

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2019	06/30/2020

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2019	06/30/2020
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:	000000701A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110109

B. DSH OB 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:

- | | | | | | |
|---|---|--|-----|----|----|
| <p>1. 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.)</p> <p>2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?</p> <p>3. 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?</p> | <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 5px;">DSH Examination Year (07/01/19 - 06/30/20)</td> </tr> <tr> <td style="padding: 5px;">Yes</td> </tr> <tr> <td style="padding: 5px;">No</td> </tr> <tr> <td style="padding: 5px;">No</td> </tr> </table> | DSH Examination Year (07/01/19 - 06/30/20) | Yes | No | No |
| DSH Examination Year (07/01/19 - 06/30/20) | | | | | |
| Yes | | | | | |
| No | | | | | |
| No | | | | | |
| <p>3a. Was the hospital open as of December 22, 1987?</p> | <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 5px;">Yes</td> </tr> </table> | Yes | | | |
| Yes | | | | | |
| <p>3b. What date did the hospital open?</p> | <table border="1" style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding: 5px;">7/1/1952</td> </tr> </table> | 7/1/1952 | | | |
| 7/1/1952 | | | | | |

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020 \$ 558,185
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020
(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 07/01/2019 - 06/30/2020 \$ 558,185

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

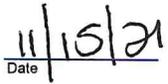
Explanation for "No" answers:

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
 Jessica Johnson
 Hospital CEO or CFO Printed Name

CFO
 Title
 478-289-1376
 Hospital CEO or CFO Telephone Number


 Date
 jsjohnson@erhospital.com
 Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Jessica Johnson
Title	CFO
Telephone Number	478-289-1376
E-Mail Address	jsjohnson@erhospital.com
Mailing Street Address	117 Kite Road
Mailing City, State, Zip	Swainsboro, GA 30401

Outside Preparer:

Name	Charles Horne
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	chorne@draffin-tucker.com

D. General Cost Report Year Information

7/1/2019 - 6/30/2020

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:

EMANUEL MEDICAL CENTER

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

7/1/2019 through 6/30/2020		
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:

12/3/2020

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
EMANUEL MEDICAL CENTER	Yes	
000000701A	Yes	
0	Yes	
0	Yes	
110109	Yes	

5. Medicaid Provider Number:

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

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

8. Medicare Provider Number:

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: (07/01/2019 - 06/30/2020)

- 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)**

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8. Out-of-State DSH Payments (See Note 2)

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- 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
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$ 95,569	\$ 303,233	\$398,802
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 678,095	\$ 1,776,180	\$2,454,275
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)	\$773,664	\$2,079,413	\$2,853,077
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	12.35%	14.58%	13.98%

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.

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- 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

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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 (07/01/2019 - 06/30/2020)

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) 5,798 (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	544,394
8. Outpatient Hospital Charity Care Charges	1,873,261
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 2,417,655

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	\$7,420,641.00			\$ 5,632,579	\$ -	\$ -	\$ 1,788,062
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$203,634.00			\$ 154,567	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$3,603,606.00			\$ 2,735,289	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$13,646,743.00	\$57,412,344.00		\$ 10,358,453	\$ 43,578,386	\$ -	\$ 17,122,248
20. Outpatient Services		\$19,630,821.00			\$ 14,900,620	\$ -	\$ 4,730,201
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ 1,106,498			\$ 839,879	
23. Outpatient Rehab Providers			\$0.00			\$ -	
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$10,489,341.00	\$ -	\$ -	\$ 7,961,851	\$ -
27. Total	\$ 21,067,384	\$ 77,043,165	\$ 15,403,079	\$ 15,991,031	\$ 58,479,006	\$ 11,691,585	\$ 23,640,511
28. Total Hospital and Non Hospital		Total from Above	\$ 113,513,628	Total from Above	\$ 86,161,623		
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	113,513,628	Total Contractual Adj. (G-3 Line 2)	85,761,781		
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)						399,842	
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						86,161,623	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -		

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

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. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)	Calculated Per Diem

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	\$ 4,064,513	\$ -	\$ -	\$98,324.00	\$ 3,966,189	6,063	\$6,136,213.00	\$ 654.16
2	03100	INTENSIVE CARE UNIT	\$ 1,505,887	\$ -	\$ -		\$ 1,505,887	722	\$1,092,082.00	\$ 2,085.72
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	\$ 5,570,400	\$ -	\$ -	\$ 98,324	\$ 5,472,076	6,785	\$ 7,228,295	
19		Weighted Average								\$ 806.49

Observation Data (Non-Distinct)

20	09200	Observation (Non-Distinct)		987	-	-	\$ 645,656	\$305,610.00	\$2,348,776.00	\$ 2,654,386	0.243241
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	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
		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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio

Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5000	OPERATING ROOM	\$817,863.00	\$ -	\$0.00		\$ 817,863	\$373,473.00	\$2,977,120.00	\$ 3,350,593	0.244095
22	5300	ANESTHESIOLOGY	\$7,078.00	\$ -	\$0.00		\$ 7,078	\$109,829.00	\$679,980.00	\$ 789,809	0.008962
23	5400	RADIOLOGY-DIAGNOSTIC	\$1,467,368.00	\$ -	\$0.00		\$ 1,467,368	\$2,284,863.00	\$20,096,890.00	\$ 22,381,753	0.065561
24	6000	LABORATORY	\$1,717,736.00	\$ -	\$0.00		\$ 1,717,736	\$3,067,700.00	\$15,789,106.00	\$ 18,856,806	0.091094
25	6500	RESPIRATORY THERAPY	\$695,951.00	\$ -	\$0.00		\$ 695,951	\$1,794,538.00	\$2,702,543.00	\$ 4,497,081	0.154756
26	6600	PHYSICAL THERAPY	\$304,296.00	\$ -	\$0.00		\$ 304,296	\$346,497.00	\$408,984.00	\$ 755,481	0.402784
27	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$1,221,869.00	\$ -	\$0.00		\$ 1,221,869	\$587,373.00	\$2,238,654.00	\$ 2,826,027	0.432363
28	7300	DRUGS CHARGED TO PATIENTS	\$1,495,678.00	\$ -	\$0.00		\$ 1,495,678	\$5,082,470.00	\$11,482,469.00	\$ 16,564,939	0.090292
29	7600	WOUND CARE	\$227,356.00	\$ -	\$0.00		\$ 227,356	\$0.00	\$534,373.00	\$ 534,373	0.425463

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

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	9100 EMERGENCY	\$2,925,813.00	\$ -	\$0.00	\$ 2,925,813	\$1,216,568.00	\$15,736,611.00	\$ 16,953,179	0.172582
31		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
32		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

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	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 10,881,008	\$ -	\$ -	\$ 10,881,008	\$ 15,168,921	\$ 74,995,506	\$ 90,164,427	
127	Weighted Average								0.127841
128	Sub Totals	\$ 16,451,408	\$ -	\$ -	\$ 16,353,084	\$ 22,397,216	\$ 74,995,506	\$ 97,392,722	
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)				\$98,219.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 16,254,865				
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 (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

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-Over (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 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	\$ 654.16		705	136	757	342	410	1,940							46.30%
2	03100 INTENSIVE CARE UNIT	\$ 2,085.72		108	22	135	79	228	344							78.12%
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	813	158	892	421	630	2,284							42.95%
19	Total Days per PS&R or Exhibit Detail			813	158	892	421	630								
20	Unreconciled Days (Explain Variance)			-	-	-	-	-								
21	Routine Charges			\$ 1,037,418	\$ 116,611	\$ 870,143	\$ 536,349	\$ 719,577	\$ 2,660,676							45.38%
21.01	Calculated Routine Charge Per Diem			\$ 1,276.04	\$ 738.36	\$ 975.50	\$ 1,273.99	\$ 1,142.19	\$ 1,121.09							
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)	0.243241		3,815	117,456	39,741	355,812	98,595	440,652	8,284	38,041	320,139	13,952	150,435	951,961	54.12%
23	5000 OPERATING ROOM	0.244095		23,540	120,282	18,927	359,224	36,528	340,675	26,228	54,919	104,387	182,729	105,223	875,100	37.83%
24	5300 ANESTHESIOLOGY	0.008952		8,232	32,790	5,988	104,578	10,572	67,365	10,384	33,337	32,384	35,176	221,607	40.83%	
25	5400 RADIOLOGY-DIAGNOSTIC	0.065561		200,934	1,009,125	72,248	2,108,343	426,112	2,291,524	170,811	473,201	764,206	2,665,494	870,105	5,682,193	45.49%
26	6000 LABORATORY	0.091094		408,481	1,093,182	121,736	1,975,401	547,037	1,155,932	264,243	861,674	1,040,652	2,094,919	1,341,496	5,086,188	50.72%
27	6500 RESPIRATORY THERAPY	0.154756		187,629	86,859	102,850	250,179	368,195	380,867	167,638	28,790	301,436	220,111	826,312	746,694	46.58%
28	6600 PHYSICAL THERAPY	0.402784		21,415	-	347	529	47,456	71,365	16,784	5,544	12,274	281	86,002	77,438	23.30%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.432363		58,701	133,948	29,757	278,151	120,075	346,345	36,495	26,894	149,397	216,506	245,028	785,337	49.41%
30	7300 DRUGS CHARGED TO PATIENTS	0.050292		780,619	719,609	294,046	1,178,386	1,010,325	1,213,389	444,342	173,462	1,384,614	1,632,508	2,529,533	3,284,846	53.31%
31	7600 WOUND CARE	0.425463		-	55,056	-	-	-	-	-	-	-	-	55,056	10,30%	
32	9100 EMERGENCY	0.172582		172,003	1,034,245	49,880	3,269,117	236,620	1,885,795	110,038	312,250	924,979	3,260,070	568,521	6,301,407	65.21%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

			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													\$ -	\$ -
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127													\$ -	\$ -
			\$ 1,865,569	\$ 4,402,552	\$ 735,500	\$ 9,879,719	\$ 2,901,516	\$ 7,993,908	\$ 1,255,246	\$ 1,991,649	\$ 5,035,420	\$ 10,318,954		

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

Cost Report Year (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

	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)	\$ 2,902,987	\$ 4,402,552	\$ 852,161	\$ 9,879,719	\$ 3,771,664	\$ 7,993,908	\$ 1,791,595	\$ 1,991,649	\$ 5,754,997	\$ 10,318,954	\$ 9,318,407	\$ 24,267,827	50.99%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 2,902,987	\$ 4,402,552	\$ 852,161	\$ 9,879,719	\$ 3,771,664	\$ 7,993,908	\$ 1,791,595	\$ 1,991,649	\$ 5,754,997	\$ 10,318,954			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 906,801	\$ 562,213	\$ 229,095	\$ 1,323,124	\$ 1,147,604	\$ 1,084,408	\$ 539,868	\$ 220,194	\$ 1,376,454	\$ 1,251,692	\$ 2,823,368	\$ 3,189,939	53.16%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 810,662	\$ 402,696	\$ -	\$ 300	\$ 22,024	\$ 53,176		\$ 908			\$ 832,686	\$ 457,080	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 272,437	\$ 868,839				\$ 5,700			\$ 272,437	\$ 874,539	
134 Private Insurance (including primary and third party liability)	\$ 4,846	\$ 135	\$ 4,463	\$ 15,080			\$ 4,800	\$ 147,719			\$ 14,109	\$ 162,934	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 200	\$ 1,296				\$ 869		\$ 217			\$ 200	\$ 2,382	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 815,708	\$ 404,127	\$ 276,900	\$ 884,219									
137 Medicaid Cost Settlement Payments (See Note B)		\$ 67,312											
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)													
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,350,451	\$ 794,581	\$ 346,340	\$ 28,073			\$ 1,696,791	\$ 822,654	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 220,205	\$ 89,897			\$ 220,205	\$ 89,897	
141 Medicare Cross-Over Bad Debt Payments					\$ 19,094	\$ 69,826					\$ 19,094	\$ 69,826	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 193,310	\$ 113	\$ 63,676	\$ 1			\$ 256,986	\$ 114	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1)	(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)									\$ 95,569	\$ 303,233			
									-	-			
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 91,093	\$ 90,774	\$ (47,805)	\$ 438,905	\$ (437,275)	\$ 165,843	\$ (95,153)	\$ (52,321)	\$ 1,280,885	\$ 948,459	\$ (489,140)	\$ 643,201	
146 Calculated Payments as a Percentage of Cost	90%	84%	121%	67%	138%	85%	118%	124%	7%	24%	117%	80%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					3,581								
148 Percent of cross-over days to total Medicare days from the cost report					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 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 (07/01/2019-06/30/2020) EMANUEL MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 240,521	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Expense	50143000.00 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	\$ 240,521	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ 240,521	

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	33,586,235
19 Uninsured Hospital Charges Sec. G	16,073,951
20 Total Hospital Charges Sec. G	97,392,722
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	34.49%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	16.50%
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.