MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

August 13, 2024

Janice Dunn
St. Mary's Sacred Heart Hospital
367 Clear Creek Parkway
Lavonia, Georgia 30553

RE: DSH Medicaid Provider Examination

Provider Number:	110027
Provider Name:	St. Mary's Sacred Heart Hospital
DSH Year(s) under Examination:	June 30, 2021

Dear Janice Dunn:

Myers and Stauffer LC has completed the mandated examinations of Georgia's fiscal 2021 DSH year to comply with the federal regulation regarding disproportionate share hospital (DSH) payments issued by CMS on December 19, 2008.

Your hospital's results are enclosed. These results are based on our examination of the DSH survey document, claims level analysis to support the uninsured services provided and payments received during each cost report year covered by a portion of the DSH year.

Thank you for your cooperation and assistance in providing the information and documentation for completing the examination. If you have any questions or concerns regarding your hospital's results, please contact us at the address or phone number below.

Sincerely,

Emily Bergstrom

Emily Bergstrom

700 W 47th Street, Suite 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
www.myersandstauffer.com

Georgia DSH Examination Results for 2021 **8/12/2024 14:57**

DSH UCC Cost & Payment Summary

Review Results

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

In order to comply with the December 19, 2008 federal regulation regarding disproportionate share hospital (DSH) payments, surveys were submitted by all facilities that received DSH payments during the 2021 state DSH year. Reviews have been completed and below are the results of those reviews. The DSH payment for the 2021 state DSH year, as well as the uncompensated care calculation (UCC) are presented below.

NOTE: If your hospital is selected for further testing or field work, the results may change and you will be notified at that time.

Georgia Medicaid DSH Examination Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2020 - 6/30/2021

	(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)
	Cost Report Year Begin	Cost Report Year End	% of Year Applicable to DSH Year	Uninsured / Medicaid Cost	Medicaid and Self-Pay Payments	Medicare Payments	Private Insurance Payments (TPL)	Cost Report Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (D)-(E)- (F)- (G)	State DSH Year Adjusted DSH TOTAL Uncompensated Care Cost (UCC) (C) x (H)
Cost Report Year 1 UCC:	7/1/2020	6/30/2021	100.00%	$ 16,710,820	$ 6,893,835	$ 5,062,213	$ 852,180	$ 3,902,591	$ 3,902,591
Cost Report Year 2 UCC:	-		0.00%						$ -
Cost Report Year 3 UCC:	-		0.00%						$ -
State DSH Year Sub-Totals:				$ 16,710,820	$ 6,893,835	$ 5,062,213	$ 852,180		$ 3,902,592
Less Supplemental Payments (UPL, etc.):									$ 232,258
State DSH Year Adjusted Uncompensated Care Calculation (UCC):									$ 3,670,334
Out-of-State DSH Payments:									$ -
DSH Payments:									$ 1,489,451
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:									**$ -**
DSH Year Low Income Utilization Ratio (LIUR):									21.82%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):									46.34%

Observations (may be included in examination report):

If you disagree with the findings presented above please respond within ten 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
Overnight Packages:	Myers and Stauffer LC Attn: DSH Examinations 700 W 47th Street, Suite 1100 Kansas City, MO 64112
Web Portal:	https://dsh.mslc.com
Phone Inquiries:	800-374-6858

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

Workpaper #:	1301	Reviewer:
Examiner:	J0C	K4M
Date:	9/22/2023	9/25/2023

2. Select Your Facility from the Drop-Down Menu Provided: ST. MARYS SACRED HEART HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2020	06/30/2021
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	000000437A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110027

B. DSH Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/20 - 06/30/21)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1966

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** $ 232,258 **4904**
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021** $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2020 - 06/30/2021** $ 232,258

Certification:

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

Explanation for "No" answers:

0

0

0

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

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

0	CFO	
Hospital CEO or CFO	Title	Date
Janice Dunn	706-389-3938	Janice.Dunn@stmarysathens.org
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	**Hospital CEO or CFO E-Mail**

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

Hospital Contact:	
Name	Brian Aho
Title	Sr. Reimbursement Analyst
Telephone Number	614-592-7772
E-Mail Address	Brian.Aho@trinity-health.org
Mailing Street Address	1230 Baxter St.
Mailing City, State, Zip	Athens, GA 30606

Outside Preparer:	
Name	0
Title:	0
Firm Name:	0
Telephone Number	0
E-Mail Address	0

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

Medicaid DSH Survey Adjustments

PROVIDER: ST. MARYS SACRED HEART HOSPITAL
FROM: 7/1/2020 TO: 6/30/2021
Mcaid Number: 000000437A
Mcare Number: 110027

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Year	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302		Reviewer:
Examiner:	A5D		K4M
Date:	9/28/2023		10/2/2023
DSH Version	8.10		7/5/2022

D. General Cost Report Year Information 7/1/2020 - 6/30/2021

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			
	7/1/2020 through 6/30/2021			
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:	12/3/2021			

	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	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	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: (07/01/2020 - 06/30/2021)

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)	$ 215,049	5203	$ 699,253	5203	$914,302
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 358,265	5203	$ 1,099,647	5203	$1,457,912
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$573,314		$1,798,900		$2,372,214
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	37.51%		38.87%		38.54%

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 (07/01/2020 - 06/30/2021)

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)	9,051 1505

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	1,721,556
8.	Outpatient Hospital Charity Care Charges	4,673,990
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 6,395,546

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

		1505 Inpatient Hospital	1505 Outpatient Hospital	1505 Non-Hospital	Contractual Adjustments: Inpatient Hospital	Contractual Adjustments: Outpatient Hospital	Contractual Adjustments: Non-Hospital	Net Hospital Revenue
		Total Patient Revenues (Charges)						
11.	Hospital	$ 6,117,358	$ -	$ -	$ 4,230,919	$ -	$ -	$ 1,886,439
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	$ 33,712,405	$ 61,122,514	$ -	$ 23,316,350	$ 42,273,872	$ -	$ 29,244,697
20.	Outpatient Services		$ 14,698,677	$ -		$ 10,165,976	$ -	$ 4,532,701
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 1,111,894	$ -	$ -	$ 769,014	$ -
27.	Total	$ 39,829,763	$ 75,821,191	$ 1,111,894	$ 27,547,269	$ 52,439,848	$ 769,014	$ 35,663,837
28.	Total Hospital and Non Hospital		Total from Above	$ 116,762,848		Total from Above	$ 80,756,131	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 116,762,848 1505	Total Contractual Adj. (G-3 Line 2) $ 80,756,131 1505
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.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			- $ -
35.	Adjusted Contractual Adjustments			80,756,131
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0) $ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) | 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
		1505	1505	1505	1505		1505	1505		
		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	$ 7,846,839	$ -	$ -	-	**$ 7,846,839**	7,494	$ 3,441,403		**$ 1,047.08**
2	03100 INTENSIVE CARE UNIT	$ 2,495,092	$ -	$ -		**$ 2,495,092**	1,914	$ 2,497,260		**$ 1,303.60**
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	$ 476,957	$ -	$ -		**$ 476,957**	601	$ 178,695		**$ 793.61**
18	Total Routine	$ 10,818,888	$ -	$ -	$ -	$ 10,818,888	10,009	$ 6,117,358		
19	Weighted Average									$ 1,080.91

		1505	1505	1505		1505	1505		
		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)	958	-	-	**$ 1,003,103**	242,339	944,408	$ 1,186,747	**0.845254**

		1505	1505	1505		1505	1505		
		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	$ 3,950,600	$ -	$ -	**$ 3,950,600**	$ 1,276,273	$ 7,059,251	$ 8,335,524	**0.473947**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 1,379,991	$ -	$ -	**$ 1,379,991**	$ 2,057,036	$ 143,478	$ 2,200,514	**0.627122**
23	5300 ANESTHESIOLOGY	$ 10	$ -	$ -	**$ 10**	268	$ 1,976	$ 2,244	**0.004456**
24	5400 RADIOLOGY-DIAGNOSTIC	$ 2,529,444	$ -	$ -	**$ 2,529,444**	$ 1,304,300	$ 8,129,126	$ 9,433,426	**0.268136**
25	5700 CT SCAN	$ 576,729	$ -	$ -	**$ 576,729**	$ 3,584,815	$ 16,286,834	$ 19,871,649	**0.029023**
26	5800 MRI	$ 150,807	$ -	$ -	**$ 150,807**	$ 247,544	$ 2,096,948	$ 2,344,492	**0.064324**
27	6000 LABORATORY	$ 2,293,355	$ -	$ -	**$ 2,293,355**	$ 6,992,488	$ 12,072,833	$ 19,065,321	**0.120289**
28	6500 RESPIRATORY THERAPY	$ 1,194,622	$ -	$ -	**$ 1,194,622**	$ 3,787,755	$ 1,502,194	$ 5,289,949	**0.225829**
29	6600 PHYSICAL THERAPY	$ 643,547	$ -	$ -	**$ 643,547**	$ 1,466,608	$ 1,302,424	$ 2,769,032	**0.232409**
30	6700 OCCUPATIONAL THERAPY	$ 270,854	$ -	$ -	**$ 270,854**	$ -	$ -	$ -	**-**
31	6900 ELECTROCARDIOLOGY	$ 437,174	$ -	$ -	**$ 437,174**	$ 791,185	$ 2,091,895	$ 2,883,080	**0.151634**
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,238,146	$ -	$ -	**$ 1,238,146**	$ 886,416	$ 553,511	$ 1,439,927	**0.859867**
33	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 1,038,725	$ -	$ -	**$ 1,038,725**	$ 739,103	$ 2,998,350	$ 3,737,453	**0.277923**
34	7300 DRUGS CHARGED TO PATIENTS	$ 3,414,826	$ -	$ -	**$ 3,414,826**	$ 10,578,614	$ 6,883,694	$ 17,462,308	**0.195554**
35	9100 EMERGENCY	$ 3,430,276	$ -	$ -	**$ 3,430,276**	$ 2,077,282	$ 11,434,648	$ 13,511,930	**0.253870**
126	**Total Ancillary**	$ 22,549,106	$ -	$ -	$ 22,549,106	$ 36,032,026	$ 73,501,570	$ 109,533,596	
127	**Weighted Average**								**0.212550**
128	**Sub Totals**	$ 33,367,994	$ -	$ -	$ 33,367,994	$ 42,149,384	$ 73,501,570	$ 115,650,954	
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**				**$ 33,367,994**				
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 (07/01/2020-06/30/2021) | ST. MARYS SACRED HEART HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		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	$ 1,047.08		355		643		927		1,124		594		3,049		55.98%
2	03100 INTENSIVE CARE UNIT	$ 1,303.60		187		26		195		146		96		554		33.96%
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	$ 793.61		55		446		-		74		26		575		100.00%
18			**Total Days**	597	4103	1,115	4203	1,122	4303	1,344	4403	716	5103	4,178		54.25%
19	Total Days per PS&R or Exhibit Detail			597		1,217		-		1,242		829				
20	Unreconciled Days (Explain Variance)			-		(102)		1,122		102		(113)				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 444,157	4103	$ 574,663	4203	$ 782,253	4303	$ 973,815	4403	$ 557,090	5103	$ 2,774,888		54.64%
21.01	Calculated Routine Charge Per Diem			$ 743.98		$ 515.39		$ 697.20		$ 724.56		$ 778.06		$ 664.17		
	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)		0.845254	$ 6,836	$ 28,664	$ 6,211	$ 72,216	$ 51,740	$ 98,940	$ 47,528	$ 166,424	$ 11,700	$ 137,617	$ 112,315	$ 366,244	52.91%
23	5000 OPERATING ROOM		0.473947	$ 27,930	$ 196,335	$ 235,388	$ 323,785	$ 74,180	$ 482,942	$ 121,360	$ 728,519	$ 132,687	$ 264,823	$ 458,858	$ 1,731,581	31.05%
24	5200 DELIVERY ROOM & LABOR ROOM		0.627122	$ 84,028	$ 1,514	$ 1,162,605	$ 62,815	$ 8,196	$ 1,952	$ 246,238	$ 14,626	$ 23,604	$ 5,426	$ 1,501,067	$ 80,907	73.22%
25	5300 ANESTHESIOLOGY		0.004456	$ -	$ -	$ -	$ -	$ -	$ 374	$ -	$ -	$ -	$ -	$ -	$ 374	16.67%
26	5400 RADIOLOGY-DIAGNOSTIC		0.268136	$ 108,239	$ 1,007,248	$ 44,203	$ 715,420	$ 215,271	$ 1,080,945	$ 239,690	$ 1,285,129	$ 152,119	$ 1,050,677	$ 607,403	$ 4,088,742	62.80%
27	5700 CT SCAN		0.029023	$ -	$ -	$ 80,722	$ 1,447,241	$ 440,540	$ 1,719,499	$ 590,483	$ 2,044,871	$ 371,434	$ 3,017,998	$ 1,111,745	$ 5,211,611	49.00%
28	5800 MRI		0.064324	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	6000 LABORATORY		0.120289	$ 445,188	$ 601,234	$ 488,269	$ 1,503,639	$ 786,209	$ 867,656	$ 1,054,024	$ 1,554,850	$ 571,525	$ 1,880,840	$ 2,773,690	$ 4,527,379	51.37%
30	6500 RESPIRATORY THERAPY		0.225829	$ 341,035	$ 121,499	$ 51,377	$ 170,862	$ 585,311	$ 432,242	$ 720,161	$ 466,157	$ 257,915	$ 369,029	$ 1,697,884	$ 1,190,760	66.78%
31	6600 PHYSICAL THERAPY		0.232409	$ 49,952	$ 75,448	$ 5,704	$ 62,688	$ 257,573	$ 117,614	$ 226,914	$ 218,145	$ 29,292	$ 33,134	$ 540,143	$ 473,895	38.89%
32	6700 OCCUPATIONAL THERAPY		-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
33	6900 ELECTROCARDIOLOGY		0.151634	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.859867	$ 45,196	$ 16,389	$ 14,261	$ 57,159	$ 120,834	$ 38,788	$ 111,986	$ 73,760	$ 68,433	$ 37,210	$ 292,277	$ 186,096	40.71%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.277923	$ 1,833	$ 15,992	$ -	$ 54,477	$ 21,234	$ 186,402	$ 25,545	$ 175,935	$ 31,220	$ 16,218	$ 48,612	$ 432,806	14.15%
36	7300 DRUGS CHARGED TO PATIENTS		0.195554	$ 622,805	$ 332,885	$ 502,523	$ 739,585	$ 1,038,311	$ 638,997	$ 1,425,773	$ 915,013	$ 873,528	$ 1,325,574	$ 3,589,412	$ 2,626,480	48.42%
37	9100 EMERGENCY		0.253870	$ 129,590	$ 633,701	$ 55,641	$ 1,924,160	$ 249,579	$ 1,010,053	$ 331,818	$ 1,442,948	$ 180,517	$ 2,639,584	$ 766,628	$ 5,010,862	63.94%
				1,862,632	3,030,909	2,646,904	7,134,047	3,848,978	6,676,404	5,141,520	9,086,377	2,703,973	10,778,130			

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

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		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		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 2,306,789 4103	$ 3,030,909 4103	$ 3,221,567 4203	$ 7,134,047 4203	$ 4,631,231 4303	$ 6,676,404 4303	$ 6,115,335 4403	$ 9,086,377 4403	$ 3,261,063 5103 (Agrees to Exhibit A)	$ 10,778,130 5103 (Agrees to Exhibit A)	$ 16,274,922	$ 25,927,737	48.81%
129	Total Charges per PS&R or Exhibit Detail	$ 2,306,789	$ 3,064,659	$ 3,592,421	$ 7,973,534	$ -	$ -	$ 5,744,481	$ 8,248,709	$ 3,651,532	$ 11,528,644			
130	Unreconciled Charges (Explain Variance)	-	(33,750)	(370,854)	(839,487)	4,631,231	6,676,404	370,854	837,668	(390,469)	(750,514)			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 1,096,108	$ 750,116	$ 2,117,538	$ 1,419,154	$ 2,042,208	$ 1,349,345	$ 2,568,095	$ 1,899,638	$ 1,324,862	$ 1,897,670	$ 7,823,949	$ 5,418,253	49.50%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 816,020 4103	$ 568,803 4103	$ 1,688 4203	$ 889 4203	$ 33,391 4303	$ 106,578 4303	$ 901,061 4403	$ 621,572 4403			$ 1,752,160	$ 1,297,842	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 1,665,214 4203	$ 1,263,471 4203	$ -	$ -	$ 11,904 4403	$ 8,762 4403			$ 1,677,117	$ 1,272,233	
134	Private Insurance (including primary and third party liability)	$ 10,760 4103	$ 25,554 4103	$ -	$ -	$ -	$ 89 4303	$ 230,007 4403	$ 564,061 4403			$ 240,767	$ 589,804	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 513 4203	$ 19,242 4203	$ -	$ -	$ 829 4403	$ 7,574 4403			$ 1,342	$ 26,816	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 826,780	$ 594,457	$ 1,667,415	$ 1,283,602									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (51,726) 4901	$ -	$ -							$ -	$ (51,726)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 1,596,995 4303	$ 1,049,146 4303	$ -	$ -			$ 1,596,995	$ 1,049,146	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 577,403 4403	$ 969,822 4403			$ 577,403	$ 969,822	
141	Medicare Cross-Over Bad Debt Payments					$ - 1505	$ - 1505	$ -	$ -			$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ 626,827 4318	$ 231,412 4318	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 626,827	$ 231,412	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 215,049 5203	$ 699,253 5203			
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)**	$ 269,328	$ 207,385	$ 450,123	$ 135,552	$ (215,005)	$ (37,880)	$ 846,891	$ (272,153)	$ 1,109,813	$ 1,198,417	$ 1,351,337	$ 32,904	
146	**Calculated Payments as a Percentage of Cost**	75%	72%	79%	90%	111%	103%	67%	114%	16%	37%	83%	99%	
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**					5,121								
148	**Percent of cross-over days to total Medicare days from the cost report**					22%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with surve
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&I
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 surve
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payment

I. Out-of-State Medicaid Data:

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Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to 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	$ 1,047.08		4		-				2		10				16	
2	03100 INTENSIVE CARE UNIT	$ 1,303.60		-		-				-		-				-	
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	$ 793.61		-		-				-		-				-	
18			**Total Days**	4		-	4603			2		10	4803			16	
19	Total Days per PS&R or Exhibit Detail			4		10				2		-					
20	Unreconciled Days (Explain Variance)			-		(10)				-		10					
				Routine Charges		**Routine Charges**				**Routine Charges**		**Routine Charges**				**Routine Charges**	
21	Routine Charges			$ 3,291		$ -	4603			$ 1,170		$ 5,550	4803			$ 10,311	
21.01	Calculated Routine Charge Per Diem			$ 822.75		$ -				$ 585.00		$ 585.00				$ 644.44	
	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)		0.845254	-	-	-		-		-	-	-		-		$ -	$ -
23	5000 OPERATING ROOM		0.473947	-	-	-		-		-	-	-		-		$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.627122	-	-	-		144		-	-	-		-		$ -	$ 144
25	5300 ANESTHESIOLOGY		0.004456	-	-	-		-		-	-	-		-		$ -	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.268136	4,769	10,907	-		1,910		2,973	-	483		4,619		$ 8,225	$ 17,436
27	5700 CT SCAN		0.029023	-	-	-		18,773		-	-	2,942		3,060		$ 2,942	$ 21,833
28	5800 MRI		0.064324	-	-	-		-		-	-	-		-		$ -	$ -
29	6000 LABORATORY		0.120289	2,431	9,248	-		12,110		3,208	363	8,111		5,576		$ 13,750	$ 27,297
30	6500 RESPIRATORY THERAPY		0.225829	107	636	-		1,186		2,786	-	11,494		800		$ 14,387	$ 2,622
31	6600 PHYSICAL THERAPY		0.232409	-	-	-		-		-	-	431		-		$ 431	$ -
32	6700 OCCUPATIONAL THERAPY		-	-	-	-		-		-	-	-		-		$ -	$ -
33	6900 ELECTROCARDIOLOGY		0.151634	-	-	-		-		-	-	-		-		$ -	$ -
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.859867	-	-	-		-		468	-	1,716		-		$ 2,184	$ -
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.277923	-	-	-		-		-	-	-		-		$ -	$ -
36	7300 DRUGS CHARGED TO PATIENTS		0.195554	7,048	6,641	-		5,230		4,523	1,395	12,361		2,415		$ 23,932	$ 15,681
37	9100 EMERGENCY		0.253870	1,122	11,849	-		17,584		1,531	463	1,531		8,460		$ 4,184	$ 38,356
				15,477	39,281	-		56,937		15,489	2,221	39,069		24,930			
	Totals / Payments																
128	**Total Charges (includes organ acquisition from Section K)**			**$ 18,768**	**$ 39,281**	**$ -**	4603	**$ 56,937**	4603	**$ 16,659**	**$ 2,221**	**$ 44,919**	4803	**$ 24,930**	4803	**$ 80,346**	**$ 123,369**
129	Total Charges per PS&R or Exhibit Detail			$ 18,768	$ 39,281	$ 44,919		$ 64,906		$ 16,659	$ 2,221	$ -		$ 16,961			
130	Unreconciled Charges (Explain Variance)			-	-	(44,919)		(7,969)		-	-	44,919		7,969			
131.01	Sampling Cost Adjustment (if applicable)															$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 7,447**	**$ 8,487**	**$ -**		**$ 8,359**		**$ 5,582**	**$ 434**	**$ 18,639**		**$ 4,799**		**$ 31,668**	**$ 22,079**
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)			$ -	$ -	$ -		$ 3,749	4603	$ -	$ -	$ -		$ -		$ -	$ 3,749
134	Private Insurance (including primary and third party liability)			$ -	$ -	$ -	4603	$ -		$ -	$ -	$ 17,153	4803	$ 4,456	4803	$ 17,153	$ 4,456
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -		$ -		$ -	$ -	$ -		$ -		$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -		$ 3,749									
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)									$ 10,040	$ 472	$ -		$ -		$ 10,040	$ 472
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -	$ -		$ 96	4803	$ -	$ 96
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -	$ -		$ -		$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -	$ -		$ -		$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 7,447	$ 8,487	$ -		$ 4,610		$ (4,458)	$ (38)	$ 1,486		$ 247		$ 4,475	$ 13,306
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%		45%		180%	109%	92%		95%		86%	40%

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

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		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 (07/01/2020-06/30/2021) 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 Primar		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 examination surveys.

Cost Report Year (07/01/2020-06/30/2021) ST. MARYS SACRED HEART HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 394,082	3001		
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)		$ 394,082	3001	-	*(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	$ (394,082)	3001	-	*(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		$ 394,082
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	42,406,374
19	Uninsured Hospital	**Charges Sec. G**	14,039,193
20	Total Hospital	**Charges Sec. G**	115,650,954
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		36.67%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		12.14%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 144,500
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 47,839
25	Provider Tax Assessment Adjustment to DSH UCC		$ 192,339

** 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 **7/1/2020** To **6/30/2021**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 6,444,049	$ (436,505)	$ 6,007,544
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 6,444,049	$ (436,505)	$ 6,007,544
4	Net Hospital Patient Revenue	Survey F-3	$ 36,006,717	$ (342,880)	$ 35,663,837
5	Medicaid Fraction		17.90%	-1.06%	16.84%
6	Inpatient Charity Care Charges	Survey F-2	$ 1,721,556	$ -	$ 1,721,556
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 1,721,556	$ -	$ 1,721,556
10	Inpatient Hospital Charges	Survey F-3	$ 40,697,490	$ (867,727)	$ 39,829,763
11	Inpatient Charity Fraction		4.23%	0.09%	4.32%
12	LIUR		22.13%	-0.97%	21.16%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	3,056	1,122	4,178
14	Out-of-State Medicaid Eligible Days	Survey I	16	-	16
15	Total Medicaid Eligible Days		3,072	1,122	4,194
16	Total Hospital Days (excludes swing-bed)	Survey F-1	9,051	-	9,051
17	MIUR		33.94%	12.40%	46.34%

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 **7/1/2020** To **6/30/2021**

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 Payments) 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	1,096,108	816,020	-	10,760	-	-	-	-	-	-	-			826,780	269,328	75.43%
2	Medicaid Fee for Service	Outpatient	757,736	485,947	-	5,771	-	-	-	-	-	-	-			491,718	266,018	64.89%
3	Medicaid Managed Care	Inpatient	2,347,849	1,688	1,676,691	209,583	1,341	-	-							1,889,303	458,546	80.47%
4	Medicaid Managed Care	Outpatient	1,792,993	889	1,270,944	395,587	26,817	-	-							1,694,237	98,756	94.49%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	2,416,475	901,061	427	20,425	-			-	577,403	-	-			1,499,316	917,159	62.05%
8	Other Medicaid Eligibles	Outpatient	1,890,630	621,572	1,319	168,641	-			-	969,822	-	-			1,761,354	129,276	93.16%
9	Uninsured	Inpatient	1,580,998	-	-	-	-	-	-	-	-	-	-	215,049	-	215,049	1,365,949	13.60%
10	Uninsured	Outpatient	2,443,644	-	-	-	-	-	-	-	-	-	-	699,253	-	699,253	1,744,391	28.62%
11	In-State Sub-total	Inpatient	7,441,430	1,718,769	1,677,118	240,768	1,341	-	-	-	577,403	-	-	215,049	-	4,430,448	3,010,982	59.54%
12	In-State Sub-total	Outpatient	6,885,003	1,108,408	1,272,263	569,999	26,817	-	-	-	969,822	-	-	699,253	-	4,646,562	2,238,441	67.49%
13	Out-of-State Medicaid	Inpatient	32,371	-	-	17,153	-	-	-	10,040	-	-	-			27,193	5,178	84.00%
14	Out-of-State Medicaid	Outpatient	27,299	-	479	463	-	-	-	472	96	-	-			1,510	25,789	5.53%
15	Sub-Total	I/P and O/P	14,386,103	2,827,177	2,949,860	828,383	28,158	-	-	10,512	1,547,321	-	-	914,302	-	9,105,713	5,280,390	63.30%

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 Payments)	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	(7,620)	82,856	-	19,883	-	(51,726)	-	-	-	-	-			51,013	(58,633)	7.46%
3	Medicaid Managed Care	Inpatient	(230,311)	-	(11,477)	(209,583)	(828)	-	-							(221,888)	(8,423)	-1.73%
4	Medicaid Managed Care	Outpatient	(373,839)	-	(7,473)	(395,587)	(7,575)	-	-							(410,635)	36,796	-4.04%
5	Medicare Cross-over (FFS)	Inpatient	2,042,208	33,391	-	-	-		-	1,596,995	-	-	626,827			2,257,213	(215,005)	0.00%
6	Medicare Cross-over (FFS)	Outpatient	1,349,345	106,578	-	89	-		-	1,049,146	-	-	231,412			1,387,225	(37,880)	0.00%
7	Other Medicaid Eligibles	Inpatient	151,620	-	11,477	209,582	829			-	-	-	-			221,888	(70,268)	4.98%
8	Other Medicaid Eligibles	Outpatient	9,008	-	7,443	395,420	7,574			-	-	-	-			410,437	(401,429)	21.16%
9	Uninsured	Inpatient	(256,136)	-	-	-	-	-	-	-	-	-	-	-	-	-	(256,136)	2.63%
10	Uninsured	Outpatient	(545,974)	-	-	-	-	-	-	-	-	-	-	-	-	-	(545,974)	8.23%
11	In-State Sub-total	Inpatient	1,707,381	33,391	(1)	(1)	1	-	-	1,596,995	-	-	626,827	-	-	2,257,213	(549,832)	13.56%
12	In-State Sub-total	Outpatient	430,920	189,434	(30)	19,805	(1)	(51,726)	-	1,049,146	-	-	231,412	-	-	1,438,040	(1,007,120)	15.68%
13	Out-of-State Medicaid	Inpatient	(703)	-	-	0	-	-	-	-	-	-	-			0	(703)	1.87%
14	Out-of-State Medicaid	Outpatient	(5,220)	-	3,270	3,993	-	-	-	-	-	-	-			7,263	(12,483)	34.20%
15	Sub-Total	I/P and O/P	2,132,378	222,824	3,239	23,797	0	(51,726)	-	2,646,141	-	-	858,239	-	-	3,702,516	(1,570,138)	14.24%
15.01																	192,339	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: ST. MARYS SACRED HEART HOSPITAL
Hospital Medicaid Number: 000000437A
Cost Report Period: From 7/1/2020 To 6/30/2021
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 Payments) 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	1,096,108	816,020	-	10,760	-	-	-	-	-	-	-			826,780	269,328	75.43%
2	Medicaid Fee for Service	Outpatient	750,116	568,803	-	25,654	-	(51,726)	-	-	-	-	-			542,731	207,385	72.35%
3	Medicaid Managed Care	Inpatient	2,117,538	1,688	1,665,214	-	513	-	-							1,667,415	450,123	78.74%
4	Medicaid Managed Care	Outpatient	1,419,154	889	1,263,471	-	19,242	-	-							1,283,602	135,552	90.45%
5	Medicare Cross-over (FFS)	Inpatient	2,042,208	33,391	-	-	-		-	1,596,995	-	-	626,827			2,257,213	(215,005)	110.53%
6	Medicare Cross-over (FFS)	Outpatient	1,349,345	106,578	-	89	-		-	1,049,146	-	-	231,412			1,387,225	(37,880)	102.81%
7	Other Medicaid Eligibles	Inpatient	2,568,095	901,061	11,904	230,007	829			-	577,403	-	-			1,721,204	846,891	67.02%
8	Other Medicaid Eligibles	Outpatient	1,899,638	621,572	8,762	564,061	7,574			-	969,822	-	-			2,171,791	(272,153)	114.33%
9	Uninsured	Inpatient	1,324,862	-	-	-	-	-	-	-	-	-	-	215,049	-	215,049	1,109,813	16.23%
10	Uninsured	Outpatient	1,897,670	-	-	-	-	-	-	-	-	-	-	699,253	-	699,253	1,198,417	36.85%
11	In-State Sub-total	Inpatient	9,148,811	1,752,160	1,677,117	240,767	1,342	-	-	1,596,995	577,403	-	626,827	215,049	-	6,687,661	2,461,150	73.10%
12	In-State Sub-total	Outpatient	7,315,923	1,297,842	1,272,233	589,804	26,816	(51,726)	-	1,049,146	969,822	-	231,412	699,253	-	6,084,602	1,231,321	83.17%
13	Out-of-State Medicaid	Inpatient	31,668	-	-	17,153	-	-	-	10,040	-	-	-			27,193	4,475	85.87%
14	Out-of-State Medicaid	Outpatient	22,079	-	3,749	4,456	-	-	-	472	96	-	-			8,773	13,306	39.73%
15	Cost Report Year Sub-Total	I/P and O/P	16,518,481	3,050,001	2,953,099	852,180	28,158	(51,726)	-	2,656,653	1,547,321	-	858,239	914,302	-	12,808,229	3,710,252	77.54%
15.01															Provider Tax Assessment Adjustment		192,339	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		3,902,591	

Medicaid DSH Survey Adjustments

PROVIDER: ST. MARYS SACRED HEART HOSPITAL
FROM: 7/1/2020 TO: 6/30/2021
Mcaid Number: 000000437A
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.
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.	$ 867,727	$ (867,727)	$ -	1505
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.	$ 244,167	$ (244,167)	$ -	1505
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.	$ -	$ 1,111,894	$ 1,111,894	1505
1	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 600,142	$ (600,142)	$ -	1505
1	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 168,872	$ (168,872)	$ -	1505
1	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 769,014	$ 769,014	1505
2	H - In-State	23	OPERATING ROOM	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 198,982	$ (2,647)	$ 196,335	4103
2	H - In-State	26	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 1,013,923	$ (6,675)	$ 1,007,248	4103
2	H - In-State	29	LABORATORY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 611,445	$ (10,211)	$ 601,234	4103
2	H - In-State	30	RESPIRATORY THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 122,135	$ (636)	$ 121,499	4103
2	H - In-State	36	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 337,064	$ (4,179)	$ 332,885	4103
2	H - In-State	37	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 643,103	$ (9,402)	$ 633,701	4103
2	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 485,947	$ 82,856	$ 568,803	4103
2	H - In-State	134	Private Insurance (including primary and third party liability)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust remove zero paids and report HS&R data.	$ 5,771	$ 19,883	$ 25,654	4103
3	H - In-State	137	Medicaid Cost Settlement Payments (See Note B)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to Medicaid cost settlement per state listing.	$ -	$ (51,726)	$ (51,726)	4901
4	H - In-State	1	ADULTS & PEDIATRICS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	723	(80)	643	4203
4	H - In-State	2	INTENSIVE CARE UNIT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	33	(7)	26	4203
4	H - In-State	10	NURSERY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	461	(15)	446	4203
4	H - In-State	21	Routine Charges	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 643,298	$ (68,635)	$ 574,663	4203
4	H - In-State	22	Observation (Non-Distinct)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 8,083	$ (1,872)	$ 6,211	4203
4	H - In-State	23	OPERATING ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 259,728	$ (24,340)	$ 235,388	4203
4	H - In-State	24	DELIVERY ROOM & LABOR ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,286,064	$ (123,459)	$ 1,162,605	4203
4	H - In-State	26	RADIOLOGY-DIAGNOSTIC	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 86,355	$ (42,152)	$ 44,203	4203
4	H - In-State	27	CT SCAN	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 39,751	$ 40,971	$ 80,722	4203
4	H - In-State	28	MRI	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 10,966	$ (10,966)	$ -	4203
4	H - In-State	29	LABORATORY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 546,545	$ (58,276)	$ 488,269	4203
4	H - In-State	30	RESPIRATORY THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 56,011	$ (4,634)	$ 51,377	4203
4	H - In-State	31	PHYSICAL THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 5,886	$ (182)	$ 5,704	4203
4	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 14,872	$ (611)	$ 14,261	4203
4	H - In-State	36	DRUGS CHARGED TO PATIENTS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 570,094	$ (67,571)	$ 502,523	4203
4	H - In-State	37	EMERGENCY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 64,768	$ (9,127)	$ 55,641	4203
4	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,676,691	$ (11,477)	$ 1,665,214	4203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
4	H - In-State	134	Private Insurance (including primary and third party liability)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 209,583	$ (209,583)	$ -	4203
4	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,341	$ (828)	$ 513	4203
4	H - In-State	22	Observation (Non-Distinct)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 82,849	$ (10,633)	$ 72,216	4203
4	H - In-State	23	OPERATING ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 422,258	$ (98,473)	$ 323,785	4203
4	H - In-State	24	DELIVERY ROOM & LABOR ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 67,649	$ (4,834)	$ 62,815	4203
4	H - In-State	26	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,536,066	$ (820,646)	$ 715,420	4203
4	H - In-State	27	CT SCAN	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 707,078	$ 740,163	$ 1,447,241	4203
4	H - In-State	28	MRI	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 195,056	$ (195,056)	$ -	4203
4	H - In-State	29	LABORATORY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,639,848	$ (136,209)	$ 1,503,639	4203
4	H - In-State	30	RESPIRATORY THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 190,263	$ (19,401)	$ 170,862	4203
4	H - In-State	31	PHYSICAL THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 78,505	$ (15,817)	$ 62,688	4203
4	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 79,924	$ (22,765)	$ 57,159	4203
4	H - In-State	35	IMPL. DEV. CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 80,868	$ (26,391)	$ 54,477	4203
4	H - In-State	36	DRUGS CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 834,881	$ (95,296)	$ 739,585	4203
4	H - In-State	37	EMERGENCY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 2,058,289	$ (134,129)	$ 1,924,160	4203
4	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,270,944	$ (7,473)	$ 1,263,471	4203
4	H - In-State	134	Private Insurance (including primary and third party liability)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 395,587	$ (395,587)	$ -	4203
4	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 26,817	$ (7,575)	$ 19,242	4203
5	H - In-State	1	ADULTS & PEDIATRICS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	-	927	927	4303
5	H - In-State	2	INTENSIVE CARE UNIT	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	-	195	195	4303
5	H - In-State	21	Routine Charges	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 782,253	$ 782,253	4303
5	H - In-State	22	Observation (Non-Distinct)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 51,740	$ 51,740	4303
5	H - In-State	23	OPERATING ROOM	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 74,180	$ 74,180	4303
5	H - In-State	24	DELIVERY ROOM & LABOR ROOM	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 8,196	$ 8,196	4303
5	H - In-State	26	RADIOLOGY-DIAGNOSTIC	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 215,271	$ 215,271	4303
5	H - In-State	27	CT SCAN	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 440,540	$ 440,540	4303
5	H - In-State	29	LABORATORY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 786,209	$ 786,209	4303
5	H - In-State	30	RESPIRATORY THERAPY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 585,311	$ 585,311	4303
5	H - In-State	31	PHYSICAL THERAPY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 257,573	$ 257,573	4303
5	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 120,834	$ 120,834	4303
5	H - In-State	35	IMPL. DEV. CHARGED TO PATIENTS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 21,234	$ 21,234	4303
5	H - In-State	36	DRUGS CHARGED TO PATIENTS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,038,311	$ 1,038,311	4303
5	H - In-State	37	EMERGENCY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 249,579	$ 249,579	4303
5	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 33,391	$ 33,391	4303
5	H - In-State	139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,596,995	$ 1,596,995	4303
6	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 626,827	$ 626,827	4318

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
5	H - In-State	22	Observation (Non-Distinct)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 98,940	$ 98,940	4303
5	H - In-State	23	OPERATING ROOM	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 482,942	$ 482,942	4303
5	H - In-State	24	DELIVERY ROOM & LABOR ROOM	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,952	$ 1,952	4303
5	H - In-State	25	ANESTHESIOLOGY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 374	$ 374	4303
5	H - In-State	26	RADIOLOGY-DIAGNOSTIC	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,080,945	$ 1,080,945	4303
5	H - In-State	27	CT SCAN	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,719,499	$ 1,719,499	4303
5	H - In-State	29	LABORATORY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 867,656	$ 867,656	4303
5	H - In-State	30	RESPIRATORY THERAPY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 432,242	$ 432,242	4303
5	H - In-State	31	PHYSICAL THERAPY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 117,614	$ 117,614	4303
5	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 38,788	$ 38,788	4303
5	H - In-State	35	IMPL. DEV. CHARGED TO PATIENTS	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 186,402	$ 186,402	4303
5	H - In-State	36	DRUGS CHARGED TO PATIENTS	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 638,997	$ 638,997	4303
5	H - In-State	37	EMERGENCY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,010,053	$ 1,010,053	4303
5	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 106,578	$ 106,578	4303
5	H - In-State	134	Private Insurance (including primary and third party liability)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 89	$ 89	4303
5	H - In-State	139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS Data.	$ -	$ 1,049,146	$ 1,049,146	4303
6	H - In-State	142	Other Medicare Cross-Over Payments (See Note D)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 231,412	$ 231,412	4318
7	H - In-State	1	ADULTS & PEDIATRICS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	1,044	80	1,124	4403
7	H - In-State	2	INTENSIVE CARE UNIT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	139	7	146	4403
7	H - In-State	10	NURSERY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	59	15	74	4403
7	H - In-State	21	Routine Charges	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 905,180	$ 68,635	$ 973,815	4403
7	H - In-State	22	Observation (Non-Distinct)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 45,656	$ 1,872	$ 47,528	4403
7	H - In-State	23	OPERATING ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 97,020	$ 24,340	$ 121,360	4403
7	H - In-State	24	DELIVERY ROOM & LABOR ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 122,779	$ 123,459	$ 246,238	4403
7	H - In-State	26	RADIOLOGY-DIAGNOSTIC	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 515,356	$ (275,666)	$ 239,690	4403
7	H - In-State	27	CT SCAN	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 237,228	$ 353,255	$ 590,483	4403
7	H - In-State	28	MRI	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 65,442	$ (65,442)	$ -	4403
7	H - In-State	29	LABORATORY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 995,748	$ 58,276	$ 1,054,024	4403
7	H - In-State	30	RESPIRATORY THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 715,527	$ 4,634	$ 720,161	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
7	H - In-State	31	PHYSICAL THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 226,732	$ 182	$ 226,914	4403
7	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 111,375	$ 611	$ 111,986	4403
7	H - In-State	36	DRUGS CHARGED TO PATIENTS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,358,202	$ 67,571	$ 1,425,773	4403
7	H - In-State	37	EMERGENCY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 322,691	$ 9,127	$ 331,818	4403
7	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 427	$ 11,477	$ 11,904	4403
7	H - In-State	134	Private Insurance (including primary and third party liability)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 20,425	$ 209,582	$ 230,007	4403
7	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 829	$ 829	4403
7	H - In-State	22	Observation (Non-Distinct)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 155,791	$ 10,633	$ 166,424	4403
7	H - In-State	23	OPERATING ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 630,046	$ 98,473	$ 728,519	4403
7	H - In-State	24	DELIVERY ROOM & LABOR ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 9,792	$ 4,834	$ 14,626	4403
7	H - In-State	26	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,924,671	$ (639,542)	$ 1,285,129	4403
7	H - In-State	27	CT SCAN	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 885,960	$ 1,158,911	$ 2,044,871	4403
7	H - In-State	28	MRI	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 244,403	$ (244,403)	$ -	4403
7	H - In-State	29	LABORATORY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,419,886	$ 134,964	$ 1,554,850	4403
7	H - In-State	30	RESPIRATORY THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 446,756	$ 19,401	$ 466,157	4403
7	H - In-State	31	PHYSICAL THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 202,328	$ 15,817	$ 218,145	4403
7	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 50,995	$ 22,765	$ 73,760	4403
7	H - In-State	35	IMPL. DEV. CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 149,544	$ 26,391	$ 175,935	4403
7	H - In-State	36	DRUGS CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 819,718	$ 95,295	$ 915,013	4403
7	H - In-State	37	EMERGENCY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,308,819	$ 134,129	$ 1,442,948	4403
7	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,319	$ 7,443	$ 8,762	4403
7	H - In-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 168,641	$ 395,420	$ 564,061	4403
7	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 7,574	$ 7,574	4403
8	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust to remove duplicate claims	709	(115)	594	5103
8	H - In-State	2	INTENSIVE CARE UNIT	13.00	Inpatient Uninsured	Adjust to remove duplicate claims	100	(4)	96	5103
8	H - In-State	10	NURSERY	13.00	Inpatient Uninsured	Adjust to remove duplicate claims	20	6	26	5103
8	H - In-State	21	Routine Charges	13.00	Inpatient Uninsured	Adjust to remove duplicate claims	$ 623,531	$ (66,441)	$ 557,090	5103
8	H - In-State	22	Observation (Non-Distinct	13.00	Inpatient Uninsured	Adjust to remove duplicate claims	$ 13,416	$ (1,716)	$ 11,700	5103

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
8	H - In-State	23	OPERATING ROOM	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 170,658	$ (37,971)	$ 132,687	5103
8	H - In-State	24	DELIVERY ROOM & LABOR ROOM	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 66,971	$ (43,367)	$ 23,604	5103
8	H - In-State	26	RADIOLOGY-DIAGNOSTIC	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 367,018	$ (214,899)	$ 152,119	5103
8	H - In-State	27	CT SCAN	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 168,944	$ 202,490	$ 371,434	5103
8	H - In-State	28	MRI	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 46,605	$ (46,605)	$ -	5103
8	H - In-State	29	LABORATORY	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 639,379	$ (67,854)	$ 571,525	5103
8	H - In-State	30	RESPIRATORY THERAPY	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 272,875	$ (14,960)	$ 257,915	5103
8	H - In-State	31	PHYSICAL THERAPY	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 32,719	$ (3,427)	$ 29,292	5103
8	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 71,369	$ (2,936)	$ 68,433	5103
8	H - In-State	36	DRUGS CHARGED TO PATIENTS	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 951,275	$ (77,747)	$ 873,528	5103
8	H - In-State	37	EMERGENCY	13.00	Inpatient Uninsurec	Adjust to remove duplicate claims	$ 195,552	$ (15,035)	$ 180,517	5103
8	H - In-State	22	Observation (Non-Distinct	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 147,210	$ (9,593)	$ 137,617	5103
8	H - In-State	23	OPERATING ROOM	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 322,998	$ (58,175)	$ 264,823	5103
8	H - In-State	24	DELIVERY ROOM & LABOR ROOM	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 11,292	$ (5,866)	$ 5,426	5103
8	H - In-State	26	RADIOLOGY-DIAGNOSTIC	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 2,713,419	$ (1,662,742)	$ 1,050,677	5103
8	H - In-State	27	CT SCAN	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 1,249,034	$ 1,768,964	$ 3,017,998	5103
8	H - In-State	28	MRI	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 344,561	$ (344,561)	$ -	5103
8	H - In-State	29	LABORATORY	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 2,027,367	$ (146,527)	$ 1,880,840	5103
8	H - In-State	30	RESPIRATORY THERAPY	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 397,524	$ (28,495)	$ 369,029	5103
8	H - In-State	31	PHYSICAL THERAPY	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 35,699	$ (2,565)	$ 33,134	5103
8	H - In-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 43,251	$ (6,041)	$ 37,210	5103
8	H - In-State	35	IMPL. DEV. CHARGED TO PATIENTS	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 35,806	$ (19,588)	$ 16,218	5103
8	H - In-State	36	DRUGS CHARGED TO PATIENTS	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 1,412,788	$ (87,214)	$ 1,325,574	5103
8	H - In-State	37	EMERGENCY	14.00	Outpatient Uninsurec	Adjust to remove duplicate claims	$ 2,787,695	$ (148,111)	$ 2,639,584	5103
9	I - Out-of-State	1	ADULTS & PEDIATRICS	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	10	(10)	-	4603
9	I - Out-of-State	21	Routine Charges	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 5,850	$ (5,850)	$ -	4603
9	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 3,425	$ (3,425)	$ -	4603
9	I - Out-of-State	29	LABORATORY	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 8,111	$ (8,111)	$ -	4603
9	I - Out-of-State	30	RESPIRATORY THERAPY	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 11,494	$ (11,494)	$ -	4603
9	I - Out-of-State	31	PHYSICAL THERAPY	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 431	$ (431)	$ -	4603
9	I - Out-of-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,716	$ (1,716)	$ -	4603
9	I - Out-of-State	36	DRUGS CHARGED TO PATIENTS	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 12,361	$ (12,361)	$ -	4603
9	I - Out-of-State	37	EMERGENCY	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,531	$ (1,531)	$ -	4603
9	I - Out-of-State	134	Private Insurance (including primary and third party liability)	7.00	Inpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 17,153	$ (17,153)	$ -	4603
9	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 24,756	$ (22,846)	$ 1,910	4603
9	I - Out-of-State	27	CT SCAN	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ -	$ 18,773	$ 18,773	4603
9	I - Out-of-State	29	LABORATORY	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 13,903	$ (1,793)	$ 12,110	4603
9	I - Out-of-State	30	RESPIRATORY THERAPY	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,398	$ (212)	$ 1,186	4603
9	I - Out-of-State	36	DRUGS CHARGED TO PATIENTS	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 5,240	$ (10)	$ 5,230	4603
9	I - Out-of-State	37	EMERGENCY	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 19,465	$ (1,881)	$ 17,584	4603
9	I - Out-of-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	8.00	Outpatient Out-of-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 479	$ 3,270	$ 3,749	4603
10	I - Out-of-State	1	ADULTS & PEDIATRICS	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	-	10	10	4803
10	I - Out-of-State	21	Routine Charges	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 5,850	$ 5,850	4803
10	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 483	$ 483	4803
10	I - Out-of-State	27	CT SCAN	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 2,942	$ 2,942	4803
10	I - Out-of-State	29	LABORATORY	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 8,111	$ 8,111	4803
10	I - Out-of-State	30	RESPIRATORY THERAPY	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 11,494	$ 11,494	4803
10	I - Out-of-State	31	PHYSICAL THERAPY	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 431	$ 431	4803

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
10	I - Out-of-State	34	MEDICAL SUPPLIES CHARGED TO PATIENT	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 1,716	$ 1,716	4803
10	I - Out-of-State	36	DRUGS CHARGED TO PATIENTS	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 12,361	$ 12,361	4803
10	I - Out-of-State	37	EMERGENCY	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 1,531	$ 1,531	4803
10	I - Out-of-State	134	Private Insurance (including primary and third party liability)	11.00	Inpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 17,153	$ 17,153	4803
10	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 3,606	$ 1,013	$ 4,619	4803
10	I - Out-of-State	27	CT SCAN	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ -	$ 3,060	$ 3,060	4803
10	I - Out-of-State	29	LABORATORY	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 3,783	$ 1,793	$ 5,576	4803
10	I - Out-of-State	30	RESPIRATORY THERAPY	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 588	$ 212	$ 800	4803
10	I - Out-of-State	36	DRUGS CHARGED TO PATIENTS	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 2,405	$ 10	$ 2,415	4803
10	I - Out-of-State	37	EMERGENCY	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 6,579	$ 1,881	$ 8,460	4803
10	I - Out-of-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims.	$ 463	$ 3,993	$ 4,456	4803
11	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to report provider tax.	$ -	$ 394,082	$ 394,082	3001
11	L - FRA	2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	2.00	Dollar Amount	Adjust to report provider tax.	$ -	$ 394,082	$ 394,082	3001
11	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to report provider tax.	-	(394,082)	(394,082)	3001

Medicaid DSH Report Notes

PROVIDER: ST. MARYS SACRED HEART HOSPITAL Mcaid Number: 000000437A
FROM: 7/1/2020 TO: 6/30/2021 Mcare Number: 110027

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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