

A. General DSH Year Information

1 DSH Year

Begin	End
07/01/2018	06/30/2019

2 Select Your Facility from the Drop-Down Menu Provided

WELLSTAR ATLANTA MEDICAL CENTER

Identification of cost reports needed to cover the DSH Year:

- 3 Cost Report Year 1
- 4 Cost Report Year 2 (if applicable)
- 5 Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
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

- 6 Medicaid Provider Number:
- 7 Medicaid Subprovider Number 1 (Psychiatric or Rehab):
- 8 Medicaid Subprovider Number 2 (Psychiatric or Rehab):
- 9 Medicare Provider Number:

Date	
	000000789A
	000001713A
	0
	110115

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** \$ 11,837,141
 (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** \$ 11,837,141

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.**

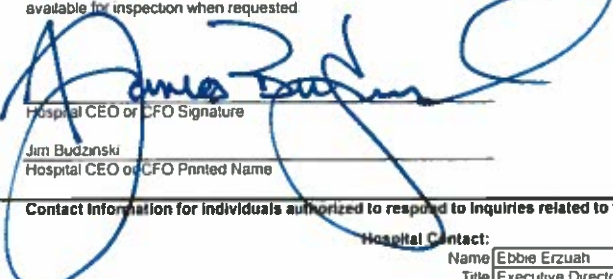
Answer
 Yes

Explanation for "No" answers:

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.

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

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

Hospital Contact:	
Name	Ebber 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

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:

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):

3a. Date CMS processed the HCRIS file into the HCRIS database:

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR ATLANTA MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000000789A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	000001713A	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110115	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)	\$	499,458	\$	1,004,704	\$1,504,162
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$	1,338,760	\$	5,115,537	\$6,454,297
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)		\$1,838,218		\$6,120,241	\$7,958,459
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:		27.17%		16.42%	18.90%

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) 107,044 (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	619,165
3. Outpatient Hospital Subsidies	237,792
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 856,957
7. Inpatient Hospital Charity Care Charges	109,208,555
8. Outpatient Hospital Charity Care Charges	168,489,462
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 277,698,017

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	\$270,808,915.00			\$ 220,502,546	\$ -	\$ -	\$ 50,306,369
12. Subprovider I (Psych or Rehab)	\$6,506,790.00			\$ 5,298,067	\$ -	\$ -	\$ 1,208,723
13. Subprovider II (Psych or Rehab)	\$15,768,195.00			\$ 12,839,042	\$ -	\$ -	\$ 2,929,153
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	\$818,862,053.00	\$502,889,603.00		\$ 666,747,501	\$ 409,471,150	\$ -	\$ 245,533,005
20. Outpatient Services		\$346,223,815.00			\$ 281,908,122	\$ -	\$ 64,315,693
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	\$ 1,111,945,953	\$ 849,113,418	\$ -	\$ 905,387,156	\$ 691,379,272	\$ -	\$ 364,292,943

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,961,059,371	Total Contractual Adj. (G-3 Line 2)	1,576,116,403
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)			+	22,945,250
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)			-	\$ 2,295,225
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				1,596,766,428
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 ATLANTA MEDICAL CENTER

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 & 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. I, Line 2 for Adults & 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	\$ 88,277,980	\$ 6,038,067	\$ 2,565	\$0.00	\$ 94,318,612	80,995	\$164,535,857.00	\$ 1,164.50
2	03100	INTENSIVE CARE UNIT	\$ 40,025,072	\$ 1,206,675	\$ 10,419		\$ 41,242,166	18,562	\$98,374,902.00	\$ 2,221.86
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	\$ 8,535,804	\$ -	\$ -		\$ 8,535,804	4,223	\$14,466,071.00	\$ 2,021.27
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 1,586,706	\$ -	\$ -		\$ 1,586,706	4,223	\$2,291,871.00	\$ 375.73
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 138,425,562	\$ 7,244,742	\$ 12,984	\$ -	\$ 145,683,288	108,003	\$ 279,668,701	
19		Weighted Average								\$ 1,348.88

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
09200 Observation (Non-Distinct)	1,361	-	-	\$ 1,584,885	\$2,682,632.00	\$6,439,102.00	\$ 9,121,734	0.173748

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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

5000	OPERATING ROOM	\$38,085,074.00	\$ 1,434,649	\$3,634.00	\$ 39,523,357	\$156,304,342.00	\$91,412,224.00	\$ 247,716,566	0.159551
5200	DELIVERY ROOM & LABOR ROOM	\$12,092,598.00	\$ -	\$0.00	\$ 12,092,598	\$19,339,756.00	\$38,707.00	\$ 19,378,463	0.624023
5400	RADIOLOGY-DIAGNOSTIC	\$22,272,899.00	\$ 127,368	\$0.00	\$ 22,400,267	\$143,373,785.00	\$207,562,366.00	\$ 350,936,151	0.063830
6000	LABORATORY	\$20,550,637.00	\$ 108,810	\$4,350.00	\$ 20,663,797	\$135,074,741.00	\$90,661,021.00	\$ 225,735,762	0.091540
6500	RESPIRATORY THERAPY	\$10,226,465.00	\$ -	\$0.00	\$ 10,226,465	\$76,879,123.00	\$3,443,093.00	\$ 80,322,216	0.127318
6600	PHYSICAL THERAPY	\$4,796,399.00	\$ -	\$0.00	\$ 4,796,399	\$22,130,720.00	\$2,481,759.00	\$ 24,612,479	0.194877
6900	ELECTROCARDIOLOGY	\$875,911.00	\$ -	\$0.00	\$ 875,911	\$7,889,567.00	\$13,493,304.00	\$ 21,382,871	0.040963
6902	CARDIOVASCULAR LAB	\$7,447,255.00	\$ -	\$40,526.00	\$ 7,487,781	\$10,143,028.00	\$5,129,334.00	\$ 15,272,362	0.490283
7000	ELECTROENCEPHALOGRAPHY	\$926,920.00	\$ -	\$0.00	\$ 926,920	\$15,831,265.00	\$5,837,463.00	\$ 21,668,728	0.042777
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$22,223,666.00	\$ -	\$0.00	\$ 22,223,666	\$43,953,578.00	\$11,353,988.00	\$ 55,307,566	0.401820
7200	IMPL. DEV. CHARGED TO PATIENTS	\$18,877,751.00	\$ -	\$0.00	\$ 18,877,751	\$42,796,198.00	\$11,235,584.00	\$ 54,031,782	0.349382

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7300 DRUGS CHARGED TO PATIENTS	\$28,845,064.00	\$ -	\$0.00	\$ 28,845,064	\$125,732,190.00	\$47,815,901.00	\$ 173,548,091	0.166208
33	7400 RENAL DIALYSIS	\$2,059,685.00	\$ -	\$0.00	\$ 2,059,685	\$25,556,034.00	\$0.00	\$ 25,556,034	0.080595
34	7601 PSYCH ANCILLARY	\$336,738.00	\$ -	\$0.00	\$ 336,738	\$1,815,330.00	\$2,698,542.00	\$ 4,513,872	0.074601
35	7626 WOUND CARE	\$940,220.00	\$ -	\$0.00	\$ 940,220	\$9,027.00	\$549,633.00	\$ 558,660	1.682991
36	7699 LITHOTRIPSY	\$644,007.00	\$ -	\$0.00	\$ 644,007	\$406,586.00	\$2,175,660.00	\$ 2,582,246	0.249398
37	9001 OP IMAGING AND SPECIALTY CARE	\$2,302,931.00	\$ -	\$0.00	\$ 2,302,931	\$12,414,503.00	\$38,672,010.00	\$ 51,086,513	0.045079
38	9003 CLINICS	\$1,192,413.00	\$ 2,759,512	\$0.00	\$ 3,951,925	\$1,059,541.00	\$2,046,476.00	\$ 3,106,017	1.272345
39	9100 EMERGENCY	\$32,878,897.00	\$ 469,035	\$0.00	\$ 33,347,932	\$78,488,923.00	\$217,559,618.00	\$ 296,048,541	0.112643
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

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	\$ 227,575,530	\$ 4,899,374	\$ 48,510	\$ 232,523,414	\$ 921,880,869	\$ 760,605,785	\$ 1,682,486,654	
127	Weighted Average								0.139144
128	Sub Totals	\$ 366,001,092	\$ 12,144,116	\$ 61,494	\$ 378,206,702	\$ 1,201,549,570	\$ 760,605,785	\$ 1,962,155,355	
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				\$ 378,206,702				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					3.32%			

* 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 ATLANTA MEDICAL CENTER

			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															
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125															
126															
127															
			\$ 133,322,148	\$ 52,325,624	\$ 59,997,565	\$ 95,350,473	\$ 75,041,190	\$ 30,201,874	\$ 86,129,168	\$ 50,359,626	\$ 122,182,031	\$ 209,260,876			

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

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

		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)	\$ 180,660,965	\$ 52,325,624	\$ 81,700,784	\$ 95,350,473	\$ 101,498,989	\$ 30,201,874	\$ 116,518,414	\$ 50,359,626	\$ 153,806,685	\$ 209,260,876	\$ 480,379,152	\$ 228,237,597	54.97%	
129	Total Charges per PS&R or Exhibit Detail	\$ 180,660,965	\$ 52,325,624	\$ 81,700,784	\$ 95,350,473	\$ 101,498,989	\$ 30,201,874	\$ 116,518,414	\$ 50,359,626	\$ 153,806,685	\$ 209,260,876				
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-				
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 53,489,971	\$ 6,908,317	\$ 27,062,709	\$ 11,342,085	\$ 24,627,645	\$ 3,828,414	\$ 30,102,605	\$ 6,258,620	\$ 35,876,490	\$ 22,369,486	\$ 135,282,930	\$ 28,337,436	59.02%	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 31,274,379	\$ 4,224,929									\$ 31,274,379	\$ 4,224,929		
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 14,182,364	\$ 8,596,488							\$ 14,182,364	\$ 8,596,488		
134	Private Insurance (including primary and third party liability)					\$ 16,508,414	\$ 2,447,735	\$ 18,684,179	\$ 4,559,900			\$ 35,192,593	\$ 7,007,635		
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 287,577	\$ 20,045	\$ 1,692	\$ 9,647	\$ 36,037	\$ 3,997	\$ 102,082	\$ 8,442			\$ 427,388	\$ 42,131		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 31,561,956	\$ 4,244,974	\$ 14,184,056	\$ 8,606,135										
137	Medicaid Cost Settlement Payments (See Note B)		\$ 434,407									\$ -	\$ 434,407		
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					\$ 376,344	\$ 236,187					\$ 376,344	\$ 236,187		
142	Other Medicare Cross-Over Payments (See Note D)					\$ 1,284,711	\$ 101,905					\$ 1,284,711	\$ 101,905		
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 499,458	\$ 1,004,704				
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)	\$ 21,928,015	\$ 2,228,936	\$ 12,878,653	\$ 2,735,950	\$ 6,422,139	\$ 1,038,590	\$ 11,316,344	\$ 1,690,278	\$ 35,377,032	\$ 21,364,782	\$ 52,545,151	\$ 7,693,754		
146	Calculated Payments as a Percentage of Cost	59%	68%	52%	76%	74%	73%	62%	73%	1%	4%	61%	73%		
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)														34,854
148	Percent of cross-over days to total Medicare days from the cost report														28%

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

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)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,164.50		103		324						427	
2	03100 INTENSIVE CARE UNIT	\$ 2,221.86		18		29						47	
3	03200 CORONARY CARE UNIT	\$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	\$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	\$ 2,021.27				8						8	
7	04000 SUBPROVIDER I	\$ -										-	
8	04100 SUBPROVIDER II	\$ -										-	
9	04200 OTHER SUBPROVIDER	\$ -										-	
10	04300 NURSERY	\$ 375.73		2		3						5	
11		\$ -										-	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
18		\$ -										-	
			Total Days	123		364		-		-		487	
19	Total Days per PS&R or Exhibit Detail			123		364		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			\$ 285,219		\$ 888,062		\$ -		\$ -		\$ 1,173,281	
21.01	Calculated Routine Charge Per Diem			\$ 2,318.85		\$ 2,439.73		\$ -		\$ -		\$ 2,409.20	
22	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.173748	2,384	4,074	5,929	31,648					\$ 8,313	\$ 35,722
23	5000 OPERATING ROOM		0.159551	72,688	35,743	370,038	58,263					\$ 442,726	\$ 94,006
24	5200 DELIVERY ROOM & LABOR ROOM		0.624023	15,197	1,271	20,101	-					\$ 35,298	\$ 1,271
25	5400 RADIOLOGY-DIAGNOSTIC		0.063830	154,568	173,777	414,575	493,453					\$ 569,143	\$ 667,230
26	6000 LABORATORY		0.091540	122,219	85,201	472,261	233,258					\$ 594,480	\$ 318,459
27	6500 RESPIRATORY THERAPY		0.127318	65,292	5,273	142,447	9,315					\$ 207,739	\$ 14,588
28	6600 PHYSICAL THERAPY		0.194877	8,887	902	33,295	3,769					\$ 42,182	\$ 4,671
29	6900 ELECTROCARDIOLOGY		0.040963	10,165	6,955	22,982	27,820					\$ 33,147	\$ 34,775
30	6902 CARDIOVASCULAR LAB		0.490283	6,966	-	47,532	6,966					\$ 54,498	\$ 6,966
31	7000 ELECTROENCEPHALOGRAPHY		0.042777	-	-	-	-					\$ -	\$ -
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.401820	25,425	14,023	80,688	7,368					\$ 106,113	\$ 21,391
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.349382	-	15,387	49,252	19,594					\$ 49,252	\$ 34,981
34	7300 DRUGS CHARGED TO PATIENTS		0.166208	98,976	42,874	386,321	137,238					\$ 485,297	\$ 180,112
35	7400 RENAL DIALYSIS		0.080595	-	-	112,590	-					\$ 112,590	\$ -
36	7601 PSYCH ANCILLARY		0.074601	4,800	800	11,166	6,400					\$ 15,966	\$ 7,200
37	7626 WOUND CARE		1.682991	-	-	-	-					\$ -	\$ -
38	7699 LITHOTRIPSY		0.249398	-	-	-	-					\$ -	\$ -
39	9001 OP IMAGING AND SPECIALTY CARE		0.045079	-	-	-	-					\$ -	\$ -
40	9003 CLINICS		1.272345	-	2,934	1,120	3,286					\$ 1,120	\$ 6,220
41	9100 EMERGENCY		0.112643	209,262	242,660	325,283	699,228					\$ 534,545	\$ 941,888
42			-									\$ -	\$ -
43			-									\$ -	\$ -
44			-									\$ -	\$ -
45			-									\$ -	\$ -
46			-									\$ -	\$ -
47			-									\$ -	\$ -
48			-									\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

			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			-								\$	-
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66			-								\$	-
67			-								\$	-
68			-								\$	-
69			-								\$	-
70			-								\$	-
71			-								\$	-
72			-								\$	-
73			-								\$	-
74			-								\$	-
75			-								\$	-
76			-								\$	-
77			-								\$	-
78			-								\$	-
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108			-								\$	-
109			-								\$	-
110			-								\$	-

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

		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										\$ -	\$ -
		\$ 796,829	\$ 631,874	\$ 2,495,580	\$ 1,737,606	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Totals / Payments

128	Total Charges (includes organ acquisition from Section K)	\$ 1,082,048	\$ 631,874	\$ 3,383,642	\$ 1,737,606	\$ -	\$ -	\$ -	\$ -	\$ 4,465,690	\$ 2,369,480
129	Total Charges per PS&R or Exhibit Detail	\$ 1,082,048	\$ 631,874	\$ 3,383,642	\$ 1,737,606	\$ -	\$ -	\$ -	\$ -		
130	Unreconciled Charges (Explain Variance)										
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 267,711	\$ 76,491	\$ 812,019	\$ 190,158	\$ -	\$ -	\$ -	\$ -	\$ 1,079,730	\$ 266,649
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ -	\$ (21,617)							\$ -	\$ (21,617)
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 131,795	\$ 75,314					\$ 131,795	\$ 75,314
134	Private Insurance (including primary and third party liability)									\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 34,310	\$ 320	\$ 2,909					\$ 320	\$ 37,219
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 12,693	\$ 132,115	\$ 78,223						
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)	\$ 267,711	\$ 63,798	\$ 679,904	\$ 111,935	\$ -	\$ -	\$ -	\$ -	\$ 947,615	\$ 175,733
144	Calculated Payments as a Percentage of Cost	0%	17%	16%	41%	0%	0%	0%	0%	12%	34%

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 ATLANTA MEDICAL CENTER

	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)	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 ATLANTA MEDICAL CENTER

	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)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	Total Cost												

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2018-06/30/2019) WELLSTAR ATLANTA MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line
1	Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 2,295,225	
1a	<i>Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment</i>	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 ----->)	\$ 2,295,225	
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	\$ 2,295,225
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital Charges Sec. G	715,451,919
19	Uninsured Hospital Charges Sec. G	363,067,561
20	Total Hospital Charges Sec. G	1,962,155,355
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	36.46%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	18.50%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 836,898
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 424,697
25	Provider Tax Assessment Adjustment to DSH UCC	\$ 1,261,595

* 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.