DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2021	06/30/2022

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	10/01/2021	09/30/2022
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	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 (07/01/21 - 06/30/22)
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 07/01/2021 - 06/30/2022** — $ 2,236,401
   (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 07/01/2021 - 06/30/2022** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06/30/2022** — $ 2,236,401

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	Senior Vice President/Chief Financial Officer Title	10/13/2023 Date
Greg Hembree Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	gshembree@achbold.org 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	Title	
Telephone Number	(229) 228-8857	Firm Name	
E-Mail Address	pbarrett@archbold.org	Telephone Number	
Mailing Street Address	920 Cairo Rd	E-Mail Address	
Mailing City, State, Zip	Thomasville, GA 31792-4255		

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D. General Cost Report Year Information 10/1/2021 - 9/30/2022

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

1. Select Your Facility from the Drop-Down Menu Provided:	John D. Archbold Memorial Hospital		
	10/1/2021 through 9/30/2022		
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:	3/10/2023		

	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	

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: (10/01/2021 - 09/30/2022)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 80,782	$ 651,669	$732,451
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,390,920	$ 6,631,245	$8,022,165
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)	$1,471,702	$7,282,914	$8,754,616
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.49%	8.95%	8.37%

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 (10/01/2021 - 09/30/2022)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	47,746	**(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	16,896,291
8.	Outpatient Hospital Charity Care Charges	31,842,816
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 48,739,107

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	$78,320,163.00			$ 53,121,983	$ -	$ -	$ 25,198,180
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$4,154,843.00			$ 2,818,093	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$251,126,909.00	$499,617,659.00		$ 170,331,098	$ 338,874,176	$ -	$ 241,539,294
20.	Outpatient Services		$51,397,402.00			$ 34,861,162	$ -	$ 16,536,240
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	$ 329,447,072	$ 551,015,061	$ 4,154,843	$ 223,453,081	$ 373,735,338	$ 2,818,093	$ 283,273,714
28.	Total Hospital and Non Hospital		Total from Above	$ 884,616,976		Total from Above	$ 600,006,512	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	884,616,976	Total Contractual Adj. (G-3 Line 2)	600,006,512
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				600,006,512
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) | 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	$ 42,928,017	$ 640,595	$ 4,078	$0.00	$ 43,572,690	40,679	$29,647,151.00		$ 1,071.13
2	03100 INTENSIVE CARE UNIT	$ 14,907,294	$ -	$ -		$ 14,907,294	4,127	$16,165,174.00		$ 3,612.14
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	$ 3,324,972	$ -	$ 7,385		$ 3,332,357	2,798	$10,974,189.00		$ 1,190.98
8	04100 SUBPROVIDER II	$ 3,849,321	$ -	$ -		$ 3,849,321	2,547	$3,107,235.00		$ 1,511.32
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 666,058	$ -	$ -		$ 666,058	1,152	$924,754.00		$ 578.18
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 65,675,662	$ 640,595	$ 11,463	$ -	$ 66,327,720	51,303	$ 60,818,503		
19	Weighted Average									$ 1,292.86

Line #	Observation Data (Non-Distinct)	*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*
20	09200 Observation (Non-Distinct)	3,557	-	-	$ 3,810,009	$2,356,639.00	$5,873,480.00	$ 8,230,119	0.462935

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	$22,740,163.00	$ -	$ 7,603		$ 22,747,766	$34,208,504.00	$68,859,490.00	$ 103,067,994	0.220706
22	5100 RECOVERY ROOM	$4,735,946.00	$ -	$ -		$ 4,735,946	$2,433,612.00	$7,719,153.00	$ 10,152,765	0.466469
23	5200 DELIVERY ROOM & LABOR ROOM	$4,612,345.00	$ -	$ -		$ 4,612,345	$1,444,718.00	$993,236.00	$ 2,437,954	1.891892
24	5300 ANESTHESIOLOGY	$839,580.00	$ -	$ 8,393		$ 847,973	$2,174,461.00	$4,460,620.00	$ 6,635,081	0.127801
25	5400 RADIOLOGY-DIAGNOSTIC	$5,849,802.00	$ 9,126	$ -		$ 5,858,928	$6,628,607.00	$21,879,516.00	$ 28,508,123	0.205518
26	5500 RADIOLOGY-THERAPEUTIC	$4,512,815.00	$ -	$ 9,806		$ 4,522,621	$1,282,146.00	$23,394,698.00	$ 24,676,844	0.183274
27	5600 RADIOISOTOPE	$1,328,769.00	$ -	$ -		$ 1,328,769	$1,059,616.00	$11,043,817.00	$ 12,103,433	0.109784
28	5700 CT SCAN	$1,673,948.00	$ -	$ -		$ 1,673,948	$16,564,890.00	$40,515,039.00	$ 57,079,929	0.029326
29	5800 MRI	$1,042,803.00	$ -	$ -		$ 1,042,803	$3,327,175.00	$13,287,876.00	$ 16,615,051	0.062763

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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	$4,012,205.00	$ -	$ -		$ 4,012,205	$8,250,794.00	$13,475,122.00	$ 21,725,916	0.184674
31	6000	LABORATORY	$12,126,767.00	$ -	$ -		$ 12,126,767	$47,845,788.00	$54,320,748.00	$ 102,166,536	0.118696
32	6300	BLOOD STORING PROCESSING & TRANS.	$2,286,656.00	$ -	$ -		$ 2,286,656	$4,040,026.00	$1,768,988.00	$ 5,809,014	0.393639
33	6400	INTRAVENOUS THERAPY	$1,490,909.00	$ -	$ -		$ 1,490,909	$1,138,773.00	$1,407,162.00	$ 2,545,935	0.585604
34	6500	RESPIRATORY THERAPY	$3,830,545.00	$ -	$ -		$ 3,830,545	$9,152,253.00	$1,521,354.00	$ 10,673,607	0.358880
35	6600	PHYSICAL THERAPY	$5,787,822.00	$ -	$ -		$ 5,787,822	$6,339,408.00	$3,648,249.00	$ 9,987,657	0.579497
36	6900	ELECTROCARDIOLOGY	$167,726.00	$ -	$ -		$ 167,726	$1,604,219.00	$3,284,889.00	$ 4,889,108	0.034306
37	7000	ELECTROENCEPHALOGRAPHY	$1,035,398.00	$ 51,101	$ 636		$ 1,087,135	$135,318.00	$3,851,777.00	$ 3,987,095	0.272663
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$22,713,504.00	$ -	$ -		$ 22,713,504	$28,675,301.00	$31,991,327.00	$ 60,666,628	0.374399
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$13,031,974.00	$ -	$ -		$ 13,031,974	$14,595,717.00	$27,887,316.00	$ 42,483,033	0.306757
40	7300	DRUGS CHARGED TO PATIENTS	$33,239,731.00	$ -	$ -		$ 33,239,731	$46,802,013.00	$113,351,332.00	$ 160,153,345	0.207549
41	7400	RENAL DIALYSIS	$2,988,383.00	$ -	$ -		$ 2,988,383	$2,771,982.00	$0.00	$ 2,771,982	1.078067
42	7600	CARDIOLOGY	$4,964,192.00	$ 111,329	$ -		$ 5,075,521	$12,936,133.00	$28,757,857.00	$ 41,693,990	0.121733
43	7601	ONCOLOGY	$6,127,449.00	$ -	$ 43,935		$ 6,171,384	$59,087.00	$8,869,862.00	$ 8,928,949	0.691166
44	7602	OP PSYCHIATRIC	$277,284.00	$ -	$ -		$ 277,284	$0.00	$141,836.00	$ 141,836	1.954962
45	7603	CARDIAC REHABILITATION	$653,825.00	$ -	$ -		$ 653,825	$612.00	$941,671.00	$ 942,283	0.693873
46	9100	EMERGENCY	$17,650,492.00	$ -	$ 1,591,649		$ 19,242,141	$11,914,498.00	$31,007,954.00	$ 42,922,452	0.448300
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2021-09/30/2022) 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**	$ 179,721,033	$ 171,556	$ 1,662,022		$ 181,554,611	$ 267,742,290	$ 524,254,369	$ 791,996,659	
127		**Weighted Average**									0.234047
128		**Sub Totals**	$ 245,396,695	$ 812,151	$ 1,673,485		$ 247,882,331	$ 328,560,793	$ 524,254,369	$ 852,815,162	
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)*					$32,747.00				
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**					$ 247,849,584				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.33%				

* 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 (10/01/2021-09/30/2022) 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	$ 1,071.13		6,942		1,301		6,286		1,780		2,058		16,309		49.66%
2	03100 INTENSIVE CARE UNIT	$ 3,612.14		728		166		1,638		286		681		2,818		85.56%
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	$ 1,190.98												-		0.00%
8	04100 SUBPROVIDER II	$ 1,511.32												-		0.00%
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 578.18		85		660		7		48				752		69.62%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	7,755		2,127		7,924		2,073		2,787		19,879		44.38%
19	Total Days per PS&R or Exhibit Detail			7,755		2,127		7,924		2,073		2,787				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 10,399,833		$ 2,173,846		$ 9,864,351		$ 2,600,943		$ 3,509,954		$ 25,038,973		47.18%
21.01	Calculated Routine Charge Per Diem			$ 1,341.05		$ 1,022.02		$ 1,244.87		$ 1,254.68		$ 1,259.40		$ 1,259.57		
	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)		0.462935	234,382	420,564	221,715	646,822	1,092,435	1,279,353	244,957	782,624	46,061	97,640	$ 1,793,489	$ 3,129,363	62.15%
23	5000 OPERATING ROOM		0.220706	2,273,134	2,430,843	2,141,198	3,839,683	5,569,569	8,884,101	889,306	2,780,355	1,955,736	3,043,878	$ 10,873,207	$ 17,934,982	32.89%
24	5100 RECOVERY ROOM		0.466469	164,831	347,142	145,155	589,282	387,721	853,637	63,923	253,927	143,889	326,148	$ 761,630	$ 2,043,988	32.33%
25	5200 DELIVERY ROOM & LABOR ROOM		1.891892	75,217	55,689	808,252	520,535	585	7,500	16,052	5,000	21,558	49,689	$ 900,106	$ 588,724	64.09%
26	5300 ANESTHESIOLOGY		0.127801	138,535	180,197	110,777	269,490	331,680	427,814	56,521	168,918	119,687	214,783	$ 637,513	$ 1,046,419	30.49%
27	5400 RADIOLOGY-DIAGNOSTIC		0.205518	548,032	958,123	207,984	1,554,377	1,302,689	2,444,208	251,803	927,330	361,647	1,738,631	$ 2,310,508	$ 5,884,038	36.33%
28	5500 RADIOLOGY-THERAPEUTIC		0.183274	311,612	1,493,256	15,304	419,381	50,330	3,047,742	168,119	1,099,462	14,265	868,194	$ 545,365	$ 6,059,841	30.34%
29	5600 RADIOISOTOPE		0.109784	85,533	310,733	12,332	186,673	258,150	1,652,205	24,744	200,012	64,301	410,203	$ 380,759	$ 2,349,623	26.48%
30	5700 CT SCAN		0.029326	1,425,921	1,777,303	394,410	2,210,453	3,370,810	4,856,324	632,268	1,260,195	416,932	5,509,165	$ 5,823,409	$ 10,104,275	38.63%
31	5800 MRI		0.062763	243,973	671,114	96,042	821,584	544,919	1,631,314	131,822	454,163	299,839	539,096	$ 1,016,756	$ 3,578,175	32.75%
32	5900 CARDIAC CATHETERIZATION		0.184674	-	-	95,774	220,260	1,191,343	1,324,582	224,534	301,096	719,072	859,400	$ 1,511,651	$ 1,845,938	22.78%
33	6000 LABORATORY		0.118696	4,853,703	3,106,442	1,962,441	5,532,151	9,001,648	4,712,629	1,881,864	2,998,666	3,005,286	4,920,848	$ 17,699,656	$ 16,349,888	41.42%
34	6300 BLOOD STORING, PROCESSING & TRANS.		0.393639	398,695	167,691	61,868	37,263	790,737	302,016	153,965	55,028	235,322	104,490	$ 1,405,265	$ 561,998	40.04%
35	6400 INTRAVENOUS THERAPY		0.585604	242,180	1,207,479	44,162	11,018	425,399	70,879	83,544	46,423	119,217	22,762	$ 795,285	$ 1,335,799	89.41%
36	6500 RESPIRATORY THERAPY		0.358880	693,254	87,292	121,319	127,262	2,068,717	203,230	388,939	66,547	394,121	225,166	$ 3,272,229	$ 484,331	41.45%
37	6600 PHYSICAL THERAPY		0.579497	360,148	115,256	32,262	191,392	758,021	357,888	313,249	162,301	238,963	140,379	$ 1,463,680	$ 826,837	26.78%
38	6900 ELECTROCARDIOLOGY		0.034306	128,375	171,913	37,950	155,237	327,861	368,716	71,984	155,861	36,406	397,705	$ 566,170	$ 851,727	38.18%
39	7000 ELECTROENCEPHALOGRAPHY		0.272663	9,142	351,708	1,306	322,908	29,118	363,816	5,224	85,666	13,713	67,895	$ 44,790	$ 1,124,098	31.40%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.374399	1,868,031	1,384,987	1,378,578	1,526,506	4,936,278	4,316,314	908,807	1,230,847	1,439,844	2,013,780	$ 9,091,694	$ 8,458,654	34.73%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.306757	762,425	997,103	185,704	573,498	2,329,886	3,951,310	492,563	1,421,181	602,301	939,847	$ 3,770,578	$ 6,943,092	28.86%
42	7300 DRUGS CHARGED TO PATIENTS		0.207549	4,679,207	5,917,054	1,364,368	3,962,022	8,950,399	17,201,534	1,307,990	3,240,357	2,865,617	3,218,623	$ 16,301,964	$ 30,320,967	32.99%
43	7400 RENAL DIALYSIS		1.078067	223,950	-	-	-	-	-	-	-	-	-	$ 223,950	$ -	8.08%
44	7600 CARDIOLOGY		0.121733	872,980	1,053,837	449,001	789,518	2,022,698	3,487,453	463,873	976,883	1,131,629	1,810,923	$ 3,808,552	$ 6,307,691	31.45%
45	7601 ONCOLOGY		0.691166	629	305,800	3,349	540,649	6,321	1,083,073	4,255	418,670	-	631,866	$ 14,554	$ 2,348,192	33.56%
46	7602 OP PSYCHIATRIC		1.954962	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
47	7603 CARDIAC REHABILITATION		0.693873	-	-	-	-	-	21,012	-	21,012	-	73,131	$ -	$ 42,024	12.22%
48	9100 EMERGENCY		0.448300	1,376,419	1,456,730	367,942	3,703,515	2,617,674	3,071,056	496,388	965,328	1,557	6,219,354	$ 4,858,423	$ 9,196,629	47.81%
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
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58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (10/01/2021-09/30/2022) 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			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
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72			-											$ -	$ -	
73			-											$ -	$ -	
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124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 21,970,308	$ 24,968,256	$ 10,259,193	$ 28,751,479	$ 48,364,988	$ 65,919,706	$ 9,276,694	$ 20,077,852	$ 14,246,963	$ 34,443,596			

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

Cost Report Year (10/01/2021-09/30/2022) 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		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 32,370,141	$ 24,968,256	$ 12,433,039	$ 28,751,479	$ 58,229,339	$ 65,919,706	$ 11,877,637	$ 20,077,852	$ 17,756,917 (Agrees to Exhibit A)	$ 34,443,596 (Agrees to Exhibit A)	$ 114,910,156	$ 139,717,293	36.15%
129	Total Charges per PS&R or Exhibit Detail	$ 32,370,141	$ 24,968,256	$ 12,433,039	$ 28,751,479	$ 58,229,339	$ 65,919,706	$ 11,877,637	$ 20,077,852	$ 17,756,917	$ 34,443,596			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 15,406,816	$ 6,007,388	$ 6,068,387	$ 7,642,422	$ 23,941,795	$ 14,826,469	$ 5,177,044	$ 4,636,911	$ 7,777,127	$ 7,945,370	$ 50,594,042	$ 33,113,190	40.32%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 8,765,495	$ 5,082,689	$ -	$ -	$ 779,774	$ 1,169,849	$ 89,822	$ -			$ 9,635,091	$ 6,252,538	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 3,755,619	$ 7,179,943	$ -	$ -	$ -	$ 30,195			$ 3,755,619	$ 7,210,138	
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ 1,013	$ 86,247	$ 157,952			$ 86,247	$ 158,965	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ 5	$ 34,307			$ 5	$ 34,307	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 8,765,495	$ 5,082,689	$ 3,755,619	$ 7,179,943									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (287,126)	$ -	$ -							$ -	$ (287,126)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 15,483,783	$ 11,249,007	$ -	$ -			$ 15,483,783	$ 11,249,007	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 3,437,722	$ 4,033,501			$ 3,437,722	$ 4,033,501	
141	Medicare Cross-Over Bad Debt Payments					$ 237,633	$ 177,705	$ -	$ -			$ 237,633	$ 177,705	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 80,782	$ 651,669			
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)**	$ 6,641,321	$ 1,211,825	$ 2,312,768	$ 462,479	$ 7,440,605	$ 2,228,895	$ 1,563,248	$ 380,956	$ 7,696,345	$ 7,293,701	$ 17,957,942	$ 4,284,155	
146	**Calculated Payments as a Percentage of Cost**	57%	80%	62%	94%	69%	85%	70%	92%	1%	8%	65%	87%	
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)**					28,026								
148	**Percent of cross-over days to total Medicare days from the cost report**					28%								

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 (10/01/2021-09/30/2022) 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	$ 1,071.13		51		17						68	
2	03100 INTENSIVE CARE UNIT	$ 3,612.14		29		3						32	
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	$ 1,190.98										-	
8	04100 SUBPROVIDER II	$ 1,511.32										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 578.18		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	82		20		-		-		102	
19	Total Days per PS&R or Exhibit Detail			82		20		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 120,565		$ 24,242						$ 144,807	
21.01	Calculated Routine Charge Per Diem			$ 1,470.30		$ 1,212.10		$ -		$ -		$ 1,419.68	
	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)		0.462935	7,580	24,260	1,038	15,349					$ 8,618	$ 39,609
23	5000 OPERATING ROOM		0.220706	24,937	18,197	32,536	12,186					$ 57,473	$ 30,383
24	5100 RECOVERY ROOM		0.466469	2,882	2,100	378	1,647					$ 3,260	$ 3,747
25	5200 DELIVERY ROOM & LABOR ROOM		1.891892	895	1,500	-	-					$ 895	$ 1,500
26	5300 ANESTHESIOLOGY		0.127801	2,140	1,260	752	420					$ 2,892	$ 1,680
27	5400 RADIOLOGY-DIAGNOSTIC		0.205518	11,593	31,782	14,621	4,526					$ 26,214	$ 36,308
28	5500 RADIOLOGY-THERAPEUTIC		0.183274	-	-	-	-					$ -	$ -
29	5600 RADIOISOTOPE		0.109784	-	-	-	-					$ -	$ -
30	5700 CT SCAN		0.029326	36,807	115,111	19,372	23,614					$ 56,179	$ 138,725
31	5800 MRI		0.062763	-	8,313	-	-					$ -	$ 8,313
32	5900 CARDIAC CATHETERIZATION		0.184674	13,663	-	-	-					$ 13,663	$ -
33	6000 LABORATORY		0.118696	116,481	134,738	43,464	46,336					$ 159,945	$ 181,074
34	6300 BLOOD STORING PROCESSING & TRANS.		0.393639	7,583	4,425	2,315	4,425					$ 9,898	$ 8,850
35	6400 INTRAVENOUS THERAPY		0.585604	2,589	620	-	-					$ 2,589	$ 620
36	6500 RESPIRATORY THERAPY		0.358880	35,919	5,160	6,512	1,206					$ 42,431	$ 6,366
37	6600 PHYSICAL THERAPY		0.579497	4,275	239	797	-					$ 5,072	$ 239
38	6900 ELECTROCARDIOLOGY		0.034306	3,220	7,590	690	2,990					$ 3,910	$ 10,580
39	7000 ELECTROENCEPHALOGRAPHY		0.272663	1,306	-	-	-					$ 1,306	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.374399	35,307	17,448	7,626	6,383					$ 42,933	$ 23,831
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.306757	3,668	897	-	-					$ 3,668	$ 897
42	7300 DRUGS CHARGED TO PATIENTS		0.207549	84,974	19,842	16,671	6,763					$ 101,645	$ 26,605
43	7400 RENAL DIALYSIS		1.078067	-	-	-	-					$ -	$ -
44	7600 CARDIOLOGY		0.121733	37,744	8,104	3,986	2,612					$ 41,730	$ 10,716
45	7601 ONCOLOGY		0.691166	-	1,219	-	938					$ -	$ 2,157
46	7602 OP PSYCHIATRIC		1.954962	-	-	-	-					$ -	$ -
47	7603 CARDIAC REHABILITATION		0.693873	-	-	-	-					$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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	9100	EMERGENCY		0.448300	31,812	158,193	15,828	38,706					$ 47,640	$ 196,899
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
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62				-									$ -	$ -
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106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2021-09/30/2022) 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			-									$ -	$ -
				$ 465,375	$ 560,998	$ 166,586	$ 168,101	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 585,940	$ 560,998	$ 190,828	$ 168,101	$ -	$ -	$ -	$ -	$ 776,768	$ 729,099
129	Total Charges per PS&R or Exhibit Detail	$ 585,940	$ 560,998	$ 190,828	$ 168,101	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 263,843	$ 133,676	$ 63,341	$ 42,128	$ -	$ -	$ -	$ -	$ 327,184	$ 175,804
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 263,843	$ 133,676	$ 63,341	$ 42,128	$ -	$ -	$ -	$ -	$ 327,184	$ 175,804
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
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 (10/01/2021-09/30/2022) | 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 (10/01/2021-09/30/2022) | 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 (10/01/2021-09/30/2022) 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)*		$ 3,571,615		
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 ---------->)		$ 3,571,615		
	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		$ 3,571,615
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	256,133,316
19	Uninsured Hospital	**Charges Sec. G**	52,200,513
20	Total Hospital	**Charges Sec. G**	852,815,162
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		30.03%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.12%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,072,694
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 218,617
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,291,311**

** 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.*