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 NORTH FULTON REGIONAL HOSP	

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:	000275976A
7	Medicaid Subprovider Number 1 (Psychiatric or Rehab)	0
8	Medicaid Subprovider Number 2 (Psychiatric or Rehab)	0
9	Medicare Provider Number:	110198

B. DSH OB Qualifying Information

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

		DSH Examination Year (07/01/18 - 06/30/19)
	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.)	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?	11/1/1983

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 705,913
   (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 Services07/01/2018 - 06/30/2019** — $ 705,913

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:

Name	Ebbie Erzuah
Title	Executive Director of Reimbursement
Telephone Number	(470) 956-4981
E-Mail Address	ebenezer.erzuah@wellstar.org
Mailing Street Address	1800 Parkway Place, Suite 500, Marietta GA 30067
Mailing City, State, Zip	

Outside Preparer:

Name	Tim Beatty
Title	Senior Director
Firm Name	Southeast Reimbursement Group
Telephone Number	770-928-3352
E-Mail Address	tim.beatty@srgllc.org

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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 NORTH FULTON REGIONAL HOSP

	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: 12/11/2019

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR NORTH FULTON REGIONAL HOSP	Yes	
5. Medicaid Provider Number:	000275976A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110198	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		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (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)	$ 129,620	$ 617,647	$747,267
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,776,168	$ 5,906,681	$7,682,849
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$1,905,788	$6,524,328	$8,430,116
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.80%	9.47%	8.86%

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)	37,185	**(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	7,500
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 7,500
7.	Inpatient Hospital Charity Care Charges	23,378,650
8.	Outpatient Hospital Charity Care Charges	38,244,443
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 61,623,093

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	$79,766,704.00			$ 60,286,643	$ -	$ -	$ 19,480,061
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$21,786,262.00			$ 16,465,775	$ -	$ -	$ 5,320,487
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	$277,100,356.00	$315,921,154.00		$ 209,428,865	$ 238,769,122	$ -	$ 144,823,522
20.	Outpatient Services		$99,084,277.00			$ 74,886,615	$ -	$ 24,197,662
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 295,338	-		$ 223,213	-
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	$ 378,653,322	$ 415,005,431	$ 295,338	$ 286,181,284	$ 313,655,738	$ 223,213	$ 193,821,732

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	793,954,091	Total Contractual Adj. (G-3 Line 2)		599,176,762
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)				+	3,207,443
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)				-	2,323,971
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					600,060,234
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 NORTH FULTON REGIONAL HOSP

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	$ 33,725,549	$ -	$ 16,325	$0.00	$ 33,741,874	31,262	$53,711,033.00		$ 1,079.33
2	03100 INTENSIVE CARE UNIT	$ 11,798,751	$ -	$ 1,247		$ 11,799,998	5,776	$23,183,680.00		$ 2,042.94
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		$ -			$ -				$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,088,919	$ -	$ -		$ 4,088,919	2,981	$5,362,398.00		$ 1,371.66
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 49,613,219	$ -	$ 17,572	$ -	$ 49,630,791	40,019	$ 82,257,111		
19	Weighted Average									$ 1,240.18

			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)	3,001	-	-	$ 3,239,069	$1,083,396.00	$4,500,403.00	$ 5,583,799	0.580083

			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	$20,483,699.00	$ -	$0.00		$ 20,483,699	$52,347,107.00	$72,195,583.00	$ 124,542,690	0.164471
22	5200	DELIVERY ROOM & LABOR ROOM	$4,984,853.00	$ -	$0.00		$ 4,984,853	$11,029,613.00	$34,902.00	$ 11,064,515	0.450526
23	5400	RADIOLOGY-DIAGNOSTIC	$12,472,012.00	$ -	$0.00		$ 12,472,012	$51,515,066.00	$115,410,917.00	$ 166,925,983	0.074716
24	6000	LABORATORY	$6,678,295.00	$ -	$0.00		$ 6,678,295	$43,358,695.00	$30,792,984.00	$ 74,151,679	0.090063
25	6300	BLOOD STORING PROCESSING & TRANS.	$909,482.00	$ -	$0.00		$ 909,482	$3,520,811.00	$306,511.00	$ 3,827,322	0.237629
26	6500	RESPIRATORY THERAPY	$6,157,163.00	$ -	$1,868.00		$ 6,159,031	$27,908,398.00	$10,815,958.00	$ 38,724,356	0.159048
27	6600	PHYSICAL THERAPY	$7,308,211.00	$ -	$3,802.00		$ 7,312,013	$17,265,371.00	$3,114,366.00	$ 20,379,737	0.358788
28	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$13,320,678.00	$ -	$0.00		$ 13,320,678	$14,533,749.00	$14,047,376.00	$ 28,581,125	0.466066
29	7200	IMPL. DEV. CHARGED TO PATIENTS	$13,478,833.00	$ -	$0.00		$ 13,478,833	$14,820,271.00	$21,366,501.00	$ 36,186,772	0.372480
30	7300	DRUGS CHARGED TO PATIENTS	$15,340,348.00	$ -	$0.00		$ 15,340,348	$38,840,247.00	$27,925,275.00	$ 66,765,522	0.229765
31	7400	RENAL DIALYSIS	$607,221.00	$ -	$0.00		$ 607,221	$5,137,205.00	$337,770.00	$ 5,474,975	0.110908

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR NORTH FULTON REGIONAL HOSP

	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	7606	INFUSION THERAPY	$798,287.00	$ -	$0.00		$ 798,287	$4,297,641.00	$11,665,178.00	$ 15,962,819	0.050009
33	7625	SLEEP DISORDERS	$135,858.00	$ -	$0.00		$ 135,858	$213,408.00	$1,472,036.00	$ 1,685,444	0.080607
34	7626	WOUND CARE	$1,246,588.00	$ -	$2,947.00		$ 1,249,535	$918,645.00	$4,197,634.00	$ 5,116,279	0.244227
35	7697	CARDIAC REHABILITATION	$813,077.00	$ -	$0.00		$ 813,077	$435,753.00	$2,515,630.00	$ 2,951,383	0.275490
36	7698	HYPERBARIC OXYGEN THERAPY	$9,675.00	$ -	$0.00		$ 9,675	$176,528.00	$2,771,264.00	$ 2,947,792	0.003282
37	7699	LITHOTRIPSY	$162,220.00	$ -	$0.00		$ 162,220	$37,562.00	$2,986,234.00	$ 3,023,796	0.053648
38	9001	RADIOLOGY CLINIC	$1,218,720.00	$ -	$0.00		$ 1,218,720	$4,221,733.00	$3,633,406.00	$ 7,855,139	0.155149
39	9002	DIAGNOSTIC CARDIOLOGY CLINIC	$388,137.00	$ -	$0.00		$ 388,137	$6,963,608.00	$4,202,516.00	$ 11,166,124	0.034760
40	9100	EMERGENCY	$11,572,801.00	$ -	$10,703.00		$ 11,583,504	$18,327,681.00	$60,126,889.00	$ 78,454,570	0.147646
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 NORTH FULTON REGIONAL HOSP

	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**	$ 118,086,158	$ -	$ 19,320		$ 118,105,478	$ 316,952,488	$ 394,419,333	$ 711,371,821	
127		**Weighted Average**									0.170578
128		**Sub Totals**	$ 167,699,377	$ -	$ 36,892		$ 167,736,269	$ 399,209,599	$ 394,419,333	$ 793,628,932	
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**					$ 167,736,269				
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 NORTH FULTON REGIONAL HOSP

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,079.33		1,460		1,050		1,170		1,203		2,112		4,883		24.96%
2	03100 INTENSIVE CARE UNIT	$ 2,042.94		683		38		258		220		565		1,199		30.75%
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	$ 1,371.66		813		933				94		58		1,840		63.67%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	2,956		2,021		1,428		1,517		2,735		7,922		26.81%
19	Total Days per PS&R or Exhibit Detail			2,956		2,021		1,428		1,517		2,735				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,145,452		$ 3,456,556		$ 3,211,145		$ 3,364,984		$ 6,015,671		$ 16,178,137		27.15%
21.01	Calculated Routine Charge Per Diem			$ 2,078.98		$ 1,710.32		$ 2,248.70		$ 2,218.18		$ 2,199.51		$ 2,042.18		

Line #	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.580083	143,089	98,390	29,220	67,266	55,885	95,775	37,121	118,545	110,894	716,031	$ 265,315	$ 379,976	26.61%
23	5000 OPERATING ROOM		0.164471	1,904,047	708,712	1,636,032	2,815,315	946,574	780,493	1,167,962	1,212,071	4,054,226	2,006,445	$ 5,654,615	$ 5,516,591	13.88%
24	5200 DELIVERY ROOM & LABOR ROOM		0.450526	1,802,120	-	3,204,685	35,676	-	1,271	959,264	4,750	170,961	14,419	$ 5,966,069	$ 41,697	56.06%
25	5400 RADIOLOGY-DIAGNOSTIC		0.074716	2,220,559	1,055,462	683,746	2,267,049	2,562,046	2,219,241	1,469,731	1,919,637	6,036,592	16,380,662	$ 6,936,082	$ 7,461,389	22.25%
26	6000 LABORATORY		0.090063	2,822,683	624,142	1,398,565	1,347,872	2,100,766	552,578	1,484,641	600,042	4,180,845	5,288,116	$ 7,806,655	$ 3,124,634	27.77%
27	6300 BLOOD STORING PROCESSING & TRANS.		0.237629	169,936	13,686	94,860	24,646	130,903	-	103,967	8,404	361,506	48,217	$ 499,666	$ 46,736	24.98%
28	6500 RESPIRATORY THERAPY		0.159048	1,623,364	111,780	459,798	227,463	1,470,183	374,190	1,179,835	194,142	2,284,537	1,295,032	$ 4,733,180	$ 907,575	24.06%
29	6600 PHYSICAL THERAPY		0.358788	587,345	2,593	81,711	2,906	469,322	141,221	398,302	67,266	497,067	75,244	$ 1,536,680	$ 213,986	11.46%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.466066	675,345	107,192	238,091	412,168	439,250	269,473	455,578	235,001	945,230	457,082	$ 1,808,264	$ 1,023,834	14.86%
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.372480	460,255	442,142	95,390	249,715	213,247	534,741	197,231	1,381,314	598,165	181,952	$ 966,123	$ 2,607,912	12.03%
32	7300 DRUGS CHARGED TO PATIENTS		0.229765	2,828,157	983,902	876,870	767,929	1,769,160	280,565	1,330,346	474,874	3,368,639	2,948,227	$ 6,804,533	$ 2,507,270	23.55%
33	7400 RENAL DIALYSIS		0.110908	162,630	-	-	-	449,096	37,530	481,635	25,020	261,909	1,813,950	$ 1,093,361	$ 62,550	59.03%
34	7606 INFUSION THERAPY		0.050009	-	-	146,238	568,878	177,417	300,521	126,443	364,716	536,404	3,404,844	$ 450,098	$ 1,234,115	35.53%
35	7625 SLEEP DISORDERS		0.080607	-	-	4,956	12,918	6,755	40,912	9,912	43,809	6,608	2,897	$ 21,623	$ 97,639	7.64%
36	7626 WOUND CARE		0.244227	-	-	-	182,239	-	385,515	-	367,149	-	533,054	$ -	$ 934,903	28.82%
37	7697 CARDIAC REHABILITATION		0.275490	573,754	71,716	-	-	-	12,081	-	-	-	23,304	$ 573,754	$ 83,797	23.07%
38	7698 HYPERBARIC OXYGEN THERAPY		0.003282	-	-	-	-	-	117,351	-	-	-	-	$ -	$ 117,351	3.98%
39	7699 LITHOTRIPSY		0.053648	-	-	-	76,063	-	37,562	-	-	-	228,762	$ -	$ 113,625	11.32%
40	9001 RADIOLOGY CLINIC		0.155149	183,050	140,031	-	37,710	-	50,639	-	42,016	-	126,747	$ 183,050	$ 270,396	7.39%
41	9002 DIAGNOSTIC CARDIOLOGY CLINIC		0.034760	-	-	52,274	-	-	-	15,856	-	1,566	-	$ 68,130	$ -	0.62%
42	9100 EMERGENCY		0.147646	709,525	1,189,869	308,956	3,057,892	753,034	976,012	507,392	929,513	2,086,963	13,289,444	$ 2,278,907	$ 6,153,286	30.74%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
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52			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	
61			-											$ -	$ -	

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

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR NORTH FULTON REGIONAL HOSP

				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	%
62			-											$ -	$ -
63			-											$ -	$ -
64			-											$ -	$ -
65			-											$ -	$ -
66			-											$ -	$ -
67			-											$ -	$ -
68			-											$ -	$ -
69			-											$ -	$ -
70			-											$ -	$ -
71			-											$ -	$ -
72			-											$ -	$ -
73			-											$ -	$ -
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122			-											$ -	$ -
123			-											$ -	$ -
124			-											$ -	$ -
125			-											$ -	$ -
126			-											$ -	$ -
127			-											$ -	$ -
				$ 16,865,859	$ 5,549,617	$ 9,311,392	$ 12,153,705	$ 11,543,638	$ 7,207,671	$ 9,925,216	$ 7,988,269	$ 25,502,112	$ 48,834,429		

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

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR NORTH FULTON REGIONAL HOSP

		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)***	$ 23,011,311	$ 5,549,617	$ 12,767,948	$ 12,153,705	$ 14,754,783	$ 7,207,671	$ 13,290,200	$ 7,988,269	$ 31,517,783 (Agrees to Exhibit A)	$ 48,834,429 (Agrees to Exhibit A)	$ 63,824,242	$ 32,899,262	22.48%
129	Total Charges per PS&R or Exhibit Detail	$ 23,011,311	$ 5,549,617	$ 12,767,948	$ 12,153,705	$ 14,754,783	$ 7,207,671	$ 13,290,200	$ 7,988,269	$ 31,517,783	$ 48,834,429			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 7,669,074	$ 988,546	$ 4,925,662	$ 1,848,955	$ 3,652,995	$ 1,173,829	$ 3,848,871	$ 1,515,853	$ 7,578,613	$ 6,157,011	$ 20,096,602	$ 5,527,183	23.61%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,651,357	$ 554,565									$ 3,651,357	$ 554,565	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,087,843	$ 1,294,369							$ 2,087,843	$ 1,294,369	
134	Private Insurance (including primary and third party liability)							$ 1,982,720	$ 1,432,982			$ 1,982,720	$ 1,432,982	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 92,225	$ 9,119	$ (50)	$ 4,001	$ 207	$ 17,445					$ 92,382	$ 30,565	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,743,582	$ 563,684	$ 2,087,793	$ 1,298,370									
137	Medicaid Cost Settlement Payments (See Note B)		$ 40,486									$ -	$ 40,486	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 2,815,573	$ 685,682					$ 2,815,573	$ 685,682	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 57,372	$ 39,902					$ 57,372	$ 39,902	
142	Other Medicare Cross-Over Payments (See Note D)					$ (6,002)				(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (6,002)	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 129,620	$ 617,647			
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)**	$ 3,925,492	$ 384,376	$ 2,837,869	$ 550,585	$ 785,845	$ 430,800	$ 1,866,151	$ 82,871	$ 7,448,993	$ 5,539,364	$ 9,415,357	$ 1,448,632	
146	**Calculated Payments as a Percentage of Cost**	49%	61%	42%	70%	78%	63%	52%	95%	2%	10%	53%	74%	
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)**					17,664								
148	**Percent of cross-over days to total Medicare days from the cost report**					8%								

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 NORTH FULTON REGIONAL HOSP

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	$ 1,079.33		29		30						59	
2	03100 INTENSIVE CARE UNIT	$ 2,042.94				12						12	
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	$ 1,371.66										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	29		42		-		-		71	
19	Total Days per PS&R or Exhibit Detail			29		42		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 46,853		$ 94,454						$ 141,307	
21.01	Calculated Routine Charge Per Diem			$ 1,615.62		$ 2,248.90		$ -		$ -		$ 1,990.24	
	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)		0.580083	-	-	8,300	5,564					$ 8,300	$ 5,564
23	5000 OPERATING ROOM		0.164471	45,119	-	1,755	7,849					$ 46,874	$ 7,849
24	5200 DELIVERY ROOM & LABOR ROOM		0.450526	10,041	-	-	-					$ 10,041	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.074716	37,926	22,226	74,783	183,222					$ 112,709	$ 205,448
26	6000 LABORATORY		0.090063	23,538	11,332	85,122	73,130					$ 108,660	$ 84,462
27	6300 BLOOD STORING PROCESSING & TRANS.		0.237629	-	-	-	-					$ -	$ -
28	6500 RESPIRATORY THERAPY		0.159048	2,140	1,337	77,923	16,622					$ 80,063	$ 17,959
29	6600 PHYSICAL THERAPY		0.358788	1,118	-	9,465	2,672					$ 10,583	$ 2,672
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.466066	5,040	239	5,438	2,426					$ 10,478	$ 2,665
31	7200 IMPL. DEV. CHARGED TO PATIENTS		0.372480	-	-	-	421					$ -	$ 421
32	7300 DRUGS CHARGED TO PATIENTS		0.229765	37,566	716	44,525	14,889					$ 82,091	$ 15,605
33	7400 RENAL DIALYSIS		0.110908	-	-	-	-					$ -	$ -
34	7606 INFUSION THERAPY		0.050009	1,061	2,354	10,563	32,053					$ 11,624	$ 34,407
35	7625 SLEEP DISORDERS		0.080607	-	-	-	-					$ -	$ -
36	7626 WOUND CARE		0.244227	-	1,401	-	4,976					$ -	$ 6,377
37	7697 CARDIAC REHABILITATION		0.275490	-	-	-	-					$ -	$ -
38	7698 HYPERBARIC OXYGEN THERAPY		0.003282	-	-	-	-					$ -	$ -
39	7699 LITHOTRIPSY		0.053648	-	-	-	-					$ -	$ -
40	9001 RADIOLOGY CLINIC		0.155149	-	-	-	-					$ -	$ -
41	9002 DIAGNOSTIC CARDIOLOGY CLINIC		0.034760	-	-	-	-					$ -	$ -
42	9100 EMERGENCY		0.147646	19,701	40,275	22,119	229,279					$ 41,820	$ 269,554
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR NORTH FULTON REGIONAL HOSP

				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			-									$ -	$ -
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93			-									$ -	$ -
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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 NORTH FULTON REGIONAL HOSP

				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			-									$ -	$ -
				$ 183,250	$ 79,880	$ 339,993	$ 573,103	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 230,103	$ 79,880	$ 434,447	$ 573,103	$ -	$ -	$ -	$ -	$ 664,550	$ 652,983
129	Total Charges per PS&R or Exhibit Detail	$ 230,103	$ 79,880	$ 434,447	$ 573,103	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 62,882	$ 9,576	$ 107,601	$ 69,776	$ -	$ -	$ -	$ -	$ 170,483	$ 79,352
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 26,295	$ 2,671							$ 26,295	$ 2,671
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 5,327	$ 42,642					$ 5,327	$ 42,642
134	Private Insurance (including primary and third party liability)									$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)				$ 4,833					$ -	$ 4,833
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 26,295	$ 2,671	$ 5,327	$ 47,475						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 36,587	$ 6,905	$ 102,274	$ 22,301	$ -	$ -	$ -	$ -	$ 138,861	$ 29,206
144	**Calculated Payments as a Percentage of Cost**	42%	28%	5%	68%	0%	0%	0%	0%	19%	63%

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

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		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		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)*	*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 NORTH FULTON REGIONAL HOSP

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							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.

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Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$2,323,971		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment		*(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 ---------->)		$ 2,323,971		
	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		$ 2,323,971
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	98,041,037
19	Uninsured Hospital	**Charges Sec. G**	80,352,212
20	Total Hospital	**Charges Sec. G**	793,628,932
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		12.35%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.12%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 287,092
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 235,294
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 522,386**

** 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.