

SFY 2026 Medicaid ICTF Survey

**Wellstar West Georgia Medical
Center**

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 WEST GEORGIA HOSPITAL

Identification of cost reports needed to cover the DSH Year:

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

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

	Data
6. Medicaid Provider Number:	000002065A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110016

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 obstetncians 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?	7/1/1996

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**
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.) \$ 4,486,521

- 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** \$ 4,486,521

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	<u>CFO</u> Title	<u>11/11/25</u> 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:

986
11/11/25
Ebie
11/11/25

Hospital Contact:

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

Outside Preparer:

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

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

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

1. Select Your Facility from the Drop-Down Menu Provided:

WELLSTAR WEST GEORGIA 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):

5 - Amended

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

6/26/2025

- 4. Hospital Name:
- 5. Medicaid Provider Number:
- 6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
- 7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
- 8. Medicare Provider Number:
- 9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):
- 10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)
- 11. Rural Referral Center (Yes or No)

Data	Correct?	If Incorrect, Proper Information
WELLSTAR WEST GEORGIA HOSPITAL	Yes	
000002065A	Yes	
0		
0		
110016	Yes	
Non-State Govt.	Yes	
Pool 2	Yes	
Yes	Yes	

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

- 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

State Name	Provider No.
Alabama	1821221144

(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)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 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)
- 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
\$	217,638	758,214	\$975,852
\$	1,374,704	6,602,997	\$7,977,701
	\$1,592,342	\$7,361,211	\$8,953,553
	13.67%	10.30%	10.90%

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

No

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

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

\$	-
\$	-
	\$-

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

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

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

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 36,890 (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	315,035
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 315,035
7. Inpatient Hospital Charity Care Charges	41,880,101
8. Outpatient Hospital Charity Care Charges	66,249,643
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 108,129,744

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.

	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	\$218,030,244.00			\$ 178,704,887	-	-	\$ 39,325,357
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			\$20,729,937.00			16,990,950	-
17. Nursing Facility			\$0.00			-	-
18. Other Long-Term Care			\$0.00			-	-
19. Ancillary Services	\$404,155,524.00	\$780,419,096.00		\$ 331,259,397	\$ 639,657,616	-	\$ 213,657,607
20. Outpatient Services		\$180,334,004.00			\$ 147,807,786	-	\$ 32,526,218
21. Home Health Agency			\$3,470,853.00			2,844,827	-
22. Ambulance			-			-	-
23. Outpatient Rehab Providers			\$0.00			-	-
24. ASC	\$0.00	\$0.00		-	-	-	-
25. Hospice			\$12,329,216.00			10,105,438	-
26. Other	\$0.00	\$0.00	\$0.00	-	-	-	-
27. Total	\$ 622,185,768	\$ 960,753,100	\$ 36,530,006	\$ 509,964,284	\$ 787,465,403	\$ 29,941,216	\$ 285,509,182
28. Total Hospital and Non Hospital		Total from Above	\$ 1,619,468,874	Total from Above	\$ 1,327,370,902		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,619,468,874	Total Contractual Adj. (G-3 Line 2)	1,325,189,605
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)				4,895,706
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)				2,714,409
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				1,327,370,902
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 WEST GEORGIA 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>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</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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	\$ 42,413,162	\$ -	\$ 6,561	\$ 0.00	\$ 42,419,723	35,646	\$167,331,999.00	\$ 1,190.03
2	03100	INTENSIVE CARE UNIT	\$ 8,142,243	\$ -	\$ 20,577		\$ 8,162,820	2,352	\$25,687,387.00	\$ 3,470.59
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	\$ 5,306,874	\$ -	\$ 13,683		\$ 5,320,557	1,996	\$11,424,661.00	\$ 2,665.61
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 55,862,279	\$ -	\$ 40,821	\$ -	\$ 55,903,100	39,994	\$ 204,444,047	
19		Weighted Average								\$ 1,397.79

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)	3,607	-	-	\$ 4,292,438	\$1,683,406.00	\$12,229,420.00	\$ 13,912,826	0.308524

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):

5000	OPERATING ROOM	\$26,610,753.00	\$ -	\$ -	\$ 26,610,753	\$46,108,409.00	\$148,340,434.00	\$ 194,448,843	0.136852
5200	DELIVERY ROOM & LABOR ROOM	\$6,004,430.00	\$ -	\$ -	\$ 6,004,430	\$21,710,271.00	\$1,658,988.00	\$ 23,369,259	0.256937
5300	ANESTHESIOLOGY	\$4,233,341.00	\$ -	\$ -	\$ 4,233,341	\$14,332,168.00	\$46,925,887.00	\$ 61,258,055	0.069107
5400	RADIOLOGY-DIAGNOSTIC	\$15,616,235.00	\$ -	\$ 66,137	\$ 15,682,372	\$11,577,574.00	\$102,085,802.00	\$ 113,663,376	0.137972
5600	RADIOISOTOPE	\$1,401,265.00	\$ -	\$ -	\$ 1,401,265	\$4,755,783.00	\$13,529,710.00	\$ 18,285,493	0.076633
5700	CT SCAN	\$2,923,908.00	\$ -	\$ -	\$ 2,923,908	\$40,412,992.00	\$89,285,383.00	\$ 129,698,375	0.022544
5800	MRI	\$791,835.00	\$ -	\$ -	\$ 791,835	\$6,326,846.00	\$17,178,855.00	\$ 23,505,701	0.033687
5900	CARDIAC CATHETERIZATION	\$4,989,428.00	\$ -	\$ 66,925	\$ 5,056,353	\$28,041,432.00	\$39,682,863.00	\$ 67,724,295	0.074661
6000	LABORATORY	\$15,156,056.00	\$ -	\$ -	\$ 15,156,056	\$85,785,967.00	\$112,506,652.00	\$ 198,292,619	0.076433

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	6500 RESPIRATORY THERAPY	\$4,317,988.00	\$ -	\$ 8,672	\$ 4,326,660	\$31,760,733.00	\$5,834,190.00	\$ 37,594,923	0.115086
31	6600 PHYSICAL THERAPY	\$4,508,375.00	\$ -	\$ -	\$ 4,508,375	\$5,144,562.00	\$7,873,233.00	\$ 13,017,795	0.346324
32	6900 ELECTROCARDIOLOGY	\$350,370.00	\$ -	\$ -	\$ 350,370	\$9,639,828.00	\$12,726,782.00	\$ 22,366,610	0.015665
33	7000 ELECTROENCEPHALOGRAPHY	\$824,562.00	\$ -	\$ 3,114	\$ 827,676	\$799,164.00	\$4,167,415.00	\$ 4,966,579	0.166649
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$15,908,007.00	\$ -	\$ -	\$ 15,908,007	\$17,585,275.00	\$23,569,081.00	\$ 41,154,356	0.386545
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$7,820,573.00	\$ -	\$ -	\$ 7,820,573	\$6,573,219.00	\$20,653,203.00	\$ 27,226,422	0.287242
36	7300 DRUGS CHARGED TO PATIENTS	\$28,043,875.00	\$ -	\$ -	\$ 28,043,875	\$52,000,633.00	\$126,869,938.00	\$ 178,870,571	0.156783
37	7400 RENAL DIALYSIS	\$1,812,940.00	\$ -	\$ -	\$ 1,812,940	\$18,565,282.00	\$1,621,186.00	\$ 20,186,468	0.089810
38	9002 WOUND CARE CENTER	\$1,424,483.00	\$ -	\$ 4,069	\$ 1,428,552	\$29,129.00	\$7,462,522.00	\$ 7,491,651	0.190686
39	9100 EMERGENCY	\$20,194,597.00	\$ -	\$ 11,278	\$ 20,205,875	\$41,422,735.00	\$137,050,675.00	\$ 178,473,410	0.113215
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 WEST GEORGIA 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	\$ 162,933,021	\$ -	\$ 160,195	\$ 163,093,216	\$ 444,255,408	\$ 931,252,219	\$ 1,375,507,627	
127	Weighted Average								0.121690
128	Sub Totals	\$ 218,795,300	\$ -	\$ 201,016	\$ 218,996,316	\$ 648,699,455	\$ 931,252,219	\$ 1,579,951,674	
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)				\$467,286.00				
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				\$ 218,529,030				
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 WEST GEORGIA 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 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	\$ 1,190.03		2,362	1,423	1,235	3,820	118	2,759	8,958								36.84%
2	03100 INTENSIVE CARE UNIT	\$ 3,470.59		350	28	86	203	2	188	669								36.52%
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	\$ 2,665.61		164	978	123	1	153	1,288									71.14%
11		\$ -		-	-	-	-	-	-	-								
12		\$ -		-	-	-	-	-	-	-								
13		\$ -		-	-	-	-	-	-	-								
14		\$ -		-	-	-	-	-	-	-								
15		\$ -		-	-	-	-	-	-	-								
16		\$ -		-	-	-	-	-	-	-								
17		\$ -		-	-	-	-	-	-	-								
18		\$ -		-	-	-	-	-	-	-								
19	Total Days per PS&R or Exhibit Detail			2,876	2,429	1,321	4,146	121	3,100	10,893								35.21%
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-								
21	Routine Charges	\$ 14,579,076	\$ 9,344,305	\$ 7,096,763	\$ 21,044,694	\$ 457,265	\$ 15,235,594	\$ 52,065,038	\$ 4,779,688									33.14%
21.01	Calculated Routine Charge Per Diem	\$ 5,069.22	\$ 3,846.98	\$ 5,372.27	\$ 5,075.95	\$ 3,779.05	\$ 4,914.84											
Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	09200 Observation (Non-Distinct)	0.308524	1,169,595	495,116	305,902	557,866	38,883	29,190	1,403,192	627,935	18,893	-	214,377	155,838	\$ 2,917,572	\$ 1,710,107	\$ 36,13%	
23	5000 OPERATING ROOM	0.138682	3,613,265	3,037,820	4,835,916	16,517,759	1,482,981	1,641,213	5,920,646	8,991,812	234,072	48,356	5,216,956	4,161,686	\$ 15,852,808	\$ 30,188,604	28.73%	
24	5200 DELIVERY ROOM & LABOR ROOM	0.256937	533,995	-	-	-	-	-	-	-	27,166	5,222	714,960	896,361	\$ 9,955,210	\$ 794,000	52.09%	
25	5300 ANESTHESIOLOGY	0.069107	616,488	1,169,770	1,237,124	5,821,597	327,770	515,012	1,532,360	2,857,780	61,876	15,085	1,340,378	1,282,553	\$ 3,913,722	\$ 10,364,159	57.79%	
26	5400 RADIOLOGY-DIAGNOSTIC	0.137972	781,710	3,663,871	539,033	4,517,679	441,255	1,590,454	1,590,740	7,255,175	16,491	68,010	948,123	6,235,029	\$ 3,320,738	\$ 17,027,179	14.40%	
27	5600 RADIOISOTOPE	0.076633	288,356	198,203	29,890	113,255	127,865	248,710	301,176	837,643	1,990	1,160	270,742	311,283	\$ 747,087	\$ 1,397,811	14.99%	
28	5700 CT SCAN	0.022544	2,434,985	2,774,617	648,262	4,358,423	1,524,436	1,771,722	3,698,328	6,524,058	44,386	75,124	3,340,358	10,712,286	\$ 8,306,011	\$ 15,428,820	29.40%	
29	5800 MRI	0.033687	432,099	443,104	94,370	558,346	163,038	256,657	634,944	1,279,767	9,072	683,668	438,305	1,344,451	\$ 2,538,494	\$ 1,160,073	51.91%	
30	5900 CARDIAC CATHETERIZATION	0.074661	1,096,084	674,012	444,822	1,226,769	667,919	688,198	2,049,305	2,575,759	27,465	51,569	2,381,301	1,728,517	\$ 4,248,130	\$ 5,164,738	30.25%	
31	6000 LABORATORY	0.076433	7,206,142	6,590,739	3,488,264	12,471,649	3,351,279	2,246,790	9,575,422	7,858,457	155,621	154,565	7,378,726	11,325,749	\$ 23,621,107	\$ 29,167,635	36.40%	
32	6500 RESPIRATORY THERAPY	0.115086	2,638,187	168,050	718,675	687,037	1,075,561	130,091	4,251,614	6,111,615	143,091	2,535	1,622,767	302,292	\$ 8,664,237	\$ 1,596,793	33.19%	
33	6600 PHYSICAL THERAPY	0.346524	378,365	142,685	22,320	259,455	177,830	92,404	555,134	666,539	8,191	45,223	240,325	253,593	\$ 1,133,749	\$ 1,160,073	51.96%	
34	6900 ELECTROCARDIOLOGY	0.015665	622,036	519,360	126,224	713,764	352,016	256,368	1,004,330	1,014,846	13,328	14,896	703,598	1,437,260	\$ 2,104,606	\$ 2,504,338	30.49%	
35	7000 ELECTROENCEPHALOGRAPHY	0.166649	47,210	144,696	14,063	264,468	35,722	63,411	88,704	396,197	-	4,613	92,915	60,177	\$ 185,699	\$ 868,772	34.41%	
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.386545	1,074,831	537,396	1,058,533	1,313,361	417,370	212,835	1,959,399	1,360,166	34,458	15,783	1,256,338	852,297	\$ 4,510,133	\$ 3,423,758	34.64%	
37	7200 IMPL. DEV. CHARGED TO PATIENTS	0.287242	317,239	428,468	64,094	319,589	116,817	127,714	636,859	1,568,379	17,053	7,031	375,061	427,430	\$ 1,135,099	\$ 2,444,158	36.28%	
38	7300 DRUGS CHARGED TO PATIENTS	0.156783	3,943,857	5,632,169	2,097,360	6,671,145	1,940,612	3,309,501	5,879,935	13,523,965	116,419	154,501	4,134,432	2,608,534	\$ 13,861,764	\$ 29,135,760	38.64%	
39	7400 RENAL DIALYSIS	0.089810	2,243	-	41,567	136,539	1,180,800	116,342	1,187,998	701,218	76,764	64,765	1,584,478	1,698,283	\$ 2,421,900	\$ 954,099	39.62%	
40	9002 WOUND CARE CENTER	0.190686	28,537	16,165	60,459	2,940	74,624	120,763	567,034	388,802	562	746	20,513	285,732	\$ 730,654	\$ 528,670	29.90%	
41	9100 EMERGENCY	0.113215	2,292,128	5,873,337	891,621	22,053,744	1,611,992	2,307,470	4,562,854	9,486,924	54,748	131,224	3,719,170	25,491,769	\$ 9,358,795	\$ 39,721,475	34.26%	
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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 WEST GEORGIA 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												
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					\$	29,707,332	\$	32,509,576	\$	22,281,762	\$	78,946,982	\$	15,128,670	\$	15,723,845	\$	51,215,626	\$	68,939,060	\$	1,059,646	\$	896,016	\$	36,119,186	\$	70,324,974		

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

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

Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report
128 Total Charges (includes organ acquisition from Section J)	\$ 44,286,408	\$ 32,509,576	\$ 31,626,067	\$ 78,946,982	\$ 22,225,433	\$ 15,723,845	\$ 72,260,520	\$ 68,939,060	\$ 1,516,911	\$ 896,016	\$ 51,355,180	\$ 70,324,974	\$ 170,398,428	\$ 196,119,463	31.06%
129 Total Charges per PS&R or Exhibit Detail	\$ 44,286,408	\$ 32,509,576	\$ 31,626,067	\$ 78,946,982	\$ 22,225,433	\$ 15,723,845	\$ 72,260,520	\$ 68,939,060	\$ 1,516,911	\$ 896,016	(Agrees to Exhibit A)	(Agrees to Exhibit A)			
130 Unreconciled Charges (Explain Variance)															
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 8,185,290	\$ 3,784,443	\$ 8,030,247	\$ 9,105,846	\$ 3,421,759	\$ 1,773,341	\$ 12,450,735	\$ 8,466,903	\$ 285,318	\$ 107,146	\$ 8,492,993	\$ 7,110,419	\$ 32,088,031	\$ 23,130,533	32.56%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 6,084,377	\$ 3,133,845											\$ 6,084,377	\$ 3,133,845	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 4,466,706	\$ 8,210,181									\$ 4,466,706	\$ 8,210,181	
134 Private Insurance (including primary and third party liability)	\$ 69,694	\$ 42,807											\$ 11,380,206	\$ 8,972,046	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 25	\$ 1,280	\$ 16	\$ 4,695	\$ 47	\$ 1,465	\$ 11,310,512	\$ 8,929,239					\$ 2,925	\$ 14,106	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 6,154,096	\$ 3,177,932	\$ 4,466,722	\$ 8,214,876											
137 Medicaid Cost Settlement Payments (See Note B)		\$ (177,976)												\$ (177,976)	
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)					\$ 3,261,237	\$ 1,345,883							\$ 3,261,237	\$ 1,345,883	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)															
141 Medicare Cross-Over Bad Debt Payments					\$ 140,934	\$ 65,461							\$ 140,934	\$ 65,461	
142 Other Medicare Cross-Over Payments (See Note D)					\$ 146,014								\$ 146,014		
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 217,638	\$ 758,214			
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)	\$ 2,031,194	\$ 784,487	\$ 3,563,525	\$ 890,970	\$ (126,473)	\$ 360,532	\$ 1,137,386	\$ (469,002)	\$ 285,318	\$ 107,146	\$ 8,275,355	\$ 6,352,205	\$ 6,605,632	\$ 1,566,987	
146 Calculated Payments as a Percentage of Cost	75%	79%	56%	90%	104%	80%	91%	106%	0%	0%	3%	11%	7%	93%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (CR, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					20,180										7%
148 Percent of cross-over days to total Medicare days from the cost report															

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WEST GEORGIA 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 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 Section G	From Section G	Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,190.03		5		5		43		32		85	
2	03100 INTENSIVE CARE UNIT	\$ 3,470.59						2				2	
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	\$ 2,665.61		1								1	
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days	6		5		45		32		88	
19	Total Days per PS&R or Exhibit Detail			6		5		45		32			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01	Routine Charges	\$ 24,360		\$ 24,360		\$ 22,868		\$ 252,605		\$ 147,353		\$ 447,186	
	Calculated Routine Charge Per Diem	\$ 4,060.00		\$ 4,573.60		\$ 5,613.44		\$ 4,604.78		\$ 5,081.66			
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	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.308524	-	-	1,053	-	6,958	-	1,347	-	9,358	-
23	5000 OPERATING ROOM		0.136852	3,906	-	-	-	114,174	13,766	29,879	-	147,959	13,766
24	5200 DELIVERY ROOM & LABOR ROOM		0.256937	16,052	746	-	-	-	2,258	-	-	18,310	746
25	5300 ANESTHESIOLOGY		0.069107	-	-	4,198	1,271	24,024	4,798	9,078	-	37,300	6,069
26	5400 RADIOLOGY-DIAGNOSTIC		0.137972	1,470	15,502	1,296	31,245	21,330	29,309	9,631	8,666	33,727	84,722
27	5600 RADIOISOTOPE		0.076633	-	-	-	-	-	10,612	-	-	-	10,612
28	5700 CT SCAN		0.022544	7,020	23,915	7,020	80,649	38,739	18,046	6,943	44,294	59,722	166,904
29	5800 MRI		0.033687	-	-	-	-	4,401	-	-	3,972	4,401	3,972
30	5900 CARDIAC CATHETERIZATION		0.074661	7,185	1,991	53,004	5,973	13,324	13,078	9,142	6,083	82,655	27,125
31	6000 LABORATORY		0.076433	18,619	34,482	20,743	67,688	122,447	35,556	58,901	22,653	220,710	160,379
32	6500 RESPIRATORY THERAPY		0.115086	-	845	-	3,380	94,026	6,561	21,477	4,026	115,503	14,812
33	6600 PHYSICAL THERAPY		0.346324	563	-	563	-	7,078	2,712	7,134	1,254	15,338	3,966
34	6900 ELECTROCARDIOLOGY		0.015665	3,136	4,704	5,488	5,488	14,896	2,352	3,920	1,568	27,440	14,112
35	7000 ELECTROENCEPHALOGRAPHY		0.166649	-	-	-	-	-	-	-	-	-	-
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.386545	1,207	637	2,925	1,612	22,456	4,788	15,613	352	42,201	7,389
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.287242	-	-	-	-	8,600	-	19,384	-	27,984	-
38	7300 DRUGS CHARGED TO PATIENTS		0.156783	4,912	3,009	11,424	7,479	57,253	10,363	37,720	2,946	111,309	23,797
39	7400 RENAL DIALYSIS		0.089810	-	-	-	-	53,823	-	31,446	1,774	85,269	1,774
40	9002 WOUND CARE CENTER		0.190686	-	-	-	-	-	2,238	-	746	-	2,984
41	9100 EMERGENCY		0.113215	3,089	93,516	12,436	203,739	57,710	50,852	24,278	61,742	97,513	409,849
42													
43													
44													
45													
46													
47													
48													
49													

I. Out-of-State Medicaid Data:

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

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Over (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										\$ -	\$ -
		\$ 67,159	\$ 179,347	\$ 120,150	\$ 408,524	\$ 661,239	\$ 205,031	\$ 288,151	\$ 160,076		

Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 91,519	\$ 179,347	\$ 143,018	\$ 408,524	\$ 913,844	\$ 205,031	\$ 435,504	\$ 160,076	\$ 1,583,885	\$ 952,978
129	Total Charges per PS&R or Exhibit Detail	\$ 91,519	\$ 179,347	\$ 143,018	\$ 408,524	\$ 913,844	\$ 205,031	\$ 435,504	\$ 160,076		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 17,426	\$ 17,130	\$ 17,056	\$ 37,173	\$ 136,863	\$ 22,564	\$ 78,556	\$ 13,325	\$ 249,901	\$ 90,192
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 701							\$ -	\$ 701
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 4,218	\$ 11,728					\$ 4,218	\$ 11,728
134	Private Insurance (including primary and third party liability)							\$ 164,541	\$ 18,164	\$ 164,541	\$ 18,164
135	Self-Pay (including Co-Pay and Spend-Down)		\$ 75				\$ 67			\$ -	\$ 142
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ 776	\$ 4,218	\$ 11,728						
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)					\$ 105,639	\$ 17,020			\$ 105,639	\$ 17,020
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)	\$ 17,426	\$ 16,354	\$ 12,838	\$ 25,445	\$ 31,224	\$ 5,477	\$ (85,985)	\$ (4,839)	\$ (24,497)	\$ 42,437
144	Calculated Payments as a Percentage of Cost	0%	5%	25%	32%	77%	76%	209%	136%	110%	53%

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 WEST GEORGIA 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 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 WEST GEORGIA 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 WEST GEORGIA HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 2,714,409	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	4610-4612950 (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 ----->)	\$ 2,714,409	
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	\$ 2,714,409
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	371,467,681
19 Uninsured Hospital Charges Sec. G	121,680,154
20 Total Hospital Charges Sec. G	1,579,951,674
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	23.51%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.70%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 638,194
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 209,051
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ 847,245
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	188,191,441
27 Uninsured Hospital Charges Sec. G	124,093,081
28 Total Hospital Charges Sec. G	1,579,951,674
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	11.91%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	7.85%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 323,319
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 213,196
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 536,515

* 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.