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

Cost Report Year (07/01/2021-06/30/2022) DONALSONVILLE HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,442.65		1,364		519		475		996		413		3,354		60.31%
2	03100 INTENSIVE CARE UNIT	$ -												-		
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 2,180.52		23		207				24		3		254		93.45%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	1,387		726		475		1,020		416		3,608		52.34%
19	Total Days per PS&R or Exhibit Detail			1,387		726		475		1,020		416				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 1,842,432		$ 858,275		$ 513,063		$ 1,179,472		$ 418,616		$ 4,393,242		58.76%
21.01	Calculated Routine Charge Per Diem			$ 1,328.36		$ 1,182.20		$ 1,080.13		$ 1,156.35		$ 1,006.29		$ 1,217.64		
	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)		1.011676	160	12,542	773	35,355	-	68,334	1,467	40,622	459	32,825	$ 2,400	$ 156,853	11.41%
23	5000 OPERATING ROOM		0.189028	76,462	49,661	455,646	331,034	42,479	232,870	100,051	199,181	108,372	236,979	$ 674,638	$ 812,746	38.35%
24	5200 DELIVERY ROOM & LABOR ROOM		12.452391	2,156	-	26,169	-	334	-	5,030	-	-	-	$ 33,689	$ -	97.98%
25	5400 RADIOLOGY-DIAGNOSTIC		0.156551	73,429	172,730	34,844	481,277	94,691	688,633	71,592	307,630	166,721	1,549,099	$ 274,556	$ 1,650,271	41.51%
26	6000 LABORATORY		0.204596	361,185	431,738	671,605	948,528	221,589	620,242	238,926	1,191,900	266,682	2,349,076	$ 1,493,305	$ 3,192,408	43.67%
27	6500 RESPIRATORY THERAPY		1.444307	17,696	3,477	6,470	8,413	56,466	14,643	14,937	13,705	36,289	25,439	$ 95,569	$ 40,238	39.56%
28	6600 PHYSICAL THERAPY		0.293651	26,756	19,594	9,952	35,566	33,904	77,044	23,492	110,309	12,696	151,438	$ 94,104	$ 242,513	30.41%
29	6700 OCCUPATIONAL THERAPY		0.627006	564	6,789	-	8,533	956	1,110	3,751	14,348	-	80,362	$ 5,271	$ 30,780	43.14%
30	6800 SPEECH PATHOLOGY		0.632915	722	165	392	830	648	722	146	438	-	2,550	$ 1,908	$ 2,155	20.18%
31	6900 ELECTROCARDIOLOGY		0.022771	5,730	8,386	1,203	6,238	6,411	24,099	5,936	8,940	4,765	31,092	$ 19,280	$ 47,663	40.11%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.063281	164,556	50,306	876,029	543,101	147,545	221,270	196,343	167,691	257,590	373,364	$ 1,384,473	$ 982,368	41.62%
33	7300 DRUGS CHARGED TO PATIENTS		0.229959	868,309	125,079	502,451	246,468	523,345	511,288	717,833	262,569	626,443	615,799	$ 2,611,938	$ 1,145,404	57.06%
34	9100 EMERGENCY		0.812272	20,846	121,124	9,192	250,310	19,746	184,478	16,441	66,240	30,161	482,001	$ 66,225	$ 622,152	34.43%
35			-											$ -	$ -	
36			-											$ -	$ -	
37			-											$ -	$ -	
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60			-											$ -	$ -	

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

Cost Report Year (07/01/2021-06/30/2022) DONALSONVILLE HOSPITAL

				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61			-											$ -	$ -	
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
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127			-											$ -	$ -	
				$ 1,618,571	$ 1,001,592	$ 2,594,727	$ 2,895,653	$ 1,148,114	$ 2,644,733	$ 1,395,945	$ 2,383,573	$ 1,510,178	$ 5,930,025			

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

Cost Report Year (07/01/2021-06/30/2022) DONALSONVILLE HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 3,461,003	$ 1,001,592	$ 3,453,002	$ 2,895,653	$ 1,661,177	$ 2,644,733	$ 2,575,417	$ 2,383,573	$ 1,928,794 (Agrees to Exhibit A)	$ 5,930,025 (Agrees to Exhibit A)	$ 11,150,599	$ 8,925,551	44.85%
129	Total Charges per PS&R or Exhibit Detail	$ 3,461,003	$ 1,001,592	$ 3,453,002	$ 2,895,653	$ 1,661,177	$ 2,644,733	$ 2,575,417	$ 2,383,573	$ 1,928,794	$ 5,930,025			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 2,406,159	$ 283,109	$ 1,946,732	$ 690,730	$ 995,997	$ 674,755	$ 1,854,238	$ 557,225	$ 945,073	$ 1,491,801	$ 7,203,126	$ 2,205,819	49.20%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 898,527	$ 156,483	$ -	$ -	$ 7,878	$ 49,503	$ -	$ 783			$ 906,405	$ 206,769	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 959,437	$ 405,148			$ -	$ -			$ 959,437	$ 405,148	
134	Private Insurance (including primary and third party liability)	$ 2,889	$ 128	$ 12,394	$ 2,730		$ 73	$ 3,228	$ 17,475			$ 18,511	$ 20,406	
135	Self-Pay (including Co-Pay and Spend-Down)							$ -				$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 901,416	$ 156,611	$ 971,831	$ 407,878									
137	Medicaid Cost Settlement Payments (See Note B)		$ 35,701									$ -	$ 35,701	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ (10,000)										$ (10,000)	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 729,909	$ 319,385	$ 7,754	$ 472			$ 737,663	$ 319,857	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 813,936	$ 139,810			$ 813,936	$ 139,810	
141	Medicare Cross-Over Bad Debt Payments					$ 49,351	$ 6,902			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 49,351	$ 6,902	
142	Other Medicare Cross-Over Payments (See Note D)					$ 166,084	$ (87)					$ 166,084	$ (87)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 38,118	$ 223,846			
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)**	$ 1,514,743	$ 90,797	$ 974,901	$ 282,852	$ 42,775	$ 298,979	$ 1,029,320	$ 398,685	$ 906,955	$ 1,267,955	$ 3,561,739	$ 1,071,313	
146	**Calculated Payments as a Percentage of Cost**	37%	68%	50%	59%	96%	56%	44%	28%	4%	15%	51%	51%	
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)**					2,388								
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.