

SFY 2026 Medicaid ICTF Survey

Wellstar Sylvan Grove 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:

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

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

	Data
6. Medicaid Provider Number:	000001856A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111319

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.)	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/29/1962

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** \$ 22,902
(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** \$ 22,902

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:

Hospital Contact:

Name	Ebbie Erzuah
Title	Executive Director of Reimbursement
Telephone Number	(478) 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	David Pylate
Title	Manager
Firm Name	Southeast Reimbursement Group LLC
Telephone Number	770-928-3352 Ext 402
E-Mail Address	david.pylate@srgllc.org

Handwritten notes:
 PE 11/11/25
 ETE 11/11/25

7/1/2023 - 6/30/2024

D. General Cost Report Year Information

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.

- Select Your Facility from the Drop-Down Menu Provided
WELLSTAR SYLVAN GROVE HOSPITAL
- Select Cost Report Year Covered by this Survey (enter "X")
7/1/2023 through 6/30/2024 X
- Status of Cost Report Used for this Survey (should be audited if available)
1 - As Submitted
- Date CMS processed the HCRIS file into the HCRIS database.
12/19/2024

Data	Correct?	If Incorrect, Proper Information
WELLSTAR SYLVAN GROVE HOSPITAL	Yes	
000001856A	Yes	
0		
0		
111319	Yes	
Non-State Govt.	Yes	
Pool 1	Yes	
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.

(List additional states on a separate attachment)

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

- Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Hospital Services (See Note 1)**
- Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)
- Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)
- Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**
- Out-of-State DSH Payments (See Note 2)**

\$ -
\$ -
\$ -
\$ -
\$ -
\$ -
\$ -

	Inpatient	Outpatient	Total
\$	\$ 119,114	\$ 119,114	\$ 119,114
\$	\$ 16,021	\$ 665,427	\$ 701,448
\$	\$ 16,021	\$ 804,541	\$ 820,562
	0.00%	14.81%	14.52%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

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.

\$ -	No
\$ -	

- Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services
- Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services
- 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 (CFR, WIS S-3, Pl. I, Col. 8, Sum of Lns 14, 16, 17, 18, 00-18, 03, 30, 31 less lines 5 & 6) 103 **(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	-
4 Unspecified IP and OP Hospital Subsidies	-
5 Non-Hospital Subsidies	-
6 Total Hospital Subsidies	\$ -
7 Inpatient Hospital Charity Care Charges	122,973
8 Outpatient Hospital Charity Care Charges	16,502,003
9 Non-Hospital Charity Care Charges	-
10 Total Charity Care Charges	\$ 18,624,876

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR (WS 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.

	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11 Hospital	\$313,983.00			\$ 246,762			\$ 67,221
12 Subprovider 1 (Psych or Rehab)	\$0.00						\$ -
13 Subprovider 1 (Psych or Rehab)	\$0.00						\$ -
14 Swing Bed - SNF			\$3,984,821.00			3,131,700	
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	\$12,614,259.00	\$42,097,879.00		\$ 9,913,639	\$ 33,085,034		\$ 11,713,465
20 Outpatient Services		\$43,333,442.00			\$ 34,056,072		\$ 9,277,370
21 Home Health Agency							
22 Ambulance							
23 Outpatient Rehab Providers							
24 ASC	\$0.00						\$ -
25 Hospice	\$0.00						\$ -
26 Other	\$0.00						\$ -
27 Total	\$ 12,928,242	\$ 85,431,321	\$ 3,984,821	\$ 10,160,401	\$ 67,141,105	\$ 3,131,700	\$ 21,058,057
28 Total Hospital and Non Hospital		Total from Above	Total from Above		Total from Above		

Contractual Adjustments (formulas below can be overwritten if amounts are known)

29 Total Per Cost Report							
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)							
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)							
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							
37 Unreconciled Difference							

Total Patient Revenues (Charges)

29 Total Per Cost Report							
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)							
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)							
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							
37 Unreconciled Difference							

Total Contractual Adj (G-3 Line 2)

29 Total Per Cost Report							
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)							
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)							
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							
37 Unreconciled Difference							

H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:
 Contract Year 2023-2024: WELLSFAR SYLVAN GROVE HOSPITAL

Contract Year	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicaid Managed Care Other (with Medical Summary)	In-State Other Medicaid Eligible (Not Reimbursed Eligible & with Extended Secondary and Non-Covered)	Medical FFS & MCO (Reimbursed and Non-Covered (Not to be Included Elsewhere))	Unrecovered	Total In-State Medicaid (Days Include Medical FFS & CO-Insured and Non-Cost Report)	% Days to be Cost Report
72								
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	\$ 3,079,450	\$ 13,075,581	\$ 80,756	\$ 177,044	\$ 5,280,318	\$ 47,854	\$ 17,990,918	

H. In-State Medicaid and All Unreimbursed Inpatient and Outpatient Hospital Data:
Cost Report Year (01/01/2020-03/31/2021) - WELLS TOWER SYLVAN GROVE HOSPITAL

Line	Description	In-State Medicaid PFS Primary	In-State Medicaid Managed Care Primary	In-State Medicaid PFS Cross-Overs with Medicaid Secondary	Other Medicaid Expenses that include Medicaid Extended Secondary - Exclude Medicaid Extended and Non-Covered	Medicaid PFS & WCO Extended and Non-Covered (Not to be Included Elsewhere)	Unreimbursed	Total Includes Medicaid (Days Include Medicaid PFS & WCO Extended and Non-Covered)	% of Total to Cost Market
128	Total Charges (includes organ acquisition from Section J)	\$ 3,979,450	\$ 13,015,581	\$ 74,178	\$ 1,121,845	\$ 277,774	\$ 22,999,884	47.9%	
129	Total Charges per F586 or F587 Data:								
130	Unreimbursed Charges (Explain Variance)	\$ 3,979,450	\$ 13,015,581	\$ 74,178	\$ 1,121,845	\$ 277,774	\$ 22,999,884	47.9%	
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ 481,508	\$ 1,650,222	\$ 39,402	\$ 887,852	\$ 27,507	\$ 2,986,950	58.1%	
132	Total Medicaid Paid Amount (includes TPL, Co-Pay and Spread-Down)	\$ 413,623	\$ 1,386,326				\$ 1,800,000		
133	Private Insurance (including primary and third party liability)	\$ 5,480	\$ 563				\$ 6,043		
134	Self-Pay (including Co-Pay and Spread-Down)	\$ 69	\$ 987				\$ 1,056		
135	Total Allowed Amount from Medicaid (PFSER or RA Data) (All Payments)	\$ 418,742	\$ 1,386,917				\$ 1,805,659		
136	Other Medicaid Payment (See Note D)								
137	Medicare Treatment (non-HMO) Paid Amount (includes consumables) (See Note F)								
138	Medicare Cross-Over Paid Amount (See Note G)								
139	Medicare Cross-Over Paid Amount (See Note H)								
140	Medicare Cross-Over Paid Amount (See Note I)								
141	Other Medicare Cross-Over Payments (See Note J)								
142	Payment from Hospital Unreimbursed During Cost Report Year (Cash Basis)								
143	Section 1311 Payment (includes Inpatient Hospital Services NOT included in Exhibits B & B.1 (from Section E))								
144	Calculated Payment Shortfall (Long-Term) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DEDU)	\$ 88,872	\$ 291,356	\$ 4,002	\$ 15,889	\$ 27,507	\$ 457,626	15.3%	
145	Calculated Payments as a Percentage of Cost	0%	64%	60%	78%	0%	61%		
146	Total Medicare Days from WIS 5.9 of the Cost Report Excluding Swing-Bed (GR, WIS 8.4, P.1, Col 6, Sum of Lins 2, 3, 4, 14, 16, 17, 18 less Area 6 & 6)	0	0	0	0	0	0	0%	
147	Percent of cross-over days to total Medicare days from the cost report	0%	0%	0%	0%	0%	0%	0%	
148	Note A: These amounts are for your information and are not used for reporting purposes. For Managed Care Cross-Over data and other details, use the hospital's loss of PFSER summaries are not available (submit less with survey). Note B: Medicaid and Medicare report amounts are not included on the claims and summary PFSER summary of PFSER. Note C: Other Medicaid Payments such as Outliers and Non-Claim Specific payments, LCH, and other payments are reported in Section G of this report. Note D: Should include other Medicare cross-over payments not included in the prior claims data reported above. This includes payments and report settlement in S. Medicare Cross-Over Medical Education payments. Note E: Managed Care payments should include all Medicare Part B payments related to the services provided, including, but not limited to, inpatient, Medicare Part B only coverage for Medicare covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or scheduled benefit). Note F: Medicare Part A benefits (due to no coverage or scheduled benefit). Note G: Medicare Part A benefits (due to no coverage or scheduled benefit). Note H: Medicare Part A benefits (due to no coverage or scheduled benefit). Note I: Medicare Part A benefits (due to no coverage or scheduled benefit). Note J: Medicare Part A benefits (due to no coverage or scheduled benefit).								

NOTE: Impatient unreimbursed payment rate is outside normal ranges, please verify this if correct.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2024) WELLSTAR SYLVAN GROVE HOSPITAL

Line #	Cost Center Description	Diem Cost for Routine Care Centers		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	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
1	Routine Cost Centers (list below):														
2	03000 ADULTS & PEDIATRICS														
3	03100 INTENSIVE CARE UNIT														
4	03200 COCONARY CARE UNIT														
5	03300 BURN/INTENSIVE CARE UNIT														
6	03400 SURGICAL INTENSIVE CARE UNIT														
7	03500 OTHER SPECIAL CARE UNIT														
8	04000 SUBPROVIDER I														
9	04100 SUBPROVIDER II														
10	04200 OTHER SUBPROVIDER														
11	04300 NURSERY														
12															
13															
14															
15															
16															
17															
18															
19	Total Days per PS&R or Exhibit Detail														
20	Unreconciled Days (Explain Variance)														
21															
21 01															
22	Ancillary Cost Centers (from W/S C) (list below):														
23	09200 Observation (Non-Diary)														
24	5400 RADIOLOGY/DIAGNOSTIC														
25	6000 LABORATORY														
26	6500 RESPIRATORY THERAPY														
27	6900 PHYSICAL THERAPY														
28	6900 ELECTROCARDIOLOGY														
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT														
30	7300 DRUGS CHARGED TO PATIENTS														
31	9100 EMERGENCY														
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i. Out-of-State Medicaid Data:

Cost Report Year: 07/01/2023-06/30/2024 | WELLSTAR SYLVAN GROVE HOSPITAL

Line Item	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	
	Count	Amount	Count	Amount	Count	Amount	Count	Amount	Count	Amount
51										
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54										
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I. Out-of-State Medicaid Data:

Cost Report Year: 07/01/2025-06/30/2024 | WELLSTAR SYLVAN GROVE 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
114					
115					
116					
117					
118					
119					
120					
121					
122					
123					
124					
125					
126					
127					
	\$ 25,454	\$ 187,073	\$ 2,621	\$ 3,845	\$ 219,093
Totals / Payments					
128	\$ 25,454	\$ 187,073	\$ 2,621	\$ 3,845	\$ 219,093
129	\$ 25,454	\$ 187,073	\$ 2,621	\$ 3,845	\$ 219,093
130					
131	\$ 3,748	\$ 25,146	\$ 287	\$ 494	\$ 29,676
132					
133					
134					
135					
136					
137					
138					
139					
140					
141					
142					
143	\$ 3,748	\$ 16,021	\$ 287	\$ 189	\$ 20,925
144	0%	0%	0%	86%	30%

Total Charges (includes organ acquisition from Section K)
Total Charges per PSAR or Exhibit Detail
Unreconciled Charges (Explain Variance)

Total Calculated Cost (includes organ acquisition from Section K)
 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)
 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)
 Private Insurance (including primary and third party liability)
 Self-Pay (including Co-Pay and Spend-Down)
 Total Allowed Amount from Medicaid PSAR or RA Detail (All Payments)
 Medicaid Cost Settlement Payments (See Note B)
 Other Medicaid Payments Reported on Cost Report Year (See Note C)
 Medicare Traditional (non-HMO) Paid Amount (excludes constraints/deficibles) (See Note F)
 Medicare Managed Care (HMO) Paid Amount (excludes constraints/deficibles)
 Medicare Cross-Over Bad Debt Payments
 Other Medicare Cross-Over Payments (See Note D)

Calculated Payment Shortfall / Longfall (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)
Calculated Payments as a Percentage of Cost

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, capitation and sub-capitation 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 SYLVAN GROVE HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	WIS A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		(WTB Account #)
2 Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (WIS A, Col. 2)		(Where is the cost included on wks A?)
3 Difference (Explain Here ----->)		
Provider Tax Assessment Reclassifications (from wks A-5 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 wks 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 wks 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	\$	
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18 Medicaid Eligible** Charges Sec. G	23,623,889	
19 Uninsured Hospital Charges Sec. G	18,051,763	
20 Total Hospital Charges Sec. G	102,342,512	
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	23.08%	
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	17.84%	
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC**	\$	
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$	
25 Provider Tax Assessment Adjustment to DSH UCC including all Medicaid eligibles**	\$	
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26 Medicaid Primary*** Charges Sec. G	18,807,558	
27 Uninsured Hospital Charges Sec. G	18,161,781	
28 Total Hospital Charges Sec. G	102,342,512	
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	18.42%	
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	17.77%	
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC**	\$	
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$	
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$	

* 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 diem 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 if benefits them. The exception is based on SPRY. For cost report periods overlapping SPRY's 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.

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 SYLVAN GROVE HOSPITAL

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

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

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

1 - As Submitted

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

12/18/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR SYLVAN GROVE HOSPITAL	Yes	
5. Medicaid Provider Number:	000001856A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	111319	Yes	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 1	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)	\$	-	\$ 119,114	\$119,114
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$	16,021	\$ 685,427	\$701,448
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)		\$16,021	\$804,541	\$820,562
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:		0.00%	14.81%	14.52%
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) 103 (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	-
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ -
7. Inpatient Hospital Charity Care Charges	122,873
8. Outpatient Hospital Charity Care Charges	16,502,003
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 16,624,876

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	\$313,983.00			\$ 246,762	-	-	\$ 67,221
12. Subprovider I (Psych or Rehab)	\$0.00			-	-	-	-
13. Subprovider II (Psych or Rehab)	\$0.00			-	-	-	-
14. Swing Bed - SNF			\$3,984,821.00			\$ 3,131,700	-
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	\$12,614,259.00	\$42,097,879.00		\$ 9,913,639	\$ 33,085,034	-	\$ 11,713,465
20. Outpatient Services		\$43,333,442.00			\$ 34,056,072	-	\$ 9,277,370
21. Home Health Agency			\$0.00			-	-
22. Ambulance			-			-	-
23. Outpatient Rehab Providers			\$0.00			-	-
24. ASC	\$0.00	\$0.00		-	-	-	-
25. Hospice			\$0.00			-	-
26. Other	\$0.00	\$0.00	\$0.00	-	-	-	-
27. Total	\$ 12,928,242	\$ 85,431,321	\$ 3,984,821	\$ 10,160,401	\$ 67,141,105	\$ 3,131,700	\$ 21,058,057
28. Total Hospital and Non Hospital		Total from Above	\$ 102,344,384		Total from Above	\$ 80,433,206	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	102,344,384	Total Contractual Adj. (G-3 Line 2)	79,351,684
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)				
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)				1,081,522
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)				-
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				80,433,206
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 SYLVAN GROVE HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)	Cost Report Worksheet C, Part I, Col.2 and Col. 4	Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26	Calculated	Days - Cost Report W/S D-1, Pt. 1, 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	\$ 5,776,525	\$ -	\$ -	\$ 5,577,665.00	\$ 198,860	174	\$ 4,278,171.00	\$ 1,142.87
2	03100	INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
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	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
10	04300	NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
11			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 0.00	\$ -
18		Total Routine	\$ 5,776,525	\$ -	\$ -	\$ 5,577,665	\$ 198,860	174	\$ 4,278,171	
19		Weighted Average								\$ 1,142.87

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
09200 Observation (Non-Distinct)	71	-	-	\$ 81,144	\$ 41,232.00	\$ 205,638.00	\$ 246,870	0.328691

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):

5400	RADIOLOGY-DIAGNOSTIC	\$ 1,790,317.00	\$ -	\$ -	\$ 1,790,317	\$ 457,191.00	\$ 21,580,351.00	\$ 22,037,542	0.081239
6000	LABORATORY	\$ 2,258,785.00	\$ -	\$ -	\$ 2,258,785	\$ 746,732.00	\$ 12,643,432.00	\$ 13,390,164	0.168690
6500	RESPIRATORY THERAPY	\$ 1,054,288.00	\$ -	\$ -	\$ 1,054,288	\$ 2,598,271.00	\$ 1,018,108.00	\$ 3,616,379	0.291531
6600	PHYSICAL THERAPY	\$ 2,851,059.00	\$ -	\$ -	\$ 2,851,059	\$ 6,112,325.00	\$ 3,386,705.00	\$ 9,499,030	0.300142
6900	ELECTROCARDIOLOGY	\$ 35,267.00	\$ -	\$ -	\$ 35,267	\$ 21,168.00	\$ 1,357,888.00	\$ 1,379,056	0.025573
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 301,412.00	\$ -	\$ -	\$ 301,412	\$ 462,555.00	\$ 310,633.00	\$ 773,188	0.389830
7300	DRUGS CHARGED TO PATIENTS	\$ 702,702.00	\$ -	\$ -	\$ 702,702	\$ 1,903,495.00	\$ 2,673,500.00	\$ 4,576,995	0.153529
9100	EMERGENCY	\$ 5,016,795.00	\$ -	\$ -	\$ 5,016,795	\$ 224,388.00	\$ 42,320,729.00	\$ 42,545,117	0.117917
		\$ 0.00	\$ -	\$ -	\$ -	\$ 0.00	\$ 0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR SYLVAN GROVE 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		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
31		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
32		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
33		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
34		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
35		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
36		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	-	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR SYLVAN GROVE 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	\$ 14,010,625	\$ -	\$ -	\$ 14,010,625	\$ 12,567,357	\$ 85,496,984	\$ 98,064,341	
127	Weighted Average								0.143699
128	Sub Totals	\$ 19,787,150	\$ -	\$ -	\$ 14,209,485	\$ 16,845,528	\$ 85,496,984	\$ 102,342,512	
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)				\$988,352.00				
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				\$ 13,221,133				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

* 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 SYLVAN GROVE HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Excludes Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
				From 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	\$ 1,142.87						18		25				5		43		46.60%	
2	03100 INTENSIVE CARE UNIT	\$ -																	
3	03200 CORONARY CARE UNIT	\$ -																	
4	03300 BURN INTENSIVE CARE UNIT	\$ -																	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -																	
6	03500 OTHER SPECIAL CARE UNIT	\$ -																	
7	04000 SUBPROVIDER I	\$ -																	
8	04100 SUBPROVIDER II	\$ -																	
9	04200 OTHER SUBPROVIDER	\$ -																	
10	04300 NURSERY	\$ -																	
11		\$ -																	
12		\$ -																	
13		\$ -																	
14		\$ -																	
15		\$ -																	
16		\$ -																	
17		\$ -																	
18		\$ -																	
19	Total Days							18		25				5		43		27.59%	
20	Total Days per PS&R or Exhibit Detail							18		25				5					
20	Unreconciled Days (Explain Variance)																		
21	Routine Charges							\$ 14,040		\$ 32,554				\$ 12,590				\$ 46,594	1.90%
21.01	Calculated Routine Charge Per Diem							\$ 780.00		\$ 1,302.16				\$ 2,578.00				\$ 1,083.58	
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	
22	09200 Observation (Non-Distinct)		0.328691		13,260					25,275		2,567			6,076		25,275	\$ 15,827	21.15%
23	5400 RADIOLOGY-DIAGNOSTIC		0.081239		888,371		2,347,853		288,228	16,577		1,454,083		19,018	4,273,881		16,577	\$ 4,778,535	41.52%
24	6000 LABORATORY		0.168690		969,347		1,944,017		2,837	206,353		15,029		20,477	832,761		2,631,381	\$ 17,865	46.79%
25	6500 RESPIRATORY THERAPY		0.291531		54,587		112,481		22,733	48,956		6,014		199,039	72,305		72,305	\$ 256,609	14.87%
26	6900 PHYSICAL THERAPY		0.300142		63,597		239,153		33,197	27,149		169,040		30,987	127,833		50,262	\$ 504,987	7.96%
27	6900 ELECTROCARDIOLOGY		0.025573		56,448		109,760		22,736	1,568		80,752		784	276,752		1,568	\$ 269,696	49.80%
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT				15,769		37,478		7,090	7,408		18,426		867	61,499		12,919	\$ 79,081	20.26%
29	7300 DRUGS CHARGED TO PATIENTS		0.153529		460,933		272,695		1,776	38,021		161,894		920	848,337		13,525	\$ 931,543	49.21%
30	9100 EMERGENCY		0.117917		1,657,138		7,952,144		504,960	20,882		2,493,988		51,161	15,085		20,882	\$ 12,608,230	83.08%
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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 SYLVAN GROVE HOSPITAL

72				In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report												
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					\$	-	\$	3,579,450	\$	-	\$	13,015,581	\$	60,136	\$	1,121,645	\$	171,044	\$	5,280,318	\$	-	\$	130,028	\$	47,954	\$	17,990,910		

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

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

	In-State Medicaid FFS Primary	In-State Medicaid Managed Care Primary	In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report							
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ -	\$ 3,579,450	\$ -	\$ 13,015,581	\$ 74,176	\$ 1,121,645	\$ 203,598	\$ 5,280,318	\$ -	\$ 130,028	\$ 60,844	\$ 17,990,919	\$ 277,774	\$ 22,996,994	40.59%
129 Total Charges per PS&R or Exhibit Detail	\$ -	\$ 3,579,450	\$ -	\$ 13,015,581	\$ 74,176	\$ 1,121,645	\$ 203,598	\$ 5,280,318	\$ -	\$ 130,028	(Agrees to Exhibit A)	(Agrees to Exhibit A)	\$ 60,844	\$ 17,990,919	
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ -	\$ 465,088	\$ -	\$ 1,620,222	\$ 38,403	\$ 143,360	\$ 69,189	\$ 657,850	\$ -	\$ 22,507	\$ 11,517	\$ 2,170,972	\$ 107,592	\$ 2,886,520	39.38%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 413,483											\$ -	\$ 413,483	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 1,368,334									\$ -	\$ 1,368,334	
134 Private Insurance (including primary and third party liability)		\$ 5,160					\$ 52,590	\$ 931,600					\$ 52,590	\$ 936,760	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 99		\$ 583		\$ 967							\$ -	\$ 3,761	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 418,742	\$ -	\$ 1,368,917									\$ -	\$ -	
137 Medicaid Cost Settlement Payments (See Note B)		\$ (23,581)											\$ -	\$ (23,581)	
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)					\$ 31,311	\$ 33,621							\$ 31,311	\$ 33,621	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)													\$ -	\$ -	
141 Medicare Cross-Over Bad Debt Payments					\$ 3,030	\$ 19,911							\$ 3,030	\$ 19,911	
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -							\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													\$ -	\$ 119,114	
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)	\$ -	\$ 69,927	\$ -	\$ 251,305	\$ 4,062	\$ 88,861	\$ 16,599	\$ (275,862)	\$ -	\$ 22,507	\$ 11,517	\$ 2,051,856	\$ 20,661	\$ 134,231	
146 Calculated Payments as a Percentage of Cost	0%	85%	0%	84%	89%	38%	76%	142%	0%	0%	0%	5%	81%	95%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					114										16%
148 Percent of cross-over days to total Medicare days from the cost report															

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

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

I. Out-of-State Medicaid Data:

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers From Section G	Medicaid Cost to Charge Ratio for Ancillary Cost Centers From Section G	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	\$ 1,142.87		-	-	-	-	-	-	-	-	-	-
2	03100 INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-
3	03200 CORONARY CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-	-	-	-	-	-	-	-	-	-
7	04000 SUBPROVIDER I	\$ -		-	-	-	-	-	-	-	-	-	-
8	04100 SUBPROVIDER II	\$ -		-	-	-	-	-	-	-	-	-	-
9	04200 OTHER SUBPROVIDER	\$ -		-	-	-	-	-	-	-	-	-	-
10	04300 NURSERY	\$ -		-	-	-	-	-	-	-	-	-	-
11		\$ -		-	-	-	-	-	-	-	-	-	-
12		\$ -		-	-	-	-	-	-	-	-	-	-
13		\$ -		-	-	-	-	-	-	-	-	-	-
14		\$ -		-	-	-	-	-	-	-	-	-	-
15		\$ -		-	-	-	-	-	-	-	-	-	-
16		\$ -		-	-	-	-	-	-	-	-	-	-
17		\$ -		-	-	-	-	-	-	-	-	-	-
18		\$ -		-	-	-	-	-	-	-	-	-	-
			Total Days	-	-	-	-	-	-	-	-	-	-
19	Total Days per PS&R or Exhibit Detail			-	-	-	-	-	-	-	-	-	-
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-	-	-	-
21	Routine Charges			Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges	Routine Charges
21.01	Calculated Routine Charge Per Diem			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
22	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)	0.328691		-	-	5,043	-	-	-	-	-	-	5,043
23	5400 RADIOLOGY-DIAGNOSTIC	0.081239		-	2,738	42,328	-	-	-	-	-	-	45,776
24	6000 LABORATORY	0.168690		-	4,411	23,786	710	-	-	-	-	-	28,610
25	6500 RESPIRATORY THERAPY	0.291531		-	3,021	4,821	-	-	-	413	-	-	7,842
26	6600 PHYSICAL THERAPY	0.300142		-	-	3,588	-	-	-	-	-	-	3,588
27	6900 ELECTROCARDIOLOGY	0.025573		-	-	-	-	-	-	-	-	-	-
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.389830		-	271	2,014	-	-	-	-	-	-	2,285
29	7300 DRUGS CHARGED TO PATIENTS	0.153529		-	719	9,285	-	-	-	232	-	-	10,344
30	9100 EMERGENCY	0.117917		-	14,294	96,208	1,803	-	-	3,300	-	-	115,605
31				-	-	-	-	-	-	-	-	-	-
32				-	-	-	-	-	-	-	-	-	-
33				-	-	-	-	-	-	-	-	-	-
34				-	-	-	-	-	-	-	-	-	-
35				-	-	-	-	-	-	-	-	-	-
36				-	-	-	-	-	-	-	-	-	-
37				-	-	-	-	-	-	-	-	-	-
38				-	-	-	-	-	-	-	-	-	-
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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 SYLVAN GROVE 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			-									-	-
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I. Out-of-State Medicaid Data:

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

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ -	\$ 25,454	\$ -	\$ 187,073	\$ -	\$ 2,621	\$ -	\$ 3,945	\$ -	\$ -
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ -	\$ 25,454	\$ -	\$ 187,073	\$ -	\$ 2,621	\$ -	\$ 3,945	\$ -	\$ 219,093
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ 25,454	\$ -	\$ 187,073	\$ -	\$ 2,621	\$ -	\$ 3,945		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ -	\$ 3,749	\$ -	\$ 25,146	\$ -	\$ 287	\$ -	\$ 494	\$ -	\$ 29,676
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)				\$ 8,525					\$ -	\$ 8,525
134	Private Insurance (including primary and third party liability)							\$ 325		\$ -	\$ 325
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$ -	\$ 8,525						
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)									\$ -	\$ -
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)	\$ -	\$ 3,749	\$ -	\$ 16,621	\$ -	\$ 287	\$ -	\$ 169	\$ -	\$ 20,826
144	Calculated Payments as a Percentage of Cost	0%	0%	0%	34%	0%	0%	0%	66%	0%	30%

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

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WELLSTAR SYLVAN GROVE HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):																	
1	Lung Acquisition	\$0.00	\$ -	\$ -	0												
2	Kidney Acquisition	\$0.00	\$ -	\$ -	0												
3	Liver Acquisition	\$0.00	\$ -	\$ -	0												
4	Heart Acquisition	\$0.00	\$ -	\$ -	0												
5	Pancreas Acquisition	\$0.00	\$ -	\$ -	0												
6	Intestinal Acquisition	\$0.00	\$ -	\$ -	0												
7	Islet Acquisition	\$0.00	\$ -	\$ -	0												
8		\$0.00	\$ -	\$ -	0												
9	Totals	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -		\$ -		\$ -	
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 SYLVAN GROVE HOSPITAL

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -	
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 SYLVAN GROVE HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*		
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		(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 ----->)	\$ -	
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	\$ -
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	23,623,889
19 Uninsured Hospital Charges Sec. G	18,051,763
20 Total Hospital Charges Sec. G	102,342,512
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	23.08%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	17.64%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ -
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ -
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	16,807,558
27 Uninsured Hospital Charges Sec. G	18,181,791
28 Total Hospital Charges Sec. G	102,342,512
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	16.42%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	17.77%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ -
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ -
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ -

* 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.