State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

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	10/01/2016	09/30/2017	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000063A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110038

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/30/1925

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

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

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

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

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 938,542

Certification:

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

Explanation for "No" answers:

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

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

	Senior Vice President and CFO	11/6/2018
Hospital CEO or CFO Signature	Title	Date
Greg Hembree	(229) 228-2880	gshembreee@archbold.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Patricia L. Barrett	Name	
Title	Director of Reimbursement/AMH	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		

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 10/1/2016 - 9/30/2017

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		
		10/1/2016 through 9/30/2017		
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:	3/29/2018		

		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	
8a.	Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
8b.	DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Non-Small Rural	Yes	

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

		State Name	Provider No.
9.	State Name & Number	Florida	0102041
10.	State Name & Number		
11.	State Name & Number		
12.	State Name & Number		
13.	State Name & Number		
14.	State Name & Number		
15.	State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

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)	$ 457,416	$ 1,264,436	$1,721,852
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,267,077	$ 8,633,852	$10,900,929
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)	$2,724,493	$9,898,288	$12,622,781
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	16.79%	12.77%	13.64%

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 (10/01/2016 - 09/30/2017)

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)	61,593	**(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	14,257,093
8.	Outpatient Hospital Charity Care Charges	14,371,377
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 28,628,470

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	$57,174,318.00			$ 38,455,485	$ -	$ -	$ 18,718,833
12.	Subprovider I (Psych or Rehab)	$1,982,977.00			$ 1,333,752	$ -	$ -	$ 649,225
13.	Subprovider II (Psych or Rehab)	$7,983,341.00			$ 5,369,601	$ -	$ -	$ 2,613,740
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$4,318,584.00			$ 2,904,683	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$273,996,520.00	$421,208,755.00		$ 184,290,246	$ 283,305,295	$ -	$ 227,609,735
20.	Outpatient Services		$55,104,364.00			$ 37,063,233	$ -	$ 18,041,131
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	$ 341,137,156	$ 476,313,119	$ 4,318,584	$ 229,449,083	$ 320,368,528	$ 2,904,683	$ 267,632,665
28.	Total Hospital and Non Hospital		Total from Above	$ 821,768,859		Total from Above	$ 552,722,293	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	821,768,859	Total Contractual Adj. (G-3 Line 2)	552,722,293
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				552,722,293

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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	$ 33,148,739	$ -	$ -	$0.00	$ 33,148,739	47,798	$33,021,612.00		$ 693.52
2	03100 INTENSIVE CARE UNIT	$ 12,427,549	$ -	$ -		$ 12,427,549	9,888	$13,908,183.00		$ 1,256.83
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	$ 1,739,750	$ -	$ 17,536		$ 1,757,286	586	$1,142,832.00		$ 2,998.78
8	04100 SUBPROVIDER II	$ 3,524,758	$ -	$ -		$ 3,524,758	3,906	$3,242,699.00		$ 902.40
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 425,461	$ -	$ -		$ 425,461	1,603	$861,301.00		$ 265.42
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 51,266,257	$ -	$ 17,536	$ -	$ 51,283,793	63,781	$ 52,176,627		
19	Weighted Average									$ 804.06

Line #		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	2,188	-	-	$ 1,517,422	$125,227.00	$3,027,964.00	$ 3,153,191	0.481234

Line #		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$18,813,561.00	$ -	$0.00		$ 18,813,561	$24,261,850.00	$38,784,411.00	$ 63,046,261	0.298409
22	5100 RECOVERY ROOM	$3,040,622.00	$ -	$0.00		$ 3,040,622	$2,071,779.00	$4,491,215.00	$ 6,562,994	0.463298
23	5200 DELIVERY ROOM & LABOR ROOM	$2,778,816.00	$ -	$0.00		$ 2,778,816	$3,034,510.00	$781,127.00	$ 3,815,637	0.728271
24	5300 ANESTHESIOLOGY	$747,375.00	$ -	$0.00		$ 747,375	$1,928,726.00	$3,346,065.00	$ 5,274,791	0.141688
25	5400 RADIOLOGY-DIAGNOSTIC	$6,120,735.00	$ -	$0.00		$ 6,120,735	$5,783,025.00	$19,717,977.00	$ 25,501,002	0.240019
26	5500 RADIOLOGY-THERAPEUTIC	$2,802,229.00	$ -	$546.00		$ 2,802,775	$696,271.00	$20,299,928.00	$ 20,996,199	0.133490
27	5600 RADIOISOTOPE	$1,364,833.00	$ -	$0.00		$ 1,364,833	$1,395,614.00	$9,530,128.00	$ 10,925,742	0.124919
28	5700 CT SCAN	$1,509,546.00	$ -	$0.00		$ 1,509,546	$17,917,136.00	$26,872,820.00	$ 44,789,956	0.033703
29	5800 MRI	$1,247,363.00	$ -	$0.00		$ 1,247,363	$2,611,652.00	$9,736,830.00	$ 12,348,482	0.101013
30	5900 CARDIAC CATHETERIZATION	$2,971,627.00	$ -	$0.00		$ 2,971,627	$3,221,810.00	$8,809,474.00	$ 12,031,284	0.246992
31	6000 LABORATORY	$11,441,891.00	$ -	$0.00		$ 11,441,891	$45,002,600.00	$41,043,411.00	$ 86,046,011	0.132974

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
32	6300	BLOOD STORING PROCESSING & TRANS.	$2,008,102.00	$ -	$0.00		$ 2,008,102	$4,329,622.00	$1,280,581.00	$ 5,610,203	0.357937
33	6400	INTRAVENOUS THERAPY	$1,433,444.00	$ -	$0.00		$ 1,433,444	$3,482,318.00	$2,908,731.00	$ 6,391,049	0.224289
34	6500	RESPIRATORY THERAPY	$3,328,612.00	$ -	$1,298.00		$ 3,329,910	$12,329,967.00	$4,073,437.00	$ 16,403,404	0.203001
35	6600	PHYSICAL THERAPY	$5,375,517.00	$ -	$0.00		$ 5,375,517	$11,674,768.00	$9,534,033.00	$ 21,208,801	0.253457
36	6900	ELECTROCARDIOLOGY	$214,991.00	$ -	$0.00		$ 214,991	$1,741,763.00	$1,728,928.00	$ 3,470,691	0.061945
37	7000	ELECTROENCEPHALOGRAPHY	$717,759.00	$ -	$0.00		$ 717,759	$195,326.00	$1,809,307.00	$ 2,004,633	0.358050
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$13,015,595.00	$ -	$0.00		$ 13,015,595	$24,134,422.00	$22,814,302.00	$ 46,948,724	0.277230
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$12,098,214.00	$ -	$0.00		$ 12,098,214	$23,453,171.00	$18,479,570.00	$ 41,932,741	0.288515
40	7300	DRUGS CHARGED TO PATIENTS	$28,333,451.00	$ -	$0.00		$ 28,333,451	$58,279,847.00	$116,250,646.00	$ 174,530,493	0.162341
41	7400	RENAL DIALYSIS	$13,080,220.00	$ -	$0.00		$ 13,080,220	$2,720,789.00	$48,968,919.00	$ 51,689,708	0.253053
42	7600	CARDIOVASCULAR	$3,099,037.00	$ -	$0.00		$ 3,099,037	$7,065,324.00	$17,194,916.00	$ 24,260,240	0.127741
43	7601	ONCOLOGY	$6,366,180.00	$ -	$35,212.00		$ 6,401,392	$21,643.00	$6,970,500.00	$ 6,992,143	0.915512
44	7602	OP PSYCHIATRIC	$3.00	$ -	$0.00		$ 3	$0.00	$436.00	$ 436	0.006881
45	7603	CARDIAC REHABILITATION	$458,652.00	$ -	$0.00		$ 458,652	$5,184.00	$543,677.00	$ 548,861	0.835643
46	9001	WOUND CARE	$1,363,366.00	$ -	$0.00		$ 1,363,366	$0.00	$1,066,939.00	$ 1,066,939	1.277829
47	9100	EMERGENCY	$12,050,361.00	$ -	$836,339.00		$ 12,886,700	$17,250,470.00	$16,049,532.00	$ 33,300,002	0.386988
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
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**	$ 155,782,102	$ -	$ 873,395		$ 156,655,497	$ 274,734,814	$ 456,115,804	$ 730,850,618	
127		**Weighted Average**									0.216423
128		**Sub Totals**	$ 207,048,359	$ -	$ 890,931		$ 207,939,290	$ 326,911,441	$ 456,115,804	$ 783,027,245	
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)*					$53,541.00				
131		NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 207,885,749				
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 (10/01/2016-09/30/2017) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 693.52		6,160		1,664		6,016		4,643		2,940		18,483		47.10%
2	03100 INTENSIVE CARE UNIT	$ 1,256.83		1,041		58		1,285		652		827		3,036		39.35%
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	$ 2,998.78												-		0.00%
8	04100 SUBPROVIDER II	$ 902.40												-		0.00%
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 265.42		80		976				90		28		1,146		73.24%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	7,281		2,698		7,301		5,385		3,795		22,665		41.62%
19	Total Days per PS&R or Exhibit Detail			7,281		2,698		7,301		5,385		3,795				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 5,304,805		$ 1,756,117		$ 7,345,917		$ 4,345,118		$ 3,334,823		$ 18,751,957		42.47%
21.01	Calculated Routine Charge Per Diem			$ 728.58		$ 650.90		$ 1,006.15		$ 806.89		$ 878.74		$ 827.35		
	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)		0.481234	64,263	443,925	1,827	136,005	4,974	598,789	3,316	266,229	-	18,951	$ 74,380	$ 1,444,948	49.06%
23	5000 OPERATING ROOM		0.298409	2,003,106	1,650,601	1,270,923	1,989,567	3,124,835	4,486,200	1,969,080	2,027,665	1,412,623	1,807,468	$ 8,367,944	$ 10,154,033	34.56%
24	5100 RECOVERY ROOM		0.463298	175,671	229,306	134,749	360,614	271,131	511,739	173,414	221,788	124,328	229,231	$ 754,965	$ 1,323,447	37.15%
25	5200 DELIVERY ROOM & LABOR ROOM		0.728271	111,843	19,621	1,766,382	384,755	11,161	6,017	391,682	163,502	41,825	22,039	$ 2,281,068	$ 573,895	76.83%
26	5300 ANESTHESIOLOGY		0.141688	134,614	133,226	90,133	176,407	237,481	337,709	146,077	154,945	119,493	161,303	$ 608,305	$ 802,287	32.12%
27	5400 RADIOLOGY-DIAGNOSTIC		0.240019	657,338	1,087,175	115,146	1,060,689	1,262,571	2,325,413	658,471	1,045,396	379,989	1,624,613	$ 2,693,526	$ 5,518,673	40.17%
28	5500 RADIOLOGY-THERAPEUTIC		0.133490	186,102	1,876,884	-	747,215	163,574	2,834,540	16,044	1,041,775	64,154	689,763	$ 365,720	$ 6,500,414	36.33%
29	5600 RADIOISOTOPE		0.124919	131,755	328,930	4,572	136,594	234,929	1,241,471	91,324	479,995	128,938	494,626	$ 462,580	$ 2,186,990	30.66%
30	5700 CT SCAN		0.033703	1,275,397	1,830,961	200,328	1,390,813	2,092,709	3,483,763	1,094,326	1,369,087	519,555	4,425,130	$ 4,662,760	$ 8,074,624	39.53%
31	5800 MRI		0.101013	253,225	395,268	64,740	357,938	484,466	1,040,328	253,713	464,144	267,392	547,050	$ 1,056,144	$ 2,257,678	33.49%
32	5900 CARDIAC CATHETERIZATION		0.246992	-	-	69,942	68,272	545,105	746,596	277,811	333,055	433,386	457,854	$ 892,858	$ 1,147,923	24.37%
33	6000 LABORATORY		0.132974	5,310,903	2,426,704	1,197,020	2,657,116	7,822,671	3,895,068	4,429,732	1,974,543	3,251,082	3,847,862	$ 18,760,326	$ 10,953,431	42.95%
34	6300 BLOOD STORING PROCESSING & TRANS.		0.357937	226,342	38,500	50,335	8,862	555,601	110,323	330,811	95,916	384,363	120,919	$ 1,163,089	$ 253,601	34.40%
35	6400 INTRAVENOUS THERAPY		0.224289	6,248	1,219,647	41,026	2,299	577,359	908,537	369,602	81,562	218,454	22,396	$ 994,235	$ 2,212,045	54.09%
36	6500 RESPIRATORY THERAPY		0.203001	1,574,015	160,510	51,040	135,410	2,407,507	371,744	1,276,494	159,022	561,411	417,655	$ 5,309,056	$ 826,686	43.50%
37	6600 PHYSICAL THERAPY		0.253457	706,483	135,178	46,176	418,916	1,041,652	748,529	783,021	397,279	432,808	319,494	$ 2,577,332	$ 1,699,902	23.80%
38	6900 ELECTROCARDIOLOGY		0.061945	115,111	132,018	10,797	89,042	223,114	295,213	118,944	130,060	36,075	278,636	$ 467,966	$ 646,333	41.35%
39	7000 ELECTROENCEPHALOGRAPHY		0.358050	21,250	146,454	1,244	92,090	47,675	245,734	18,660	115,976	12,440	127,582	$ 88,829	$ 600,254	41.36%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.277230	2,223,952	934,936	783,540	977,320	3,771,804	3,086,698	2,245,585	1,187,551	1,461,032	1,570,674	$ 9,024,881	$ 6,186,505	38.99%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.288515	1,852,415	815,660	388,787	281,705	3,057,514	2,614,392	1,830,551	843,317	953,066	811,788	$ 7,129,267	$ 4,555,074	32.14%
42	7300 DRUGS CHARGED TO PATIENTS		0.162341	6,509,684	9,394,542	1,250,128	2,952,559	9,387,423	9,397,882	5,473,006	4,267,175	4,054,108	3,838,851	$ 22,620,241	$ 26,012,158	32.46%
43	7400 RENAL DIALYSIS		0.253053	205,296	-	192,095	532,519	626,544	222,806	210,466	80,015	51,609	67,735	$ 1,234,401	$ 835,340	4.24%
44	7600 CARDIOVASCULAR		0.127741	827,573	613,271	268,406	337,237	1,346,101	1,987,760	646,894	775,653	827,756	929,676	$ 3,088,974	$ 3,713,921	35.30%
45	7601 ONCOLOGY		0.915512	55	201,466	3,020	367,841	8,762	843,805	5,554	403,347	-	138,416	$ 17,391	$ 1,816,459	28.21%
46	7602 OP PSYCHIATRIC		0.006881	-	-	-	-	-	218	-	-	-	-	$ -	$ 218	50.00%
47	7603 CARDIAC REHABILITATION		0.835643	486	-	162	2,106	648	37,260	486	29,646	324	23,360	$ 1,782	$ 69,012	17.21%
48	9001 WOUND CARE		1.277829	-	-	-	48,900	-	89,987	-	44,579	-	564,296	$ -	$ 183,466	70.13%
49	9100 EMERGENCY		0.386988	1,083,150	1,360,867	188,801	2,548,243	1,742,767	2,384,160	920,260	1,051,599	33,240	5,329,286	$ 3,934,978	$ 7,344,869	50.31%
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
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80			-											$ -	$ -	
81			-											$ -	$ -	

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

Cost Report Year (10/01/2016-09/30/2017) 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		% Survey
82			-											$ -	$ -	
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
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107			-											$ -	$ -	
108			-											$ -	$ -	
109			-											$ -	$ -	
110			-											$ -	$ -	
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115			-											$ -	$ -	
116			-											$ -	$ -	
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119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 25,656,277	$ 25,575,650	$ 8,191,319	$ 18,261,034	$ 41,050,078	$ 44,852,681	$ 23,735,324	$ 19,204,821	$ 15,769,451	$ 28,886,654			

Totals / Payments

128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 30,961,082	$ 25,575,650	$ 9,947,436	$ 18,261,034	$ 48,395,995	$ 44,852,681	$ 28,080,442	$ 19,204,821	$ 19,104,274 (Agrees to Exhibit A)	$ 28,886,654 (Agrees to Exhibit A)	$ 117,384,955	$ 107,894,186	35.01%
129	Total Charges per PS&R or Exhibit Detail	$ 30,961,082	$ 25,575,650	$ 9,947,436	$ 18,261,034	$ 48,395,995	$ 44,852,681	$ 28,080,442	$ 19,204,821	$ 19,104,274	$ 28,886,654			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 10,766,930	$ 5,046,352	$ 4,187,246	$ 4,528,407	$ 14,115,297	$ 9,834,633	$ 9,140,234	$ 4,342,515	$ 6,199,083	$ 6,701,991	$ 38,209,707	$ 23,751,907	36.13%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 10,444,880	$ 4,592,880	$ -	$ -	$ 1,271,897	$ 749,374	$ 7,205,793	$ 4,062,338			$ 18,922,570	$ 9,404,592	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 3,562,029	$ 4,069,342	$ -	$ -	$ 1,124,219	$ 911,854			$ 4,686,248	$ 4,981,196	
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)	$ 10,444,880	$ 4,592,880	$ 3,562,029	$ 4,069,342									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (182,002)	$ -	$ -							$ -	$ (182,002)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 11,322,060	$ 7,806,740	$ -	$ -			$ 11,322,060	$ 7,806,740	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 194,898	$ 481,890	$ -	$ -			$ 194,898	$ 481,890	
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)									$ 457,416	$ 1,264,436			
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)**	$ 322,050	$ 635,474	$ 625,217	$ 459,065	$ 1,326,442	$ 796,629	$ 810,222	$ (631,677)	$ 5,741,667	$ 5,437,555	$ 3,083,931	$ 1,259,491	
146	**Calculated Payments as a Percentage of Cost**	97%	87%	85%	90%	91%	92%	91%	115%	7%	19%	92%	95%	

147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**	36,189
148	**Percent of cross-over days to total Medicare days from the cost report**	20%

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 693.52				54				4		58	
2	03100 INTENSIVE CARE UNIT	$ 1,256.83				28						28	
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	$ 2,998.78										-	
8	04100 SUBPROVIDER II	$ 902.40										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 265.42										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		82		-		4		86	
19	Total Days per PS&R or Exhibit Detail			-		82		-		4			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges $ -		Routine Charges $ 71,669		Routine Charges $ -		Routine Charges $ 2,560		Routine Charges $ 74,229	
21.01	Calculated Routine Charge Per Diem			$ -		$ 874.01		$ -		$ 640.00		$ 863.13	
	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)		0.481234			-	1,658			-	6,973	$ -	$ 8,631
23	5000 OPERATING ROOM		0.298409			28,839	3,075			7,653	4,565	$ 36,492	$ 7,640
24	5100 RECOVERY ROOM		0.463298			1,856	858			1,547	2,021	$ 3,403	$ 2,879
25	5200 DELIVERY ROOM & LABOR ROOM		0.728271			7,011	1,131			4,672	-	$ 11,683	$ 1,131
26	5300 ANESTHESIOLOGY		0.141688			1,924	-			476	352	$ 2,400	$ 352
27	5400 RADIOLOGY-DIAGNOSTIC		0.240019			9,260	12,104			275	6,525	$ 9,535	$ 18,629
28	5500 RADIOLOGY-THERAPEUTIC		0.133490			2,124	6,424			-	-	$ 2,124	$ 6,424
29	5600 RADIOISOTOPE		0.124919			26,069	50,107			-	-	$ 26,069	$ 50,107
30	5700 CT SCAN		0.033703			-	-			-	23,027	$ -	$ 23,027
31	5800 MRI		0.101013			7,253	-			-	-	$ 7,253	$ -
32	5900 CARDIAC CATHETERIZATION		0.246992			-	-			-	-	$ -	$ -
33	6000 LABORATORY		0.132974			74,016	42,324			1,426	28,667	$ 75,442	$ 70,991
34	6300 BLOOD STORING PROCESSING & TRANS.		0.357937			7,803	-			-	-	$ 7,803	$ -
35	6400 INTRAVENOUS THERAPY		0.224289			9,913	-			-	-	$ 9,913	$ -
36	6500 RESPIRATORY THERAPY		0.203001			13,077	4,650			-	3,462	$ 13,077	$ 8,112
37	6600 PHYSICAL THERAPY		0.253457			14,161	-			868	3,909	$ 15,029	$ 3,909
38	6900 ELECTROCARDIOLOGY		0.061945			885	2,832			-	2,301	$ 885	$ 5,133
39	7000 ELECTROENCEPHALOGRAPHY		0.358050			-	-			-	-	$ -	$ -
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.277230			47,564	5,852			5,385	4,710	$ 52,949	$ 10,562
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.288515			12,616	-			16,934	380	$ 29,550	$ 380
42	7300 DRUGS CHARGED TO PATIENTS		0.162341			102,271	11,440			5,986	9,118	$ 108,257	$ 20,558
43	7400 RENAL DIALYSIS		0.253053			-	-			-	2,253	$ -	$ 2,253
44	7600 CARDIOVASCULAR		0.127741			511	2,054			-	2,086	$ 511	$ 4,140
45	7601 ONCOLOGY		0.915512			-	-			-	-	$ -	$ -
46	7602 OP PSYCHIATRIC		0.006881			-	-			-	-	$ -	$ -
47	7603 CARDIAC REHABILITATION		0.835643			-	-			-	-	$ -	$ -
48	9001 WOUND CARE		1.277829			-	253			-	213	$ -	$ 466
49	9100 EMERGENCY		0.386988			6,912	71,689			-	33,000	$ 6,912	$ 104,689
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
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68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) 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	
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ 374,065	$ 216,451	$ -	$ -	$ 45,222	$ 133,562		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ 445,734	$ 216,451	$ -	$ -	$ 47,782	$ 133,562	$ 493,516	$ 350,013
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ 445,734	$ 216,451	$ -	$ -	$ 47,782	$ 133,562		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ 151,307	$ 51,514	$ -	$ -	$ 17,070	$ 30,469	$ 168,377	$ 81,983
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)	$ -	$ -	$ 38,100	$ 26,243	$ -	$ -	$ 9,481	$ 27,834	$ 47,581	$ 54,077
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)	$ -	$ -	$ 38,100	$ 26,243						
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)**	$ -	$ -	$ 113,207	$ 25,271	$ -	$ -	$ 7,589	$ 2,635	$ 120,796	$ 27,906
144	**Calculated Payments as a Percentage of Cost**	0%	0%	25%	51%	0%	0%	56%	91%	28%	66%

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 (10/01/2016-09/30/2017) 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 Acquistion 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 (10/01/2016-09/30/2017) 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 Acquistion 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 (10/01/2016-09/30/2017) 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)*		$ 3,115,512		
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 ---------->)		$ 3,115,512		
	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	$ 3,115,512	

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