

SFY 2026 Medicaid ICTF Survey

Wellstar North Fulton Hospital

A. General DSH Year Information

1 DSH Year:

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

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

Identification of cost reports needed to cover the DSH Year:

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

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

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

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

Data	
	000275976A
	0
	0
	110198

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)
Yes
No
No
Yes
11/1/1983

- 1 Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)
- 2 Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 3 Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?
- 3a Was the hospital open as of December 22, 1987?
- 3b What date did the hospital open?

C. Disclosure of Other Medicaid Payments Received:

For State DSH Year 2026

- 1 **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** \$ 1,200,194
(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 Services 07/01/2025 - 06/30/2026** \$ 1,200,194

Certification:


Answer
Yes

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

Explanation for "No" answers:

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

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

 _____ Hospital CEO or CFO Signature	CFO _____ Title	11/11/25 _____ 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:

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11/11/25

Hospital Contact:

Name	Ebbie Erzuah
Title	Executive Director of Reimbursement
Telephone Number	(470) 956-4981
E-Mail Address	ebenezer.erzuah@wellstar.org
Mailing Street Address	1800 Parkway Place, Suite 500
Mailing City, State, Zip	Manetta GA 30067

Outside Preparer:

Name	Michael Watson
Title	Consultant
Firm Name	Southeast Reimbursement Group
Telephone Number	770-928-3352 ext 401
E-Mail Address	michael.watson@srqlic.org

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 NORTH FULTON REGIONAL HOSP

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

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

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

1 - As Submitted

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

12/19/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR NORTH FULTON REGIONAL HOSP	Yes	
5. Medicaid Provider Number:	000275976A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110198	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		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

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

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-		
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-		
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-		
4. Total Section 1011 Payments Related to Hospital Services (See Note 1)		\$-		
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-		
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-		
7. Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)		\$-		
8. Out-of-State DSH Payments (See Note 2)	\$	-		
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)				\$2,533,968
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)				\$17,325,511
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)				\$19,859,479
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:				
		15.89%	11.71%	12.76%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? <i>Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.</i>		No		
14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	\$	-		
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	\$	-		
16. Total Medicaid managed care non-claims payments (see question 13 above) received		\$-		

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

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

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

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 60,107 (See Note in Section F-3, below)

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

2. Inpatient Hospital Subsidies	1,800
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	\$ 1,800
7. Inpatient Hospital Charity Care Charges	79,974,632
8. Outpatient Hospital Charity Care Charges	54,739,938
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 134,714,570

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$313,420,621.00			\$ 253,070,388	-	-	\$ 60,350,233
12. Subprovider I (Psych or Rehab)	\$0.00			-	-	-	-
13. Subprovider II (Psych or Rehab)	\$34,416,347.00			\$ 27,789,359	-	-	\$ 6,626,988
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	\$711,212,606.00	\$650,172,682.00		\$ 574,266,139	\$ 524,979,666	-	\$ 262,139,483
20. Outpatient Services		\$166,199,071.00			\$ 134,196,860	-	\$ 32,002,211
21. Home Health Agency			\$0.00			-	
22. Ambulance			\$ 301,961			\$ 243,817	
23. Outpatient Rehab Providers			\$0.00	-	-	-	-
24. ASC	\$0.00	\$0.00		-	-	-	-
25. Hospice			\$0.00	-	-	-	-
26. Other	\$0.00	\$0.00	\$0.00	-	-	-	-
27. Total	\$ 1,059,049,574	\$ 816,371,753	\$ 301,961	\$ 855,125,887	\$ 659,176,526	\$ 243,817	\$ 361,118,914
28. Total Hospital and Non Hospital		Total from Above	\$ 1,875,723,288		Total from Above	\$ 1,514,546,230	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,875,723,288	Total Contractual Adj. (G-3 Line 2)	1,501,479,545
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)			+	16,418,804
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)			-	3,352,119
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36. Adjusted Contractual Adjustments				1,514,546,230
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 NORTH FULTON REGIONAL HOSP

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)		Calculated Per Diem

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

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 58,880,193	\$ 223,891	\$ 13,697	\$0.00	\$ 59,117,781	46,430	\$214,594,087.00	\$ 1,273.27
2	03100	INTENSIVE CARE UNIT	\$ 33,471,893	\$ -	\$ 21,084		\$ 33,492,977	13,110	\$71,228,580.00	\$ 2,554.77
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ 4,498,506	\$ -	\$ 15,585		\$ 4,514,091	1,426	\$16,009,666.00	\$ 3,165.56
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 3,401,308	\$ -	\$ -		\$ 3,401,308	2,090	\$10,303,695.00	\$ 1,627.42
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 100,251,900	\$ 223,891	\$ 50,366	\$ -	\$ 100,526,157	63,056	\$ 312,136,028	
19		Weighted Average								\$ 1,594.24

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)	3,296	-	\$ 4,196,698	\$3,887,165.00	\$908,405.00	\$ 4,795,570	0.875120

		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col. 2 and Col. 4	Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$41,330,144.00	\$ 957,768	\$ 473	\$ 42,288,385	\$187,211,419.00	\$196,609,878.00	\$ 383,821,297	0.110177
22	5200	DELIVERY ROOM & LABOR ROOM	\$8,712,441.00	\$ -	\$ -	\$ 8,712,441	\$21,250,887.00	\$165,190.00	\$ 21,416,077	0.406818
23	5400	RADIOLOGY-DIAGNOSTIC	\$23,015,214.00	\$ -	\$ -	\$ 23,015,214	\$106,251,732.00	\$188,881,526.00	\$ 295,133,258	0.077982
24	6000	LABORATORY	\$13,681,363.00	\$ -	\$ 23,004	\$ 13,704,367	\$107,974,006.00	\$49,346,718.00	\$ 157,320,724	0.087111
25	6300	BLOOD STORING PROCESSING & TRANS.	\$1,757,202.00	\$ -	\$ -	\$ 1,757,202	\$15,247,123.00	\$766,069.00	\$ 16,013,192	0.109735
26	6500	RESPIRATORY THERAPY	\$10,975,571.00	\$ -	\$ 7,037	\$ 10,982,608	\$72,047,660.00	\$25,259,211.00	\$ 97,306,871	0.112866
27	6600	PHYSICAL THERAPY	\$8,912,576.00	\$ -	\$ -	\$ 8,912,576	\$23,190,318.00	\$11,739,736.00	\$ 34,930,054	0.255155
28	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$34,723,433.00	\$ -	\$ -	\$ 34,723,433	\$48,996,179.00	\$27,590,305.00	\$ 76,586,484	0.453389
29	7200	IMPL. DEV. CHARGED TO PATIENTS	\$17,470,518.00	\$ -	\$ -	\$ 17,470,518	\$30,046,772.00	\$28,290,585.00	\$ 58,337,357	0.299474

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR NORTH FULTON REGIONAL HOSP

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	7300 DRUGS CHARGED TO PATIENTS	\$22,850,107.00	\$ -	\$ -	\$ 22,850,107	\$85,389,056.00	\$44,963,803.00	\$ 130,352,859	0.175294
31	7400 RENAL DIALYSIS	\$1,348,090.00	\$ -	\$ -	\$ 1,348,090	\$11,649,584.00	\$8,957,142.00	\$ 20,606,726	0.065420
32	7606 INFUSION THERAPY	\$1,643,299.00	\$ -	\$ -	\$ 1,643,299	\$384,160.00	\$3,979,019.00	\$ 4,363,179	0.376629
33	7625 SLEEP DISORDERS	\$1,499,907.00	\$ -	\$ -	\$ 1,499,907	\$4,362,266.00	\$8,089,650.00	\$ 12,451,916	0.120456
34	7626 WOUND CARE	\$1,847,902.00	\$ -	\$ 8,794	\$ 1,856,696	\$4,303,723.00	\$1,155,944.00	\$ 5,459,667	0.340075
35	7697 CARDIAC REHABILITATION	\$1,663,034.00	\$ -	\$ -	\$ 1,663,034	\$668,582.00	\$4,337,632.00	\$ 5,006,214	0.332194
36	7699 LITHOTRIPSY	\$640.00	\$ -	\$ -	\$ 640	\$0.00	\$266,295.00	\$ 266,295	0.002403
37	9001 RADIOLOGY CLINIC	\$4,269,265.00	\$ -	\$ 3,814	\$ 4,273,079	\$18,553,562.00	\$40,719,711.00	\$ 59,273,273	0.072091
38	9002 DIAGNOSTIC RADIOLOGY CLINIC	\$604,422.00	\$ -	\$ -	\$ 604,422	\$13,543,999.00	\$7,908,502.00	\$ 21,452,501	0.028175
39	9100 EMERGENCY	\$21,149,753.00	\$ 278,156	\$ 12,333	\$ 21,440,242	\$40,800,697.00	\$103,072,056.00	\$ 143,872,753	0.149022
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 NORTH FULTON REGIONAL HOSP

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	\$ 217,454,881	\$ 1,235,924	\$ 55,455	\$ 218,746,260	\$ 795,758,890	\$ 753,007,377	\$ 1,548,766,267	
127	Weighted Average								0.143949
128	Sub Totals	\$ 317,706,781	\$ 1,459,815	\$ 105,821	\$ 319,272,417	\$ 1,107,894,918	\$ 753,007,377	\$ 1,860,902,295	
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				\$ 319,272,417				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				0.46%				

* 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 NORTH FULTON REGIONAL HOSP

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,273.27		1,935	1,434	1,059	1,751	46	4,980	6,225	26.63%							
2	03100 INTENSIVE CARE UNIT	\$ 2,554.77		1,147	163	209	372	4	1,048	1,895	22.94%							
3	03200 CORONARY CARE UNIT	\$ -		-	-	-	-	-	-	-								
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-								
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-								
6	03500 OTHER SPECIAL CARE UNIT	\$ 3,165.56		137	320	-	45	10	220	512	61.33%							
7	04000 SUBPROVIDER I	\$ -		-	-	-	-	-	-	-								
8	04100 SUBPROVIDER II	\$ -		-	-	-	-	-	-	-								
9	04200 OTHER SUBPROVIDER	\$ -		-	-	-	-	-	-	-								
10	04300 NURSERY	\$ 1,627.42		175	500	-	47	16	313	738	90.29%							
11	\$ -			-	-	-	-	-	-	-								
12	\$ -			-	-	-	-	-	-	-								
13	\$ -			-	-	-	-	-	-	-								
14	\$ -			-	-	-	-	-	-	-								
15	\$ -			-	-	-	-	-	-	-								
16	\$ -			-	-	-	-	-	-	-								
17	\$ -			-	-	-	-	-	-	-								
18	\$ -			-	-	-	-	-	-	-								
19	Total Days			3,394	2,417	1,268	2,215	76	6,561	9,370	29.82%							
20	Total Days per PS&R or Exhibit Detail			3,394	2,417	1,268	2,215	76	6,561									
21	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-								
22	Routine Charges			\$ 18,572,064	\$ 12,210,085	\$ 6,285,924	\$ 11,843,274	\$ 376,435	\$ 34,722,429	\$ 48,911,348	27.32%							
23	Calculated Routine Charge Per Diem			\$ 5,472.03	\$ 5,051.75	\$ 4,957.35	\$ 5,346.85	\$ 4,953.09	\$ 5,292.25	\$ 5,219.99								
24	Ancillary Cost Centers (from WIS C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges						
25	09200 Observation (Non-Distinct)		0.875120	1,004,956	218,888	112,101	135,645	24,687	43,780	239,398	116,540	173,935	271,903	\$ 1,381,141	\$ 514,653	49.87%		
26	5000 OPERATING ROOM		0.110177	6,830,936	2,477,513	5,344,246	5,282,426	2,683,538	1,930,639	6,785,619	5,780,155	214,105	24,203,478	5,950,616	\$ 21,614,339	\$ 15,470,733	17.70%	
27	5200 DELIVERY ROOM & LABOR ROOM		0.406818	626,998	-	5,042,136	31,585	24,136	-	802,703	134	219,300	2,484,064	16,906	\$ 6,495,973	\$ 31,720	43.16%	
28	5400 RADIOLOGY-DIAGNOSTIC		0.077892	4,039,336	1,700,010	1,197,548	3,443,251	1,719,766	2,262,179	3,599,136	3,821,575	27,063	14,393,749	20,523,363	\$ 10,525,768	\$ 11,031,016	18.44%	
29	6000 LABORATORY		0.087111	5,917,592	801,388	2,650,575	2,247,671	2,438,813	585,039	3,790,418	1,339,823	89,194	12,278,432	8,378,626	\$ 14,797,398	\$ 4,973,221	30.27%	
30	6300 BLOOD STORING, PROCESSING & TRANS.		0.109735	1,089,008	37,386	291,817	56,396	426,760	6,305	435,164	54,369	88,572	2,353,955	188,358	\$ 2,242,749	\$ 154,456	31.56%	
31	6500 RESPIRATORY THERAPY		0.112866	5,358,154	189,196	1,997,249	256,167	1,768,387	643,356	3,065,949	578,037	39,135	6,248,419	1,652,631	\$ 12,189,738	\$ 1,666,751	22.44%	
32	6600 PHYSICAL THERAPY		0.255155	646,054	32,878	620,469	223,415	249,852	327,403	696,118	459,871	1,634	1,588,756	725,158	\$ 2,111,690	\$ 1,034,567	19.79%	
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.453389	1,818,895	208,463	955,548	548,561	798,318	184,999	1,709,435	558,228	69,432	5,409,688	900,623	\$ 5,282,196	\$ 1,500,250	17.86%	
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.299474	876,083	512,302	377,517	613,493	559,599	180,800	761,089	505,058	-	3,059,191	610,600	\$ 2,574,287	\$ 1,731,653	13.84%	
35	7300 DRUGS CHARGED TO PATIENTS		0.175294	4,712,893	812,131	2,007,985	941,100	2,139,000	286,934	3,158,969	1,259,506	48,235	9,540,349	2,603,142	\$ 12,018,846	\$ 3,299,670	22.22%	
36	7400 RENAL DIALYSIS		0.065420	109,540	-	399,526	91,733	676,201	69,359	849,047	41,338	7,263	1,578,444	5,202,778	\$ 2,022,414	\$ 202,440	18.95%	
37	7606 INFUSION THERAPY		0.376629	35,281	-	102,451	7,731	36,144	8,043	114,790	202	786	55,722	583,109	\$ 253,384	\$ 21,825	31.85%	
38	7625 SLEEP DISORDERS		0.120456	47,842	-	55,733	166,282	126,319	95,732	262,735	136,961	3,241	474,927	3,134,390	\$ 492,629	\$ 398,974	36.30%	
39	7626 WOUND CARE		0.340075	38,867	-	148,719	16,509	233,962	-	302,627	716	2,601	561,918	358	\$ 724,175	\$ 17,225	24.00%	
40	7697 CARDIAC REHABILITATION		0.332194	643,966	103,177	-	35,136	16,350	48,891	13,080	51,082	-	107,910	123,239	\$ 673,396	\$ 236,286	22.91%	
41	7699 LITHOTRIPSY		0.002403	-	-	53,250	-	-	-	-	-	-	-	-	\$ 53,259	\$ 30,000	30.00%	
42	9001 RADIOLOGY CLINIC		0.072091	276,751	137,114	465,297	1,026,303	280,202	379,031	828,731	941,240	11,250	2,241,298	2,967,401	\$ 1,850,986	\$ 2,483,688	16.31%	
43	9002 DIAGNOSTIC RADIOLOGY CLINIC		0.028175	165,358	-	216,749	180,069	255,371	99,737	392,559	158,952	12,492	1,422,248	264,501	\$ 1,030,037	\$ 418,758	14.98%	
44	9100 EMERGENCY		0.149022	1,179,516	1,261,325	512,391	4,792,672	853,087	1,002,938	1,083,360	2,486,599	8,156	5,267,892	21,838,081	\$ 3,638,354	\$ 9,543,534	26.67%	
45				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
46				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
47				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
48				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
49				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
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51				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	
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71				-	-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	-	

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR NORTH FULTON REGIONAL HOSP

			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 Base											
72																												
73																												
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			\$	35,383,300	\$	8,491,570	\$	22,319,984	\$	20,228,119	\$	15,281,279	\$	8,103,275	\$	28,734,178	\$	18,195,974	\$	811,814	\$	124,923	\$	93,444,356	\$	76,035,783		

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR NORTH FULTON REGIONAL HOSP

	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)	\$ 53,955,364	\$ 8,491,570	\$ 34,530,068	\$ 20,228,119	\$ 21,567,203	\$ 8,103,275	\$ 40,577,452	\$ 18,195,974	\$ 1,188,249	\$ 124,923	\$ 128,166,785	\$ 76,035,783	\$ 150,630,087	\$ 55,018,939	23.38%	
129 Total Charges per PS&R or Exhibit Detail	\$ 53,955,364	\$ 8,491,570	\$ 34,530,068	\$ 20,228,119	\$ 21,567,203	\$ 8,103,275	\$ 40,577,452	\$ 18,195,974	\$ 1,188,249	\$ 124,923	(Agrees to Exhibit A)	(Agrees to Exhibit A)				
130 Unreconciled Charges (Explain Variance)											\$ 128,166,785	\$ 76,035,783				
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 12,073,457	\$ 1,322,900	\$ 8,631,945	\$ 2,742,431	\$ 4,072,325	\$ 1,025,120	\$ 7,847,042	\$ 2,471,930		\$ 304,565	\$ 14,545	\$ 24,050,773	\$ 9,139,730	\$ 32,624,769	\$ 7,562,471	23.38%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 5,521,914	\$ 917,196												\$ 5,521,914	\$ 917,196	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 3,852,264	\$ 2,106,120										\$ 3,852,264	\$ 2,106,120	
134 Private Insurance (including primary and third party liability)									\$ 6,799,423	\$ 2,248,336				\$ 6,799,423	\$ 2,248,336	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 132,046	\$ 21,799	\$ 53	\$ 3,099			\$ 807							\$ 133,418	\$ 30,080	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 5,653,960	\$ 938,995	\$ 3,852,317	\$ 2,109,219												
137 Medicaid Cost Settlement Payments (See Note B)		\$ 88,967													\$ 88,967	
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)					\$ 2,984,386	\$ 659,677								\$ 2,984,386	\$ 659,677	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)																
141 Medicare Cross-Over Bad Debt Payments					\$ 117,030	\$ 26,676								\$ 117,030	\$ 26,676	
142 Other Medicare Cross-Over Payments (See Note D)					\$ (173,323)	\$ 2,424								\$ (173,323)	\$ 2,424	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 790,163	\$ 1,743,805				
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)	\$ 6,419,497	\$ 295,028	\$ 4,779,628	\$ 633,212	\$ 1,144,232	\$ 335,536	\$ 1,046,300	\$ 219,219	\$ 304,562	\$ 14,545	\$ 23,260,610	\$ 7,395,925	\$ 13,389,657	\$ 1,482,995		
146 Calculated Payments as a Percentage of Cost	47%	78%	45%	77%	72%	67%	87%	91%	0%	0%	3%	10%	59%	80%		
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					30,283										4%	
148 Percent of cross-over days to total Medicare days from the cost report																

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR NORTH FULTON REGIONAL HOSP

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,273.27			212		31		40		283		
2	03100 INTENSIVE CARE UNIT	\$ 2,554.77			39		1		24		64		
3	03200 CORONARY CARE UNIT	\$ -			-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	\$ -			-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -			-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	\$ 3,165.56			-		-		-		-		
7	04000 SUBPROVIDER I	\$ -			-		-		-		-		
8	04100 SUBPROVIDER II	\$ -			-		-		-		-		
9	04200 OTHER SUBPROVIDER	\$ -			-		-		-		-		
10	04300 NURSERY	\$ 1,627.42			-		-		-		-		
11		\$ -			-		-		-		-		
12		\$ -			-		-		-		-		
13		\$ -			-		-		-		-		
14		\$ -			-		-		-		-		
15		\$ -			-		-		-		-		
16		\$ -			-		-		-		-		
17		\$ -			-		-		-		-		
18		\$ -			-		-		-		-		
			Total Days		-		251		32		64		347
19	Total Days per PS&R or Exhibit Detail				-		251		32		64		
20	Unreconciled Days (Explain Variance)				-		-		-		-		
			Routine Charges		\$ -		\$ 1,102,847		\$ 93,439		\$ 433,922		\$ 1,630,208
21	Routine Charges				\$ -		\$ 4,393,81		\$ 2,919,97		\$ 6,780,04		\$ 4,698,01
21.01	Calculated Routine Charge Per Diem				\$ -		\$ -		\$ -		\$ -		\$ -
	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
22	09200 Observation (Non-Distinct)	0.875120	2,634	5,819	4,324	2,910	34,010	-	42,739	6,958			
23	5000 OPERATING ROOM	0.110177	18,343	353,651	822	27,892	-	68,147	449,690	19,165			
24	5200 DELIVERY ROOM & LABOR ROOM	0.406818	-	-	-	-	-	-	-	-			
25	5400 RADIOLOGY-DIAGNOSTIC	0.077982	18,375	379,970	197,822	36,915	38,783	128,127	43,724	545,013	298,705		
26	6000 LABORATORY	0.087111	21,944	422,013	161,127	57,858	9,348	96,349	12,290	576,219	204,709		
27	6300 BLOOD STORING PROCESSING & TRANS.	0.109735	-	48,797	-	6,305	-	-	-	55,102	-		
28	6500 RESPIRATORY THERAPY	0.112866	3,920	32,614	16,708	6,391	3,920	5,488	2,352	44,493	26,900		
29	6600 PHYSICAL THERAPY	0.255155	-	38,146	4,784	2,041	1,842	7,821	-	48,008	6,626		
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.453309	2,126	90,390	3,552	9,959	111	28,490	-	128,838	5,789		
31	7200 IMPL. DEV. CHARGED TO PATIENTS	0.299474	-	98,543	-	-	-	-	-	98,543	-		
32	7300 DRUGS CHARGED TO PATIENTS	0.175294	3,116	1,080,623	45,116	37,880	2,146	278,715	2,150	1,397,218	52,528		
33	7400 RENAL DIALYSIS	0.065420	-	10,357	-	-	-	314	-	10,671	-		
34	7606 INFUSION THERAPY	0.376629	1,095	-	3,650	1,563	-	-	-	1,563	4,745		
35	7625 SLEEP DISORDERS	0.120456	-	7,809	-	-	-	14,178	-	21,987	-		
36	7626 WOUND CARE	0.340075	-	3,709	-	-	-	112	-	3,821	-		
37	7697 CARDIAC REHABILITATION	0.332194	-	-	-	-	4,220	-	-	-	4,220		
38	7699 LITHOTRIPSY	0.002403	-	-	-	-	-	-	-	-	-		
39	9001 RADIOLOGY CLINIC	0.072091	4,946	15,647	55,643	1,624	4,377	5,618	12,962	22,889	77,927		
40	9002 DIAGNOSTIC RADIOLOGY CLINIC	0.028175	-	50,980	-	2,686	-	8,708	-	62,374	-		
41	9100 EMERGENCY	0.149022	61,915	122,683	436,468	58,167	44,724	40,208	33,573	221,058	576,680		
42													
43													
44													
45													
46													
47													
48													
49													

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR NORTH FULTON REGIONAL HOSP

		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										\$ -	\$ -
		\$ -	\$ 138,414	\$ 2,761,751	\$ 930,015	\$ 252,190	\$ 109,471	\$ 716,285	\$ 107,051	\$ -	\$ -

Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 138,414	\$ 3,864,598	\$ 930,015	\$ 345,629	\$ 109,471	\$ 1,150,207	\$ 107,051	\$ 5,360,435	\$ 1,284,952
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 138,414	\$ 3,864,598	\$ 930,015	\$ 345,629	\$ 109,471	\$ 1,150,207	\$ 107,051		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 19,618	\$ 782,434	\$ 116,392	\$ 78,103	\$ 13,560	\$ 240,699	\$ 11,060	\$ 1,101,236	\$ 160,630
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 992							\$ -	\$ 992
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 89,941	\$ 48,167					\$ 89,941	\$ 48,167
134	Private Insurance (including primary and third party liability)							\$ 28,415	\$ 5,472	\$ 28,415	\$ 5,472
135	Self-Pay (including Co-Pay and Spend-Down)				\$ 3,515				\$ 170	\$ -	\$ 3,685
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 992	\$ 89,941	\$ 51,682					\$ -	\$ -
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)					\$ 70,200	\$ 8,214			\$ 70,200	\$ 8,214
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)	\$ -	\$ 18,626	\$ 692,493	\$ 64,710	\$ 7,903	\$ 5,346	\$ 212,284	\$ 5,418	\$ 912,680	\$ 94,100
144	Calculated Payments as a Percentage of Cost	0%	5%	11%	44%	90%	61%	12%	51%	17%	41%

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 NORTH FULTON REGIONAL HOSP

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

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

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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)*	\$ 3,352,119	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	450003412590.00 (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 ----->)	\$ 3,352,119	
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	\$ 3,352,119
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	213,607,584
19 Uninsured Hospital Charges Sec. G	204,202,568
20 Total Hospital Charges Sec. G	1,860,902,295
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	11.48%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	10.97%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC**	\$ 384,780
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 367,838
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles***	\$ 752,618
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	122,138,149
27 Uninsured Hospital Charges Sec. G	205,515,740
28 Total Hospital Charges Sec. G	1,860,902,295
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	6.56%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	11.04%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC**	\$ 220,012
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 370,204
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC**	\$ 590,216

* 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.