

SFY 2026 Medicaid ICTF Survey

**Wellstar Windy Hill 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:	000001999A
7 Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8 Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9 Medicare Provider Number:	112007

**B. DSH Qualifying Information**

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

<b>DSH Examination Year (07/01/25 - 06/30/26)</b>
Yes

**During the DSH Examination Year:**

1 Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)

2 Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?

3 Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?

3a Was the hospital open as of December 22, 1987?

3b What date did the hospital open?

**C. Disclosure of Other Medicaid Payments Received:**

For State DSH Year 2026

- 1 **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** \$ 121,882  
*(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** \$ 121,882

**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	 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	(470) 956-4981
E-Mail Address	ebenezer_erzuah@wellstar.org
Mailing Street Address	1800 Parkway Place, Suite 500
Mailing City, State, Zip	Marietta, GA 30067

**Outside Preparer:**

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

98  
11/11/25  
Ebbie  
11/11/25

**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 WINDY HILL HOSPITAL

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

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

X

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

1 - As Submitted

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

12/4/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WELLSTAR WINDY HILL HOSPITAL	Yes	
5. Medicaid Provider Number:	000001999A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	112007	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 2	Yes	
11. Rural Referral Center (Yes or No)	No	Yes	

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

	State Name	Provider No.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

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

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	\$	-		
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-		
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	\$	-		
4. <b>Total Section 1011 Payments Related to Hospital Services (See Note 1)</b>		\$-		
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. <b>Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)</b>		\$-		
8. <b>Out-of-State DSH Payments (See Note 2)</b>	\$	-		
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	\$	-	\$ 1,183,179	\$1,183,179
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$	37,997	\$ 17,194,033	\$17,232,030
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)		\$37,997	\$18,377,212	\$18,415,209
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:		0.00%	6.44%	6.43%
13. Did your hospital receive any Medicaid <u>managed care</u> 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) 9,852 (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	3,080
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	\$ 3,080
7. Inpatient Hospital Charity Care Charges	6,125,246
8. Outpatient Hospital Charity Care Charges	9,154,714
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 15,279,960

**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	\$0.00			\$ -	\$ -	\$ -	\$ -
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$0.00			\$ -	
15. Swing Bed - NF			\$0.00			\$ -	
16. Skilled Nursing Facility			\$0.00			\$ -	
17. Nursing Facility			\$0.00			\$ -	
18. Other Long-Term Care			\$48,399,628.00			\$ 38,906,222	
19. Ancillary Services	\$86,174,501.00	\$760,625,924.00		\$ 69,271,695	\$ 611,431,997	\$ -	\$ 166,096,733
20. Outpatient Services		\$114,910.00			\$ 92,371	\$ -	\$ 22,539
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	\$ 86,174,501	\$ 760,740,834	\$ 48,399,628	\$ 69,271,695	\$ 611,524,368	\$ 38,906,222	\$ 166,119,272
28. Total Hospital and Non Hospital		Total from Above	\$ 895,314,963		Total from Above	\$ 719,702,285	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	895,314,963	Total Contractual Adj. (G-3 Line 2)	721,440,066
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)				77,645
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)				1,815,426
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				719,702,285
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 WINDY HILL 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 &amp; 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. I, Line 2 for Adults &amp; 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	\$ 19,378,222	\$ -	\$ 9,203	\$0.00	\$ 19,387,425	9,864	\$ 47,747,945.00	\$ 1,965.47
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 Routine	\$ 19,378,222	\$ -	\$ 9,203	\$ -	\$ 19,387,425	9,864	\$ 47,747,945	
19		Weighted Average								\$ 1,965.47

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)	12	-	\$ 23,586	\$233,170.00	\$15,116.00	\$ 248,286	0.094995

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	Total Cost	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
--	--	---	------------	--	---	--	--

**Ancillary Cost Centers (from W/S C excluding Observation) (list below):**

5000	OPERATING ROOM	\$18,805,436.00	\$ -	\$ -	\$ 18,805,436	\$3,603,634.00	\$175,731,017.00	\$ 179,334,651	0.104862
5400	RADIOLOGY-DIAGNOSTIC	\$4,325,524.00	\$ -	\$ -	\$ 4,325,524	\$1,642,671.00	\$34,205,183.00	\$ 35,847,854	0.120663
5600	RADIOISOTOPE	\$184,048.00	\$ -	\$ -	\$ 184,048	\$6,361.00	\$2,166,233.00	\$ 2,172,594	0.084713
5700	CT SCAN	\$2,938,581.00	\$ -	\$ -	\$ 2,938,581	\$1,427,423.00	\$50,859,113.00	\$ 52,286,536	0.056201
5800	MRI	\$1,750,400.00	\$ -	\$ -	\$ 1,750,400	\$131,495.00	\$31,993,178.00	\$ 32,124,673	0.054488
5900	CARDIAC CATHETERIZATION	\$708,052.00	\$ -	\$ 1,845	\$ 709,897	\$147,406.00	\$4,316,793.00	\$ 4,464,199	0.159020
6000	LABORATORY	\$1,794,272.00	\$ -	\$ 4,955	\$ 1,799,227	\$9,356,829.00	\$6,041,809.00	\$ 15,398,638	0.116843
6500	RESPIRATORY THERAPY	\$5,359,875.00	\$ -	\$ 2,118	\$ 5,361,993	\$42,742,560.00	\$881,470.00	\$ 43,624,030	0.122914
6600	PHYSICAL THERAPY	\$84,304,661.00	\$ -	\$ -	\$ 84,304,661	\$4,165,840.00	\$398,840,889.00	\$ 403,006,729	0.209189

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WINDY HILL 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	6900 ELECTROCARDIOLOGY	\$16,063.00	\$ -	\$ -	\$ 16,063	\$142,580.00	\$48,716.00	\$ 191,296	0.083969
31	7000 ELECTROENCEPHALOGRAPHY	\$1,805,910.00	\$ -	\$ -	\$ 1,805,910	\$127,329.00	\$6,720,625.00	\$ 6,847,954	0.263715
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$6,712,708.00	\$ -	\$ -	\$ 6,712,708	\$2,714,006.00	\$12,558,949.00	\$ 15,272,955	0.439516
33	7200 IMPL. DEV. CHARGED TO PATIENTS	\$5,895,367.00	\$ -	\$ -	\$ 5,895,367	\$40,149.00	\$23,060,878.00	\$ 23,101,027	0.255199
34	7300 DRUGS CHARGED TO PATIENTS	\$5,642,233.00	\$ -	\$ -	\$ 5,642,233	\$15,692,110.00	\$10,626,819.00	\$ 26,318,929	0.214379
35	7400 RENAL DIALYSIS	\$615,520.00	\$ -	\$ -	\$ 615,520	\$7,211,758.00	\$0.00	\$ 7,211,758	0.085350
36		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

**G. Cost Report - Cost / Days / Charges**

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WINDY HILL 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	<b>Total Ancillary</b>	\$ 140,858,650	\$ -	\$ 8,918	\$ 140,867,568	\$ 89,385,321	\$ 758,066,788	\$ 847,452,109	
127	<b>Weighted Average</b>								0.166252
128	<b>Sub Totals</b>	\$ 160,236,872	\$ -	\$ 18,121	\$ 160,254,993	\$ 137,133,266	\$ 758,066,788	\$ 895,200,054	
129	NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)				\$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)				\$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	<b>Grand Total</b>				\$ 160,254,993				
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 WINDY HILL 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				
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>			
1	03000 ADULTS & PEDIATRICS	\$ 1,965.47		664	-	-	-	738	-	593	-	96	-	472	-	2,091	-	26.24%	
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		\$ -																	
				<b>Total Days</b>				<b>738</b>		<b>593</b>		<b>96</b>		<b>472</b>		<b>2,091</b>		<b>26.21%</b>	
19	Total Days per PS&R or Exhibit Detail				664	-	738	-	593	-	96	-	472	-	2,091	-			
20	Unreconciled Days (Explain Variance)																		
21	<b>Routine Charges</b>				<b>\$ 2,348,869</b>	<b>\$ -</b>	<b>\$ 3,040,938</b>	<b>\$ -</b>	<b>\$ 3,218,165</b>	<b>\$ -</b>	<b>\$ 592,914</b>	<b>\$ -</b>	<b>\$ 2,032,558</b>	<b>\$ -</b>	<b>\$ 8,607,972</b>	<b>\$ -</b>		<b>22.40%</b>	
21.01	Calculated Routine Charge Per Diem				\$ 3,537.45	\$ -	\$ 4,120.51	\$ -	\$ 5,426.92	\$ -	\$ 6,176.19	\$ -	\$ 4,306.27	\$ -	\$ 4,116.68	\$ -			
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
22	09200 Observation (Non-Distinct)		0.094995	-	-	-	-	-	-	-	4,340	-	-	-	-	\$ -	\$ 4,340	1.75%	
23	5000 OPERATING ROOM		0.104862	396,974	2,196,479	-	13,669,868	183,843	531,893	109,580	4,118,716	1,050	36,878	153,949	2,875,342	\$ 690,197	\$ 20,516,956	13.54%	
24	5400 RADIOLOGY-DIAGNOSTIC		0.120663	78,389	163,196	-	628,091	194,699	199,395	177,417	600,575	11,878	4,561	87,829	786,589	\$ 450,505	\$ 1,591,258	8.19%	
25	5600 RADIOISOTOPE		0.084713	2,863	2,863	-	2,951	32,419	-	46,233	-	-	-	13,997	-	\$ -	\$ 84,495	0.25%	
26	5700 CT SCAN		0.056201	51,685	207,231	-	512,530	96,255	340,496	50,160	1,211,572	-	-	19,545	58,311	7,582,351	\$ 198,100	2,271,829	19.39%
27	5800 MRI		0.054488	3,972	210,507	-	536,520	9,511	291,450	-	922,080	-	26,547	8,802	462,745	\$ 13,483	\$ 1,960,557	17.11%	
28	5900 CARDIAC CATHETERIZATION		0.159020	10,870	-	-	24,864	19,054	40,037	4,706	65,884	-	8,178	6,778	96,706	\$ 34,630	\$ 130,585	5.31%	
29	6000 LABORATORY		0.116843	591,520	60,170	-	193,390	844,084	41,055	392,944	106,971	38,668	-	104,708	356,352	\$ 1,828,548	\$ 1,828,548	17.89%	
30	6500 RESPIRATORY THERAPY		0.122914	1,650,841	-	-	845	3,334,271	11,441	3,345,611	26,258	634,427	-	1,464,304	17,263	\$ 8,330,723	\$ 38,544	24.04%	
31	6600 PHYSICAL THERAPY		0.209189	196,742	4,006,481	-	16,237,957	228,407	2,943,892	221,281	15,911,874	94,333	3,360,402	229,110	5,183,808	\$ 646,430	\$ 39,100,204	12.07%	
32	6900 ELECTROCARDIOLOGY		0.083969	13,328	3,317	-	248	15,680	-	1,568	908	1,568	-	6,272	372	\$ 30,576	\$ 4,473	23.02%	
33	7000 ELECTROENCEPHALOGRAPHY		0.263715	4,613	130,114	-	376,505	7,215	2,209	228,516	-	1,105	-	7,019	72,908	\$ 14,036	\$ 784,273	12.84%	
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.439516	156,708	123,618	-	1,052,146	239,493	35,482	155,512	269,631	20,353	199	106,121	228,861	\$ 551,683	\$ 1,480,877	15.64%	
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.255199	7,822	216,187	-	1,214,068	6,454	71,701	7,822	362,922	-	-	7,067	617,958	\$ 22,098	\$ 1,864,878	10.44%	
36	7300 DRUGS CHARGED TO PATIENTS		0.214379	910,262	607,203	-	542,830	873,537	36,193	546,221	409,476	77,582	30,423	473,786	209,101	\$ 2,330,020	\$ 1,495,702	17.55%	
37	7400 RENAL DIALYSIS		0.085350	18,017	-	-	-	461,358	-	65,826	-	10,309	-	579,486	-	\$ 545,201	\$ -	15.77%	
38																			
39																			
40																			
41																			
42																			
43																			
44																			
45																			
46																			
47																			
48																			
49																			
50																			
51																			
52																			
53																			
54																			
55																			
56																			
57																			
58																			
59																			
60																			
61																			
62																			
63																			
64																			
65																			
66																			
67																			
68																			
69																			
70																			
71																			

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WINDY HILL 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												
72																														
73																														
74																														
75																														
76																														
77																														
78																														
79																														
80																														
81																														
82																														
83																														
84																														
85																														
86																														
87																														
88																														
89																														
90																														
91																														
92																														
93																														
94																														
95																														
96																														
97																														
98																														
99																														
100																														
101																														
102																														
103																														
104																														
105																														
106																														
107																														
108																														
109																														
110																														
111																														
112																														
113																														
114																														
115																														
116																														
117																														
118																														
119																														
120																														
121																														
122																														
123																														
124																														
125																														
126																														
127																														
					\$	4,091,743	\$	7,827,396	\$	-	\$	34,993,213	\$	6,513,631	\$	4,624,593	\$	5,080,856	\$	24,285,955	\$	888,168	\$	3,488,181	\$	3,545,185	\$	18,084,407		

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

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WINDY HILL 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
<b>Totals / Payments</b>															
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 6,440,612	\$ 7,827,396	\$ -	\$ 34,993,213	\$ 9,554,569	\$ 4,624,593	\$ 8,299,021	\$ 24,285,955	\$ 1,481,082	\$ 3,488,181	\$ 5,577,743	\$ 18,084,407	\$ 24,294,202	\$ 71,731,157	13.38%
129 Total Charges per PS&R or Exhibit Detail	\$ 6,440,612	\$ 7,827,396	\$ -	\$ 34,993,213	\$ 9,554,569	\$ 4,624,593	\$ 8,299,021	\$ 24,285,955	\$ 1,481,082	\$ 3,488,181	\$ 5,577,743	\$ 18,084,407	\$ 24,294,202	\$ 71,731,157	
130 Unreconciled Charges (Explain Variance)															
131 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 1,944,077	\$ 1,371,351	\$ -	\$ 5,978,966	\$ 2,395,218	\$ 800,608	\$ 1,899,191	\$ 4,341,066	\$ 318,815	\$ 718,163	\$ 1,430,677	\$ 2,250,182	\$ 6,238,486	\$ 12,491,991	14.02%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 1,357,001	\$ 1,381,679											\$ 1,357,001	\$ 1,381,679	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 6,096,150										\$ 6,096,150	
134 Private Insurance (including primary and third party liability)	\$ 4,746	\$ 24,084					\$ 908,074	\$ 3,733,209					\$ 912,820	\$ 3,757,293	
135 Self-Pay (including Co-Pay and Spend-Down)		\$ 237		\$ 6,136		\$ 849								\$ 11,335	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 1,361,747	\$ 1,406,000	\$ -	\$ 6,102,286											
137 Medicaid Cost Settlement Payments (See Note B)		\$ (163,812)												\$ (163,812)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)															
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					\$ 1,376,246	\$ 476,962							\$ 1,376,246	\$ 476,962	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)															
141 Medicare Cross-Over Bad Debt Payments					\$ 66,624	\$ 6,080							\$ 66,624	\$ 6,080	
142 Other Medicare Cross-Over Payments (See Note D)															
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													\$ -	\$ 1,183,179	
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)													\$ -	\$ -	
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 582,330	\$ 129,163	\$ -	\$ (123,320)	\$ 952,348	\$ 316,717	\$ 991,117	\$ 603,744	\$ 318,815	\$ 718,163	\$ 1,430,677	\$ 1,067,003	\$ 2,525,795	\$ 926,304	
146 <b>Calculated Payments as a Percentage of Cost</b>	70%	91%	0%	102%	60%	60%	48%	86%	0%	0%	0%	53%	60%	93%	
147 <b>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 &amp; 6)</b>					4,849										15%
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>															

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.**  
**NOTE: Outpatient 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 WINDY HILL 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-Over (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)
<b>Routine Cost Centers (list below):</b>				<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>		<b>Days</b>	
1	03000 ADULTS & PEDIATRICS	\$ 1,965.47		-		22		-		-		22	
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		\$ -											
			<b>Total Days</b>	-		22		-		-		22	
19	Total Days per PS&R or Exhibit Detail				-	22		-		-		-	
20	Unreconciled Days (Explain Variance)				-	-		-		-		-	
21	<b>Routine Charges</b>												
21.01	Routine Charges	\$ -		\$ -		\$ 56,716		\$ -		\$ -		\$ 56,716	
	Calculated Routine Charge Per Diem	\$ -		\$ -		2,578.00		\$ -		\$ -		2,578.00	
22	<b>Ancillary Cost Centers (from W/S C) (list below):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>
22	09200 Observation (Non-Distinct)	0.094995		-		-		-		-		-	
23	5000 OPERATING ROOM	0.104862		-		-		-		-		-	
24	5400 RADIOLOGY-DIAGNOSTIC	0.120663		-		8,515		-		-		8,515	
25	5600 RADIOISOTOPE	0.084713		-		-		-		-		-	
26	5700 CT SCAN	0.056201		-		7,276		-		-		7,276	
27	5800 MRI	0.054488		-		-	3,972	-		-		-	3,972
28	5900 CARDIAC CATHETERIZATION	0.159020		-		-		-		-		-	
29	6000 LABORATORY	0.116843		-		11,963		-		-		11,963	
30	6500 RESPIRATORY THERAPY	0.122914		-		-		-		-		-	
31	6600 PHYSICAL THERAPY	0.209189		-		16,067		-	9,988	-	1,907	16,067	11,895
32	6900 ELECTROCARDIOLOGY	0.083969		-		784		-		-		784	
33	7000 ELECTROENCEPHALOGRAPHY	0.263715		-		-		-		-		-	
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.439516		-		1,015		-		-		1,015	
35	7200 IMPL. DEV. CHARGED TO PATIENTS	0.255199		-		-		-		-		-	
36	7300 DRUGS CHARGED TO PATIENTS	0.214379		-		2,668		-		-		2,668	
37	7400 RENAL DIALYSIS	0.085350		-		2,005		-		-		2,005	
38		-		-		-		-		-		-	
39		-		-		-		-		-		-	
40		-		-		-		-		-		-	
41		-		-		-		-		-		-	
42		-		-		-		-		-		-	
43		-		-		-		-		-		-	
44		-		-		-		-		-		-	
45		-		-		-		-		-		-	
46		-		-		-		-		-		-	
47		-		-		-		-		-		-	
48		-		-		-		-		-		-	
49		-		-		-		-		-		-	



**I. Out-of-State Medicaid Data:**

Cost Report Year (07/01/2023-06/30/2024) WELLSTAR WINDY HILL 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										\$ -	\$ -
		\$ -	\$ -	\$ 50,293	\$ 3,972	\$ -	\$ 9,988	\$ -	\$ 1,907	\$ -	\$ -

<b>Totals / Payments</b>											
128	<b>Total Charges (includes organ acquisition from Section K)</b>	\$ -	\$ -	\$ 107,009	\$ 3,972	\$ -	\$ 9,988	\$ -	\$ 1,907	\$ 107,009	\$ 15,867
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ -	\$ 107,009	\$ 3,972	\$ -	\$ 9,988	\$ -	\$ 1,907		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	<b>Total Calculated Cost (includes organ acquisition from Section K)</b>	\$ -	\$ -	\$ 50,691	\$ 216	\$ -	\$ 2,089	\$ -	\$ 399	\$ 50,691	\$ 2,704
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)									\$ -	\$ -
134	Private Insurance (including primary and third party liability)								\$ 238	\$ -	\$ 238
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$ -	\$ -						
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)						\$ 925			\$ -	\$ 925
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	<b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ -	\$ -	\$ 50,691	\$ 216	\$ -	\$ 1,164	\$ -	\$ 161	\$ 50,691	\$ 1,541
144	<b>Calculated Payments as a Percentage of Cost</b>	0%	0%	0%	0%	0%	44%	0%	60%	0%	43%

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 WINDY HILL 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
<b>Organ Acquisition Cost Centers (list below):</b>																	
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	<b>Totals</b>	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -		\$ -		\$ -	
10	<b>Total Cost</b>																

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 WINDY HILL 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)
<b>Organ Acquisition Cost Centers (list below):</b>													
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	<b>Totals</b>	\$ -	\$ -	\$ -	0	\$ -		\$ -		\$ -		\$ -	
20	<b>Total Cost</b>												

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 WINDY HILL HOSPITAL

**Worksheet A Provider Tax Assessment Reconciliation:**

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 1,815,426	
1a Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	45000-CC 4722950-RC45013 (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 ----->)	\$ 1,815,426	
<b>Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)</b>		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
<b>DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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))
<b>DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)</b>		
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	\$ 1,815,426
<b>Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible &amp; Uninsured:</b>	
18 Medicaid Eligible*** Charges Sec. G	101,117,498
19 Uninsured Hospital Charges Sec. G	23,662,150
20 Total Hospital Charges Sec. G	895,200,054
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	11.30%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	2.64%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 205,062
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 47,986
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ 253,048
<b>Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary &amp; Uninsured:</b>	
26 Medicaid Primary*** Charges Sec. G	49,372,202
27 Uninsured Hospital Charges Sec. G	28,631,413
28 Total Hospital Charges Sec. G	895,200,054
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC**	5.52%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	3.20%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 100,125
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 58,063
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 158,188

\* 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.