

A. General DSH Year Information

	Begin	End
1. DSH Year:	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:	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:

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?

6/30/1925

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** \$ 2,191,385
 (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** \$ 2,191,385

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: 1px solid black;">Name</td><td style="border: 1px solid black;">Patricia L. Barrett</td></tr> <tr><td style="border: 1px solid black;">Title</td><td style="border: 1px solid black;">Director of Reimbursement</td></tr> <tr><td style="border: 1px solid black;">Telephone Number</td><td style="border: 1px solid black;">(229) 228-8857</td></tr> <tr><td style="border: 1px solid black;">E-Mail Address</td><td style="border: 1px solid black;">pbarrett@archbold.org</td></tr> <tr><td style="border: 1px solid black;">Mailing Street Address</td><td style="border: 1px solid black;">920 Cairo Rd</td></tr> <tr><td style="border: 1px solid black;">Mailing City, State, Zip</td><td style="border: 1px solid black;">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: 1px solid black;">Name</td><td style="border: 1px solid black;"></td></tr> <tr><td style="border: 1px solid black;">Title</td><td style="border: 1px solid black;"></td></tr> <tr><td style="border: 1px solid black;">Firm Name</td><td style="border: 1px solid black;"></td></tr> <tr><td style="border: 1px solid black;">Telephone Number</td><td style="border: 1px solid black;"></td></tr> <tr><td style="border: 1px solid black;">E-Mail Address</td><td style="border: 1px solid black;"></td></tr> </table>	Name		Title		Firm Name		Telephone Number		E-Mail Address	
Name	Patricia L. Barrett																						
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Firm Name																							
Telephone Number																							
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	
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- 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:	JOHN D. ARCHBOLD MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000063A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110038	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Non-Small Rural	Yes	

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

	State Name	Provider No.
9. State Name & Number	Florida	0102041
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
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)	\$ 218,872	\$ 1,160,404	\$1,379,276
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 1,707,277	\$ 6,596,623	\$8,303,900
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	\$1,926,149	\$7,757,027	\$9,683,176
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.36%	14.96%	14.24%

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)

59,961

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

13,793,929
17,730,405
-
\$ 31,524,334

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	\$68,639,711.00			\$ 45,874,657	\$ -	\$ -	\$ 22,765,054
12. Subprovider I (Psych or Rehab)	\$6,081,515.00			\$ 4,064,519	\$ -	\$ -	\$ 2,016,996
13. Subprovider II (Psych or Rehab)	\$5,174,783.00			\$ 3,458,514	\$ -	\$ -	\$ 1,716,269
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$4,672,340.00			\$ 3,122,711	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$300,218,660.00	\$385,902,223.00		\$ 200,648,107	\$ 257,913,851	\$ -	\$ 227,558,925
20. Outpatient Services		\$49,221,321.00			\$ 32,896,572	\$ -	\$ 16,324,749
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	\$ 380,114,669	\$ 435,123,544	\$ 4,672,340	\$ 254,045,798	\$ 290,810,423	\$ 3,122,711	\$ 270,381,992

- 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

819,910,553

Total Contractual Adj. (G-3 Line 2)

547,978,932

+
+
+
-
-
547,978,932

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) 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
		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. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, 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	\$ 36,174,484	\$ -	\$ 2,039	\$ 0.00	\$ 36,176,523	49,516	\$42,161,635.00	\$ 730.60
2	03100	INTENSIVE CARE UNIT	\$ 12,469,887	\$ -	\$ -	\$ -	\$ 12,469,887	4,771	\$15,839,531.00	\$ 2,613.68
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
7	04000	SUBPROVIDER I	\$ 3,400,810	\$ -	\$ -	\$ -	\$ 3,400,810	3,378	\$6,539,021.00	\$ 1,006.75
8	04100	SUBPROVIDER II	\$ 3,448,274	\$ -	\$ -	\$ -	\$ 3,448,274	2,722	\$3,000,671.00	\$ 1,266.82
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 514,919	\$ -	\$ -	\$ -	\$ 514,919	1,417	\$1,022,926.00	\$ 363.39
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 56,008,374	\$ -	\$ 2,039	\$ -	\$ 56,010,413	61,804	\$ 68,563,784	
19		Weighted Average								\$ 906.26

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	1,843	-	-	\$ 1,346,496	\$688,259.00	\$5,062,059.00	\$ 5,750,318	0.234160

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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below)

21	5000	OPERATING ROOM	\$20,563,907.00	\$ -	\$ 0.00	\$ 20,563,907	\$37,867,062.00	\$51,688,885.00	\$ 89,555,947	0.229621
22	5100	RECOVERY ROOM	\$3,570,405.00	\$ -	\$ 0.00	\$ 3,570,405	\$2,998,667.00	\$6,127,938.00	\$ 9,126,605	0.391208
23	5200	DELIVERY ROOM & LABOR ROOM	\$2,922,210.00	\$ -	\$ 0.00	\$ 2,922,210	\$2,714,325.00	\$660,570.00	\$ 3,374,895	0.865867
24	5300	ANESTHESIOLOGY	\$907,773.00	\$ -	\$13,074.00	\$ 920,847	\$2,448,361.00	\$3,753,489.00	\$ 6,201,850	0.148479
25	5400	RADIOLOGY-DIAGNOSTIC	\$5,464,252.00	\$ -	\$ 0.00	\$ 5,464,252	\$7,491,784.00	\$17,819,752.00	\$ 25,311,536	0.215880
26	5500	RADIOLOGY-THERAPEUTIC	\$2,814,156.00	\$ -	\$960.00	\$ 2,815,116	\$1,103,230.00	\$22,980,935.00	\$ 24,084,165	0.116887
27	5600	RADIOISOTOPE	\$1,501,097.00	\$ -	\$ 0.00	\$ 1,501,097	\$1,398,814.00	\$11,621,758.00	\$ 13,020,572	0.115287
28	5700	CT SCAN	\$1,429,173.00	\$ -	\$ 0.00	\$ 1,429,173	\$16,430,927.00	\$32,298,593.00	\$ 48,729,520	0.029329
29	5800	MRI	\$799,034.00	\$ -	\$ 0.00	\$ 799,034	\$3,285,658.00	\$8,978,348.00	\$ 12,264,006	0.065153

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2018-09/30/2019) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	5900 CARDIAC CATHETERIZATION	\$3,093,878.00	\$ -	\$0.00	\$ 3,093,878	\$6,857,151.00	\$9,143,796.00	\$ 16,000,947	0.193356
31	6000 LABORATORY	\$11,321,561.00	\$ -	\$0.00	\$ 11,321,561	\$54,553,448.00	\$37,114,800.00	\$ 91,668,248	0.123506
32	6300 BLOOD STORING PROCESSING & TRANS.	\$2,248,073.00	\$ -	\$0.00	\$ 2,248,073	\$4,373,750.00	\$886,641.00	\$ 5,260,391	0.427359
33	6400 INTRAVENOUS THERAPY	\$1,311,255.00	\$ -	\$0.00	\$ 1,311,255	\$1,527,265.00	\$935,609.00	\$ 2,462,874	0.532408
34	6500 RESPIRATORY THERAPY	\$3,367,140.00	\$ -	\$2,849.00	\$ 3,369,989	\$12,161,639.00	\$2,779,619.00	\$ 14,941,258	0.225549
35	6600 PHYSICAL THERAPY	\$4,362,663.00	\$ -	\$0.00	\$ 4,362,663	\$7,622,072.00	\$2,432,138.00	\$ 10,054,210	0.433914
36	6900 ELECTROCARDIOLOGY	\$153,088.00	\$ -	\$0.00	\$ 153,088	\$800,005.00	\$1,622,961.00	\$ 2,422,966	0.063182
37	7000 ELECTROENCEPHALOGRAPHY	\$796,050.00	\$ -	\$0.00	\$ 796,050	\$165,645.00	\$2,388,321.00	\$ 2,553,966	0.311692
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$18,465,134.00	\$ -	\$0.00	\$ 18,465,134	\$32,899,981.00	\$22,463,386.00	\$ 55,363,367	0.333526
39	7200 IMPL. DEV. CHARGED TO PATIENTS	\$13,139,699.00	\$ -	\$0.00	\$ 13,139,699	\$23,744,449.00	\$15,843,651.00	\$ 39,588,100	0.331910
40	7300 DRUGS CHARGED TO PATIENTS	\$31,287,391.00	\$ -	\$0.00	\$ 31,287,391	\$64,690,241.00	\$94,502,787.00	\$ 159,193,028	0.196537
41	7400 RENAL DIALYSIS	\$2,706,270.00	\$ -	\$0.00	\$ 2,706,270	\$2,879,530.00	\$0.00	\$ 2,879,530	0.939830
42	7600 RADIOLOGY	\$3,751,598.00	\$ -	\$0.00	\$ 3,751,598	\$12,815,123.00	\$21,004,866.00	\$ 33,819,989	0.110928
43	7601 ONCOLOGY	\$6,389,323.00	\$ -	\$32,255.00	\$ 6,421,578	\$95,794.00	\$7,321,383.00	\$ 7,417,177	0.865771
44	7603 RADIOLOGY	\$606,465.00	\$ -	\$0.00	\$ 606,465	\$6,834.00	\$725,703.00	\$ 732,537	0.827897
45	9001 WOUND CARE	\$1,301,031.00	\$ -	\$0.00	\$ 1,301,031	\$19,263.00	\$1,335,666.00	\$ 1,354,929	0.960221
46	9100 EMERGENCY	\$14,512,376.00	\$ -	\$1,752,881.00	\$ 16,265,257	\$10,333,178.00	\$29,407,762.00	\$ 39,740,940	0.409282
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) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$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	\$ 158,785,002	\$ -	\$ 1,802,019	\$ 160,587,021	\$ 311,972,455	\$ 410,901,416	\$ 722,873,871	
127	Weighted Average								0.224013
128	Sub Totals	\$ 214,793,376	\$ -	\$ 1,804,058	\$ 216,597,434	\$ 380,536,239	\$ 410,901,416	\$ 791,437,655	
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)				\$42,497.00				
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				\$ 216,554,937				
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) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-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	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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis	Inpatient	Outpatient	
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 730.80		7,550		1,566		6,049		2,341		3,045		17,506		43.24%
2	03100 INTENSIVE CARE UNIT	\$ 2,613.68		847		115		1,019		392		912		2,473		71.33%
3	03200 CORONARY CARE UNIT	\$ -														
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -														
6	03500 OTHER SPECIAL CARE UNIT	\$ -														
7	04000 SUBPROVIDER I	\$ 1,006.75														0.00%
8	04100 SUBPROVIDER II	\$ 1,266.82														0.00%
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ 363.39		58		807				15		51		880		65.70%
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18		\$ -														
18			Total Days	8,555		2,488		7,068		2,748		4,008		20,859		40.37%
19	Total Days per PS&R or Exhibit Detail			8,555		2,488		7,068		2,748		4,008				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			\$ 7,061,594		\$ 2,275,076		\$ 9,270,317		\$ 3,076,504		\$ 4,643,689		\$ 21,703,491		38.57%
21.01	Calculated Routine Charge Per Diem			\$ 827.77		\$ 914.42		\$ 1,311.59		\$ 1,119.54		\$ 1,158.61		\$ 1,040.49		
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)		0.234160	53,634	398,578	108,142	648,755	676,033	922,471	138,905	395,401	13,660	67,817	976,714	\$ 2,365,205	60.01%
23	5000 OPERATING ROOM		0.229621	2,762,210	1,896,550	1,604,740	2,906,499	4,861,066	7,023,901	1,763,091	982,380	2,363,200	2,574,507	\$ 10,991,107	\$ 12,809,330	32.14%
24	5100 RECOVERY ROOM		0.391208	229,062	280,156	135,365	501,011	373,008	763,632	137,934	152,621	207,065	331,917	\$ 875,369	\$ 1,697,410	34.22%
25	5200 DELIVERY ROOM & LABOR ROOM		0.865867	101,952	22,411	1,410,901	365,323	1,131	1,131	29,395	92,863	15,164	\$ 1,547,431	\$ 398,975	81.10%	
26	5300 ANESTHESIOLOGY		0.148479	173,442	163,926	93,548	218,561	290,302	384,902	112,702	77,547	169,492	\$ 669,994	\$ 844,936	30.15%	
27	5400 RADIOLOGY-DIAGNOSTIC		0.215880	664,182	960,976	157,938	1,163,577	1,228,468	2,233,671	411,291	810,609	449,718	1,696,609	\$ 2,461,879	\$ 5,168,833	38.75%
28	5500 RADIOLOGY-THERAPEUTIC		0.116887	42,230	1,687,309	23,487	773,943	209,446	2,975,762	54,163	1,248,040	30,499	776,703	\$ 329,326	\$ 6,685,054	32.48%
29	5600 RADIOISOTOPE		0.115287	114,546	423,964	10,860	179,496	221,647	1,674,574	84,859	834,075	206,266	648,272	\$ 431,912	\$ 3,112,109	33.84%
30	5700 CT SCAN		0.029329	1,459,397	1,853,320	329,703	1,529,854	2,471,929	4,000,495	734,485	1,647,336	690,534	5,104,015	\$ 4,995,514	\$ 9,031,005	40.83%
31	5800 MRI		0.065153	288,815	462,905	71,808	363,653	484,076	1,159,092	140,646	546,019	282,078	544,540	\$ 965,345	\$ 2,531,668	35.32%
32	5900 CARDIAC CATHETERIZATION		0.193356	-	-	52,673	88,242	810,467	1,105,358	359,211	436,708	596,060	723,729	\$ 1,222,351	\$ 1,630,308	26.08%
33	6000 LABORATORY		0.123506	5,442,559	2,514,714	1,432,945	3,094,730	8,469,962	4,183,572	2,766,323	1,438,615	4,383,334	4,482,085	\$ 18,111,759	\$ 11,231,631	41.66%
34	6300 BLOOD STORING PROCESSING & TRANS.		0.427359	261,747	34,708	79,771	11,074	598,518	146,253	205,148	34,955	47,862	\$ 1,112,759	\$ 226,990	32.16%	
35	6400 INTRAVENOUS THERAPY		0.532408	261,747	637,021	32,931	368	366,698	140,038	98,391	7,324	134,495	6,568	\$ 759,767	\$ 784,751	68.56%
36	6500 RESPIRATORY THERAPY		0.225549	1,314,013	169,057	107,731	169,748	2,109,777	394,550	719,591	173,245	568,727	418,522	\$ 4,251,112	\$ 906,600	41.23%
37	6600 PHYSICAL THERAPY		0.433914	463,197	90,850	89,575	131,218	824,599	265,173	293,200	72,192	318,653	57,679	\$ 1,670,571	\$ 559,453	25.98%
38	6800 ELECTROCARDIOLOGY		0.063182	72,717	89,095	10,176	58,894	137,132	198,178	44,734	69,961	22,907	191,428	\$ 264,759	\$ 416,128	37.13%
39	7000 ELECTROENCEPHALOGRAPHY		0.311692	15,880	294,880	1,470	165,379	31,850	6,370	8,370	4,291	67,257	\$ 55,370	\$ 811,687	\$ 26,988	3.31%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.333526	2,622,055	1,114,601	910,748	1,189,755	4,632,439	3,209,645	1,606,124	636,914	1,798,638	1,952,090	\$ 9,771,366	\$ 6,150,915	35.61%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.331910	1,645,350	680,798	403,176	329,431	3,359,967	2,840,703	1,314,795	156,345	965,810	578,099	\$ 6,723,288	\$ 4,007,277	31.01%
42	7300 DRUGS CHARGED TO PATIENTS		0.196537	6,477,113	5,581,763	1,598,166	3,136,204	9,202,413	14,052,623	2,315,096	4,771,222	4,394,336	\$ 19,592,788	\$ 28,619,174	36.10%	
43	7400 RENAL DIALYSIS		0.939830	180,532	-	-	-	-	-	-	-	64,266	-	\$ 180,532	\$ -	8.50%
44	7600 RADIOLOGY		0.110928	1,130,154	938,297	304,974	430,786	1,861,548	2,975,637	560,366	1,038,884	1,375,588	1,371,293	\$ 3,857,042	\$ 5,383,604	35.49%
45	7601 ONCOLOGY		0.865171	4,304	19,499	5,217	77,745	77,745	769,030	172,698	-	410,907	-	\$ 9,521	\$ 1,058,972	32.14%
46	7603 CARDIAC REHABILITATION		0.827897	201	-	-	804	603	603	13,162	603	15,354	1,608	\$ 43,312	\$ -	3.31%
47	9001 WOUND CARE		0.960221	-	348,768	4,881	266,772	5,713	217,571	1,814	132,442	-	126,076	\$ 12,408	\$ 965,553	81.53%
48	9100 EMERGENCY		0.409282	1,288,844	1,872,634	264,629	3,721,024	1,916,438	3,036,903	643,634	1,111,546	-	6,974,558	\$ 4,113,545	\$ 9,742,107	52.85%
49														\$ -	\$ -	
50														\$ -	\$ -	
51														\$ -	\$ -	
52														\$ -	\$ -	
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58														\$ -	\$ -	
59														\$ -	\$ -	
60														\$ -	\$ -	

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

Cost Report Year (10/01/2018-09/30/2019) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
Totals / Payments													
128 Total Charges (includes organ acquisition from Section J)	\$ 34,118,852	\$ 22,536,780	\$ 11,520,631	\$ 21,522,032	\$ 54,419,800	\$ 55,063,550	\$ 17,619,375	\$ 18,060,606	\$ 24,233,853 (Agrees to Exhibit A)	\$ 33,760,307 (Agrees to Exhibit A)	\$ 117,678,658	\$ 117,182,968	37.11%
129 Total Charges per PS&R or Exhibit Detail	\$ 34,118,852	\$ 22,536,780	\$ 11,520,631	\$ 21,522,032	\$ 54,419,800	\$ 55,063,550	\$ 17,619,375	\$ 18,060,606	\$ 24,233,853	\$ 33,760,307			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 14,022,311	\$ 4,976,928	\$ 4,678,763	\$ 5,366,427	\$ 16,941,974	\$ 11,856,470	\$ 6,009,889	\$ 3,530,400	\$ 8,693,762	\$ 7,566,876	\$ 41,652,937	\$ 25,730,225	38.75%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 11,067,186	\$ 4,648,789	\$ -	\$ -	\$ 1,110,155	\$ 1,035,435	\$ 497,294	\$ 544,300			\$ 12,674,635	\$ 6,228,524	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 3,988,369	\$ 5,257,534	\$ -	\$ -	\$ -	\$ -			\$ 3,988,369	\$ 5,257,534	
134 Private Insurance (including primary and third party liability)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ -	\$ 2,295	\$ 14,265	\$ 733	\$ 1,902			\$ 3,028	\$ 16,167	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 11,067,186	\$ 4,648,789	\$ 3,988,369	\$ 5,257,534									
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (4,043)	\$ -	\$ -							\$ -	\$ (4,043)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 13,681,762	\$ 9,016,928	\$ -	\$ -			\$ 13,681,762	\$ 9,016,928	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 4,161,950	\$ 2,407,425			\$ 4,161,950	\$ 2,407,425	
141 Medicare Cross-Over Bad Debt Payments					\$ 195,996	\$ 292,719	\$ -	\$ -			\$ 195,996	\$ 292,719	
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 218,872 (Agrees to Exhibit B and B-1)	\$ 1,160,404 (Agrees to Exhibit B and B-1)	\$ -	\$ -	
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)	\$ 2,955,125	\$ 332,182	\$ 690,394	\$ 108,893	\$ 1,951,766	\$ 1,497,123	\$ 1,349,912	\$ 576,773	\$ 8,474,890	\$ 6,406,472	\$ 6,947,197	\$ 2,514,971	
146 Calculated Payments as a Percentage of Cost	79%	93%	85%	98%	88%	87%	78%	84%	3%	15%	83%	90%	
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)					36,684								
148 Percent of cross-over days to total Medicare days from the cost report					19%								

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 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 (10/01/2018-09/30/2019) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From 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	
1	03000 ADULTS & PEDIATRICS	\$ 730.60		12		30				21		63	
2	03100 INTENSIVE CARE UNIT	\$ 2,613.68		3		11				4		18	
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ -											
7	04000 SUBPROVIDER I	\$ 1,006.75											
8	04100 SUBPROVIDER II	\$ 1,266.82											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ 363.39											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days	15		41		-		25		81	
19	Total Days per PS&R or Exhibit Detail			15		41		-		25		-	
20	Unreconciled Days (Explain Variance)												
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			\$ 19,154		\$ 48,736		\$ -		\$ 29,939		\$ 97,829	
21.01	Calculated Routine Charge Per Diem			\$ 1,276.93		\$ 1,188.68		\$ -		\$ 1,197.56		\$ 1,207.77	
	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)		0.234160	51	13,199	-	12,822		1,112	\$ 51	\$ 27,133		
23	5000 OPERATING ROOM		0.229621	7,211	3,959	15,804	9,390		9,390	\$ 23,015	\$ 22,739		
24	5100 RECOVERY ROOM		0.391208	556	6,775	1,112	1,132		1,132	\$ 1,668	\$ 9,039		
25	5200 DELIVERY ROOM & LABOR ROOM		0.865867	-	-	3,995	1,736		2,113	\$ 3,995	\$ 3,849		
26	5300 ANESTHESIOLOGY		0.148479	380	166	1,229	546		380	\$ 1,609	\$ 1,092		
27	5400 RADIOLOGY-DIAGNOSTIC		0.215880	1,630	5,194	2,549	11,618		3,339	\$ 7,518	\$ 23,860		
28	5500 RADIOLOGY-THERAPEUTIC		0.116887	-	-	-	-		-	\$ -	\$ -		
29	5600 RADIOISOTOPE		0.115287	-	4,658	2,587	-		-	\$ 2,587	\$ 4,658		
30	5700 CT SCAN		0.029329	5,542	10,210	10,647	32,876		3,889	\$ 20,078	\$ 57,361		
31	5800 MRI		0.065153	-	-	2,806	-		4,966	\$ 7,772	\$ -		
32	5900 CARDIAC CATHETERIZATION		0.193356	-	-	-	-		-	\$ -	\$ -		
33	6000 LABORATORY		0.123506	9,648	38,628	34,774	57,945		12,377	\$ 56,799	\$ 122,762		
34	6300 BLOOD STORING PROCESSING & TRANS.		0.427359	-	-	5,608	-		-	\$ 5,608	\$ -		
35	6400 INTRAVENOUS THERAPY		0.532408	-	-	-	1,353		184	\$ 184	\$ 2,706		
36	6500 RESPIRATORY THERAPY		0.225549	2,453	2,452	6,186	3,036		184	\$ 8,823	\$ 6,843		
37	6600 PHYSICAL THERAPY		0.433914	-	-	3,297	-		2,795	\$ 6,092	\$ -		
38	6900 ELECTROCARDIOLOGY		0.063182	288	1,056	288	2,112		192	\$ 768	\$ 3,648		
39	7000 ELECTROENCEPHALOGRAPHY		0.311692	-	-	490	-		490	\$ 980	\$ -		
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.333526	5,709	3,817	13,885	11,524		2,223	\$ 5,814	\$ 21,155		
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.331910	-	-	-	406		-	\$ 406	\$ 812		
42	7300 DRUGS CHARGED TO PATIENTS		0.198537	17,108	10,038	33,112	13,180		9,664	\$ 59,884	\$ 31,454		
43	7400 RENAL DIALYSIS		0.939830	-	-	-	-		-	\$ -	\$ -		
44	7600 RADIOLOGY		0.110928	-	3,541	2,742	2,290		5,032	\$ 7,774	\$ 5,831		
45	7601 ONCOLOGY		0.865771	-	-	-	-		-	\$ -	\$ -		
46	7603 CARDIAC REHABILITATION		0.827897	-	-	-	-		-	\$ -	\$ -		
47	9001 WOUND CARE		0.960221	-	-	-	291		-	\$ -	\$ 672		

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

	9100	EMERGENCY		0.409282	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	
					4,828	34,055	10,801	82,018			3,816	38,215	\$ 19,445	\$ 154,288
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2018-09/30/2019) JOHN D. ARCHBOLD MEMORIAL HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
110										\$ -	\$ -
111										\$ -	\$ -
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 55,404	\$ 137,748	\$ 151,912	\$ 244,275	\$ -	\$ -	\$ 49,151	\$ 117,879		

Totals / Payments

128	Total Charges (Includes organ acquisition from Section K)	\$ 74,558	\$ 137,748	\$ 200,648	\$ 244,275	\$ -	\$ -	\$ 79,090	\$ 117,879	\$ 354,296	\$ 499,902
129	Total Charges per PS&R or Exhibit Detail	\$ 74,558	\$ 137,748	\$ 200,648	\$ 244,275	\$ -	\$ -	\$ 79,090	\$ 117,879		
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 28,070	\$ 31,600	\$ 85,269	\$ 60,024	\$ -	\$ -	\$ 34,762	\$ 30,675	\$ 148,101	\$ 122,299
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 30,980	\$ 12,817							\$ 30,980	\$ 12,817
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 26,219	\$ 20,094					\$ 26,219	\$ 20,094
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)	\$ 30,980	\$ 12,817	\$ 26,219	\$ 20,094						
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)	\$ (2,910)	\$ 18,783	\$ 59,050	\$ 39,930	\$ -	\$ -	\$ 34,762	\$ 30,675	\$ 90,902	\$ 89,388
144	Calculated Payments as a Percentage of Cost	110%	41%	31%	33%	0%	0%	0%	0%	39%	27%

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)

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-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)

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-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) 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)*	\$ 3,540,220	
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 ----->)	\$ 3,540,220	
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	\$ 3,540,220
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	235,715,824
19 Uninsured Hospital Charges Sec. G	57,994,160
20 Total Hospital Charges Sec. G	791,437,655
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	29.78%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.33%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 1,054,392
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 259,417
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 1,313,809

* 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.