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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

2. Select Your Facility from the Drop-Down Menu Provided: WAYNE MEMORIAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2022	06/30/2023
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	000002054A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110124

B. DSH Qualifying Information

Questions 1-10 below should be answered in accordance with 1923(d) of the social security act

During the DSH Examination Year:

	DSH Examination Year (07/01/24 - 06/30/25)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	1/1/1958

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** — $ 1,205,416
   (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** — $ 2,168,830
   (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** — $ 3,374,246

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	CFO	2/17/25

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Greg Jones	912-530-3305	gjones1@wmhweb.com

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

Hospital Contact:

Name	Greg Jones
Title	CFO
Telephone Number	912-530-3305
E-Mail Address	gjones1@wmhweb.com
Mailing Street Address	865 South First Street
Mailing City, State, Zip	Jesup, GA 31545

Outside Preparer:

Name	Jimmie O. Richter, Jr.
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	404-719-4059
E-Mail Address	jrichter@draffin-tucker.com

DSH Version 9.00 9/11/2024

D. General Cost Report Year Information 7/1/2022 - 6/30/2023

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:	WAYNE MEMORIAL HOSPITAL		
	7/1/2022 through 6/30/2023		
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:	5/9/2024		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	WAYNE MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000002054A	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:	110124	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: (07/01/2022 - 06/30/2023

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)	$ 35,344	$ 418,125	$453,469
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 284,630	$ 2,269,428	$2,554,058
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)	$319,974	$2,687,553	$3,007,527
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.05%	15.56%	15.08%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 2,168,830	<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.
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	$2,168,830	

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 (07/01/2022 - 06/30/2023)

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)	10,949	(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	4,510,950
8.	Outpatient Hospital Charity Care Charges	9,004,396
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 13,515,346

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	$8,562,678.00			$ 6,459,420	$ -	$ -	$ 2,103,258
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$44,128.00			$ 33,289	
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	$63,352,956.00	$186,163,632.00		$ 47,791,516	$ 140,436,103	$ -	$ 61,288,969
20.	Outpatient Services		$44,494,214.00			$ 33,565,063	$ -	$ 10,929,151
21.	Home Health Agency			$2,304,407.00			$ 1,738,374	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$572,178.00	$0.00	$1,196,248.00	$ 431,633	$ -	$ 902,413	$ 140,545
27.	Total	$ 72,487,812	$ 230,657,846	$ 3,544,783	$ 54,682,570	$ 174,001,166	$ 2,674,075	$ 74,461,922
28.	Total Hospital and Non Hospital		Total from Above	$ 306,690,441		Total from Above	$ 231,357,811	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	306,690,441	Total Contractual Adj. (G-3 Line 2)	226,741,337
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	4,616,474
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				231,357,811
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) WAYNE 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	$ 9,687,679	$ -	$ -	$101,975.00	$ 9,585,704	9,168	$6,291,816.00		$ 1,045.56
2	03100	INTENSIVE CARE UNIT	$ 2,859,317	$ -	$ -		$ 2,859,317	1,017	$2,314,990.00		$ 2,811.52
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	$ 1,385,157	$ -	$ -		$ 1,385,157	1,341	$572,178.00		$ 1,032.93
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 13,932,153	$ -	$ -	$ 101,975	$ 13,830,178	11,526	$ 9,178,984		
19		Weighted Average									$ 1,199.91

Line #		Observation Data (Non-Distinct)	*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	577	-	-	$ 603,288	$122,401.00	$1,484,688.00	$ 1,607,089	0.375392

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below)	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
21	5000	OPERATING ROOM	$8,849,178.00	$ -	$ -		$ 8,849,178	$17,325,220.00	$47,871,737.00	$ 65,196,957	0.135730
22	5200	DELIVERY ROOM & LABOR ROOM	$2,766,133.00	$ -	$ -		$ 2,766,133	$672,385.00	$361,963.00	$ 1,034,348	2.674277
23	5300	ANESTHESIOLOGY	$84,088.00	$ -	$ -		$ 84,088	$1,868,813.00	$4,893,444.00	$ 6,762,257	0.012435
24	5400	RADIOLOGY-DIAGNOSTIC	$4,436,002.00	$ -	$ -		$ 4,436,002	$4,296,537.00	$31,797,435.00	$ 36,093,972	0.122901
25	5600	RADIOISOTOPE	$577,948.00	$ -	$ -		$ 577,948	$174,407.00	$1,708,137.00	$ 1,882,544	0.307004
26	6000	LABORATORY	$6,138,682.00	$ -	$ -		$ 6,138,682	$6,343,945.00	$13,767,574.00	$ 20,111,519	0.305232
27	6500	RESPIRATORY THERAPY	$1,321,665.00	$ -	$ -		$ 1,321,665	$4,453,061.00	$4,458,718.00	$ 8,911,779	0.148305
28	6600	PHYSICAL THERAPY	$1,225,416.00	$ -	$ -		$ 1,225,416	$760,834.00	$894,905.00	$ 1,655,739	0.740102
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$6,097,262.00	$ -	$ -		$ 6,097,262	$9,507,400.00	$19,186,883.00	$ 28,694,283	0.212490
30	7200	IMPL. DEV. CHARGED TO PATIENTS	$4,545,843.00	$ -	$ -		$ 4,545,843	$3,629,645.00	$9,961,938.00	$ 13,591,583	0.334460
31	7300	DRUGS CHARGED TO PATIENTS	$12,834,425.00	$ -	$ -		$ 12,834,425	$14,320,709.00	$51,260,898.00	$ 65,581,607	0.195702

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) WAYNE 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	$3,970,007.00	$ -	$ -		$ 3,970,007	$4,396,944.00	$38,490,181.00	$ 42,887,125	0.092569
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 (07/01/2022-06/30/2023) WAYNE 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**	$ 52,846,649	$ -	$ -		$ 52,846,649	$ 67,872,301	$ 226,138,501	$ 294,010,802	
127		**Weighted Average**									0.181796
128		**Sub Totals**	$ 66,778,802	$ -	$ -		$ 66,676,827	$ 77,051,285	$ 226,138,501	$ 303,189,786	
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)*					$28,072.00				
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**					$ 66,648,755				
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 (07/01/2022-06/30/2023): WAYNE 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 Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days) Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (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	$ 1,045.56		591		1,040		514		898				934		3,045		47.40%
2	03100 INTENSIVE CARE UNIT	$ 2,811.52		135		46		117		123				186		421		60.57%
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	$ 1,032.93		29		767		-		152				17		948		71.96%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			Total Days	755		1,853		631		1,173		-		1,200		4,414		49.05%
19	Total Days per PS&R or Exhibit Detail			755		1,853		631		1,173		-		1,200				
20	Unreconciled Days (Explain Variance):			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 661,699		$ 1,152,810		$ 562,717		$ 914,824		$ -		$ 1,035,386		$ 3,293,150		47.52%
21.01	Calculated Routine Charge Per Diem			$ 876.69		$ 621.35		$ 893.37		$ 779.99		$ -		$ 862.82		$ 746.07		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.375392	58,256	263,017	11,722	70,422	11,857	51,262	19,479	212,436			12,649	81,021	$ 96,315	$ 597,156	48.83%
23	5000 OPERATING ROOM		0.135730	585,152	1,489,277	2,812,910	4,590,998	647,279	814,514	2,038,180	5,157,628			936,864	1,148,631	$ 6,083,221	$ 12,130,417	
24	5200 DELIVERY ROOM & LABOR ROOM		2.674277	7,224	4,555	262,646	179,383	378	1,680	114,170	58,220			7,606	4,906	$ 514,416	$ 244,086	
25	5300 ANESTHESIOLOGY		0.012435	66,640	193,040	269,880	462,103	72,496	87,384	218,456	496,809			98,036	111,067	$ 657,736	$ 1,239,126	
26	5400 RADIOLOGY-DIAGNOSTIC		0.122901	294,460	674,801	768,156	2,742,882	876,880	982,276	451,217	3,274,510			496,091	3,025,557	$ 1,290,713	$ 7,694,567	19.28%
27	5600 RADIOISOTOPE		0.307004	13,232	13,275	1,870	44,451	8,808	47,249	12,173	179,427			26,208	72,129	$ 36,086	$ 284,362	40.86%
28	6000 LABORATORY		0.305232	436,327	611,630	706,776	1,895,284	514,250	470,231	711,439	1,903,813			892,192	1,166,046	$ 2,368,795	$ 4,580,948	128.99%
29	6500 RESPIRATORY THERAPY		0.148305	384,578	84,889	96,540	235,896	437,808	150,511	561,765	549,644			787,078	226,146	$ 1,480,219	$ 1,024,050	6.38%
30	6600 PHYSICAL THERAPY		0.740102	45,702	53,945	9,591	133,941	42,614	25,077	79,466	111,382			42,051	4,502	$ 192,873	$ 293,145	28.34%
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.212490	448,477	753,789	1,460,887	2,178,626	509,921	369,238	1,196,861	2,004,187			540,436	810,096	$ 3,595,145	$ 5,332,809	51.44%
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.334460	9,915	-	77,218	439,128	26,764	78,687	402,741	1,164,464			37,262	78,263	$ 521,642	$ 1,882,219	28.34%
33	7300 DRUGS CHARGED TO PATIENTS		0.195702	1,267,138	1,231,200	1,328,340	3,337,547	1,068,620	1,922,772	1,508,478	5,541,963			1,467,010	3,124,410	$ 5,100,276	$ 11,933,084	1313.04%
34	9100 EMERGENCY		0.092569	347,127	2,130,169	226,803	6,154,780	462,953	1,093,047	428,080	3,695,585			538,141	8,244,065	$ 1,464,033	$ 15,244,562	82.32%
35			-													$ -	$ -	0.00%
36			-													$ -	$ -	0.00%
37			-													$ -	$ -	0.00%
38			-													$ -	$ -	
39			-													$ -	$ -	
40			-													$ -	$ -	
41			-													$ -	$ -	
42			-													$ -	$ -	
43			-													$ -	$ -	
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72			-													$ -	$ -	
73			-													$ -	$ -	

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

Cost Report Year (07/01/2022-06/30/2023) WAYNE 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 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
74			-													$ -	$ -	
75			-													$ -	$ -	
76			-													$ -	$ -	
77			-													$ -	$ -	
78			-													$ -	$ -	
79			-													$ -	$ -	
80			-													$ -	$ -	
81			-													$ -	$ -	
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125			-													$ -	$ -	
126			-													$ -	$ -	
127			-													$ -	$ -	
				$ 3,879,758	$ 7,467,830	$ 7,580,354	$ 24,535,131	$ 4,218,906	$ 6,199,076	$ 7,775,486	$ 24,282,295	$ -	$ -	$ 5,060,458	$ 16,102,601			

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

Cost Report Year (07/01/2022-06/30/2023) [redacted] WAYNE 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 (but 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)*	$ 4,541,625	$ 7,467,030	$ 8,732,964	$ 24,535,131	$ 4,780,623	$ 6,196,076	$ 8,640,410	$ 24,282,295	$ -	$ -	$ 6,095,848 (Agrees to Exhibit A)	$ 16,102,601 (Agrees to Exhibit A)	$ 26,695,622	$ 82,480,531	36.93%
129	Total Charges per PS&R or Exhibit Detail	$ 45-41,625	$ 7,467,030	$ 8,732,964	$ 24,535,131	$ 4,780,623	$ 6,196,076	$ 8,640,410	$ 24,282,295	$ -	$ -	$ 6,095,848	$ 16,102,601			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 1,773,130	$ 1,236,463	$ 4,324,296	$ 4,240,557	$ 1,650,747	$ 1,051,642	$ 3,171,406	$ 4,319,379	$ -	$ -	$ 2,520,539	$ 2,375,577	$ 10,919,579	$ 10,848,041	40.22%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 914,564	$ 1,388,712			$ 160,306	$ 122,675	$ 31,504	$ 237,133					$ 1,096,494	$ 1,448,417	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 2,947,295	$ 3,132,137	$ -	$ -	$ 125,782	$ 117,562					$ 3,073,077	$ 3,247,699	
134	Private Insurance (including primary and third party liability)	$ 37,148	$ 4,124			$ 3,200	$ 1,333	$ 938,947	$ 1,848,451					$ 979,296	$ 1,854,310	
135	Self-Pay (including Co-Pay and Spend-Down)				$ 2,593	$ -	$ 110	$ 700	$ 11,614					$ 700	$ 14,319	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 951,833	$ 1,092,836	$ 2,947,295	$ 3,132,702											
137	Medicaid Cost Settlement Payments (See Note B)		$ 39,922											$ -	$ 30,922	
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)					$ 1,175,170	$ 861,957	$ 119,982	$ 119,097					$ 1,295,152	$ 972,054	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)						$ 26	$ 1,123,396	$ 2,141,054					$ 1,123,396	$ 2,141,080	
141	Medicare Cross-Over Bad Debt Payments					$ 80,827	$ 54,224					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 80,827	$ 54,224	
142	Other Medicare Cross-Over Payments (See Note D)					$ (33,364)	$ (1,512)	$ 2,949	$ 40,194					$ (30,445)	$ 41,682	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 35,344	$ 418,125			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 821,297	$ 112,705	$ 1,377,001	$ 1,107,855	$ 274,638	$ 12,929	$ 828,146	$ (190,145)	$ -	$ -	$ 2,485,195	$ 1,957,452	$ 3,301,082	$ 1,043,344	
146	**Calculated Payments as a Percentage of Cost**	54%	91%	68%	74%	83%	99%	74%	104%	0%	0%	1%	18%	70%	90%	
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**					4,522										
148	**Percent of cross-over days to total Medicare days from the cost report**					1.4%										

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 payment

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) WAYNE MEMORIAL HOSPITAL

	Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000	ADULTS & PEDIATRICS	$ 1,045.56		1						32		33	
2	03100	INTENSIVE CARE UNIT	$ 2,811.52		3						3		6	
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	$ 1,032.93										-	
11			$ -										-	
12			$ -										-	
13			$ -										-	
14			$ -										-	
15			$ -										-	
16			$ -										-	
17			$ -										-	
18				Total Days	4		-		-		35		39	
19		Total Days per PS&R or Exhibit Detail			4		-		-		35			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
21		Routine Charges			Routine Charges $ 5,722		Routine Charges		Routine Charges		Routine Charges $ 27,980		Routine Charges $ 33,702	
21.01		Calculated Routine Charge Per Diem			$ 1,430.50		$ -		$ -		$ 799.43		$ 864.15	
		Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200	Observation (Non-Distinct)		0.375392	-	1,177					-	-	$ -	$ 1,177
23	5000	OPERATING ROOM		0.135730	-	49,647					64,622	-	$ 64,622	$ 49,647
24	5200	DELIVERY ROOM & LABOR ROOM		2.674277	-	376					-	-	$ -	$ 376
25	5300	ANESTHESIOLOGY		0.012435	-	5,543					6,831	-	$ 6,831	$ 5,543
26	5400	RADIOLOGY-DIAGNOSTIC		0.122901	4,452	40,212					14,814	12,547	$ 19,266	$ 52,759
27	5600	RADIOISOTOPE		0.307004	-	2,807					1,059	-	$ 1,059	$ 2,807
28	6000	LABORATORY		0.305232	1,538	23,019					18,595	9,384	$ 20,133	$ 32,383
29	6500	RESPIRATORY THERAPY		0.148305	2,312	4,825					424	264	$ 2,736	$ 5,089
30	6600	PHYSICAL THERAPY		0.740102	-	293					1,572	-	$ 1,572	$ 293
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.212490	1,490	29,965					29,697	1,604	$ 31,187	$ 31,569
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.334460	-	7,279					712	-	$ 712	$ 7,279
33	7300	DRUGS CHARGED TO PATIENTS		0.195702	2,057	32,925					57,551	9,266	$ 59,608	$ 42,191
34	9100	EMERGENCY		0.092569	3,328	113,347					5,770	11,322	$ 9,098	$ 124,669
35				-									$ -	$ -
36				-									$ -	$ -
37				-									$ -	$ -
38				-									$ -	$ -
39				-									$ -	$ -
40				-									$ -	$ -
41				-									$ -	$ -
42				-									$ -	$ -
43				-									$ -	$ -
44				-									$ -	$ -
45				-									$ -	$ -
46				-									$ -	$ -
47				-									$ -	$ -
48				-									$ -	$ -
49				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) WAYNE MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
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109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) WAYNE MEMORIAL 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	
112		-									$ -	$ -
113		-									$ -	$ -
114		-									$ -	$ -
115		-									$ -	$ -
116		-									$ -	$ -
117		-									$ -	$ -
118		-									$ -	$ -
119		-									$ -	$ -
120		-									$ -	$ -
121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ 15,177	$ 311,414	$ -	$ -	$ -	$ -	$ 201,648	$ 44,367		
	Totals / Payments											
128	**Total Charges (includes organ acquisition from Section K)**		$ 20,899	$ 311,414	$ -	$ -	$ -	$ -	$ 229,628	$ 44,367	$ 250,527	$ 355,781
129	Total Charges per PS&R or Exhibit Detail		$ 20,899	$ 311,414	$ -	$ -	$ -	$ -	$ 229,628	$ 44,367		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 11,867	$ 47,755	$ -	$ -	$ -	$ -	$ 78,142	$ 7,642	$ 90,009	$ 55,397
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 17,051						$ 189	$ -	$ 17,240
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)									$ 5,764	$ -	$ 5,764
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ -	$ 17,051	$ -	$ -						
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)									$ 2,582	$ -	$ 2,582
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
141	Medicare Cross-Over Bad Debt Payments										$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)										$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**		$ 11,867	$ 30,704	$ -	$ -	$ -	$ -	$ 78,142	$ (893)	$ 90,009	$ 29,811
144	**Calculated Payments as a Percentage of Cost**		0%	36%	0%	0%	0%	0%	0%	112%	0%	46%

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.

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 (07/01/2022-06/30/2023) WAYNE 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)*		$ 1,175,516		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	8311-6019	*(W/S account #.)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 1,175,516	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ———>)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments(from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments(from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,175,516		

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	89,782,461
19	Uninsured Hospital	Charges Sec. G	22,198,449
20	Total Hospital	Charges Sec. G	303,189,786
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		29.61%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.32%
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	45,609,062
27	Uninsured Hospital	Charges Sec. G	22,198,449
28	Total Hospital	Charges Sec. G	303,189,786
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		15.04%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		7.32%
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.*