DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	10/01/2020	09/30/2021
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 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 (07/01/20 - 06/30/21)
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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** — $ 1,582,707
   (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 07/01/2020 - 06/30/2021** — $ -
   (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 Services07/01/2020 - 06/30/2021** — $ 1,582,707

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.

Hospital CEO or CFO Signature	Title	Date
	Senior Vice President and CFO	11/14/2022

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Greg Hembree	(229) 228-2880	

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

Hospital Contact:	
Name	Patricia L. Barrett
Title	Director of Reimbursement
Telephone Number	
E-Mail Address	
Mailing Street Address	920 Cairo Rd
Mailing City, State, Zip	Thomasville, GA 31792-4255

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH Version 8.10 7/5/2022

D. General Cost Report Year Information 10/1/2020 - 9/30/2021

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	John D. Archbold Memorial Hospital		
	10/1/2020 through 9/30/2021		
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):	5 - Amended		
3a. Date CMS processed the HCRIS file into the HCRIS database:	5/13/2022		

	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	FL	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: (10/01/2020 - 09/30/2021)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 116,735	$ 689,015	$805,750
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,427,058	$ 6,275,180	$7,702,238
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)	$1,543,793	$6,964,195	$8,507,988
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	7.56%	9.89%	9.47%

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 (10/01/2020 - 09/30/2021)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	52,914 (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	24,620,343
8.	Outpatient Hospital Charity Care Charges	38,777,146
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 63,397,489

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	$68,138,438.00			$ 46,061,124	$ -	$ -	$ 22,077,314
12.	Subprovider I (Psych or Rehab)	$6,809,696.00			$ 4,603,309	$ -	$ -	$ 2,206,387
13.	Subprovider II (Psych or Rehab)	$5,854,965.00			$ 3,957,917	$ -	$ -	$ 1,897,048
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$3,795,564.00			$ 2,565,776	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$277,731,174.00	$470,530,670.00		$ 187,744,400	$ 318,075,558	$ -	$ 242,441,886
20.	Outpatient Services		$50,441,946.00			$ 34,098,415	$ -	$ 16,343,531
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	$ 358,534,273	$ 520,972,616	$ 3,795,564	$ 242,366,749	$ 352,173,973	$ 2,565,776	$ 284,966,167
28.	Total Hospital and Non Hospital		Total from Above	$ 883,302,453		Total from Above	$ 597,106,498	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	883,302,453	Total Contractual Adj. (G-3 Line 2)	597,106,498
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				597,106,498
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) | 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	$ 46,427,375	$ -	$ 4,078	$0.00	$ 46,431,453	49,874	$35,802,513.00		$ 930.98
2	03100 INTENSIVE CARE UNIT	$ 14,402,554	$ -	$ -		$ 14,402,554	4,724	$17,226,880.00		$ 3,048.80
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	$ -	$ -	$ -		$ -	-	$7,621,540.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$3,486,953.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 597,962	$ -	$ -		$ 597,962	1,350	$1,030,515.00		$ 442.93
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 61,427,891	$ -	$ 4,078	$ -	$ 61,431,969	55,948	$ 65,168,401		
19	Weighted Average									$ 1,098.02

		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)	3,034	-	-	$ 2,824,593	$1,877,648.00	$5,374,409.00	$ 7,252,057	0.389489

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*		*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	$21,857,673.00	$ -	$ 7,485		$ 21,865,158	$34,297,701.00	$63,816,797.00	$ 98,114,498	0.222853
22	5100 RECOVERY ROOM	$3,966,936.00	$ -	$ -		$ 3,966,936	$2,421,002.00	$6,866,050.00	$ 9,287,052	0.427147
23	5200 DELIVERY ROOM & LABOR ROOM	$3,875,489.00	$ -	$ -		$ 3,875,489	$2,644,378.00	$641,420.00	$ 3,285,798	1.179467
24	5300 ANESTHESIOLOGY	$905,638.00	$ -	$ 12,954		$ 918,592	$2,146,854.00	$4,074,774.00	$ 6,221,628	0.147645
25	5400 RADIOLOGY-DIAGNOSTIC	$4,964,800.00	$ -	$ -		$ 4,964,800	$7,157,265.00	$20,560,685.00	$ 27,717,950	0.179119
26	5500 RADIOLOGY-THERAPEUTIC	$3,573,935.00	$ -	$ 9,937		$ 3,583,872	$714,555.00	$24,239,530.00	$ 24,954,085	0.143619
27	5600 RADIOISOTOPE	$1,402,597.00	$ -	$ -		$ 1,402,597	$3,578,502.00	$8,617,286.00	$ 12,195,788	0.115007
28	5700 CT SCAN	$1,537,154.00	$ -	$ -		$ 1,537,154	$17,549,738.00	$37,944,940.00	$ 55,494,678	0.027699
29	5800 MRI	$1,062,118.00	$ -	$ -		$ 1,062,118	$3,482,335.00	$11,489,399.00	$ 14,971,734	0.070942

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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
30	5900	CARDIAC CATHETERIZATION	$3,227,169.00	$ -	$ -		$ 3,227,169	$6,655,907.00	$12,823,992.00	$ 19,479,899	0.165667
31	6000	LABORATORY	$13,085,447.00	$ -	$ -		$ 13,085,447	$56,935,157.00	$52,822,344.00	$ 109,757,501	0.119221
32	6300	BLOOD STORING PROCESSING & TRANS.	$2,322,337.00	$ -	$ -		$ 2,322,337	$4,371,283.00	$1,659,098.00	$ 6,030,381	0.385106
33	6400	INTRAVENOUS THERAPY	$1,353,189.00	$ -	$ -		$ 1,353,189	$1,554,104.00	$1,480,422.00	$ 3,034,526	0.445931
34	6500	RESPIRATORY THERAPY	$3,770,719.00	$ -	$ 2,175		$ 3,772,894	$9,493,420.00	$2,143,726.00	$ 11,637,146	0.324211
35	6600	PHYSICAL THERAPY	$5,107,959.00	$ -	$ -		$ 5,107,959	$7,102,011.00	$3,830,400.00	$ 10,932,411	0.467231
36	6900	ELECTROCARDIOLOGY	$153,878.00	$ -	$ -		$ 153,878	$902,198.00	$2,090,426.00	$ 2,992,624	0.051419
37	7000	ELECTROENCEPHALOGRAPHY	$761,687.00	$ -	$ 700		$ 762,387	$165,463.00	$2,009,376.00	$ 2,174,839	0.350549
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$21,395,505.00	$ -	$ -		$ 21,395,505	$29,798,109.00	$29,972,452.00	$ 59,770,561	0.357961
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$12,536,913.00	$ -	$ -		$ 12,536,913	$16,659,772.00	$25,965,903.00	$ 42,625,675	0.294116
40	7300	DRUGS CHARGED TO PATIENTS	$35,485,564.00	$ -	$ -		$ 35,485,564	$58,546,231.00	$106,550,396.00	$ 165,096,627	0.214938
41	7400	RENAL DIALYSIS	$2,723,361.00	$ -	$ -		$ 2,723,361	$2,527,354.00	$242,288.00	$ 2,769,642	0.983290
42	7600	CARDIOLOGY	$4,639,729.00	$ -	$ -		$ 4,639,729	$13,046,204.00	$26,677,787.00	$ 39,723,991	0.116799
43	7601	ONCOLOGY	$5,768,315.00	$ -	$ 35,083		$ 5,803,398	$64,579.00	$8,515,566.00	$ 8,580,145	0.676375
44	7602	OP PSYCHIATRIC	$196,589.00	$ -	$ -		$ 196,589	$0.00	$2,210.00	$ 2,210	88.954299
45	7603	CARDIAC REHABILITATION	$557,730.00	$ -	$ -		$ 557,730	$1,049.00	$880,457.00	$ 881,506	0.632701
46	9001	WOUND CARE	$1,301,964.00	$ -	$ 8,514		$ 1,310,478	$8,168.00	$1,035,789.00	$ 1,043,957	1.255299
47	9100	EMERGENCY	$16,742,757.00	$ -	$ 825,481		$ 17,568,238	$11,566,380.00	$30,368,605.00	$ 41,934,985	0.418940
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) 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
90		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 174,277,152	$ -	$ 902,329		$ 175,179,481	$ 295,267,367	$ 492,696,527	$ 787,963,894	
127	**Weighted Average**									0.225904
128	**Sub Totals**	$ 235,705,043	$ -	$ 906,407		$ 236,611,450	$ 360,435,768	$ 492,696,527	$ 853,132,295	
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)*					$30,071.00				
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**					$ 236,581,379				
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 (10/01/2020-09/30/2021) | 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	$ 930.98		7,247		1,417		6,705		1,394		2,757		16,763		41.89%
2	03100 INTENSIVE CARE UNIT	$ 3,048.80		854		218		1,266		220		785		2,558		70.98%
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	$ 442.93		74		746				11		46		831		64.96%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	8,175		2,381		7,971		1,625		3,588		20,152		42.63%
19	Total Days per PS&R or Exhibit Detail			8,175		2,381		7,971		1,625		3,588				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 10,463,733		$ 2,350,093		$ 9,250,586		$ 1,935,423		$ 4,302,230		$ 23,999,835		43.65%
21.01	Calculated Routine Charge Per Diem			$ 1,279.97		$ 987.02		$ 1,160.53		$ 1,191.03		$ 1,199.06		$ 1,190.94		
	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)		0.389489	195,867	354,099	188,284	604,584	812,398	917,945	155,660	413,217	90,544	56,295	$ 1,352,209	$ 2,289,845	52.53%
23	5000 OPERATING ROOM		0.222853	2,636,891	2,370,922	2,078,644	3,188,483	4,885,079	7,911,866	444,867	1,380,029	2,470,945	3,209,848	$ 10,045,481	$ 14,851,300	31.22%
24	5100 RECOVERY ROOM		0.427147	191,547	302,950	173,091	497,708	341,532	795,267	30,258	128,875	180,496	365,695	$ 736,428	$ 1,724,800	32.44%
25	5200 DELIVERY ROOM & LABOR ROOM		1.179467	90,570	27,968	1,327,810	337,234	9,836	4,198	46,035	7,846	45,031	20,354	$ 1,474,251	$ 377,246	58.52%
26	5300 ANESTHESIOLOGY		0.147645	163,321	177,382	110,985	224,170	292,835	377,999	27,118	110,611	153,757	220,339	$ 594,259	$ 890,162	29.92%
27	5400 RADIOLOGY-DIAGNOSTIC		0.179119	717,744	1,013,074	188,996	1,401,851	1,281,741	2,192,927	164,055	535,462	457,997	1,809,441	$ 2,352,536	$ 5,143,314	35.36%
28	5500 RADIOLOGY-THERAPEUTIC		0.143619	91,528	2,075,268	33,647	719,354	95,953	2,574,732	3,430	297,067	25,050	820,281	$ 224,558	$ 5,666,421	26.99%
29	5600 RADIOISOTOPE		0.115007	108,762	373,683	5,767	170,472	163,352	1,300,518	31,575	128,529	89,682	604,329	$ 309,456	$ 1,973,202	24.46%
30	5700 CT SCAN		0.027699	1,812,928	1,998,066	357,959	1,938,070	3,183,010	4,115,272	449,214	540,832	694,002	5,851,368	$ 5,803,111	$ 8,592,240	37.98%
31	5800 MRI		0.070942	314,597	586,867	85,875	476,087	582,396	1,309,051	43,514	145,813	273,305	630,065	$ 1,026,382	$ 2,517,818	29.78%
32	5900 CARDIAC CATHETERIZATION		0.165667	-	-	74,786	97,293	1,055,062	1,402,167	77,538	323,881	628,704	1,107,256	$ 1,207,386	$ 1,823,341	24.53%
33	6000 LABORATORY		0.119221	6,347,493	3,105,973	2,227,242	5,321,699	9,588,291	4,552,426	1,665,245	2,144,841	4,022,386	5,402,436	$ 19,828,271	$ 15,124,939	40.61%
34	6300 BLOOD STORING, PROCESSING & TRANS.		0.385106	494,180	106,160	85,940	32,609	727,179	201,711	273,922	136,005	276,816	94,035	$ 1,581,221	$ 476,485	40.34%
35	6400 INTRAVENOUS THERAPY		0.445931	269,294	1,056,490	40,715	31,183	442,638	257,119	101,658	15,969	166,940	56,554	$ 854,305	$ 1,360,761	80.69%
36	6500 RESPIRATORY THERAPY		0.324211	916,643	124,082	203,441	141,027	1,640,667	252,227	264,998	77,391	570,139	356,331	$ 3,025,749	$ 594,727	39.26%
37	6600 PHYSICAL THERAPY		0.467231	494,904	111,505	49,035	210,628	788,315	348,828	260,351	125,288	289,875	145,495	$ 1,592,605	$ 796,249	26.01%
38	6900 ELECTROCARDIOLOGY		0.051419	89,141	97,524	17,236	95,727	170,646	200,964	21,645	62,868	24,102	257,855	$ 298,668	$ 457,083	34.82%
39	7000 ELECTROENCEPHALOGRAPHY		0.350549	20,058	218,081	1,779	160,088	41,270	230,043	2,372	20,511	13,639	69,350	$ 65,479	$ 628,723	35.74%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.357961	2,421,376	1,431,739	1,359,993	1,315,057	4,609,583	4,012,670	556,158	702,946	1,922,986	2,309,014	$ 8,947,110	$ 7,462,412	34.63%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.294116	1,346,255	987,090	257,391	560,640	2,676,428	3,254,885	145,054	555,955	800,144	1,065,684	$ 4,425,128	$ 5,358,570	27.35%
42	7300 DRUGS CHARGED TO PATIENTS		0.214938	5,822,320	5,789,134	1,779,697	3,519,794	8,351,214	15,590,191	2,260,000	1,414,806	4,061,351	3,068,191	$ 18,213,231	$ 26,313,925	31.34%
43	7400 RENAL DIALYSIS		0.983290	214,648	-	-	-	-	-	-	-	-	-	$ 214,648	$ -	7.75%
44	7600 CARDIOLOGY		0.116799	1,417,473	1,153,546	355,519	601,352	2,237,873	3,175,520	212,249	469,335	1,143,083	2,114,527	$ 4,223,114	$ 5,399,753	32.45%
45	7601 ONCOLOGY		0.676375	-	154,413	2,244	293,754	4,875	607,561		35,790	-	387,454	$ 7,119	$ 1,091,518	17.32%
46	7602 OP PSYCHIATRIC		88.954299	-	-	-	-	-	-		-	-	-	$ -	$ -	0.00%
47	7603 CARDIAC REHABILITATION		0.632701	-	-	-	612	204	39,804		22,032	-	11,122	$ 204	$ 62,448	8.37%
48	9001 WOUND CARE		1.255299	-	81,056	3,154	105,078	4,098	148,599	1,926	352,408	-	98,206	$ 9,178	$ 687,141	76.14%
49	9100 EMERGENCY		0.418940	1,592,914	1,615,443	327,879	3,741,897	2,491,458	2,984,265	347,639	498,264	13,705	7,116,131	$ 4,759,890	$ 8,839,869	49.77%
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2020-09/30/2021) 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		%
61			-											$ -	$ -	
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
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126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 27,770,454	$ 25,312,515	$ 11,337,109	$ 25,786,451	$ 46,477,933	$ 58,758,755	$ 7,586,481	$ 10,646,571	$ 18,414,679	$ 37,247,656			

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

Cost Report Year (10/01/2020-09/30/2021) John D. Archbold Memorial Hospital

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 38,234,187	$ 25,312,515	$ 13,687,202	$ 25,786,451	$ 55,728,519	$ 58,758,755	$ 9,521,904	$ 10,646,571	$ 22,716,909 (Agrees to Exhibit A)	$ 37,247,656 (Agrees to Exhibit A)	$ 117,171,812	$ 120,504,292	35.00%
129	Total Charges per PS&R or Exhibit Detail	$ 38,234,187	$ 25,312,515	$ 13,687,202	$ 25,786,451	$ 55,728,519	$ 58,758,755	$ 9,521,904	$ 10,646,571	$ 22,716,909	$ 37,247,656			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 15,651,992	$ 5,595,248	$ 6,111,584	$ 6,294,196	$ 20,364,210	$ 12,931,679	$ 3,725,483	$ 2,654,043	$ 8,880,730	$ 8,198,241	$ 45,853,269	$ 27,475,166	38.35%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,095,219	$ 4,857,789	$ -	$ -	$ 764,654	$ 1,013,567	$ 8,969	$ 37,671			$ 10,868,842	$ 5,909,027	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 4,301,903	$ 6,397,578	$ -	$ -	$ 53,790	$ 11,172			$ 4,355,693	$ 6,408,750	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ 954	$ 6,840	$ 867,889	$ 636,173			$ 868,843	$ 643,013	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ 48	$ -	$ -	$ -	$ 11,271			$ -	$ 11,319	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 10,095,219	$ 4,857,789	$ 4,301,903	$ 6,397,626									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (294,865)	$ -	$ -							$ -	$ (294,865)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 14,892,737	$ 10,008,481	$ -	$ 544			$ 14,892,737	$ 10,009,025	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 2,274,149	$ 1,593,387			$ 2,274,149	$ 1,593,387	
141	Medicare Cross-Over Bad Debt Payments					$ 290,852	$ 234,604	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 290,852	$ 234,604	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 116,735	$ 689,015			
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)**	$ 5,556,773	$ 1,032,324	$ 1,809,681	$ (103,430)	$ 4,415,013	$ 1,668,187	$ 520,686	$ 363,825	$ 8,763,995	$ 7,509,226	$ 12,302,153	$ 2,960,906	
146	**Calculated Payments as a Percentage of Cost**	64%	82%	70%	102%	78%	87%	86%	86%	1%	8%	73%	89%	
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)**					30,635								
148	**Percent of cross-over days to total Medicare days from the cost report**					26%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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	$ 930.98		43		60						103	
2	03100 INTENSIVE CARE UNIT	$ 3,048.80		8		2						10	
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	$ 442.93										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	51		62		-		-		113	
19	Total Days per PS&R or Exhibit Detail			51		62		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 62,729		$ 78,087						$ 140,816	
21.01	Calculated Routine Charge Per Diem			$ 1,229.98		$ 1,259.47		$ -		$ -		$ 1,246.16	
	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)		0.389489	165	2,411	5,250	12,599					$ 5,415	$ 15,010
23	5000 OPERATING ROOM		0.222853	24,710	11,394	10,862	11,219					$ 35,572	$ 22,613
24	5100 RECOVERY ROOM		0.427147	1,312	695	1,080	2,239					$ 2,392	$ 2,934
25	5200 DELIVERY ROOM & LABOR ROOM		1.179467	4,812	776		388					$ 4,812	$ 1,164
26	5300 ANESTHESIOLOGY		0.147645	1,148	399	672	569					$ 1,820	$ 968
27	5400 RADIOLOGY-DIAGNOSTIC		0.179119	8,369	6,677	7,007	15,429					$ 15,376	$ 22,106
28	5500 RADIOLOGY-THERAPEUTIC		0.143619	-	-							$ -	$ -
29	5600 RADIOISOTOPE		0.115007	-	5,052	871						$ 871	$ 5,052
30	5700 CT SCAN		0.027699	33,306	36,831	1,985	64,419					$ 35,291	$ 101,250
31	5800 MRI		0.070942	3,377	4,632	3,101						$ 6,478	$ 4,632
32	5900 CARDIAC CATHETERIZATION		0.165667	-	-		11,722					$ -	$ 11,722
33	6000 LABORATORY		0.119221	44,515	47,839	37,294	69,045					$ 81,809	$ 116,884
34	6300 BLOOD STORING PROCESSING & TRANS.		0.385106	-			4,206					$ -	$ 4,206
35	6400 INTRAVENOUS THERAPY		0.445931	1,218		8,199	609					$ 9,417	$ 609
36	6500 RESPIRATORY THERAPY		0.324211	4,558	3,819	10,319	2,981					$ 14,877	$ 6,800
37	6600 PHYSICAL THERAPY		0.467231	13,252	1,218	4,678						$ 17,930	$ 1,218
38	6900 ELECTROCARDIOLOGY		0.051419	819	1,755	351	1,287					$ 1,170	$ 3,042
39	7000 ELECTROENCEPHALOGRAPHY		0.350549	-								$ -	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.357961	18,345	11,345	15,543	12,017					$ 33,888	$ 23,362
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.294116	8,204		779						$ 8,983	$ -
42	7300 DRUGS CHARGED TO PATIENTS		0.214938	28,176	14,119	24,677	11,871					$ 52,853	$ 25,990
43	7400 RENAL DIALYSIS		0.983290	-		-						$ -	$ -
44	7600 CARDIOLOGY		0.116799	3,172	3,155	3,278						$ 6,450	$ 3,155
45	7601 ONCOLOGY		0.676375	-								$ -	$ -
46	7602 OP PSYCHIATRIC		88.954299	-	-							$ -	$ -
47	7603 CARDIAC REHABILITATION		0.632701	-	-							$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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	
48	9001	WOUND CARE		1.255299	-	-		305					$ -	$ 305
49	9100	EMERGENCY		0.418940	13,648	51,876	7,307	70,271					$ 20,955	$ 122,147
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
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108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 213,106	$ 203,993	$ 143,253	$ 291,176	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 275,835	$ 203,993	$ 221,340	$ 291,176	$ -	$ -	$ -	$ -	$ 497,175	$ 495,169
129	Total Charges per PS&R or Exhibit Detail	$ 275,835	$ 203,993	$ 221,340	$ 291,176	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 113,746	$ 44,673	$ 96,805	$ 63,226	$ -	$ -	$ -	$ -	$ 210,551	$ 107,899
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 61,137	$ 24,261	$ -	$ -					$ 61,137	$ 24,261
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 23,205	$ 25,600					$ 23,205	$ 25,600
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -					$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ 2					$ -	$ 2
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 61,137	$ 24,261	$ 23,205	$ 25,602						
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)**	$ 52,609	$ 20,412	$ 73,600	$ 37,624	$ -	$ -	$ -	$ -	$ 126,209	$ 58,036
144	**Calculated Payments as a Percentage of Cost**	54%	54%	24%	40%	0%	0%	0%	0%	40%	46%

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 (10/01/2020-09/30/2021) | 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 (10/01/2020-09/30/2021) | 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 (10/01/2020-09/30/2021) 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)*		$ 3,539,939		
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 ---------->)		$ 3,539,939		
	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		$ 3,539,939
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	238,668,448
19	Uninsured Hospital	**Charges Sec. G**	59,964,565
20	Total Hospital	**Charges Sec. G**	853,132,295
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		27.98%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.03%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 990,317
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 248,814
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,239,131**

** 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.*