GA DSH Payment Results for SFY 2024 - Pool 2 **4/8/2024 8:16**

DSH Uncompensated Care Cost & Allocation Factor Summary

Preliminary Results

Provider Name	SAINT MARY'S HOSPITAL
Mcaid Provider Number	000001823A
Mcare Provider Number	110006

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2023 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2023 - 6/30/2024

	(A)	(B)	(C)	(D)	(E)
	Cost Report Year Begin	Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	7/1/2021 -	6/30/2022	$ 19,913,042	$ (68,530)	$ 19,844,408

Less: 2022 Net UPL Payments	$ 804,552
Less: 2024 Net DPP Payments	$ 15,731,741
Plus: 2023 Net DPP Recoupments	$ -
Less: GME Payments	$ 162,830
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 94,021
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 466,986
Uncompensated Care Allocation Factor	$ 3,706,291
Hospital Specific DSH Limit	$ 1,805,908
2024 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	13.27%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	24.89%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail:	gadsh@mslc.com
Fax:	816-945-5301
Web Portal Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.11	2/10/2023

D. General Cost Report Year Information 7/1/2021 - 6/30/2022

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: **SAINT MARY'S HOSPITAL**

	7/1/2021 through 6/30/2022		
2. Select Cost Report Year Covered by this Survey:	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:	5/12/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	SAINT MARY'S HOSPITAL	Yes	
5. Medicaid Provider Number:	000001823A	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:	110006	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	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	Florida	007970100
10. State Name & Number	South Carolina	20996894
11. State Name & Number	Tennessee	1871556621
12. State Name & Number	Illinois	58056622301
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: (07/01/2021 - 06/30/2022)

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)	$ 402,966	$ 1,317,878	$1,720,844
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,668,032	$ 9,087,515	$11,755,547
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$3,070,998	$10,405,393	$13,476,391
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	13.12%	12.67%	12.77%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No

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

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

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2021 - 06/30/2022)

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)	47,798

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	100,000
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 100,000
7.	Inpatient Hospital Charity Care Charges	18,802,569
8.	Outpatient Hospital Charity Care Charges	19,888,899
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 38,691,468

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 86,665,348	$ -	$ -	$ 64,661,813	$ -	$ -	$ 22,003,535
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ 8,267,085	$ -	$ -	$ 6,168,148	$ -	$ -	$ 2,098,937
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 311,083,400	$ 495,919,997	$ -	$ 232,102,185	$ 370,010,470	$ -	$ 204,890,742
20.	Outpatient Services		$ 66,589,626	$ -		$ 49,683,132	$ -	$ 16,906,494
21.	Home Health Agency			$ 8,259,854			$ 6,162,753	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 6,572,826			$ 4,904,046	
26.	Other	**$ -**	**$ -**	**$ 2,302,528**	$ -	$ -	$ 1,717,937	$ -
27.	Total	$ 406,015,833	$ 562,509,623	$ 17,135,208	$ 302,932,146	$ 419,693,602	$ 12,784,736	$ 245,899,707
28.	Total Hospital and Non Hospital		Total from Above	$ 985,660,664		Total from Above	$ 735,410,485	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 985,660,664	Total Contractual Adj. (G-3 Line 2)		$ 735,410,485
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	$ -
35.	Adjusted Contractual Adjustments					735,410,485
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) | SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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	$ 41,707,984	$ 2,027,221	$ -	-	$ 43,735,205	31,638	$47,627,159.00		$ 1,382.36
2	03100 INTENSIVE CARE UNIT	$ 25,306,123	$ 640,760	$ 14,832		$ 25,961,715	12,309	$ 44,555,787		$ 2,109.17
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	$ 1,301,253	$ -	$ -		$ 1,301,253	4,632	$ 2,749,487		$ 280.93
18	Total Routine	$ 68,315,360	$ 2,667,981	$ 14,832	$ -	$ 70,998,173	48,579	$ 94,932,433		
19	Weighted Average									$ 1,461.50

		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)	1,248	-	-	$ 1,725,185	43,428	5,406,733	$ 5,450,161	0.316538

		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	$ 52,660,243	$ 913,388	$ -	$ 53,573,631	$ 66,935,087	$ 178,456,960	$ 245,392,047	0.218319
22	5200 DELIVERY ROOM & LABOR ROOM	$ 4,227,593	$ -	$ -	$ 4,227,593	$ 6,925,670	$ 699,004	$ 7,624,674	0.554462
23	5400 RADIOLOGY-DIAGNOSTIC	$ 9,961,870	$ -	$ -	$ 9,961,870	$ 14,559,506	$ 40,329,521	$ 54,889,027	0.181491
24	5700 CT SCAN	$ 1,564,309	$ -	$ -	$ 1,564,309	$ 13,365,861	$ 28,579,432	$ 41,945,293	0.037294
25	5800 MRI	$ 708,581	$ -	$ -	$ 708,581	$ 5,084,787	$ 8,128,832	$ 13,213,619	0.053625
26	5900 CARDIAC CATHETERIZATION	$ 9,254,392	$ -	$ -	$ 9,254,392	$ 15,081,340	$ 27,156,027	$ 42,237,367	0.219104
27	6000 LABORATORY	$ 7,428,055	$ -	$ 5,478	$ 7,433,533	$ 18,392,596	$ 31,225,754	$ 49,618,350	0.149814
28	6300 BLOOD STORING PROCESSING & TRANS.	$ 1,403,056	$ -	$ -	$ 1,403,056	$ 1,469,583	$ 476,385	$ 1,945,968	0.721007
29	6400 INTRAVENOUS THERAPY	$ 6,584,328	$ -	$ -	$ 6,584,328	$ 4,546,344	$ 24,703,784	$ 29,250,128	0.225104
30	6500 RESPIRATORY THERAPY	$ 3,307,920	$ 336,482	$ -	$ 3,644,402	$ 17,183,251	$ 2,107,094	$ 19,290,345	0.188924
31	6600 PHYSICAL THERAPY	$ 4,814,419	$ -	$ -	$ 4,814,419	$ 14,705,325	$ 8,257,206	$ 22,962,531	0.209664
32	6900 ELECTROCARDIOLOGY	$ 3,373,241	$ 439,759	$ -	$ 3,813,000	$ 10,735,135	$ 14,106,533	$ 24,841,668	0.153492
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 12,712,303	$ -	$ -	$ 12,712,303	$ 21,550,577	$ 25,197,077	$ 46,747,654	0.271935
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 11,024,405	$ -	$ -	$ 11,024,405	$ 54,009,241	$ 70,505,706	$ 124,514,947	0.088539
35	7300 DRUGS CHARGED TO PATIENTS	$ 15,628,813	$ -	$ -	$ 15,628,813	$ 44,686,126	$ 26,372,561	$ 71,058,687	0.219942
36	7600 CARDIOLOGY	$ 798,552	$ 219,879	$ -	$ 1,018,431	$ 1,852,970	$ 9,618,122	$ 11,471,092	0.088782
37	9000 CLINIC	$ 749,657	$ -	$ -	$ 749,657	$ 1,596	$ 84,668	$ 86,264	8.690265
38	9001 WOUND CARE CENTER	$ 1,418,110	$ -	$ -	$ 1,418,110	$ 15,338	$ 4,244,662	$ 4,260,000	0.332890

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Net 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
39	9100	EMERGENCY	$ 10,407,336	$ 370,908	$ 47,062	**$ 10,825,306**	$ 12,023,347	$ 44,769,854	$ 56,793,201	**0.190609**
126		**Total Ancillary**	$ 158,027,183	$ 2,280,416	$ 52,540	$ 160,360,139	$ 323,167,108	$ 550,425,915	$ 873,593,023	
127		**Weighted Average**								**0.185539**
128		**Sub Totals**	$ 226,342,543	$ 4,948,397	$ 67,372	$ 231,358,312	$ 418,099,541	$ 550,425,915	$ 968,525,456	
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)				$ -				
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)				$ -				
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**				**$ 231,358,312**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost				**2.19%**				

* 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 (07/01/2021-06/30/2022 | SAINT MARY'S 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)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				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 Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,382.36		1,348		2,354		-		2,858		2,269		6,560		29.08%
2	03100 INTENSIVE CARE UNIT	$ 2,109.17		850		289		-		1,435		1,037		2,574		29.39%
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	$ 280.93		185		2,471		-		96		84		2,752		61.23%
18			**Total Days**	2,383		5,114		-		4,389		3,390		11,886		32.30%
19	Total Days per PS&R or Exhibit Detail			2,210		5,114		-		4,389		3,390				
20	Unreconciled Days (Explain Variance			173		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 4,775,568		$ 8,442,990		$ -		$ 8,096,676		$ 6,350,273		$ 21,315,234		29.17%
21.01	Calculated Routine Charge Per Dien			$ 2,004.02		$ 1,650.96		$ -		$ 1,844.77		$ 1,873.24		$ 1,793.31		
	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**	
22	09200 Observation (Non-Distinct		0.316538	$ 5,544	$ 132,290	$ 1,386	$ 159,398	$ -	$ -	$ 12,166	$ 970,602	$ 5,929	$ 220,111	$ 19,096	$ 1,262,290	27.66%
23	5000 OPERATING ROOM		0.218319	$ 2,977,219	$ 3,523,880	$ 3,308,634	$ 6,255,226	$ -	$ -	$ 7,640,943	$ 11,103,847	$ 5,336,600	$ 5,758,467	$ 13,926,796	$ 20,882,953	18.73%
24	5200 DELIVERY ROOM & LABOR ROOM		0.554462	$ 153,220	$ 3,664	$ 4,745,566	$ 150,558	$ -	$ -	$ 65,233	$ -	$ 174,647	$ 3,206	$ 4,964,019	$ 154,222	69.46%
25	5400 RADIOLOGY-DIAGNOSTIC		0.181491	$ 395,970	$ 720,963	$ 387,093	$ 2,585,398	$ -	$ -	$ 837,882	$ 2,088,862	$ 777,763	$ 2,398,111	$ 1,620,945	$ 5,395,223	18.60%
26	5700 CT SCAN		0.037294	$ 11,086	$ 805,998	$ 415,655	$ 2,042,433	$ -	$ -	$ 1,523,034	$ 2,208,871	$ 1,527,587	$ 3,331,374	$ 1,949,775	$ 5,057,302	28.32%
27	5800 MRI		0.053625	$ 187,216	$ 269,786	$ 175,221	$ 427,392	$ -	$ -	$ 461,045	$ 948,917	$ 630,311	$ 623,761	$ 823,482	$ 1,646,095	28.18%
28	5900 CARDIAC CATHETERIZATION		0.219104	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	6000 LABORATORY		0.149814	$ 1,287,576	$ 1,042,950	$ 1,980,152	$ 2,766,766	$ -	$ -	$ 1,942,227	$ 1,778,522	$ 1,778,221	$ 6,132,722	$ 5,209,955	$ 5,588,238	37.75%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.721007	$ 92,512	$ 41,850	$ 113,739	$ 21,335	$ -	$ -	$ 151,354	$ 41,955	$ 160,124	$ 37,844	$ 357,605	$ 105,140	33.95%
31	6400 INTRAVENOUS THERAPY		0.225104	$ 373,197	$ 685,218	$ 169,698	$ 1,229,493	$ -	$ -	$ 545,248	$ 1,214,886	$ 469,874	$ 1,656,281	$ 1,088,143	$ 3,129,597	21.71%
32	6500 RESPIRATORY THERAPY		0.188924	$ 1,240,401	$ 40,408	$ 465,731	$ 118,843	$ -	$ -	$ 1,691,987	$ 334,851	$ 1,154,189	$ 108,423	$ 3,398,119	$ 494,102	26.75%
33	6600 PHYSICAL THERAPY		0.209664	$ 394,999	$ 35,703	$ 259,502	$ 1,173,024	$ -	$ -	$ 1,144,793	$ 617,947	$ 656,103	$ 309,040	$ 1,799,294	$ 1,826,674	20.01%
34	6900 ELECTROCARDIOLOGY		0.153492	$ 459,656	$ 347,616	$ 281,875	$ 560,616	$ -	$ -	$ 1,806,329	$ 2,106,680	$ 1,578,503	$ 1,119,661	$ 2,547,860	$ 3,014,912	33.27%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.271935	$ 797,191	$ 351,246	$ 832,376	$ 500,411	$ -	$ -	$ 2,102,108	$ 1,533,676	$ 1,411,231	$ 724,973	$ 3,731,675	$ 2,385,333	17.66%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.088539	$ 1,043,437	$ 107,726	$ 730,914	$ 310,879	$ -	$ -	$ 6,206,388	$ 4,720,304	$ 1,688,359	$ 610,228	$ 7,980,739	$ 5,138,909	12.38%
37	7300 DRUGS CHARGED TO PATIENTS		0.219942	$ 1,992,767	$ 1,001,481	$ 2,975,787	$ 1,375,573	$ -	$ -	$ 4,034,518	$ 2,600,063	$ 4,407,942	$ 1,701,757	$ 9,003,072	$ 4,977,117	28.30%
38	7600 CARDIOLOGY		0.088782	$ 196,995	$ 148,978	$ 120,804	$ 240,264	$ -	$ -	$ 774,141	$ 902,863	$ 676,501	$ 479,855	$ 1,091,940	$ 1,292,105	30.87%
39	9000 CLINIC		8.690265	$ 783	$ 45,469	$ 718	$ 19,834	$ -	$ -	$ 1,134	$ 16,916	$ 539	$ -	$ 2,635	$ 82,219	99.28%
40	9001 WOUND CARE CENTER		0.332890	$ -	$ 45,469	$ 435	$ 61,420	$ -	$ -	$ 1,454	$ 128,620	$ -	$ 88,930	$ 1,889	$ 235,509	7.66%
41	9100 EMERGENCY		0.190609	$ 730,853	$ 2,551,581	$ 622,354	$ 9,265,045	$ -	$ -	$ 1,276,732	$ 3,372,348	$ 1,062,377	$ 7,384,636	$ 2,629,939	$ 15,188,974	46.37%
				12,340,622	11,902,275	17,587,640	29,263,908	-	-	32,218,716	36,690,730	23,496,800	32,689,380			

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

Cost Report Year (07/01/2021-06/30/2022 SAINT MARY'S 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)		Uninsured		Total In-State Medicaid		% Survey
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 17,116,190	$ 11,902,275	$ 26,030,630	$ 29,263,908	$ -	$ -	$ 40,315,392	$ 36,690,730	$ 29,847,073 (Agrees to Exhibit A)	$ 32,689,380 (Agrees to Exhibit A)	$ 83,462,212	$ 77,856,913	23.14%
129	Total Charges per PS&R or Exhibit Detail	$ 17,321,234	$ 12,081,612	$ 26,030,630	$ 29,263,908	$ -	$ -	$ 40,315,392	$ 36,690,730	$ 29,847,073	$ 32,689,380			
130	Unreconciled Charges (Explain Variance)	(205,044)	(179,337)	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 6,169,581	$ 2,632,931	$ 9,690,793	$ 5,575,266	$ -	$ -	$ 12,636,891	$ 6,649,773	$ 9,698,613	$ 5,602,832	$ 28,497,265	$ 14,857,970	25.38%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,882,108	$ 2,159,205	$ -	$ -	$ -	$ -	$ 245,582	$ 331,268			$ 4,127,690	$ 2,490,473	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 5,485,584	$ 4,205,590	$ -	$ -	$ -	$ -			$ 5,485,584	$ 4,205,590	
134	Private Insurance (including primary and third party liability)	$ 45,762	$ 6,375	$ 1,109,287	$ 945,442	$ -	$ -	$ 305,155	$ 286,810			$ 1,460,204	$ 1,238,627	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 3,877	$ 26,309	$ -	$ -	$ 17,695	$ 4,270			$ 21,572	$ 30,579	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,927,870	$ 2,165,580	$ 6,598,748	$ 5,177,341									
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)					$ -	$ -	$ 1,232	$ -			$ 1,232	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 8,869,872	$ 4,798,500			$ 8,869,872	$ 4,798,500	
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 402,966	$ 1,317,878			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 2,241,711	$ 467,351	$ 3,092,045	$ 397,925	$ -	$ -	$ 3,197,355	$ 1,228,925	$ 9,295,647	$ 4,284,954	$ 8,531,111	$ 2,094,201	
146	**Calculated Payments as a Percentage of Cost**	64%	82%	68%	93%	0%	0%	75%	82%	4%	24%	70%	86%	
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**					24,645								
148	**Percent of cross-over days to total Medicare days from the cost report**					0%								

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 s
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 P
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 s
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 pay
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 pa

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid 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	$ 1,382.36		7		-		-		-		7	
2	03100 INTENSIVE CARE UNIT	$ 2,109.17		6		-		-		-		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	$ 280.93		-		-		-		-		-	
18			**Total Days**	13		-		-		-		13	
19	Total Days per PS&R or Exhibit Detail			13		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 23,536		$ -		$ -		$ -		$ 23,536	
21.01	Calculated Routine Charge Per Diem			$ 1,810.46		$ -		$ -		$ -		$ 1,810.46	
	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)		0.316538	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.218319	48,858	-	-	-	-	-	-	-	$ 48,858	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.554462	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.181491	4,283	15,306	-	-	-	-	-	-	$ 4,283	$ 15,306
26	5700 CT SCAN		0.037294	8,132	4,435	-	-	-	-	-	-	$ 8,132	$ 4,435
27	5800 MRI		0.053625	-	-	-	-	-	-	-	-	$ -	$ -
28	5900 CARDIAC CATHETERIZATION		0.219104	-	-	-	-	-	-	-	-	$ -	$ -
29	6000 LABORATORY		0.149814	8,184	15,636	-	-	-	-	-	-	$ 8,184	$ 15,636
30	6300 BLOOD STORING PROCESSING & TRANS.		0.721007	-	-	-	-	-	-	-	-	$ -	$ -
31	6400 INTRAVENOUS THERAPY		0.225104	1,264	6,318	-	-	-	-	-	-	$ 1,264	$ 6,318
32	6500 RESPIRATORY THERAPY		0.188924	5,628	244	-	-	-	-	-	-	$ 5,628	$ 244
33	6600 PHYSICAL THERAPY		0.209664	3,011	-	-	-	-	-	-	-	$ 3,011	$ -
34	6900 ELECTROCARDIOLOGY		0.153492	-	2,972	-	-	-	-	-	-	$ -	$ 2,972
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.271935	1,374	105	-	-	-	-	-	-	$ 1,374	$ 105
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.088539	-	-	-	-	-	-	-	-	$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.219942	18,086	3,439	-	-	-	-	-	-	$ 18,086	$ 3,439
38	7600 CARDIOLOGY		0.088782	-	1,274	-	-	-	-	-	-	$ -	$ 1,274
39	9000 CLINIC		8.690265	-	246	-	-	-	-	-	-	$ -	$ 246
40	9001 WOUND CARE CENTER		0.332890	-	-	-	-	-	-	-	-	$ -	$ -
41	9100 EMERGENCY		0.190609	3,878	66,622	-	-	-	-	-	-	$ 3,878	$ 66,622
				102,698	116,597	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 126,234**	**$ 116,597**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 126,234**	**$ 116,597**
129	Total Charges per PS&R or Exhibit Detail			$ 126,234	$ 116,597	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 42,375**	**$ 22,945**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 42,375**	**$ 22,945**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ 252	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 252
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)			$ -	$ 293	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 293
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 545	$ -	$ -						
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)							$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S 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)		Total Out-Of-State Medicaid	
142	Other Medicare Cross-Over Payments (See Note D					$ -	$ -	$ -	$ -	$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 42,375	$ 22,400	$ -	$ -	$ -	$ -	$ -	$ -	$ 42,375	$ 22,400
144	**Calculated Payments as a Percentage of Cost**	0%	2%	0%	0%	0%	0%	0%	0%	0%	2%

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 (07/01/2021-06/30/2022) SAINT MARY'S 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)		Uninsured	
							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 Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below)															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section D 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 (07/01/2021-06/30/2022) SAINT MARY'S 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)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below)													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey
Note B: Enter Organ Acquisition Payments in Section E 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 examinatic surveys.

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 3,074,857		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(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 ---------->)	0	$ 3,074,857		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
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		$ 3,074,857
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	161,561,956
19	Uninsured Hospital	**Charges Sec. G**	62,536,453
20	Total Hospital	**Charges Sec. G**	968,525,456
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		16.68%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.46%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 512,924
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 198,540
25	Provider Tax Assessment Adjustment to DSH UCC		$ 711,464

** 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.*

DSH Examination Eligibility Summary

Hospital Name	**SAINT MARY'S HOSPITAL**
Hospital Medicaid Number	**000001823A**
Cost Report Period	From **7/1/2021** To **6/30/2022**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 18,516,888	$ (69,954)	$ 18,446,934
2	Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
3	Total		$ 18,616,888	$ (69,954)	$ 18,546,934
4	Net Hospital Patient Revenue	Survey F-3	$ 246,484,298	$ (584,591)	$ 245,899,707
5	Medicaid Fraction		7.55%	-0.01%	7.54%
6	Inpatient Charity Care Charges	Survey F-2	$ 18,802,569	$ -	$ 18,802,569
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
9	Adjusted Inpatient Charity Care		$ 18,760,747	$ -	$ 18,760,648
10	Inpatient Hospital Charges	Survey F-3	$ 406,017,129	$ (1,296)	$ 406,015,833
11	Inpatient Charity Fraction		4.62%	0.00%	4.62%
12	LIUR		12.17%	-0.01%	12.16%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	11,713	173	11,886
14	Out-of-State Medicaid Eligible Days	Survey I	13	-	13
15	Total Medicaid Eligible Days		11,726	173	11,899
16	Total Hospital Days (excludes swing-bed)	Survey F-1	47,798	-	47,798
17	MIUR		24.53%	0.36%	24.89%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **SAINT MARY'S HOSPITAL**
Hospital Medicaid Number: **000001823A**
Cost Report Period: From **7/1/2021** To **6/30/2022**

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	6,201,948	3,882,108	-	79,302	-	-	-	-	-	-	-			3,961,410	2,240,538	63.87%
2	Medicaid Fee for Service	Outpatient	2,668,893	2,159,205	-	42,789	-	-	-	-	-	-	-			2,201,994	466,899	82.51%
3	Medicaid Managed Care	Inpatient	9,725,849	-	5,485,584	1,109,287	3,877	-	-							6,598,748	3,127,101	67.85%
4	Medicaid Managed Care	Outpatient	5,575,810	-	4,205,590	945,442	26,309	-	-							5,177,341	398,469	92.85%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	12,679,488	245,582	-	305,155	17,695			1,232	8,869,872	-	-			9,439,536	3,239,952	74.45%
8	Other Medicaid Eligibles	Outpatient	6,653,083	331,268	-	286,810	4,270			-	4,798,500	-	-			5,420,848	1,232,235	81.48%
9	Uninsured	Inpatient	9,732,418	-	-	-	-	-	-	-	-	-	-	402,966	-	402,966	9,329,452	4.14%
10	Uninsured	Outpatient	5,603,582	-	-	-	-	-	-	-	-	-	-	1,317,878	-	1,317,878	4,285,704	23.52%
11	In-State Sub-total	Inpatient	38,339,703	4,127,690	5,485,584	1,493,744	21,572	-	-	1,232	8,869,872	-	-	402,966	-	20,402,660	17,937,043	53.22%
12	In-State Sub-total	Outpatient	20,501,368	2,490,473	4,205,590	1,275,041	30,579	-	-	-	4,798,500	-	-	1,317,878	-	14,118,061	6,383,307	68.86%
13	Out-of-State Medicaid	Inpatient	42,479	-	-	-	-	-	-	-	-	-	-			-	42,479	0.00%
14	Out-of-State Medicaid	Outpatient	22,945	252	-	293	-	-	-	-	-	-	-			545	22,400	2.38%
15	Sub-Total	I/P and O/P	58,906,495	6,618,415	9,691,174	2,769,078	52,151	-	-	1,232	13,668,372	-	-	1,720,844	-	34,521,266	24,385,229	58.60%

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	(32,367)	-	-	(33,540)	-	-	-	-	-	-	-			(33,540)	1,173	-0.21%
2	Medicaid Fee for Service	Outpatient	(35,962)	-	-	(36,414)	-	-	-	-	-	-	-			(36,414)	452	-0.26%
3	Medicaid Managed Care	Inpatient	(35,056)	-	-	-	-	-	-							-	(35,056)	0.25%
4	Medicaid Managed Care	Outpatient	(544)	-	-	-	-	-	-							-	(544)	0.01%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7	Other Medicaid Eligibles	Inpatient	(42,597)	-	-	-	-			-	-	-	-			-	(42,597)	0.25%
8	Other Medicaid Eligibles	Outpatient	(3,310)	-	-	-	-			-	-	-	-			-	(3,310)	0.04%
9	Uninsured	Inpatient	(33,805)	-	-	-	-	-	-	-	-	-	-	-	-	-	(33,805)	0.01%
10	Uninsured	Outpatient	(750)	-	-	-	-	-	-	-	-	-	-	-	-	-	(750)	0.00%
11	In-State Sub-total	Inpatient	(143,825)	-	-	(33,540)	-	-	-	-	-	-	-	-	-	(33,540)	(110,285)	0.11%
12	In-State Sub-total	Outpatient	(40,566)	-	-	(36,414)	-	-	-	-	-	-	-	-	-	(36,414)	(4,152)	-0.04%
13	Out-of-State Medicaid	Inpatient	(104)	-	-	-	-	-	-	-	-	-	-			-	(104)	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	(184,495)	-	-	(69,954)	-	-	-	-	-	-	-	-	-	(69,954)	(114,541)	0.06%
15.01																	711,464	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: **SAINT MARY'S HOSPITAL**
Hospital Medicaid Number: **000001823A**
Cost Report Period: From **7/1/2021** To **6/30/2022**
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	6,169,581	3,882,108	-	45,762	-	-	-	-	-	-	-			3,927,870	2,241,711	63.67%
2	Medicaid Fee for Service	Outpatient	2,632,931	2,159,205	-	6,375	-	-	-	-	-	-	-			2,165,580	467,351	82.25%
3	Medicaid Managed Care	Inpatient	9,690,793	-	5,485,584	1,109,287	3,877	-	-							6,598,748	3,092,045	68.09%
4	Medicaid Managed Care	Outpatient	5,575,266	-	4,205,590	945,442	26,309	-	-							5,177,341	397,925	92.86%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	12,636,891	245,582	-	305,155	17,695			1,232	8,869,872	-	-			9,439,536	3,197,355	74.70%
8	Other Medicaid Eligibles	Outpatient	6,649,773	331,268	-	286,810	4,270			-	4,798,500	-	-			5,420,848	1,228,925	81.52%
9	Uninsured	Inpatient	9,698,613	-	-	-	-	-	-	-	-	-	-	402,966	-	402,966	9,295,647	4.15%
10	Uninsured	Outpatient	5,602,832	-	-	-	-	-	-	-	-	-	-	1,317,878	-	1,317,878	4,284,954	23.52%
11	In-State Sub-total	Inpatient	38,195,878	4,127,690	5,485,584	1,460,204	21,572	-	-	1,232	8,869,872	-	-	402,966	-	20,369,120	17,826,758	53.33%
12	In-State Sub-total	Outpatient	20,460,802	2,490,473	4,205,590	1,238,627	30,579	-	-	-	4,798,500	-	-	1,317,878	-	14,081,647	6,379,155	68.82%
13	Out-of-State Medicaid	Inpatient	42,375	-	-	-	-	-	-	-	-	-	-			-	42,375	0.00%
14	Out-of-State Medicaid	Outpatient	22,945	252	-	293	-	-	-	-	-	-	-			545	22,400	2.38%
15	Cost Report Year Sub-Total	I/P and O/P	58,722,000	6,618,415	9,691,174	2,699,124	52,151	-	-	1,232	13,668,372	-	-	1,720,844	-	34,451,312	24,270,688	58.67%
15.01															Provider Tax Assessment Adjustment		711,464	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		24,982,152	

Medicaid DSH Survey Adjustments

PROVIDER: SAINT MARY'S HOSPITAL
Mcaid Number: 000001823A
FROM: 7/1/2021 TO: 6/30/2022
Mcare Number: 110006

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	F - MIUR/LIUR Data	26	Other	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 1,296	$ (1,296)	$ -	
1	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 2,301,232	$ (2,301,232)	$ -	
1	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ -	$ 2,302,528	$ 2,302,528	
1	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 967	$ (967)	$ -	
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 1,716,970	$ (1,716,970)	$ -	
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 1,717,937	$ 1,717,937	
	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Adjust to cost report.	$ 34,322,273.00	$ 7,385,711	$ 41,707,984.00	
1	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Adjust to cost report.	$ 7,385,711.00	$ (7,385,711)	$ -	
	G - CR Data	1	ADULTS & PEDIATRICS	8.00	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	Adjust to cost report.	26,015	5,623	31,638	
1	G - CR Data	8	SUBPROVIDER II	8.00	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	Adjust to cost report.	5,623	(5,623)	-	
	G - CR Data	1	ADULTS & PEDIATRICS	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to cost report.	$ 39,360,074.00	$ 8,267,085	$ 47,627,159.00	
1	G - CR Data	8	SUBPROVIDER II	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to cost report.	$ 8,267,085.00	$ (8,267,085)	$ -	
2	H - In-State	1	ADULTS & PEDIATRICS	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	1,360	(12)	1,348	
2	H - In-State	10	NURSERY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to include nursery days	-	185	185	
2	H - In-State	21	Routine Charges	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 4,793,436	$ (17,868)	$ 4,775,568	
2	H - In-State	23	OPERATING ROOM	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 3,063,075	$ (85,856)	$ 2,977,219	
2	H - In-State	24	DELIVERY ROOM & LABOR ROOM	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 167,304	$ (14,084)	$ 153,220	
2	H - In-State	25	RADIOLOGY-DIAGNOSTIC	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 396,308	$ (338)	$ 395,970	
2	H - In-State	29	LABORATORY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 1,294,098	$ (6,522)	$ 1,287,576	
2	H - In-State	31	INTRAVENOUS THERAPY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 374,752	$ (1,555)	$ 373,197	
2	H - In-State	32	RESPIRATORY THERAPY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 1,246,833	$ (6,432)	$ 1,240,401	
2	H - In-State	34	ELECTROCARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 462,145	$ (2,489)	$ 459,656	
2	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 853,816	$ (56,625)	$ 797,191	
2	H - In-State	37	DRUGS CHARGED TO PATIENTS	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 1,996,940	$ (4,173)	$ 1,992,767	
2	H - In-State	38	CARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 198,062	$ (1,067)	$ 196,995	
2	H - In-State	41	EMERGENCY	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 738,888	$ (8,035)	$ 730,853	
2	H - In-State	134	Private Insurance (including primary and third party liabilit	5.00	Inpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 79,302	$ (33,540)	$ 45,762	
2	H - In-State	22	Observation (Non-Distinct	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 133,676	$ (1,386)	$ 132,290	
2	H - In-State	23	OPERATING ROOM	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 3,533,634	$ (9,754)	$ 3,523,880	
2	H - In-State	25	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 731,668	$ (10,705)	$ 720,963	
2	H - In-State	26	CT SCAN	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 810,538	$ (4,540)	$ 805,998	
2	H - In-State	29	LABORATORY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 1,060,349	$ (17,399)	$ 1,042,950	
2	H - In-State	31	INTRAVENOUS THERAPY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 722,529	$ (37,311)	$ 685,218	
2	H - In-State	32	RESPIRATORY THERAPY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 42,085	$ (1,677)	$ 40,408	
2	H - In-State	33	PHYSICAL THERAPY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 36,098	$ (395)	$ 35,703	
2	H - In-State	34	ELECTROCARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 351,518	$ (3,902)	$ 347,616	
2	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 352,550	$ (1,305)	$ 351,246	
2	H - In-State	37	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 1,014,823	$ (13,342)	$ 1,001,481	
2	H - In-State	38	CARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 150,651	$ (1,673)	$ 148,978	
2	H - In-State	39	CLINIC	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 45,574	$ (105)	$ 45,469	
2	H - In-State	40	WOUND CARE CENTER	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 45,573	$ (104)	$ 45,469	
2	H - In-State	41	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 2,627,320	$ (75,740)	$ 2,551,581	
2	H - In-State	134	Private Insurance (including primary and third party liabilit	6.00	Outpatient In-State Medicaid FFS Priman	Adjust to exclude zero paids	$ 42,789	$ (36,414)	$ 6,375	
5	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to hospital's data.	$ -	$ 3,074,857	$ 3,074,857	

Medicaid DSH Report Notes

PROVIDER: SAINT MARY'S HOSPITAL
Mcaid Number: 000001823A
FROM: 7/1/2021 TO: 6/30/2022
Mcare Number: 110006

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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