

SFY 2026 Medicaid ICTF Survey

Wellstar Douglas Hospital

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2025	06/30/2026

2. Select Your Facility from the Drop-Down Menu Provided:

Identification of cost reports needed to cover the DSH Year:

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

Cost Report Begin Date(s)	Cost Report End Date(s)
07/01/2023	06/30/2024

Must also complete a separate survey file for each cost report period listed - SFE DSH SURVEY PART II FILES

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

Data
000000624A
0
0
110184

B. DSH Qualifying Information

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

During the DSH Examination Year:

DSH Examination
 Year (07/01/25 -
 06/30/26)

1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)

2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3a Was the hospital open as of December 22, 1987?

3b What date did the hospital open?

C. Disclosure of Other Medicaid Payments Received:

For State DSH Year 2026

- 1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** \$ -
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
- 2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2025 - 06/30/2026** \$ 3,925,510
(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis
- 3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2025 - 06/30/2026** \$ 3,925,510

Certification:

Answer
Yes

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

Explanation for "No" answers:

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

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

 _____ Hospital CEO or CFO Signature	 _____ Title	 _____ Date
_____ Hospital CEO or CFO Printed Name	_____ Hospital CEO or CFO Telephone Number	_____ Hospital CEO or CFO E-Mail

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

Hospital Contact:

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

Outside Preparer:

Name	Jennifer A. Johnson
Title	Associate Director
Firm Name	Southeast Reimbursement Group
Telephone Number	770-928-3352 ext. 106
E-Mail Address	jennifer.johnson@srqlic.org

*9/8
11/11/25
Call
11/11/25*

D. General Cost Report Year Information 7/1/2023 - 6/30/2024

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:

WELLSTAR DOUGLAS HOSPITAL

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

7/1/2023 through 6/30/2024		
X		

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

1 - As Submitted

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

12/3/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR DOUGLAS HOSPITAL	Yes	
5. Medicaid Provider Number:	000000624A	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	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2		
11. Rural Referral Center (Yes or No)	No		

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

	State Name	Provider No.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2023 - 06/30/2024)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-			
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-			
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-			
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)		\$-			
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-			
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-			
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)		\$-			
8. Out-of-State DSH Payments (See Note 2)	\$	-			
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$	109,943	\$	864,122	\$974,065
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$	1,054,415	\$	7,347,253	\$8,401,668
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)		\$1,164,358		\$8,211,375	\$9,375,733
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:		9.44%		10.52%	10.39%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? <i>Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.</i>		No			
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	\$	-			
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$	-			
16. Total Medicaid managed care non-claims payments (see question 13 above) received		\$-			

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2023 - 06/30/2024)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 32,978 (See Note in Section F-3, below)

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2. Inpatient Hospital Subsidies	1,800
3. Outpatient Hospital Subsidies	70
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 1,870
7. Inpatient Hospital Charity Care Charges	39,997,440
8. Outpatient Hospital Charity Care Charges	73,074,508
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 113,071,948

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$208,216,103.00			\$ 175,808,008	-	-	\$ 32,408,095
12. Subprovider I (Psych or Rehab)	\$0.00			-	-	-	-
13. Subprovider II (Psych or Rehab)	\$0.00			-	-	-	-
14. Swing Bed - SNF			\$0.00			-	
15. Swing Bed - NF			\$0.00			-	
16. Skilled Nursing Facility			\$0.00			-	
17. Nursing Facility			\$0.00			-	
18. Other Long-Term Care			\$0.00			-	
19. Ancillary Services	\$441,498,541.00	\$544,314,441.00		\$ 372,780,865	\$ 459,593,836	-	\$ 153,438,281
20. Outpatient Services		\$209,840,655.00			\$ 177,179,704	-	\$ 32,660,951
21. Home Health Agency			\$0.00			-	
22. Ambulance			-			-	
23. Outpatient Rehab Providers			\$0.00			-	
24. ASC	\$0.00	\$0.00				-	
25. Hospice			\$0.00			-	
26. Other	\$0.00	\$0.00	\$0.00			-	
27. Total	\$ 649,714,644	\$ 754,155,096	\$ -	\$ 548,588,873	\$ 636,773,540	\$ -	\$ 218,507,327
28. Total Hospital and Non Hospital		Total from Above	\$ 1,403,869,740		Total from Above	\$ 1,185,362,413	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,403,869,740	Total Contractual Adj. (G-3 Line 2)	1,177,235,856
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	10,935,654
33. 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)			-	2,809,097
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36. Adjusted Contractual Adjustments			-	1,185,362,413
37. Unreconciled Difference	Unreconciled Difference (Should be \$0)	\$ -	Unreconciled Difference (Should be \$0)	\$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
		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

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

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 46,359,320	\$ 3,982,597	\$ -	\$ 0.00	\$ 50,341,917	30,690	\$ 133,600,325.00	\$ 1,640.34
2	03100	INTENSIVE CARE UNIT	\$ 12,085,290	\$ 439,629	\$ 5,940		\$ 12,530,859	4,518	\$ 54,495,765.00	\$ 2,773.54
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ 2,375,232	\$ -	\$ -		\$ 2,375,232	382	\$ 1,624,417.00	\$ 6,217.88
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
10	04300	NURSERY	\$ 3,257,953	\$ -	\$ -		\$ 3,257,953	1,177	\$ 6,073,387.00	\$ 2,768.01
11			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$ 0.00	\$ -
18		Total Routine	\$ 64,077,795	\$ 4,422,226	\$ 5,940	\$ -	\$ 68,505,961	36,767	\$ 195,793,894	
19		Weighted Average								\$ 1,863.25

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	4,019	-	-	\$ 6,592,526	\$ 1,777,166.00	\$ 12,268,319.00	\$ 14,045,485	0.469370

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	Total Cost	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
			Calculated				

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

5000	OPERATING ROOM	\$ 19,274,735.00	\$ 442,181	\$ -	\$ 19,716,916	\$ 22,730,965.00	\$ 98,460,698.00	\$ 121,191,663	0.162692
5200	DELIVERY ROOM & LABOR ROOM	\$ 5,608,246.00	\$ -	\$ -	\$ 5,608,246	\$ 27,121,908.00	\$ 1,969,376.00	\$ 29,091,284	0.192781
5300	ANESTHESIOLOGY	\$ 279,516.00	\$ -	\$ -	\$ 279,516	\$ 14,853,206.00	\$ 31,952,504.00	\$ 46,805,710	0.005972
5400	RADIOLOGY-DIAGNOSTIC	\$ 11,106,722.00	\$ -	\$ -	\$ 11,106,722	\$ 33,747,169.00	\$ 71,924,923.00	\$ 105,672,092	0.105106
5600	RADIOISOTOPE	\$ 1,933,215.00	\$ -	\$ -	\$ 1,933,215	\$ 2,518,985.00	\$ 13,007,418.00	\$ 15,526,403	0.124511
5700	CT SCAN	\$ 5,322,913.00	\$ -	\$ -	\$ 5,322,913	\$ 28,485,175.00	\$ 120,948,778.00	\$ 149,433,953	0.035621
5800	MRI	\$ 1,905,572.00	\$ -	\$ -	\$ 1,905,572	\$ 6,657,595.00	\$ 21,372,777.00	\$ 28,030,372	0.067982
5900	CARDIAC CATHETERIZATION	\$ 6,129,076.00	\$ -	\$ 3,739	\$ 6,132,815	\$ 20,835,408.00	\$ 21,468,018.00	\$ 42,303,426	0.144972
6000	LABORATORY	\$ 13,290,149.00	\$ -	\$ 10,862	\$ 13,301,011	\$ 100,084,230.00	\$ 70,718,712.00	\$ 170,802,942	0.077873

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
30	6500 RESPIRATORY THERAPY	\$7,012,824.00	\$ -	\$ 2,050	\$ 7,014,874	\$59,301,138.00	\$5,909,853.00	\$ 65,210,991	0.107572
31	6600 PHYSICAL THERAPY	\$5,393,900.00	\$ -	\$ -	\$ 5,393,900	\$9,960,966.00	\$10,698,554.00	\$ 20,659,520	0.261085
32	6900 ELECTROCARDIOLOGY	\$87,786.00	\$ -	\$ -	\$ 87,786	\$5,766,056.00	\$10,766,672.00	\$ 16,532,728	0.005310
33	7000 ELECTROENCEPHALOGRAPHY	\$1,540,457.00	\$ -	\$ -	\$ 1,540,457	\$538,258.00	\$7,462,856.00	\$ 8,001,114	0.192530
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$12,188,561.00	\$ -	\$ -	\$ 12,188,561	\$20,363,669.00	\$14,195,362.00	\$ 34,559,031	0.352688
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$4,578,327.00	\$ -	\$ -	\$ 4,578,327	\$3,650,662.00	\$14,085,969.00	\$ 17,736,631	0.258128
36	7300 DRUGS CHARGED TO PATIENTS	\$15,777,064.00	\$ -	\$ -	\$ 15,777,064	\$66,277,246.00	\$26,642,717.00	\$ 92,919,963	0.169792
37	7400 RENAL DIALYSIS	\$1,709,739.00	\$ -	\$ -	\$ 1,709,739	\$9,319,353.00	\$5,748,153.00	\$ 15,067,506	0.113472
38	9100 EMERGENCY	\$32,457,185.00	\$ 889,463	\$ -	\$ 33,346,648	\$32,113,704.00	\$168,439,452.00	\$ 200,553,156	0.166273
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 145,595,987	\$ 1,331,644	\$ 16,651	\$ 146,944,282	\$ 466,102,859	\$ 728,041,111	\$ 1,194,143,970	
127	Weighted Average								0.128575
128	Sub Totals	\$ 209,673,782	\$ 5,753,870	\$ 22,591	\$ 215,450,243	\$ 661,896,753	\$ 728,041,111	\$ 1,389,937,864	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 215,450,243				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					2.74%			

* 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 (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report (Includes all payers)		
				Inpatient		Outpatient		Inpatient		Outpatient		Inpatient		Outpatient		Inpatient			Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal	From Hospital's Own Internal		Inpatient	Outpatient
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days				
1	03000 ADULTS & PEDIATRICS	\$ 1,640.34		2,335	1,144	828	2,901	72	2,160	7,280	36.28%									
2	03100 INTENSIVE CARE UNIT	\$ 2,773.54		564	29	380	547	21	190	1,541	39.02%									
3	03200 CORONARY CARE UNIT	\$ -		-	-	-	-	-	-	-										
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-										
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-										
6	03500 OTHER SPECIAL CARE UNIT	\$ 6,217.88		67	246	10	10	13	10	338	90.84%									
7	04000 SUBPROVIDER I	\$ -		-	-	-	-	-	-	-										
8	04100 SUBPROVIDER II	\$ -		-	-	-	-	-	-	-										
9	04200 OTHER SUBPROVIDER	\$ -		-	-	-	-	-	-	-										
10	04300 NURSERY	\$ 2,768.01		126	644	73	4	60	847	77.66%										
11		\$ -		-	-	-	-	-	-	-										
12		\$ -		-	-	-	-	-	-	-										
13		\$ -		-	-	-	-	-	-	-										
14		\$ -		-	-	-	-	-	-	-										
15		\$ -		-	-	-	-	-	-	-										
16		\$ -		-	-	-	-	-	-	-										
17		\$ -		-	-	-	-	-	-	-										
18		\$ -		-	-	-	-	-	-	-										
19	Total Days per PS&R or Exhibit Detail			3,092	2,063	1,208	3,531	110	2,420	10,004	34.54%									
20	Unrecorded Days (Explain Variance)			-	-	-	-	-	-	-										
21	Routine Charges	\$ 16,971,381	\$ 12,982,131	\$ 7,485,561	\$ 20,014,552	\$ 701,841	\$ 12,170,095	\$ 5,743,905	\$ 5,743,905	36.29%										
21.01	Calculated Routine Charge Per Diem	\$ 5,488.80	\$ 6,292.84	\$ 6,196.66	\$ 5,668.32	\$ 6,380.37	\$ 5,028.96	\$ 5,743.90												
Ancillary Cost Centers (from WIS C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges				
22	09200 Observation (Non-Distinct)	0.469370	1,461,863	684,352	206,018	296,583	31,543	71,489	946,324	757,679	4,253	10,643	134,212	321,586	\$ 2,645,748	\$ 1,810,102	35.55%			
23	5000 OPERATING ROOM	0.162692	3,138,599	1,761,030	2,081,081	4,214,376	1,037,469	692,049	2,954,004	3,939,308	118,902	-	2,221,849	1,075,168	\$ 9,211,153	\$ 10,606,762	20.23%			
24	5200 DELIVERY ROOM & LABOR ROOM	0.192781	511,957	1,580	5,431,113	3,277,284	355,385	185,412	2,405,910	1,719,720	218,034	14,158	1,119,090	1,229,265	\$ 8,704,265	\$ 5,183,977	57.47%			
25	5300 ANESTHESIOLOGY	0.005912	659,432	575,517	908,794	2,417,085	300,897	253,665	1,041,293	1,792,075	36,654	-	1,011,544	987,228	\$ 2,910,416	\$ 5,035,342	21.58%			
26	5400 RADIOLOGY-DIAGNOSTIC	0.105106	968,824	1,304,599	397,177	5,792,886	557,289	685,283	1,444,144	3,869,816	50,017	92,664	1,134,088	7,168,520	\$ 3,387,434	\$ 11,652,584	22.60%			
27	5600 RADIOISOTOPE	0.124511	168,095	165,942	68,171	171,265	73,897	185,197	238,866	888,625	3,161	158	286,359	235,832	\$ 547,029	\$ 1,411,028	16.47%			
28	5700 CT SCAN	0.035621	2,610,534	3,140,724	1,019,820	6,843,796	1,807,577	1,807,270	4,101,029	6,985,519	121,460	145,020	3,720,621	16,333,565	\$ 9,405,060	\$ 18,577,308	32.96%			
29	5800 MRI	0.087982	459,834	177,271	911,107	244,279	223,547	737,376	1,247,140	48,091	868,616	-	781,301	888,616	\$ 1,770,454	\$ 2,841,628	21.19%			
30	5900 CARDIAC CATHETERIZATION	0.144972	1,410,092	268,385	495,851	327,660	520,500	231,925	2,138,189	1,436,664	78,567	4,092	2,355,979	5,18,892	\$ 4,564,633	\$ 2,264,034	23.95%			
31	6000 LABORATORY	0.077873	9,485,239	3,306,799	3,627,935	9,867,585	3,917,138	1,057,409	10,796,334	4,827,478	301,941	124,525	8,445,430	12,603,581	\$ 27,826,646	\$ 19,059,271	40.83%			
32	6500 RESPIRATORY THERAPY	0.107572	6,196,826	249,483	1,005,894	929,490	3,237,467	252,714	7,297,986	598,113	213,892	7,794	1,934,931	856,718	\$ 17,738,174	\$ 2,029,801	30.70%			
33	6600 PHYSICAL THERAPY	0.281085	281,818	52,251	149,668	53,294	153,091	230,804	566,471	760,945	11,502	25,437	291,167	1,220,743	\$ 1,159,846	\$ 1,676,294	21.40%			
34	6900 ELECTROCARDIOLOGY	0.005310	506,592	372,461	124,684	751,708	203,056	150,970	630,464	725,477	14,112	-	1,464,796	1,707,213	\$ 1,464,796	\$ 2,000,616	36.34%			
35	7000 ELECTROENCEPHALOGRAPHY	0.192530	101,303	287,586	8,832	555,700	50,784	39,294	65,203	521,511	3,280	1,105	60,461	77,522	\$ 226,122	\$ 1,404,091	22.31%			
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.352688	1,153,378	266,732	784,649	924,713	496,892	1,462,562	781,227	51,243	4,705	882,487	775,593	\$ 3,897,518	\$ 2,115,235	22.56%				
37	7200 IMPL. DEV. CHARGED TO PATIENTS	0.258128	241,348	147,373	6,887	229,944	183,324	56,387	345,854	560,654	-	-	224,551	125,905	\$ 771,413	\$ 994,359	21.07%			
38	7300 DRUGS CHARGED TO PATIENTS	0.169792	6,712,520	1,637,262	2,033,676	1,891,820	2,972,103	273,601	6,049,633	1,884,553	169,593	21,677	4,433,557	3,139,563	\$ 17,767,933	\$ 5,667,236	34.14%			
39	7400 RENAL DIALYSIS	0.113472	136,849	-	219,286	178,953	568,774	141,962	1,955,025	696,088	15,848	14,701	316,435	2,771,186	\$ 2,879,934	\$ 1,015,004	40.63%			
40	9100 EMERGENCY	0.166273	2,375,507	5,150,384	992,065	27,904,568	1,462,857	1,745,715	4,546,959	9,386,952	133,307	291,843	3,612,606	33,666,585	\$ 9,377,388	\$ 44,187,619	49.39%			
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report											
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			\$	38,798,103	\$	19,829,294	\$	19,739,073	\$	67,916,197	\$	17,974,422	\$	8,427,255	\$	49,721,365	\$	43,359,545	\$	1,560,885	\$	823,861	\$	33,635,143	\$	86,416,566		

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to	
Totals / Payments																
128 Total Charges (includes organ acquisition from Section J)	\$ 55,769,464	\$ 19,829,294	\$ 32,721,204	\$ 67,916,197	\$ 25,459,983	\$ 8,427,255	\$ 69,736,217	\$ 43,359,545	\$ 2,262,726	\$ 823,861	\$ 45,805,238	\$ 86,416,566	\$ 183,686,868	\$ 139,532,290	33.38%	
129 Total Charges per PS&R or Exhibit Detail	\$ 55,769,464	\$ 19,829,294	\$ 32,721,204	\$ 67,916,197	\$ 25,459,983	\$ 8,427,255	\$ 69,736,217	\$ 43,359,545	\$ 2,262,726	\$ 823,861	(Agrees to Exhibit A)	(Agrees to Exhibit A)				
130 Unreconciled Charges (Explain Variance)											\$ 45,805,238	\$ 86,416,566				
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 11,443,641	\$ 2,573,085	\$ 8,173,277	\$ 8,958,315	\$ 4,622,263	\$ 987,507	\$ 13,021,950	\$ 5,517,852	\$ 475,562	\$ 99,527	\$ 8,358,977	\$ 10,354,728	\$ 37,261,131	\$ 18,036,759	34.99%	
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,174,959	\$ 2,272,960											\$ 6,174,959	\$ 2,272,960		
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 3,614,485	\$ 7,481,930			\$ 9,620,953	\$ 5,468,956					\$ 13,235,438	\$ 12,950,886		
134 Private Insurance (including primary and third party liability)	\$ 76,459	\$ 26,739											\$ 76,459	\$ 26,739		
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 675	\$ 2	\$ 7,470	\$ 830	\$ 1,333	\$ 1,636	\$ 3,041					\$ 2,468	\$ 12,519		
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 6,251,418	\$ 2,300,374	\$ 3,614,487	\$ 7,489,400												
137 Medicaid Cost Settlement Payments (See Note B)		\$ (12,871)														
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)																
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					\$ 3,295,468	\$ 695,332							\$ 3,295,468	\$ 695,332		
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																
141 Medicare Cross-Over Bad Debt Payments					\$ 132,325	\$ 33,013							\$ 132,325	\$ 33,013		
142 Other Medicare Cross-Over Payments (See Note D)					\$ 72,155	\$ 5,814							\$ 72,155	\$ 5,814		
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 109,943	\$ 864,122				
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											\$ -	\$ -				
145 Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ 5,192,223	\$ 285,582	\$ 4,558,790	\$ 1,468,915	\$ 1,121,485	\$ 252,015	\$ 3,399,361	\$ 45,855	\$ 475,562	\$ 99,527	\$ 8,249,034	\$ 9,490,806	\$ 14,271,859	\$ 2,052,367		
146 Calculated Payments as a Percentage of Cost	55%	89%	44%	84%	76%	74%	74%	90%	0%	0%	1%	8%	62%	89%		
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					18,219										7%	
148 Percent of cross-over days to total Medicare days from the cost report																

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments, DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
 Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,640.34		156				30		51		237	
2	03100 INTENSIVE CARE UNIT	\$ 2,773.54		31						1		32	
3	03200 CORONARY CARE UNIT	\$ -											
4	03300 BURN INTENSIVE CARE UNIT	\$ -											
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -											
6	03500 OTHER SPECIAL CARE UNIT	\$ 6,217.88		1								1	
7	04000 SUBPROVIDER I	\$ -											
8	04100 SUBPROVIDER II	\$ -											
9	04200 OTHER SUBPROVIDER	\$ -											
10	04300 NURSERY	\$ 2,768.01		7								7	
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days	195		-		30		52		277	
19	Total Days per PS&R or Exhibit Detail			195		-		30		52			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges												
21.01	Routine Charges	\$ 964,549		\$ 964,549		\$ -		\$ 138,732		\$ 319,595		\$ 1,422,876	
	Calculated Routine Charge Per Diem	\$ 4,946.41		\$ -		\$ -		\$ 4,624.40		\$ 6,146.06		\$ 5,136.74	
22	Ancillary Cost Centers (from W/S C) (list below):												
22	09200 Observation (Non-Distinct)	0.469370		28,965	15,362			3,908	7,709	822	10,526	\$ 33,695	\$ 33,597
23	5000 OPERATING ROOM	0.162692		299,391	53,483			19,112	-	3,427	11,728	\$ 321,930	\$ 65,211
24	5200 DELIVERY ROOM & LABOR ROOM	0.192781		129,875	36,032			14,724	-	176	10,013	\$ 144,775	\$ 46,045
25	5300 ANESTHESIOLOGY	0.005972		75,002	29,340			10,148	-	1,453	8,008	\$ 86,603	\$ 37,348
26	5400 RADIOLOGY-DIAGNOSTIC	0.105106		106,956	250,157			12,161	20,738	16,510	14,512	\$ 135,627	\$ 285,407
27	5600 RADIOISOTOPE	0.124511		28,356	9,452			-	17,363	9,452	9,452	\$ 37,808	\$ 36,267
28	5700 CT SCAN	0.035621		266,228	491,734			53,714	46,737	82,664	60,275	\$ 402,606	\$ 598,746
29	5800 MRI	0.067992		37,675	44,201			18,557	10,817	26,381	14,339	\$ 82,813	\$ 69,357
30	5900 CARDIAC CATHETERIZATION	0.144972		114,000	16,590			15,470	6,939	31,862	7,362	\$ 161,332	\$ 30,891
31	6000 LABORATORY	0.077873		662,533	441,239			96,200	31,598	98,696	40,696	\$ 857,429	\$ 513,535
32	6500 RESPIRATORY THERAPY	0.107572		286,393	33,662			55,479	7,732	113,374	583	\$ 455,247	\$ 41,977
33	6600 PHYSICAL THERAPY	0.261085		16,789	9,431			7,563	2,462	7,317	1,196	\$ 31,669	\$ 13,089
34	6900 ELECTROCARDIOLOGY	0.005310		39,984	47,040			6,272	7,840	7,056	9,532	\$ 53,312	\$ 64,412
35	7000 ELECTROENCEPHALOGRAPHY	0.192530		2,208	-			-	-	2,208	7,867	\$ 4,416	\$ 7,867
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.352688		81,457	20,276			7,997	1,237	12,293	3,962	\$ 101,746	\$ 25,474
37	7200 IMPL. DEV. CHARGED TO PATIENTS	0.258128		14,581	-			1,920	-	-	-	\$ 16,501	\$ -
38	7300 DRUGS CHARGED TO PATIENTS	0.169792		317,446	116,645			27,695	6,341	47,969	9,874	\$ 393,109	\$ 132,860
39	7400 RENAL DIALYSIS	0.113472		10,754	1,025			-	-	691	-	\$ 11,445	\$ 1,025
40	9100 EMERGENCY	0.166273		287,973	1,243,808			36,959	87,474	30,503	83,418	\$ 355,435	\$ 1,414,700
41												\$ -	\$ -
42												\$ -	\$ -
43												\$ -	\$ -
44												\$ -	\$ -
45												\$ -	\$ -
46												\$ -	\$ -
47												\$ -	\$ -
48												\$ -	\$ -
49												\$ -	\$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 2,806,765	\$ 2,859,476	\$ -	\$ -	\$ 387,880	\$ 254,987	\$ 492,852	\$ 303,344	\$ -	\$ -

Totals / Payments

128	Total Charges (includes organ acquisition from Section K)	\$ 3,771,314	\$ 2,859,476	\$ -	\$ -	\$ 526,612	\$ 254,987	\$ 812,447	\$ 303,344	\$ 5,110,373	\$ 3,417,807
129	Total Charges per PS&R or Exhibit Detail	\$ 3,771,314	\$ 2,859,476	\$ -	\$ -	\$ 526,612	\$ 254,987	\$ 812,447	\$ 303,344		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 721,530	\$ 348,007	\$ -	\$ -	\$ 93,380	\$ 31,400	\$ 139,571	\$ 37,771	\$ 954,481	\$ 417,178
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 61,890	\$ 87,187							\$ 61,890	\$ 87,187
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									\$ -	\$ -
134	Private Insurance (including primary and third party liability)									\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 528						\$ 350	\$ -	\$ 878
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 61,890	\$ 87,715	\$ -	\$ -						
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) (See Note F)					\$ 94,031	\$ 17,952			\$ 94,031	\$ 17,952
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 87,674	\$ 48,595	\$ 87,674	\$ 48,595
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)	\$ 659,640	\$ 260,292	\$ -	\$ -	\$ (651)	\$ 13,448	\$ 51,897	\$ (11,174)	\$ 710,886	\$ 262,566
144	Calculated Payments as a Percentage of Cost	9%	25%	0%	0%	101%	57%	63%	130%	26%	37%

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 (07/01/2023-06/30/2024)

WELLSTAR DOUGLAS HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured			
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):																			
1	Lung Acquisition	\$0.00	\$ -	\$ -		0													
2	Kidney Acquisition	\$0.00	\$ -	\$ -		0													
3	Liver Acquisition	\$0.00	\$ -	\$ -		0													
4	Heart Acquisition	\$0.00	\$ -	\$ -		0													
5	Pancreas Acquisition	\$0.00	\$ -	\$ -		0													
6	Intestinal Acquisition	\$0.00	\$ -	\$ -		0													
7	Islet Acquisition	\$0.00	\$ -	\$ -		0													
8		\$0.00	\$ -	\$ -		0													
9	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-	
10	Total Cost																		

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

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

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (07/01/2023-06/30/2024)

WELLSTAR DOUGLAS HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
						From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -		0							
12	Kidney Acquisition	\$ -	\$ -	\$ -		0							
13	Liver Acquisition	\$ -	\$ -	\$ -		0							
14	Heart Acquisition	\$ -	\$ -	\$ -		0							
15	Pancreas Acquisition	\$ -	\$ -	\$ -		0							
16	Intestinal Acquisition	\$ -	\$ -	\$ -		0							
17	Islet Acquisition	\$ -	\$ -	\$ -		0							
18		\$ -	\$ -	\$ -		0							
19	Totals	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -
20	Total Cost												

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR DOUGLAS HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 2,809,097	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	44100-4012 (WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		(Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ 2,809,097	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment		(Adjusted to / (from))
9 Reason for adjustment		(Adjusted to / (from))
10 Reason for adjustment		(Adjusted to / (from))
11 Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
12 Reason for adjustment		
13 Reason for adjustment		
14 Reason for adjustment		
15 Reason for adjustment		
16 Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ -	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 2,809,097
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	334,833,926
19 Uninsured Hospital Charges Sec. G	132,221,804
20 Total Hospital Charges Sec. G	1,389,937,864
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	24.09%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.51%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC**	\$ 676,707
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 267,223
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ 943,930
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	182,866,949
27 Uninsured Hospital Charges Sec. G	135,308,391
28 Total Hospital Charges Sec. G	1,389,937,864
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	13.16%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	9.73%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC**	\$ 369,578
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 273,461
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC**	\$ 643,039

* 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.

***For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.