RESPIRATORY THERAPY		0.805913	-	-	-	-	-	-	-	-	$ -	$ -
27	6600 PHYSICAL THERAPY		1.038404	-	-	-	-	-	-	-	-	$ -	$ -
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.301572	-	-	-	-	-	-	-	-	$ -	$ -
29	7300 DRUGS CHARGED TO PATIENTS		0.297862	-	-	-	-	-	-	-	-	$ -	$ -
30	9100 EMERGENCY		1.301732	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	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)			$ -	$ -	$ -	$ -						
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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
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.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

Out-of-State Medicaid FFS Primary	Out-of-State Medicaid Managed Care Primary	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Total Out-Of-State Medicaid

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 (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-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	$ -	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 (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care 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 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	$ -	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 (07/01/2020-06/30/2021) CLINCH MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
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 ---------->)	CAH	$ -		
	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		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	3,390,059
19	Uninsured Hospital	**Charges Sec. G**	1,333,348
20	Total Hospital	**Charges Sec. G**	18,522,770
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		18.30%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.20%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		$ -

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

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

DSH Examination Eligibility Summary

Hospital Name	**CLINCH MEMORIAL HOSPITAL**
Hospital Medicaid Number	**000000415A**
Cost Report Period	From **7/1/2020** To **6/30/2021**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 766,013	$ -	$ 766,013
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 766,013	$ -	$ 766,013
4	Net Hospital Patient Revenue	Survey F-3	$ 10,274,730	$ -	$ 10,274,730
5	Medicaid Fraction		7.46%	0.00%	7.46%
6	Inpatient Charity Care Charges	Survey F-2	$ 20,443	$ -	$ 20,443
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 20,443	$ -	$ 20,443
10	Inpatient Hospital Charges	Survey F-3	$ 7,471,934	$ -	$ 7,471,934
11	Inpatient Charity Fraction		0.27%	0.00%	0.27%
12	LIUR		7.73%	0.00%	7.73%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	296	-	296
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		296	-	296
16	Total Hospital Days (excludes swing-bed)	Survey F-1	688	-	688
17	MIUR		43.02%	0.00%	43.02%

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: **CLINCH MEMORIAL HOSPITAL**
Hospital Medicaid Number: **000000415A**
Cost Report Period: From **7/1/2020** To **6/30/2021**

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	120,452	97,097	-	-	-	-	-	-	-	-	-			97,097	23,355	80.61%
2	Medicaid Fee for Service	Outpatient	381,928	264,977	-	915	-	38,775	-	-	-	-	-			304,667	77,261	79.77%
3	Medicaid Managed Care	Inpatient	18,905	-	18,351	-	-	-	-							18,351	554	97.07%
4	Medicaid Managed Care	Outpatient	567,009	-	259,176	838	39	-	-							260,053	306,956	45.86%
5	Medicare Cross-over (FFS)	Inpatient	367,371	19,754	-	-	-		-	322,786	-	14,452	6,581			363,573	3,798	98.97%
6	Medicare Cross-over (FFS)	Outpatient	993,862	57,957	-	-	-		-	724,836	-	41,657	152,631			977,081	16,781	98.31%
7	Other Medicaid Eligibles	Inpatient	202,637	277	-	-	-			172,183	-	-	-			172,460	30,177	85.11%
8	Other Medicaid Eligibles	Outpatient	347,147	7,857	-	57,149	698			195,306	-	-	-			261,010	86,137	75.19%
9	Uninsured	Inpatient	151,584	-	-	-	-	-	-	-	-	-	-	2,534	-	2,534	149,050	1.67%
10	Uninsured	Outpatient	1,008,804	-	-	-	-	-	-	-	-	-	-	104,072	-	104,072	904,732	10.32%
11	In-State Sub-total	Inpatient	860,949	117,128	18,351	-	-	-	-	494,969	-	14,452	6,581	2,534	-	654,015	206,934	75.96%
12	In-State Sub-total	Outpatient	3,298,750	330,791	259,176	58,902	737	38,775	-	920,142	-	41,657	152,631	104,072	-	1,906,883	1,391,867	57.81%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	4,159,699	447,919	277,527	58,902	737	38,775	-	1,415,111	-	56,109	159,212	106,606	-	2,560,898	1,598,801	61.56%

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
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	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
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	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **CLINCH MEMORIAL HOSPITAL**
Hospital Medicaid Number: **000000415A**
Cost Report Period: From **7/1/2020** To **6/30/2021**

As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	120,452	97,097	-	-	-	-	-	-	-	-	-			97,097	23,355	80.61%
2	Medicaid Fee for Service	Outpatient	381,928	264,977	-	915	-	38,775	-	-	-	-	-			304,667	77,261	79.77%
3	Medicaid Managed Care	Inpatient	18,905	-	18,351	-	-	-	-							18,351	554	97.07%
4	Medicaid Managed Care	Outpatient	567,009	-	259,176	838	39	-	-							260,053	306,956	45.86%
5	Medicare Cross-over (FFS)	Inpatient	367,371	19,754	-	-	-		-	322,786	-	14,452	6,581			363,573	3,798	98.97%
6	Medicare Cross-over (FFS)	Outpatient	993,862	57,957	-	-	-		-	724,836	-	41,657	152,631			977,081	16,781	98.31%
7	Other Medicaid Eligibles	Inpatient	202,637	277	-	-	-			172,183	-	-	-			172,460	30,177	85.11%
8	Other Medicaid Eligibles	Outpatient	347,147	7,857	-	57,149	698			195,306	-	-	-			261,010	86,137	75.19%
9	Uninsured	Inpatient	151,584	-	-	-	-	-	-	-	-	-	-	2,534	-	2,534	149,050	1.67%
10	Uninsured	Outpatient	1,008,804	-	-	-	-	-	-	-	-	-	-	104,072	-	104,072	904,732	10.32%
11	In-State Sub-total	Inpatient	860,949	117,128	18,351	-	-	-	-	494,969	-	14,452	6,581	2,534	-	654,015	206,934	75.96%
12	In-State Sub-total	Outpatient	3,298,750	330,791	259,176	58,902	737	38,775	-	920,142	-	41,657	152,631	104,072	-	1,906,883	1,391,867	57.81%
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	4,159,699	447,919	277,527	58,902	737	38,775	-	1,415,111	-	56,109	159,212	106,606	-	2,560,898	1,598,801	61.56%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	1,598,801

Medicaid DSH Survey Adjustments

PROVIDER: CLINCH MEMORIAL HOSPITAL
FROM: 7/1/2020 TO: 6/30/2021
Mcaid Number: 000000415A
Mcare Number: 111308

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.

Medicaid DSH Report Notes

PROVIDER: CLINCH MEMORIAL HOSPITAL Mcaid Number: 000000415A
FROM: 7/1/2020 TO: 6/30/2021 Mcare Number: 111308

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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