

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2018	06/30/2019

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2018	09/30/2019
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:	000001339A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111331

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

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.)

DSH Examination Year (07/01/18 - 06/30/19)
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?

9/11/1949

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** \$ 59,593
 (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 07/01/2018 - 06/30/2019** \$ -
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019** \$ 59,593

Certification:

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

Answer
Yes

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Senior Vice President and CFO	10/21/2020
	Title	Date
Greg Hembree	(229) 228-2880	gshembree@archbold.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

<p>Hospital Contact:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="border: none;">Name</td><td style="border: 1px solid black; padding: 2px;">Patricia L. Barrett</td></tr> <tr><td style="border: none;">Title</td><td style="border: 1px solid black; padding: 2px;">Director of Reimbursement</td></tr> <tr><td style="border: none;">Telephone Number</td><td style="border: 1px solid black; padding: 2px;">(229) 228-8857</td></tr> <tr><td style="border: none;">E-Mail Address</td><td style="border: 1px solid black; padding: 2px;">pbarrett@archbold.org</td></tr> <tr><td style="border: none;">Mailing Street Address</td><td style="border: 1px solid black; padding: 2px;">920 Cairo Rd</td></tr> <tr><td style="border: none;">Mailing City, State, Zip</td><td style="border: 1px solid black; padding: 2px;">Thomasville, GA 31792-4255</td></tr> </table>	Name	Patricia L. Barrett	Title	Director of Reimbursement	Telephone Number	(229) 228-8857	E-Mail Address	pbarrett@archbold.org	Mailing Street Address	920 Cairo Rd	Mailing City, State, Zip	Thomasville, GA 31792-4255	<p>Outside Preparer:</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="border: none;">Name</td><td style="border: 1px solid black; height: 15px;"></td></tr> <tr><td style="border: none;">Title</td><td style="border: 1px solid black; height: 15px;"></td></tr> <tr><td style="border: none;">Firm Name</td><td style="border: 1px solid black; height: 15px;"></td></tr> <tr><td style="border: none;">Telephone Number</td><td style="border: 1px solid black; height: 15px;"></td></tr> <tr><td style="border: none;">E-Mail Address</td><td style="border: 1px solid black; height: 15px;"></td></tr> </table>	Name		Title		Firm Name		Telephone Number		E-Mail Address	
Name	Patricia L. Barrett																						
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E-Mail Address																							

D. General Cost Report Year Information 10/1/2018 - 9/30/2019

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:

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

10/1/2018 through 9/30/2019		
X		

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

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	MITCHELL COUNTY HOSPITAL	Yes	
5. Medicaid Provider Number:	000001339A	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:	111331	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year

	State Name	Provider No.
9. State Name & Number	Florida	020989100
10. State Name & Number		
11. State Name & Number		
12. 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: (10/01/2018 - 09/30/2019)

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)	\$ 15	\$ 119,524	\$119,539
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 955	\$ 360,800	\$361,755
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)	\$970	\$480,324	\$481,294
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	1.55%	24.88%	24.84%

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 (10/01/2018 - 09/30/2019)

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)

201

(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

-
-
250,000
-
\$ 250,000

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

73,922
2,443,271
-
\$ 2,517,193

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)			
11. Hospital	\$223,905.00			\$ 118,575	\$ -	\$ -	\$ 105,330
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$3,577,798.00			\$ 1,894,724	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$10,856,733.00			\$ 5,749,490	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$11,400,096.00	\$20,529,610.00		\$ 6,037,244	\$ 10,872,036	\$ -	\$ 15,020,426
20. Outpatient Services		\$9,161,258.00			\$ 4,851,603	\$ -	\$ 4,309,655
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	\$5,926,108.00	\$ -	\$ -	\$ 3,138,338	\$ -
27. Total	\$ 11,624,001	\$ 29,690,868	\$ 20,360,639	\$ 6,155,819	\$ 15,723,640	\$ 10,782,553	\$ 19,435,411

- 29. Total Per Cost Report
- 30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 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
- 36. Unreconciled Difference

61,675,508

Total Contractual Adj. (G-3 Line 2)

32,662,011

+
+
+
-
-

32,662,011

Unreconciled Difference (Should be \$0)

\$ -

Unreconciled Difference (Should be \$0)

\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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
		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

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

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 3,283,317	\$ -	\$ -	\$ 3,111,593.00	\$ 171,724	232	\$ 3,746,839.00	\$ 740.19
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ 0.00	\$ -
18		Total Routine	\$ 3,283,317	\$ -	\$ -	\$ 3,111,593	\$ 171,724	232	\$ 3,746,839	\$ 740.19
19		Weighted Average								\$ 740.19

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)	31	-	\$ 22,946	\$ 196.00	\$ 60,497	0.379292

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

21	5400	RADIOLOGY-DIAGNOSTIC	\$ 766,382.00	\$ -	\$ 0.00	\$ 766,382	\$ 189,725.00	\$ 2,498,355.00	\$ 2,688,080	0.285104
22	5700	CT SCAN	\$ 152,018.00	\$ -	\$ 0.00	\$ 152,018	\$ 329,668.00	\$ 5,979,894.00	\$ 6,309,562	0.024093
23	5800	MRI	\$ 88,528.00	\$ -	\$ 0.00	\$ 88,528	\$ 15,534.00	\$ 302,216.00	\$ 317,750	0.278609
24	6000	LABORATORY	\$ 1,290,673.00	\$ -	\$ 0.00	\$ 1,290,673	\$ 1,610,327.00	\$ 6,663,818.00	\$ 8,274,145	0.155989
25	6500	RESPIRATORY THERAPY	\$ 597,625.00	\$ -	\$ 0.00	\$ 597,625	\$ 922,864.00	\$ 240,577.00	\$ 1,163,441	0.513670
26	6600	PHYSICAL THERAPY	\$ 877,855.00	\$ -	\$ 0.00	\$ 877,855	\$ 1,954,062.00	\$ 1,096,044.00	\$ 3,050,106	0.287811
27	6601	PHYSICAL THERAPY - SNF	\$ 321,109.00	\$ -	\$ 0.00	\$ 321,109	\$ 353,606.00	\$ 0.00	\$ 353,606	0.908098
28	6700	OCCUPATIONAL THERAPY	\$ 426,782.00	\$ -	\$ 0.00	\$ 426,782	\$ 1,802,238.00	\$ 256,692.00	\$ 2,058,930	0.207283
29	6701	OCCUPATIONAL THERAPY - SNF	\$ 196,961.00	\$ -	\$ 0.00	\$ 196,961	\$ 257,803.00	\$ 0.00	\$ 257,803	0.763998

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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	6800 SPEECH PATHOLOGY	\$170,601.00	\$ -	\$0.00	\$ 170,601	\$173,585.00	\$156,815.00	\$ 330,400	0.516347
31	6801 SPEECH PATHOLOGY - SNF	\$55,601.00	\$ -	\$0.00	\$ 55,601	\$111,359.00	\$0.00	\$ 111,359	0.499295
32	6900 ELECTROCARDIOLOGY	\$35,743.00	\$ -	\$0.00	\$ 35,743	\$45,724.00	\$595,127.00	\$ 640,851	0.055774
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$180,205.00	\$ -	\$0.00	\$ 180,205	\$438,607.00	\$309,738.00	\$ 748,345	0.240805
34	7300 DRUGS CHARGED TO PATIENTS	\$1,021,796.00	\$ -	\$0.00	\$ 1,021,796	\$3,392,712.00	\$1,101,601.00	\$ 4,494,313	0.227353
35	9100 EMERGENCY	\$2,341,627.00	\$ -	\$0.00	\$ 2,341,627	\$250,588.00	\$8,612,179.00	\$ 8,862,767	0.264209
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 8,523,506	\$ -	\$ -	\$ 8,523,506	\$ 11,848,598	\$ 27,873,357	\$ 39,721,955	
127	Weighted Average								0.215157
128	Sub Totals	\$ 11,806,823	\$ -	\$ -	\$ 8,695,230	\$ 15,595,437	\$ 27,873,357	\$ 43,468,794	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$1,161,936.00				
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				\$ 7,533,294				
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 (10/01/2018-09/30/2019) MITCHELL COUNTY 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-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis				
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days			
1	03000 ADULTS & PEDIATRICS	\$ 740.19		14		7		22		15		35		58		46.27%	
2	03100 INTENSIVE CARE UNIT	\$ -															
3	03200 CORONARY CARE UNIT	\$ -															
4	03300 BURN INTENSIVE CARE UNIT	\$ -															
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -															
6	03500 OTHER SPECIAL CARE UNIT	\$ -															
7	04000 SUBPROVIDER I	\$ -															
8	04100 SUBPROVIDER II	\$ -															
9	04200 OTHER SUBPROVIDER	\$ -															
10	04300 NURSERY	\$ -															
11		\$ -															
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
18		\$ -															
				Total Days		14		7		22		15		35		58	40.09%
19	Total Days per PS&R or Exhibit Detail			14		7		22		15		35		58			
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-			
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	2.02%
21.01	Calculated Routine Charge Per Diem	\$ 9.660		\$ 9.660		\$ 8.280		\$ 8.3573		\$ 8.3933		\$ 8.3869		\$ 8.0055		\$ 46.432	
22	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	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.379292	51	4,371	-	10,055	-	-	6,914	-	1,008	-	51	22,348	37.02%	
23	5400 RADIOLOGY-DIAGNOSTIC		0.285104	1,655	196,521	204	422,093	1,158	276,816	688	132,893	3,085	386,010	3,705	986,323	51.44%	
24	5700 CT SCAN		0.024083	5,091	273,366	10,137	688,057	988	784,159	988	293,848	5,028	1,354,844	17,204	2,039,430	54.34%	
25	5800 MRI		0.278609	-	6,086	-	8,270	-	40,873	2,504	-	-	37,846	5,008	74,889	37.06%	
26	6000 LABORATORY		0.155989	17,598	485,464	7,589	892,864	27,711	567,598	19,604	168,293	38,170	1,223,655	72,502	2,114,219	41.78%	
27	6500 RESPIRATORY THERAPY		0.513670	3,397	13,844	-	33,519	5,756	30,572	2,651	8,400	7,836	44,755	11,804	86,335	12.97%	
28	6600 PHYSICAL THERAPY		0.287811	855	73,405	-	45,820	2,275	110,875	1,811	57,504	-	35,262	4,941	287,604	10.75%	
29	6601 PHYSICAL THERAPY - SNF		0.908098	-	-	-	-	-	-	-	-	-	-	-	-	0.00%	
30	6700 OCCUPATIONAL THERAPY		0.207263	462	14,578	-	36,324	2,269	27,592	1,551	10,722	-	16,481	4,282	89,216	5.34%	
31	6701 OCCUPATIONAL THERAPY - SNF		0.783988	-	-	-	-	-	-	-	-	-	-	-	-	0.00%	
32	6800 SPEECH PATHOLOGY		0.518347	255	672	-	91,550	432	3,515	432	-	-	1,735	1,119	112,403	34.88%	
33	6801 SPEECH PATHOLOGY - SNF		0.499295	-	-	-	21,750	-	-	-	-	-	-	-	21,750	19.53%	
34	6900 ELECTROCARDIOLOGY		0.055774	2,386	27,441	-	-	2,770	104,997	2,386	37,534	4,676	41,580	7,542	169,972	34.92%	
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.240805	4,219	21,255	219	51,272	2,604	36,964	985	9,834	1,774	72,180	8,027	119,325	26.95%	
36	7300 DRUGS CHARGED TO PATIENTS		0.227353	6,772	608,031	6,005	147,949	14,760	101,463	6,302	25,811	31,732	293,460	33,839	883,054	27.68%	
37	9100 EMERGENCY		0.284209	3,802	552,591	2,922	1,812,382	-	787,146	-	312,302	-	2,223,347	6,724	3,464,421	64.39%	
38			-	-	-	-	-	-	-	-	-	-	-	-	-		
39			-	-	-	-	-	-	-	-	-	-	-	-	-		
40			-	-	-	-	-	-	-	-	-	-	-	-	-		
41			-	-	-	-	-	-	-	-	-	-	-	-	-		
42			-	-	-	-	-	-	-	-	-	-	-	-	-		
43			-	-	-	-	-	-	-	-	-	-	-	-	-		
44			-	-	-	-	-	-	-	-	-	-	-	-	-		
45			-	-	-	-	-	-	-	-	-	-	-	-	-		
46			-	-	-	-	-	-	-	-	-	-	-	-	-		
47			-	-	-	-	-	-	-	-	-	-	-	-	-		
48			-	-	-	-	-	-	-	-	-	-	-	-	-		
49			-	-	-	-	-	-	-	-	-	-	-	-	-		
50			-	-	-	-	-	-	-	-	-	-	-	-	-		
51			-	-	-	-	-	-	-	-	-	-	-	-	-		
52			-	-	-	-	-	-	-	-	-	-	-	-	-		
53			-	-	-	-	-	-	-	-	-	-	-	-	-		
54			-	-	-	-	-	-	-	-	-	-	-	-	-		
55			-	-	-	-	-	-	-	-	-	-	-	-	-		
56			-	-	-	-	-	-	-	-	-	-	-	-	-		
57			-	-	-	-	-	-	-	-	-	-	-	-	-		
58			-	-	-	-	-	-	-	-	-	-	-	-	-		
59			-	-	-	-	-	-	-	-	-	-	-	-	-		
60			-	-	-	-	-	-	-	-	-	-	-	-	-		

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

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61															
62															
63															
64															
65															
66															
67															
68															
69															
70															
71															
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78															
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116															
117															
118															
119															
120															
121															
122															
123															
124															
125															
126															
127															
			\$ 46,543	\$ 2,237,625	\$ 27,076	\$ 4,261,905	\$ 63,227	\$ 2,879,484	\$ 39,902	\$ 1,094,275	\$ 92,301	\$ 5,731,155			

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

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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)	\$ 56,203	\$ 2,237,625	\$ 32,872	\$ 4,261,905	\$ 81,613	\$ 2,879,484	\$ 52,492	\$ 1,094,275	\$ 121,655	\$ 5,731,155	\$ 223,180	\$ 10,473,289	38.16%
129 Total Charges per PS&R or Exhibit Detail	\$ 56,203	\$ 2,237,625	\$ 32,872	\$ 4,261,905	\$ 81,613	\$ 2,879,484	\$ 52,492	\$ 1,094,275	\$ 121,655	\$ 5,731,155			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 19,633	\$ 452,784	\$ 8,858	\$ 903,209	\$ 30,101	\$ 501,309	\$ 19,309	\$ 201,570	\$ 44,789	\$ 1,055,414	\$ 77,901	\$ 2,058,872	43.05%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 30,559	\$ 408,593	\$ -	\$ -	\$ 8,685	\$ 230,114	\$ 7,321	\$ 41,455			\$ 46,565	\$ 680,162	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 8,811	\$ 1,204,711	\$ -	\$ -	\$ -	\$ -			\$ 8,811	\$ 1,204,711	
134 Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ -	\$ 38	\$ 1,804	\$ -	\$ 117			\$ 38	\$ 1,921	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 30,559	\$ 408,593	\$ 8,811	\$ 1,204,711									
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (30,068)	\$ -	\$ -								\$ (30,068)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -								\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 21,882	\$ 299,928	\$ -	\$ -			\$ 21,882	\$ 299,928	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 11,993	\$ 125,086			\$ 11,993	\$ 125,086	
141 Medicare Cross-Over Bad Debt Payments					\$ 2,438	\$ 24,385	\$ -	\$ -			\$ 2,438	\$ 24,385	
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 15	\$ 119,524			
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)	\$ (10,926)	\$ 74,259	\$ 47	\$ (301,502)	\$ (2,942)	\$ (54,922)	\$ (5)	\$ 34,912	\$ 44,774	\$ 935,890	\$ (13,826)	\$ (247,253)	
146 Calculated Payments as a Percentage of Cost	156%	84%	99%	133%	110%	111%	100%	83%	0%	11%	118%	112%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					120								
148 Percent of cross-over days to total Medicare days from the cost report					18%								

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 refers to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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 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 PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
	Routine Cost Centers (list below):			Days	Days	Days	Days	Days	Days	Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 740.19											
2	03100 INTENSIVE CARE UNIT	\$ -											
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ -											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days										
19	Total Days per PS&R or Exhibit Detail												
20	Unreconciled Days (Explain Variance)												
				Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges		Routine Charges	
21	Routine Charges												
21.01	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -
	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)		0.379292										
23	5400 RADIOLOGY-DIAGNOSTIC		0.285104							1,507			1,507
24	5700 CT SCAN		0.024093		6,995					5,105			12,100
25	5800 MRI		0.278609										
26	6000 LABORATORY		0.155989		3,842					4,141			7,983
27	6500 RESPIRATORY THERAPY		0.513670		107					92			199
28	6600 PHYSICAL THERAPY		0.287811										
29	6601 PHYSICAL THERAPY - SNF		0.908098										
30	6700 OCCUPATIONAL THERAPY		0.207283										
31	6701 OCCUPATIONAL THERAPY - SNF		0.763998										
32	6800 SPEECH PATHOLOGY		0.516347										
33	6801 SPEECH PATHOLOGY - SNF		0.499295										
34	6900 ELECTROCARDIOLOGY		0.055774										
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.240805		241					110			351
36	7300 DRUGS CHARGED TO PATIENTS		0.227353		397					1,461			1,858
37	9100 EMERGENCY		0.264209		6,888					5,444			12,332
38													
39													
40													
41													
42													
43													
44													
45													
46													
47													

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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				-								-	-
49				-								-	-
50				-								-	-
51				-								-	-
52				-								-	-
53				-								-	-
54				-								-	-
55				-								-	-
56				-								-	-
57				-								-	-
58				-								-	-
59				-								-	-
60				-								-	-
61				-								-	-
62				-								-	-
63				-								-	-
64				-								-	-
65				-								-	-
66				-								-	-
67				-								-	-
68				-								-	-
69				-								-	-
70				-								-	-
71				-								-	-
72				-								-	-
73				-								-	-
74				-								-	-
75				-								-	-
76				-								-	-
77				-								-	-
78				-								-	-
79				-								-	-
80				-								-	-
81				-								-	-
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100				-								-	-
101				-								-	-
102				-								-	-
103				-								-	-
104				-								-	-
105				-								-	-
106				-								-	-
107				-								-	-
108				-								-	-
109				-								-	-

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) MITCHELL COUNTY 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										\$ -	\$ -
		\$ -	\$ 18,470	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 17,860	\$ -	\$ -
Totals / Payments											
128	Total Charges (Includes organ acquisition from Section K)	\$ -	\$ 18,470	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 17,860	\$ -	\$ 36,330
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 18,470	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 17,860	\$ -	\$ -
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 2,791	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,043	\$ -	\$ 5,834
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 1,938						\$ 1,410	\$ -	\$ 3,348
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)	\$ -	\$ 1,938	\$ -	\$ -					\$ -	\$ -
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)	\$ -	\$ 853	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,633	\$ -	\$ 2,486
144	Calculated Payments as a Percentage of Cost	0%	69%	0%	0%	0%	0%	0%	46%	0%	57%

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 (10/01/2018-09/30/2019)

MITCHELL COUNTY 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-Over (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)
						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 (10/01/2018-09/30/2019)

MITCHELL COUNTY 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-Over (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)
						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 (10/01/2018-09/30/2019) MITCHELL COUNTY HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	10,732,799
19 Uninsured Hospital Charges Sec. G	5,852,810
20 Total Hospital Charges Sec. G	43,468,794
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	24.69%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	13.46%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC	\$ -

* Assessment must exclude any non-hospital assessment such as Nursing Facility.

** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.