SFY 2026 Medicaid ICTF Survey

Wellstar Spalding Regional Hospital

A. General DSH Year Information

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

2 Select Your Facility from the Drop-Down Menu Provided: WELLSTAR SPALDING REGIONAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	07/01/2023	06/30/2024	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number	000000866A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab)	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab)	0
9. Medicare Provider Number:	110031

B. DSH Qualifying Information

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

During the DSH Examination Year:

		DSH Examination Year (07/01/25 - 06/30/26)
1	Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2	Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3	Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a	Was the hospital open as of December 22, 1987?	Yes
3b	What date did the hospital open?	7/1/1966

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** — $ 2,742,776

   (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** — $ 2,742,776

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: CFO | Date: 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	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	Marietta, GA 30067

Outside Preparer:

Name	David Pylate
Title	Manager
Firm Name	Southeast Reimbursement Group, LLC
Telephone Number	770-928-3352 Ext 402
E-Mail Address	david.pylate@srgllc.org

11/11/25

11/11/25

DSH Version 9.02 4/22/2025

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

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

1. Select Your Facility from the Drop-Down Menu Provided: WELLSTAR SPALDING REGIONAL HOSPITAL

	7/1/2023 through 6/30/2024		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	12/19/2024		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR SPALDING REGIONAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000866A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110031	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	Florida	020770400
13. State Name & Number	Illinois	1972535318
14. State Name & Number	Oklahoma	200214650A
15. State Name & Number	South Carolina	10499B
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)

	Amount
1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 409,746	$ 507,941	$917,687
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,088,061	$ 3,846,562	$4,934,623
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$1,497,807	$4,354,503	$5,852,310
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	27.36%	11.66%	15.68%

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.

	Amount
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)	38,616	**(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	-
3. Outpatient Hospital Subsidies	21,592
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	$ 21,592
7. Inpatient Hospital Charity Care Charges	30,581,551
8. Outpatient Hospital Charity Care Charges	53,208,930
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 83,790,481

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	$208,401,519.00			$ 176,363,006	$ -	$ -	$ 32,038,513
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	$472,472,908.00	$505,961,771.00		$ 399,837,499	$ 428,177,967	$ -	$ 150,419,212
20. Outpatient Services		$0.00			$ -	$ -	$ -
21. Home Health Agency			$0.00			$ -	
22. Ambulance	-	-	$ 36,033,407	-	-	$ 30,493,827	-
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	$ 680,874,427	$ 505,961,771	$ 36,033,407	$ 576,200,505	$ 428,177,967	$ 30,493,827	$ 182,457,725
28. Total Hospital and Non Hospital		Total from Above	$ 1,222,869,605		Total from Above	$ 1,034,872,300	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,222,869,605	Total Contractual Adj. (G-3 Line 2)	1,031,286,054
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)			+	5,653,403
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	2,067,157
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				1,034,872,300
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 SPALDING REGIONAL HOSPITAL

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

Line #	Code	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	$ 37,791,789	$ 3,894,330	$ -	$0.00	$ 41,686,119	34,279	$152,799,757.00		$ 1,216.08
2	03100	INTENSIVE CARE UNIT	$ 13,212,654	$ 919,106	$ 14,484		$ 14,146,244	4,613	$32,465,986.00		$ 3,066.60
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ 2,426,277	$ -	$ 5,608		$ 2,431,885	937	$11,215,723.00		$ 2,595.39
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 1,295,851	$ -	$ -		$ 1,295,851	1,473	$4,244,550.00		$ 879.74
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 54,726,571	$ 4,813,436	$ 20,092	$ -	$ 59,560,099	41,302	$ 200,726,016		
19		Weighted Average									$ 1,442.06

Line #	Code	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)		2,773	-	-	$ 3,372,190	$6,210,433.00	$4,236,486.00	$ 10,446,919	0.322793

Line #	Code	Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5000	OPERATING ROOM	$14,582,053.00	$ -	$ -		$ 14,582,053	$75,935,828.00	$86,376,738.00	$ 162,312,566	0.089839
22	5200	DELIVERY ROOM & LABOR ROOM	$6,724,345.00	$ -	$ 230		$ 6,724,575	$9,775,598.00	$9,196.00	$ 9,784,794	0.687247
23	5400	RADIOLOGY-DIAGNOSTIC	$9,299,193.00	$ -	$ -		$ 9,299,193	$57,212,452.00	$121,185,070.00	$ 178,397,522	0.052126
24	6000	LABORATORY	$7,797,796.00	$ -	$ 6,768		$ 7,804,564	$89,277,075.00	$61,377,463.00	$ 150,654,538	0.051804
25	6300	BLOOD STORING PROCESSING & TRANS.	$2,261,423.00	$ -	$ -		$ 2,261,423	$9,260,808.00	$6,227,949.00	$ 15,488,757	0.146004
26	6400	INTRAVENOUS THERAPY	$943,547.00	$ -	$ -		$ 943,547	$760,829.00	$2,548,891.00	$ 3,309,720	0.285084
27	6500	RESPIRATORY THERAPY	$4,881,397.00	$ -	$ 2,255		$ 4,883,652	$49,595,201.00	$3,645,912.00	$ 53,241,113	0.091727
28	6600	PHYSICAL THERAPY	$4,489,239.00	$ -	$ -		$ 4,489,239	$7,315,805.00	$10,724,293.00	$ 18,040,098	0.248848
29	6900	ELECTROCARDIOLOGY	$3,493,473.00	$ -	$ -		$ 3,493,473	$27,742,265.00	$17,056,618.00	$ 44,798,883	0.077981

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) | WELLSTAR SPALDING REGIONAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$7,806,479.00	$ -	$ -	$ 7,806,479	$16,825,795.00	$8,148,529.00	$ 24,974,324	0.312580
31	7200	IMPL. DEV. CHARGED TO PATIENTS	$3,875,441.00	$ -	$ -	$ 3,875,441	$5,426,653.00	$5,817,143.00	$ 11,243,796	0.344674
32	7300	DRUGS CHARGED TO PATIENTS	$15,224,177.00	$ -	$ -	$ 15,224,177	$53,959,498.00	$32,948,292.00	$ 86,907,790	0.175176
33	7400	RENAL DIALYSIS	$2,338,971.00	$ -	$ -	$ 2,338,971	$24,671,182.00	$1,138,594.00	$ 25,809,776	0.090623
34	7625	SLEEP DISORDERS	$703,675.00	$ -	$ 2,060	$ 705,735	$712,785.00	$5,389,180.00	$ 6,101,965	0.115657
35	7626	WOUND CARE	$1,491,324.00	$ -	$ -	$ 1,491,324	$5,456,862.00	$35,611,249.00	$ 41,068,111	0.036313
36	9100	EMERGENCY	$20,913,133.00	$ 252,958	$ 56,732	$ 21,222,823	$39,798,108.00	$103,726,084.00	$ 143,524,192	0.147869
37			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) | WELLSTAR SPALDING REGIONAL HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
91		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 106,825,666	$ 252,958	$ 68,045	$ 107,146,669	$ 479,937,177	$ 506,167,687	$ 986,104,864	
127	**Weighted Average**								0.112076
128	**Sub Totals**	$ 161,552,237	$ 5,066,394	$ 88,137	$ 166,706,768	$ 680,663,193	$ 506,167,687	$ 1,186,830,880	
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**				$ 166,706,768				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				3.13%				

* 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 SPALDING REGIONAL HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		
Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	% Survey to Cost Report Totals (Includes all payers)
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal	From Hospital's Own Internal			
		Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000	ADULTS & PEDIATRICS	$ 1,216.08		2,909		1,628		1,395		3,921		346		2,794		10,199		41.41%
2	03100	INTENSIVE CARE UNIT	$ 3,066.60		463		45		221		355		5		318		1,089		30.52%
3	03200	CORONARY CARE UNIT	$ -														-		
4	03300	BURN INTENSIVE CARE UNIT	$ -														-		
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500	OTHER SPECIAL CARE UNIT	$ 2,595.39		120		558				16		5		16		699		76.31%
7	04000	SUBPROVIDER I	$ -														-		
8	04100	SUBPROVIDER II	$ -														-		
9	04200	OTHER SUBPROVIDER	$ -														-		
10	04300	NURSERY	$ 879.74		64		1,049				66		4		61		1,183		84.45%
11			$ -														-		
12			$ -														-		
13			$ -														-		
14			$ -														-		
15			$ -														-		
16			$ -														-		
17			$ -														-		
18				Total Days	3,556		3,280		1,616		4,358		360		3,189		13,170		39.74%
19		Total Days per PS&R or Exhibit Detail			3,556		3,280		1,616		4,358		360		3,189				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 18,194,355		$ 16,223,606		$ 8,600,760		$ 22,014,175		$ 1,338,250		$ 15,538,737		$ 65,032,896		40.28%
21.01		Calculated Routine Charge Per Diem			$ 5,116.52		$ 4,946.22		$ 5,322.25		$ 5,051.44		$ 3,717.36		$ 4,872.60		$ 4,937.96		
		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)		0.322793	1,710,146	1,724,973	342,790	336,891	40,789	84,093	1,102,623	535,564	-	-	170,082	188,343	$ 3,196,348	$ 2,681,521	59.93%
23	5000	OPERATING ROOM		0.089839	3,931,239	2,788,839	8,402,120	6,674,831	2,194,549	1,891,075	7,798,235	8,857,976	180,534	91,409	6,125,886	3,005,757	$ 22,326,143	$ 20,212,721	32.09%
24	5200	DELIVERY ROOM & LABOR ROOM		0.687247	321,767	-	5,541,874	-	38,263	-	1,477,797	-	-	-	92,385	-	$ 7,379,701	$ -	76.58%
25	5400	RADIOLOGY-DIAGNOSTIC		0.052126	4,380,078	5,425,092	1,427,439	8,675,609	2,356,947	2,683,198	6,227,000	10,361,807	237,389	119,563	4,920,010	15,688,312	$ 14,391,464	$ 27,145,706	35.17%
26	6000	LABORATORY		0.051804	7,575,326	3,831,566	4,751,465	6,286,016	3,784,871	1,396,075	10,361,034	6,023,232	302,138	96,766	7,227,582	7,508,255	$ 26,472,696	$ 17,536,889	39.47%
27	6300	BLOOD STORING PROCESSING & TRANS.		0.146004	695,761	272,703	374,760	202,971	474,466	176,974	1,059,355	652,987	27,551	15,558	825,990	454,375	$ 2,604,342	$ 1,305,635	34.02%
28	6400	INTRAVENOUS THERAPY		0.285084	746,946	1,279,021	30,568	577,207	3,347	72,476	13,831	436,994	-	3,719	7,613	136,877	$ 794,692	$ 2,365,698	100.00%
29	6500	RESPIRATORY THERAPY		0.091727	6,242,450	232,533	1,541,781	426,374	2,760,396	90,064	6,294,864	384,709	201,831	14,655	2,759,075	407,001	$ 16,839,491	$ 1,133,680	40.26%
30	6600	PHYSICAL THERAPY		0.248848	513,169	194,209	284,684	1,996,172	286,958	175,658	807,851	1,173,209	114,132	100,922	535,602	1,101,062	$ 1,892,662	$ 3,539,248	40.50%
31	6900	ELECTROCARDIOLOGY		0.077981	1,612,188	660,750	393,440	665,226	771,878	287,701	2,538,754	1,556,314	77,979	48,874	3,100,935	1,466,333	$ 5,316,260	$ 3,169,991	29.65%
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.312580	1,197,234	345,928	1,092,305	677,014	691,032	167,948	1,951,283	893,313	63,913	13,751	1,255,263	331,438	$ 4,931,854	$ 2,084,203	34.88%
33	7200	IMPL. DEV. CHARGED TO PATIENTS		0.344674	73,585	122,332	117,125	77,436	61,426	113,608	401,407	484,857	42,260	6,538	536,008	133,836	$ 653,543	$ 798,233	19.36%
34	7300	DRUGS CHARGED TO PATIENTS		0.175176	4,912,138	1,098,321	2,380,822	2,229,888	2,375,171	1,658,787	6,279,432	2,960,521	327,883	20,039	4,380,221	1,833,727	$ 15,947,563	$ 7,947,517	35.13%
35	7400	RENAL DIALYSIS		0.090623	-	-	43,271	493,313	107,994	570,529	139,304	5,832,233	746	151,992	44,451	454,625	$ 290,569	$ 6,896,075	30.38%
36	7625	SLEEP DISORDERS		0.115657	72,315	430,313	9,029	568,600	47,637	117,219	70,463	473,456	3,280	7,867	78,038	88,489	$ 199,444	$ 1,589,588	32.23%
37	7626	WOUND CARE		0.036313	42,687	-	573,605	814,292	1,780,931	469,725	4,086,961	2,046,642	92,566	3,588	1,305,506	429,137	$ 6,484,184	$ 3,330,659	28.36%
38	9100	EMERGENCY		0.147869	2,761,742	5,879,074	843,739	14,735,644	1,754,196	2,220,163	4,597,561	8,509,055	125,384	173,202	3,695,038	21,165,804	$ 9,957,238	$ 31,343,936	46.57%
39				-													$ -	$ -	
40				-													$ -	$ -	
41				-													$ -	$ -	
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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 SPALDING REGIONAL HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
72				-													$ -	$ -	
73				-													$ -	$ -	
74				-													$ -	$ -	
75				-													$ -	$ -	
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126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 36,788,771	$ 24,285,654	$ 28,150,817	$ 45,437,484	$ 19,530,851	$ 12,175,293	$ 55,207,755	$ 51,182,869	$ 1,797,586	$ 868,443	$ 37,059,685	$ 54,393,371			

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

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

Line	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 54,983,126	$ 24,285,654	$ 44,374,423	$ 45,437,484	$ 28,131,611	$ 12,175,293	$ 77,221,930	$ 51,182,869	$ 3,135,836	$ 868,443	$ 52,598,422	$ 54,393,371	$ 204,711,090	$ 133,081,300	37.63%
												(Agrees to Exhibit A)	**(Agrees to Exhibit A)**			
129	Total Charges per PS&R or Exhibit Detail	$ 54,983,126	$ 24,285,654	$ 44,374,423	$ 45,437,484	$ 28,131,611	$ 12,175,293	$ 77,221,930	$ 51,182,869	$ 3,135,836	$ 868,443	$ 52,598,422	$ 54,393,371			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,891,167	$ 3,076,058	$ 10,739,327	$ 5,216,104	$ 4,377,336	$ 1,322,978	$ 12,722,271	$ 5,370,135	$ 668,186	$ 103,546	$ 8,469,928	$ 5,736,334	$ 37,730,101	$ 14,985,275	40.29%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 5,774,540	$ 2,337,156											$ 5,774,540	$ 2,337,156	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 5,384,344	$ 4,497,403									$ 5,384,344	$ 4,497,403	
134	Private Insurance (including primary and third party liability)	$ 58,802	$ 35,556					$ 10,056,242	$ 5,030,315					$ 10,115,044	$ 5,065,871	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 971	$ 6	$ 2,256	$ 518	$ 1,376	$ 531	$ 2,719					$ 1,055	$ 7,322	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 5,833,342	$ 2,373,683	$ 5,384,350	$ 4,499,659											
137	Medicaid Cost Settlement Payments (See Note B)		$ 189,112											$ -	$ 189,112	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 3,788,729	$ 926,528							$ 3,788,729	$ 926,528	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 157,133	$ 59,521							$ 157,133	$ 59,521	
142	Other Medicare Cross-Over Payments (See Note D)					$ 81,324						(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 81,324	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 409,746	$ 507,941			
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)**	$ 4,057,825	$ 513,263	$ 5,354,977	$ 716,445	$ 349,632	$ 335,553	$ 2,665,498	$ 337,101	$ 668,186	$ 103,546	$ 8,060,182	$ 5,228,393	$ 12,427,932	$ 1,902,362	
146	**Calculated Payments as a Percentage of Cost**	59%	83%	50%	86%	92%	75%	79%	94%	0%	0%	5%	9%	67%	87%	
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)**					20,245										
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).

I. Out-of-State Medicaid Data:

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

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
			From 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	$ 1,216.08		8		46		1		-		55	
2	03100	INTENSIVE CARE UNIT	$ 3,066.60				1						1	
3	03200	CORONARY CARE UNIT	$ -										-	
4	03300	BURN INTENSIVE CARE UNIT	$ -										-	
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500	OTHER SPECIAL CARE UNIT	$ 2,595.39										-	
7	04000	SUBPROVIDER I	$ -										-	
8	04100	SUBPROVIDER II	$ -										-	
9	04200	OTHER SUBPROVIDER	$ -										-	
10	04300	NURSERY	$ 879.74										-	
11			$ -										-	
12			$ -										-	
13			$ -										-	
14			$ -										-	
15			$ -										-	
16			$ -										-	
17			$ -										-	
18				Total Days	8		47		1		-		56	
19	Total Days per PS&R or Exhibit Detail				8		47		1		-			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ 60,536		$ 219,355		$ 7,072		$ -		$ 286,963	
21.01		Calculated Routine Charge Per Diem			$ 7,567.00		$ 4,667.13		$ 7,072.00		$ -		$ 5,124.34	
	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)		0.322793	2,708	-	7,063	-	-	-	-	15,109	$ 9,771	$ 15,109
23	5000	OPERATING ROOM		0.089839	60,566	-	64,343	21,294	-	1,624	-	-	$ 124,909	$ 22,918
24	5200	DELIVERY ROOM & LABOR ROOM		0.687247	-	-	21,125	-	-	-	-	-	$ 21,125	$ -
25	5400	RADIOLOGY-DIAGNOSTIC		0.052126	18,856	51,401	26,568	99,300	14,828	1,318	-	30,167	$ 60,252	$ 182,186
26	6000	LABORATORY		0.051804	74,894	26,793	108,616	83,502	4,831	2,091	-	10,982	$ 188,341	$ 123,368
27	6300	BLOOD STORING PROCESSING & TRANS.		0.146004	18,915	-	11,144	6,305	-	-	-	-	$ 30,059	$ 6,305
28	6400	INTRAVENOUS THERAPY		0.285084	-	-	-	1,121	-	-	-	-	$ -	$ 1,121
29	6500	RESPIRATORY THERAPY		0.091727	7,605	845	60,715	2,020	6,412	-	-	-	$ 74,732	$ 2,865
30	6600	PHYSICAL THERAPY		0.248848	1,126	10,452	7,316	2,236	1,362	-	-	-	$ 9,804	$ 12,688
31	6900	ELECTROCARDIOLOGY		0.077981	784	2,352	81,091	8,624	4,681	784	-	2,352	$ 86,556	$ 14,112
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.312580	2,009	247	25,452	2,089	619	-	-	285	$ 28,080	$ 2,621
33	7200	IMPL. DEV. CHARGED TO PATIENTS		0.344674	-	-	6,538	-	-	-	-	-	$ 6,538	$ -
34	7300	DRUGS CHARGED TO PATIENTS		0.175176	6,916	3,008	42,912	19,253	596	48	-	1,380	$ 50,424	$ 23,689
35	7400	RENAL DIALYSIS		0.090623	-	-	-	1,492	-	-	-	-	$ -	$ 1,492
36	7625	SLEEP DISORDERS		0.115657	-	-	-	-	-	-	-	-	$ -	$ -
37	7626	WOUND CARE		0.036313	-	-	3,136	-	-	-	-	-	$ 3,136	$ -
38	9100	EMERGENCY		0.147869	11,974	80,907	59,006	193,723	3,875	6,732	-	21,116	$ 74,855	$ 302,478
39				-									$ -	$ -
40				-									$ -	$ -
41				-									$ -	$ -
42				-									$ -	$ -
43				-									$ -	$ -
44				-									$ -	$ -
45				-									$ -	$ -
46				-									$ -	$ -
47				-									$ -	$ -
48				-									$ -	$ -
49				-									$ -	$ -

I. Out-of-State Medicaid Data:

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

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
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67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
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110				-									$ -	$ -
111				-									$ -	$ -
112				-									$ -	$ -

I. Out-of-State Medicaid Data:

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

Line	Description		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
113		-									$ -	$ -
114		-									$ -	$ -
115		-									$ -	$ -
116		-									$ -	$ -
117		-									$ -	$ -
118		-									$ -	$ -
119		-									$ -	$ -
120		-									$ -	$ -
121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ 206,353	$ 176,005	$ 525,025	$ 440,959	$ 37,204	$ 12,597	$ -	$ 81,391		
	Totals / Payments											
128	**Total Charges (includes organ acquisition from Section K)**		$ 266,889	$ 176,005	$ 744,380	$ 440,959	$ 44,276	$ 12,597	$ -	$ 81,391	$ 1,055,545	$ 710,952
129	Total Charges per PS&R or Exhibit Detail		$ 266,889	$ 176,005	$ 744,380	$ 440,959	$ 44,276	$ 12,597	$ -	$ 81,391		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 28,317	$ 19,497	$ 130,502	$ 46,876	$ 4,402	$ 1,388	$ -	$ 10,655	$ 163,221	$ 78,416
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)										$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 14,123	$ 13,443					$ 14,123	$ 13,443
134	Private Insurance (including primary and third party liability)									$ 11,008	$ -	$ 11,008
135	Self-Pay (including Co-Pay and Spend-Down)										$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ -	$ -	$ 14,123	$ 13,443						
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)						$ 1,354	$ 1,049			$ 1,354	$ 1,049
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)**		$ 28,317	$ 19,497	$ 116,379	$ 33,433	$ 3,048	$ 339	$ -	$ (353)	$ 147,744	$ 52,916
144	**Calculated Payments as a Percentage of Cost**		0%	0%	11%	29%	31%	76%	0%	103%	9%	33%

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 SPALDING REGIONAL HOSPITAL

Line	Organ Acquisition Cost Centers (list below):	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)
		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*
1	Lung Acquisition	$0.00	$ -	$ -		0
2	Kidney Acquisition	$0.00	$ -	$ -		0
3	Liver Acquisition	$0.00	$ -	$ -		0
4	Heart Acquisition	$0.00	$ -	$ -		0
5	Pancreas Acquisition	$0.00	$ -	$ -		0
6	Intestinal Acquisition	$0.00	$ -	$ -		0
7	Islet Acquisition	$0.00	$ -	$ -		0
8		$0.00	$ -	$ -		0
9	**Totals**	$ -	$ -	$ -	$ -	-
10	**Total Cost**					

Line	Cost Center	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)
		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*
1	Lung Acquisition												
2	Kidney Acquisition												
3	Liver Acquisition												
4	Heart Acquisition												
5	Pancreas Acquisition												
6	Intestinal Acquisition												
7	Islet Acquisition												
8													
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 SPALDING REGIONAL HOSPITAL

Line	Organ Acquisition Cost Centers (list below):	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)
		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*
11	Lung Acquisition	$ -	$ -	$ -	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0
18		$ -	$ -	$ -	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-
20	**Total Cost**					

Line	Cost Center	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)*
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.

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

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description	Explanation	Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 2,067,157		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	4010-4012950	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 2,067,157		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

Line	Description		Amount
17	Gross Allowable Assessment Not Included in the Cost Report		$ 2,067,157
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	343,563,166
19	Uninsured Hospital	**Charges Sec. G**	106,991,793
20	Total Hospital	**Charges Sec. G**	1,186,830,880
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		28.95%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.01%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 598,399
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 186,352
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 784,751**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	170,708,920
27	Uninsured Hospital	**Charges Sec. G**	110,996,072
28	Total Hospital	**Charges Sec. G**	1,186,830,880
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		14.38%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		9.35%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 297,331
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 193,327
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 490,658**

** 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.*