SFY 2026 Medicaid ICTF Survey

Wellstar MCG Health

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026 DSH Version 6.02 2/10/2023

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 MCG Health

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:	000000723A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110034

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?	6/14/1966

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** — $ 31,460,879
   (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** — $ -
   (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** — $ 31,460,879

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
	CFO	11/11/25

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	Lewis Cantrell
Title	Director
Firm Name	Southeast Reimbursement Group
Telephone Number	615-333-0655
E-Mail Address	lewis.cantrell@srglic.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 MCG HEALTH		
		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 MCG HEALTH	Yes	
5.	Medicaid Provider Number:	000000723A	Yes	
6.	Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7.	Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8.	Medicare Provider Number:	110034	Yes	
9.	Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
10.	PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	Yes	
11.	Rural Referral Center (Yes or No)	No	Yes	

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

		State Name	Provider No.
12.	State Name & Number	South Carolina	315846
13.	State Name & Number	South Carolina	358127
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)**	$ 18,809,095

		Inpatient	Outpatient	Total
9.	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 523,456	$ 2,218,638	$2,742,094
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,335,656	$ 12,450,918	$14,786,574
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)	$2,859,111	$14,669,556	$17,528,667
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	18.31%	15.12%	15.64%

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)	143,499	**(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	350,767
3.	Outpatient Hospital Subsidies	38,982
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 389,749
7.	Inpatient Hospital Charity Care Charges	132,981,162
8.	Outpatient Hospital Charity Care Charges	99,799,767
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 232,780,929

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	$435,995,843.00			$ 327,440,559	$ -	$ -	$ 108,555,284
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	$1,728,541,736.00	$2,246,798,180.00		$ 1,298,165,296	$ 1,687,385,016	$ -	$ 989,789,604
20.	Outpatient Services		$433,614,677.00			$ 325,652,262	$ -	$ 107,962,415
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	$ 2,164,537,579	$ 2,680,412,857	$ -	$ 1,625,605,855	$ 2,013,037,278	$ -	$ 1,206,307,303
28.	Total Hospital and Non Hospital		Total from Above	$ 4,844,950,436		Total from Above	$ 3,638,643,133	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	4,844,950,436	Total Contractual Adj. (G-3 Line 2)	3,649,174,143
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)			+	549,856
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)			-	11,080,866
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				3,638,643,133
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 MCG HEALTH

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	$ 158,016,060	$ 25,838,059	$ 248,425	$0.00	$ 184,102,544	117,983	$264,279,037.00		$ 1,560.42
2	03100 INTENSIVE CARE UNIT	$ 25,641,812	$ -	$ 4,425		$ 25,646,237	7,409	$34,927,318.00		$ 3,461.50
3	03200 CORONARY CARE UNIT	$ 11,852,905	$ -	$ 45,300		$ 11,898,205	4,682	$22,337,381.00		$ 2,541.27
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 6,607,973	$ -	$ -		$ 6,607,973	3,138	$14,031,875.00		$ 2,105.79
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11	3101 PEDIATRIC INTENSIVE CARE UNIT	$ 10,324,006	$ -	$ 3,825		$ 10,327,831	3,809	$26,408,224.00		$ 2,711.43
12	3401 TRAUMA INTENSIVE CARE UNIT	$ 7,643,122	$ -	$ 50,100		$ 7,693,222	3,673	$19,440,913.00		$ 2,094.53
13	3402 NEONATAL INTENSIVE CARE UNIT	$ 21,797,273	$ -	$ 733		$ 21,798,006	13,239	$54,574,095.00		$ 1,646.50
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 241,883,151	$ 25,838,059	$ 352,808	$ -	$ 268,074,018	153,933	$ 435,998,843		
19	Weighted Average									$ 1,741.50

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)	10,434	-	-	$ 16,281,422	$4,045,262.00	$12,971,705.00	$ 17,016,967	0.956776

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	$148,542,378.00	$ 4,786,394	$ 396,457		$ 153,725,229	$130,235,658.00	$183,558,603.00	$ 313,794,261	0.489892
22	5200 DELIVERY ROOM & LABOR ROOM	$8,434,937.00	$ -	$ 17,790		$ 8,452,727	$21,232,066.00	$202,933.00	$ 21,434,999	0.394342
23	5300 ANESTHESIOLOGY	$3,732,780.00	$ 3,981,603	$ 117,865		$ 7,832,248	$50,772,452.00	$58,431,607.00	$ 109,204,059	0.071721
24	5400 RADIOLOGY-DIAGNOSTIC	$30,550,467.00	$ 1,482,511	$ 133,485		$ 32,166,463	$102,970,848.00	$120,221,854.00	$ 223,192,702	0.144120
25	5500 RADIOLOGY-THERAPEUTIC	$11,321,188.00	$ -	$ 6,710		$ 11,327,898	$1,629,657.00	$108,962,227.00	$ 110,591,884	0.102430
26	5600 RADIOISOTOPE	$8,931,186.00	$ -	$ -		$ 8,931,186	$1,640,743.00	$54,562,522.00	$ 56,203,265	0.158909
27	5700 CT SCAN	$3,930,092.00	$ -	$ 7,455		$ 3,937,547	$134,121,390.00	$179,418,275.00	$ 313,539,665	0.012558
28	5800 MRI	$4,318,496.00	$ -	$ 4,326		$ 4,322,822	$22,168,211.00	$50,292,912.00	$ 72,461,123	0.059657
29	5900 CARDIAC CATHETERIZATION	$9,320,433.00	$ -	$ 13,325		$ 9,333,758	$34,154,441.00	$31,014,317.00	$ 65,168,758	0.143224

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) | WELLSTAR MCG HEALTH

	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	6000	LABORATORY	$49,214,062.00	$ 974,222	$ 26,157		$ 50,214,441	$245,115,966.00	$210,680,228.00	$ 455,796,194	0.110169
31	6200	WHOLE BLOOD & PACKED RED BLOOD CELL	$7,374,886.00	$ -	$ -		$ 7,374,886	$50,804,437.00	$16,206,627.00	$ 67,011,064	0.110055
32	6500	RESPIRATORY THERAPY	$17,921,990.00	$ -	$ 43,629		$ 17,965,619	$109,949,953.00	$7,972,354.00	$ 117,922,307	0.152351
33	6600	PHYSICAL THERAPY	$6,640,058.00	$ -	$ -		$ 6,640,058	$12,893,223.00	$16,438,139.00	$ 29,331,362	0.226381
34	6700	OCCUPATIONAL THERAPY	$3,623,803.00	$ -	$ -		$ 3,623,803	$11,579,283.00	$3,972,483.00	$ 15,551,766	0.233016
35	6800	SPEECH PATHOLOGY	$1,970,942.00	$ -	$ -		$ 1,970,942	$7,834,073.00	$3,992,157.00	$ 11,826,230	0.166659
36	6900	ELECTROCARDIOLOGY	$22,453,460.00	$ -	$ 22,050		$ 22,475,510	$44,909,762.00	$94,950,729.00	$ 139,860,491	0.160699
37	7000	ELECTROENCEPHALOGRAPHY	$3,178,819.00	$ 1,863,729	$ 21,925		$ 5,064,473	$13,486,917.00	$24,882,313.00	$ 38,369,230	0.131993
38	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$28,809,549.00	$ -	$ -		$ 28,809,549	$82,326,665.00	$69,037,819.00	$ 151,364,484	0.190332
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$56,139,676.00	$ -	$ -		$ 56,139,676	$84,958,305.00	$82,415,585.00	$ 167,373,890	0.335415
40	7300	DRUGS CHARGED TO PATIENTS	$160,648,258.00	$ -	$ -		$ 160,648,258	$379,637,738.00	$924,111,877.00	$ 1,303,749,615	0.123220
41	7400	RENAL DIALYSIS	$3,683,331.00	$ -	$ -		$ 3,683,331	$9,369,344.00	$1,617,795.00	$ 10,987,139	0.335240
42	7700	ALLOGENEIC HSCT ACQUISITION	$1,844,448.00	$ -	$ -		$ 1,844,448	$1,517,007.00	$3,854,826.00	$ 5,371,833	0.343355
43	9000	CLINIC	$61,993,096.00	$ -	$ 247,775		$ 62,240,871	$416,299.00	$200,155,553.00	$ 200,571,852	0.310317
44	9100	EMERGENCY	$46,230,620.00	$ 3,430,955	$ 303,100		$ 49,964,675	$128,606,169.00	$218,055,223.00	$ 346,661,392	0.144131
45	9201	OBSERVATION BEDS (DISTINCT PART)	$2,741,712.00	$ -	$ -		$ 2,741,712	$1,341,118.00	$2,432,197.00	$ 3,773,315	0.726606
46	10500	KIDNEY ACQUISITION	$10,042,059.00	$ -	$ -		$ 10,042,059	$40,824,748.00	$7,338,859.00	$ 48,163,607	-
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 MCG HEALTH

	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**	$ 713,592,726	$ 16,519,414	$ 1,362,049		$ 731,474,189	$ 1,728,541,735	$ 2,687,751,719	$ 4,416,293,454	
127		**Weighted Average**									0.168885
128		**Sub Totals**	$ 955,475,877	$ 42,357,473	$ 1,714,857		$ 999,548,207	$ 2,164,540,578	$ 2,687,751,719	$ 4,852,292,297	
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**					$ 999,548,207				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					4.43%				

* 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 MCG HEALTH

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 Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,560.42		7,522		7,677		2,763		9,255		178		9,109		27,395		39.69%
2	03100 INTENSIVE CARE UNIT	$ 3,461.50		2,956		104		199		471		9		531		3,740		61.44%
3	03200 CORONARY CARE UNIT	$ 2,541.27		22		65		125		295		6		332		513		21.81%
4	03300 BURN INTENSIVE CARE UNIT	$ -				-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,105.79		12		36		69		164		3		184		284		18.03%
6	03500 OTHER SPECIAL CARE UNIT	$ -				-		-		-		-		-		-		
7	04000 SUBPROVIDER I	$ -				-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -				-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -				-		-		-		-		-		-		
10	04300 NURSERY	$ -				-		-		-		-		-		-		
11	3101 PEDIATRIC INTENSIVE CARE UNIT	$ 2,711.43		599		1,220		28		378		-		84		2,225		65.77%
12	3401 TRAUMA INTENSIVE CARE UNIT	$ 2,094.53		154		212		48		208		-		570		622		40.57%
13	3402 NEONATAL INTENSIVE CARE UNIT	$ 1,646.50		19		5,293		-		1,897		200		305		7,409		69.11%
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	11,284		14,607		3,232		12,668		397		11,115		42,188		40.25%
19	Total Days per PS&R or Exhibit Detail			11,284		14,607		3,232		12,668		397		11,115				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 34,032,966		$ 46,984,061		$ 9,327,209		$ 40,330,542		$ 1,482,033		$ 32,725,327		$ 130,674,778		43.49%
21.01	Calculated Routine Charge Per Diem			$ 3,016.04		$ 3,216.54		$ 2,885.89		$ 3,183.66		$ 3,733.08		$ 2,944.25		$ 3,097.44		
	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)		0.956776	625,960	1,272,446	408,064	1,561,356	135,167	244,796	413,329	1,296,412	4,510	18,408	155,836	1,633,386	$ 1,582,521	$ 4,375,010	53.48%
23	5000 OPERATING ROOM		0.489892	8,333,964	10,114,524	11,389,032	19,588,591	2,125,599	2,308,895	7,632,929	9,229,739	247,313	224,015	10,932,601	5,545,651	$ 29,481,524	$ 41,241,749	32.93%
24	5200 DELIVERY ROOM & LABOR ROOM		0.394342	900,856	-	4,288,709	-	136,250	-	1,430,553	-	29,667	-	1,435,776	-	$ 6,756,368	$ -	44.95%
25	5300 ANESTHESIOLOGY		0.071721	2,533,278	2,228,651	3,156,845	5,719,864	890,540	703,014	2,825,951	2,972,112	70,545	69,048	4,169,590	1,703,364	$ 9,406,614	$ 11,623,640	29.42%
26	5400 RADIOLOGY-DIAGNOSTIC		0.144120	4,498,416	2,171,517	5,623,467	9,626,110	3,521,647	1,280,223	9,554,409	5,910,617	189,890	112,515	13,501,017	8,607,749	$ 23,197,939	$ 18,988,466	34.41%
27	5500 RADIOLOGY-THERAPEUTIC		0.102430	77,735	3,889,547	109,059	2,033,331	35,874	1,322,769	128,317	6,822,456	-	69,580	105,746	4,305,298	$ 350,985	$ 14,068,102	19.00%
28	5600 RADIOISOTOPE		0.158909	122,467	2,391,258	58,963	635,438	57,428	865,050	189,714	3,267,909	-	282	133,513	2,489,926	$ 428,572	$ 7,159,655	26.83%
29	5700 CT SCAN		0.012558	6,878,999	5,452,501	3,448,627	5,705,342	3,064,546	2,521,566	7,902,762	9,978,557	145,275	78,701	13,120,493	21,362,671	$ 21,294,934	$ 23,657,965	29.63%
30	5800 MRI		0.059657	1,240,680	1,965,380	1,228,122	3,028,068	425,759	529,506	1,542,513	2,471,896	52,732	51,005	2,405,464	2,337,625	$ 4,437,074	$ 7,994,850	28.66%
31	5900 CARDIAC CATHETERIZATION		0.143224	3,761,659	1,173,402	462,396	894,703	832,574	238,734	2,952,470	1,464,021	-	-	2,642,359	340,400	$ 8,009,099	$ 3,770,860	26.01%
32	6000 LABORATORY		0.110169	18,593,607	8,039,966	16,664,369	10,338,318	6,742,275	3,611,256	21,022,108	11,534,178	647,717	261,528	22,636,821	14,065,670	$ 63,022,358	$ 33,523,717	34.45%
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.110055	2,796,574	4,398,242	3,244,781	1,312,079	1,194,501	516,846	2,390,335	857,352	164,580	29,755	3,564,161	1,130,897	$ 9,626,191	$ 7,084,519	36.70%
34	6500 RESPIRATORY THERAPY		0.152351	13,275,457	1,649,363	11,209,361	732,232	2,219,547	94,461	13,896,501	510,816	446,588	14,373	7,081,522	242,473	$ 40,600,866	$ 2,986,873	50.20%
35	6600 PHYSICAL THERAPY		0.226381	954,076	305,548	1,327,096	135,936	231,799	46,192	1,144,149	296,383	34,757	20,836	882,482	135,811	$ 3,657,120	$ 784,058	22.13%
36	6700 OCCUPATIONAL THERAPY		0.233016	846,987	66,522	1,209,284	53,301	211,679	21,266	1,044,637	169,878	27,101	3,422	807,594	69,853	$ 3,312,587	$ 310,966	34.19%
37	6800 SPEECH PATHOLOGY		0.166659	583,103	21,485	1,160,798	79,770	196,157	19,884	749,882	102,785	27,185	16,751	496,369	35,246	$ 2,689,940	$ 223,924	35.46%
38	6900 ELECTROCARDIOLOGY		0.160699	1,369,079	1,917,823	2,706,822	5,307,071	1,174,381	930,603	3,767,876	4,650,791	86,003	120,462	3,628,462	2,295,262	$ 9,017,959	$ 12,806,288	24.23%
39	7000 ELECTROENCEPHALOGRAPHY		0.131993	874,681	715,874	1,250,839	2,660,546	450,208	180,417	1,419,301	1,449,732	2,836	15,964	954,924	560,046	$ 3,995,029	$ 5,006,569	33.60%
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.190332	4,027,625	1,901,049	3,923,000	3,183,320	1,540,547	769,512	5,177,058	3,029,839	70,189	57,566	6,755,712	1,735,251	$ 14,668,230	$ 8,883,719	25.19%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.335415	3,662,813	3,510,866	2,709,730	2,826,155	1,618,901	593,042	4,713,753	4,487,705	37,512	73,253	5,353,312	1,301,918	$ 12,705,197	$ 11,417,767	22.30%
42	7300 DRUGS CHARGED TO PATIENTS		0.123220	27,155,922	16,752,051	23,645,384	21,757,942	6,494,927	11,595,846	22,975,136	57,975,794	640,924	918,137	26,863,654	14,098,777	$ 80,271,369	$ 108,081,633	21.76%
43	7400 RENAL DIALYSIS		0.335240	617,448	-	103,704	2,235	1,021,346	83,346	1,167,318	200,189	24,448	1,862	427,486	445,018	$ 2,909,816	$ 285,770	43.95%
44	7700 ALLOGENEIC HSCT ACQUISITION		0.343355	-	-	-	-	-	-	-	-	-	-	-	-	$ -	$ -	0.00%
45	9000 CLINIC		0.310317	24,356	6,117,734	159,267	14,270,444	11,744	2,617,168	32,762	9,842,815	2,213	182,704	6,428	9,268,779	$ 228,129	$ 32,848,161	25.30%
46	9100 EMERGENCY		0.144131	7,541,755	11,988,010	6,687,746	29,468,205	2,466,612	3,072,341	8,512,520	12,674,266	145,214	311,956	16,045,095	36,807,918	$ 25,208,634	$ 57,202,822	44.64%
47	9201 OBSERVATION BEDS (DISTINCT PART)		0.726606	26,082	232,588	17,003	283,628	5,632	44,049	17,222	235,492	188	3,292	6,493	289,143	$ 65,938	$ 795,756	36.00%
48	10500 KIDNEY ACQUISITION	-														$ -	$ -	0.00%
49		-														$ -	$ -	
50		-														$ -	$ -	
51		-														$ -	$ -	
52		-														$ -	$ -	
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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 MCG HEALTH

					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
70				-													$ -	$ -	
71				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
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116				-													$ -	$ -	
117				-													$ -	$ -	
118				-													$ -	$ -	
119				-													$ -	$ -	
120				-													$ -	$ -	
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122				-													$ -	$ -	
123				-													$ -	$ -	
124				-													$ -	$ -	
125				-													$ -	$ -	
126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 111,323,580	$ 88,276,346	$ 106,192,269	$ 141,203,983	$ 36,805,639	$ 34,210,779	$ 122,603,505	$ 151,431,733	$ 3,097,388	$ 2,655,415	$ 144,112,910	$ 130,808,134			

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

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

		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
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 145,356,546	$ 88,276,346	$ 153,176,330	$ 141,203,983	$ 48,535,312	$ 34,210,779	$ 167,052,557	$ 151,431,733	$ 4,579,421	$ 2,655,415	$ 176,838,237 (Agrees to Exhibit A)	$ 130,808,134 (Agrees to Exhibit A)	$ 514,120,746	$ 415,122,842	30.10%
129	Total Charges per PS&R or Exhibit Detail	$ 145,356,546	$ 88,276,346	$ 153,176,330	$ 141,203,983	$ 48,535,312	$ 34,210,779	$ 167,052,557	$ 151,431,733	$ 4,579,421	$ 2,655,415	$ 176,838,237	$ 130,808,134			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 42,508,852	$ 17,288,365	$ 44,854,353	$ 29,350,134	$ 12,181,977	$ 5,720,997	$ 42,863,587	$ 25,378,031	$ 1,161,918	$ 477,109	$ 42,240,552	$ 20,186,994	$ 142,408,769	$ 77,737,527	33.20%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 31,362,878	$ 17,096,192			$ 282,318	$ 476,058	$ 997,661	$ 1,164,441					$ 32,642,857	$ 18,736,691	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 34,599,541	$ 21,773,062	$ 12,932	$ 76	$ 1,151,072	$ 373,596					$ 35,763,545	$ 22,146,734	
134	Private Insurance (including primary and third party liability)	$ 189,542	$ 72,430	$ 16,140	$ 12,104	$ 46,725	$ 1,337	$ 37,599,157	$ 16,825,512					$ 37,851,565	$ 16,911,382	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 22,538		$ 87,179	$ 53,405	$ 27,675	$ 4,395	$ 195,669	$ 27,643	$ -	$ -			$ 333,061	$ 85,443	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 31,574,958	$ 17,168,622	$ 34,702,860	$ 21,838,570											
137	Medicaid Cost Settlement Payments (See Note B)		$ 15,982											$ -	$ 15,982	
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)	$ 155,719				$ 9,292,098	$ 3,203,785							$ 9,447,817	$ 3,203,785	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 145,600	$ 88,941							$ 145,600	$ 88,941	
142	Other Medicare Cross-Over Payments (See Note D)					$ 4,911,751	$ 1,027,043					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 4,911,751	$ 1,027,043	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 523,456	$ 2,218,638			
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)**	$ 10,778,174	$ 103,761	$ 10,151,493	$ 7,511,564	$ (2,537,122)	$ 919,363	$ 2,920,028	$ 6,986,840	$ 1,161,918	$ 477,109	$ 41,717,096	$ 17,968,356	$ 21,312,573	$ 15,521,527	
146	**Calculated Payments as a Percentage of Cost**	75%	99%	77%	74%	121%	84%	93%	72%	0%	0%	1%	11%	85%	80%	
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)**					51,691										
148	**Percent of cross-over days to total Medicare days from the cost report**					8%										

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

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 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	$ 1,560.42		1,307		1,846		640		2,384		6,178	
2	03100 INTENSIVE CARE UNIT	$ 3,461.50		57		47		28		149		281	
3	03200 CORONARY CARE UNIT	$ 2,541.27		35		30		17		94		176	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,105.79		20		16		10		52		98	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
11	3101 PEDIATRIC INTENSIVE CARE UNIT	$ 2,711.43		86		78		8		24		196	
12	3401 TRAUMA INTENSIVE CARE UNIT	$ 2,094.53		115		81		15		87		298	
13	3402 NEONATAL INTENSIVE CARE UNIT	$ 1,646.50		223		1,137		-		75		1,435	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	1,843		3,235		718		2,865		8,661	
19	Total Days per PS&R or Exhibit Detail			1,843		3,235		718		2,865			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 5,704,224		$ 10,108,459		$ 1,914,917		$ 8,492,019		$ 26,219,619	
21.01	Calculated Routine Charge Per Diem			$ 3,095.08		$ 3,124.72		$ 2,667.02		$ 2,964.06		$ 3,027.32	
	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)		0.956776	58,761	107,239	145,074	553,139	17,263	51,397	90,272	307,540	$ 311,370	$ 1,019,315
23	5000 OPERATING ROOM		0.489892	1,292,366	1,252,741	1,985,690	5,108,721	494,477	667,812	2,221,307	2,625,129	$ 5,993,839	$ 9,654,403
24	5200 DELIVERY ROOM & LABOR ROOM		0.394342	229,899	-	831,108	-	44,833	-	307,453	-	$ 1,413,294	$ -
25	5300 ANESTHESIOLOGY		0.071721	471,104	387,014	550,162	1,490,526	192,670	205,093	884,561	900,250	$ 2,098,497	$ 2,982,882
26	5400 RADIOLOGY-DIAGNOSTIC		0.144120	1,183,881	998,476	2,273,741	2,684,563	568,424	264,087	2,625,571	1,601,426	$ 6,651,617	$ 5,548,553
27	5500 RADIOLOGY-THERAPEUTIC		0.102430	-	335,150	8,286	663,428	-	191,319	-	909,092	$ 8,286	$ 2,098,990
28	5600 RADIOISOTOPE		0.158909	28,681	94,552	3,468	426,761	-	141,293	30,907	771,844	$ 63,056	$ 1,434,450
29	5700 CT SCAN		0.012558	1,248,278	662,464	1,445,245	3,028,090	659,796	674,450	2,601,356	2,925,205	$ 5,954,675	$ 7,290,209
30	5800 MRI		0.059657	250,894	305,765	245,529	1,078,262	126,387	159,227	455,521	869,960	$ 1,078,331	$ 2,413,214
31	5900 CARDIAC CATHETERIZATION		0.143224	-	15,793	226,755	120,939	149,323	205,104	688,603	782,291	$ 1,064,681	$ 1,124,127
32	6000 LABORATORY		0.110169	2,998,798	1,013,584	4,448,119	3,346,401	1,315,446	869,865	5,491,689	3,364,958	$ 14,254,052	$ 8,594,808
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.110055	548,723	71,621	660,125	358,609	128,107	68,544	709,188	449,279	$ 2,046,143	$ 948,053
34	6500 RESPIRATORY THERAPY		0.152351	1,790,927	63,964	2,651,405	199,727	418,183	13,947	2,562,050	128,084	$ 7,422,565	$ 405,722
35	6600 PHYSICAL THERAPY		0.226381	169,394	34,829	274,405	81,005	61,107	14,513	278,338	63,276	$ 783,244	$ 193,623
36	6700 OCCUPATIONAL THERAPY		0.233016	139,899	13,097	241,918	31,375	65,146	10,099	248,872	35,375	$ 695,835	$ 89,946
37	6800 SPEECH PATHOLOGY		0.166659	115,598	20,687	262,379	60,483	25,483	3,081	188,242	27,804	$ 591,702	$ 112,055
38	6900 ELECTROCARDIOLOGY		0.160699	473,752	329,363	723,822	948,942	192,792	437,200	945,005	1,889,364	$ 2,335,372	$ 3,604,868
39	7000 ELECTROENCEPHALOGRAPHY		0.131993	178,433	194,888	368,429	659,930	128,079	42,961	285,023	498,540	$ 959,964	$ 1,396,318
40	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.190332	701,807	257,231	1,037,110	818,762	265,634	216,207	1,592,198	1,075,592	$ 3,596,748	$ 2,367,792
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.335415	925,739	284,712	492,558	712,172	333,864	471,500	1,711,487	1,496,656	$ 3,463,648	$ 2,965,040
42	7300 DRUGS CHARGED TO PATIENTS		0.123220	4,479,006	1,950,071	8,213,229	6,306,509	1,771,491	4,893,042	7,646,060	17,519,717	$ 22,109,786	$ 30,669,339
43	7400 RENAL DIALYSIS		0.335240	40,467	-	129,945	17,254	160,237	4,157	329,738	52,203	$ 660,387	$ 73,614
44	7700 ALLOGENEIC HSCT ACQUISITION		0.343355	-	-	-	-	-	-	-	-	$ -	$ -
45	9000 CLINIC		0.310317	11,656	1,039,039	18,845	3,741,298	5,195	629,849	6,624	2,759,215	$ 42,320	$ 8,169,400
46	9100 EMERGENCY		0.144131	1,456,457	1,711,556	2,231,109	6,985,427	734,010	638,719	2,136,374	3,148,204	$ 6,557,951	$ 12,483,905
47	9201 OBSERVATION BEDS (DISTINCT PART)		0.726606	2,448	19,194	6,045	100,951	719	9,206	3,761	55,395	$ 12,974	$ 184,746
48	10500 KIDNEY ACQUISITION		-									$ -	$ -
49			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

				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			-									$ -	$ -
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112			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

				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			-									$ -	$ -
				$ 18,796,967	$ 11,163,031	$ 29,474,500	$ 39,523,272	$ 7,858,666	$ 10,882,670	$ 34,040,201	$ 44,256,401		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 24,501,191	$ 11,163,031	$ 39,994,810	$ 39,523,272	$ 10,528,643	$ 10,882,670	$ 42,944,071	$ 44,256,401	$ 117,968,715	$ 105,825,374
129	Total Charges per PS&R or Exhibit Detail	$ 24,501,191	$ 11,163,031	$ 39,994,810	$ 39,523,272	$ 10,528,643	$ 10,882,670	$ 42,944,071	$ 44,256,401		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 6,306,574	$ 2,156,285	$ 10,425,712	$ 7,913,830	$ 2,672,721	$ 1,803,890	$ 10,616,001	$ 7,361,623	$ 30,021,008	$ 19,235,628
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,955,584	$ 1,185,420			$ 34,383	$ 127,463	$ 12,859	$ 258,119	$ 2,002,826	$ 1,571,002
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 4,357,468	$ 4,951,781		$ 247	$ 75,391	$ 75,768	$ 4,432,859	$ 5,027,796
134	Private Insurance (including primary and third party liability)	$ 2,916	$ 576	$ 9,878	$ 7,776		$ 2,150	$ 9,774,404	$ 6,489,940	$ 9,787,199	$ 6,500,442
135	Self-Pay (including Co-Pay and Spend-Down)	$ 33,798	$ 13,676	$ 19,598	$ 17,492	$ 1,635	$ 1,621	$ 3,817	$ 20,503	$ 58,847	$ 53,292
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,992,298	$ 1,199,673	$ 4,386,944	$ 4,977,049						
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)	$ 15,734				$ 1,945,788	$ 1,153,374			$ 1,961,522	$ 1,153,374
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)**	$ 4,298,542	$ 956,612	$ 6,038,768	$ 2,936,781	$ 690,916	$ 519,035	$ 749,530	$ 517,294	$ 11,777,755	$ 4,929,722
144	**Calculated Payments as a Percentage of Cost**	32%	56%	42%	63%	74%	71%	93%	93%	61%	74%

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 MCG HEALTH

		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	$12,223,356.00	$ 540,906	$ 12,764,262		125					$ 2,402,464	6	$ 4,118,510	10				
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**	$ 12,223,356	$ 540,906	$ 12,764,262	$ -	125	$ -	-	$ -	-	$ 2,402,464	6	$ 4,118,510	10	$ -	-	$ -	-
10	**Total Cost**							-		-		612,685		1,021,141		-		-

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

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		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	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	$ 12,223,356	$ 540,906	$ 12,764,262	$ -	125			$ 411,851	1	$ 755,060	2	$ 411,851	1
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ 12,223,356	$ 540,906	$ 12,764,262	$ -	125	$ -	-	$ 411,851	1	$ 755,060	2	$ 411,851	1
20	**Total Cost**							-		102,114		204,228		102,114

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

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Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 11,080,866		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	150000-410001	*(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 ---------->)		$ 11,080,866		
	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		$ 11,080,866
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	1,160,272,513
19	Uninsured Hospital	**Charges Sec. G**	307,646,371
20	Total Hospital	**Charges Sec. G**	4,852,292,297
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		23.91%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.34%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 2,649,639
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 702,552
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 3,352,191**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	643,195,509
27	Uninsured Hospital	**Charges Sec. G**	314,881,207
28	Total Hospital	**Charges Sec. G**	4,852,292,297
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		13.26%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.49%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 1,468,824
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 719,074
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 2,187,898**

** 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.*