DSH Version 6.00 2/21/2020

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	WELLSTAR SPALDING REGIONAL 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	07/01/2018	06/30/2019	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4	Cost Report Year 2 (if applicable)			
5	Cost Report Year 3 (if applicable)			

		Data
6	Medicaid Provider Number	000000866A
7	Medicaid Subprovider Number 1 (Psychiatric or Rehab)	0
8	Medicaid Subprovider Number 2 (Psychiatric or Rehab)	0
9	Medicare Provider Number	110031

B. DSH OB Qualifying Information

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

	During the DSH Examination Year:	DSH Examination Year (07/01/18 - 06/30/19)
1	Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2	Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3	Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a	Was the hospital open as of December 22, 1987?	Yes
3b	What date did the hospital open?	07/01/1966

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 1,575,421
   (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 1-I should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2018 - 06/30/2019** — $ 1,575,421

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:

Other Protested Item "New Hampshire Hospital Association v. Azar". We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Costs

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	EVP Title	10/21/20 Date
Jim Budzinski Hospital CEO or CFO Printed Name	(470) 644-0012 Hospital CEO or CFO Telephone Number	jim.budzinski@wellstar.org Hospital CEO or CFO E-Mail

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

Hospital Contact:		Outside Preparer:	
Name	Ebbie Erzuah	Name	Tim Beatty
Title	Executive Director of Reimbursement	Title	Senior Director
Telephone Number	(470) 956-4981	Firm Name	Southeast Reimbursement Group
E-Mail Address	ebenezer.erzuah@wellstar.org	Telephone Number	770-315-5063
Mailing Street Address	1800 Parkway Place, Suite 500, Marietta GA 30067	E-Mail Address	tim.beatty@srgllc.org
Mailing City, State, Zip			

DSH Version 8.00 3/31/2020

D. General Cost Report Year Information 7/1/2018 - 6/30/2019

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: WELLSTAR SPALDING REGIONAL HOSPITAL

	7/1/2018 through 6/30/2019		
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: 12/10/2019

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR SPALDING REGIONAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000866A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110031	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	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	020770400
10. State Name & Number	Illinois	1972535318
11. State Name & Number	Oklahoma	200214650A
12. State Name & Number	South Carolina	10499B
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2018 - 06/30/2019)

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)	$ 35,259	$ 232,323	$267,582
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 713,313	$ 2,519,787	$3,233,100
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)	$748,572	$2,752,110	$3,500,682
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	4.71%	8.44%	7.64%

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 (07/01/2018 - 06/30/2019)

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)	36,667	**(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	36,240
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 36,240
7.	Inpatient Hospital Charity Care Charges	25,008,821
8.	Outpatient Hospital Charity Care Charges	54,156,890
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 79,165,711

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	$82,662,996.00			$ 68,586,809	$ -	$ -	$ 14,076,187
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	$315,666,328.00	$397,351,109.00		$ 261,913,397	$ 329,688,565	$ -	$ 121,415,475
20.	Outpatient Services		$0.00			$ -	$ -	$ -
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 14,632,204	-	-	$ 12,140,573	-
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	$ 398,329,324	$ 397,351,109	$ 14,632,204	$ 330,500,206	$ 329,688,565	$ 12,140,573	$ 135,491,662

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	810,312,637	Total Contractual Adj. (G-3 Line 2)	670,570,799
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)			+	2,666,786
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)			-	908,241
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				672,329,344
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) | WELLSTAR SPALDING REGIONAL 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	$ 28,993,847	$ -	$ -	$0.00	$ 28,993,847	31,413	$55,465,255.00		$ 922.99
2	03100 INTENSIVE CARE UNIT	$ 9,756,737	$ -	$ 2,016		$ 9,758,753	4,478	$16,273,856.00		$ 2,179.27
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	$ 2,273,879	$ -	$ 1,357		$ 2,275,236	2,715	$3,006,830.00		$ 838.02
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 41,024,463	$ -	$ 3,373	$ -	$ 41,027,836	38,606	$ 74,745,941		
19	Weighted Average									$ 1,062.73

			Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	2,124	-	-	$ 1,960,431	$1,604,512.00	$3,234,461.00	$ 4,838,973	0.405134

			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	$11,550,721.00	$ -	$0.00		$ 11,550,721	$46,293,951.00	$57,187,069.00	$ 103,481,020	0.111622
22	5200	DELIVERY ROOM & LABOR ROOM	$5,203,491.00	$ -	$2,834.00		$ 5,206,325	$8,886,213.00	$0.00	$ 8,886,213	0.585888
23	5400	RADIOLOGY-DIAGNOSTIC	$8,106,994.00	$ -	$0.00		$ 8,106,994	$46,982,686.00	$106,524,291.00	$ 153,506,977	0.052812
24	6000	LABORATORY	$7,202,238.00	$ -	$1,646.00		$ 7,203,884	$58,694,697.00	$43,553,534.00	$ 102,248,231	0.070455
25	6300	BLOOD STORING PROCESSING & TRANS.	$1,250,339.00	$ -	$0.00		$ 1,250,339	$4,103,803.00	$1,909,446.00	$ 6,013,249	0.207931
26	6400	INTRAVENOUS THERAPY	$688,604.00	$ -	$0.00		$ 688,604	$6,958,885.00	$16,801,683.00	$ 23,760,568	0.028981
27	6500	RESPIRATORY THERAPY	$3,248,191.00	$ -	$820.00		$ 3,249,011	$26,748,398.00	$2,440,740.00	$ 29,189,138	0.111309
28	6600	PHYSICAL THERAPY	$2,830,324.00	$ -	$0.00		$ 2,830,324	$5,397,107.00	$7,278,681.00	$ 12,675,788	0.223286
29	6900	ELECTROCARDIOLOGY	$3,025,109.00	$ -	$0.00		$ 3,025,109	$22,402,735.00	$18,577,836.00	$ 40,980,571	0.073818
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$7,263,794.00	$ -	$0.00		$ 7,263,794	$13,446,937.00	$7,461,547.00	$ 20,908,484	0.347409
31	7200	IMPL. DEV. CHARGED TO PATIENTS	$6,819,972.00	$ -	$0.00		$ 6,819,972	$9,972,698.00	$7,334,768.00	$ 17,307,466	0.394048

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) | WELLSTAR SPALDING REGIONAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7300	DRUGS CHARGED TO PATIENTS	$12,851,310.00	$ -	$0.00		$ 12,851,310	$39,918,572.00	$29,070,340.00	$ 68,988,912	0.186281
33	7400	RENAL DIALYSIS	$890,069.00	$ -	$0.00		$ 890,069	$8,241,543.00	$650,221.00	$ 8,891,764	0.100100
34	7625	SLEEP DISORDERS	$651,815.00	$ -	$8,890.00		$ 660,705	$318,700.00	$6,472,170.00	$ 6,790,870	0.097293
35	7626	WOUND CARE	$1,209,311.00	$ -	$0.00		$ 1,209,311	$1,162,983.00	$9,693,681.00	$ 10,856,664	0.111389
36	7698	HYPERBARIC OXYGEN THERAPY	$3,464.00	$ -	$0.00		$ 3,464	$4,012.00	$3,362,056.00	$ 3,366,068	0.001029
37	9100	EMERGENCY	$13,386,856.00	$ -	$0.00		$ 13,386,856	$19,093,444.00	$79,100,566.00	$ 98,194,010	0.136331
38			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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
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**	$ 86,182,602	$ -	$ 14,190		$ 86,196,792	$ 320,231,876	$ 400,653,090	$ 720,884,966	
127		**Weighted Average**									0.122290
128		**Sub Totals**	$ 127,207,065	$ -	$ 17,563		$ 127,224,628	$ 394,977,817	$ 400,653,090	$ 795,630,907	
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**					$ 127,224,628				
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 (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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	$ 922.99		3,575		2,168		2,761		3,016		2,234		11,520		47.04%
2	03100 INTENSIVE CARE UNIT	$ 2,179.27		727		90		439		394		321		1,650		44.55%
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	$ 838.02		105		2,101		-		79		56		2,285		86.22%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	4,407		4,359		3,200		3,489		2,611		15,455		46.92%
19	Total Days per PS&R or Exhibit Detail			4,407		4,359		3,200		3,489		2,611				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 8,928,502		$ 6,138,187		$ 6,930,046		$ 6,990,198		$ 5,238,492		$ 28,986,933		45.97%
21.01	Calculated Routine Charge Per Diem			$ 2,025.98		$ 1,408.16		$ 2,165.64		$ 2,003.50		$ 2,006.32		$ 1,875.57		

				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	**Ancillary Cost Centers (from W/S C) (from Section G):**															
22	09200 Observation (Non-Distinct)		0.405134	184,195	621,868	115,027	183,543	95,969	215,770	170,421	346,361	61,813	315,444	$ 565,612	$ 1,367,542	47.75%
23	5000 OPERATING ROOM		0.111622	3,494,519	2,452,882	5,299,283	5,850,123	3,841,320	3,502,229	4,056,481	4,026,912	3,019,109	2,783,363	$ 16,691,603	$ 15,832,146	37.07%
24	5200 DELIVERY ROOM & LABOR ROOM		0.585888	240,280	-	5,904,312		27,803		959,100	-	97,578	-	$ 7,131,495	$ -	81.49%
25	5400 RADIOLOGY-DIAGNOSTIC		0.052812	4,942,004	6,303,410	1,516,033	8,086,783	3,914,096	5,398,047	3,864,443	7,163,997	4,289,010	18,059,197	$ 14,236,576	$ 26,952,237	41.49%
26	6000 LABORATORY		0.070455	7,295,846	3,818,117	4,025,030	4,963,124	5,195,162	2,557,055	5,287,608	3,110,428	4,999,361	8,139,992	$ 21,803,646	$ 14,448,724	48.49%
27	6300 BLOOD STORING PROCESSING & TRANS.		0.207931	674,945	107,556	84,882	58,681	465,133	116,533	289,579	96,251	315,880	97,700	$ 1,514,539	$ 379,021	38.81%
28	6400 INTRAVENOUS THERAPY		0.028981	806,768	1,372,890	812,498	2,008,609	530,338	987,648	511,388	1,181,433	660,052	3,977,644	$ 2,660,992	$ 5,550,580	54.28%
29	6500 RESPIRATORY THERAPY		0.111309	3,647,163	162,862	1,173,379	208,888	2,913,145	126,192	2,930,513	226,837	1,280,751	351,296	$ 10,664,200	$ 724,779	44.86%
30	6600 PHYSICAL THERAPY		0.223286	564,360	126,171	135,106	1,364,837	460,072	255,896	560,348	689,667	220,288	120,686	$ 1,719,886	$ 2,436,572	35.58%
31	6900 ELECTROCARDIOLOGY		0.073818	1,684,609	1,563,456	404,959	1,147,064	1,882,850	1,156,728	1,582,344	1,843,727	1,975,312	1,968,688	$ 5,554,762	$ 5,710,975	37.16%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.347409	1,333,932	393,028	836,495	564,577	1,315,897	457,558	1,221,402	574,085	746,802	390,691	$ 4,707,726	$ 1,989,249	37.58%
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.394048	763,859	301,332	147,370	257,125	833,077	332,622	834,722	534,743	228,909	219,503	$ 2,579,028	$ 1,425,822	25.77%
34	7300 DRUGS CHARGED TO PATIENTS		0.186281	5,777,735	1,029,590	2,398,334	2,055,313	3,598,964	1,475,442	3,613,033	2,775,506	3,097,553	2,201,447	$ 15,388,066	$ 7,335,851	40.76%
35	7400 RENAL DIALYSIS		0.100100	942,658	-	50,040	-	1,859,464	150,120	444,105	100,080	143,865	556,695	$ 3,296,267	$ 250,200	48.33%
36	7625 SLEEP DISORDERS		0.097293	-	-	-	-	-	-	-		-		$ -	$ -	0.00%
37	7626 WOUND CARE		0.111389	-	-	410,939	445,654	48,569	549,615	110,330	288,894	46,007	610,978	$ 569,838	$ 1,284,163	23.19%
38	7698 HYPERBARIC OXYGEN THERAPY		0.001029	-	-	-	20,060		240,720	-	473,416	-	-	$ -	$ 734,196	21.81%
39	9100 EMERGENCY		0.136331	2,134,842	6,802,126	663,947	13,051,835	1,758,068	3,648,626	1,572,499	4,729,211	1,848,869	20,450,614	$ 6,129,356	$ 28,231,798	57.90%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
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 (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
67				-											$ -	$ -
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69				-											$ -	$ -
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123				-											$ -	$ -
124				-											$ -	$ -
125				-											$ -	$ -
126				-											$ -	$ -
127				-											$ -	$ -
					$ 34,487,715	$ 25,055,288	$ 23,977,635	$ 40,266,217	$ 28,739,928	$ 21,170,803	$ 28,008,315	$ 28,161,548	$ 23,031,159	$ 60,243,938		

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

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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)***	$ 43,416,217	$ 25,055,288	$ 30,115,822	$ 40,266,217	$ 35,669,974	$ 21,170,803	$ 34,998,513	$ 28,161,548	$ 28,269,651 (Agrees to Exhibit A)	$ 60,243,938 (Agrees to Exhibit A)	$ 144,200,525	$ 114,653,856	43.80%
129	Total Charges per PS&R or Exhibit Detail	$ 43,416,217	$ 25,055,288	$ 30,115,822	$ 40,266,217	$ 35,669,974	$ 21,170,803	$ 34,998,513	$ 28,161,548	$ 28,269,651	$ 60,243,938			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,398,660	$ 2,725,914	$ 9,587,494	$ 4,496,561	$ 7,126,884	$ 2,291,799	$ 7,709,521	$ 3,171,503	$ 5,427,003	$ 5,856,839	$ 33,822,559	$ 12,685,777	45.57%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,975,663	$ 2,364,907	$ -	$ -							$ 6,975,663	$ 2,364,907	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 5,906,331	$ 4,275,552							$ 5,906,331	$ 4,275,552	
134	Private Insurance (including primary and third party liability)	$ 57,535	$ 7,874	$ -	$ -			$ 6,653,044	$ 3,491,942			$ 6,710,579	$ 3,499,816	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ 4,974	$ 364	$ 18,580	$ 4,184	$ 25,275	$ 4,170	$ (7,434)			$ 8,718	$ 41,395	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,033,198	$ 2,377,755	$ 5,906,695	$ 4,294,132									
137	Medicaid Cost Settlement Payments (See Note B)		$ (14,402)									$ -	$ (14,402)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,587,025	$ 2,104,822					$ 5,587,025	$ 2,104,822	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 86,498	$ 162,707					$ 86,498	$ 162,707	
142	Other Medicare Cross-Over Payments (See Note D)					$ 172,166				(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 172,166	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 35,259	$ 232,323			
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)**	$ 2,365,462	$ 362,561	$ 3,680,799	$ 202,429	$ 1,277,011	$ (1,005)	$ 1,052,307	$ (313,005)	$ 5,391,744	$ 5,624,516	$ 8,375,579	$ 250,980	
146	**Calculated Payments as a Percentage of Cost**	75%	87%	62%	95%	82%	100%	86%	110%	1%	4%	75%	98%	
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)**					19,241								
148	**Percent of cross-over days to total Medicare days from the cost report**					17%								

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.

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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 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	$ 922.99		14				8		2		24	
2	03100 INTENSIVE CARE UNIT	$ 2,179.27		18				6				24	
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	$ 838.02										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	32		-		14		2		48	
19	Total Days per PS&R or Exhibit Detail			32		-		14		2			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 93,144				$ 35,564		$ 2,966		$ 131,674	
21.01	Calculated Routine Charge Per Diem			$ 2,910.75		$ -		$ 2,540.29		$ 1,483.00		$ 2,743.21	
	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)		0.405134	-	-			-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.111622	13,798	3,166			18,309	-	-	-	$ 32,107	$ 3,166
24	5200 DELIVERY ROOM & LABOR ROOM		0.585888	11,974				-	-	-	-	$ 11,974	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.052812	34,167	55,779			14,560	35,168	-	17,781	$ 48,727	$ 108,728
26	6000 LABORATORY		0.070455	98,912	53,408			20,331	6,333	3,035	5,499	$ 122,278	$ 65,240
27	6300 BLOOD STORING PROCESSING & TRANS.		0.207931	26,689				-	-	-	-	$ 26,689	$ -
28	6400 INTRAVENOUS THERAPY		0.028981	11,726	23,702			4,444	2,707	3,044	3,375	$ 19,214	$ 29,784
29	6500 RESPIRATORY THERAPY		0.111309	46,759	3,618			22,951	-	-	55	$ 69,710	$ 3,673
30	6600 PHYSICAL THERAPY		0.223286	7,243				5,422	-	-	-	$ 12,665	$ -
31	6900 ELECTROCARDIOLOGY		0.073818	13,440	2,140			4,018	535	-	535	$ 17,458	$ 3,210
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.347409	11,008	1,501			8,583	379	14	589	$ 19,605	$ 2,469
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.394048	-	-			7,155	-	-	-	$ 7,155	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.186281	73,735	9,930			10,774	908	1,861	1,235	$ 86,370	$ 12,073
35	7400 RENAL DIALYSIS		0.100100	50,040	-			-	-	-	-	$ 50,040	$ -
36	7625 SLEEP DISORDERS		0.097293		-			-	-	-	-	$ -	$ -
37	7626 WOUND CARE		0.111389	6,792	-			-	-	-	-	$ 6,792	$ -
38	7698 HYPERBARIC OXYGEN THERAPY		0.001029	-	-			-	-	-	-	$ -	$ -
39	9100 EMERGENCY		0.136331	17,788	140,387			7,233	14,579	3,767	12,424	$ 28,788	$ 167,390
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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	
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			-									$ -	$ -
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86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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	
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 424,071	$ 293,631	$ -	$ -	$ 123,780	$ 60,609	$ 11,721	$ 41,493		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ 517,215	$ 293,631	$ -	$ -	$ 159,344	$ 60,609	$ 14,687	$ 41,493	$ 691,246	$ 395,733
129	Total Charges per PS&R or Exhibit Detail			$ 517,215	$ 293,631	$ -	$ -	$ 159,344	$ 60,609	$ 14,687	$ 41,493		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 108,931	$ 29,820	$ -	$ -	$ 37,690	$ 4,710	$ 3,013	$ 3,598	$ 149,634	$ 38,128
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 6,456	$ 7,666							$ 6,456	$ 7,666
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)									$ 4,874	$ 7,080	$ 4,874	$ 7,080
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 1,608			$ -	$ 634		$ 109	$ -	$ 2,351
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 6,456	$ 9,274	$ -	$ -						
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)							$ 30,163	$ 4,098			$ 30,163	$ 4,098
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)**			$ 102,475	$ 20,546	$ -	$ -	$ 7,527	$ (22)	$ (1,861)	$ (3,591)	$ 108,141	$ 16,933
144	**Calculated Payments as a Percentage of Cost**			6%	31%	0%	0%	80%	100%	162%	200%	28%	56%

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 (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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 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)		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 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 (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL 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 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)	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	$ -	$ -	$ -	$ -	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 (07/01/2018-06/30/2019) WELLSTAR SPALDING REGIONAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 908,241		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	0.00	*(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 ---------->)		$ 908,241		
	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		$ 908,241
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	259,941,359
19	Uninsured Hospital	**Charges Sec. G**	88,513,589
20	Total Hospital	**Charges Sec. G**	795,630,907
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		32.67%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.12%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 296,732
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 101,041
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 397,773**

** 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.*

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.