SFY 2026 Medicaid ICTF Survey

Wellstar Kennestone Hospital

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2023	06/30/2024
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001119A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110035

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.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1968

C. Disclosure of Other Medicaid Payments Received:

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** — $ 24,944,223

   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2025 - 06/30/2026** — $ 24,944,223

Certification:

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

Explanation for "No" answers:

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	Marietta, 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@srgllc.org

11/11/25

11/11/25

DSH Version 9.02 4/22/2025

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 KENNESTONE HOSPITAL

	7/1/2023 through 6/30/2024		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	12/3/2024		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR KENNESTONE HOSPITAL		
5. Medicaid Provider Number:	000001119A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110035		
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
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)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 2,089,741	$ 5,701,766	$7,791,507
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 13,944,733	$ 47,077,797	$61,022,530
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)	$16,034,474	$52,779,563	$68,814,037
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	13.03%	10.80%	11.32%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2023 - 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)	245,763	**(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	140,617
3. Outpatient Hospital Subsidies	50,106
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	$ 190,723
7. Inpatient Hospital Charity Care Charges	292,404,289
8. Outpatient Hospital Charity Care Charges	205,516,820
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	$ 497,921,109

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)			
	Inpatient Hospital	**Outpatient Hospital**	**Non-Hospital**	**Inpatient Hospital**	**Outpatient Hospital**	**Non-Hospital**	Net Hospital Revenue
11. Hospital	$1,436,854,608.00			$ 1,143,025,265	$ -	$ -	$ 293,829,343
12. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13. Subprovider II (Psych or Rehab)	$41,861,146.00			$ 33,300,758	$ -	$ -	$ 8,560,388
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	$3,553,893,140.00	$2,705,688,390.00		$ 2,827,140,356	$ 2,152,389,095	$ -	$ 1,280,052,079
20. Outpatient Services		$608,889,318.00			$ 484,374,599	$ -	$ 124,514,719
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	$ 5,032,608,894	$ 3,314,577,708	$ -	$ 4,003,466,379	$ 2,636,763,694	$ -	$ 1,706,956,529
28. Total Hospital and Non Hospital		Total from Above	$ 8,347,186,602		Total from Above	$ 6,640,230,073	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	8,347,186,602	Total Contractual Adj. (G-3 Line 2)		6,635,866,387
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	22,411,020
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)				-	18,047,334
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					6,640,230,073
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 KENNESTONE HOSPITAL

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

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 270,037,776	$ 22,325,283	$ 8,270	$0.00	$ 292,371,329	207,497	$872,336,063.00		$ 1,409.04
2	03100	INTENSIVE CARE UNIT	$ 72,152,270	$ 2,186,659	$ 21,155		$ 74,360,084	20,130	$280,224,536.00		$ 3,693.99
3	03200	CORONARY CARE UNIT	$ 20,149,392	$ 997,993	$ 13,601		$ 21,160,986	5,986	$64,710,039.00		$ 3,535.08
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ 22,775,080	$ -	$ -		$ 22,775,080	8,784	$131,919,280.00		$ 2,592.79
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 11,007,561	$ -	$ -		$ 11,007,561	15,720	$59,145,767.00		$ 700.23
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 396,122,079	$ 25,509,935	$ 43,026	$ -	$ 421,675,040	258,117	$ 1,408,335,685		
19		Weighted Average									$ 1,633.66

Line #		Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)		15,881	-	-	$ 22,376,964	$5,796,047.00	$42,945,469.00	$ 48,741,516	0.459095

Line #		Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$122,336,139.00	$ 8,355,983	$ -		$ 130,692,122	$672,060,719.00	$572,921,969.00	$ 1,244,982,688	0.104975
22	5200	DELIVERY ROOM & LABOR ROOM	$26,199,661.00	$ -	$ -		$ 26,199,661	$166,219,213.00	$11,654,608.00	$ 177,873,821	0.147294
23	5300	ANESTHESIOLOGY	$2,968,926.00	$ 266,095	$ -		$ 3,235,021	$189,815,653.00	$188,247,484.00	$ 378,063,137	0.008557
24	5400	RADIOLOGY-DIAGNOSTIC	$53,020,645.00	$ 845,235	$ -		$ 53,865,880	$109,540,215.00	$483,890,486.00	$ 593,430,701	0.090770
25	5600	RADIOISOTOPE	$4,713,636.00	$ -	$ -		$ 4,713,636	$9,094,394.00	$49,532,885.00	$ 58,627,279	0.080400
26	5700	CT SCAN	$21,963,705.00	$ -	$ -		$ 21,963,705	$291,299,348.00	$440,359,067.00	$ 731,658,415	0.030019
27	5800	MRI	$11,056,860.00	$ -	$ -		$ 11,056,860	$45,369,832.00	$118,330,088.00	$ 163,699,920	0.067543
28	5900	CARDIAC CATHETERIZATION	$34,434,539.00	$ -	$ 130,258		$ 34,564,797	$192,720,737.00	$166,390,810.00	$ 359,111,547	0.096251
29	6000	LABORATORY	$58,764,774.00	$ 567,094	$ 30,601		$ 59,362,469	$543,607,978.00	$198,544,831.00	$ 742,152,809	0.079987

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR KENNESTONE 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	$26,436,271.00	$ -	$ 1,008	$ 26,437,279	$283,213,277.00	$9,417,053.00	$ 292,630,330	0.090344
31	6600	PHYSICAL THERAPY	$27,595,873.00	$ 306,475	$ 14,305	$ 27,916,653	$30,902,207.00	$74,319,774.00	$ 105,221,981	0.265312
32	6900	ELECTROCARDIOLOGY	$623,307.00	$ -	$ -	$ 623,307	$37,658,886.00	$29,625,520.00	$ 67,284,406	0.009264
33	7000	ELECTROENCEPHALOGRAPHY	$4,112,257.00	$ -	$ -	$ 4,112,257	$11,445,965.00	$15,329,340.00	$ 26,775,305	0.153584
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$140,428,033.00	$ -	$ -	$ 140,428,033	$228,582,262.00	$117,715,612.00	$ 346,297,874	0.405512
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$106,705,650.00	$ -	$ -	$ 106,705,650	$251,035,375.00	$124,665,017.00	$ 375,700,392	0.284018
36	7300	DRUGS CHARGED TO PATIENTS	$96,152,090.00	$ -	$ -	$ 96,152,090	$454,762,594.00	$96,286,902.00	$ 551,049,496	0.174489
37	7400	RENAL DIALYSIS	$5,057,621.00	$ -	$ -	$ 5,057,621	$56,563,520.00	$12,150,457.00	$ 68,713,977	0.073604
38	9000	CLINIC	$4,510,406.00	$ 6,191,224	$ -	$ 10,701,630	$113,650.00	$7,256,274.00	$ 7,369,924	1.452068
39	9100	EMERGENCY	$95,741,121.00	$ 9,916,553	$ 78,556	$ 105,736,230	$231,897,586.00	$366,995,897.00	$ 598,893,483	0.176553
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 KENNESTONE 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**	$ 842,821,514	$ 26,448,659	$ 254,728		$ 869,524,901	$ 3,811,699,458	$ 3,126,579,543	$ 6,938,279,001	
127		**Weighted Average**									0.128548
128		**Sub Totals**	$ 1,238,943,593	$ 51,958,594	$ 297,754		$ 1,291,199,941	$ 5,220,035,143	$ 3,126,579,543	$ 8,346,614,686	
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**					$ 1,291,199,941				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					4.19%				

* 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 KENNESTONE 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)		
Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	% Survey to Cost Report Totals (Includes all payers)
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal	From Hospital's Own Internal			
	Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
1	03000	ADULTS & PEDIATRICS	$ 1,409.04		7,172		7,277		4,293		12,042		810		18,613		31,594		26.67%
2	03100	INTENSIVE CARE UNIT	$ 3,693.99		2,229		447		510		1,188		216		2,332		4,590		35.05%
3	03200	CORONARY CARE UNIT	$ 3,535.08		2,006		55		164		363		39		613		2,627		54.36%
4	03300	BURN INTENSIVE CARE UNIT	$ -														-		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500	OTHER SPECIAL CARE UNIT	$ 2,592.79		635		4,511				1,794		89		739		7,029		88.52%
7	04000	SUBPROVIDER I	$ -														-		
8	04100	SUBPROVIDER II	$ -														-		
9	04200	OTHER SUBPROVIDER	$ -														-		
10	04300	NURSERY	$ 700.23		1,443		2,978				443		30		979		4,894		37.39%
11			$ -														-		
12			$ -														-		
13			$ -														-		
14			$ -														-		
15			$ -														-		
16			$ -														-		
17			$ -														-		
18				Total Days	13,485		15,268		4,967		15,830		1,184		23,276		50,734		29.08%
19	Total Days per PS&R or Exhibit Detail				13,485		15,268		4,967		15,830		1,184		23,276				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 72,330,906		$ 94,003,419		$ 24,710,301		$ 88,598,101		$ 7,204,530		$ 112,870,972		$ 279,642,727		28.24%
21.01		Calculated Routine Charge Per Diem			$ 5,363.80		$ 6,156.89		$ 4,974.89		$ 5,596.85		$ 6,084.91		$ 4,849.24		$ 5,511.94		
	Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200	Observation (Non-Distinct)		0.459095	4,497,568	1,031,493	1,419,551	1,246,980	158,489	222,725	2,044,831	1,131,321	20,019	2,525	803,034	1,411,182	$ 8,120,439	$ 3,632,518	29.00%
23	5000	OPERATING ROOM		0.104975	26,853,564	7,002,192	26,865,798	21,756,036	9,085,276	5,881,071	37,987,345	20,743,105	2,031,885	366,552	67,000,274	25,530,582	$ 100,791,983	$ 55,382,404	20.40%
24	5200	DELIVERY ROOM & LABOR ROOM		0.147294	2,991,176	-	23,585,624	2,727,695	583,655	46,726	8,382,787	900,835	437,781	25,359	9,043,732	1,781,257	$ 35,543,242	$ 3,675,256	28.51%
25	5300	ANESTHESIOLOGY		0.008557	5,483,408	3,160,820	7,107,211	7,427,989	2,020,936	1,788,969	9,551,429	6,573,767	402,343	113,940	16,540,668	9,873,605	$ 24,162,984	$ 18,951,545	18.69%
26	5400	RADIOLOGY-DIAGNOSTIC		0.090770	4,688,493	4,959,379	2,941,369	12,599,969	1,991,391	4,725,031	5,476,779	13,563,324	501,645	225,996	9,849,760	22,473,677	$ 15,098,032	$ 35,847,703	14.30%
27	5600	RADIOISOTOPE		0.080400	452,676	372,122	69,726	308,411	161,107	552,922	480,827	1,689,275	14,673	10,804	721,143	899,902	$ 1,164,336	$ 2,922,731	9.86%
28	5700	CT SCAN		0.030019	9,637,218	5,613,316	5,048,909	13,603,243	6,121,080	5,241,695	13,709,293	15,267,854	898,176	207,952	32,769,410	69,297,642	$ 34,516,500	$ 39,726,108	24.63%
29	5800	MRI		0.067543	1,905,921	1,731,911	814,699	6,044,875	848,460	1,320,448	2,321,027	4,529,942	108,763	83,609	4,760,585	3,859,183	$ 5,890,107	$ 13,627,176	17.45%
30	5900	CARDIAC CATHETERIZATION		0.096251	3,970,528	821,495	2,785,539	1,776,200	3,254,622	1,262,108	8,154,934	4,372,315	469,572	84,887	15,042,556	3,425,363	$ 18,165,623	$ 8,232,118	12.79%
31	6000	LABORATORY		0.079987	31,671,123	5,709,936	20,734,478	18,376,395	13,573,808	2,982,729	34,952,042	9,203,391	3,096,515	284,493	61,002,799	36,817,722	$ 100,931,451	$ 36,272,451	32.62%
32	6500	RESPIRATORY THERAPY		0.090344	17,177,691	264,015	15,916,749	1,619,355	6,184,345	126,795	18,260,058	607,678	2,106,703	9,963	17,772,113	1,355,688	$ 57,538,842	$ 2,617,843	28.33%
33	6600	PHYSICAL THERAPY		0.265312	1,899,035	341,397	1,217,289	2,505,785	776,164	729,057	2,272,796	2,468,789	159,862	262,847	3,526,261	4,593,236	$ 6,165,284	$ 6,045,028	19.98%
34	6900	ELECTROCARDIOLOGY		0.009264	1,743,864	665,930	501,760	1,178,279	897,928	441,223	1,884,114	1,201,032	100,352	30,576	3,066,528	4,545,486	$ 5,027,666	$ 3,486,464	24.61%
35	7000	ELECTROENCEPHALOGRAPHY		0.153584	724,277	367,419	233,011	1,183,581	342,941	167,663	668,327	720,890	99,540	139,075	1,103,556	209,706	$ 1,968,556	$ 2,439,553	22.64%
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.405512	8,974,785	1,162,221	7,168,512	2,606,448	3,093,094	982,728	11,568,906	3,106,120	604,985	99,422	16,845,408	4,427,424	$ 30,805,298	$ 7,857,517	17.72%
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.284018	6,738,855	3,268,739	3,454,058	1,684,366	2,726,110	2,146,439	12,240,157	7,179,675	183,205	19,464	11,042,381	2,899,048	$ 25,159,180	$ 14,279,219	14.35%
38	7300	DRUGS CHARGED TO PATIENTS		0.174489	24,254,139	2,737,552	14,926,214	4,089,921	9,024,079	907,986	26,878,285	3,226,675	1,983,497	86,239	39,802,490	9,505,918	$ 75,082,716	$ 10,962,134	25.27%
39	7400	RENAL DIALYSIS		0.073604	183,803	-	1,456,505	468,027	2,846,724	297,964	5,636,473	560,601	1,158,082	31,616	4,134,461	7,327,054	$ 10,123,505	$ 1,326,593	35.55%
40	9000	CLINIC		1.452068	64,561	-	1,492	746	-	187,932	4,476	559,939	2,238	746	14,174	673,271	$ 70,529	$ 748,617	20.53%
41	9100	EMERGENCY		0.176553	6,444,741	7,471,058	5,812,214	35,215,364	5,501,707	4,049,761	11,261,734	12,217,946	868,070	358,662	25,279,860	79,172,310	$ 29,020,396	$ 58,954,129	32.93%
42				-													$ -	$ -	
43				-													$ -	$ -	
44				-													$ -	$ -	
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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 KENNESTONE 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
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
75				-													$ -	$ -	
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125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 160,357,425	$ 46,680,993	$ 142,060,707	$ 136,419,666	$ 69,191,916	$ 34,061,972	$ 213,736,620	$ 109,824,475	$ 15,247,906	$ 2,444,726	$ 340,121,193	$ 290,079,255			

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

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

	Totals / Payments	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
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 232,688,331	$ 46,680,993	$ 236,064,126	$ 136,419,666	$ 93,902,217	$ 34,061,972	$ 302,334,721	$ 109,824,475	$ 22,452,436	$ 2,444,726	$ 452,992,165	$ 290,079,255	$ 864,989,395	$ 326,987,105	23.50%
												(Agrees to Exhibit A)	**(Agrees to Exhibit A)**			
129	Total Charges per PS&R or Exhibit Detail	$ 232,688,331	$ 46,680,993	$ 236,064,126	$ 136,419,666	$ 93,902,217	$ 34,061,972	$ 302,334,721	$ 109,824,475	$ 22,452,436	$ 2,444,726	$ 452,992,165	$ 290,079,255			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 50,468,141	$ 5,910,425	$ 44,722,461	$ 16,453,331	$ 17,085,863	$ 4,232,858	$ 56,168,869	$ 13,879,009	$ 4,127,340	$ 328,452	$ 81,509,216	$ 32,590,538	$ 168,445,334	$ 40,475,623	25.35%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 24,872,387	$ 4,599,376	$ -										$ 24,872,387	$ 4,599,376	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 25,524,897	$ 14,034,861									$ 25,524,897	$ 14,034,861	
134	Private Insurance (including primary and third party liability)	$ 271,470	$ 81,813		$ -			$ 55,434,905	$ 13,385,805					$ 55,706,375	$ 13,467,618	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 275	$ 1,869	$ 320	$ 15,606	$ 5,928	$ 5,645	$ 7,935	$ 15,184					$ 14,458	$ 38,304	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 25,144,132	$ 4,683,058	$ 25,525,217	$ 14,050,467											
137	Medicaid Cost Settlement Payments (See Note B)		$ (291,948)											$ -	$ (291,948)	
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)					$ 13,274,951	$ 2,788,810							$ 13,274,951	$ 2,788,810	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 447,085	$ 184,071							$ 447,085	$ 184,071	
142	Other Medicare Cross-Over Payments (See Note D)					$ 605,754	$ 90,710					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 605,754	$ 90,710	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 2,089,741	$ 5,701,766			
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)**	$ 25,324,009	$ 1,519,315	$ 19,197,244	$ 2,402,864	$ 2,752,145	$ 1,163,622	$ 726,029	$ 478,020	$ 4,127,340	$ 328,452	$ 79,419,475	$ 26,888,772	$ 47,999,427	$ 5,563,821	
146	**Calculated Payments as a Percentage of Cost**	50%	74%	57%	85%	84%	73%	99%	97%	0%	0%	3%	17%	72%	86%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					113,674										
148	**Percent of cross-over days to total Medicare days from the cost report**					4%										

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).

I. Out-of-State Medicaid Data:

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

Line #	Code	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: Inpatient	Out-of-State Medicaid FFS Primary: Outpatient	Out-of-State Medicaid Managed Care Primary: Inpatient	Out-of-State Medicaid Managed Care Primary: Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary): Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary): Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary): Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary): Outpatient	Total Out-Of-State Medicaid: Inpatient	Total Out-Of-State Medicaid: Outpatient
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000	ADULTS & PEDIATRICS	$ 1,409.04		611				121		160		892	
2	03100	INTENSIVE CARE UNIT	$ 3,693.99		108				4		21		133	
3	03200	CORONARY CARE UNIT	$ 3,535.08		13						1		14	
4	03300	BURN INTENSIVE CARE UNIT	$ -										-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500	OTHER SPECIAL CARE UNIT	$ 2,592.79		1						7		8	
7	04000	SUBPROVIDER I	$ -										-	
8	04100	SUBPROVIDER II	$ -										-	
9	04200	OTHER SUBPROVIDER	$ -										-	
10	04300	NURSERY	$ 700.23		1						3		4	
11			$ -										-	
12			$ -										-	
13			$ -										-	
14			$ -										-	
15			$ -										-	
16			$ -										-	
17			$ -										-	
18				Total Days	734		-		125		192		1,051	
19		Total Days per PS&R or Exhibit Detail			734		-		125		192			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21		Routine Charges			$ 3,744,760				$ 507,407		$ 1,006,789		$ 5,258,956	
21.01		Calculated Routine Charge Per Diem			$ 5,101.85		$ -		$ 4,059.26		$ 5,243.69		$ 5,003.76	
		Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200	Observation (Non-Distinct)		0.459095	37,729	59,183			-	2,234	35,421	11,340	$ 73,150	$ 72,757
23	5000	OPERATING ROOM		0.104975	2,136,528	192,182			210,844	120,984	214,560	53,145	$ 2,561,932	$ 366,311
24	5200	DELIVERY ROOM & LABOR ROOM		0.147294	145,462	13,731			13,531	822	24,024	15	$ 183,017	$ 14,568
25	5300	ANESTHESIOLOGY		0.008557	459,475	34,420			40,382	40,423	37,165	11,601	$ 537,022	$ 86,444
26	5400	RADIOLOGY-DIAGNOSTIC		0.090770	347,766	307,441			47,117	15,584	80,424	41,298	$ 475,307	$ 364,323
27	5600	RADIOISOTOPE		0.080400	19,933	2,951			-	7,911	11,935	4,492	$ 31,868	$ 15,354
28	5700	CT SCAN		0.030019	1,038,938	1,096,507			224,574	74,456	200,173	151,122	$ 1,463,684	$ 1,322,085
29	5800	MRI		0.067543	117,802	57,406			36,596	5,844	15,206	10,817	$ 169,604	$ 74,067
30	5900	CARDIAC CATHETERIZATION		0.096251	362,022	6,606			55,342	9,081	80,512	8,849	$ 497,876	$ 24,536
31	6000	LABORATORY		0.079987	2,086,736	783,176			294,777	32,771	414,357	109,072	$ 2,795,869	$ 925,020
32	6500	RESPIRATORY THERAPY		0.090344	1,037,656	100,022			29,606	2,025	339,176	2,799	$ 1,406,438	$ 104,846
33	6600	PHYSICAL THERAPY		0.265312	112,951	58,096			16,989	10,556	47,600	20,780	$ 177,540	$ 89,432
34	6900	ELECTROCARDIOLOGY		0.009264	105,056	123,088			22,736	4,704	22,736	26,656	$ 150,528	$ 154,448
35	7000	ELECTROENCEPHALOGRAPHY		0.153584	71,105	-			14,429	-	16,587	-	$ 102,121	$ -
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.405512	553,429	32,958			67,623	10,243	48,068	5,550	$ 669,120	$ 48,751
37	7200	IMPL. DEV. CHARGED TO PATIENTS		0.284018	250,100	15,593			28,027	-	7,686	10,746	$ 285,813	$ 26,339
38	7300	DRUGS CHARGED TO PATIENTS		0.174489	1,270,580	171,983			129,705	16,951	202,111	25,576	$ 1,602,396	$ 214,510
39	7400	RENAL DIALYSIS		0.073604	243,862	20,438			52,146	166	11,004	179	$ 307,011	$ 20,783
40	9000	CLINIC		1.452068	-	-			-	2,887	-	746	$ -	$ 3,633
41	9100	EMERGENCY		0.176553	836,070	2,218,697			139,763	64,774	109,372	220,649	$ 1,085,206	$ 2,504,120
42				-									$ -	$ -
43				-									$ -	$ -
44				-									$ -	$ -
45				-									$ -	$ -
46				-									$ -	$ -
47				-									$ -	$ -
48				-									$ -	$ -
49				-									$ -	$ -

I. Out-of-State Medicaid Data:

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

Line					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	
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
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68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
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110				-									$ -	$ -
111				-									$ -	$ -
112				-									$ -	$ -

I. Out-of-State Medicaid Data:

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

Line	Description		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		-									$ -	$ -
			$ 11,233,199	$ 5,294,477	$ -	$ -	$ 1,424,187	$ 422,415	$ 1,918,115	$ 715,434		
	Totals / Payments											
128	**Total Charges (includes organ acquisition from Section K)**		$ 14,977,959	$ 5,294,477	$ -	$ -	$ 1,931,594	$ 422,415	$ 2,924,904	$ 715,434	$ 19,834,457	$ 6,432,326
129	Total Charges per PS&R or Exhibit Detail		$ 14,977,959	$ 5,294,477	$ -	$ -	$ 1,931,594	$ 422,415	$ 2,924,904	$ 715,434		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 2,668,479	$ 644,494	$ -	$ -	$ 348,274	$ 48,147	$ 548,726	$ 85,671	$ 3,565,479	$ 778,312
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 743,919	$ 141,369							$ 743,919	$ 141,369
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)								$ 305,760	$ 90,411	$ 305,760	$ 90,411
135	Self-Pay (including Co-Pay and Spend-Down)		$ 36,167	$ 404				$ 275		$ 110	$ 36,167	$ 789
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 780,086	$ 141,773	$ -	$ -						
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)						$ 244,656	$ 28,324			$ 244,656	$ 28,324
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)**		$ 1,888,393	$ 502,721	$ -	$ -	$ 103,618	$ 19,548	$ 242,966	$ (4,850)	$ 2,234,977	$ 517,419
144	**Calculated Payments as a Percentage of Cost**		29%	22%	0%	0%	70%	59%	56%	106%	37%	34%

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

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR KENNESTONE 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)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From 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 KENNESTONE 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)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

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

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description	Explanation	Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 18,047,334		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	45000 CC 3112590 RC45013	*(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 ---------->)		$ 18,047,334		
	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:

Line	Description	Source	Amount
17	Gross Allowable Assessment Not Included in the Cost Report		$ 18,047,334
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	1,243,140,446
19	Uninsured Hospital	**Charges Sec. G**	743,071,420
20	Total Hospital	**Charges Sec. G**	8,346,614,686
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		14.89%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.90%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 2,687,961
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 1,606,694
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 4,294,655**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	672,125,552
27	Uninsured Hospital	**Charges Sec. G**	767,968,582
28	Total Hospital	**Charges Sec. G**	8,346,614,686
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		8.05%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.20%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 1,453,293
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 1,660,528
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 3,113,821**

** 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.*