State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

2. Select Your Facility from the Drop-Down Menu Provided: Arthur M. Blank 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	01/01/2024	12/31/2024
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:	000000943A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113300

B. DSH Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/25 - 06/30/26)
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.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
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?	6/1/1928

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** — $ 11,878,195
   (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 07/01/2025 - 06/30/2026**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2025 - 06/30/2026** — $ 11,878,195

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	SVP & CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Ruth Fowler	404-785-7006	ruth.fowler@choa.org

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

Hospital Contact:	
Name	Sherry Cameron
Title	Reimbursement Manager
Telephone Number	404-785-7964
E-Mail Address	sherry.cameron@choa.org
Mailing Street Address	1575 Northeast Expressway
Mailing City, State, Zip	Atlanta, GA 30329

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH Version 9.02 4/22/2025

D. General Cost Report Year Information 1/1/2024 - 12/31/2024

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:	ARTHUR M. BLANK HOSPITAL		
	1/1/2024 through 12/31/2024		
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:	6/2/2025		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ARTHUR M. BLANK HOSPITAL		
5. Medicaid Provider Number:	000000943A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	113300		
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Private		
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2		
11. Rural Referral Center (Yes or No)	No		

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.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2024 - 12/31/2024)

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)	$ 281,885	$ 778,219	$1,060,104
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 709,717	$ 6,069,774	$6,779,491
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)	$991,602	$6,847,993	$7,839,595
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	28.43%	11.36%	13.52%

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 (01/01/2024 - 12/31/2024)

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)	98,635	**(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	33,351,670
8.	Outpatient Hospital Charity Care Charges	41,183,448
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 74,535,118

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	$588,939,644.00			$ 357,032,456	$ -	$ -	$ 231,907,188
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$1,310,528,036.00	$832,908,654.00		$ 794,480,467	$ 504,933,613	$ -	$ 844,022,610
20.	Outpatient Services		$166,978,145.00			$ 101,227,041	$ -	$ 65,751,104
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 20,129,205			$ 12,202,913	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$5,581,649.00	$1,395.00	$0.00	$ 3,383,759	$ 846	$ -	$ 2,198,439
27.	Total	$ 1,905,049,329	$ 999,888,194	$ 20,129,205	$ 1,154,896,682	$ 606,161,499	$ 12,202,913	$ 1,143,879,341
28.	Total Hospital and Non Hospital		Total from Above	$ 2,925,066,728		Total from Above	$ 1,773,261,095	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,925,066,728	Total Contractual Adj. (G-3 Line 2)	1,773,261,095
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	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)"			-	
36.	Adjusted Contractual Adjustments				1,773,261,095
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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	$ 132,387,189	$ 14,219,782	$ -	$0.00	$ 146,606,971	69,589	$193,485,256.00		$ 2,106.75
2	03100	INTENSIVE CARE UNIT	$ 107,148,726	$ 4,978,323	$ -		$ 112,127,049	24,363	$267,419,174.00		$ 4,602.35
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 41,014,593	$ -	$ -		$ 41,014,593	15,168	$128,035,214.00		$ 2,704.02
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 280,550,508	$ 19,198,105	$ -	$ -	$ 299,748,613	109,120	$ 588,939,644		
19		Weighted Average									$ 2,746.96

		Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	10,485	-	-	$ 22,089,274	$15,806,311.00	$47,705,360.00	$ 63,511,671	0.347799

Line #		Cost Center Description	*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	$52,494,128.00	$ 1,909,236	$ -		$ 54,403,364	$227,676,651.00	$134,152,242.00	$ 361,828,893	0.150357
22	5300	ANESTHESIOLOGY	$11,049,159.00	$ 860,080	$ -		$ 11,909,239	$53,044,514.00	$47,067,152.00	$ 100,111,666	0.118960
23	5400	RADIOLOGY-DIAGNOSTIC	$24,906,105.00	$ 1,120,689	$ -		$ 26,026,794	$71,899,964.00	$103,393,069.00	$ 175,293,033	0.148476
24	5500	RADIOLOGY-THERAPEUTIC	$21,266,928.00	$ 1,824,941	$ -		$ 23,091,869	$13,184,950.00	$12,724,136.00	$ 25,909,086	0.891265
25	5600	RADIOISOTOPE	$751,259.00	$ 43,659	$ -		$ 794,918	$622,996.00	$1,901,301.00	$ 2,524,297	0.314907
26	6000	LABORATORY	$86,595,163.00	$ 462,162	$ -		$ 87,057,325	$192,962,822.00	$150,886,144.00	$ 343,848,966	0.253185
27	6400	INTRAVENOUS THERAPY	$3,183,877.00	$ -	$ -		$ 3,183,877	$1,610,575.00	$7,986,578.00	$ 9,597,153	0.331752
28	6500	RESPIRATORY THERAPY	$70,667,989.00	$ 723,394	$ -		$ 71,391,383	$141,110,883.00	$3,681,204.00	$ 144,792,087	0.493061
29	6600	PHYSICAL THERAPY	$8,101,159.00	$ 41,980	$ -		$ 8,143,139	$15,096,484.00	$3,476,796.00	$ 18,573,280	0.438433

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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	6700	OCCUPATIONAL THERAPY	$5,492,008.00	$ -	$ -		$ 5,492,008	$7,075,840.00	$246,692.00	$ 7,322,532	0.750015
31	6900	ELECTROCARDIOLOGY	$23,804,150.00	$ -	$ -		$ 23,804,150	$54,077,726.00	$49,832,355.00	$ 103,910,081	0.229084
32	7000	ELECTROENCEPHALOGRAPHY	$8,979,345.00	$ 593,425	$ -		$ 9,572,770	$34,194,284.00	$11,964,668.00	$ 46,158,952	0.207387
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$22,358,710.00	$ -	$ -		$ 22,358,710	$24,264,382.00	$20,635,158.00	$ 44,899,540	0.497972
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$41,178,766.00	$ -	$ -		$ 41,178,766	$36,418,447.00	$21,675,698.00	$ 58,094,145	0.708828
35	7300	DRUGS CHARGED TO PATIENTS	$123,579,699.00	$ -	$ -		$ 123,579,699	$385,873,929.00	$208,001,921.00	$ 593,875,850	0.208090
36	7400	RENAL DIALYSIS	$3,128,716.00	$ -	$ -		$ 3,128,716	$4,608,246.00	$127,073.00	$ 4,735,319	0.660719
37	7800	CAR T-CELL IMMUNOTHERAPY	$9,613,491.00	$ -	$ -		$ 9,613,491	$1,000,099.00	$7,451,107.00	$ 8,451,206	1.137529
38	9000	CLINIC	$20,136,796.00	$ -	$ -		$ 20,136,796	$857,586.00	$9,295,735.00	$ 10,153,321	1.983272
39	9100	EMERGENCY	$52,140,258.00	$ 1,982,113	$ -		$ 54,122,371	$30,785,082.00	$157,682,409.00	$ 188,467,491	0.287171
40	10500	KIDNEY ACQUISITION	$2,219,692.00	$ 159,522	$ -		$ 2,379,214	$1,746,559.00	$0.00	$ 1,746,559	-
41	10600	HEART ACQUISITION	$3,196,860.00	$ 75,899	$ -		$ 3,272,759	$2,191,345.00	$0.00	$ 2,191,345	-
42	10700	LIVER ACQUISITION	$589,272.00	$ -	$ -		$ 589,272	$10.00	$0.00	$ 10	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 595,433,530	$ 9,797,100	$ -		$ 605,230,630	$ 1,316,109,685	$ 999,886,798	$ 2,315,996,483	
127		**Weighted Average**									0.268626
128		**Sub Totals**	$ 875,984,038	$ 28,995,205	$ -		$ 904,979,243	$ 1,905,049,329	$ 999,886,798	$ 2,904,936,127	
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)*					$0.00				
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**					$ 904,979,243				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					3.31%				

* 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 (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	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 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**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 2,106.75		16,546		16,468		307		6,383		53		1,133		39,757		69.18%
2	03100 INTENSIVE CARE UNIT	$ 4,602.35		5,571		7,584		34		3,586		13		201		16,788		69.73%
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	$ 2,704.02		1,940		4,946				2,885		-		2		9,771		64.43%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	24,057		28,998		341		12,854		66		1,336		66,316		62.00%
19	Total Days per PS&R or Exhibit Detail			24,057		28,998		341		12,854		66		1,336				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 132,292,546		$ 175,166,355		$ 1,300,268		$ 84,278,799		$ 299,104		$ 5,836,261		$ 393,037,968		67.73%
21.01	Calculated Routine Charge Per Diem			$ 5,499.13		$ 6,040.64		$ 3,813.10		$ 6,556.62		$ 4,531.88		$ 4,368.46		$ 5,926.74		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.347799	2,204,179	4,435,692	6,181,023	20,699,957	88,583	117,714	1,557,548	3,068,677	44,657	51,789	379,955	1,503,261	$ 10,031,333	$ 28,322,040	63.50%
23	5000 OPERATING ROOM		0.150357	46,386,341	16,514,899	65,255,447	41,316,796	1,120,012	345,321	27,167,891	9,773,095	199,866	49,195	3,481,799	1,900,633	$ 139,929,691	$ 67,950,111	59.01%
24	5300 ANESTHESIOLOGY		0.118960	10,431,562	7,719,384	15,134,234	14,940,248	188,911	34,702	6,266,015	3,789,029	51,361	23,609	738,617	729,819	$ 32,020,722	$ 26,483,363	59.98%
25	5400 RADIOLOGY-DIAGNOSTIC		0.148476	12,996,481	9,459,436	20,949,510	32,837,230	213,953	94,482	7,908,977	7,201,551	92,467	294,235	1,343,728	3,368,495	$ 42,068,921	$ 49,592,699	55.20%
26	5500 RADIOLOGY-THERAPEUTIC		0.891265	1,208,906	435,896	2,793,960	3,624,112	-	6,270	458,224	2,006,489	-	13,117	18,433	228,260	$ 4,461,090	$ 6,072,767	41.66%
27	5600 RADIOISOTOPE		0.314907	54,219	373,126	104,331	324,838	-	-	121,130	193,630	-	39	6,274	55,210	$ 279,680	$ 891,594	48.84%
28	6000 LABORATORY		0.253185	45,825,945	20,955,523	52,189,070	46,377,734	928,133	1,768,879	23,440,837	12,053,600	145,124	491,712	2,713,246	4,996,869	$ 122,383,985	$ 81,155,736	61.62%
29	6400 INTRAVENOUS THERAPY		0.331752	1,511,406	2,648,035	21,168	1,377,460	-	25,752	9,087	856,490	-	5,372	1,543	115,385	$ 1,541,660	$ 4,907,737	68.48%
30	6500 RESPIRATORY THERAPY		0.493061	36,766,778	450,232	37,555,928	983,409	115,040	2,569	21,226,648	342,680	21,087	8,321	746,443	71,306	$ 95,664,394	$ 1,778,890	67.88%
31	6600 PHYSICAL THERAPY		0.438433	3,618,255	508,273	5,200,525	780,295	30,845	-	2,360,553	82,796	7,249	6,778	201,456	60,780	$ 11,210,178	$ 1,371,364	69.23%
32	6700 OCCUPATIONAL THERAPY		0.750015	1,787,348	6,819	1,432,001	803,898	18,937	-	557,444	189,025	5,157	3,113	75,270	45,390	$ 3,795,730	$ 999,742	67.25%
33	6900 ELECTROCARDIOLOGY		0.229084	11,981,307	6,231,259	16,029,247	17,635,610	39,346	76,922	7,057,849	4,477,380	8,321	133,770	500,096	1,309,670	$ 35,107,749	$ 28,421,171	63.02%
34	7000 ELECTROENCEPHALOGRAPHY		0.207387	6,969,978	1,619,625	12,823,923	7,033,513	46,800	21,316	5,880,852	1,261,211	5,943	70,135	363,075	503,487	$ 25,721,553	$ 9,935,665	79.29%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.497972	5,433,396	3,731,046	6,903,225	5,153,126	86,710	60,472	3,032,425	1,715,950	14,739	29,030	240,932	436,060	$ 15,455,756	$ 10,660,594	59.77%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.708828	8,193,551	2,789,719	8,367,556	6,745,087	19,096	3,247	4,674,241	1,682,403	10,494	19,127	204,572	248,250	$ 21,254,444	$ 11,220,456	56.73%
37	7300 DRUGS CHARGED TO PATIENTS		0.208090	106,468,579	44,909,268	90,366,843	51,334,990	1,247,428	431,225	48,155,886	24,035,521	106,845	65,296	3,663,434	2,981,158	$ 246,238,736	$ 120,711,004	62.94%
38	7400 RENAL DIALYSIS		0.660719	451,585	-	891,101	19,434	-	-	473,623	8,044	-	45	1	5,199	$ 1,816,309	$ 27,478	39.05%
39	7800 CAR T-CELL IMMUNOTHERAPY		1.137529	581,896	1,707,619	-	1,163,791	-	-	-	-	-	-	-	-	$ 581,896	$ 2,871,410	40.86%
40	9000 CLINIC		1.983272	438	1,869,050	144,974	2,025,492	1,331	100,864	34,991	835,110	431	44,943	1,678	243,843	$ 181,734	$ 4,830,516	52.23%
41	9100 EMERGENCY		0.287171	5,606,357	11,072,428	11,205,350	77,075,201	82,995	100,688	2,723,617	6,526,681	123,463	213,212	989,282	11,632,805	$ 19,618,319	$ 94,774,998	67.57%
42	10500 KIDNEY ACQUISITION		-					-								$ -	$ -	0.00%
43	10600 HEART ACQUISITION		-					-								$ -	$ -	0.00%
44	10700 LIVER ACQUISITION		-					-								$ -	$ -	0.00%
45			-													$ -	$ -	
46			-													$ -	$ -	
47			-													$ -	$ -	
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70			-													$ -	$ -	

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

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													$ -	$ -	-
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
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125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 308,478,503	$ 137,437,327	$ 353,549,416	$ 332,252,220	$ 4,228,120	$ 3,190,423	$ 163,107,838	$ 80,099,362	$ 837,203	$ 1,522,837	$ 15,669,834	$ 30,435,880			

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

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
128	**Total Charges *(includes organ acquisition from Section J)***	$ 441,282,945	$ 137,437,327	$ 528,899,459	$ 332,252,220	$ 5,859,331	$ 3,190,423	$ 247,460,265	$ 80,099,362	$ 1,136,307	$ 1,522,837	$ 21,506,095 (Agrees to Exhibit A)	$ 30,435,880 (Agrees to Exhibit A)	$ 1,223,501,999	$ 552,979,332	62.94%
129	Total Charges per PS&R or Exhibit Detail	$ 441,282,945	$ 137,437,327	$ 528,899,459	$ 332,252,220	$ 5,859,331	$ 3,190,423	$ 247,460,265	$ 80,099,362	$ 1,136,307	$ 1,522,837	$ 21,506,095	$ 30,435,880			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 148,802,869	$ 37,261,628	$ 176,185,196	$ 88,041,672	$ 1,991,218	$ 947,417	$ 81,510,676	$ 21,460,667	$ 367,556	$ 456,476	$ 6,983,746	$ 8,261,202	$ 408,489,959	$ 147,711,384	63.14%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 110,150,431	$ 24,535,714			$ 45,784	$ 39,089	$ -	$ -					$ 110,196,215	$ 24,574,803	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 154,636,072	$ 95,473,458			$ 810,950	$ 173,663					$ 155,447,022	$ 95,647,121	
134	Private Insurance (including primary and third party liability)	$ 709,282	$ 31,640	$ 4,202	$ 38,115			$ 144,890,433	$ 45,511,691					$ 145,603,917	$ 45,581,446	
135	Self-Pay (including Co-Pay and Spend-Down)	-	-	$ -	$ -		$ 9	$ 100	$ 7,884					$ 100	$ 7,893	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 110,859,713	$ 24,567,354	$ 154,640,274	$ 95,511,573											
137	Medicaid Cost Settlement Payments (See Note B)		$ 1,769,239											$ -	$ 1,769,239	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)													$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 75,758	$ 8,455							$ 75,758	$ 8,455	
142	Other Medicare Cross-Over Payments (See Note D)					$ 1,105,332	$ 203,771					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 1,105,332	$ 203,771	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 281,885	$ 778,219			
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)**	$ 37,943,156	$ 10,925,035	$ 21,544,922	$ (7,469,901)	$ 764,344	$ 696,093	$ (64,190,807)	$ (24,232,571)	$ 367,556	$ 456,476	$ 6,701,861	$ 7,482,983	$ (3,938,385)	$ (20,081,344)	
146	**Calculated Payments as a Percentage of Cost**	75%	71%	88%	108%	62%	27%	179%	213%	0%	0%	4%	9%	101%	114%	
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)**					822										
148	**Percent of cross-over days to total Medicare days from the cost report**					41%										

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 surve
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 payment
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 payment
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary)		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	$ 2,106.75										-	
2	03100 INTENSIVE CARE UNIT	$ 4,602.35										-	
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	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 2,704.02										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.347799									$ -	$ -
23	5000 OPERATING ROOM		0.150357									$ -	$ -
24	5300 ANESTHESIOLOGY		0.118960									$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.148476									$ -	$ -
26	5500 RADIOLOGY-THERAPEUTIC		0.891265									$ -	$ -
27	5600 RADIOISOTOPE		0.314907									$ -	$ -
28	6000 LABORATORY		0.253185									$ -	$ -
29	6400 INTRAVENOUS THERAPY		0.331752									$ -	$ -
30	6500 RESPIRATORY THERAPY		0.493061									$ -	$ -
31	6600 PHYSICAL THERAPY		0.438433									$ -	$ -
32	6700 OCCUPATIONAL THERAPY		0.750015									$ -	$ -
33	6900 ELECTROCARDIOLOGY		0.229084									$ -	$ -
34	7000 ELECTROENCEPHALOGRAPHY		0.207387									$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.497972									$ -	$ -
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.708828									$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.208090									$ -	$ -
38	7400 RENAL DIALYSIS		0.660719									$ -	$ -
39	7800 CAR T-CELL IMMUNOTHERAPY		1.137529									$ -	$ -
40	9000 CLINIC		1.983272									$ -	$ -
41	9100 EMERGENCY		0.287171									$ -	$ -
42	10500 KIDNEY ACQUISITION		-									$ -	$ -
43	10600 HEART ACQUISITION		-									$ -	$ -
44	10700 LIVER ACQUISITION		-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
48				-									$ -	$ -
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
83				-									$ -	$ -
84				-									$ -	$ -
85				-									$ -	$ -
86				-									$ -	$ -
87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
90				-									$ -	$ -
91				-									$ -	$ -
92				-									$ -	$ -
93				-									$ -	$ -
94				-									$ -	$ -
95				-									$ -	$ -
96				-									$ -	$ -
97				-									$ -	$ -
98				-									$ -	$ -
99				-									$ -	$ -
100				-									$ -	$ -
101				-									$ -	$ -
102				-									$ -	$ -
103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -
134	Private Insurance (including primary and third party liability)											$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)											$ -	$ -
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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From 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	$2,577,407.00	$ 85,313	$ 2,662,720		42	$ 73,628	1	$ 183,688	2	$ 330,943	4	$ 73,628	1				
3	Liver Acquisition	$651,972.00	$ 21,580	$ 673,552		5												
4	Heart Acquisition	$3,295,368.00	$ 109,077	$ 3,404,445		17	$ 438,269	2										
5	Pancreas Acquisition	$0.00	$ -	$ -		0												
6	Intestinal Acquisition	$0.00	$ -	$ -		0												
7	Islet Acquisition	$0.00	$ -	$ -		0												
8		$0.00	$ -	$ -		0												
9	**Totals**	$ 6,524,747	$ 215,970	$ 6,740,717	$ -	64	$ 511,897	3	$ 183,688	2	$ 330,943	4	$ 73,628	1	$ -	-	$ -	-
10	**Total Cost**							463,921		126,796		253,592		63,398		-		-

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 (01/01/2024-12/31/2024) ARTHUR M. BLANK 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 & with Medicaid Secondary)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ 2,577,407	$ 85,313	$ 2,662,720	$ -	42								
13	Liver Acquisition	$ 651,972	$ 21,580	$ 673,552	$ -	5								
14	Heart Acquisition	$ 3,295,368	$ 109,077	$ 3,404,445	$ -	17								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ 6,524,747	$ 215,970	$ 6,740,717	$ -	64	$ -	-	$ -	-	$ -	-	$ -	-
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 (01/01/2024-12/31/2024) ARTHUR M. BLANK HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	1,779,140,475
19	Uninsured Hospital	**Charges Sec. G**	51,941,975
20	Total Hospital	**Charges Sec. G**	2,904,936,127
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		61.25%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		1.79%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ -**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	1,439,871,950
27	Uninsured Hospital	**Charges Sec. G**	54,601,118
28	Total Hospital	**Charges Sec. G**	2,904,936,127
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		49.57%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		1.88%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ -**

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

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

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*