MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

August 2, 2024

Brian Aho
Saint Mary's Hospital
1230 Baxter Street
Athens, Georgia 30606

RE: DSH Medicaid Provider Examination

Provider Number:	110006
Provider Name:	Saint Mary's Hospital
DSH Year(s) under Examination:	June 30, 2021

Dear Brian Aho:

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,

Keaton Pagani

Keaton Pagani

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 **8/2/2024 14:08**

DSH UCC Cost & Payment Summary

Review Results

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

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%	$ 65,690,683	$ 18,288,173	$ 33,293,135	$ 3,132,253	$ 10,977,122	$ 10,977,122
Cost Report Year 2 UCC:	-		0.00%						$ -
Cost Report Year 3 UCC:	-		0.00%						$ -
State DSH Year Sub-Totals:				$ 65,690,683	$ 18,288,173	$ 33,293,135	$ 3,132,253		$ 10,977,122
Less Supplemental Payments (UPL, etc.):									$ 2,699,258
State DSH Year Adjusted Uncompensated Care Calculation (UCC):									$ 8,277,864
Out-of-State DSH Payments:									$ -
DSH Payments:									$ 1,189,246
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:									**$ -**
DSH Year Low Income Utilization Ratio (LIUR):									12.93%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):									33.42%

Observations (may be included in examination report):

1. Claims were included in exhibit A as uninsured for days and charges that were also included in exhibit B as insured for self-pay payments for the same dates of service. Exhibit A and exhibit B claims should be reviewed in future years to ensure the inclusion of the claims in the appropriate classification.

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
Examiner:	MP
Date:	11/9/2023
Reviewer:	CBS
	11/27/2023

2. Select Your Facility from the Drop-Down Menu Provided: SAINT MARY'S 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:	000001823A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110006

B. DSH Qualifying Information

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

	DSH Examination Year (07/01/20 - 06/30/21)
During the DSH Examination Year:	
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** $ 2,699,258 **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** $ 2,699,258

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	Jnaice.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

Medicaid DSH Survey Adjustments

PROVIDER: SAINT MARY'S HOSPITAL
FROM: 7/1/2020 TO: 6/30/2021
Mcaid Number: 000001823A
Mcare Number: 110006

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:	MP	CBS
Date:	11/9/2023	11/27/2023
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: SAINT MARY'S 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:	SAINT MARY'S HOSPITAL	Yes	
5. Medicaid Provider Number:	000001823A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110006	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number	Florida	007970100
10. State Name & Number	South Carolina	20996894
11. State Name & Number	Tennessee	1871556621
12. State Name & Number	Illinois	58056622301
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2020 - 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)	$ 515,877	5203	$ 1,519,196	5203	$2,035,073
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,395,217	5203	$ 9,579,016	5203	$11,974,233
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$2,911,094		$11,098,212		$14,009,306
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	17.72%		13.69%		14.53%

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)	46,996	1405

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

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	100,000
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 100,000
7.	Inpatient Hospital Charity Care Charges	17,841,274
8.	Outpatient Hospital Charity Care Charges	19,860,492
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 37,701,766

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
		1405	1405	1405				
11.	Hospital	$ 72,715,422	$ -	$ -	$ 53,487,364	$ -	$ -	$ 19,228,058
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ 7,298,823	$ -	$ -	$ 5,368,803	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 303,060,485	$ 452,053,783	$ -	$ 222,922,539	$ 332,517,705	$ -	$ 199,674,025
20.	Outpatient Services		$ 55,397,677	$ -		$ 40,748,931	$ -	$ 14,648,746
21.	Home Health Agency			$ 7,911,013			$ 5,819,113	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 7,453,038			$ 5,482,239	
26.	Other	$ 212	$ 672,671	$ -	$ 156	$ 494,797	$ -	$ 177,930
27.	Total	$ 375,776,119	$ 508,124,131	$ 22,662,874	$ 276,410,058	$ 373,761,433	$ 16,670,155	$ 233,728,758
28.	Total Hospital and Non Hospital		Total from Above	$ 906,563,124		Total from Above	$ 666,841,647	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 906,563,124	1405	Total Contractual Adj. (G-3 Line 2)	$ 666,841,647	1405
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					666,841,647	
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) | SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):	1405	1405	1405	1405		1405	1405		
1	03000 ADULTS & PEDIATRICS	$ 28,103,061	$ 1,645,090	$ -	-	**$ 29,748,151**	26,672	$ 31,472,652		**$ 1,115.33**
2	03100 INTENSIVE CARE UNIT	$ 20,712,749	$ 519,976	$ 57,250		**$ 21,289,975**	12,141	$ 38,960,846		**$ 1,753.56**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 1,020,947	$ -	$ -		**$ 1,020,947**	4,543	$ 2,281,924		**$ 224.73**
18	Total Routine	$ 49,836,757	$ 2,165,066	$ 57,250	$ -	$ 52,059,073	43,356	$ 72,715,422		
19	Weighted Average									$ 1,200.73

			1405	1405	1405		1405	1405		
			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)		2,489	-	-	**$ 2,776,056**	79,849	4,556,803	$ 4,636,652	**0.598720**

		Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*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 Ob	1405	1405	1405			1405	1405		
21	5000 OPERATING ROOM	$ 41,450,050	$ 741,214	$ -		**$ 42,191,264**	$ 62,597,580	$ 149,365,000	$ 211,962,580	**0.199051**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 3,279,201	$ -	$ -		**$ 3,279,201**	$ 8,981,957	$ 160,932	$ 9,142,889	**0.358661**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 8,457,539	$ -	$ -		**$ 8,457,539**	$ 12,894,058	$ 39,463,411	$ 52,357,469	**0.161535**
24	5700 CT SCAN	$ 1,278,731	$ -	$ -		**$ 1,278,731**	$ 12,657,919	$ 27,911,469	$ 40,569,388	**0.031520**
25	5800 MRI	$ 584,739	$ -	$ -		**$ 584,739**	$ 4,312,674	$ 7,275,541	$ 11,588,215	**0.050460**
26	5900 CARDIAC CATHETERIZATION	$ 7,254,870	$ -	$ -		**$ 7,254,870**	$ 14,192,198	$ 28,844,152	$ 43,036,350	**0.168575**
27	6000 LABORATORY	$ 7,293,342	$ -	$ 5,978		**$ 7,299,320**	$ 17,981,157	$ 30,893,280	$ 48,874,437	**0.149348**
28	6300 BLOOD STORING PROCESSING & TRANS.	$ 1,171,020	$ -	$ -		**$ 1,171,020**	$ 1,679,071	$ 425,616	$ 2,104,687	**0.556387**
29	6400 INTRAVENOUS THERAPY	$ 5,671,940	$ -	$ -		**$ 5,671,940**	$ 4,209,637	$ 25,168,944	$ 29,378,581	**0.193064**
30	6500 RESPIRATORY THERAPY	$ 2,867,068	$ 273,055	$ -		**$ 3,140,123**	$ 16,479,884	$ 1,849,058	$ 18,328,942	**0.171320**
31	6600 PHYSICAL THERAPY	$ 4,214,825	$ -	$ -		**$ 4,214,825**	$ 13,488,502	$ 7,295,167	$ 20,783,669	**0.202795**
32	6900 ELECTROCARDIOLOGY	$ 2,866,393	$ 356,864	$ -		**$ 3,223,257**	$ 8,819,268	$ 12,314,829	$ 21,134,097	**0.152515**
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 10,849,833	$ -	$ -		**$ 10,849,833**	$ 17,510,921	$ 18,729,946	$ 36,240,867	**0.299381**
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 9,083,199	$ -	$ -		**$ 9,083,199**	$ 59,215,384	$ 64,204,178	$ 123,419,562	**0.073596**
35	7300 DRUGS CHARGED TO PATIENTS	$ 12,816,081	$ -	$ -		**$ 12,816,081**	$ 46,707,251	$ 28,081,122	$ 74,788,373	**0.171365**
36	7600 CARDIOLOGY	$ 754,679	$ 178,432	$ -		**$ 933,111**	$ 1,333,024	$ 10,071,138	$ 11,404,162	**0.081822**

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) SAINT MARY'S HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
37	9000	CLINIC	$ 650,750	$ -	$ -		**$ 650,750**	$ 4,452	$ 94,548	$ 99,000	**6.573232**
38	9001	WOUND CARE CENTER	$ 1,172,992	$ -	$ -		**$ 1,172,992**	$ 13,535	$ 3,584,203	$ 3,597,738	**0.326036**
39	9100	EMERGENCY	$ 8,657,084	$ 300,992	$ -		**$ 8,958,076**	$ 11,113,572	$ 35,950,715	$ 47,064,287	**0.190337**
126		**Total Ancillary**	$ 130,374,336	$ 1,850,557	$ 5,978		$ 132,230,871	$ 314,271,893	$ 496,240,052	$ 810,511,945	
127		**Weighted Average**									**0.166570**
128		**Sub Totals**	$ 180,211,093	$ 4,015,623	$ 63,228		$ 184,289,944	$ 386,987,315	$ 496,240,052	$ 883,227,367	
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**					**$ 184,289,944**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					**2.23%**				

* 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) SAINT MARY'S 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	$ 1,115.33		1,585		2,190		2,523		3,147		1,628		9,445		45.92%
2	03100 INTENSIVE CARE UNIT	$ 1,753.56		637		205		1,101		1,382		1,016		3,325		35.98%
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 I	$ -		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300 NURSERY	$ 224.73		188		2,483		-		206		69		2,877		64.85%
18			Total Days	2,410 4103		4,878 4203		3,624 4303		4,735 4403		2,713 5103		15,647		45.07%
19	Total Days per PS&R or Exhibit Detail			2,455		5,640		-		4,203		2,891				
20	Unreconciled Days (Explain Variance)			(45)		(762)		3,624		532		(178)				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 4,048,896 4103		$ 6,247,536 4203		$ 6,077,178 4303		$ 7,634,016 4403		$ 4,783,294 5103		$ 24,007,325		39.74%
21.01	Calculated Routine Charge Per Diem			$ 1,679.92		$ 1,280.76		$ 1,676.93		$ 1,612.25		$ 1,763.10		$ 1,534.31		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.598720	$ 6,318	$ 121,968	$ 15,631	$ 195,103	$ 3,542	$ 439,572	$ 13,475	$ 832,838	$ -	$ 271,149	$ 38,966	$ 1,589,481	40.99%
23	5000 OPERATING ROOM		0.199051	$ 3,764,029	$ 3,108,794	$ 1,962,118	$ 6,246,117	$ 8,034,612	$ 14,213,929	$ 7,430,045	$ 12,281,129	$ 4,490,948	$ 6,495,044	$ 21,190,804	$ 35,849,968	32.10%
24	5200 DELIVERY ROOM & LABOR ROOM		0.358661	$ 61,007	$ 2,255	$ 3,668,222	$ 34,151	$ -	$ -	$ 1,061,225	$ 5,125	$ 134,062	$ 1,845	$ 4,790,454	$ 41,531	54.34%
25	5400 RADIOLOGY-DIAGNOSTIC		0.161535	$ 404,722	$ 809,681	$ 244,849	$ 2,050,442	$ 748,219	$ 2,240,353	$ 796,832	$ 2,114,570	$ 654,712	$ 2,518,390	$ 2,194,622	$ 7,215,046	24.13%
26	5700 CT SCAN		0.031520	$ -	$ 1,052,208	$ 323,673	$ 1,819,258	$ 1,387,066	$ 2,564,143	$ 1,301,266	$ 2,158,403	$ 1,170,072	$ 3,582,053	$ 3,012,005	$ 7,594,012	37.95%
27	5800 MRI		0.050460	$ 234,732	$ 340,833	$ 151,339	$ 517,439	$ 506,506	$ 929,613	$ 472,768	$ 834,559	$ 555,770	$ 577,258	$ 1,365,345	$ 2,622,444	44.19%
28	5900 CARDIAC CATHETERIZATION		0.168575	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	6000 LABORATORY		0.149348	$ 1,213,505	$ 972,606	$ 1,712,761	$ 1,958,237	$ 1,857,846	$ 1,464,077	$ 2,146,208	$ 1,732,756	$ 1,492,049	$ 6,716,022	$ 6,929,320	$ 6,127,676	43.64%
30	6300 BLOOD STORING, PROCESSING & TRANS.		0.556387	$ 99,096	$ 7,571	$ 54,047	$ 31,795	$ 185,989	$ 35,209	$ 199,538	$ 27,269	$ 163,173	$ 32,889	$ 538,670	$ 101,844	40.51%
31	6400 INTRAVENOUS THERAPY		0.193064	$ 373,733	$ 745,118	$ 189,484	$ 1,119,486	$ 499,882	$ 1,064,399	$ 466,506	$ 1,064,276	$ 345,767	$ 1,634,540	$ 1,529,615	$ 3,982,278	25.62%
32	6500 RESPIRATORY THERAPY		0.171320	$ 919,639	$ 43,818	$ 298,651	$ 57,654	$ 1,269,795	$ 209,421	$ 1,434,792	$ 368,289	$ 949,327	$ 104,420	$ 3,922,877	$ 679,182	31.21%
33	6600 PHYSICAL THERAPY		0.202795	$ 318,860	$ 55,292	$ 152,559	$ 1,062,692	$ 793,434	$ 483,346	$ 875,230	$ 601,767	$ 545,614	$ 222,323	$ 2,140,083	$ 2,203,097	24.67%
34	6900 ELECTROCARDIOLOGY		0.152515	$ 782,069	$ 548,120	$ 340,626	$ 726,028	$ 2,354,217	$ 2,779,162	$ 2,110,955	$ 2,402,281	$ 1,925,715	$ 1,569,578	$ 5,587,867	$ 6,455,591	73.59%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.299381	$ 837,698	$ 182,196	$ 459,078	$ 517,361	$ 2,153,684	$ 1,385,418	$ 2,054,151	$ 1,068,518	$ 1,060,827	$ 570,888	$ 5,504,571	$ 3,153,493	28.40%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.073596	$ 2,044,821	$ 229,341	$ 360,039	$ 434,100	$ 7,598,816	$ 6,609,456	$ 6,389,546	$ 4,995,675	$ 1,531,396	$ 952,395	$ 16,363,222	$ 12,268,572	25.21%
37	7300 DRUGS CHARGED TO PATIENTS		0.171365	$ 1,391,589	$ 1,540,028	$ 2,559,363	$ 1,169,084	$ 3,688,873	$ 3,573,963	$ 4,427,270	$ 2,768,797	$ 3,865,003	$ 2,273,267	$ 12,067,095	$ 9,051,872	36.53%
38	7600 CARDIOLOGY		0.081822	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.05%
39	9000 CLINIC		6.573232	$ -	$ -	$ -	$ 9,851	$ 234	$ 4,376	$ 468	$ 9,755	$ 585	$ 20,787	$ 702	$ 23,982	46.52%
40	9001 WOUND CARE CENTER		0.326036	$ 117	$ 114,682	$ 145	$ 54,195	$ -	$ 123,722	$ 1,019	$ 147,475	$ -	$ 68,054	$ 1,281	$ 440,074	14.16%
41	9100 EMERGENCY		0.190337	$ 707,844	$ 2,208,596	$ 533,466	$ 6,115,156	$ 1,154,935	$ 2,954,047	$ 1,157,147	$ 2,777,786	$ 869,183	$ 6,700,116	$ 3,553,392	$ 14,055,585	53.76%
				13,159,739	12,083,107	13,026,051	24,117,149	32,237,660	41,074,205	32,307,441	36,181,267	19,754,203	34,310,968			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 17,208,337 4103	$ 12,083,107 4103	$ 19,273,587 4203	$ 24,117,149 4203	$ 38,314,839 4303	$ 41,074,205 4303	$ 39,941,457 4403	$ 36,181,267 4403	$ 24,537,497 (Agrees to Exhibit A) 5103	$ 34,310,968 (Agrees to Exhibit A) 5103	$ 114,738,220	$ 113,455,728	32.57%
129	Total Charges per PS&R or Exhibit Detail			$ 17,421,568	$ 12,302,755	$ 22,862,278	$ 26,140,414	$ -	$ -	$ 36,710,378	$ 34,308,681	$ 24,807,310	$ 34,320,990			
130	Unreconciled Charges (Explain Variance)			(213,231)	(219,648)	(3,588,691)	(2,023,265)	38,314,839	41,074,205	3,231,079	1,872,586	(269,813)	(10,022)			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 5,203,708	$ 2,062,538	$ 6,293,628	$ 4,282,771	$ 9,808,689	$ 6,728,625	$ 11,372,959	$ 6,228,730	$ 6,934,844	$ 5,708,588	$ 32,678,984	$ 19,302,664	35.16%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 4,683,564 4103	$ 1,973,354 4103	$ -	$ 633 4203	$ 212,801 4303	$ 371,501 4303	$ 202,283 4403	$ 217,996 4403			$ 5,098,648	$ 2,563,484	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 5,113,835 4203	$ 3,403,455 4203	$ -	$ -	$ -	$ 99,732			$ 5,213,567	$ 3,433,080	
134	Private Insurance (including primary and third party liability)			$ 101,513 4103	$ 74,939 4103	$ - 4203	$ - 4203	$ 1,484 4303	$ 3,034 4303	$ 1,906,064 4403	$ 1,004,207 4403			$ 2,009,061	$ 1,082,180	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ 22 4203	$ 20,681 4203	$ -	$ -	$ 24,099 4403	$ 45,046 4403			$ 24,121	$ 65,727	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 4,785,077	$ 2,048,293	$ 5,113,857	$ 3,424,769									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (147,443) 4901	$ -	$ -							$ -	$ (147,443)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 9,470,053 4303	$ 5,746,305 4303	$ -	$ -			$ 9,470,053	$ 5,746,305	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 8,669,930 4403	$ 4,753,867 4403			$ 8,669,930	$ 4,753,867	
141	Medicare Cross-Over Bad Debt Payments							$ 97,815 1405	$ 73,754 1405	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 97,815	$ 73,754	
142	Other Medicare Cross-Over Payments (See Note D)							$ 2,953,278 4318	$ 1,523,430 4318	$ -	$ -			$ 2,953,278	$ 1,523,430	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 515,877 5203	$ 1,519,196 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)**			$ 418,631	$ 161,688	$ 1,179,771	$ 858,002	$ (2,926,742)	$ (989,399)	$ 470,851	$ 177,989	$ 6,418,967	$ 4,189,392	$ (857,489)	$ 208,280	
146	**Calculated Payments as a Percentage of Cost**			92%	92%	81%	80%	130%	115%	96%	97%	7%	27%	103%	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)**							24,471								
148	**Percent of cross-over days to total Medicare days from the cost report**							15%								

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&F
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 surv
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 paymen

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) SAINT MARY'S HOSPITAL

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		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,115.33		12		-		1		20		33	
2	03100 INTENSIVE CARE UNIT	$ 1,753.56		6		-		-		21		27	
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	$ 224.73		-		-		-		-		-	
18			**Total Days**	18		-		1		41 4803		60	
19	Total Days per PS&R or Exhibit Detail			18		-		1		41			
20	Unreconciled Days (Explain Variance			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 27,507		$ -		$ 1,341		$ 78,465 4803		$ 107,313	
21.01	Calculated Routine Charge Per Dier			$ 1,528.17		$ -		$ 1,341.00		$ 1,913.78		$ 1,788.55	
	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)		0.598720	-	539	-	-	-	-	-	539	$ -	$ 1,078
23	5000 OPERATING ROOM		0.199051	325	-	-	-	-	-	3,544	-	$ 3,869	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.358661	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.161535	2,234	16,990	-	-	338	3,348	8,497	18,088	$ 11,069	$ 38,426
26	5700 CT SCAN		0.031520	7,335	9,070	-	-	-	-	10,535	12,146	$ 17,870	$ 21,216
27	5800 MRI		0.050460	-	-	-	-	-	-	-	-	$ -	$ -
28	5900 CARDIAC CATHETERIZATION		0.168575	-	-	-	-	-	-	-	-	$ -	$ -
29	6000 LABORATORY		0.149348	7,302	15,085	-	-	2,110	1,192	22,510	15,544	$ 31,922	$ 31,821
30	6300 BLOOD STORING, PROCESSING & TRANS.		0.556387	2,098	5,613	-	-	681	-	2,098	5,613	$ 4,877	$ 11,226
31	6400 INTRAVENOUS THERAPY		0.193064	3,155	13,370	-	-	1,397	-	3,155	13,544	$ 7,707	$ 26,914
32	6500 RESPIRATORY THERAPY		0.171320	410	666	-	-	-	-	63,228	666	$ 63,638	$ 1,332
33	6600 PHYSICAL THERAPY		0.202795	-	5,630	-	-	-	-	4,103	5,630	$ 4,103	$ 11,260
34	6900 ELECTROCARDIOLOGY		0.152515	2,652	1,966	-	-	246	-	5,776	2,457	$ 8,674	$ 4,423
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.299381	156	112	-	-	-	32	1,513	112	$ 1,669	$ 256
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.073596	-	-	-	-	-	-	-	-	$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.171365	6,221	4,575	-	-	1,165	8	45,977	5,002	$ 53,363	$ 9,585
38	7600 CARDIOLOGY		0.081822	1,136	842	-	-	105	-	2,476	1,053	$ 3,717	$ 1,895
39	9000 CLINIC		6.573232	-	-	-	-	-	-	-	-	$ -	$ -
40	9001 WOUND CARE CENTER		0.326036	-	-	-	-	-	-	-	-	$ -	$ -
41	9100 EMERGENCY		0.190337	6,663	51,766	-	-	1,701	2,441	6,663	55,592	$ 15,027	$ 109,799
				39,687	126,224	-	-	7,743	7,021	180,075	135,986		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 67,194**	**$ 126,224**	**$ -**	**$ -**	**$ 9,084**	**$ 7,021**	**$ 258,540 4803**	**$ 135,986 4803**	**$ 334,818**	**$ 269,231**
129	Total Charges per PS&R or Exhibit Detail			$ 67,194	$ 126,224	$ -	$ -	$ 9,084	$ 7,021	$ 258,540	$ 135,986		
130	Unreconciled Charges (Explain Variance			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 30,378**	**$ 23,605**	**$ -**	**$ -**	**$ 2,703**	**$ 1,194**	**$ 89,027**	**$ 24,875**	**$ 122,108**	**$ 49,674**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dow			$ -	$ 902	$ -	$ -	$ -	$ -	$ -	$ 902 4803	$ -	$ 1,804
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liabilit			$ -	$ -	$ -	$ -	$ -	$ -	$ 40,152 4803	$ 860 4803	$ 40,152	$ 860
135	Self-Pay (including Co-Pay and Spend-Dowr			$ -	$ 56	$ -	$ -	$ -	$ -	$ -	$ 56 4803	$ -	$ 112
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payment			$ -	$ 958	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note E			$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note I			$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductible							$ 5,524	$ 756	$ -	$ -	$ 5,524	$ 756
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductible							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payment							$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D							$ (2,194) 4318	$ 617 4318	$ -	$ -	$ (2,194)	$ 617
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 30,378	$ 22,647	$ -	$ -	$ (627)	$ (179)	$ 48,875	$ 23,057	$ 78,626	$ 45,525
144	**Calculated Payments as a Percentage of Cost**			0%	4%	0%	0%	123%	115%	45%	7%	36%	8%

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
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the su
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education pay
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

J. Transplant Facilities Only: Organ Acquisition Cost In-State Medicaid and Uninsured

Cost Report Year (07/01/2020-06/30/2021) SAINT MARY'S HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section D as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (07/01/2020-06/30/2021) SAINT MARY'S HOSPITAL

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care 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) SAINT MARY'S HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			3001 Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 2,744,506		
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)		$ 2,744,506	-	*(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	$ (2,744,506)	-	*(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		$ 2,744,506
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	228,797,997
19	Uninsured Hospital	**Charges Sec. G**	58,848,465
20	Total Hospital	**Charges Sec. G**	883,227,367
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		25.90%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.66%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 710,958
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 182,863
25	Provider Tax Assessment Adjustment to DSH UCC		$ 893,821

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

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

DSH Examination Eligibility Summary

Hospital Name	**SAINT MARY'S HOSPITAL**
Hospital Medicaid Number	**000001823A**
Cost Report Period	From **7/1/2020** 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)	$ 17,901,048	$ (1,540,697)	$ 16,360,351
2	Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
3	Total		$ 18,001,048	$ (1,540,697)	$ 16,460,351
4	Net Hospital Patient Revenue	Survey F-3	$ 235,658,778	$ (1,930,020)	$ 233,728,758
5	Medicaid Fraction		7.64%	-0.60%	7.04%
6	Inpatient Charity Care Charges	Survey F-2	$ 17,841,274	$ -	$ 17,841,274
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
9	Adjusted Inpatient Charity Care		$ 17,798,290	$ -	$ 17,798,761
10	Inpatient Hospital Charges	Survey F-3	$ 383,074,942	$ (7,298,823)	$ 375,776,119
11	Inpatient Charity Fraction		4.65%	0.09%	4.74%
12	LIUR		12.29%	-0.51%	11.78%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	12,298	3,349	15,647
14	Out-of-State Medicaid Eligible Days	Survey I	60	-	60
15	Total Medicaid Eligible Days		12,358	3,349	15,707
16	Total Hospital Days (excludes swing-bed)	Survey F-1	46,996	-	46,996
17	MIUR		26.30%	7.12%	33.42%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: SAINT MARY'S HOSPITAL
Hospital Medicaid Number: 000001823A
Cost Report Period: From 7/1/2020 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	5,267,923	4,628,555	-	118,644	-	-	-	-	-	-	-			4,747,199	520,724	90.12%
2	Medicaid Fee for Service	Outpatient	2,449,640	1,970,562	-	43,763	-	-	-	-	-	-	-			2,014,325	435,315	82.23%
3	Medicaid Managed Care	Inpatient	7,675,264	-	5,213,567	1,304,039	427	-	-							6,518,033	1,157,231	84.92%
4	Medicaid Managed Care	Outpatient	4,621,464	633	3,433,080	728,642	33,340	-	-							4,195,695	425,769	90.79%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	10,209,423	204,379	-	602,025	23,694			-	8,672,909	-	-			9,503,007	706,416	93.08%
8	Other Medicaid Eligibles	Outpatient	5,851,168	219,557	-	275,565	32,443			-	4,756,860	-	-			5,284,425	566,743	90.31%
9	Uninsured	Inpatient	7,100,054	-	-	-	-	-	-	-	-	-	-	499,638	-	499,638	6,600,416	7.04%
10	Uninsured	Outpatient	5,676,786	-	-	-	-	-	-	-	-	-	-	1,411,473	-	1,411,473	4,265,313	24.86%
11	In-State Sub-total	Inpatient	30,252,664	4,832,934	5,213,567	2,024,708	24,121	-	-	-	8,672,909	-	-	499,638	-	21,267,877	8,984,787	70.30%
12	In-State Sub-total	Outpatient	18,599,058	2,190,752	3,433,080	1,047,970	65,783	-	-	-	4,756,860	-	-	1,411,473	-	12,905,918	5,693,140	69.39%
13	Out-of-State Medicaid	Inpatient	122,108	-	-	40,152	-	-	-	5,524	-	-	-			45,676	76,432	37.41%
14	Out-of-State Medicaid	Outpatient	49,674	1,804	-	860	112	-	-	756	-	-	-			3,532	46,142	7.11%
15	Sub-Total	I/P and O/P	49,023,504	7,025,490	8,646,647	3,113,690	90,016	-	-	6,280	13,429,769	-	-	1,911,111	-	34,223,003	14,800,501	69.81%

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	(64,215)	55,009	-	(17,131)	-	-	-	-	-	-	-			37,878	(102,093)	1.84%
2	Medicaid Fee for Service	Outpatient	(387,102)	2,792	-	31,176	-	(147,443)	-	-	-	-	-			(113,475)	(273,627)	9.93%
3	Medicaid Managed Care	Inpatient	(1,381,636)	-	(99,732)	(1,304,039)	(405)	-	-							(1,404,176)	22,540	-3.67%
4	Medicaid Managed Care	Outpatient	(338,693)	-	(29,625)	(728,642)	(12,659)	-	-							(770,926)	432,233	-10.82%
5	Medicare Cross-over (FFS)	Inpatient	9,808,689	212,801	-	1,484	-		-	9,470,053	-	97,815	2,953,278			12,735,431	(2,926,742)	0.00%
6	Medicare Cross-over (FFS)	Outpatient	6,728,625	371,501	-	3,034	-		-	5,746,305	-	73,754	1,523,430			7,718,024	(989,399)	0.00%
7	Other Medicaid Eligibles	Inpatient	1,163,536	(2,096)	99,732	1,304,039	405			-	(2,979)	-	-			1,399,101	(235,565)	2.78%
8	Other Medicaid Eligibles	Outpatient	377,562	(1,561)	29,625	728,642	12,603			-	(2,993)	-	-			766,316	(388,754)	6.83%
9	Uninsured	Inpatient	(165,210)	-	-	-	-	-	-	-	-	-	-	16,239	-	16,239	(181,449)	0.40%
10	Uninsured	Outpatient	31,802	-	-	-	-	-	-	-	-	-	-	107,723	-	107,723	(75,921)	1.75%
11	In-State Sub-total	Inpatient	9,361,164	265,714	-	(15,647)	-	-	-	9,470,053	(2,979)	97,815	2,953,278	16,239	-	12,784,473	(3,423,309)	15.66%
12	In-State Sub-total	Outpatient	6,412,194	372,732	-	34,210	(56)	(147,443)	-	5,746,305	(2,993)	73,754	1,523,430	107,723	-	7,707,662	(1,295,468)	13.03%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	(2,194)			(2,194)	2,194	-1.80%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	617			617	(617)	1.24%
15	Sub-Total	I/P and O/P	15,773,358	638,446	-	18,563	(56)	(147,443)	-	15,216,358	(5,972)	171,569	4,475,131	123,962	-	20,490,558	(4,717,200)	14.63%
15.01																	893,821	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: SAINT MARY'S HOSPITAL
Hospital Medicaid Number: 000001823A
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	5,203,708	4,683,564	-	101,513	-	-	-	-	-	-	-			4,785,077	418,631	91.96%
2	Medicaid Fee for Service	Outpatient	2,062,538	1,973,354	-	74,939	-	(147,443)	-	-	-	-	-			1,900,850	161,688	92.16%
3	Medicaid Managed Care	Inpatient	6,293,628	-	5,113,835	-	22	-	-							5,113,857	1,179,771	81.25%
4	Medicaid Managed Care	Outpatient	4,282,771	633	3,403,455	-	20,681	-	-							3,424,769	858,002	79.97%
5	Medicare Cross-over (FFS)	Inpatient	9,808,689	212,801	-	1,484	-		-	9,470,053	-	97,815	2,953,278			12,735,431	(2,926,742)	129.84%
6	Medicare Cross-over (FFS)	Outpatient	6,728,625	371,501	-	3,034	-		-	5,746,305	-	73,754	1,523,430			7,718,024	(989,399)	114.70%
7	Other Medicaid Eligibles	Inpatient	11,372,959	202,283	99,732	1,906,064	24,099			-	8,669,930	-	-			10,902,108	470,851	95.86%
8	Other Medicaid Eligibles	Outpatient	6,228,730	217,996	29,625	1,004,207	45,046			-	4,753,867	-	-			6,050,741	177,989	97.14%
9	Uninsured	Inpatient	6,934,844	-	-	-	-	-	-	-	-	-	-	515,877	-	515,877	6,418,967	7.44%
10	Uninsured	Outpatient	5,708,588	-	-	-	-	-	-	-	-	-	-	1,519,196	-	1,519,196	4,189,392	26.61%
11	In-State Sub-total	Inpatient	39,613,828	5,098,648	5,213,567	2,009,061	24,121	-	-	9,470,053	8,669,930	97,815	2,953,278	515,877	-	34,052,350	5,561,478	85.96%
12	In-State Sub-total	Outpatient	25,011,252	2,563,484	3,433,080	1,082,180	65,727	(147,443)	-	5,746,305	4,753,867	73,754	1,523,430	1,519,196	-	20,613,580	4,397,672	82.42%
13	Out-of-State Medicaid	Inpatient	122,108	-	-	40,152	-	-	-	5,524	-	-	(2,194)			43,482	78,626	35.61%
14	Out-of-State Medicaid	Outpatient	49,674	1,804	-	860	112	-	-	756	-	-	617			4,149	45,525	8.35%
15	Cost Report Year Sub-Total	I/P and O/P	64,796,862	7,663,936	8,646,647	3,132,253	89,960	(147,443)	-	15,222,638	13,423,797	171,569	4,475,131	2,035,073	-	54,713,561	10,083,301	84.44%
15.01															Provider Tax Assessment Adjustment		893,821	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		10,977,122	

Medicaid DSH Survey Adjustments

PROVIDER: SAINT MARY'S HOSPITAL
FROM: 7/1/2020 TO: 6/30/2021
Mcaid Number: 000001823A
Mcare Number: 110006

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	E - Disclosure of Medicaid / Uninsured Payments	9	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	1.00	Amount - Inpatient	Adjust due to A/B matches.	$ 499,638	$ 16,239	$ 515,877	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	1.00	Amount - Inpatient	Adjust due to A/B matches.	$ 2,411,456	$ (16,239)	$ 2,395,217	5203
1	E - Disclosure of Medicaid / Uninsured Payments	9	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	2.00	Amount - Outpatient	Adjust due to A/B matches.	$ 1,411,473	$ 107,723	$ 1,519,196	5203
1	E - Disclosure of Medicaid / Uninsured Payments	10	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	2.00	Amount - Outpatient	Adjust due to A/B matches.	$ 9,686,739	$ (107,723)	$ 9,579,016	5203
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust to classify Subprovider IRF revenue as Other Revenue	$ 7,298,823	$ (7,298,823)	$ -	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust to classify Subprovider IRF revenue as Other Revenue	$ -	$ 7,298,823	$ 7,298,823	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	4.00	Inpatient Contractuals	Adjust to classify Subprovider IRF revenue as Other Revenue	$ 5,368,803	$ (5,368,803)	$ -	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	6.00	Non-Hospital Contractuals	Adjust to classify Subprovider IRF revenue as Other Revenue	$ -	$ 5,368,803	$ 5,368,803	1405
2	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Adjust to exlcude Subprovider IRF amounts.	$ 6,207,717.00	$ (6,207,717)	$ -	1405
2	G - CR Data	8	SUBPROVIDER II	8.00	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to exlcude Subprovider IRF amounts.	5,499	(5,499)	-	1405
2	G - CR Data	8	SUBPROVIDER II	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to exlcude Subprovider IRF amounts.	$ 7,298,823.00	$ (7,298,823)	$ -	1405
3	H - In-State	1	ADULTS & PEDIATRICS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	1,629	(44)	1,585	4103
3	H - In-State	2	INTENSIVE CARE UNIT	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	638	(1)	637	4103
3	H - In-State	21	Routine Charges	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 4,110,284	$ (61,686)	$ 4,048,598	4103
3	H - In-State	22	Observation (Non-Distinct)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 6,006	$ 312	$ 6,318	4103
3	H - In-State	23	OPERATING ROOM	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 3,797,903	$ (33,874)	$ 3,764,029	4103
3	H - In-State	24	DELIVERY ROOM & LABOR ROOM	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 78,178	$ (17,171)	$ 61,007	4103
3	H - In-State	25	RADIOLOGY-DIAGNOSTIC	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 407,855	$ (3,133)	$ 404,722	4103
3	H - In-State	27	MRI	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 237,932	$ (3,200)	$ 234,732	4103
3	H - In-State	29	LABORATORY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 1,234,125	$ (20,620)	$ 1,213,505	4103
3	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 100,458	$ (1,362)	$ 99,096	4103
3	H - In-State	31	INTRAVENOUS THERAPY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 376,857	$ (3,124)	$ 373,733	4103
3	H - In-State	32	RESPIRATORY THERAPY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 919,861	$ (222)	$ 919,639	4103
3	H - In-State	33	PHYSICAL THERAPY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 324,131	$ (5,271)	$ 318,860	4103
3	H - In-State	34	ELECTROCARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 550,367	$ 231,702	$ 782,069	4103
3	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 842,623	$ (4,965)	$ 837,658	4103
3	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 2,058,395	$ (13,574)	$ 2,044,821	4103
3	H - In-State	37	DRUGS CHARGED TO PATIENTS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 1,420,897	$ (29,308)	$ 1,391,589	4103
3	H - In-State	38	CARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 235,872	$ (235,872)	$ -	4103
3	H - In-State	39	CLINIC	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 117	$ (117)	$ -	4103
3	H - In-State	40	WOUND CARE CENTER	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ -	$ 117	$ 117	4103
3	H - In-State	41	EMERGENCY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 719,707	$ (11,863)	$ 707,844	4103
3	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 4,628,555	$ 55,009	$ 4,683,564	4103

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
3	H - In-State	134	Private Insurance (including primary and third party liability)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 118,644	$ (17,131)	$ 101,513	4103
3	H - In-State	22	Observation (Non-Distinct)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 123,816	$ (1,848)	$ 121,968	4103
3	H - In-State	23	OPERATING ROOM	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 3,159,197	$ (50,403)	$ 3,108,794	4103
3	H - In-State	24	DELIVERY ROOM & LABOR ROOM	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 7,380	$ (5,125)	$ 2,255	4103
3	H - In-State	25	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 836,854	$ (27,173)	$ 809,681	4103
3	H - In-State	26	CT SCAN	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 1,057,969	$ (5,761)	$ 1,052,208	4103
3	H - In-State	29	LABORATORY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 996,798	$ (24,192)	$ 972,606	4103
3	H - In-State	31	INTRAVENOUS THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 756,345	$ (11,227)	$ 745,118	4103
3	H - In-State	32	RESPIRATORY THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 49,335	$ (5,517)	$ 43,818	4103
3	H - In-State	33	PHYSICAL THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 55,620	$ (328)	$ 55,292	4103
3	H - In-State	34	ELECTROCARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 389,113	$ 159,007	$ 548,120	4103
3	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 184,523	$ (2,327)	$ 182,196	4103
3	H - In-State	37	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 1,560,830	$ (20,802)	$ 1,540,028	4103
3	H - In-State	38	CARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 166,763	$ (166,763)	$ -	4103
3	H - In-State	39	CLINIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 57,341	$ (57,341)	$ -	4103
3	H - In-State	40	WOUND CARE CENTER	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 57,341	$ 57,341	$ 114,682	4103
3	H - In-State	41	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to exclude zero paid claims and noncovered codes.	$ 2,265,785	$ (57,189)	$ 2,208,596	4103
3	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 1,970,562	$ 2,792	$ 1,973,354	4103
3	H - In-State	134	Private Insurance (including primary and third party liability)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 43,763	$ 31,176	$ 74,939	4103
4	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.	$ -	$ (147,443)	$ (147,443)	4901
5	H - In-State	1	ADULTS & PEDIATRICS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	2,827	(637)	2,190	4103
5	H - In-State	2	INTENSIVE CARE UNIT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	212	(7)	205	4203
5	H - In-State	10	NURSERY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	2,601	(118)	2,483	4203
5	H - In-State	21	Routine Charges	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 7,290,663	$ (1,043,127)	$ 6,247,536	4203
5	H - In-State	23	OPERATING ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 2,364,031	$ (401,913)	$ 1,962,118	4203
5	H - In-State	24	DELIVERY ROOM & LABOR ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 4,696,331	$ (1,028,109)	$ 3,668,222	4203
5	H - In-State	25	RADIOLOGY-DIAGNOSTIC	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 279,855	$ (35,006)	$ 244,849	4203
5	H - In-State	26	CT SCAN	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 351,802	$ (28,129)	$ 323,673	4203
5	H - In-State	27	MRI	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 159,918	$ (8,579)	$ 151,339	4203
5	H - In-State	29	LABORATORY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,961,428	$ (248,667)	$ 1,712,761	4203
5	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 61,558	$ (7,511)	$ 54,047	4203
5	H - In-State	31	INTRAVENOUS THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 198,855	$ (9,371)	$ 189,484	4203
5	H - In-State	32	RESPIRATORY THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 388,311	$ (89,660)	$ 298,651	4203
5	H - In-State	33	PHYSICAL THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 160,036	$ (7,477)	$ 152,559	4203
5	H - In-State	34	ELECTROCARDIOLOGY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 255,148	$ 85,478	$ 340,626	4203
5	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 535,841	$ (76,763)	$ 459,078	4203
5	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 392,112	$ (32,073)	$ 360,039	4203
5	H - In-State	37	DRUGS CHARGED TO PATIENTS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 3,032,865	$ (473,502)	$ 2,559,363	4203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
5	H - In-State	38	CARDIOLOGY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 109,349	$ (109,349)	$ -	4203
5	H - In-State	41	EMERGENCY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 608,399	$ (74,933)	$ 533,466	4203
5	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 due to non-covered codes and Medicaid secondary claims.	$ 5,213,567	$ (99,732)	$ 5,113,835	4203
5	H - In-State	134	Private Insurance (including primary and third party liability)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,304,039	$ (1,304,039)	$ -	4203
5	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 427	$ (405)	$ 22	4203
5	H - In-State	22	Observation (Non-Distinct)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 209,579	$ (14,476)	$ 195,103	4203
5	H - In-State	23	OPERATING ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 6,803,929	$ (557,812)	$ 6,246,117	4203
5	H - In-State	25	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 2,223,804	$ (173,362)	$ 2,050,442	4203
5	H - In-State	26	CT SCAN	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,967,526	$ (148,268)	$ 1,819,258	4203
5	H - In-State	27	MRI	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 573,983	$ (56,544)	$ 517,439	4203
5	H - In-State	29	LABORATORY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 2,109,513	$ (151,276)	$ 1,958,237	4203
5	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 33,893	$ (2,098)	$ 31,795	4203
5	H - In-State	31	INTRAVENOUS THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,223,368	$ (104,882)	$ 1,118,486	4203
5	H - In-State	32	RESPIRATORY THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 64,059	$ (6,405)	$ 57,654	4203
5	H - In-State	33	PHYSICAL THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,104,451	$ (41,759)	$ 1,062,692	4203
5	H - In-State	34	ELECTROCARDIOLOGY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 551,353	$ 174,675	$ 726,028	4203
5	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 556,804	$ (39,443)	$ 517,361	4203
5	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 466,085	$ (31,985)	$ 434,100	4203
5	H - In-State	37	DRUGS CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 1,336,003	$ (166,919)	$ 1,169,084	4203
5	H - In-State	38	CARDIOLOGY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 236,294	$ (236,294)	$ -	4203
5	H - In-State	39	CLINIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 10,712	$ (861)	$ 9,851	4203
5	H - In-State	40	WOUND CARE CENTER	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 55,340	$ (1,145)	$ 54,195	4203
5	H - In-State	41	EMERGENCY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 6,579,567	$ (464,411)	$ 6,115,156	4203
5	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 due to non-covered codes and Medicaid secondary claims.	$ 3,433,080	$ (29,625)	$ 3,403,455	4203
5	H - In-State	134	Private Insurance (including primary and third party liability)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 728,642	$ (728,642)	$ -	4203
5	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust due to non-covered codes and Medicaid secondary claims.	$ 33,340	$ (12,659)	$ 20,681	4203
6	H - In-State	1	ADULTS & PEDIATRICS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	-	2,523	2,523	4303
6	H - In-State	2	INTENSIVE CARE UNIT	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	-	1,101	1,101	4303
6	H - In-State	21	Routine Charges	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 6,077,179	$ 6,077,179	4303
6	H - In-State	22	Observation (Non-Distinct)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 3,542	$ 3,542	4303
6	H - In-State	23	OPERATING ROOM	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 8,034,612	$ 8,034,612	4303
6	H - In-State	25	RADIOLOGY-DIAGNOSTIC	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 748,219	$ 748,219	4303
6	H - In-State	26	CT SCAN	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,387,066	$ 1,387,066	4303
6	H - In-State	27	MRI	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 506,506	$ 506,506	4303
6	H - In-State	29	LABORATORY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,857,846	$ 1,857,846	4303
6	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 185,989	$ 185,989	4303

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
6	H - In-State	31	INTRAVENOUS THERAPY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 499,892	$ 499,892	4303
6	H - In-State	32	RESPIRATORY THERAPY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,269,795	$ 1,269,795	4303
6	H - In-State	33	PHYSICAL THERAPY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 793,434	$ 793,434	4303
6	H - In-State	34	ELECTROCARDIOLOGY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,354,217	$ 2,354,217	4303
6	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,153,684	$ 2,153,684	4303
6	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 7,598,816	$ 7,598,816	4303
6	H - In-State	37	DRUGS CHARGED TO PATIENTS	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 3,688,873	$ 3,688,873	4303
6	H - In-State	39	CLINIC	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 234	$ 234	4303
6	H - In-State	41	EMERGENCY	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,154,935	$ 1,154,935	4303
6	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.	$ -	$ 212,801	$ 212,801	4303
6	H - In-State	134	Private Insurance (including primary and third party liability)	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,484	$ 1,484	4303
6	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.	$ -	$ 9,470,053	$ 9,470,053	4303
7	H - In-State	141	Medicare Cross-Over Bad Debt Payments	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to report 65% of CR crossover bad debt.	$ -	$ 97,815	$ 97,815	1405
8	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.	$ -	$ 2,953,278	$ 2,953,278	4318
6	H - In-State	22	Observation (Non-Distinct)	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 439,572	$ 439,572	4303
6	H - In-State	23	OPERATING ROOM	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 14,213,929	$ 14,213,929	4303
6	H - In-State	25	RADIOLOGY-DIAGNOSTIC	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,240,353	$ 2,240,353	4303
6	H - In-State	26	CT SCAN	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,564,143	$ 2,564,143	4303
6	H - In-State	27	MRI	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 929,613	$ 929,613	4303
6	H - In-State	29	LABORATORY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,464,077	$ 1,464,077	4303
6	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 35,209	$ 35,209	4303
6	H - In-State	31	INTRAVENOUS THERAPY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,064,399	$ 1,064,399	4303
6	H - In-State	32	RESPIRATORY THERAPY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 209,421	$ 209,421	4303
6	H - In-State	33	PHYSICAL THERAPY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 483,346	$ 483,346	4303
6	H - In-State	34	ELECTROCARDIOLOGY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,779,162	$ 2,779,162	4303
6	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 1,385,418	$ 1,385,418	4303
6	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 6,609,456	$ 6,609,456	4303
6	H - In-State	37	DRUGS CHARGED TO PATIENTS	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 3,573,963	$ 3,573,963	4303
6	H - In-State	39	CLINIC	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 4,376	$ 4,376	4303
6	H - In-State	40	WOUND CARE CENTER	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 123,722	$ 123,722	4303
6	H - In-State	41	EMERGENCY	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to MMIS data.	$ -	$ 2,954,047	$ 2,954,047	4303
6	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.	$ -	$ 371,501	$ 371,501	4303
6	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.	$ -	$ 3,034	$ 3,034	4303
6	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.	$ -	$ 5,746,305	$ 5,746,305	4303
7	H - In-State	141	Medicare Cross-Over Bad Debt Payments	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to report 65% of CR crossover bad debt.	$ -	$ 73,754	$ 73,754	1405

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
8	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.	$ -	$ 1,523,430	$ 1,523,430	4318
9	H - In-State	1	ADULTS & PEDIATRICS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	2,732	415	3,147	4403
9	H - In-State	2	INTENSIVE CARE UNIT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	1,383	(1)	1,382	4403
9	H - In-State	10	NURSERY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	88	118	206	4403
9	H - In-State	21	Routine Charges	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 6,899,579	$ 734,437	$ 7,634,016	4403
9	H - In-State	23	OPERATING ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 7,028,782	$ 401,263	$ 7,430,045	4403
9	H - In-State	24	DELIVERY ROOM & LABOR ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 33,116	$ 1,028,109	$ 1,061,225	4403
9	H - In-State	25	RADIOLOGY-DIAGNOSTIC	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 764,060	$ 32,772	$ 796,832	4403
9	H - In-State	26	CT SCAN	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,280,472	$ 20,794	$ 1,301,266	4403
9	H - In-State	27	MRI	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 464,189	$ 8,579	$ 472,768	4403
9	H - In-State	29	LABORATORY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,906,141	$ 239,067	$ 2,145,208	4403
9	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 195,487	$ 4,051	$ 199,538	4403
9	H - In-State	31	INTRAVENOUS THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 460,290	$ 6,216	$ 466,506	4403
9	H - In-State	32	RESPIRATORY THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,345,543	$ 89,249	$ 1,434,792	4403
9	H - In-State	33	PHYSICAL THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 867,753	$ 7,477	$ 875,230	4403
9	H - In-State	34	ELECTROCARDIOLOGY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,465,525	$ 645,430	$ 2,110,955	4403
9	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,977,544	$ 76,607	$ 2,054,151	4403
9	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 6,327,473	$ 32,073	$ 6,359,546	4403
9	H - In-State	37	DRUGS CHARGED TO PATIENTS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 3,960,802	$ 466,468	$ 4,427,270	4403
9	H - In-State	38	CARDIOLOGY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 628,082	$ (628,082)	$ -	4403
9	H - In-State	41	EMERGENCY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,090,578	$ 66,569	$ 1,157,147	4403
9	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 204,379	$ (2,096)	$ 202,283	4403
9	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 due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ -	$ 99,732	$ 99,732	4403
9	H - In-State	134	Private Insurance (including primary and third party liability)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 602,025	$ 1,304,039	$ 1,906,064	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
9	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 23,694	$ 405	$ 24,099	4403
9	H - In-State	140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 8,672,909	$ (2,979)	$ 8,669,930	4403
9	H - In-State	22	Observation (Non-Distinct)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 818,901	$ 13,937	$ 832,838	4403
9	H - In-State	23	OPERATING ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 11,723,317	$ 557,812	$ 12,281,129	4403
9	H - In-State	25	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,963,990	$ 150,580	$ 2,114,570	4403
9	H - In-State	26	CT SCAN	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 2,021,380	$ 137,023	$ 2,158,403	4403
9	H - In-State	27	MRI	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 778,015	$ 56,544	$ 834,559	4403
9	H - In-State	29	LABORATORY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,600,509	$ 132,247	$ 1,732,756	4403
9	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 30,784	$ (3,515)	$ 27,269	4403
9	H - In-State	31	INTRAVENOUS THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 963,934	$ 90,341	$ 1,054,275	4403
9	H - In-State	32	RESPIRATORY THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 362,550	$ 5,739	$ 368,289	4403
9	H - In-State	33	PHYSICAL THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 565,638	$ 36,129	$ 601,767	4403
9	H - In-State	34	ELECTROCARDIOLOGY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,640,675	$ 761,606	$ 2,402,281	4403
9	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 1,029,187	$ 39,331	$ 1,068,518	4403
9	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 4,963,690	$ 31,985	$ 4,995,675	4403
9	H - In-State	37	DRUGS CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 2,611,386	$ 157,411	$ 2,768,797	4403
9	H - In-State	38	CARDIOLOGY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 703,146	$ (703,146)	$ -	4403
9	H - In-State	39	CLINIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 8,894	$ 861	$ 9,755	4403
9	H - In-State	40	WOUND CARE CENTER	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 146,330	$ 1,145	$ 147,475	4403
9	H - In-State	41	EMERGENCY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 2,371,230	$ 406,556	$ 2,777,786	4403
9	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 219,557	$ (1,561)	$ 217,996	4403
9	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 due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ -	$ 29,625	$ 29,625	4403
9	H - In-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 275,565	$ 728,642	$ 1,004,207	4403
9	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 32,443	$ 12,603	$ 45,046	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
9	H - In-State	140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust due to Medicaid data set duplicates, non-covered codes, Medicaid secondary claims.	$ 4,756,860	$ (2,993)	$ 4,753,867	4403
10	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	1,802	(174)	1,628	5103
10	H - In-State	2	INTENSIVE CARE UNIT	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	1,020	(4)	1,016	5103
10	H - In-State	21	Routine Charges	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 5,024,156	$ (240,862)	$ 4,783,294	5103
10	H - In-State	23	OPERATING ROOM	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 4,494,817	$ (3,869)	$ 4,490,948	5103
10	H - In-State	25	RADIOLOGY-DIAGNOSTIC	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 655,050	$ (338)	$ 654,712	5103
10	H - In-State	29	LABORATORY	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 1,495,438	$ (3,389)	$ 1,492,049	5103
10	H - In-State	31	INTRAVENOUS THERAPY	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 347,583	$ (1,816)	$ 345,767	5103
10	H - In-State	34	ELECTROCARDIOLOGY	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 1,351,926	$ 573,789	$ 1,925,715	5103
10	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 1,061,734	$ (907)	$ 1,060,827	5103
10	H - In-State	37	DRUGS CHARGED TO PATIENTS	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 3,875,546	$ (10,543)	$ 3,865,003	5103
10	H - In-State	38	CARDIOLOGY	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 579,397	$ (579,397)	$ -	5103
10	H - In-State	41	EMERGENCY	13.00	Inpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 871,664	$ (2,481)	$ 869,183	5103
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	13.00	Inpatient Uninsured	Adjust due to A/B matches.	$ 499,638	$ 16,239	$ 515,877	5203
10	H - In-State	23	OPERATING ROOM	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 6,496,686	$ (1,642)	$ 6,495,044	5103
10	H - In-State	25	RADIOLOGY-DIAGNOSTIC	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 2,519,658	$ (1,268)	$ 2,518,390	5103
10	H - In-State	26	CT SCAN	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 3,584,228	$ (2,175)	$ 3,582,053	5103
10	H - In-State	29	LABORATORY	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 6,717,272	$ (1,250)	$ 6,716,022	5103
10	H - In-State	31	INTRAVENOUS THERAPY	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 1,635,415	$ (875)	$ 1,634,540	5103
10	H - In-State	34	ELECTROCARDIOLOGY	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 1,098,705	$ 470,873	$ 1,569,578	5103
10	H - In-State	37	DRUGS CHARGED TO PATIENTS	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 2,273,515	$ (248)	$ 2,273,267	5103
10	H - In-State	38	CARDIOLOGY	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 470,873	$ (470,873)	$ -	5103
10	H - In-State	41	EMERGENCY	14.00	Outpatient Uninsured	Adjust due to Medicaid data set duplicates & non-covered codes.	$ 6,702,680	$ (2,564)	$ 6,700,116	5103
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	14.00	Outpatient Uninsured	Adjust due to A/B matches.	$ 1,411,473	$ 107,723	$ 1,519,196	5203
8	I - Out-of-State	142	Other Medicare Cross-Over Payments (See Note D)	9.00	Inpatient Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ (2,194)	$ (2,194)	4318
8	I - Out-of-State	142	Other Medicare Cross-Over Payments (See Note D)	10.00	Outpatient Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to include Medicare cost report settlements applicable to cross-overs.	$ -	$ 617	$ 617	4318
11	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to tax amount.	$ -	$ 2,744,506	$ 2,744,506	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 tax amount.	$ -	$ 2,744,506	$ 2,744,506	3001
11	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to tax amount.	-	(2,744,506)	(2,744,506)	3001

Medicaid DSH Report Notes

PROVIDER: SAINT MARY'S HOSPITAL Mcaid Number: 000001823A
FROM: 7/1/2020 TO: 6/30/2021 Mcare Number: 110006

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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