State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part I For State DSH Year 2022

A. General DSH Year Information DSH Year: Select Your Facility from the Drop-Down Menu Provided: WEL Identification of cost reports needed to cover the DSH Year: S. Cost Report Year 1 C. Cost Report Year 2 (if applicable) C. Cost Report Year 3 (if applicable)	Begin 07/01/2021	End 06/30/2022] PITAL			
Identification of cost reports needed to cover the DSH Year; 3. Cost Report Year 1 4. Cost Report Year 2 (if applicable)	Cost Report	PITAL			
3. Cost Report Year 1 4. Cost Report Year 2 (if applicable)					
4. Cost Report Year 2 (if applicable)		Cost Report			
4. Cost Report Year 2 (if applicable)	Begin Date(s)	End Date(s)			
	07/01/2021	06/30/2022	Must also complete a separate survey file for	each cost report period list	ed - SEE DSH SURVEY PART II FILES
	Data				
6. Medicaid Provider Number:	0	00000624A			
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0				
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0				
9. Medicare Provider Number:	1	10184			
. DSH Qualifying Information					
Questions 1-3, below, should be answered in the accordance with Se	c. 1923(d) of the Social	Security Act.		102203-000	
			DSH Examina Year (07/01/		
During the DSH Examination Year:			06/30/22		

- 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 set in 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?



	Yes	_
_		_
	8/6/1074	

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	State of Georgia Disproportionate Share Hospital (DSH) Examination Survey Part 1 For State DSH Year 2022
Disclosure of Other Medicaid Payments Received:	
1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022 (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payr	\$ 2,065,395 ments should NOT be included.)
2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/	
(Should include all non-claim specific payments for hospital services such as lump sum payments for 101 Medic 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 sht	
NOTE: Hospital portion of suppremental payments reported on DSH Survey Part II, Section E, Question 14 site	suio de reported here il palo on a SF-Y basis.
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06	\$ 2,065,395
ertification:	
	Answer
 Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments. 	Yes
Explanation for "No" answers:	
The following certification is to be completed by the hospital's CEO or CFO: I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are to records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, has payment on the claim. I understand that this information will be used to determine the Medicaid program's comp provisions. Detailed support exists for all amounts reported in the survey. These reports will be retained for a p available for inspection when requested. Hospital QEO or CFO Signature Anthony J. Budzinski Hospital GEO or CFO Printed Name Contact Information for individuals authorized to respond to indutries related to this survey:	ve been reported on the DSH survey regardless of whether the hospital received plance with federal Disproportionate Share Hospital (DSH) eligibility and payments seriod of not less than 5 years following the due date of the survey, and will be made <u>IO/10/23</u>
A Hospital Contact:	Outside Preparer:
Name Ebenezer Erzuah Title Executive Director - Reimbursement	Name Jennifer Johnson
Telephone Number 470-956-4981	Title Senior Manager Firm Name Southeast Reimbursement Group
E-Mail Address ebenezer.erzuah@wellstar.org Mailing Street Address 1800 Parkway Drive	Telephone Number 770-928-3352 ext 106
Mailing City, State, Zip Marietta, Georgia 30067	E-Mail Address jennifer.johnson@srgllc.org
Jolio IXV E-Mail Address <u>leohezer er una gweilstar og</u> Mailing Streit Address <u>leoho Parkway Drive</u> Mailing City, State, Zip <u>Marietta, Georgia 30067</u>	

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General Instructions and Identification of Cost Reports that Cover the DSH Year:

- 1. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.
- 2. Select the "Survey Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 applicable cost report years, Line 4 Hospital Name, Line 5 in-state Medicaid provider number, Line 6 Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 -Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.
- 3. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

NOTE: For the 2022 DSH Survey, if your hospital completed the DSH survey for 2021, the first cost report year should follow the last cost report year reported on the 2021 DSH survey. The last cost report year on the 2022 survey must end on or after the end of the 2022 DSH year. If your hospital did not complete the 2021 survey, you must report data for each cost report year that covers the 2022 DSH year.

4. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Exhibit A - Support of Uninsured I/P and O/P Hospital Services:

- 1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.
- 2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).
- 3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.
- 4. The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 128 of the DSH survey.

Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:

 See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

- 2. Exhibit B population should include all payments received from patients during the cost report year regardless of dates of service and insurance status.
- Only the payments received from uninsured patients should be included on Section H of the DSH survey, line 143. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 143 should reconcile to Section E, line 9.

Section D - General Cost Report Year Information

- 1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.
- 2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E - Disclosure of Medicaid / Uninsured Payments Received

- 1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.
- 2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.
- 3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.
- 4. Line 13 is a drop-down menu. Please answer 'Yes' or 'No' to the question.
- 5. Lines 14 and 15 should be completed if you answered 'Yes' to line 13. Please provide the amount of lump sum (non-claims-based) payments received from Medicaid Managed Care plans. Please also provide supporting documentation for the amounts reported in the form of cancelled checks, general ledger records, or some other financial records.

Section F - MIUR / LIUR Qualifying Data from the Cost Report

Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

- 2. For Lines 2 through 6 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate cell. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified cell. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.
- 3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

- 4. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.
- 5. For Lines 7 through 10 report the applicable charity care charges. Charity care charges are used in the calculation of the low-income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. Any charity care charges related to non-hospital services should be reported on the non-hospital charity care charges line. Total charity care charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

- 6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.
- 7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

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.

- 1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H In-State", "Sec. I Out-of-State.
- 2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.
- 3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.
- 4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H In-State", and "Sec. I Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

- This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.
- 2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G CR Data" has been completed.
- 3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

In-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state version generated from the MMIS. Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Same requirements as above, except payments received from the Medicaid Managed Care entity should be reported on the line titled "Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)". If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). NOTE: 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.

In-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total crossover days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

<u>N/A</u>

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total crossover days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

In-State Other Medicaid Eligibles (Not Included Elsewhere)

In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number. This would include Medicare Part C crossovers not reported elsewhere on the survey.

<u>N/A</u>		
N/A		
<u>N/A</u>		
N/A		
<u>N/A</u>		
N/A		
<u>N/A</u> N/A		

<u>Uninsured</u>

Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance) or third party liability for the specific service provided. See "Uninsured Definitions" tab for additional details.

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I - Calculation of Out-of-State Medicaid Costs:

 This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

Out-of-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

- 1. This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section H.
- 2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

- 1. This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.
- 2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
- The following columns will <u>NOT</u> need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Section L. Provider Tax Assessment Reconciliation / Adjustment:

1. This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.

The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.

2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.

- 3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.
- 4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).
- 5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.
- 6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.

Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangments outside of the state's assessed tax).

Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.

- 8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.
- 9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report this amount is used to determine the amount that will be added back to your hospital's DSH UCC.
- 10. The amount on Line 25 may NOT be the final amount added into your DSH UCC. The examination will review the various adjustments and reconciliations and make a final determination.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be uploaded to the secure web portal at https://dsh.mslc.com or sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit To:

Myers and Stauffer LC Attention: DSH Examinations 700 W. 47th Street, Suite 1100 Kansas City, Missouri 64112 Web Portal: https://dsh.mslc.com Phone: (800) 374-6858 E-mail: GADSH@mslc.com

Version 8.11

Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who have no source of third party coverage for a specific inpatient hospital or outpatient hospital service (reported based on date of service). (*42 CFR 447.295 (b)*)

Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the

- facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments provided for hospital patients that met the uninsured definition for the specific inpatient or outpatient hospital service provided. The payments must be reported on a cash basis (report in the year provided, regardless of the year of service). (73 FR dated 12/19/08, pages 77913 & 77927)

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))

Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

Do <u>NOT</u> Include In Hospital Uninsured <u>Charges</u>:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage for the specific inpatient or outpatient hospital service provided. Exclude charges for all non-hospital services. (42 CFR 447.295 (b))

Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)

Exclude bad debts and charity care associated with patients that have insurance or other third party coverage for the specific inpatient or outpatient hospital service provided. (42 CFR 447.299 (15) and 42 CFR 447.295 (b))

Exclude claims denied by an active health insurance carrier unless the entire claim was denied due to exhaustion of benefits or due to the benefit package not covering the specific inpatient or

• outpatient hospital service provided. (73 FR dated 12/19/08, pages 77910-77911, 77913 and 42 CFR 447.295 (b))

Exclude uninsured charges for services that are not medically necessary (including elective

- procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)
- Exclude charges for services to prisoners (wards of the state). (73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)

Exclude patient charges covered under an automobile or liability policy that actually covers the

hospital service (insured). (45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)

Exclude contractual adjustments required by law or contract with respect to services provided to

patients covered by Medicare, Medicaid or other government or private third party payers (insured).
 (42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)

Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). *(73 FR dated 12/19/08, page 77916)*

Exclude charges related to accounts with unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). (42 CFR 447.299 (15))

Exclude charges associated with the provision of durable medical equipment (DME) or prescribed

■ drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health

- agencies (HHA). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). (42
 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)
- Exclude non-Title XIX charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

Do <u>NOT</u> Include In Hospital Uninsured <u>Payments</u>:

Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. (42 *CFR* 447.299 (12))

Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). (42 CFR 447.299

Commercial and Medicare accounts (cost not included so neither is payment). (42 CFR 447.299 (15))

Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on

Worksheet "C" Part I) (not hospital services). (42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)

December 3, 2014 Final Rule Highlights:

Medicaid Eligible Individuals:

• If an individual is Medicaid eligible for any day during a single inpatient stay for a particular service, states must classify the individual as Medicaid eligible.

• If an individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, states cannot include any costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

• If an individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, states should classify the individual as uninsured and include all costs and revenues associated with the particular service when calculating the hospital-specific DSH limit.

Uninsured and Underinsured:

• Individuals who have exhausted benefits before obtaining services will be considered uninsured.

• Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for the particular service. If the individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, the costs and revenues of the service cannot be included in the hospital-specific DSH limit.

• Individuals with high deductible or catastrophic plans are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims cannot be included in the hospital-specific DSH limit.

• The costs and revenues, including the payments from private insurance for Medicaid eligible individuals, should be included in the calculation of the hospital-specific DSH limit.

Scope of Inpatient and Outpatient Hospital Services:

• To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, the service must meet the federal and state definitions of inpatient or outpatient hospital services and must be included in the state's definition of an inpatient or outpatient hospital service under the approved state plan.

• FQHC services are not inpatient or outpatient hospital services and cannot be included in the hospital-specific DSH limit.

• Example: If transplant services are not covered under the approved state plan, costs associated with transplants cannot be included in calculating the hospital-specific DSH limit.

• Example: NF, HHA, employed physicians or other licensed practitioners are not recognized as inpatient or outpatient hospital services and are not covered under the inpatient or outpatient hospital Medicaid benefit service categories and cannot be included in the hospital-specific DSH limit.

• Administratively necessary days (days awaiting placement) are recognized as inpatient hospital services and should be included in the hospital-specific DSH limit.

Timing of Service Specific Determination:

• The determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire claim's services.

• When benefits have been exhausted for individuals with a source of third party coverage, only costs associated with separate services provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific limit. These services must be a separate service based on the definition of a service for Medicaid (e.g., separate inpatient stay or separate outpatient billing period).

• Uncompensated care costs incurred by hospitals due to unpaid co-pays, co-insurance, or deductibles associated with a non-Medicaid eligible individual cannot be included in the calculation of the hospital-specific DSH limit.

Physician Services:

• Services that are not inpatient or outpatient hospital services, including physician services, must be excluded when calculating the hospital-specific DSH limit.

• Exception: Costs where insurance pays an all inclusive rate are allowable.

• Physician costs under Section 1115 waivers are still excluded from the DSH limit calculation.

Prisoners:

• Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage.

■ Indian Health Services:

• For Medicaid DSH purposes, American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs (direct health care services) and for services specifically authorized under CHS.

• Determining factor in deciding whether an American Indian or Alaska Native has health insurance for I/P or O/P hospital service is if the providing entity is an IHS facility or tribal health program.

• Contract Services (Non-IHS provider): if the service is specifically authorized via a purchase order or equivalent document, it is considered to be insured. If it does not have an authorization, it is considered an uninsured service.

Example of Exhibit A - Uninsured Charges

								DSH Required	i Fields (A-R)								
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)		Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charge for Services Provided (N)	Routine Days	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Covered Service ***, if
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	\$ 4,000.0) 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	\$ 4,500.0) 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	\$ 5,200.2	i		S -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	\$ 2,700.0)		\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	\$ 15,000.7	5		\$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	\$ 1,000.2	i		S -	
Uninsured Charges	Medicare		12345	444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	\$ 150.0)	\$ 500.00	\$ -	Exhausted
Uninsured Charges	Medicare		12345	444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	\$ 750.0)	\$ 500.00	s -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	\$ 1,100.0)		\$ -	Non-Covered Service

Notes for Completing Exhibit A:

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

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

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

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

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payer Plan (B)	Secondary	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *		s Charges for s Services	When Services Were Provided s (Insured or	Claim Status (Exhausted or Non- Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Khausted" or (U)="Non-Covered Service", (Q)(((Q)+(R)+(S))*(N) , 0) *****
	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 90		 Insured 		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 90	0\$	 Insured 		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 90	0 \$	 Insured 		\$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	\$ 50	No	Inpatient	\$ 10,000	\$ 90	0\$	 Insured 		\$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	\$ 150	No	Outpatient	\$ 2,000	s	- \$ 5	0 Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	\$ 150	No	Outpatient	\$ 2,000	s	- \$ 5	0 Insured	Exhausted	\$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	\$ 150	No	Outpatient	\$ 2,000	s	- \$ 5	0 Insured	Exhausted	\$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,00	0 \$	 Uninsured 		\$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	\$ 90	No	Inpatient	\$ 15,000	\$ 1,00	0 \$	- Uninsured		\$ 84
Self Pay Payments	United Healthcar	е	500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	\$ 130	No	Inpatient	\$ 14,000	\$ 40	0 \$ 5	0 Insured	Non-Covered Service	\$ 126

Notes for Completing Exhibit B: * Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

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

**** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

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

Example of Exhibit C	(Other Medicaid Eligible example)
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Claim Type (A) ** Primary Payer Plan (B) Plan (C) Other Medical Eligibles Blue Cross Medicaid Other Medical Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid	Provider # (D) 12345	r # (D) Number (PCN) (E) 15 888888	Patient's Medicaid Recipient # (F) 123456789 123456789	Patient's Birth Date (G) 1/1/1960 1/1/1960	Patient's Social Security Number (H)	Patient's Gender (I) Male	Name (J) James, Samuel	Admit Date (K) 9/1/2009	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Cod	Provided	s Days of D) Care (P)					Total Private Insurance Payments for Services Provided (U)		Sum of All Payments Received on Claim 2)+(R)+(S)+(T)+(U)+ V)		Comments
Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid		5 888888	123456789		999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Innation	120											
Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid	10015	5 888888	123456789	1/1/1960	000 00 000								.200	s	- 5	\$ 50	s -	\$ 1.500				
Other Medicaid Eligibles Blue Cross Medicaid Other Medicaid Eligibles Blue Cross Medicaid	12345				999-99-999		James, Samuel	9/1/2009	9/4/2009	Inpatient	206	s ·	500	ŝ	- š -	\$ 50	ŝ -		s -	1,550	Ý	
Other Medicaid Eligibles Blue Cross Medicaid	12345	15 888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	s	100 -	Ś	- S	\$ 50	š -	\$ 1,500	s - 1	1,550	Y	
	12345	15 888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	S	375 -	s	- 5	\$ 50	s -	\$ 1,500	s - :	1,550	Y	
	12345	15 888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	S ·	.500 -	s	- 5	\$ 50	s -	\$ 1,500	s - :	1,550	Y	
	12345		978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	S	100 -	s	- 5	s -	s -	\$ 900			Y	
Other Medicaid Eligibles Aetna Medicaid	12345		978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	s	375 -	\$	- \$ -	s -	S -	\$ 900	\$ 75 :		Y	
Other Medicaid Eligibles Aetna Medicaid	12345	15 666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	S ·	.500 -	s	- 5	s -	s -	\$ 900	\$ 75 :	975	Y	
Other Medicaid Eligibles Cigna Medicaid	12345	15 555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	S	375 -	s	- 5	\$ 100	s -	\$ 1,000	s - :	\$ 1,100	Y	
Other Medicaid Eligibles Cigna Medicaid		15 555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	S ·	.500 -	\$	- \$ -	\$ 100	S -	\$ 1,000	s - :	\$ 1,100	Y	

Notes for Completing Exhibit C: • All charges for non-hospital services should be <u>excluded</u>.

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

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

Out-of-State Medicaid Provider Number. List all states where you had	I 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						
13. State Name & Number						
14. State Name & Number						
15. State Name & Number			J			
(List additional states on a separate attachment)						
E. Disclosure of Medicaid / Uninsured Payments Received: (07	/01/2021 - 06/30/2022)					
1. Section 1011 Payment Related to Hospital Services Included in Exhibits B	& B-1 (See Note 1)		2			
 Section 1011 Payment Related to Inospital Services included in Exhibits B Section 1011 Payment Related to Inpatient Hospital Services NOT Include 			<u>с</u>			
 Section 1011 Payment Related to Outpatient Hospital Services NOT Include Section 1011 Payment Related to Outpatient Hospital Services NOT Include 			<u> </u>			
4. Total Section 1011 Payments Related to Hospital Services (See Note			\$-			
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhib			\$ -			
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in			\$ -			
7. Total Section 1011 Payments Related to Non-Hospital Services (See	Note 1)		\$-			
8. Out-of-State DSH Payments (See Note 2)			\$-			
			Ŷ			
			Inpatient	Outpatient	Total	
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)			\$ 158,889 \$	879,876	\$1,038,765	
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)			\$ 990,972 \$	6,917,083	\$7.908.055	
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column	(N) on Exhibit B less physician and non-bospital portion of pay	(ments)	\$1,149,861	\$7,796,959	\$8,946,820	
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Ba		inicita)	13.82%	11.28%	11.61%	
12. Uninsuleu Cash Dasis Fallent Fayments as a Felcentage of Total Cash Da	asis ratient rayments.		13.02 /0	11.2076	11.01%	
13. Did your hospital receive any Medicaid managed care payments not p	and at the claim lovel?		No			
Should include all non-claim-specific payments such as lump sum payments for ful		us pavments, capitation pavme		the MCO), or other incentive	payments.	
	, , , , , , , , , , , , , , , , , , ,					
14. Total Medicaid managed care non-claims payments (see question 13 abov	e) received applicable to hospital services		\$ -			
15. Total Medicaid managed care non-claims payments (see question 13 abov			\$ -			
	,		\$-			
16. Total Medicaid managed care non-claims payments (see question 13 abov	e) received		2-			
Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Presc these funds during any cost report year covered by the survey, they must be repor "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 10	orted here. If you can document that a portion of the	payment received is related				
Printed 6/21/2024		Property of Myers and Stauff	er LC			

			Deri Version
D. General Cost Report Year Information	7/1/2021	- 6/30/2022	
The following information is provided based on the information we received fr of the information. If you disagree with one of these items, please provide the			
1. Select Your Facility from the Drop-Down Menu Provided:	WELLSTAR DOUGLAS H	OSPITAL]
	7/1/2021 through		
	6/30/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	Х]
2. Status of Cost Roport Lload for this Suprov (Should be audited if qualitable	V: C American	1	

3. Status of Cost Report Used for this Survey (Should be audited if available): 5 - Amended

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR DOUGLAS HOSPITAL	Yes	
5. Medicaid Provider Number:	00000624A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110184	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

5/12/2023

Ε.

DSH Version 8.11

2/10/2023

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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 (07/01/2	021 - 06/30/2022)						
F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio	o (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 lin	nes 5 & 6)	32,302	(See Note in Section F-	3, below)	
F-2. Cash Subsidies for Patient Services Received from State or Lo 2. Inpatient Hospital Subsidies	cal Governments and Chari	ty Care Charges (Used in L	ow-Income Utilization Rati	o (LIUR) Calculation): 14,536			
3. Outpatient Hospital Subsidies 4. Unspecified I/P and O/P Hospital Subsidies				7,953			
5. Non-Hospital Subsidies 6. Total Hospital Subsidies				- \$ 22,489			
 7. Inpatient Hospital Charity Care Charges 8. Outpatient Hospital Charity Care Charges 				36,204,964 63,210,629			
 9. Non-Hospital Charity Care Charges 10. Total Charity Care Charges 				- \$ 99,415,593			
F-3. Calculation of Net Hospital Revenue from Patient Services (Us	ed for LIUR) (W/S G-2 and G-3	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				Contractual Adjustme	nts (formulas below can be		
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.	Total	Patient Revenues (Charges	5)		are known)	over writtern in amounts	
Formulas can be overwritten as needed with actual data.							
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	\$153,872,171.00			\$ 126,857,362	\$ -	\$ -	\$ 27,014,809
12. Subprovider I (Psych or Rehab) 13. Subprovider II (Psych or Rehab)	\$0.00 \$0.00			\$- \$-	<u>\$</u> - <u>\$</u> -	\$ - \$ -	\$ - <u>\$ -</u>
14. Swing Bed - SNF 15. Swing Bed - NF			\$0.00 \$0.00			\$- \$-	
16. Skilled Nursing Facility 17. Nursing Facility			\$0.00 \$0.00			<u>\$</u> - \$-	
18. Other Long-Term Care 19. Ancillary Services	\$333,281,736,00	\$439,713,028.00	\$0.00	\$ 274,768,605	\$ 362,514,121	\$- \$-	\$ 135,712,038
20. Outpatient Services 21. Home Health Agency	000012011100100	\$168,889,628.00	\$0.00		\$ 139,238,256	\$ \$	\$ 29,651,372
22. Ambulance			\$-			\$ -	
23. Outpatient Rehab Providers 24. ASC	\$0.00	\$0.00	\$0.00	\$	\$ \$	\$ \$	\$ - <u>\$ -</u>
25. Hospice 26. Other	\$0.00	\$0.00	\$0.00 \$0.00	\$-	\$-	<u>\$</u> - \$-	\$-
27. Total	\$ 487,153,907	\$ 608,602,656	\$-	\$ 401,625,968	\$ 501,752,376	\$-	\$ 192,378,219
28. Total Hospital and Non Hospital		Total from Above	\$ 1,095,756,563		Total from Above	\$ 903,378,344	
29. Total Per Cost Report	Total Patien	t Revenues (G-3 Line 1)	1,095,756,563	Total Cont	ractual Adj. (G-3 Line 2)	902,325,521	
 Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on works revenue) 	sheet G-3, Line 2 (impact is a	decrease in net patient					
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLU	DED 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 Rever	nue INCLUDED on worksheet	G-3 Line 2 (impact is a			+	-	
decrease in net patient revenue)		0 0, 2/10 2 (impaorio a			+	3,382,413	

- Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)
- 34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an
- increase in net patient revenue)
- 35. Adjusted Contractual Adjustments 36. Unreconciled Difference

- Unreconciled Difference (Should be \$0)
- Unreconciled Difference (Should be \$0)

2,329,590

903,378,344

\$

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable			Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
hosp coi hosp data sl	ital. If d npleted ital has nould be	data in this section must be verified by the lata is already present in this section, it was using CMS HCRIS cost report data. If the a more recent version of the cost report, the e updated to the hospital's version of the cost ilas can be overwritten as needed with actual data.	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
		ne Cost Centers (list below):							1			
1		ADULTS & PEDIATRICS	\$ 44,644,992	\$-		\$0.00		44,644,992	30,222	\$105,976,326.00		\$ 1,477.23
2		INTENSIVE CARE UNIT	\$ 11,003,867	\$-	\$ 2,691		\$	11,006,558	2,920	\$33,201,655.00		\$ 3,769.37
3	03200		<u>\$</u> -	\$ -	<u>\$</u> -		\$	-	-	\$0.00		\$ -
4 5	03300	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	<u>\$</u> - \$-	\$ - \$-	<u>\$</u> - \$-		\$ \$	-	-	\$0.00 \$0.00		\$ \$
5 6	03400 03500	OTHER SPECIAL CARE UNIT	<u> </u>	\$- \$-	<u> </u>		\$ \$	-	-	\$0.00		\$- \$-
0 7	03500	SUBPROVIDER I	<u> </u>	Ψ	- \$-		э \$	-	-	\$0.00		\$ -
8		SUBPROVIDER II	ş - \$ -	φ - \$	φ - \$ -		ې \$	-	-	\$0.00		\$ -
9		OTHER SUBPROVIDER	- 	<u> </u>			ې \$	-	-	\$0.00		\$ -
10			\$ 4,736,779	φ - \$ -	<u> </u>		\$	4,736,779	1,549	\$4,593,543.00		\$ 3,057.96
10	04300	-	\$ 4,730,779 \$ -	\$ -	\$ -		\$	4,730,773	1,040	\$0.00		\$ 3,037.50
12			<u> </u>	φ - \$ -	<u> </u>		\$			\$0.00		\$ -
13			<u> </u>	φ - \$ -	<u> </u>		\$			\$0.00		\$ -
14			\$ -	\$-	\$-		\$	-	-	\$0.00		\$-
15			\$-	\$-	\$ -		\$	-	-	\$0.00		\$-
16			\$-	\$-	\$-		\$	-	-	\$0.00		\$ -
17			\$ -	\$ -			\$	-	-	\$0.00		\$ -
18				\$-	\$ 2.691	\$ -	\$	60.388.329	34.691	\$ 143.771.524		
19		Weighted Average	φ 00,000,000	Ψ -	φ 2,001	φ -	Ψ	00,000,020	04,001	φ 140,771,024		\$ 1,740.75
19		weighted Average										ъ 1,740.75
	Obser	vation 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	Ľ	alculated (Per Diems Above Itiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200	Observation (Non-Distinct)		2.657			\$	3.925.000	\$1,127,392.00	\$7.054.190.00	\$ 8.181.582	0.479736
20	00200			2,007			Ψ	0,020,000	ψ1,121,002.00	φ1,00-1,100.00	φ 0,101,002	0.410100
		_										
			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
		ary Cost Centers (from W/S C excluding Obser									h.	
21		OPERATING ROOM	\$14,212,041.00		\$ -		\$	14,212,041	\$18,633,598.00	\$51,880,387.00		
22		DELIVERY ROOM & LABOR ROOM	\$4,947,422.00	\$-	\$ 1,888		\$	4,949,310	\$14,965,597.00	\$797,053.00	\$ 15,762,650	0.313990
23		ANESTHESIOLOGY	\$1,852,983.00	\$ -	<u>\$</u> -		\$	1,852,983	\$7,471,170.00	\$16,755,339.00	\$ 24,226,509	0.076486
24		RADIOLOGY-DIAGNOSTIC	\$8,176,306.00	\$ -	<u>\$</u> -		\$	8,176,306	\$13,956,744.00	\$59,380,735.00	\$ 73,337,479	0.111489
25		RADIOISOTOPE	\$1,498,236.00		\$ -		\$	1,498,236	\$1,766,686.00	\$13,191,893.00	\$ 14,958,579	0.100159
26		CT SCAN	\$5,064,391.00		1		\$	5,064,391	\$34,656,327.00	\$104,141,850.00		0.036487
27		MRI CARDIAC CATHETERIZATION	\$1,615,274.00		\$- \$3.253		\$ \$	1,615,274	\$6,071,507.00	\$17,573,588.00		0.068313
28 29		LABORATORY	\$5,051,873.00 \$11,311,998.00		1		\$	5,055,126 11,319,197	\$24,066,355.00 \$74,989,506.00	\$20,677,618.00 \$54,832,367.00		0.112979 0.087190
29	0000		φτι,στι, σ 90.00	φ -	ψ 7,199		φ	11,319,19/	\$14,509,500.00	φ04,032,307.0U	φ ι∠9,021,073	0.067 190

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022)

WELLSTAR DOUGLAS HOSPITAL

Line		Total Allowable	Intern & Resident Costs Removed	Add-Back (If			I/P Days and I/P	I/P Routine Charges and O/P		Medicaid Per Diem /
#	Cost Center Description	Cost	on Cost Report *	Applicable		Total Cost		Ancillary Charges	Total Charges	Cost or Other Ratios
	RESPIRATORY THERAPY	\$6,838,005.00		\$ 1,298	\$	6,839,303	\$31,788,342.00	\$3,360,580.00		0.194581
	PHYSICAL THERAPY	\$3,752,484.00		\$ -	\$	3,752,484	\$3,258,386.00	\$7,806,481.00		0.339135
	ELECTROCARDIOLOGY	\$111,179.00		\$ -	\$	111,179	\$4,234,954.00	\$7,704,639.00		0.009312
		\$1,056,275.00		\$ -	\$	1,056,275	\$513,274.00	\$4,123,279.00		0.227815
7100	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	\$7,834,492.00 \$4,025,727.00		<u>\$</u> - \$-	\$ \$	7,834,492 4,025,727	\$13,205,499.00 \$2,824,187.00	\$12,000,527.00 \$9,470,301.00		0.310818 0.327442
	DRUGS CHARGED TO PATIENTS	\$20,742,934.00		ъ	\$	20,742,934	\$2,824,187.00	\$56,277,881.00		0.327442
	RENAL DIALYSIS	\$1,110,467.00		- \$-	\$	1,110,467	\$9,019,075.00	\$3,891,413.00		0.086013
	EMERGENCY	\$23,323,292.00		φ - \$ -	\$	23.323.292	\$30,575,595.00	\$134,701,155.00		0.141117
5100	EMERGENOT	\$0.00		φ - \$ -	\$	20,020,202	\$0.00	\$0.00		-
		\$0.00		\$-	\$	-	\$0.00	\$0.00		-
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		\$0.00		\$-	\$	-	\$0.00	\$0.00		-
		\$0.00			\$	-	\$0.00	\$0.00		-
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		\$0.00	\$-	\$ -	\$	-	\$0.00	\$0.00		-
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G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022)

WELLSTAR DOUGLAS HOSPITAL

			Intern & Resident					I/P Routine		
Line #	Cost Center Description	Total Allowable Cost	Costs Removed	Add-Back (If		Total Cost	I/P Days and I/P	Charges and O/P	Total Charges	Medicaid Per Diem
#	Cost Center Description	\$0.00	on Cost Report *	Applicable S -		Total Cost		Ancillary Charges	Total Charges	Cost or Other Ratio
		\$0.00		\$ - \$-	\$ \$	-	\$0.00 \$0.00	\$0.00 \$0.00		-
		\$0.00		Ψ	\$		\$0.00	\$0.00		
		\$0.00		Ŧ	\$	-	\$0.00	\$0.00		-
		\$0.00		\$-	\$	-	\$0.00	\$0.00		-
		\$0.00	\$ -	\$ -	\$	-	\$0.00	\$0.00	\$-	-
		\$0.00	\$ -	\$-	\$	-	\$0.00	\$0.00	\$ -	-
		\$0.00			\$	-	\$0.00		\$-	-
		\$0.00			\$	-	\$0.00	\$0.00		-
		\$0.00			\$	-	\$0.00	\$0.00		-
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		\$0.00			\$	-	\$0.00	\$0.00		-
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		\$0.00			\$	-	\$0.00	\$0.00		-
		\$0.00			\$	-	\$0.00	\$0.00		-
		\$0.00			\$	-	\$0.00	\$0.00		-
	Total Ancillary	\$ 122,525,379	\$ -	\$ 13,638	\$	122,539,017	\$ 365,886,927	\$ 585,621,276	\$ 951,508,203	
	Weighted Average								. , ,	0.13290
										0.10200
	Sub Totals	\$ 182.911.017	\$ -	\$ 16.329	\$	400 007 040	\$ 509.658.451	¢ 505 004 070	\$ 1.095.279.727	
	SNF, and Swing Bed Cost for Medicaid (•			182,927,346 \$0.00	\$ 509,658,451	\$ 585,621,276	\$ 1,095,279,727	
,	rksheet D, Part V, Title 19, Column 5-7, Li		epon worksneer D-3,	The T9, Column 3, L	ine 200 and	\$0.00				
	SNF, and Swing Bed Cost for Medicare (rksheet D, Part V, Title 18, Column 5-7, Li		eport Worksheet D-3	, Title 18, Column 3, L	ine 200 and	\$0.00				
NF,	SNF, and Swing Bed Cost for Other Paye	ers (Hospital must calcula	te. Submit support for	r calculation of cost.)						
	er Cost Adjustments (support must be sub			,						
Juie	Grand Total	onnicou)			\$	182,927,346				
<u> </u>					¢					
Tota	al Intern/Resident Cost as a Percent of Otl	ther 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 (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

Barrow Barrow<	Medicaid Per Medicaid Cost to	Medicaid	Total In-Stat	ured	Unin					anaged Care Primary	In-State Medicaid M	id FFS Primary	In-State Medica	Modicaid Cost to	Modicald Por
	Diem Cost for Charge Ratio for Routine Cost Ancillary Cost Inpatient Outpatient	Outpatient	Inpatient	Outpatient (See Exhibit A)	Inpatient (See Exhibit A)	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Charge Ratio for Ancillary Cost	Diem Cost for Routine Cost
Note Note <th< td=""><td>From Section G From PS&R Summary (Note A) Summary (Note A</td><td></td><td></td><td></td><td>From Hospital's Own Internal Analysis</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>From Section G</td><td>From Section G</td></th<>	From Section G From PS&R Summary (Note A) Summary (Note A				From Hospital's Own Internal Analysis									From Section G	From Section G
No. 1.12 1.20			Dava		Dava		Dava		Dava		Dava		Dava		tion O'
	\$ 1,477.23 1,006 1,456 1,208 2,298 2,213 5,968		5,968		2,213		2,298		1,208		1,456		1,006		\$ 1,477.23
					369		478		318		97		1,450		
					-		-				-				E UNIT \$ -
			-		-		-				-				
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Non- Non- <th< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td><td>***</td><td></td></th<>					-						-			***	
i i					- 87						- 839		190		
Image: Part of the			-												\$ -
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Ball of the Real Ball Date			-												
Durand Dig Guide Name Control Control Control Control Control Control Cont	Total Days 2,646 2,392 1,526 2,661 2,669 9,425		9,425		2,669		2,861		1,526		2,392		2,646	Total Days	
Non-control					2,669		2,861		1,526		2,392		2,646		tail
Rest B	Days (Explain Variance)				<u>.</u>										nreconciled Days (Explain Variance)
Calculate Room 1 3,040 1 3,040 1 <th< th=""><th>Routine Charges Routine Charge</th><th></th><th>Routine Charges</th><th></th><th></th><th></th><th>Routine Charges</th><th></th><th></th><th></th><th>Routine Charges</th><th></th><th></th><th></th><th></th></th<>	Routine Charges Routine Charge		Routine Charges				Routine Charges				Routine Charges				
Distriction															ne Per Diem
D00 Dervales (Non-Dervales (Non-					• • • • • • • • •		•		•						-
SND DELIVERY ROOM & LAGR ROOM 0.333990 477999 9.912 4.138,468 274,799 75,141 73,844 1.215,411 19797 207,28 50,000 10 </td <td>Accuracy Charges Ancuracy Charges Ancura</td> <td>Ancillary Charges \$ 1,863,467</td> <td>\$ 1,144,881</td> <td>Ancillary Charges 669,236</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Ancillary Charges 201,106</td> <td>Ancillary Charges 48,973</td> <td>Ancillary Charges 749,249</td> <td></td> <td>0.479736</td> <td>t)</td>	Accuracy Charges Ancuracy Charges Ancura	Ancillary Charges \$ 1,863,467	\$ 1,144,881	Ancillary Charges 669,236						Ancillary Charges 201,106	Ancillary Charges 48,973	Ancillary Charges 749,249		0.479736	t)
Same Active State Control Contro Control Contro <t< td=""><td></td><td>\$ 8,109,571</td><td></td><td>1 769 202</td><td>0.010.110</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>		\$ 8,109,571		1 769 202	0.010.110										
Soci MacoloscyciadeNostric 6.0111489 6.07239 1.052.07 6.024.07 7.433 2.234.08 1.027.05 6.237.07 6.237.07 6.237.07 6.237.07 6.237.07 6.237.07 7.433 2.236.07 1.231.98 0.237.07 6.237.07 5.324.07 1.117.22 6.337.07 1.117.22 6.337.07 6.327.07 6.337.07 6.327.07 6.337.07<	U.313990 47/1918 9912 47.436,48 274,749 175,141 74,874 1,215,411 167,912 209,726 57,580 5 0,077,19 1 171,68 1 200,719 5 1 172,488 5 1 172,								1,000,243						
9700 7700 7250 x 3377 x 3377 x 3470 x 7200 x		\$ 2,662,565	\$ 6,007,119 \$ 1,974,888	573,880	269,726	187,912	1,215,411	74,874	1,000,243 175,141	274,798	4,138,648	9,912	477,918	0.313990	BOR ROOM
9800 MRI 0.006313 332.021 960.09 113.839 986.829 346.391 44.533 1.122.85 960.700 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 82.001.65 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77.65 72.001.05 2.77		\$ 11,187,827	\$ 1,974,888 \$ 2,979,918	573,880 582,152 6,258,770	269,726 863,258 1,231,958	187,912 846,073 2,794,030	1,215,411 550,500 1,067,344	74,874 319,549 844,434	1,000,243 175,141 223,353 686,164	274,798 1,171,683 6,244,147	4,138,648 729,919 556,181	9,912 325,260 1,305,216	477,918 471,116 670,229	0.313990 0.076486 0.111489	
0000 0.08790 0.08790 0.08790 0.088920 2.219.986 3.488.83 7.490202 4.137.54 1.155.35 5.202.800 1.856.800	0.100159 81,607 273,026 40,065 267,010 78,438 248,568 94,162 725,436 147,783 371,752 \$ 294,271 \$	\$ 11,187,827 \$ 1,514,040	\$ 1,974,888 \$ 2,979,918 \$ 294,271	573,880 582,152 6,258,770 371,752	269,726 863,258 1,231,958 147,783	187,912 846,073 2,794,030 725,436	1,215,411 550,500 1,067,344 94,162	74,874 319,549 844,434 248,568	1,000,243 175,141 223,353 686,164 78,438	274,798 1,171,683 6,244,147 267,010	4,138,648 729,919 556,181 40,065	9,912 325,260 1,305,216 273,026	477,918 471,116 670,229 81,607	0.313990 0.076486 0.111489 0.100159	
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0000 ELECTROCARDIOLOGY 000312 277.78 50.00300 99.37 700.284 200.854 170.052 30.70 134.125 \$ 8 1.686.27 000 ELECTROCARDIPHY 0.278.76 5.526 1/4.58 289.77 40.38 10.465 289.77 40.38 10.465 289.77 1.81.252 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.41.050 \$ 1.43.050 \$ 1.42.04 1.42.04 1.45.20 1.22.57.07 6.07.45.07 0.03.050 \$ 1.43.050 \$ 7.43.050 \$ 7.43.050 \$ 7.43.050 \$ 7.43.050 \$ 7.43.050 \$ 7.43.050	0.100159 0.100159	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501	\$ 1,974,888 \$ 2,979,918 \$ 294,271 \$ 7,323,533 \$ 1,294,838 \$ 3,157,548	573,880 582,152 6,258,770 371,752 15,222,592 760,008 852,164	269,726 863,258 1,231,958 147,783 3,485,057 680,799 2,077,463	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032	1,215,411 550,500 1,067,344 94,162 2,392,001 432,533 1,015,865	74,874 319,549 844,434 248,568 2,363,837 341,650 272,801	1,000,243 175,141 223,353 686,164 78,438 1,713,120 346,391 618,248	274,798 1,171,683 6,244,147 2667,010 7,299,970 865,829 393,269	4,138,648 729,919 556,181 40,065 1,003,380 163,893 554,577	9,912 325,260 1,305,216 273,026 3,317,489 506,990 274,399	477,918 471,116 670,229 81,607 2,215,032 352,021 968,858	0.313990 0.076486 0.111489 0.100159 0.036487 0.068313 0.112979	TIC
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7200 IMPL DEV. CHARGED TO PATIENTS 0.32742 18289 338.05 14.04 40.550 91.180 243.065 647.30 222.35 538.30 513.80 311.18 \$13.80 \$17.30 \$13.80 317.31 \$13.80 \$17.30 \$13.80 317.31 \$13.80 \$17.30 \$13.80 317.31 \$13.80 \$17.30 \$13.80 317.31 \$13.80 \$17.30 \$13.80 \$17.31 \$13.80 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$17.30 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$13.80 \$10.80 \$10.80 \$10.80 \$10.80 \$10.80 \$10.80 <td>0.100159 81:607 273:026 40:065 267:010 78:438 248:568 94:162 725:436 147:783 371:782 \$ 294:271 \$ 0.09847 2.21:632 3.37:490 1003:30 729970 1713:100 2.383:37 2.292:001 5.44:25:436 147:783 371:782 \$ 7.292:431 \$ 0.06813 3.52:021 506:990 163:893 865.829 346:391 341:650 432:533 1,122:385 680:799 760:008 \$ 1.294:888 \$ 0.112979 966:888 274:399 544:57 332:64:61 7.419:002 4.137:464 \$ 3.202:01 1.015:685 1.061:052 2.077:463 852:175:488 \$ 0.087190 66:68:20 2.749:666 3.444:613 7.499:002 4.137:454 1(85:37 6.320:800 3.352:99 7.455:39 9.686:004 \$ 2.022:107 \$ 0.194581 3.025:138 171:048 939:846 71794 2.(65:735 75.073 3.038:355 305:426 1.654:058 \$ 9.214:354</td> <td>\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 948,530</td> <td>\$ 1,974,888 \$ 2,979,918 \$ 294,271 \$ 7,323,533 \$ 1,294,838 \$ 3,157,548 \$ 20,221,087 \$ 9,214,354 \$ 855,509</td> <td>573,880 582,152 6,258,770 371,752 15,222,592 760,008 852,164 9,586,020 773,132 1,096,707</td> <td>269,726 863,258 1,231,958 147,783 3,485,057 680,799 2,077,463 7,465,359 1,654,058 234,413</td> <td>187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 365,680</td> <td>1,215,411 550,500 1,067,344 94,162 2,392,001 432,533 1,015,865 6,320,800 3,083,635 371,151</td> <td>74,874 319,549 844,434 248,568 2,363,837 341,650 272,801 1,185,337 75,073 186,341</td> <td>1,000,243 175,141 223,353 686,164 78,438 1,713,120 346,391 618,248 4,137,454 2,165,735 202,525</td> <td>274,798 1,177,683 6,244,147 267,010 7,299,970 865,829 393,269 7,499,002 7,17,947 325,928</td> <td>4,138,648 729,919 556,181 40,065 1,003,380 163,893 554,577 3,494,613 939,846 116,732</td> <td>9,912 325,260 1,305,216 273,026 3,317,489 506,990 274,399 2,719,986 171,048 70,581</td> <td>477,918 471,116 670,229 81,607 2,215,032 352,021 968,858 6,268,220 3,025,138 165,102</td> <td>0.313990 0.076486 0.111489 0.00159 0.036487 0.068313 0.112979 0.087190 0.194581 0.339135</td> <td></td>	0.100159 81:607 273:026 40:065 267:010 78:438 248:568 94:162 725:436 147:783 371:782 \$ 294:271 \$ 0.09847 2.21:632 3.37:490 1003:30 729970 1713:100 2.383:37 2.292:001 5.44:25:436 147:783 371:782 \$ 7.292:431 \$ 0.06813 3.52:021 506:990 163:893 865.829 346:391 341:650 432:533 1,122:385 680:799 760:008 \$ 1.294:888 \$ 0.112979 966:888 274:399 544:57 332:64:61 7.419:002 4.137:464 \$ 3.202:01 1.015:685 1.061:052 2.077:463 852:175:488 \$ 0.087190 66:68:20 2.749:666 3.444:613 7.499:002 4.137:454 1(85:37 6.320:800 3.352:99 7.455:39 9.686:004 \$ 2.022:107 \$ 0.194581 3.025:138 171:048 939:846 71794 2.(65:735 75.073 3.038:355 305:426 1.654:058 \$ 9.214:354	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 948,530	\$ 1,974,888 \$ 2,979,918 \$ 294,271 \$ 7,323,533 \$ 1,294,838 \$ 3,157,548 \$ 20,221,087 \$ 9,214,354 \$ 855,509	573,880 582,152 6,258,770 371,752 15,222,592 760,008 852,164 9,586,020 773,132 1,096,707	269,726 863,258 1,231,958 147,783 3,485,057 680,799 2,077,463 7,465,359 1,654,058 234,413	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 365,680	1,215,411 550,500 1,067,344 94,162 2,392,001 432,533 1,015,865 6,320,800 3,083,635 371,151	74,874 319,549 844,434 248,568 2,363,837 341,650 272,801 1,185,337 75,073 186,341	1,000,243 175,141 223,353 686,164 78,438 1,713,120 346,391 618,248 4,137,454 2,165,735 202,525	274,798 1,177,683 6,244,147 267,010 7,299,970 865,829 393,269 7,499,002 7,17,947 325,928	4,138,648 729,919 556,181 40,065 1,003,380 163,893 554,577 3,494,613 939,846 116,732	9,912 325,260 1,305,216 273,026 3,317,489 506,990 274,399 2,719,986 171,048 70,581	477,918 471,116 670,229 81,607 2,215,032 352,021 968,858 6,268,220 3,025,138 165,102	0.313990 0.076486 0.111489 0.00159 0.036487 0.068313 0.112979 0.087190 0.194581 0.339135	
7300 DRUGS CHARGED TO PATIENTS 0.1607471 5.503.895 3.010.395 \$ 1.780 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 3.027.97 \$ 5.023.895 \$ 3.010.395 \$ 1.780 \$ 8.027.15 \$ 3.027.97 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 8.027.15 \$ 3.027.97 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 8.027.15 \$ 3.027.97 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.027.915 \$ 5.023.895 \$ 3.010.395 \$ 1.789 \$ 3.010.395 \$ 1.789 \$ 3.010.395 \$ 1.789 \$	0.100159 0.1001595 0.1015855 0.10158	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494	\$ 1.974.888 \$ 2.979.918 \$ 294.271 \$ 7.323.533 \$ 1.294.838 \$ 3.157.548 \$ 20.221.087 \$ 9.214.354 \$ 855.509 \$ 877.758	573,880 582,152 6,258,770 15,222,592 760,008 852,164 9,586,020 773,132 1,096,707 1,341,925	269.726 863,258 1,231,958 3,485,057 680,799 2,077,463 7,465,359 1,654,058 234,413 353,760	187,912 846,073 2,794,030 5,442,542 1,122,385 1,061,032 3,526,939 305,426 365,680 470,298	1,215,411 550,500 1,067,344 94,162 2,392,001 432,533 1,015,865 6,320,800 3,083,635 371,151 300,716	74,874 319,549 844,434 248,568 2,363,837 341,650 272,801 1,185,337 75,073 186,341 1770,052	1,000,243 175,141 223,353 686,154 78,438 1,713,120 346,391 618,248 4,137,454 2,165,735 202,525 209,854	274,798 1,171,1883 6,244,147 267,010 7,299,970 865,829 393,269 7,499,002 717,947 325,028 702,624	4,138,648 729,919 556,181 40,065 1,003,380 163,893 554,577 3,494,613 939,846 116,732 993,812	9.912 325,260 1,305,216 3,317,489 506,990 2,74,399 2,719,986 171,048 70,581 303,300	477,918 477,116 670,229 81,607 2,215,032 352,021 968,858 6,268,220 3,025,138 165,102 267,876	0.313990 0.076486 0.111489 0.0036487 0.068313 0.12979 0.087190 0.194581 0.393155 0.099315	TIC ZATION PY Y
9000 MERGENCY 0.14117 1,817,829 4,604,740 1,217,099 24,444,702 1,900,386 3,279,175 6,815,677 3,387,039 27,754,916 \$ 0,014,015 \$ 0,024,016	0.100159 0.1001599 0.1001598 0.1001598 0.1	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 1,269,494 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,788,945	\$ 1.974.888 \$ 2.979.918 \$ 294.271 \$ 7.323.533 \$ 1.294.838 \$ 3.157.548 \$ 20.221.087 \$ 9.214.354 \$ 855.509 \$ 877.758 \$ 144.059 \$ 2.960.116	573.880 582,152 6,258,770 371,752 760,008 852,164 9,566,020 773,132 1,006,707 1,341,925 546,653	269.726 863.258 1.231.958 147.783 3.485.057 7.463.599 2.077.463 7.465.359 1.054.058 234.413 353.760 3.7.752 1.013.604	187.912 846.073 2,794.030 725.436 5,442.542 1,122,385 1,061.032 3,526.939 305.426 366.680 470.298 322.879 622.289	1,215,411 550,500 1,067,344 94,162 2,392,001 432,833 1,015,865 6,320,800 3,083,635 371,151 300,716 34,089 912,645	74.874 319,549 844,434 246,568 2,368,837 341,650 272,801 1,185,337 75,073 186,341 170,052 104,093 225,596	1,000,243 175,141 223,353 686,164 78,438 1,713,120 346,391 618,248 4,137,454 2,165,735 202,525 200,854 40,038 463,277	274,798 1,171,683 6,244,147 267,010 7,299,970 865,829 393,269 7,499,002 711,947 325,928 702,624 269,767 638,610	4,138,648 729,919 556,181 40,065 1,003,380 163,893 554,577 3,494,613 938,846 116,732 99,312 14,636 784,558	9.912 325,260 1,305,216 273,026 3,317,489 506,990 2,719,986 171,048 70,581 303,300 142,005 2996,451	477,918 670,229 81,607 2,215,032 352,021 968,858 6,268,220 3,025,138 166,102 267,876 55,296 799,635	0.313990 0.076486 0.111489 0.0036487 0.036487 0.036487 0.036487 0.04581 0.339135 0.009312 0.227815 0.310818	TIC ZATION PY Y GRAPHY URGED TO PATIENT
Image: state stat	0.100:59 81:607 273:026 40:065 287:010 78:438 244:568 94:162 725:436 147.783 377.782 \$ 294.271	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 948,530 \$ 1,646,274 \$ 864,744	\$ 1.974.888 \$ 2.979.918 \$ 294.271 \$ 7.323.533 \$ 1.294.838 \$ 3.157.548 \$ 0.221.087 \$ 9.214.354 \$ 855.509 \$ 877.758 \$ 144.059 \$ 2.960.116 \$ 513.693	573.880 582.152 6.258.770 371.752 15.222.582 760.008 852.164 9.586.020 773.132 1.096.707 1.341.925 54.665 536.933 117,511	269.726 863.258 1,231.958 3,447.783 3,445.057 680.799 2,077.463 7,465.359 1,654.058 2,244.413 3,53.760 3,7.752 1,013.604 158.304	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,3526,939 306,426 346,826 346,826 346,827 365,839 470,286 347,852	1.215,411 550,500 1,067,342 94,162 2,392,001 432,533 1,015,865 6,320,800 3,083,835 3,71,151 300,716 34,089 912,645 245,239	74.874 319.540 844,434 245,685 2,365,837 341,650 272,801 1,185,337 75,073 108,6341 170,052 104,093 225,596 249,965	1,000,243 175,141 223,353 686,164 78,438 1,713,120 346,391 613,248 4,137,454 2,165,735 2008,854 40,038 463,277 91,136	274,798 1,171,683 6,244,147 267,010 7,299,970 865,829 7499,002 711,947 3325,928 702,624 280,767 638,610 40,550	4.138.648 729.919 556.181 40.065 1.003.880 163.893 554.577 3.444.613 939.846 116.732 99.312 14.638 784.588 14.934	9.912 325,260 1,305,216 2,73,026 3,317,489 506,990 2,719,986 171,048 70,581 303,300 142,005 296,451 35,625	477.918 471.116 670.229 81.607 2.215.032 352.021 966.858 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395	0.313990 0.076486 0.111489 0.0059 0.036487 0.068313 0.112879 0.087190 0.194581 0.339135 0.009312 0.227815 0.310818 0.337442	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
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Image: state stat	0.100159 81:607 273:026 40:065 267:010 77.493 244:568 94:162 725:363 147:783 371.782 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 2.94:271 \$ 5.94:271	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 948,533 \$ 1,646,274 \$ 864,744 \$ 1,788,945 \$ 6,937 \$ 8,937,150	\$ 1.974.888 \$ 2.979.918 \$ 294.271 \$ 7.323.533 \$ 1.294.438 \$ 3.157.548 \$ 20.221.087 \$ 9.214.354 \$ 855.509 \$ 144.059 \$ 2.960.116 \$ 513.693 \$ 17.682.247	573.880 582.152 6.258.770 371,752 15.222.562 760.008 852.164 9.586.020 773.132 1.096.707 1.341.925 54.655 536.933 117.511 3.010.395 627.368	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.42,539 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,798 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 717,947 325,928 702,824 702,824 269,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.100159 0.036487 0.038487 0.088313 0.112879 0.087190 0.194581 0.0387190 0.098712 0.028715 0.330818 0.330818 0.327442 0.100747 0.08613 0.341117	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
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Image: state of the state	0.100159 0.100159	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247	\$ 1.974.888 \$ 2.979.918 \$ 7.942.513 \$ 7.325.425.53 \$ 1.294.538 \$ 3.157.548 \$ 2.92.21.087 \$ 2.92.41.354 \$ 855.509 \$ 877.758 \$ 8.2.960.116 \$ 513.693 \$ 17.682.247 \$ 9.42.065 \$ 8.014.449 \$ 8.014.449\$\$ 8	573.880 582.152 6.258.770 3711.752 760.008 852.164 9.586.020 773.132 1.006.707 1.341.925 5.64.855 5.36.933 1.177.511 3.010.385 627.784.916	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.425,239 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,798 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 717,947 325,928 702,824 702,824 269,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.100159 0.036487 0.036487 0.036487 0.047190 0.142879 0.0497190 0.146841 0.329135 0.329135 0.327442 0.327442 0.166747 0.086013 0.1461117 0.046113 0.14611417 0.046113 0.14611417	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
Image: Second	0.100159 0.100159 0.100159 0.100159 0.10057 2273.026 140.005 2270.10 7.29.07 7.173.120 2.393.17.480 1.47.385 1.22.485.83 1.22.485.83 1.22.485.83 1.22.485.84 1.47.385 7.29.097 7.173.120 2.393.17.52 5.20.277.485 5.20.277.485 2.390.10 5.44.576 3.445.583 1.12.385 0.445.533 1.12.385 0.600.99 700.008 \$.1294.838 5.20.277.485 5.20.277.477 5.20.477	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247	\$ 1.974.688 \$ 2.979.918 \$ 2.94.271 \$ 7.325.273 \$ 7.325.475.48 \$ 3.157.548 \$ 2.921.087 \$ 9.214.57.48 \$ 9.214.57.48 \$ 9.214.564 \$ 9.214.564 \$ 9.214.564 \$ 9.214.564 \$ 9.200.116 \$ 1.51.802.247 \$ 9.42.065 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$	573.880 582.152 6.258,770 371,752 760.008 852,164 9.566.020 7773,132 1.006,707 1.341,925 54.655 536.933 117,511 3.010.395 627,388 227,794,916	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.425,239 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,788 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 7,17,947 325,928 702,824 702,824 289,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.100159 0.036487 0.036487 0.036487 0.047190 0.194581 0.399135 0.2097190 0.098312 0.272452 0.272815 0.310816 0.327442 0.160747 0.066013 0.141117 0.066013 0.141117	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
Image: state stat	1010150 11007 273.020 100.066 2270.00 78.438 248.668 94.162 775.436 147.738 371.720 \$7.292.578 0.008613 352.021 506.900 163.838 865.529 346.391 341.650 432.533 11.122.86 660.7078 780.008 \$1.294.838 \$3.167.468 \$3.167.4	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247	\$ 1.974.688 \$ 2.979.918 \$ 2.94.271 \$ 7.325.273 \$ 7.325.475.48 \$ 3.157.548 \$ 2.921.087 \$ 9.214.57.48 \$ 9.214.57.48 \$ 9.214.564 \$ 9.214.564 \$ 9.214.564 \$ 9.214.564 \$ 9.200.116 \$ 1.51.802.247 \$ 9.42.065 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$	573.880 582.152 6.258,770 371,752 760.008 852,164 9.566.020 7773,132 1.006,707 1.341,925 54.655 536.933 117,511 3.010.395 627,388 227,794,916	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.42,539 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,788 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 7,17,947 325,928 702,824 702,824 289,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.000159 0.036487 0.036487 0.036487 0.047190 0.194581 0.339135 0.209312 0.227815 0.310818 0.339135 0.310818 0.327442 0.160747 0.066013 0.141117 0.14117 0	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
	0.1000159 016077 273.020 40.08 267.010 78.88 246.588 94.102 772.880 147.783 577.782 § 294.271 § 0.006813 352.021 656.950 163.830 7259.970 1713.102 239.837 422.820.01 54.42.94 3.45.505 15.22.783 § 723.020 8 54.571 3.45.551 15.22.783 § 723.020 15.42.94 725.80 11.15.865 11.15.865 11.15.865 11.15.865 11.15.865 11.15.865 11.15.865 10.015.032 2.074.80 855.577 33.020 13.744 17.18.307 65.20.80 3.35.20 17.85.30 72.011.833 10.15.865 10.015.032 2.074.85.30 77.85.80 85.20.20 17.85.80 85.20.20 17.85.80 14.20.83 17.85.80 3.35.20 17.85.80 18.20.2011 3.35.60 1.85.81.85 85.20.71 18.83.77 6.20.200 3.35.60 17.85.80 17.85.80 3.35.60 1.85.81 18.20.27.16 85.77 8.02.27.16 8.77.85 8.77.78 8.77.78 8.77.78 8.77.78 8.77.78 8.77.78 8.77.78 <td< td=""><td>\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247</td><td>\$ 1.974.688 \$ 2.979.918 \$ 2.94.271 \$ 7.325.273 \$ 1.244.838 \$ 3.157.548 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.2960.116 \$ 153.802 \$ 9.402.685 \$ 9.402.685 \$ 9.42.682 \$ 9.42.682 \$ 9.42.682 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -</td><td>573.880 582.152 6.258,770 371,752 760.008 852,164 9.566.020 7773,132 1.006,707 1.341,925 54.655 536.933 117,511 3.010.395 627,388 227,794,916</td><td>269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716</td><td>187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559</td><td>1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.42,539 6.074,470 557,984</td><td>74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013</td><td>1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082</td><td>274,788 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 7,17,947 325,928 702,824 702,824 289,767 633,610 40,550 2,254,442 56,666</td><td>4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670</td><td>9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109</td><td>477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351</td><td>0.313990 0.076486 0.111489 0.000159 0.036487 0.036487 0.037190 0.194581 0.39135 0.2097190 0.39135 0.30918 0.30918 0.30918 0.300813 0.441117 0.060747 0.06073 0.141117 0.14117 0.1417</td><td>TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS</td></td<>	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247	\$ 1.974.688 \$ 2.979.918 \$ 2.94.271 \$ 7.325.273 \$ 1.244.838 \$ 3.157.548 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.2960.116 \$ 153.802 \$ 9.402.685 \$ 9.402.685 \$ 9.42.682 \$ 9.42.682 \$ 9.42.682 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	573.880 582.152 6.258,770 371,752 760.008 852,164 9.566.020 7773,132 1.006,707 1.341,925 54.655 536.933 117,511 3.010.395 627,388 227,794,916	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.42,539 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341.650 272.801 1,185,337 75.073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,788 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 7,17,947 325,928 702,824 702,824 289,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,559 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.000159 0.036487 0.036487 0.037190 0.194581 0.39135 0.2097190 0.39135 0.30918 0.30918 0.30918 0.300813 0.441117 0.060747 0.06073 0.141117 0.14117 0.1417	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
	0.100169 81.607 273.020 40.065 287100 784.80 246.568 94.12 722.481 147.783 737.722 § 294.271 § 0.036813 332.021 565.990 1163.890 365.290 346.691 432.533 1.122.385 680.799 750.208 § 1.223.481 § 1.223.481 552.990 7.322.833.85 § 0.01707 968.868 274.390 554.577 7305.280 661.246 272.001 10.1656 1061.032 2.077.453 852.090 7.322.838 § 2.227.878 § 2.207.878 § 2.207.878 § 2.207.878 § 2.207.878 § 2.207.878 § 2.207.878 § 2.227.877 § 2.227.877 § 2.227.877 § 2.227.877 § 2.207.878 § 2.207.878 § 2.207.878 § 2.227.877 § 2.227.877 § 2.227.878 § 2.227.878 § 2.227.878 § 2.277.878 § 2.277.878 §	\$ 11,187,827 \$ 1,514,040 \$ 18,423,838 \$ 2,836,854 \$ 2,001,501 \$ 14,931,264 \$ 1,269,494 \$ 14,931,264 \$ 14,931,264 \$ 948,530 \$ 1,646,274 \$ 864,744 \$ 1,768,945 \$ 763,993 \$ 8,937,150 \$ 334,247	\$ 1.974.688 \$ 2.979.918 \$ 2.94.271 \$ 7.325.273 \$ 1.244.838 \$ 3.157.548 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.214.554 \$ 9.2960.116 \$ 153.802 \$ 9.402.685 \$ 9.402.685 \$ 9.42.682 \$ 9.42.682 \$ 9.42.682 \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ - \$ -	573.880 582.152 6.258,770 371,752 760.008 852,164 9.566.020 7773,132 1.006,707 1.341,925 54.655 536.933 117,511 3.010.395 627,388 227,794,916	269.726 863.258 1,231.956 3,485.057 680.799 2,077.463 7,465.359 1,054.058 234.413 353.760 37.752 1,013.604 158.304 158.304 5,203.665 105.716	187,912 846,073 2,794,030 725,436 5,442,542 1,122,385 1,061,032 3,526,939 305,426 470,289 326,879 622,289 437,852 2,292,375 182,559	1.215,411 550,500 1.067,344 94,162 2.392,001 4.32,533 1.015,865 6.320,800 3.083,635 3.71,151 300,716 3.4,089 9.12,645 2.42,539 6.074,470 557,984	74.874 319.549 844.334 246,568 2,363,837 341,650 272,801 1,185,337 75,073 168,341 170,052 104,093 225,599 249,965 1,282,547 8,3013	1,000,243 175,141 223,353 606,164 7,8,338 1,713,120 3,46,391 6,13,246 4,137,454 2,165,735 2008,854 4,0,038 4,63,277 9,1,136 3,362,097 2,71,082	274,788 1,171,683 6,244,147 267,010 7,299,970 865,829 7,499,002 7,17,947 325,928 702,824 702,824 289,767 633,610 40,550 2,254,442 56,666	4,138,648 729,919 556,181 40,065 1,003,880 163,893 554,577 3,494,613 939,846 116,732 99,312 14,636 784,558 14,624 2,737,412 60,670	9.912 325,260 1,305,215 273,025 3,317,489 506,990 274,399 2,719,986 177,1048 70,581 300,300 142,005 296,451 35,625 3,107,786 11,109	477.918 471.116 670.229 81.607 2.215.032 352.021 968.559 6.268.220 3.025.138 165.102 267.876 55.296 799.635 162.395 5.508.267 5.2.351	0.313990 0.076486 0.111489 0.100159 0.036487 0.036487 0.036487 0.047190 0.142679 0.049313 0.142679 0.049312 0.227815 0.310818 0.310819 0.327442 0.160747 0.068013 0.160747 0.046013 0.160747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.161747 0.046013 0.046117 0.046013 0.046117 0.046013 0.0461170000000000000000000000000000000000	TIC FATION PY GRAPHY GRAPHY ARGED TO PATIENT TO PATIENTS
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

I I <th>~</th> <th></th> <th>In-State Medicaid FFS Primary</th> <th>In-State Medicaid Managed Care Primary</th> <th>In-State Medicare FFS Cross-Overs (with Medicaid Secondary)</th> <th>In-State Other Medicaid Eligibles (Not Included Elsewhere)</th> <th>Uninsured</th> <th>Total In-State Medicaid %</th>	~		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 %
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Property of Myers and Stauffer LC

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

Cost Report Year (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicald Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere)	Uninsured	Total In-State Medicaid
128	Total Charges (includes organ acquisition from Section J)	\$ 33,858,038 \$ 19,091,866	\$ 25,602,159 \$ 57,177,517	\$ 24,462,458 \$ 11,763,818	\$ 42,127,013 \$ 30,895,560	\$ 41,587,104 \$ 71,998,419 (Agrees to Exhibit A) (Agrees to Exhibit A)	\$ 126,049,667 \$ 118,928,762 33.50%
129 130	Total Charges per PS&R or Exhibit Detail Unreconciled Charges (Explain Variance)	\$ 33,858,038 \$ 19,091,866	\$ 25,602,159 \$ 57,177,517	\$ 24,462,458 \$ 11,763,818	\$ 42,127,013 \$ 30,895,560	\$ 41,587,104 \$ 71,998,419	
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 11,415,698 \$ 2,505,546	\$ 8,528,606 \$ 7,073,735	\$ 5,392,816 \$ 1,543,491	\$ 9,943,641 \$ 4,031,159	\$ 9,002,253 \$ 8,389,512	\$ 35,280,761 \$ 15,153,931 37.96%
132 133 134 135 136 137 138 139 140 141 142 143 144	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down) Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E) Private Insurance (including primary and third party liability) Self-Pay (including Co-Pay and Spend-Down) Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments) Medicaid Cost Settlement Payments (See Note B) Other Medicaid Payments Reported on Cost Report Year (See Note C) Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductbles) Medicare Total Allowed Apyments Medicare Cross-Over Bad Debt Payments Other Medicare Cross-Over Payments (See Note D) Payment from Hospital Uninsured During Cost Report Year (Cash Basis) Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Se	\$ 4,521,140 \$ 61,733 \$ 14,669 \$ 2,122,560 \$ 14,669 \$ 2,132,659 \$ 2,132,659 \$ 49,426 \$ 49,426 \$ defined by the second se	\$ 4,042,807 \$ 6,144,972 \$ 75 \$ 1,151 \$ 4,042,882 \$ 6,146,123 	\$ 3,854,005 \$ 1,044,349 \$ 199,449 \$ 153,094 \$ 79,091	\$ 7,338,506 \$ 4,308,203 \$ (1,200) \$ 2,406	(Agrees to E-thibit B and B-1) B-1) B-1) 5 158,880 5 079,876 5 - 5 -	\$ 4.521,140 \$ 2.122,590 \$ 4.042,807 \$ 6.144,972 \$ 7.400,239 \$ 4.322,672 \$ 2.703 \$ 3.889 \$ - \$ 49,426 \$ - \$ - \$ 3.854.005 \$ 1.044,349 \$ - \$ - \$ 9.854.005 \$ 1.044,349 \$ - \$ - \$ 1.99.449 \$ 79,001 \$ 153.094 \$ -
145 146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH) Calculated Payments as a Percentage of Cost	\$ 6,832,825 40% \$ 319,061 87%	\$ 4,485,724 47% \$ 927,612 87%	\$ 1,182,440 78% 73%	\$ 2,606,335 74% \$ (279,450) 107%	\$ 8,843,364 2% 7,509,636	\$ 15,107,324 57% \$ 1,386,942 91%
147 148	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, C Percent of cross-over days to total Medicare days from the cost report	Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less line	s 5 & 6)	<u>17,037</u> 9%			

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 A - Insee amounts must agree to your inputent and outpatient webcala paid claims summary. For waraged or claims, use the rospital soigs in Foor's 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 (RAS summary or PSAR). Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should Not Payments made on a state fiscal year basis should Not eroported 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 Graduab Medicare Juncare Labor D). Note E - Medicaid Managed Care 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 (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

				Out-of-State Med	licaid FFS Primary		caid Managed Care mary	Out-of-State Medica (with Medical	are FFS Cross-Overs d Secondary)		Medicaid Eligibles (Not Elsewhere)	Total Out-Of-S	State Medicaid
		Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost										
.ine #	Cost Center Description	Centers	Centers	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)		
	ost Centers (list below):			Days		Days		Days		Days		Days	
	ULTS & PEDIATRICS TENSIVE CARE UNIT	\$ 1,477.23 \$ 3,769.37		133				18		106 94		257 103	
	RONARY CARE UNIT	\$ 3,709.37		0				3		94		-	
	RN INTENSIVE CARE UNIT	\$ -										-	
	RGICAL INTENSIVE CARE UNIT HER SPECIAL CARE UNIT	\$ - \$ -										-	
	BPROVIDER I	\$ -											
	BPROVIDER II	\$ -										-	
	HER SUBPROVIDER	\$ - \$ 3,057.96											
		\$ 3,037.90										-	
		\$ -										-	
		\$ - \$ -											
		\$ -										-	
		\$ -										-	
		\$-	Total Days	139				21		200		- 360	
			Total Days	139		-		21		200		300	
otal Days p	per PS&R or Exhibit Detail			139		-		21		200			
	Unreconciled Days (Explain Variance)				<u> </u>		<u> </u>		·	I Contraction of the second		
				Routine Charges		Deutine Obernee							
	utine Charges					Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	culated Routine Charge Per Diem			\$ 582,923		s -		\$ 94,758		\$ 1,144,168		\$ 1,821,849	
	lculated Routine Charge Per Diem			\$ 582,923 \$ 4,193.69		\$-		\$ 94,758 \$ 4,512.29		\$ 1,144,168 \$ 5,720.84		\$ 1,821,849 \$ 5,060.69	
	Cost Centers (from W/S C) (list below):		0.479736	\$ 582,923 \$ 4,193.69 Ancillary Charges	Ancillary Charges		Ancillary Charges	\$ 94,758	Ancillary Charges	\$ 1,144,168 \$ 5,720.84 Ancillary Charges	Ancillary Charges	\$ 1,821,849 \$ 5,060.69 Ancillary Charges	
200 Obs 000 OPE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM		0.479736 0.201549	\$ 582,923 \$ 4,193.69 Ancillary Charges 1,615 148,052	Ancillary Charges 39,538 12,677	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges		\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924	2,207	\$ 1,821,849 \$ 5,060.69	\$ 41,74 \$ 12,6
200 Obs 000 OPE 200 DEL	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM		0.201549 0.313990	\$ 582,923 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317	39,538 12,677 6,392	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges - 6,098 663		\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924 7,020	2,207 - 1,263	\$ 1,821,849 \$ 5,060.69 Ancillary Charges \$ 6,284 \$ 211,074 \$ 23,001	\$ 41,74 \$ 12,6 \$ 11,5
200 Obs 000 OPE 200 DEL 300 ANE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY		0.201549 0.313990 0.076486	\$ 582,923 \$ 4,193.69 Ancillary Charges 1.615 148,052 15,317 44,851	39,538 12,677 6,392 6,524	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges - - 6,098 663 3,128	- - 3,880 -	\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924 7,020 12,512	2,207 - 1,263 -	\$ 1,821,849 \$ 5,060.69 Ancillary Charges \$ 6,284 \$ 211,074 \$ 23,001 \$ 60,491	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5
200 Obs 000 OPE 200 DEL 300 ANE 400 RAD	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM		0.201549 0.313990	\$ 582,923 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317	39,538 12,677 6,392	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges 6,08 663 3,128 10,506		\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924 7,020	2,207 - 1,263 - 26,800 -	\$ 1,821,849 \$ 5,060.69 Ancillary Charges \$ 6,284 \$ 211,074 \$ 23,001	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 326,5
200 Obs 000 OPE 200 DEL 300 ANE 400 RAE 600 RAE 700 CT \$	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN		0.201549 0.313990 0.076486 0.111489 0.100159 0.036487	\$ 582,923 \$ 4,193,69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462	39,538 12,677 6,392 6,524 283,227 18,155 452,250	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges - 6,098 - 663 - 3,128 - 10,506 - 25,455		\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996	2,207 - - - - - - - - - - - - - - - - - - -	\$ 1,821,849 \$ 5,060.69 Ancillary Charges \$ 6,284 \$ 211,074 \$ 23,001 \$ 60,491 \$ 151,337 \$ 17,702 \$ 286,913	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 326,5 \$ 326,5 \$ 18,1 \$ 595,2
200 Obs 000 OPE 200 DEL 300 ANE 400 RAE 600 RAE 500 CT \$ 800 MRI	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN II		0.201549 0.313990 0.076486 0.111489 0.100159 0.036487 0.068313	\$ 582,923 \$ 4,193,69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566	39,538 12,677 6,392 6,524 283,227 18,155 452,250 13,249	\$-	Ancillary Charges	\$ 94,758 \$ 4,512.29 Ancillary Charges 		\$ 1,144,168 \$ 5,720.84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221	2,207 - - - 26,800 - - - - - - - - - - - - - - - - - -	\$ 1,821,849 \$ 5,060,69 \$ 6,284 \$ 211,074 \$ 23,001 \$ 60,491 \$ 151,337 \$ 17,702 \$ 286,913 \$ 45,211	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 326,5 \$ 326,5 \$ 18,1 \$ 595,2 \$ 17,7
200 Obs 5000 OPE 5200 DEL 5300 ANE 5400 RAE 5600 RAE 5700 CT \$ 5800 MRI 5900 CAE 5000 LAB	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLSOTOPE SCAN RUAC CATHETERIZATION BORATORY		0.201549 0.313990 0.076446 0.111489 0.100159 0.036487 0.068313 0.112979 0.087190	\$ 582,923 \$ 4,193,69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 138,326 343,776	39,538 12,677 6,392 6,524 283,227 18,155 452,260 13,249 39,525 443,181	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges - 6,098 6633 3,128 10,506 - 25,455 19,424 7,898 61,598	3,880 16,511 74,794 23,904	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,802	2,207 1,263 26,800 68,222 4,458 3,711 45,591	\$ 1,821,849 \$ 5,060,69 Anclilary Charges 6 6,284 \$ 211,074 \$ 23,001 \$ 151,337 \$ 17,702 \$ 286,913 \$ 45,211 \$ 166,207 \$ 666,176 \$	\$ 41,74 \$ 12,66 \$ 11,55 \$ 326,55 \$ 326,55 \$ 18,11 \$ 595,22 \$ 17,77 \$ 43,22 \$ 512,66
200 Obs 5000 OPE 5200 DEL 5300 ANE 5400 RAE 5600 RAE 5700 CT \$ 5800 MRI 5900 CAF 5000 LAB 5500 RES	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN 81 RDIAC CATHETERIZATION BORATORY SPIRATORY THERAPY		0.201549 0.313990 0.076485 0.111489 0.100159 0.036487 0.068313 0.112979 0.087190 0.194581	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 12,794 163,462 5,566 138,326 343,776 64,353	39,538 12,677 6,392 6,524 283,227 18,155 452,260 13,249 39,525 443,181 21,273	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges 6,098 663 3,120 10,500 	3,880 	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 225,020 579,206	2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061	\$ 1.821 849 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 17.702 \$ 286.913 \$ 462.211 \$ 166.207 \$ 656.176 \$ 62.52.153	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 326,5 \$ 326,5 \$ 18,11 \$ 595,21 \$ 17,77 \$ 43,22 \$ 512,6 \$ 24,1
200 Obs 5000 OPE 5200 DEL 5300 ANE 5400 RAE 5400 RAE 5700 CT \$ 5800 MRI 5900 CAF 5000 LAB 5500 RES 5600 PHY	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LUVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN IN RDIAC CATHETERIZATION BORATORY SPIRATORY THERAPY		0 201549 0.313990 0.076486 0.111489 0.036487 0.036487 0.068313 0.112979 0.087190 0.087190 0.339135	\$ 582,923 \$ 4,193,69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 138,326 343,776 64,353 2,106	39,538 12,677 6,592 6,524 283,227 18,155 452,250 13,249 39,525 443,181 21,273 33,723	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges - 6,098 663 3,128 10,506 - 25,455 19,424 7,898 61,594 8,694 3,292	3,880 16,511 74,794 23,904 780 725	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 2250,802 579,206 33,308	2,207 - 1,263 - - - - - - - - - - - - - - - - - - -	\$ 1.821.840 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 45.211 \$ 45.211 \$ 45.211 \$ 666.173 \$ 656.176 \$ 656.176 \$ 652.153 \$ 38.707	\$ 41,74 \$ 12,66 \$ 11,53 \$ 326,53 \$ 326,55 \$ 326,55
200 Obs 5000 OPE 5200 DEL 5300 ANE 5400 RAE 5600 RAE 5700 CT S 5800 MRI 5800 CAE 5900 CAE 5900 CAE 5600 PHY 5900 ELE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN 81 RDIAC CATHETERIZATION BORATORY SPIRATORY THERAPY		0.201549 0.313990 0.076485 0.111489 0.100159 0.036487 0.068313 0.112979 0.087190 0.194581	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 12,794 163,462 5,566 138,326 343,776 64,353	39,538 12,677 6,392 6,524 283,227 18,155 452,260 13,249 39,525 443,181 21,273	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges 6,098 663 3,120 10,500 	3,880 	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 225,020 579,206	2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061	\$ 1.821 849 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 17.702 \$ 286.913 \$ 462.211 \$ 166.207 \$ 656.176 \$ 62.52.153	\$ 41,77 (\$ 12,67) (\$ 11,52) (\$ 6,52) (\$ 326,55) (\$ 326,55) (\$ 326,55) (\$ 595,26) (\$ 595,
200 Obs 200 Obs 200 DEL 200 DEL 200 ANE 400 RAC 6600 RAC 6600 RAC 6600 ALS 600 LAB 500 RES 6600 PHY 900 ELE 100 MEL	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC SCAN SPIRATORY THERAPY SOFTACATHERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCENCEPHALOGRAPHY DICAL SUPPLIES CHARGED TO PATIEN		0 201549 0.313990 0.076486 0.111489 0.036487 0.0868313 0.112979 0.087190 0.194581 0.339135 0.039135 0.0227815 0.310818	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 138,326 343,776 64,353 2,1816 - - - 42,544 -	39,538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 443,181 24,273 33,723 52,722	\$-	Ancillary Charges	\$ 94758 \$ 4,512.29 Ancillary Charges 6,098 663 3,128 10,506 25,455 19,424 7,898 61,598 6,598 6,598 8,594 3,292 1,818	3.880 3.880 	\$ 1,144,168 \$ 1,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912	2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061 2,266 8,484	\$ 1.821.849 \$ 5,060.69 Ancillary Charges 6,284 \$ 211.074 \$ 260.491 \$ 211.074 \$ 20.491 \$ 211.074 \$ 20.491 \$ 161.337 \$ 17.702 \$ 286.913 \$ 166.207 \$ 665.176 \$ 656.176 \$ 656.176 \$ 42.348 \$ 1.707 \$ 8.847 \$ 8.847	\$ 41,7 \$ 12,67 \$ 12
200 Obs 5000 OPE 5000 DEL 5000 ANE 5400 RAD 5400 RAD 5600 RAD 5700 CT 5 5800 MRI 5900 CAR 5000 LAB 5500 RES 5600 PHY 5900 ELE 7000 ELE 7000 ELE 7000 ELE 7000 ELE	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN N RDIAC CATHETERIZATION BORATORY SPIRATORY THERAPY SPIRATORY THERAPY YSICAL THERAPY SPIRATORY THERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDIOLOGY DICAL SUPPLIES CHARGED TO PATIENTS		0 201549 0.313990 0.076486 0.111489 0.036487 0.068313 0.112979 0.087190 0.194581 0.399135 0.0227815 0.327442	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 138,326 343,776 64,353 2,106 21,816 - - 42,544 15,454 -	39 538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 443,181 21,273 33,723 52,722 7,777 9,200	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges 6,098 663 3,128 10,506 - 28,455 19,424 7,888 6,1,598 8,594 1,818 - 1,818 -	3.880 	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,602 579,206 33,308 18,714 1,707 27,912 10,382	2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061 236 8,484 	\$ 1.821 849 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 17.702 \$ 286.913 \$ 462.211 \$ 166.207 \$ 656.176 \$ 38.707 \$ 38.707 \$ 42.348 \$ 1707 \$ 45.847 \$ 25.836	\$ 41,77 \$ 12,67 \$ 11,55 \$ 65,55 \$ 326,55 \$ 18,15 \$ 595,26 \$ 77,75 \$ 43,22 \$ 512,67 \$ 24,11 \$ 34,66 \$ 64,84 \$ 7,77 \$ 10,46 \$ 10,46
200 Obs 5000 OPE 5200 DEL 5300 ANE 5400 RAL 5600 RAL 5700 CT \$ 5800 MRI 5900 CAR 5000 LAB 5500 RES 5600 PHY 9900 ELE 100 MEC 100 MEC 100 MEC	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC DIOLOGY-DUAGNOSTIC SCAN SPIRATORY THERAPY SOFTACARDIOLOGY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCENCEPHALOGRAPHY DICAL SUPPLIES CHARGED TO PATIEN		0 201549 0.313990 0.076486 0.111489 0.036487 0.0868313 0.112979 0.087190 0.194581 0.339135 0.039135 0.0227815 0.310818	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 138,326 343,776 64,353 2,1816 - - - 42,544 -	39539 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 443,181 21,273 33,723 52,727 7,777	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges - - - - - - - - - - - - - - - - - - -		\$ 1,144,168 \$ 1,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912	2,207 1,263 26,800 	\$ 1.821.849 \$ 5,060.69 Ancillary Charges 6,284 \$ 211.074 \$ 260.491 \$ 211.074 \$ 20.491 \$ 211.074 \$ 20.491 \$ 161.337 \$ 17.702 \$ 286.913 \$ 166.207 \$ 665.176 \$ 656.176 \$ 656.176 \$ 42.348 \$ 1.707 \$ 8.847 \$ 8.847	\$ 41,74 \$ 12,66 \$ 11,63 \$ 6,52 \$ 326,53 \$ 18,15 \$ 595,22 \$ 17,27 \$ 512,67 \$ 43,23 \$ 512,67 \$ 64,84 \$ 7,77 \$ 10,46 \$ 93,46
200 Obs 200 Obs 200 DEL 300 ANE 4400 RAL 6000 RAL 700 CT 800 MRI 900 CAB 500 RES 6000 LAB 7000 LB 7000 RE 7000 ME 7000 <td>Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LUVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN ROIAC CATHETERIZATION BORATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY YSICAL THERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCOCEPHALOGGRAPHY DICAL SUPPLIES CHARGED TO PATIENTS UGS CHARGED TO PATIENTS</td> <td></td> <td>0 201549 0.313990 0.076436 0.111489 0.00159 0.08313 0.068313 0.08313 0.087190 0.112979 0.087190 0.194581 0.330135 0.009312 0.227815 0.310818 0.327442 0.300818 0.327442 0.160747 0.086013 0.141117</td> <td>\$ 582,923 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 343,776 64,353 2,106 21,816 - 42,544 15,545 15,545 15,545 15,545 15,254</td> <td>39,538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 442,181 21,273 33,723 52,722 7,777 9,200 - 81,275</td> <td>\$-</td> <td>Ancillary Charges</td> <td>\$ 94,758 \$ 4,512,29 Ancillary Charges </td> <td>3,880 </td> <td>\$ 1,144,168 \$ 5,720,84 Ancillary Charges 56,924 7,020 12,612 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912 10,382 240,029</td> <td>2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061 2,266 8,484 45,91 2,266 4,591 2,266 4,591 2,266 4,595</td> <td>\$ 1.821 840 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 166.207 \$ 666.176 \$ 665.176 \$ 656.176 \$ 38.707 \$ 365.847 \$ 1.707 \$ 35.2433 \$ 1.707 \$ 38.707 \$ 35.847 \$ 1.707 \$ 25.836 \$ 1.707</td> <td>\$ 41,7 \$ 12,67 \$ 11,55 \$ 6,52 \$ 326,55 \$ 18,11 \$ 595,225 \$ 17,77 \$ 12,67 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 93,46 \$ 93,45 \$ 93,45 \$ 8,00</td>	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LUVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOISOTOPE SCAN ROIAC CATHETERIZATION BORATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY YSICAL THERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCOCEPHALOGGRAPHY DICAL SUPPLIES CHARGED TO PATIENTS UGS CHARGED TO PATIENTS		0 201549 0.313990 0.076436 0.111489 0.00159 0.08313 0.068313 0.08313 0.087190 0.112979 0.087190 0.194581 0.330135 0.009312 0.227815 0.310818 0.327442 0.300818 0.327442 0.160747 0.086013 0.141117	\$ 582,923 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 343,776 64,353 2,106 21,816 - 42,544 15,545 15,545 15,545 15,545 15,254	39,538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 442,181 21,273 33,723 52,722 7,777 9,200 - 81,275	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges 	3,880 	\$ 1,144,168 \$ 5,720,84 Ancillary Charges 56,924 7,020 12,612 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912 10,382 240,029	2,207 1,263 26,800 68,222 4,458 3,711 45,591 2,061 2,266 8,484 45,91 2,266 4,591 2,266 4,591 2,266 4,595	\$ 1.821 840 \$ 5.060.69 Ancillary Charges 6.284 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 166.207 \$ 666.176 \$ 665.176 \$ 656.176 \$ 38.707 \$ 365.847 \$ 1.707 \$ 35.2433 \$ 1.707 \$ 38.707 \$ 35.847 \$ 1.707 \$ 25.836 \$ 1.707	\$ 41,7 \$ 12,67 \$ 11,55 \$ 6,52 \$ 326,55 \$ 18,11 \$ 595,225 \$ 17,77 \$ 12,67 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 24,11 \$ 93,46 \$ 93,45 \$ 93,45 \$ 8,00
200 Obs 200 Obs 200 DEL 300 ANE 4400 RAL 6000 RAL 700 CT 800 MRI 900 CAB 500 RES 6000 LAB 7000 LB 7000 RE 7000 ME 7000 <td>Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC SPIRATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDEDIOLOGY ECTROCARDED TO PATIENTS VAL DIALYSIS</td> <td></td> <td>0 201549 0.313990 0.076486 0.111489 0.100159 0.036487 0.068313 0.112979 0.087190 0.194581 0.339135 0.027815 0.339135 0.327442 0.310818 0.327442 0.160747 0.086013 0.141117</td> <td>\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 343,276 64,353 2,106 218,106 - - 42,544 15,454 15,454 12,794 1,700</td> <td>39 538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 442,131 21,273 3,723 52,722 7,777 9,200 81,275 2,320</td> <td>\$-</td> <td>Ancillary Charges</td> <td>\$ 94,758 \$ 4,512,29 Ancillary Charges </td> <td>3.880 3.880 - - - - - - - - - - - - - - - - - -</td> <td>\$ 1,144,168 \$ 1,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912 10,382 240,029 915</td> <td>2,207 1,263 26,600 26,600 26,600 26,600 4,458 3,711 45,591 2,061 2,061 2,061 6,8484 493 - 6,645 1,416</td> <td>\$ 1.821 849 \$ 5,060.69 Ancillary Charges 6.284 \$ 211.074 \$ 260.49 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 17.702 \$ 266.913 \$ 452.211 \$ 166.207 \$ 656.176 \$ 652.153 \$ 38.707 \$ 25.836 \$ 471.124 \$ 25.836 \$ 27.26</td> <td>\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 16,5 \$ 6,5 \$ 18,11 \$ 595,21 \$ 17,71 \$ 43,22 \$ 12,61 \$ 24,11 \$ 24,11 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,13 \$ 24,13 \$ 24,13 \$ 34,64 \$ 34,64 \$ 39,44 \$ 8,00</td>	Cost Centers (from W/S C) (list below): servation (Non-Distinct) ERATING ROOM LIVERY ROOM & LABOR ROOM ESTHESIOLOGY DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC DIOLOGY-DIAGNOSTIC SPIRATORY SPIRATORY THERAPY YSICAL THERAPY YSICAL THERAPY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDIOLOGY ECTROCARDEDIOLOGY ECTROCARDED TO PATIENTS VAL DIALYSIS		0 201549 0.313990 0.076486 0.111489 0.100159 0.036487 0.068313 0.112979 0.087190 0.194581 0.339135 0.027815 0.339135 0.327442 0.310818 0.327442 0.160747 0.086013 0.141117	\$ 582,023 \$ 4,193.69 Ancillary Charges 1,615 148,052 15,317 44,851 89,592 12,794 163,462 5,566 343,276 64,353 2,106 218,106 - - 42,544 15,454 15,454 12,794 1,700	39 538 12,677 6,392 6,524 283,227 18,155 452,250 13,249 39,525 442,131 21,273 3,723 52,722 7,777 9,200 81,275 2,320	\$-	Ancillary Charges	\$ 94,758 \$ 4,512,29 Ancillary Charges 	3.880 3.880 - - - - - - - - - - - - - - - - - -	\$ 1,144,168 \$ 1,720,84 Ancillary Charges 4,669 56,924 7,020 12,512 51,239 4,907 97,996 20,221 19,983 250,802 579,206 33,308 18,714 1,707 27,912 10,382 240,029 915	2,207 1,263 26,600 26,600 26,600 26,600 4,458 3,711 45,591 2,061 2,061 2,061 6,8484 493 - 6,645 1,416	\$ 1.821 849 \$ 5,060.69 Ancillary Charges 6.284 \$ 211.074 \$ 260.49 \$ 211.074 \$ 23.001 \$ 60.491 \$ 151.337 \$ 17.702 \$ 266.913 \$ 452.211 \$ 166.207 \$ 656.176 \$ 652.153 \$ 38.707 \$ 25.836 \$ 471.124 \$ 25.836 \$ 27.26	\$ 41,7 \$ 12,6 \$ 11,5 \$ 6,5 \$ 16,5 \$ 6,5 \$ 18,11 \$ 595,21 \$ 17,71 \$ 43,22 \$ 12,61 \$ 24,11 \$ 24,11 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,12 \$ 24,13 \$ 24,13 \$ 24,13 \$ 34,64 \$ 34,64 \$ 39,44 \$ 8,00
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I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

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I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

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	Totals / Payments															
	Totais / Fayments															
128	Total Charges (includes organ acquisition from Section K)	\$ 2,054,203	\$	2,859,055	\$	-	\$-	\$	326,372	\$ 229,734	\$	2,629,098	\$ 297,431	\$	5,009,673 \$	3,386,219
129	Total Charges per PS&R or Exhibit Detail	\$ 2,054,203	\$	2,859,055	\$	-	\$-	\$	326,372	\$ 229,734	\$	2,629,098	\$ 297,431			
130	Unreconciled Charges (Explain Variance)			-		-	-		-	-		-	-			
404	Total Calculated Cost (includes organ acquisition from Section K)	\$ 407.39	ŝ	340.438	\$		s -	¢	67,371	\$ 23,198	¢	744,926	\$ 31,291	¢	1.219.694 \$	394,927
131	Total Calculated Cost (includes organ acquisition from Section K)	۵ 407,391	2	340,438	۵ ۵	-	ۍ د ۱	\$	67,371	\$ 23,198	\$	744,920	\$ 31,291	Э	1,219,094 \$	394,927
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 88.63	s	131.347										\$	88,631 \$	131,347
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	¢ 00,00	- I	101,011										\$	- \$	-
134	Private Insurance (including primary and third party liability)										\$	568,989	\$ 36,073	\$	568,989 \$	36,073
135	Self-Pay (including Co-Pay and Spend-Down)		s	67							Ť	,	• • • • • •	\$	- \$	67
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 88,63	s	131,414	s	-	\$ -							Ť	÷	
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)				B			\$	50,567	\$ 16,983				\$	50,567 \$	16,983
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)	\$ 318,766		209,024	\$	-	\$-	\$	16,804	\$ 6,215	\$	175,937	\$ (4,782)	\$	511,507 \$	210,457
144	Calculated Payments as a Percentage of Cost	220	6	39%		0%	0%		75%	73%		76%	115%		58%	47%

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 (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

		Total			Revenue for	Total	In-State Medic	aid FFS Primary	In-State Medicaid N	fanaged Care Primary		FS Cross-Overs (with Secondary)		d Eligibles (Not Included where)	Unir	nsured
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)						
		Cost Report Worksheet D-4, PL III, Col. 1, Ln 61	Add-On Cost Facto on Section G, Line 133 x Total Cost Report Organ Acquisition Cost		Similar to Instructions from Cost Report W/S D-4 Pt: III, Col. 1, Ln 66 (substitute 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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis							
(Organ Acquisition Cost Centers (list below):			1	, <u> </u>			-		·	·					
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				-						
	Islet Acquisition	\$0.00 \$0.00		\$ -		U										
8		\$0.00	\$ ·	\$ -		U		L		l L					LI	
9	Totals	\$-	\$.	\$ -	\$-	-	\$-	-	\$-	-	\$ -	-	\$-	-	\$-	-
10	Total Cost	<i></i> .						-		-]	-		-		-

10 Total Cost
Note 8: 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 8: These amounts must agree to your inpatient and outpatient Medicaid total payments.
Note 8: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into on-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accruation 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 (07/01/2021-06/30/2022) WELLSTAR DOUGLAS HOSPITAL

		Total			Revenue for	Total	Out-of-State Med	icaid FFS Primary	Out-of-State Medicaid	Managed Care Primary		FFS Cross-Overs (with Secondary)		fedicaid Eligibles (Not Elsewhere)
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Medicaid/ Cross- Over / Uninsured Organs Sold	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)							
Org	an Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	s -	\$-	\$ -	0								
12	Kidney Acquisition	\$-	s -	\$-	\$-	0								
13	Liver Acquisition	\$-	s -	\$-	\$-	0								
14	Heart Acquisition	\$ -	s -	s -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	s -	\$ -	0								
16	Intestinal Acquisition	\$-	\$-	\$ -	\$ -	0								
17	Islet Acquisition	\$-	\$-	\$ -	\$-	0								
18	1	\$ -	\$ -	\$-	\$-	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 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 SDSH examination surveys.

Cost Report Year (07/01/2021-06/30/2022)

WELLSTAR DOUGLAS HOSPITAL

ksheet A P	rovider Tax Assessment Reconci	liation:			
				W/S A Cost Center	
			Dollar Amount	Line	
	ital Gross Provider Tax Assessment (fi		\$ 2,329,590		
		ccount # that includes Gross Provider Tax Assessment	Contractual Adjustment	44100-4012 (WTB Account #)	
2 Hosp	ital Gross Provider Tax Assessment In	cluded in Expense on the Cost Report (W/S A, Col. 2)	\$ -	(Where is the cost included on w	₪/s A?)
3 Differ	ence (Explain Here>)		\$ 2,329,590		
Prov	ider Tax Assessment Reclassificatio	ons (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))	
пен	LICC ALLOWARIE - Provider Tay A	ssessment Adjustments (from w/s A-8 of the Medicare cost report)			
8	Reason for adjustment	ssessment Aujustments (nom w/s A-o of the medicate cost report)		(Adjusted to / (from))	
9	Reason for adjustment			(Adjusted to / (from))	
-					
10 11	Reason for adjustment			(Adjusted to / (from))	
11	Reason for adjustment			(Adjusted to / (from))	
		x Assessment Adjustments (from w/s A-8 of the Medicare cost repo	ort)		
12	Reason for adjustment				
13	Reason for adjustment				
14	Reason for adjustment				
15	Reason for adjustment				
16 Total	Net Provider Tax Assessment Expens	e Included in the Cost Report	\$ -		
UCC Prov	ider Tax Assessment Adjustment				
17 Gross	s Allowable Assessment Not Included i	n the Cost Report	\$ 2,329,590		
Appo	rtionment of Provider Tax Assessm	ent Adjustment to Medicaid & Uninsured:			
18		ges Sec. G	253,374,322		
19		ges Sec. G	113,585,523		
20		ges Sec. G	1,095,279,727		
20	·	essment Adjustment to include in DSH Medicaid UCC	23.13%		
21		essment Adjustment to include in DSH Uninsured UCC	10.37%		
23	Medicaid Provider Tax Assessn		\$ 538,911		
24	Uninsured Provider Tax Assess der Tax Assessment Adjustment to DS		\$ 241,589 \$ 780,500		
05 D -					

* 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.