

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2021	06/30/2022

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

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2021	06/30/2022

4. Cost Report Year 2 (if applicable)

5. Cost Report Year 3 (if applicable)

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

	Data
6. Medicaid Provider Number:	000000415A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111308

B. DSH Qualifying Information

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

During the DSH Examination Year:

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

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

3b. What date did the hospital open?

DSH Examination
Year (07/01/21 -
06/30/22)

Yes

No

No

Yes

1/1/1956

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022

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

\$ 61,967

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022

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

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

\$ -

3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2021 - 06/30/2022

\$ 61,967

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?

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

Answer

Yes

Explanation for "No" answers:

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

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


Hospital CEO or CFO Signature

CFO
Title

10/6/23
Date

Madison Pope
Hospital CEO or CFO Printed Name

912-487-5211
Hospital CEO or CFO Telephone Number

mpope@clinchmh.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:
Name: Madison Pope
Title: CFO
Telephone Number: 912-487-5211
E-Mail Address: mpope@clinchmh.org
Mailing Street Address: 1050 Valdosta Highway
Mailing City, State, Zip: Homerville, GA 31634

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

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:

CLINCH MEMORIAL HOSPITAL

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

7/1/2021 through 6/30/2022
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:

12/7/2022

4. Hospital Name:

CLINCH MEMORIAL HOSPITAL

5. Medicaid Provider Number:

000000415A

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

0

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

0

8. Medicare Provider Number:

111308

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

Non-State Govt.

Data	Correct?	If Incorrect, Proper Information
CLINCH MEMORIAL HOSPITAL	Yes	
000000415A	Yes	
0	Yes	
0	Yes	
111308	Yes	
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:

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

13. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

State Name	Provider No.

E. Disclosure of Medicaid / Uninsured Payments Received: (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)**

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

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

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

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

\$-

\$-

Inpatient	Outpatient	Total
\$ 7,197	\$ 129,187	\$136,384
\$ 13,782	\$ 335,719	\$349,501
\$20,979	\$464,906	\$485,885
34.31%	27.79%	28.07%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

No

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)

582

(See Note in Section F-3, below)

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

2. Inpatient Hospital Subsidies
3. Outpatient Hospital Subsidies
4. Unspecified I/P and O/P Hospital Subsidies
5. Non-Hospital Subsidies
6. Total Hospital Subsidies

\$	-

7. Inpatient Hospital Charity Care Charges
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

	5,700
	156,487
\$	162,187

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$2,367,681.00			\$ 318,000	\$ -	\$ -	\$ 2,049,681
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$4,357,916.00	\$7,629,182.00		\$ 585,306	\$ 1,024,666	\$ -	\$ 10,377,126
20. Outpatient Services		\$2,142,072.00			\$ 287,699	\$ -	\$ 1,854,373
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ 275			\$ 37	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$835,426.00	\$ -	\$ -	\$ 112,205	\$ -
27. Total	\$ 6,725,597	\$ 9,771,254	\$ 835,701	\$ 903,306	\$ 1,312,365	\$ 112,242	\$ 14,281,180
28. Total Hospital and Non Hospital		Total from Above	\$ 17,332,552		Total from Above	\$ 2,327,913	

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

Unreconciled Difference (Should be \$0)

\$ -

Total Contractual Adj. (G-3 Line 2)

1,826,786

Unreconciled Difference (Should be \$0)

\$ -

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>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</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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.

Routine Cost Centers (list below):

1	03000 ADULTS & PEDIATRICS	\$ 5,372,891	\$ -	\$ -	\$ 3,428,786.00	\$ 1,944,105	1,039	\$ 2,211,368.00	\$ 1,871.13
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	\$ 5,372,891	\$ -	\$ -	\$ 3,428,786	\$ 1,944,105	1,039	\$ 2,211,368	\$ 1,871.13
19	Weighted Average								

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)		457	-	-	\$ 855,106	\$ 17,376.00	\$ 198,256.00	\$ 215,632	3.965580
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		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$ 170,905.00	\$ -	\$ -	\$ 170,905	\$ 0.00	\$ 187,344.00	\$ 187,344	0.912252
22	5400 RADIOLOGY-DIAGNOSTIC	\$ 1,507,880.00	\$ -	\$ -	\$ 1,507,880	\$ 185,385.00	\$ 2,543,101.00	\$ 2,728,486	0.552643
23	6000 LABORATORY	\$ 1,821,605.00	\$ -	\$ -	\$ 1,821,605	\$ 350,717.00	\$ 2,186,117.00	\$ 2,536,834	0.718062
24	6500 RESPIRATORY THERAPY	\$ 1,858,503.00	\$ -	\$ -	\$ 1,858,503	\$ 756,604.00	\$ 1,029,936.00	\$ 1,786,540	1.040281
25	6600 PHYSICAL THERAPY	\$ 1,110,523.00	\$ -	\$ -	\$ 1,110,523	\$ 787,035.00	\$ 512,066.00	\$ 1,299,101	0.854840
26	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 624,751.00	\$ -	\$ -	\$ 624,751	\$ 746,385.00	\$ 317,162.00	\$ 1,063,547	0.587422
27	7300 DRUGS CHARGED TO PATIENTS	\$ 1,112,903.00	\$ -	\$ -	\$ 1,112,903	\$ 1,529,380.00	\$ 812,510.00	\$ 2,341,890	0.475216
28	9100 EMERGENCY	\$ 2,450,334.00	\$ -	\$ -	\$ 2,450,334	\$ 17,580.00	\$ 1,924,356.00	\$ 1,941,936	1.261800
29		\$ 0.00	\$ -	\$ -	\$ -	\$ 0.00	\$ 0.00	\$ -	-
30		\$ 0.00	\$ -	\$ -	\$ -	\$ 0.00	\$ 0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
32		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	\$ 10,657,404	\$ -	\$ -	\$ 10,657,404	\$ 4,390,462	\$ 9,710,848	\$ 14,101,310	
127	Weighted Average								0.816414
128	Sub Totals	\$ 16,030,295	\$ -	\$ -	\$ 12,601,509	\$ 6,601,830	\$ 9,710,848	\$ 16,312,678	
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)				\$1,591,359.00				
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				\$ 11,010,150				
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)

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		% Survey to Cost Report Totals
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):			Days	Days	Days	Days	Days	Days	Days	Days	Days	Days	Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,871.13	52	1	107	55	71	215	49.14%						
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			52	1	107	55	71	215	27.53%						
Total Days per PS&R or Exhibit Detail			52	1	107	55	71								
Unreconciled Days (Explain Variance)			-	-	-	-	-								
Routine Charges			\$ 29,900	\$ 575	\$ 61,530	\$ 31,625	\$ 40,825	\$ 123,630	7.44%						
Calculated Routine Charge Per Diem			\$ 575.00	\$ 575.00	\$ 575.05	\$ 575.00	\$ 575.00	\$ 575.02							
Ancillary Cost Centers (from WIS 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		
22	09200 Observation (Non-Distinct)	3.965580	3,604	8,364	4,522	37,516	3,672	19,610	5,468	26,501	7,276	70,012	50.67%		
23	5000 OPERATING ROOM	0.912252	-	17,436	-	15,136	-	62,755	-	5,080	-	100,407	53.59%		
24	5400 RADIOLOGY-DIAGNOSTIC	0.552643	17,577	117,301	2,469	198,577	9,767	377,261	13,808	137,149	14,696	332,712	44.76%		
25	6000 LABORATORY	0.718062	30,402	125,516	808	175,214	30,229	217,740	24,007	151,169	14,274	220,890	39.03%		
26	6500 RESPIRATORY THERAPY	1.040281	26,102	69,293	-	55,285	37,680	138,914	23,517	49,332	18,302	56,447	26.58%		
27	6600 PHYSICAL THERAPY	0.854840	12,838	18,314	172	30,100	34,924	53,135	25,302	8,481	496	73,236	14.27%		
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.587422	19,627	38,408	1,953	22,777	31,332	59,178	22,533	22,139	14,555	35,378	25.19%		
29	7300 DRUGS CHARGED TO PATIENTS	0.475216	41,579	51,351	400	42,618	63,450	82,156	49,002	48,049	32,015	90,603	21.40%		
30	9100 EMERGENCY	1.261800	6,595	135,524	-	347,511	3,231	241,557	7,934	107,616	5,381	349,990	62.07%		
31		-	-												
32		-	-												
33		-	-												
34		-	-												
35		-	-												
36		-	-												
37		-	-												
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57		-	-												
58		-	-												
59		-	-												
60		-	-												

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

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

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	%
61				-											\$ -	-
62				-											\$ -	-
63				-											\$ -	-
64				-											\$ -	-
65				-											\$ -	-
66				-											\$ -	-
67				-											\$ -	-
68				-											\$ -	-
69				-											\$ -	-
70				-											\$ -	-
71				-											\$ -	-
72				-											\$ -	-
73				-											\$ -	-
74				-											\$ -	-
75				-											\$ -	-
76				-											\$ -	-
77				-											\$ -	-
78				-											\$ -	-
79				-											\$ -	-
80				-											\$ -	-
81				-											\$ -	-
82				-											\$ -	-
83				-											\$ -	-
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91				-											\$ -	-
92				-											\$ -	-
93				-											\$ -	-
94				-											\$ -	-
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123				-											\$ -	-
124				-											\$ -	-
125				-											\$ -	-
126				-											\$ -	-
127				-											\$ -	-
					\$ 158,324	\$ 581,507	\$ 5,802	\$ 891,739	\$ 210,614	\$ 1,270,211	\$ 169,776	\$ 548,625	\$ 105,186	\$ 1,114,202		

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

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

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%	
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)													32.00%
	\$ 188,224	\$ 581,507	\$ 6,377	\$ 891,739	\$ 272,144	\$ 1,270,211	\$ 201,401	\$ 548,625	\$ 146,011 (Agrees to Exhibit A)	\$ 1,114,202 (Agrees to Exhibit A)	\$ 668,146	\$ 3,292,082		
129	Total Charges per PS&R or Exhibit Detail													
130	\$ 188,224	\$ 581,507	\$ 6,377	\$ 891,739	\$ 272,144	\$ 1,270,211	\$ 201,401	\$ 548,625	\$ 146,011	\$ 1,114,202				
	-	-	-	-	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section J)													45.55%
	\$ 220,873	\$ 509,736	\$ 5,300	\$ 822,661	\$ 349,002	\$ 1,139,395	\$ 234,971	\$ 496,940	\$ 222,922	\$ 1,013,188	\$ 810,146	\$ 2,968,732		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)													
	\$ 99,395	\$ 327,776			\$ 9,429	\$ 51,027		\$ 3,187			\$ 108,824	\$ 381,990		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)													
			\$ 5,179	\$ 396,340				\$ 23,757			\$ 5,179	\$ 420,097		
134	Private Insurance (including primary and third party liability)													
				\$ 4,327				\$ 65,932			\$ -	\$ 70,259		
135	Self-Pay (including Co-Pay and Spend-Down)													
							\$ 3	\$ 1,703			\$ 3	\$ 1,703		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)													
	\$ 99,395	\$ 327,776	\$ 5,179	\$ 400,667										
137	Medicaid Cost Settlement Payments (See Note B)													
	\$ 112,159										\$ -	\$ 112,159		
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													
											\$ -	\$ -		
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)													
					\$ 216,120	\$ 829,560	\$ 95,844	\$ 58,785			\$ 311,964	\$ 888,345		
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													
							\$ 67,778	\$ 264,203			\$ 67,778	\$ 264,203		
141	Medicare Cross-Over Bad Debt Payments													
					\$ 11,309	\$ 48,591					\$ 11,309	\$ 48,591		
142	Other Medicare Cross-Over Payments (See Note D)													
					\$ 111,706	\$ 192,332					\$ 111,706	\$ 192,332		
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													
									\$ 7,197 (Agrees to Exhibit B and B-1)	\$ 129,187 (Agrees to Exhibit B and B-1)				
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)													
									\$ -	\$ -				
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)													
146	\$ 121,478	\$ 69,801	\$ 121	\$ 421,994	\$ 438	\$ 17,885	\$ 71,346	\$ 79,373	\$ 215,725	\$ 884,001	\$ 193,383	\$ 589,053		
	45%	86%	98%	49%	100%	98%	70%	84%	3%	13%	76%	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)													
148	Percent of cross-over days to total Medicare days from the cost report													
					345	31%								

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.

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 (07/01/2021-06/30/2022) 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		(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		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ -	

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	3,960,228
19 Uninsured Hospital Charges Sec. G	1,260,213
20 Total Hospital Charges Sec. G	16,312,678
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.28%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.73%
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.