

**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 PAULDING 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
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:	000001438A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110042

**B. DSH OB Qualifying Information**

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

**During the DSH Examination Year:**

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
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?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

DSH Examination  
 Year (07/01/18 -  
 06/30/19)

Yes

No

No

Yes

7/1/1966

**C. Disclosure of Other Medicaid Payments Received:**

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** \$ 691,818  
 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019** \$ -  
 (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.  
 NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.
3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2018 - 06/30/2019** \$ 691,818

**Certification:**

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

Answer
Yes

Explanation for "No" answers:

---



---



---

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

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

*Jim Budzinski 12/16/20*

Jim Budzinski 12/16/20 (Dec 16, 2020 18:07 EST)  
 Hospital CEO or CFO Signature

Executive Vice President  
 Title

Dec 16, 2020

Date

James Budzinski  
 Hospital CEO or CFO Printed Name

470-644-0011  
 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:**

*JB*

12/15/20

**Hospital Contact:**

Name	Ebenezer Erzuah
Title	Executive Director Reimbursement
Telephone Number	470-956-4981
E-Mail Address	ebenezer.erzuah@wellstar.org
Mailing Street Address	1800 Parkway Drive Marietta Ga 30067
Mailing City, State, Zip	Marietta, Georgia 30067

**Outside Preparer:**

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

**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 PAULDING HOSPITAL

2. Select Cost Report Year Covered by this Survey (enter "X"):

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

5/13/2020

4. Hospital Name:

Data	Correct?	If Incorrect, Proper Information
WELLSTAR PAULDING HOSPITAL	Yes	
Medicaid Provider Number: 000001438A	Yes	
Medicaid Subprovider Number 1 (Psychiatric or Rehab): 0	Yes	
Medicaid Subprovider Number 2 (Psychiatric or Rehab): 0	Yes	
Medicare Provider Number: 110042	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal): Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban): Urban	Yes	

5. Medicaid Provider Number:

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

8. Medicare Provider Number:

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

DSH Pool Classification (Small Rural, Non-Small Rural, Urban):

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

9. State Name & Number

10. State Name & Number

11. State Name & Number

12. State Name & Number

14. State Name & Number

15. State Name & Number

(List additional states on a separate attachment)

State Name	Provider No.
See Attached List	

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

- Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)**
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**

\$	-
\$	-
\$	-
	\$-
\$	-
\$	-
	\$-
\$	-

8. Out-of-State DSH Payments (See Note 2)

\$	-
----	---

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

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)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
\$	39,383	\$ 642,449	\$681,832
\$	1,045,182	\$ 7,433,434	\$8,478,616
	\$1,084,565	\$8,075,883	\$9,160,448
	3.63%	7.96%	7.44%

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) 28,371 (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	16,495,241
8. Outpatient Hospital Charity Care Charges	50,142,809
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 66,638,050

**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	\$72,560,724.00			\$ 58,263,141	\$ -	\$ -	\$ 14,297,583
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			\$14,614,891.00			\$ 11,735,129	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$0.00			\$ -	
19. Ancillary Services	\$239,544,287.00	\$511,319,453.00		\$ 192,343,762	\$ 410,567,535	\$ -	\$ 147,952,443
20. Outpatient Services		\$161,501,538.00			\$ 129,678,791	\$ -	\$ 31,822,747
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 312,105,011	\$ 672,820,991	\$ 14,614,891	\$ 250,606,904	\$ 540,246,325	\$ 11,735,129	\$ 194,072,773

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	999,540,893	Total Contractual Adj. (G-3 Line 2)	802,588,358
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				
35. Adjusted Contractual Adjustments				802,588,358
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 PAULDING 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern &amp; Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col. 2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults &amp; Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

**NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.**

**Routine Cost Centers (list below):**

1	03000	ADULTS & PEDIATRICS	\$ 31,853,040	\$ -	\$ -	\$ 0.00	\$ 31,853,040	29,050	\$55,875,678.00	\$ 1,096.49
2	03100	INTENSIVE CARE UNIT	\$ 5,301,017	\$ -	\$ -	\$ -	\$ 5,301,017	2,270	\$9,957,597.00	\$ 2,335.25
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	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 37,154,057	\$ -	\$ -	\$ -	\$ 37,154,057	31,320	\$ 65,833,275	
19		Weighted Average								\$ 1,186.27

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)	3,084	-	\$ 3,381,575	\$517,215.00	\$4,527,223.00	\$ 5,044,438	0.670357

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	\$8,583,841.00	\$ -	\$0.00	\$ 8,583,841	\$14,512,151.00	\$41,540,801.00	\$ 56,052,952	0.153138
22	5300	ANESTHESIOLOGY	\$98,149.00	\$ -	\$0.00	\$ 98,149	\$5,891,730.00	\$15,306,844.00	\$ 21,198,574	0.004630
23	5400	RADIOLOGY-DIAGNOSTIC	\$9,725,603.00	\$ -	\$17,527.00	\$ 9,743,130	\$20,163,240.00	\$132,978,926.00	\$ 153,142,166	0.063621
24	5600	RADIOISOTOPE	\$986,413.00	\$ -	\$0.00	\$ 986,413	\$4,347,100.00	\$14,271,786.00	\$ 18,618,886	0.052979
25	5700	CT SCAN	\$3,350,571.00	\$ -	\$0.00	\$ 3,350,571	\$35,642,628.00	\$122,230,960.00	\$ 157,873,588	0.021223
26	5900	CARDIAC CATHETERIZATION	\$3,280,852.00	\$ -	\$1,408.00	\$ 3,282,260	\$27,372,289.00	\$26,975,156.00	\$ 54,347,445	0.060394
27	6000	LABORATORY	\$5,301,684.00	\$ -	\$4,326.00	\$ 5,306,010	\$51,535,391.00	\$51,058,711.00	\$ 102,594,102	0.051718
28	6500	RESPIRATORY THERAPY	\$3,645,777.00	\$ -	\$1,471.00	\$ 3,647,248	\$22,659,717.00	\$3,265,765.00	\$ 25,925,482	0.140682
29	6600	PHYSICAL THERAPY	\$4,651,639.00	\$ -	\$0.00	\$ 4,651,639	\$4,652,177.00	\$10,826,575.00	\$ 15,478,752	0.300518
30	6900	ELECTROCARDIOLOGY	\$185,927.00	\$ -	\$52,376.00	\$ 238,303	\$5,108,075.00	\$8,216,837.00	\$ 13,324,912	0.017884

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR PAULDING 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
31	7000 ELECTROENCEPHALOGRAPHY	\$619,892.00	\$ -	\$0.00	\$ 619,892	\$251,215.00	\$5,384,503.00	\$ 5,635,718	0.109993
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$7,652,549.00	\$ -	\$0.00	\$ 7,652,549	\$9,471,320.00	\$8,997,225.00	\$ 18,468,545	0.414356
33	7200 IMPL. DEV. CHARGED TO PATIENTS	\$5,594,887.00	\$ -	\$0.00	\$ 5,594,887	\$6,070,241.00	\$9,269,502.00	\$ 15,339,743	0.364731
34	7300 DRUGS CHARGED TO PATIENTS	\$20,869,390.00	\$ -	\$0.00	\$ 20,869,390	\$37,699,125.00	\$80,288,725.00	\$ 117,987,850	0.176877
35	7400 RENAL DIALYSIS	\$555,285.00	\$ -	\$0.00	\$ 555,285	\$4,456,657.00	\$537,930.00	\$ 4,994,587	0.111177
36	9100 EMERGENCY	\$18,487,123.00	\$ -	\$0.00	\$ 18,487,123	\$24,384,212.00	\$109,350,690.00	\$ 133,734,902	0.138237
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR PAULDING 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
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	<b>Total Ancillary</b>	\$ 93,589,582	\$ -	\$ 77,108	\$ 93,666,690	\$ 274,734,483	\$ 645,028,159	\$ 919,762,642	
127	<b>Weighted Average</b>								0.105514
128	<b>Sub Totals</b>	\$ 130,743,639	\$ -	\$ 77,108	\$ 130,820,747	\$ 340,567,758	\$ 645,028,159	\$ 985,595,917	
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)				\$353,629.00				
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	<b>Grand Total</b>				\$ 130,467,118				
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 PAULDING 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 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				
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>			
1	03000 ADULTS & PEDIATRICS	\$ 1,096.49		2,073		307		1,651		70		2,297		4,101		24.73%	
2	03100 INTENSIVE CARE UNIT	\$ 2,335.25		240		18		218		15		267		489		33.44%	
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	\$ -															
11		\$ -															
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
				<b>Total Days</b>		<b>325</b>		<b>1,867</b>		<b>85</b>		<b>2,564</b>		<b>4,590</b>		<b>22.92%</b>	
19	Total Days per PS&R or Exhibit Detail				<b>2,313</b>		<b>325</b>		<b>1,867</b>		<b>85</b>		<b>2,564</b>				
20	Unreconciled Days (Explain Variance)																
21.01	Routine Charges				<b>\$ 4,843,114</b>		<b>\$ 645,507</b>		<b>\$ 4,440,008</b>		<b>\$ 162,980</b>		<b>\$ 5,381,524</b>		<b>\$ 10,091,609</b>		<b>23.58%</b>
	Calculated Routine Charge Per Diem				<b>\$ 2,093.87</b>		<b>\$ 1,986.18</b>		<b>\$ 2,378.15</b>		<b>\$ 1,917.41</b>		<b>\$ 2,098.88</b>		<b>\$ 2,198.61</b>		
<b>Ancillary Cost Centers (from WIS C) (from Section G):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)	0.670357	261,007	165,486	137,299	105,826	195,291	462,556	7,531	11,764	113,571	417,010	\$ 601,128	\$ 745,632		37.23%	
23	5000 OPERATING ROOM	0.153138	996,826	743,208	465,594	2,831,039	1,975,264	1,975,264	61,718	392,665	1,959,154	3,409,344	\$ 2,547,377	\$ 5,942,176		24.78%	
24	5300 ANESTHESIOLOGY	0.004630	392,208	304,515	158,861	769,344	405,480	579,396	16,849	94,843	715,901	548,058	\$ 973,398	\$ 1,748,098		18.84%	
25	5400 RADIOLOGY-DIAGNOSTIC	0.063621	1,129,429	3,586,788	308,041	5,967,182	1,027,602	4,597,937	56,863	817,408	1,711,442	9,241,780	\$ 2,521,935	\$ 14,969,315		18.61%	
26	5600 RADIOISOTOPE	0.052979	293,689	244,869	25,925	219,340	263,884	650,492	-	10,701	419,888	666,141	\$ 583,498	\$ 1,325,402		10.09%	
27	5700 CT SCAN	0.021223	2,050,268	3,114,407	671,577	5,096,607	2,148,908	5,855,424	132,657	708,729	3,371,639	17,949,965	\$ 5,003,410	\$ 14,775,167		26.14%	
28	5900 CARDIAC CATHETERIZATION	0.060394	1,245,305	323,218	212,611	272,465	1,057,791	1,207,448	36,330	19,982	2,750,474	1,199,655	\$ 2,552,037	\$ 1,823,113		15.33%	
29	6000 LABORATORY	0.051718	4,225,174	2,386,156	863,221	5,228,699	3,631,250	2,602,787	174,047	759,179	5,599,017	9,616,091	\$ 8,893,692	\$ 10,976,821		34.32%	
30	6500 RESPIRATORY THERAPY	0.140682	2,231,267	91,918	167,011	475,069	2,066,742	162,723	50,889	28,590	1,411,927	536,326	\$ 4,515,909	\$ 758,300		27.89%	
31	6600 PHYSICAL THERAPY	0.300518	179,417	109,683	16,021	268,239	222,028	335,402	4,107	58,707	563,053	920,189	\$ 421,573	\$ 772,031		17.30%	
32	6900 ELECTROCARDIOLOGY	0.017884	316,185	282,567	59,385	484,089	333,605	467,402	10,700	68,468	29,960	1,362,256	\$ 719,875	\$ 1,302,526		25.69%	
33	7000 ELECTROENCEPHALOGRAPHY	0.109993	17,462	188,576	1,652	257,534	21,532	362,358	1,652	73,209	14,164	50,176	\$ 42,298	\$ 861,676		17.94%	
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.414356	676,686	201,168	128,884	412,455	592,028	348,621	16,798	50,221	670,834	481,762	\$ 1,414,176	\$ 1,012,665		19.84%	
35	7200 IMPL. DEV. CHARGED TO PATIENTS	0.364731	224,098	286,677	35,692	130,236	460,358	423,068	2,103	23,658	377,480	283,278	\$ 722,251	\$ 863,639		14.65%	
36	7300 DRUGS CHARGED TO PATIENTS	0.176877	3,118,775	2,391,545	581,731	3,199,097	2,802,942	5,028,068	150,428	575,476	3,705,063	7,632,493	\$ 6,653,876	\$ 11,194,186		24.70%	
37	7400 RENAL DIALYSIS	0.111177	490,625	-	-	-	423,850	168,885	43,785	-	106,335	-	\$ 958,260	\$ 168,885		24.70%	
38	9100 EMERGENCY	0.138237	1,440,710	4,444,134	439,562	18,238,730	1,306,265	3,766,602	73,147	2,023,124	2,460,598	21,741,407	\$ 3,259,684	\$ 28,472,590		41.98%	
39													\$ -	\$ -			
40													\$ -	\$ -			
41													\$ -	\$ -			
42													\$ -	\$ -			
43													\$ -	\$ -			
44													\$ -	\$ -			
45													\$ -	\$ -			
46													\$ -	\$ -			
47													\$ -	\$ -			
48													\$ -	\$ -			
49													\$ -	\$ -			
50													\$ -	\$ -			
51													\$ -	\$ -			
52													\$ -	\$ -			
53													\$ -	\$ -			
54													\$ -	\$ -			
55													\$ -	\$ -			
56													\$ -	\$ -			
57													\$ -	\$ -			
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 PAULDING 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																							
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																							
110																							
111																							
112																							
113																							
114																							
115																							
116																							
117																							
118																							
119																							
120																							
121																							
122																							
123																							
124																							
125																							
126																							
127																							
			\$	19,289,111	\$	18,864,915	\$	4,272,867	\$	43,955,951	\$	17,982,795	\$	29,194,433	\$	839,604	\$	5,716,723	\$	25,980,500	\$	76,055,931	

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

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR PAULDING HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 24,132,225	\$ 18,864,915	\$ 4,918,374	\$ 43,955,951	\$ 22,422,803	\$ 29,194,433	\$ 1,002,584	\$ 5,716,723	\$ 31,362,024	\$ 76,055,931	\$ 52,475,986	\$ 97,732,022	26.22%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 24,132,225	\$ 18,864,915	\$ 4,918,374	\$ 43,955,951	\$ 22,422,803	\$ 29,194,433	\$ 1,002,584	\$ 5,716,723	\$ 31,362,024	\$ 76,055,931			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 5,130,427	\$ 1,973,307	\$ 894,992	\$ 4,784,287	\$ 4,483,358	\$ 3,184,106	\$ 202,070	\$ 618,378	\$ 5,972,870	\$ 7,418,462	\$ 10,710,847	\$ 10,560,078	26.64%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 4,363,738	\$ 1,912,825			\$ 514,607	\$ 271,817					\$ 4,878,345	\$ 2,184,642	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 842,136	\$ 4,922,872							\$ 842,136	\$ 4,922,872	
134 Private Insurance (including primary and third party liability)	\$ 158,743	\$ 111,205			\$ 4,250	\$ 2,838	\$ 522,341	\$ 1,581,176			\$ 685,334	\$ 1,695,219	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 4,075	\$ 1,090	\$ 6,396	\$ 63	\$ 3,962		\$ 3,916			\$ 1,153	\$ 18,339	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 4,522,481	\$ 2,028,105	\$ 843,226	\$ 4,929,258									
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)					\$ 3,201,650	\$ 2,459,831					\$ 3,201,650	\$ 2,459,831	
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 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 39,383	\$ 642,449			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 607,946	\$ (54,798)	\$ 51,766	\$ (144,971)	\$ 762,788	\$ 445,658	\$ (320,271)	\$ (966,714)	\$ 5,933,487	\$ 6,776,013	\$ 1,102,229	\$ (720,825)	
146 <b>Calculated Payments as a Percentage of Cost</b>	88%	103%	94%	103%	83%	86%	258%	256%	1%	9%	90%	107%	
147 <b>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 &amp; 6)</b>					17,086								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					11%								

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.**

**I. Out-of-State Medicaid Data:**

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR PAULDING HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
<b>Routine Cost Centers (list below):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>	
1	03000 ADULTS & PEDIATRICS	\$ 1,096.49			23							23	
2	03100 INTENSIVE CARE UNIT	\$ 2,335.25			3							3	
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	\$ -											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
					26							26	
19	Total Days			26									
19	Total Days per PS&R or Exhibit Detail			26									
20	Unreconciled Days (Explain Variance)												
21	Routine Charges			\$ 52,369								\$ 52,369	
21.01	Calculated Routine Charge Per Diem			\$ 2,014.19								\$ 2,014.19	
<b>Ancillary Cost Centers (from W/S C) (list below):</b>				<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>		<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)		0.670357		555							555	
23	5000 OPERATING ROOM		0.153138		22,670		9,459					22,670	9,459
24	5300 ANESTHESIOLOGY		0.004630		5,388		2,430					5,388	2,430
25	5400 RADIOLOGY-DIAGNOSTIC		0.063621		14,898		37,628					14,898	37,628
26	5600 RADIOISOTOPE		0.052979		147							147	
27	5700 CT SCAN		0.021223		53,620		111,400					53,620	111,400
28	5900 CARDIAC CATHETERIZATION		0.060394		6,966							6,966	
29	6000 LABORATORY		0.051718		65,289		55,902					65,289	55,902
30	6500 RESPIRATORY THERAPY		0.140682		4,979		4,344					4,979	4,344
31	6600 PHYSICAL THERAPY		0.300518		1,276							1,276	
32	6900 ELECTROCARDIOLOGY		0.017884		2,675		5,885					2,675	5,885
33	7000 ELECTROENCEPHALOGRAPHY		0.109993										
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.414356		8,400		2,065					8,400	2,065
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.364731										
36	7300 DRUGS CHARGED TO PATIENTS		0.176877		44,665		31,218					44,665	31,218
37	7400 RENAL DIALYSIS		0.111177										
38	9100 EMERGENCY		0.138237		20,869		191,836					20,869	191,836
39													
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 PAULDING 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	
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 251,842	\$ 452,722	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Totals / Payments</b>											
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ 304,211	\$ 452,722	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 304,211	\$ 452,722
129	Total Charges per PS&R or Exhibit Detail	\$ 304,211	\$ 452,722	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)										
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ 57,010	\$ 43,094	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 57,010	\$ 43,094
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 2,743	\$ 19,699							\$ 2,743	\$ 19,699
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)	\$ 2,743	\$ 19,699	\$ -	\$ -						
137	Medicaid Cost Settlement Payments (See Note B)									\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments									\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)									\$ -	\$ -
143	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 54,267	\$ 23,395	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 54,267	\$ 23,395
144	<b>Calculated Payments as a Percentage of Cost</b>	5%	46%	0%	0%	0%	0%	0%	0%	5%	46%

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 PAULDING HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						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)
<b>Organ Acquisition Cost Centers (list below):</b>															
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	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
10	<b>Total Cost</b>														

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 PAULDING HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						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)
<b>Organ Acquisition Cost Centers (list below):</b>													
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	<b>Totals</b>	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	<b>Total Cost</b>												

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 PAULDING HOSPITAL

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 1,640,254	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		2405553.00 (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 ----->)	Reported as Contractual Reserve	
	\$ 1,640,254	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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	\$ 1,640,254
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid &amp; Uninsured:</b>	
18 Medicaid Hospital Charges Sec. G	150,964,941
19 Uninsured Hospital Charges Sec. G	107,417,955
20 Total Hospital Charges Sec. G	985,595,917
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	15.32%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.90%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 251,240
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 178,768
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 430,008

\* 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.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O)***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q)†	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S)†	Insurance Status When Services Were Provided (Insured or Uninsured) (T)†	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections if (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service", (Q)/((Q)+(R)+(S))/(N)†
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 900	\$ -	Insured		\$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	\$ 150	No	Outpatient	\$ 2,000	\$ -	\$ 50	Insured	Exhausted	\$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,000	\$ -	Uninsured		\$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	\$ 130	No	Inpatient	\$ 14,000	\$ 400	\$ 50	Insured	Non-Covered Service	\$ 126

**Notes for Completing Exhibit B:**  
 \* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.  
 \*\* Other Non-Hospital Charges should include RHC, FOHC, Pharmacy, etc...  
 \*\*\* If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.  
 \*\*\*\* 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.  
 \*\*\*\*\* The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

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.

Example of Exhibit C (Other Medicaid Eligible example)

Claim Type (A) **	Primary Payer Plan (B)	Secondary Payer Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Patient's Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) †	Routine Days of Care (P) †	Total Medicare Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Medicaid MCO Payments for Services Provided (T)	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All		
																						Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)		
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	\$ 1,200	3	\$ -	\$ -	\$ 50	\$ -	\$ 1,500	\$ -	\$ 1,550	\$ 1,550	
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	\$ 1,500	1	\$ -	\$ -	\$ 50	\$ -	\$ 1,500	\$ -	\$ 1,550	\$ 1,550	
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	\$ 100	-	\$ -	\$ -	\$ 50	\$ -	\$ 1,500	\$ -	\$ 1,550	\$ 1,550	
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	\$ 375	-	\$ -	\$ -	\$ 50	\$ -	\$ 1,500	\$ -	\$ 1,550	\$ 1,550	
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	\$ 1,500	-	\$ -	\$ -	\$ 50	\$ -	\$ 1,500	\$ -	\$ 1,550	\$ 1,550	
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	\$ 100	-	\$ -	\$ -	\$ -	\$ -	\$ 900	\$ 75	\$ 975	\$ 975	
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	\$ 375	-	\$ -	\$ -	\$ -	\$ -	\$ 900	\$ 75	\$ 975	\$ 975	
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ -	\$ 900	\$ 75	\$ 975	\$ 975	
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	\$ 375	-	\$ -	\$ -	\$ -	\$ 100	\$ -	\$ 1,000	\$ -	\$ 1,100	\$ 1,100
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	\$ 1,500	-	\$ -	\$ -	\$ -	\$ 100	\$ -	\$ 1,000	\$ -	\$ 1,100	\$ 1,100

Notes for Completing Exhibit C:

† All charges for non-hospital services should be included.

\*\* A separate Exhibit C file should be submitted for each claim type reported (e.g. Medicaid Managed Care, Other Medicaid Eligibles, Out-of-State Medicaid, etc.). The format above should be used for each Exhibit C.

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.

# PAULDING HOSPITAL Amended 2019 DSH Survey Part II - Combined

Final Audit Report

2020-12-16

Created:	2020-12-16
By:	Jimmy Swartz (jimmy.swartz@wellstar.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAABIFr-Zdd1TD96BIF_SleDSjfr7Ax8Kgm

## "PAULDING HOSPITAL Amended 2019 DSH Survey Part II - Combined" History

-  Document created by Jimmy Swartz (jimmy.swartz@wellstar.org)  
2020-12-16 - 12:44:02 PM GMT - IP address: 162.41.8.17
-  Document emailed to Jim Budzinski 12/16/20 (jim.budzinski@wellstar.org) for signature  
2020-12-16 - 12:44:42 PM GMT
-  Email viewed by Jim Budzinski 12/16/20 (jim.budzinski@wellstar.org)  
2020-12-16 - 11:06:53 PM GMT - IP address: 104.47.49.254
-  Document e-signed by Jim Budzinski 12/16/20 (jim.budzinski@wellstar.org)  
Signature Date: 2020-12-16 - 11:07:12 PM GMT - Time Source: server- IP address: 162.41.8.12
-  Agreement completed.  
2020-12-16 - 11:07:12 PM GMT