State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

DSH Version 6.02 2/10/2023

General DSH Year Information

	Begin	End
. DSH Year:	07/01/2024	06/30/2025
. Select Your Facility from the Drop-Down Menu Provided:	WILLS MEMORIAL HOSPITAL	

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
. Cost Report Year 1	05/01/2022	04/30/2023	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
. Cost Report Year 2 (if applicable)			
. Cost Report Year 3 (if applicable)			

	Data
. Medicaid Provider Number:	000002087A
. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
. Medicare Provider Number:	111325

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 (07/01/24 - 06/30/25)
. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
. 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
. Was the hospital open as of December 22, 1987?	Yes
. What date did the hospital open?	3/27/1978

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Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** — $ 60,966
   (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 07/01/2024 - 06/30/2025** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** — $ 60,966

ɔrtification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CEO Title	2/5/2025 Date
Tracie Haughey Hospital CEO or CFO Printed Name	706-678-9213 Hospital CEO or CFO Telephone Number	thaughey@willsmemorialhospital.com Hospital CEO or CFO E-Mail

Contact information for individuals authorized to respond to inquiries related to this survey:

Hospital Contact:

Name	Tracie Haughey
Title	CEO
Telephone Number	706-678-9213
E-Mail Address	thaughey@willsmemorialhospital.com
Mailing Street Address	120 Gordon Street
Mailing City, State, Zip	Washington, GA 30673

Outside Preparer:

Name	Wilson E. Joiner, III
Title	Partner
Firm Name	Dralfin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bjoiner@dralfin-tucker.com

DSH Version 9.00 9/11/2024

D. General Cost Report Year Information 5/1/2022 - 4/30/2023

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:	WILLS MEMORIAL HOSPITAL
	5/1/2022 through 4/30/2023
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:	9/9/2023

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WILLS MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000002087A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	111325	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	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.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (05/01/2022 - 04/30/2023

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 7,581	$ 75,926	$83,507
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 8,949	$ 256,960	$265,909
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$16,530	$332,886	$349,416
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	45.86%	22.81%	23.90%

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 (05/01/2022 - 04/30/2023)

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) — 692 (See Note in Section F-3, below)

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

2. Inpatient Hospital Subsidies	
3. Outpatient Hospital Subsidies	
4. Unspecified I/P and O/P Hospital Subsidies	
5. Non-Hospital Subsidies	
6. Total Hospital Subsidies	$ -
7. Inpatient Hospital Charity Care Charges	37,214
8. Outpatient Hospital Charity Care Charges	424,621
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	$ 461,835

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

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

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$385,872.00			$ 139,468	$ -	$ -	$ 246,404
12. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13. Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$625,075.00			$ 225,925	
15. Swing Bed - NF			$0.00			$ -	
16. Skilled Nursing Facility			$0.00			$ -	
17. Nursing Facility			$0.00			$ -	
18. Other Long-Term Care			$0.00			$ -	
19. Ancillary Services	$3,757,406.00	$11,077,250.00		$ 1,358,065	$ 4,003,727	$ -	$ 9,472,864
20. Outpatient Services		$3,545,412.00			$ 1,281,443	$ -	$ 2,263,969
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	$3,093,778.00	$ -	$ -	$ 1,118,206	$ -
27. Total	$ 4,143,278	$ 14,622,662	$ 3,718,853	$ 1,497,534	$ 5,285,170	$ 1,344,131	$ 11,983,237
28. Total Hospital and Non Hospital		Total from Above	$ 22,484,793		Total from Above	$ 8,126,834	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	22,484,793	Total Contractual Adj. (G-3 Line 2)	7,560,184
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)			+	566,650
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36. Adjusted Contractual Adjustments				8,126,834
37. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2022-04/30/2023) WILLS MEMORIAL HOSPITAL

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 4,930,526	$ -	$ -	$2,929,402.00	$ 2,001,124	1,380	$972,893.00		$ 1,450.09
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 4,930,526	$ -	$ -	$ 2,929,402	$ 2,001,124	1,380	$ 972,893		
19	Weighted Average									$ 1,450.09

Line #		*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*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	688	-	-	$ 997,662	$20,363.00	$637,064.00	$ 657,427	1.517525

Line #		*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*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below)								
21	5000 OPERATING ROOM	$381,399.00	$ -	$ -	$ 381,399	$7,731.00	$333,166.00	$ 340,897	1.118810
22	5400 RADIOLOGY-DIAGNOSTIC	$1,173,403.00	$ -	$ -	$ 1,173,403	$243,268.00	$3,181,073.00	$ 3,424,341	0.342665
23	6000 LABORATORY	$1,466,499.00	$ -	$ -	$ 1,466,499	$252,814.00	$2,089,250.00	$ 2,342,064	0.626157
24	6500 RESPIRATORY THERAPY	$1,727,898.00	$ -	$ -	$ 1,727,898	$872,564.00	$1,515,621.00	$ 2,388,185	0.723519
25	6600 PHYSICAL THERAPY	$958,107.00	$ -	$ -	$ 958,107	$430,013.00	$975,916.00	$ 1,405,929	0.681476
26	6700 OCCUPATIONAL THERAPY	$353,907.00	$ -	$ -	$ 353,907	$489,568.00	$233,854.00	$ 723,422	0.489212
27	6800 SPEECH PATHOLOGY	$131,288.00	$ -	$ -	$ 131,288	$115,043.00	$37,047.00	$ 152,090	0.863226
28	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$292,647.00	$ -	$ -	$ 292,647	$215,658.00	$659,330.00	$ 874,988	0.334458
29	7200 IMPL. DEV. CHARGED TO PATIENTS	$6,222.00	$ -	$ -	$ 6,222	$0.00	$64,843.00	$ 64,843	0.095955
30	7300 DRUGS CHARGED TO PATIENTS	$791,078.00	$ -	$ -	$ 791,078	$1,099,074.00	$1,427,321.00	$ 2,526,395	0.313125
31	9000 CLINIC	$197,538.00	$ -	$ -	$ 197,538	$0.00	$102,771.00	$ 102,771	1.922118

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2022-04/30/2023) WILLS MEMORIAL 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
32	9100	EMERGENCY	$1,772,816.00	$ -	$ -	$ 1,772,816	$196,373.00	$3,218,398.00	$ 3,414,771	0.519161
33			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
34			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
35			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
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	$ -	-
90			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (05/01/2022-04/30/2023) WILLS MEMORIAL 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
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	$ 9,252,802	$ -	$ -	$ 9,252,802	$ 3,942,469	$ 14,475,654	$ 18,418,123	
127		Weighted Average								0.556542
128		Sub Totals	$ 14,183,328	$ -	$ -	$ 11,253,926	$ 4,915,362	$ 14,475,654	$ 19,391,016	
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)*				$1,213,257.00				
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				$ 10,040,669				
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 (MM/DD/YYYY-MM/DD/YYYY): WILLS MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Payables (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	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	$ 1,450.09		93				64		146				40		303		49.97%
2	03100 INTENSIVE CARE UNIT	$ -														-		
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ -														-		
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			Total Days	93		-		64		146		-		40		303		24.86%
19	Total Days per PS&R or Exhibit Detail			93		-		64		146		-		40				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21.01	Calculated Routine Charge Per Diem			$ 47,430		$ -		$ 37,640		$ 84,456		$ -		$ 20,400		$ 164,526		19.01%
				$ 510.00				$ 510.00		$ 578.47				$ 510.00		$ 542.99		
	Ancillary Cost Centers (from WS C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		1.517525	3,737	9,472		8,193	2,590	35,044	-	186,194			4,369	49,224	$ 6,327	$ 236,903	45.15%
23	5000 OPERATING ROOM		1.118810	-	-		6,837	-	19,005	-	64,560			-	-	$ -	$ 90,392	
24	5400 RADIOLOGY-DIAGNOSTIC		0.342665	29,684	105,204		249,626	36,763	146,248	59,586	468,642			9,123	324,744	$ 126,033	$ 969,918	
25	6000 LABORATORY		0.626157	40,971	118,911		163,570	34,097	92,144	57,324	314,639			13,611	280,867	$ 132,393	$ 689,814	
26	6500 RESPIRATORY THERAPY		0.723519	29,172	19,561		37,809	18,785	47,789	70,788	251,346			7,992	37,507	$ 118,745	$ 356,505	152.76%
27	6600 PHYSICAL THERAPY		0.681476	5,229	13,757		37,537	5,949	51,009	10,762	61,705			424	3,848	$ 21,946	$ 184,000	6.14%
28	6700 OCCUPATIONAL THERAPY		0.489212	4,716	-		1,695	6,122	28,568	11,869	16,878			281	1,940	$ 23,327	$ 47,281	3.11%
29	6800 SPEECH PATHOLOGY		0.863226	167	264		-	1,696	5,072	5,573	2,562			-	599	$ 7,636	$ 7,918	0.64%
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.334458	14,418	32,380		99,578	11,406	27,682	21,753	103,568			1,591	68,665	$ 47,577	$ 263,228	28.48%
31	7200 IMPL DEV. CHARGED TO PATIENTS		0.095955	-	-		-	-	-	-	18,396			-	-	$ -	$ 18,396	2.54%
32	7300 DRUGS CHARGED TO PATIENTS		0.313125	51,146	27,992		32,915	47,246	118,490	42,576	344,333			44,293	95,680	$ 140,969	$ 523,730	529.68%
33	9000 CLINIC		1.922110	-	5,982		844	-	18,766	-	14,926			-	2,502	$ -	$ 40,510	1.92%
34	9100 EMERGENCY		0.519161	34,271	170,500		456,199	24,799	143,617	34,175	446,605			70,353	514,699	$ 93,245	$ 1,257,121	2944.78%
35			-													$ -	$ -	0.00%
36			-													$ -	$ -	0.00%
37			-													$ -	$ -	0.00%
38			-													$ -	$ -	
39			-													$ -	$ -	
40			-													$ -	$ -	
41			-													$ -	$ -	
42			-													$ -	$ -	
43			-													$ -	$ -	
44			-													$ -	$ -	
45			-													$ -	$ -	
46			-													$ -	$ -	
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72			-													$ -	$ -	
73			-													$ -	$ -	

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

Cost Report Year 05/01/2022-04/30/2023 | WILLS MEMORIAL 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 Eligible's (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
74		-													$ -	$ -	
75		-													$ -	$ -	
76		-													$ -	$ -	
77		-													$ -	$ -	
78		-													$ -	$ -	
79		-													$ -	$ -	
80		-													$ -	$ -	
81		-													$ -	$ -	
82		-													$ -	$ -	
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121		-													$ -	$ -	
122		-													$ -	$ -	
123		-													$ -	$ -	
124		-													$ -	$ -	
125		-													$ -	$ -	
126		-													$ -	$ -	
127		-													$ -	$ -	
			$ 213,517	$ 504,043	$ -	$ 1,132,952	$ 190,255	$ 733,972	$ 314,420	$ 2,314,764	$ -	$ -	$ 152,034	$ 1,390,673			

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

Cost Report Year (05/01/2022-04/30/2023) WILLS MEMORIAL 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)*	$ 260,947	$ 504,043	$ -	$ 1,132,952	$ 222,895	$ 733,972	$ 398,882	$ 2,314,764	$ -	$ -	$ 172,434 (Agrees to Exhibit A)	$ 1,399,673 (Agrees to Exhibit A)	$ 882,723	$ 4,685,731	30.82%
129	Total Charges per PS&R or Exhibit Detail	$ 260,947	$ 504,043	$ -	$ 1,132,952	$ 222,895	$ 733,972	$ 398,882	$ 2,314,764	$ -	$ -	$ 172,434	$ 1,399,673			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	Total Calculated Cost (includes organ acquisition from Section J)	$ 242,110	$ 268,263	$ -	$ 561,678	$ 184,738	$ 427,283	$ 375,552	$ 1,365,328	$ -	$ -	$ 133,412	$ 724,503	$ 802,400	$ 2,622,552	42.66%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 131,550	$ 231,448			$ 49,541	$ 24,602	$ 9,739	$ 67,611					$ 190,830	$ 323,861	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 372,760				$ 34,533					$ -	$ 372,760	
134	Private Insurance (including primary and third party liability)	$ 12,726	$ 314			$ 6,362								$ 19,088	$ 34,847	
135	Self-Pay (including Co-Pay and Spend-Down)				$ 2,232		$ 230		$ 37					$ -	$ 2,499	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 144,276	$ 231,762	$ -	$ 374,992											
137	Medicaid Cost Settlement Payments (See Note B)		$ (19,214)											$ -	$ (19,214)	
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)					$ 281,417	$ 135,065							$ 281,417	$ 135,065	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 284,362	$ 1,118,833					$ 284,362	$ 1,118,833	
141	Medicare Cross-Over Bad Debt Payments					$ 1,655	$ 22,421							$ 1,855	$ 22,421	
142	Other Medicare Cross-Over Payments (See Note D)					$ (156,881)	$ 236,974							$ (156,881)	$ 236,974	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ 7,581	$ 75,926			
145												$ -	$ -			
146	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	$ 97,834	$ 55,715	$ -	$ 186,686	$ 2,444	$ 7,991	$ 81,451	$ 144,114	$ -	$ -	$ 125,831	$ 648,577	$ 181,729	$ 394,506	
	Calculated Payments as a Percentage of Cost	60%	79%	0%	67%	99%	98%	78%	89%	0%	0%	6%	10%	77%	85%	
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6					505										
148	Percent of cross-over days to total Medicare days from the cost report					13%										

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 surve
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 payment
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).

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 (05/01/2022-04/30/2023) WILLS MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	Charges Sec. G	5,568,455
19	Uninsured Hospital	Charges Sec. G	1,572,107
20	Total Hospital	Charges Sec. G	19,391,016
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		28.72%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.11%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	Charges Sec. G	1,897,942
27	Uninsured Hospital	Charges Sec. G	1,572,107
28	Total Hospital	Charges Sec. G	19,391,016
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		9.79%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.11%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		$ -

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*