GA DSH Payment Results for SFY 2024 - Pool 1 **4/8/2024 7:25**

DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

Provider Name	ST. MARYS SACRED HEART HOSPITAL
Mcaid Provider Number	000000437A
Mcare Provider Number	110027

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	$ 5,472,041	$ -	$ 5,472,041

Less: 2022 Gross UPL Payments	$ 214,817
Less: 2024 Gross DPP Payments	$ 1,009,491
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ (51,886)
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ -
Hospital Specific DSH Limit (Total UCC)	$ 4,195,847
2024 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	21.28%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	21.28%

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 #:	1302	Reviewer:
Examiner:	DGB	
Date:	11/15/2023	
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: ST. MARYS SACRED HEART 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:	ST. MARYS SACRED HEART HOSPITAL	Yes	
5. Medicaid Provider Number:	000000437A	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:	110027	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	South Carolina	413823
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: (07/01/2021 - 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)	$ 116,945	$ 372,697	$489,642
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 402,485	$ 1,826,166	$2,228,651
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$519,430	$2,198,863	$2,718,293
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	22.51%	16.95%	18.01%

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)	9,775

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	1,708,894
8. Outpatient Hospital Charity Care Charges	5,549,130
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 7,258,024

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	$ 7,869,155	$ -	$ -	$ 5,459,719	$ -	$ -	$ 2,409,436
12. Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13. Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$ -			$ -	
15. Swing Bed - NF			$ -			$ -	
16. Skilled Nursing Facility			$ -			$ -	
17. Nursing Facility			$ -			$ -	
18. Other Long-Term Care			$ -			$ -	
19. Ancillary Services	$ 37,114,666	$ 63,501,428	$ -	$ 25,750,623	$ 44,058,091	$ -	$ 30,807,379
20. Outpatient Services		$ 18,685,712	$ -		$ 12,964,383	$ -	$ 5,721,329
21. Home Health Agency			$ -			$ -	
22. Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	
23. Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24. ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25. Hospice			$ -			$ -	
26. Other	$ 836,976	$ 113,547	$ -	$ 580,705	$ 78,780	$ -	$ 291,038
27. Total	$ 45,820,797	$ 82,300,687	$ -	$ 31,791,047	$ 57,101,254	$ -	$ 39,229,183
28. Total Hospital and Non Hospital		Total from Above	$ 128,121,484		Total from Above	$ 88,892,301	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 128,121,484	Total Contractual Adj. (G-3 Line 2)	$ 88,892,301
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				88,892,301
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) ST. MARYS SACRED HEART 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	$ 10,283,250	$ -	$ -	-	**$ 10,283,250**	8,617	$ 4,654,820		**$ 1,193.37**
2	03100 INTENSIVE CARE UNIT	$ 3,492,976	$ -	$ -		**$ 3,492,976**	1,907	$ 3,015,363		**$ 1,831.66**
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	$ 544,961	$ -	$ -		**$ 544,961**	647	$ 198,972		**$ 842.29**
11	0	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 14,321,187	$ -	$ -	$ -	$ 14,321,187	11,171	$ 7,869,155		
19	Weighted Average									$ 1,282.00

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)		1,396	-	-	**$ 1,665,945**	254,276	1,483,892	$ 1,738,168	**0.958449**

Line #	Cost Center Description	*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	$ 3,353,745	$ -	$ -		**$ 3,353,745**	$ 1,230,127	$ 7,082,502	$ 8,312,629	**0.403452**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 1,553,059	$ -	$ -		**$ 1,553,059**	$ 2,331,092	$ 123,444	$ 2,454,536	**0.632730**
23	5300 ANESTHESIOLOGY	$ 719,135	$ -	$ -		**$ 719,135**	$ 172,816	$ 1,087,202	$ 1,260,018	**0.570734**
24	5400 RADIOLOGY-DIAGNOSTIC	$ 2,924,899	$ -	$ -		**$ 2,924,899**	$ 1,664,523	$ 8,035,173	$ 9,699,696	**0.301545**
25	5700 CT SCAN	$ 619,744	$ -	$ -		**$ 619,744**	$ 3,556,568	$ 16,343,022	$ 19,899,590	**0.031144**
26	5800 MRI	$ 308,454	$ -	$ -		**$ 308,454**	$ 258,773	$ 2,217,878	$ 2,476,651	**0.124545**
27	6000 LABORATORY	$ 2,643,197	$ -	$ -		**$ 2,643,197**	$ 7,574,069	$ 12,747,382	$ 20,321,451	**0.130069**
28	6500 RESPIRATORY THERAPY	$ 1,449,965	$ -	$ -		**$ 1,449,965**	$ 3,994,929	$ 1,704,450	$ 5,699,379	**0.254408**
29	6600 PHYSICAL THERAPY	$ 1,045,203	$ -	$ -		**$ 1,045,203**	$ 1,556,007	$ 1,598,003	$ 3,154,010	**0.331389**
30	6900 ELECTROCARDIOLOGY	$ 369,584	$ -	$ -		**$ 369,584**	$ 1,012,798	$ 1,997,356	$ 3,010,154	**0.122779**
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,364,991	$ -	$ -		**$ 1,364,991**	$ 815,157	$ 489,288	$ 1,304,445	**1.046415**
32	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 1,005,741	$ -	$ -		**$ 1,005,741**	$ 607,612	$ 3,007,717	$ 3,615,329	**0.278188**
33	7300 DRUGS CHARGED TO PATIENTS	$ 3,489,372	$ -	$ -		**$ 3,489,372**	$ 12,340,195	$ 7,068,012	$ 19,408,207	**0.179788**
34	9100 EMERGENCY	$ 4,211,508	$ -	$ -		**$ 4,211,508**	$ 2,327,670	$ 14,619,874	$ 16,947,544	**0.248503**
35		$ -	$ -	$ -		**$ -**	$ -	$ -	$ -	**-**
126	**Total Ancillary**	$ 25,058,597	$ -	$ -		$ 25,058,597	$ 39,696,612	$ 79,605,195	$ 119,301,807	
127	**Weighted Average**									**0.224008**

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS SACRED HEART 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
128	**Sub Totals**	$ 39,379,784	$ -	$ -		$ 39,379,784	$ 47,565,767	$ 79,605,195	$ 127,170,962	
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**					**$ 39,379,784**				
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 (07/01/2021-06/30/2022 ST. MARYS SACRED HEART 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	$ 1,193.37		426		822		-		732		686		1,980		36.99%
2	03100	INTENSIVE CARE UNIT	$ 1,831.66		164		40		-		67		127		271		20.87%
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	$ 842.29		38		437		-		5		105		480		90.42%
11		0	$ -		-		-		-		-		-		-		
18				Total Days	628		1,299		-		804		918		2,731		37.38%
19	Total Days per PS&R or Exhibit Detail				628		1,299		-		804		918				
20		Unreconciled Days (Explain Variance			-		-		-		-		-				
					Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21		Routine Charges			$ 570,895		$ 831,092		$ -		$ 643,386		$ 743,484		$ 2,045,373		35.48%
21.01		Calculated Routine Charge Per Dien			$ 909.07		$ 639.79		$ -		$ 800.23		$ 809.90		$ 748.95		
	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		0.958449	$ 10,288	$ 26,806	$ 5,200	$ 62,108	$ -	$ -	$ 47,580	$ 348,604	$ 49,348	$ 142,243	$ 63,068	$ 437,518	39.87%
23	5000	OPERATING ROOM		0.403452	$ 44,902	$ 215,754	$ 261,645	$ 428,181	$ -	$ -	$ 85,486	$ 428,740	$ 118,219	$ 313,279	$ 392,033	$ 1,072,675	22.95%
24	5200	DELIVERY ROOM & LABOR ROOM		0.632730	$ 62,999	$ 729	$ 1,280,924	$ 89,422	$ -	$ -	$ 6,498	$ 316	$ 95,515	$ 11,817	$ 1,350,421	$ 90,467	63.08%
25	5300	ANESTHESIOLOGY		0.570734	$ 2,480	$ 38,847	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,480	$ 38,847	3.28%
26	5400	RADIOLOGY-DIAGNOSTIC		0.301545	$ 117,544	$ 974,275	$ 237,414	$ 2,466,340	$ -	$ -	$ 474,093	$ 1,941,632	$ 645,205	$ 1,257,631	$ 829,051	$ 5,382,247	84.12%
27	5700	CT SCAN		0.031144	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,257,631	$ -	$ -	6.32%
28	5800	MRI		0.124545	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,257,630	$ -	$ -	50.78%
29	6000	LABORATORY		0.130069	$ 501,347	$ 641,454	$ 721,147	$ 2,003,495	$ -	$ -	$ 645,609	$ 895,170	$ 739,645	$ 2,162,783	$ 1,868,103	$ 3,540,119	41.02%
30	6500	RESPIRATORY THERAPY		0.254408	$ 383,865	$ 109,756	$ 153,319	$ 186,982	$ -	$ -	$ 419,014	$ 297,968	$ 338,350	$ 384,796	$ 956,198	$ 594,706	39.96%
31	6600	PHYSICAL THERAPY		0.331389	$ 80,510	$ 64,855	$ 11,038	$ 194,339	$ -	$ -	$ 173,578	$ 116,238	$ 43,717	$ 85,056	$ 265,126	$ 375,432	24.39%
32	6900	ELECTROCARDIOLOGY		0.122779	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.046415	$ 55,535	$ 17,121	$ 35,687	$ 72,981	$ -	$ -	$ 77,073	$ 28,951	$ 48,354	$ 45,567	$ 168,295	$ 119,053	29.23%
34	7200	IMPL. DEV. CHARGED TO PATIENTS		0.278188	$ 16,288	$ 36,031	$ -	$ 20,452	$ -	$ -	$ 79,119	$ 153,458	$ 35,224	$ 33,451	$ 95,407	$ 209,941	10.35%
35	7300	DRUGS CHARGED TO PATIENTS		0.179788	$ 747,431	$ 284,638	$ 1,134,079	$ 819,256	$ -	$ -	$ 963,181	$ 559,711	$ 1,068,492	$ 1,352,710	$ 2,844,691	$ 1,663,605	35.75%
36	9100	EMERGENCY		0.248503	$ 157,019	$ 764,235	$ 105,885	$ 2,839,505	$ -	$ -	$ 220,188	$ 763,043	$ 265,455	$ 3,215,434	$ 483,092	$ 4,366,783	49.30%
37				-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
					2,180,208	3,174,501	3,946,338	9,183,061	-	-	3,191,419	5,533,831	3,447,524	11,520,028			

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

Cost Report Year (07/01/2021-06/30/2022 ST. MARYS SACRED HEART HOSPITAL

Line	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
128	**Total Charges** *(includes organ acquisition from Section J)*	**$ 2,751,103**	**$ 3,174,501**	**$ 4,777,430**	**$ 9,183,061**	**$ -**	**$ -**	**$ 3,834,805**	**$ 5,533,831**	**$ 4,191,008** (Agrees to Exhibit A)	**$ 11,520,028** (Agrees to Exhibit A)	**$ 11,363,338**	**$ 17,891,393**	35.46%
129	Total Charges per PS&R or Exhibit Detail	$ 2,751,103	$ 3,174,501	$ 4,777,430	$ 9,183,061	$ -	$ -	$ 3,834,805	$ 5,533,831	$ 4,191,008	$ 11,520,028			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	**$ 1,371,064**	**$ 831,035**	**$ 2,818,925**	**$ 2,340,110**	**$ -**	**$ -**	**$ 1,806,286**	**$ 1,686,777**	**$ 2,004,937**	**$ 2,351,861**	$ 5,996,275	$ 4,857,922	38.72%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,007,413	$ 634,454	$ -	$ 78	$ -	$ -	$ 19,559	$ 75,280			$ 1,026,972	$ 709,812	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 1,731,516	$ 1,420,516	$ -	$ -	$ 1,302	$ 389			$ 1,732,818	$ 1,420,905	
134	Private Insurance (including primary and third party liability)	$ 3,945	$ 3,857	$ 441,680	$ 506,652	$ -	$ -	$ 10,702	$ 70,978			$ 456,327	$ 581,487	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 6,414	$ 22,583	$ -	$ -	$ -	$ 6,945			$ 6,414	$ 29,528	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,011,358	$ 638,311	$ 2,179,610	$ 1,949,829									
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)					$ -	$ -	$ 1,288,880	$ 721,894			$ 1,288,880	$ 721,894	
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 116,945	$ 372,697			
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)**	$ 359,706	$ 192,724	$ 639,315	$ 390,281	$ -	$ -	$ 485,843	$ 811,291	$ 1,887,992	$ 1,979,164	$ 1,484,864	$ 1,394,296	
146	**Calculated Payments as a Percentage of Cost**	74%	77%	77%	83%	0%	0%	73%	52%	6%	16%	75%	71%	
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**					5,378								
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 su
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 pay

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS SACRED HEART 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)		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	$ 1,193.37		5		-		-		-		5	
2	03100	INTENSIVE CARE UNIT	$ 1,831.66		-		-		-		-		-	
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	$ 842.29		-		-		-		-		-	
11			$ -		-		-		-		-		-	
18				**Total Days**	5		-		-		-		5	
19	Total Days per PS&R or Exhibit Detail				5		-		-		-			
20	Unreconciled Days (Explain Variance)				-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ 3,510		$ -		$ -		$ -		$ 3,510	
21.01		Calculated Routine Charge Per Diem			$ 702.00		$ -		$ -		$ -		$ 702.00	
	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)		0.958449	-	-	-	-	-	-	-	832	$ -	$ 832
23	5000	OPERATING ROOM		0.403452	5,867	-	-	-	-	-	-	5,302	$ 5,867	$ 5,302
24	5200	DELIVERY ROOM & LABOR ROOM		0.632730	-	-	-	-	-	-	-	-	$ -	$ -
25	5300	ANESTHESIOLOGY		0.570734	-	-	-	-	-	-	-	-	$ -	$ -
26	5400	RADIOLOGY-DIAGNOSTIC		0.301545	2,819	17,801	-	-	-	-	-	24,884	$ 2,819	$ 42,685
27	5700	CT SCAN		0.031144	-	-	-	-	-	-	-	-	$ -	$ -
28	5800	MRI		0.124545	-	-	-	-	-	-	-	-	$ -	$ -
29	6000	LABORATORY		0.130069	6,440	10,417	-	-	-	-	-	7,358	$ 6,440	$ 17,775
30	6500	RESPIRATORY THERAPY		0.254408	2,504	1,141	-	-	-	-	-	-	$ 2,504	$ 1,141
31	6600	PHYSICAL THERAPY		0.331389	-	-	-	-	-	-	-	-	$ -	$ -
32	6900	ELECTROCARDIOLOGY		0.122779	-	-	-	-	-	-	-	-	$ -	$ -
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.046415	-	-	-	-	-	-	-	-	$ -	$ -
34	7200	IMPL. DEV. CHARGED TO PATIENTS		0.278188	-	-	-	-	-	-	-	-	$ -	$ -
35	7300	DRUGS CHARGED TO PATIENTS		0.179788	1,308	3,461	-	-	-	-	-	5,056	$ 1,308	$ 8,517
36	9100	EMERGENCY		0.248503	873	16,552	-	-	-	-	-	6,830	$ 873	$ 23,382
37				-	-	-	-	-	-	-	-	-	$ -	$ -
					19,811	49,372	-	-	-	-	-	50,262		
	Totals / Payments													
128	**Total Charges (includes organ acquisition from Section K)**				**$ 23,321**	**$ 49,372**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 50,262**	**$ 23,321**	**$ 99,634**
129	Total Charges per PS&R or Exhibit Detail				$ 23,321	$ 49,372	$ -	$ -	$ -	$ -	$ -	$ 50,262		
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)												$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**				**$ 11,111**	**$ 11,748**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 14,004**	**$ 11,111**	**$ 25,752**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,071	$ -	$ 7,071
135	Self-Pay (including Co-Pay and Spend-Down)				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)				$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)								$ -	$ -	$ -	$ 1,793	$ -	$ 1,793
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)								$ -	$ -	$ -	$ 3,784	$ -	$ 3,784
141	Medicare Cross-Over Bad Debt Payments								$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)								$ -	$ -	$ -	$ -	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS SACRED HEART HOSPITAL

Line	Description	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	
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 11,111	$ 11,748	$ -	$ -	$ -	$ -	$ -	$ 1,356	$ 11,111	$ 13,104
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	90%	0%	49%

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) | ST. MARYS SACRED HEART 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) | ST. MARYS SACRED HEART 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 examinati surveys.

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS SACRED HEART HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description	Explanation	Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	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	$ -		
	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:

Line	Description		Amount
17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	29,377,686
19	Uninsured Hospital	**Charges Sec. G**	15,711,036
20	Total Hospital	**Charges Sec. G**	127,170,962
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		23.10%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		12.35%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider 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.*

DSH Examination Eligibility Summary

Hospital Name	**ST. MARYS SACRED HEART HOSPITAL**
Hospital Medicaid Number	**000000437A**
Cost Report Period	From **7/1/2021** To **6/30/2022**

		Source	As-Reported	Adjustments	As-Adjusted
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 5,875,638	$ -	$ 5,875,638
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 5,875,638	$ -	$ 5,875,638
4	Net Hospital Patient Revenue	Survey F-3	$ 39,229,183	$ -	$ 39,229,183
5	Medicaid Fraction		14.98%	0.00%	14.98%
6	Inpatient Charity Care Charges	Survey F-2	$ 1,708,894	$ -	$ 1,708,894
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 1,708,894	$ -	$ 1,708,894
10	Inpatient Hospital Charges	Survey F-3	$ 45,820,797	$ -	$ 45,820,797
11	Inpatient Charity Fraction		3.73%	0.00%	3.73%
12	LIUR		18.71%	0.00%	18.71%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	2,731	-	2,731
14	Out-of-State Medicaid Eligible Days	Survey I	5	-	5
15	Total Medicaid Eligible Days		2,736	-	2,736
16	Total Hospital Days (excludes swing-bed)	Survey F-1	9,775	-	9,775
17	MIUR		27.99%	0.00%	27.99%

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	ST. MARYS SACRED HEART HOSPITAL
Hospital Medicaid Number	000000437A
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	1,371,064	1,007,413	-	3,945	-	-	-	-	-	-	-			1,011,358	359,706	73.76%
2 Medicaid Fee for Service	Outpatient	831,035	634,454	-	3,857	-	-	-	-	-	-	-			638,311	192,724	76.81%
3 Medicaid Managed Care	Inpatient	2,818,925	-	1,731,516	441,680	6,414	-	-							2,179,610	639,315	77.32%
4 Medicaid Managed Care	Outpatient	2,340,110	78	1,420,516	506,652	22,583	-	-							1,949,829	390,281	83.32%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7 Other Medicaid Eligibles	Inpatient	1,806,286	19,559	1,302	10,702	-			-	1,288,880	-	-			1,320,443	485,843	73.10%
8 Other Medicaid Eligibles	Outpatient	1,686,777	75,280	389	70,978	6,945			-	721,894	-	-			875,486	811,291	51.90%
9 Uninsured	Inpatient	2,004,937	-	-	-	-	-	-	-	-	-	-	116,945	-	116,945	1,887,992	5.83%
10 Uninsured	Outpatient	2,351,861	-	-	-	-	-	-	-	-	-	-	372,697	-	372,697	1,979,164	15.85%
11 In-State Sub-total	Inpatient	8,001,212	1,026,972	1,732,818	456,327	6,414	-	-	-	1,288,880	-	-	116,945	-	4,628,356	3,372,856	57.85%
12 In-State Sub-total	Outpatient	7,209,783	709,812	1,420,905	581,487	29,528	-	-	-	721,894	-	-	372,697	-	3,836,323	3,373,460	53.21%
13 Out-of-State Medicaid	Inpatient	11,111	-	-	-	-	-	-	-	-	-	-			-	11,111	0.00%
14 Out-of-State Medicaid	Outpatient	25,752	-	-	7,071	-	-	-	1,793	3,784	-	-			12,648	13,104	49.11%
15 Sub-Total	I/P and O/P	15,247,858	1,736,784	3,153,723	1,044,885	35,942	-	-	1,793	2,014,558	-	-	489,642	-	8,477,327	6,770,531	55.60%

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	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2 Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3 Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4 Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8 Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9 Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10 Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11 In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12 In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15 Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name	**ST. MARYS SACRED HEART HOSPITAL**
Hospital Medicaid Number	**000000437A**
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)
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2 Medicaid Fee for Service	Outpatient	831,035	634,454	-	3,857	-	-	-	-	-	-	-			638,311	192,724	76.81%
3 Medicaid Managed Care	Inpatient	2,818,925	-	1,731,516	441,680	6,414	-	-							2,179,610	639,315	77.32%
4 Medicaid Managed Care	Outpatient	2,340,110	78	1,420,516	506,652	22,583	-	-							1,949,829	390,281	83.32%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
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7 Other Medicaid Eligibles	Inpatient	1,806,286	19,559	1,302	10,702	-			-	1,288,880	-	-			1,320,443	485,843	73.10%
8 Other Medicaid Eligibles	Outpatient	1,686,777	75,280	389	70,978	6,945			-	721,894	-	-			875,486	811,291	51.90%
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13 Out-of-State Medicaid	Inpatient	11,111	-	-	-	-	-	-	-	-	-	-			-	11,111	0.00%
14 Out-of-State Medicaid	Outpatient	25,752	-	-	7,071	-	-	-	1,793	3,784	-	-			12,648	13,104	49.11%
15 Cost Report Year Sub-Total	I/P and O/P	15,247,858	1,736,784	3,153,723	1,044,885	35,942	-	-	1,793	2,014,558	-	-	489,642	-	8,477,327	6,770,531	55.60%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	6,770,531

Medicaid DSH Survey Adjustments

PROVIDER: ST. MARYS SACRED HEART HOSPITAL
Mcaid Number: 000000437A
FROM: 7/1/2021 TO: 6/30/2022
Mcare Number: 110027

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.

Medicaid DSH Report Notes

PROVIDER: ST. MARYS SACRED HEART HOSPITAL   Mcaid Number: 000000437A
FROM: 7/1/2021   TO: 6/30/2022   Mcare Number: 110027

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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