State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2018

DSH Version 5.25 4/17/2019

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2017	06/30/2018

2. Select Your Facility from the Drop-Down Menu Provided: JOHN D. ARCHBOLD MEMORIAL HOSPITAL

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	10/01/2017	09/30/2018
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:	000000063A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110038

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:

	DSH Examination Year (07/01/17 - 06/30/18)
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.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
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?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/30/1925

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/19 - 06/30/20)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Geri E. Justice, M.D.
Barbara McCollum, M.D.

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is 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?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2017 - 06/30/2018**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 1,392,873

Certification:

	Answer
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.**	**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.

	Senior Vice President and CFO	11/14/2019
Hospital CEO or CFO Signature	Title	Date
Greg Hembree	(229) 228-2880	gshembree@archbold.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Patricia L. Barrett	Name	
Title	Director of Reimbursement/AMC	Title:	
Telephone Number	(229) 228-8857	Firm Name:	
E-Mail Address	pbarrett@archbold.org	Telephone Number	
Mailing Street Address	920 Cairo Rd Thomasville, GA 31792-4255	E-Mail Address	

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D. General Cost Report Year Information 10/1/2017 - 9/30/2018

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: JOHN D. ARCHBOLD MEMORIAL HOSPITAL

	10/1/2017 through 9/30/2018		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 3/13/2019

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	JOHN D. ARCHBOLD MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000063A	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:	110038	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Non-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	Florida	0102041
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: (10/01/2017 - 09/30/2018)

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)	$ 293,258	$ 1,182,216	$1,475,474
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,442,503	$ 6,057,710	$7,500,213
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)	$1,735,761	$7,239,926	$8,975,687
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	16.90%	16.33%	16.44%

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 (10/01/2017 - 09/30/2018)

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)	60,398	**(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	12,744,228
8.	Outpatient Hospital Charity Care Charges	11,891,347
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 24,635,575

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$61,712,166.00			$ 40,555,986	$ -	$ -	$ 21,156,180
12.	Subprovider I (Psych or Rehab)	$5,043,681.00			$ 3,314,605	$ -	$ -	$ 1,729,076
13.	Subprovider II (Psych or Rehab)	$6,368,037.00			$ 4,184,945	$ -	$ -	$ 2,183,092
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$4,428,675.00			$ 2,910,436	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$287,019,855.00	$367,416,088.00		$ 188,623,639	$ 241,458,416	$ -	$ 224,353,888
20.	Outpatient Services		$45,408,945.00			$ 29,841,840	$ -	$ 15,567,105
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 360,143,739	$ 412,825,033	$ 4,428,675	$ 236,679,176	$ 271,300,256	$ 2,910,436	$ 264,989,341
28.	Total Hospital and Non Hospital		Total from Above	$ 777,397,447		Total from Above	$ 510,889,867	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	777,397,447	Total Contractual Adj. (G-3 Line 2)	510,889,867
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.	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				510,889,867

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)**	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 34,376,115	$ -	$ -	$0.00	$ 34,376,115	45,712	$37,099,753.00		$ 752.02
2	03100 INTENSIVE CARE UNIT	$ 12,239,589	$ -	$ -		$ 12,239,589	9,483	$15,925,901.00		$ 1,290.69
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	$ 2,623,277	$ -	$ 9,255		$ 2,632,532	1,984	$4,779,236.00		$ 1,326.88
8	04100 SUBPROVIDER II	$ 3,709,343	$ -	$ -		$ 3,709,343	3,425	$3,458,976.00		$ 1,083.02
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 456,648	$ -	$ -		$ 456,648	1,338	$880,429.00		$ 341.29
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 53,404,972	$ -	$ 9,255	$ -	$ 53,414,227	61,942	$ 62,144,295		
19	Weighted Average									$ 862.33

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)	1,544	-	-	$ 1,161,119	$115,924.00	$2,447,460.00	$ 2,563,384	0.452963

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	$18,598,197.00	$ -	$0.00		$ 18,598,197	$34,013,459.00	$50,392,264.00	$ 84,405,723	0.220343
22	5100 RECOVERY ROOM	$3,365,758.00	$ -	$0.00		$ 3,365,758	$2,927,731.00	$5,475,644.00	$ 8,403,375	0.400525
23	5200 DELIVERY ROOM & LABOR ROOM	$2,806,531.00	$ -	$0.00		$ 2,806,531	$2,605,837.00	$667,482.00	$ 3,273,319	0.857396
24	5300 ANESTHESIOLOGY	$863,995.00	$ -	$14,389.00		$ 878,384	$2,312,884.00	$3,620,649.00	$ 5,933,533	0.148037
25	5400 RADIOLOGY-DIAGNOSTIC	$5,416,560.00	$ -	$0.00		$ 5,416,560	$6,857,935.00	$17,801,125.00	$ 24,659,060	0.219658
26	5500 RADIOLOGY-THERAPEUTIC	$2,890,921.00	$ -	$0.00		$ 2,890,921	$1,390,564.00	$21,408,514.00	$ 22,799,078	0.126800
27	5600 RADIOISOTOPE	$1,317,220.00	$ -	$0.00		$ 1,317,220	$1,197,526.00	$9,634,061.00	$ 10,831,587	0.121609
28	5700 CT SCAN	$1,060,189.00	$ -	$0.00		$ 1,060,189	$15,132,090.00	$31,417,341.00	$ 46,549,431	0.022776
29	5800 MRI	$895,548.00	$ -	$0.00		$ 895,548	$3,553,180.00	$9,057,193.00	$ 12,610,373	0.071017
30	5900 CARDIAC CATHETERIZATION	$2,354,945.00	$ -	$0.00		$ 2,354,945	$5,776,791.00	$6,735,165.00	$ 12,511,956	0.188216

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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	6000	LABORATORY	$10,876,334.00	$ -	$0.00		$ 10,876,334	$51,576,948.00	$34,930,814.00	$ 86,507,762	0.125727
32	6300	BLOOD STORING PROCESSING & TRANS.	$2,116,511.00	$ -	$0.00		$ 2,116,511	$4,349,577.00	$933,919.00	$ 5,283,496	0.400589
33	6400	INTRAVENOUS THERAPY	$1,296,872.00	$ -	$0.00		$ 1,296,872	$1,856,698.00	$940,054.00	$ 2,796,752	0.463706
34	6500	RESPIRATORY THERAPY	$3,359,649.00	$ -	$4,858.00		$ 3,364,507	$12,284,443.00	$1,975,358.00	$ 14,259,801	0.235943
35	6600	PHYSICAL THERAPY	$4,067,942.00	$ -	$0.00		$ 4,067,942	$8,676,792.00	$2,915,766.00	$ 11,592,558	0.350910
36	6900	ELECTROCARDIOLOGY	$191,803.00	$ -	$0.00		$ 191,803	$939,969.00	$1,583,513.00	$ 2,523,482	0.076007
37	7000	ELECTROENCEPHALOGRAPHY	$767,161.00	$ -	$0.00		$ 767,161	$172,665.00	$1,857,001.00	$ 2,029,666	0.377974
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$16,815,881.00	$ -	$0.00		$ 16,815,881	$29,345,125.00	$21,735,470.00	$ 51,080,595	0.329203
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$14,285,771.00	$ -	$0.00		$ 14,285,771	$28,549,060.00	$19,069,686.00	$ 47,618,746	0.300003
40	7300	DRUGS CHARGED TO PATIENTS	$30,285,632.00	$ -	$0.00		$ 30,285,632	$57,942,142.00	$85,351,749.00	$ 143,293,891	0.211353
41	7400	RENAL DIALYSIS	$4,300,359.00	$ -	$0.00		$ 4,300,359	$3,252,354.00	$5,279,722.00	$ 8,532,076	0.504023
42	7600	CARDIOLOGY	$3,352,219.00	$ -	$0.00		$ 3,352,219	$12,503,101.00	$18,452,574.00	$ 30,955,675	0.108291
43	7601	ONCOLOGY	$6,405,601.00	$ -	$26,273.00		$ 6,431,874	$106,152.00	$7,441,860.00	$ 7,548,012	0.852128
44	7602	OP PSYCHIATRIC	$132.00	$ -	$0.00		$ 132	$0.00	$1,245.00	$ 1,245	0.106024
45	7603	CARDIAC REHABILITATION	$503,541.00	$ -	$0.00		$ 503,541	$9,156.00	$711,795.00	$ 720,951	0.698440
46	9001	WOUND CARE	$1,274,269.00	$ -	$0.00		$ 1,274,269	$35,837.00	$999,979.00	$ 1,035,816	1.230208
47	9100	EMERGENCY	$12,844,994.00	$ -	$1,737,755.00		$ 14,582,749	$9,540,602.00	$25,882,202.00	$ 35,422,804	0.411677
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	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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	$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**	$ 152,314,535	$ -	$ 1,783,275		$ 154,097,810	$ 297,024,542	$ 388,719,605	$ 685,744,147	
127		**Weighted Average**									0.226409
128		**Sub Totals**	$ 205,719,507	$ -	$ 1,792,530		$ 207,512,037	$ 359,168,837	$ 388,719,605	$ 747,888,442	
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)*					$54,137.00				
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**					$ 207,457,900				
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 (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 752.02		6,246		1,553		6,203		2,594		2,805		16,596		44.12%
2	03100 INTENSIVE CARE UNIT	$ 1,290.69		983		112		1,224		415		826		2,734		37.72%
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	$ 1,326.88												-		0.00%
8	04100 SUBPROVIDER II	$ 1,083.02												-		0.00%
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 341.29		65		833				38		29		936		72.12%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	7,294		2,498		7,427		3,047		3,661		20,266		38.79%
19	Total Days per PS&R or Exhibit Detail			7,294		2,498		7,427		3,047		3,661				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 5,826,581		$ 1,980,118		$ 8,505,754		$ 3,108,353		$ 3,768,758		$ 19,420,806		37.46%
21.01	Calculated Routine Charge Per Diem			$ 798.82		$ 792.68		$ 1,145.25		$ 1,020.14		$ 1,029.43		$ 958.29		
	Ancillary Cost Centers (from WS 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)		0.452963	55,573	470,659	-	143,340	3,316	516,575	5,040	83,317	-	4,145	$ 63,929	$ 1,213,891	50.13%
23	5000 OPERATING ROOM		0.220343	2,338,841	2,020,014	1,574,101	2,692,944	5,000,582	6,326,730	890,853	867,743	1,750,117	2,301,870	$ 9,804,377	$ 11,907,431	30.64%
24	5100 RECOVERY ROOM		0.400525	184,010	269,864	155,396	491,701	407,614	640,721	86,285	78,545	167,619	269,772	$ 833,305	$ 1,480,831	32.85%
25	5200 DELIVERY ROOM & LABOR ROOM		0.857396	93,469	32,490	1,414,730	422,942	12,099	3,497	103,235	27,922	43,750	7,697	$ 1,623,533	$ 486,851	66.37%
26	5300 ANESTHESIOLOGY		0.148037	148,288	160,993	92,731	209,047	310,433	370,376	59,655	70,579	133,699	171,869	$ 611,107	$ 810,595	29.18%
27	5400 RADIOLOGY-DIAGNOSTIC		0.219658	548,419	925,732	137,035	1,126,048	1,088,287	2,375,274	319,066	392,280	326,538	1,529,021	$ 2,092,807	$ 4,819,334	35.68%
28	5500 RADIOLOGY-THERAPEUTIC		0.126800	363,200	1,550,904	34,928	675,999	32,794	3,393,788	34,237	254,447	66,572	979,994	$ 465,159	$ 5,875,138	32.40%
29	5600 RADIOISOTOPE		0.121609	83,777	308,038	13,429	125,046	168,767	1,294,638	22,260	76,464	115,700	498,586	$ 288,233	$ 1,804,186	25.01%
30	5700 CT SCAN		0.022776	1,363,122	1,482,874	277,671	1,527,156	2,360,067	3,940,090	543,707	475,510	572,840	4,894,281	$ 4,544,567	$ 7,425,630	37.64%
31	5800 MRI		0.071017	257,393	454,772	79,980	367,630	577,241	1,073,112	79,459	181,818	239,146	509,314	$ 994,073	$ 2,077,332	30.34%
32	5900 CARDIAC CATHETERIZATION		0.188216	-	-	9,574	100,431	814,165	850,972	152,739	119,579	449,131	455,471	$ 976,478	$ 1,070,982	23.67%
33	6000 LABORATORY		0.125727	5,054,531	2,257,967	1,255,973	2,873,394	8,103,621	3,833,977	2,455,504	1,127,805	3,526,772	3,829,744	$ 16,869,629	$ 10,093,143	39.84%
34	6300 BLOOD STORING, PROCESSING & TRANS.		0.400589	333,424	40,158	49,292	8,458	596,349	208,278	227,795	54,378	266,524	60,612	$ 1,206,860	$ 311,272	35.04%
35	6400 INTRAVENOUS THERAPY		0.463706	193,540	139,463	33,601	312	409,664	446,311	143,975	4,659	162,288	7,861	$ 780,780	$ 590,745	55.19%
36	6500 RESPIRATORY THERAPY		0.235943	1,108,561	114,922	102,478	125,480	2,184,354	301,187	635,021	40,840	568,464	318,380	$ 4,030,414	$ 582,429	38.78%
37	6600 PHYSICAL THERAPY		0.350910	499,078	70,380	52,917	211,552	783,550	316,874	402,352	198,517	303,022	187,757	$ 1,737,897	$ 797,323	26.22%
38	6900 ELECTROCARDIOLOGY		0.076007	81,282	87,816	10,614	78,199	168,442	201,751	39,837	35,665	24,116	187,513	$ 300,175	$ 403,431	36.38%
39	7000 ELECTROENCEPHALOGRAPHY		0.377974	20,175	208,704	3,213	137,721	34,884	223,417	5,508	48,846	7,375	43,086	$ 63,780	$ 618,688	36.11%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.329203	2,057,321	1,191,803	825,794	1,163,416	4,430,339	3,188,531	1,085,984	400,757	1,465,441	1,640,430	$ 8,400,038	$ 5,944,507	34.35%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.300003	1,670,934	935,675	497,319	381,174	4,063,373	2,554,200	602,295	390,366	982,711	860,548	$ 6,833,921	$ 4,261,415	27.20%
42	7300 DRUGS CHARGED TO PATIENTS		0.211353	5,495,576	4,722,636	1,180,002	2,586,459	8,382,065	12,607,327	2,428,174	964,139	3,732,646	2,949,023	$ 17,485,817	$ 20,880,561	31.50%
43	7400 RENAL DIALYSIS		0.504023	220,330	-	118,548	465,214	523,978	168,338	104,946	145,817	33,124	78,429	$ 967,802	$ 779,369	21.82%
44	7600 CARDIOLOGY		0.108291	851,888	842,496	234,017	452,028	2,088,113	2,157,444	363,855	353,076	980,484	1,247,662	$ 3,537,873	$ 3,805,044	31.07%
45	7601 ONCOLOGY		0.852128	-	242,292	137	316,019	3,302	815,695	3,363	44,495	-	496,362	$ 6,802	$ 1,418,501	25.46%
46	7602 OP PSYCHIATRIC		0.106024	-	-		-		747	249	-	-	-	$ 249	$ 747	80.00%
47	7603 CARDIAC REHABILITATION		0.698440	-	-		5,014	1,090	60,822	218	23,108	872	26,730	$ 1,308	$ 88,944	16.35%
48	9001 WOUND CARE		1.230208	-	62,188	1,116	69,621	8,306	103,675	5,238	256,192	127	83,680	$ 14,660	$ 491,676	57.10%
49	9100 EMERGENCY		0.411677	1,167,461	1,886,629	218,208	3,060,807	1,832,746	2,883,971	515,444	461,104	3,767	5,917,270	$ 3,733,859	$ 8,292,511	50.99%
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
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81			-											$ -	$ -	
82			-											$ -	$ -	

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

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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		%
83	-											$ -	$ -	
84	-											$ -	$ -	
85	-											$ -	$ -	
86	-											$ -	$ -	
87	-											$ -	$ -	
88	-											$ -	$ -	
89	-											$ -	$ -	
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122	-											$ -	$ -	
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124	-											$ -	$ -	
125	-											$ -	$ -	
126	-											$ -	$ -	
127	-											$ -	$ -	
	Totals / Payments	$ 24,190,793	$ 20,479,069	$ 8,372,804	$ 19,817,152	$ 44,389,541	$ 50,858,318	$ 11,316,294	$ 7,177,968	$ 15,922,845	$ 29,557,107			
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 30,017,374	$ 20,479,069	$ 10,352,922	$ 19,817,152	$ 52,895,295	$ 50,858,318	$ 14,424,647	$ 7,177,968	$ 19,691,603 (Agrees to Exhibit A)	$ 29,557,107 (Agrees to Exhibit A)	$ 107,690,238	$ 98,332,507	34.26%
129	Total Charges per PS&R or Exhibit Detail	$ 30,017,374	$ 20,479,069	$ 10,352,922	$ 19,817,152	$ 52,895,295	$ 50,858,318	$ 14,424,647	$ 7,177,968	$ 19,691,603	$ 29,557,107			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 11,263,874	$ 4,645,628	$ 4,367,369	$ 5,149,453	$ 16,050,855	$ 11,284,049	$ 5,081,982	$ 1,858,573	$ 6,466,892	$ 6,660,977	$ 36,764,080	$ 22,937,703	35.24%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,414,810	$ 4,187,665	$ -	$ -	$ 1,381,597	$ 879,922	$ 77,781	$ 19,045			$ 11,874,188	$ 5,086,632	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 3,584,482	$ 4,985,250	$ -	$ -	$ -	$ -			$ 3,584,482	$ 4,985,250	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,194,928	$ 1,495,688			$ 3,194,928	$ 1,495,688	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ 7,933	$ 11,512	$ 5,582	$ 6,665			$ 13,515	$ 18,177	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 10,414,810	$ 4,187,665	$ 3,584,482	$ 4,985,250									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 275,062	$ -	$ -							$ -	$ 275,062	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 13,308,795	$ 9,008,466	$ -	$ -			$ 13,308,795	$ 9,008,466	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 127,426	$ 384,277	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 127,426	$ 384,277	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 293,258	$ 1,182,216			
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)**	$ 849,064	$ 182,901	$ 782,887	$ 164,203	$ 1,225,104	$ 999,872	$ 1,803,691	$ 337,175	$ 6,173,634	$ 5,478,761	$ 4,660,746	$ 1,684,151	
146	**Calculated Payments as a Percentage of Cost**	92%	96%	82%	97%	92%	91%	65%	82%	5%	18%	87%	93%	
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)**					36,517								
148	**Percent of cross-over days to total Medicare days from the cost report**					20%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with 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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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	$ 752.02								83		83	
2	03100 INTENSIVE CARE UNIT	$ 1,290.69								17		17	
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	$ 1,326.88										-	
8	04100 SUBPROVIDER II	$ 1,083.02										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 341.29										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		100		100	
19	Total Days per PS&R or Exhibit Detail			-		-		-		100			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 103,660		$ 103,660	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 1,036.60		$ 1,036.60	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.452963							-	3,150	$ -	$ 3,150
23	5000 OPERATING ROOM		0.220343							80,882	14,101	$ 80,882	$ 14,101
24	5100 RECOVERY ROOM		0.400525							5,181	3,773	$ 5,181	$ 3,773
25	5200 DELIVERY ROOM & LABOR ROOM		0.857396							9,858	754	$ 9,858	$ 754
26	5300 ANESTHESIOLOGY		0.148037							3,270	913	$ 3,270	$ 913
27	5400 RADIOLOGY-DIAGNOSTIC		0.219658							15,183	14,464	$ 15,183	$ 14,464
28	5500 RADIOLOGY-THERAPEUTIC		0.126800							-	-	$ -	$ -
29	5600 RADIOISOTOPE		0.121609							2,798	-	$ 2,798	$ -
30	5700 CT SCAN		0.022776							33,297	49,942	$ 33,297	$ 49,942
31	5800 MRI		0.071017							5,987	-	$ 5,987	$ -
32	5900 CARDIAC CATHETERIZATION		0.188216							-	9,574	$ -	$ 9,574
33	6000 LABORATORY		0.125727							92,129	57,453	$ 92,129	$ 57,453
34	6300 BLOOD STORING PROCESSING & TRANS.		0.400589							6,332	-	$ 6,332	$ -
35	6400 INTRAVENOUS THERAPY		0.463706							1,769	-	$ 1,769	$ -
36	6500 RESPIRATORY THERAPY		0.235943							24,134	6,110	$ 24,134	$ 6,110
37	6600 PHYSICAL THERAPY		0.350910							10,659	3,266	$ 10,659	$ 3,266
38	6900 ELECTROCARDIOLOGY		0.076007							1,391	1,498	$ 1,391	$ 1,498
39	7000 ELECTROENCEPHALOGRAPHY		0.377974							-	-	$ -	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.329203							73,419	22,942	$ 73,419	$ 22,942
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.300003							4,681	6,875	$ 4,681	$ 6,875
42	7300 DRUGS CHARGED TO PATIENTS		0.211353							73,979	15,290	$ 73,979	$ 15,290
43	7400 RENAL DIALYSIS		0.504023							2,080	711	$ 2,080	$ 711
44	7600 CARDIOLOGY		0.108291							9,820	38,580	$ 9,820	$ 38,580
45	7601 ONCOLOGY		0.852128							-	-	$ -	$ -
46	7602 OP PSYCHIATRIC		0.106024							-	-	$ -	$ -
47	7603 CARDIAC REHABILITATION		0.698440							-	-	$ -	$ -
48	9001 WOUND CARE		1.230208							-	1,259	$ -	$ 1,259
49	9100 EMERGENCY		0.411677							21,429	93,089	$ 21,429	$ 93,089

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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	
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
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87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
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104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -
112				-									$ -	$ -
113				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ 478,278	$ 343,744		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ 581,938	$ 343,744	$ 581,938	$ 343,744
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ 581,938	$ 343,744		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ 194,675	$ 80,123	$ 194,675	$ 80,123
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)									$ 19,043	$ 16,894	$ 19,043	$ 16,894
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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ 175,632	$ 63,229	$ 175,632	$ 63,229
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	10%	21%	10%	21%

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

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

Cost Report Year (10/01/2017-09/30/2018) | JOHN D. ARCHBOLD 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	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (10/01/2017-09/30/2018) | JOHN D. ARCHBOLD 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 Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

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 (10/01/2017-09/30/2018) JOHN D. ARCHBOLD 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)*		$ 3,402,909		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	18700-711478	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)			5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 3,402,909		
	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		$ 3,402,909
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	206,948,427
19	Uninsured Hospital	**Charges Sec. G**	49,248,710
20	Total Hospital	**Charges Sec. G**	747,888,442
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		27.67%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.59%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 941,620
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 224,083
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,165,703**

** 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.*