MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

August 8, 2025

Janice Dunn
St. Mary's Good Samaritan
1230 Baxter Street
Athens, Georgia 30606

RE: DSH Medicaid Provider Examination

Provider Number:	111329
Provider Name:	St. Mary's Good Samaritan
DSH Year(s) under Examination:	June 30, 2022

Dear Janice Dunn:

Myers and Stauffer LC has completed the mandated examinations of Georgia's fiscal 2022 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,

Kyla Kincaid

Kyla Kincaid

700 W 47th Street, Suite 1100 | Kansas City, MO 64112
PH 816.945.5300 | PH 800.374.6858 | FX 816.945.5301
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Georgia DSH Examination Results for 2022 **8/8/2025 14:23**

DSH UCC Cost & Payment Summary

Review Results

Provider Name	ST. MARYS GOOD SAMARITAN
Mcaid Provider Number	000001328A
Mcare Provider Number	111329

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 2022 state DSH year. Reviews have been completed and below are the results of those reviews. The DSH payment for the 2022 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: 7/1/2021 - 6/30/2022

	(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:	7/1/2021 -	6/30/2022	100.00%	$ 6,939,702	$ 1,964,609	$ 1,606,039	$ 234,349	$ 3,134,705	$ 3,134,705
Cost Report Year 2 UCC:	-		0.00%						$ -
Cost Report Year 3 UCC:	-		0.00%						$ -
State DSH Year Sub-Totals:				$ 6,939,702	$ 1,964,609	$ 1,606,039	$ 234,349		$ 3,134,705
Less Supplemental Payments (UPL, etc.):									$ 38,431
State DSH Year Adjusted Uncompensated Care Calculation (UCC):									$ 3,096,274
Out-of-State DSH Payments:									$ -
DSH Payments:									$ 822,565
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:									**$ -**
DSH Year Low Income Utilization Ratio (LIUR):									7.25%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):									28.01%

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 2022

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End			
1. DSH Year:	07/01/2021	06/30/2022	Workpaper #:	1301	Reviewer:
			Examiner:	KRK	DMH
			Date:	11/4/2024	11/25/2024
2. Select Your Facility from the Drop-Down Menu Provided:	ST. MARYS GOOD SAMARITAN				

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	07/01/2021	06/30/2022
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

	Data
6. Medicaid Provider Number:	000001328A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	111329

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 (07/01/21 - 06/30/22)
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?	No
3b. What date did the hospital open?	2/1/2003

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022** $ 38,431 **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 07/01/2021 - 06/30/2022** $ -
   (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 Services07/01/2021 - 06/30/2022** $ 38,431 **4904**

Certification:

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

Explanation for "No" answers:

0

0

0

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

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

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

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

Hospital Contact:		**Outside Preparer:**	
Name	Brian Aho	Name	0
Title	Sr. Reimbursement Analyst	Title:	0
Telephone Number	614-592-7772	Firm Name:	0
E-Mail Address	Brian.Aho@trinity-health.org	Telephone Number	0
Mailing Street Address	1230 Baxter St.	E-Mail Address	0
Mailing City, State, Zip	Athens, GA 30606		

Medicaid DSH Survey Adjustments

PROVIDER: ST. MARYS GOOD SAMARITAN
FROM: 7/1/2021 TO: 6/30/2022
Mcaid Number: 000001328A
Mcare Number: 111329

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:	KRK	DMH
Date:	11/4/2024	1/7/2025
DSH Version	8.11	2/10/2023

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

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided: ST. MARYS GOOD SAMARITAN

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

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 1/30/2023

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ST. MARYS GOOD SAMARITAN	Yes	
5. Medicaid Provider Number:	000001328A	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:	111329	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	

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

	State Name	Provider No.
9. State Name & Number	Florida	289480
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2021 - 06/30/2022)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient		Outpatient		Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 10,677	5203	$ 246,049	5203	$256,726
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 159,483	5203	$ 2,258,474	5203	$2,417,957
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$170,160		$2,504,523		$2,674,683
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.27%		9.82%		9.60%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

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

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

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

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	4,038	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	200,000
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 200,000
7.	Inpatient Hospital Charity Care Charges	186,815
8.	Outpatient Hospital Charity Care Charges	1,913,161
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 2,099,976

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	$ 6,344,656	$ -	$ -	$ 4,254,711	$ -	$ -	$ 2,089,945
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 12,796,941	$ 59,327,247	$ -	$ 8,581,598	$ 39,784,711	$ -	$ 23,757,879
20.	Outpatient Services		$ 11,897,485	$ -		$ 7,978,425	$ -	$ 3,919,060
21.	Home Health Agency			$ -			$ -	
22.	Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	$ -
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 892,322	$ -	$ -	$ 598,389	$ -
27.	Total	$ 19,141,597	$ 71,224,732	$ 892,322	$ 12,836,310	$ 47,763,136	$ 598,389	$ 29,766,883
28.	Total Hospital and Non Hospital		Total from Above	$ 91,258,651		Total from Above	$ 61,197,835	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 91,258,651	1405	Total Contractual Adj. (G-3 Line 2)	$ 61,197,835	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.	Adjusted Contractual Adjustments					61,197,835	
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) | ST. MARYS GOOD SAMARITAN

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	$ 7,998,729	$ -	$ -	1,397,434	$ 6,601,295	4,790	$ 6,344,656		$ 1,378.14
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$ -		$ -
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	$ -	$ -	$ -		$ -	-	$ -		$ -
18	Total Routine	$ 7,998,729	$ -	$ -	$ 1,397,434	$ 6,601,295	4,790	$ 6,344,656		
19	Weighted Average									$ 1,378.14

Line #			*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)		752	-	-	$ 1,036,361	22,145	798,854	$ 820,999	1.262317
			1405	1405	1405		1405	1405		

Line #		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	$ 3,585,805	$ -	$ -		**$ 3,585,805**	$ 1,176,826	$ 10,668,235	$ 11,845,061	**0.302726**
22	5400 RADIOLOGY-DIAGNOSTIC	$ 3,917,367	$ -	$ -		**$ 3,917,367**	$ 2,040,500	$ 21,952,732	$ 23,993,232	**0.163270**
23	6000 LABORATORY	$ 2,750,637	$ -	$ -		**$ 2,750,637**	$ 3,115,151	$ 11,095,539	$ 14,210,690	**0.193561**
24	6500 RESPIRATORY THERAPY	$ 893,082	$ -	$ -		**$ 893,082**	$ 747,613	$ 777,743	$ 1,525,356	**0.585491**
25	6600 PHYSICAL THERAPY	$ 1,314,012	$ -	$ -		**$ 1,314,012**	$ 1,351,082	$ 1,525,850	$ 2,876,932	**0.456741**
26	6900 ELECTROCARDIOLOGY	$ 238,410	$ -	$ -		**$ 238,410**	$ 410,700	$ 1,713,893	$ 2,124,593	**0.112214**
27	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 864,445	$ -	$ -		**$ 864,445**	$ 405,041	$ 1,560,079	$ 1,965,120	**0.439894**
28	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 1,256,761	$ -	$ -		**$ 1,256,761**	$ 12,454	$ 4,306,113	$ 4,318,567	**0.291013**
29	7300 DRUGS CHARGED TO PATIENTS	$ 2,660,806	$ -	$ -		**$ 2,660,806**	$ 3,537,574	$ 5,727,063	$ 9,264,637	**0.287200**
30	9100 EMERGENCY	$ 4,433,487	$ -	$ -		**$ 4,433,487**	$ 1,342,285	$ 9,734,201	$ 11,076,486	**0.400261**
126	**Total Ancillary**	$ 21,914,812	$ -	$ -		$ 21,914,812	$ 14,161,371	$ 69,860,302	$ 84,021,673	
127	**Weighted Average**									**0.273158**
128	**Sub Totals**	$ 29,913,541	$ -	$ -		$ 28,516,107	$ 20,506,027	$ 69,860,302	$ 90,366,329	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) | ST. MARYS GOOD SAMARITAN

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
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)				$ 264,653	1405			
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**				**$ 28,251,454**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				**0.00%**				

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

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	$ 1,378.14		252		77		-		802		161		1,131		32.00%
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
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	$ -		-		-		-		-		-		-		
18			**Total Days**	252	4103	77	4203	-		802	4403	161	5103	1,131		32.00%
19	Total Days per PS&R or Exhibit Detail			252		77		-		802		161				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 259,560	4103	$ 63,860	4203	$ -		$ 818,850	4403	$ 165,830	5103	$ 1,142,270		20.62%
21.01	Calculated Routine Charge Per Diem			$ 1,030.00		$ 829.35		$ -		$ 1,021.01		$ 1,030.00		$ 1,009.96		
	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)		1.262317	$ 645	$ 22,238	$ -	$ 12,857	$ -	$ -	$ 2,279	$ 122,292	$ -	$ 58,910	$ 2,924	$ 157,387	26.70%
23	5000 OPERATING ROOM		0.302726	$ 28,016	$ 158,649	$ -	**$ 211,261**	$ -	$ -	$ 58,769	**$ 516,942**	$ 29,399	$ 147,541	$ 86,785	$ 886,852	9.71%
24	5400 RADIOLOGY-DIAGNOSTIC		0.163270	$ 68,248	$ 613,545	$ 26,187	**$ 1,041,651**	$ -	$ -	$ 288,914	**$ 1,659,432**	$ 118,177	$ 1,390,836	$ 383,349	$ 3,314,628	21.74%
25	6000 LABORATORY		0.193561	$ 210,384	$ 386,007	$ 42,857	**$ 938,415**	$ -	$ -	$ 438,662	**$ 872,341**	$ 140,939	$ 810,396	$ 691,903	$ 2,196,763	27.06%
26	6500 RESPIRATORY THERAPY		0.585491	$ 47,296	$ 32,316	$ 4,592	**$ 50,632**	$ -	$ -	$ 134,221	**$ 98,831**	$ 14,285	$ 68,402	$ 186,109	$ 181,779	29.57%
27	6600 PHYSICAL THERAPY		0.456741	$ 20,510	$ 2,153	$ 3,461	**$ 2,854**	$ -	$ -	$ 173,424	**$ 132,539**	$ 28,199	$ 46,064	$ 197,395	$ 137,546	14.22%
28	6900 ELECTROCARDIOLOGY		0.112214	$ 536	$ 427	$ -	$ 768	$ -	$ -	$ 3,404	$ 19,639	$ 512	$ 29,843	$ 3,940	$ 20,834	2.59%
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.439894	$ 27,657	$ 26,694	$ 2,647	**$ 60,988**	$ -	$ -	$ 46,316	**$ 73,037**	$ 14,335	$ 34,951	$ 76,620	$ 160,719	14.59%
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.291013	$ 1,725	$ 10,533	$ -	**$ 30,026**	$ -	$ -	$ 5,554	**$ 162,883**	$ -	$ 6,039	$ 7,279	$ 203,442	5.02%
31	7300 DRUGS CHARGED TO PATIENTS		0.287200	$ 159,399	$ 172,300	$ 62,945	**$ 246,966**	$ -	$ -	$ 556,208	**$ 336,442**	$ 124,135	$ 412,097	$ 778,552	$ 755,708	22.37%
32	9100 EMERGENCY		0.400261	$ 81,888	$ 440,233	$ 16,040	**$ 1,473,395**	$ -	$ -	$ 149,385	**$ 774,335**	$ 62,563	$ 1,229,444	$ 247,313	$ 2,687,963	38.27%
				646,304	1,865,095	158,729	4,069,813	-	-	1,857,136	4,768,713	532,544	4,234,523			

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

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 905,864 4103	$ 1,865,095 4103	$ 222,589 4203	$ 4,069,813 4203	$ -	$ -	$ 2,675,986 4403	$ 4,768,713 4403	$ 698,374 5103 (Agrees to Exhibit A)	$ 4,234,523 5103 (Agrees to Exhibit A)	$ 3,804,439	$ 10,703,621	21.54%
129	Total Charges per PS&R or Exhibit Detail	$ 905,864	$ 1,865,095	$ 222,589	$ 4,340,399	$ -	$ -	$ 2,675,986	$ 4,498,127	$ 698,374	$ 4,234,523			
130	Unreconciled Charges (Explain Variance)	-	-	-	(270,586)	-	-	-	270,586	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 536,795	$ 511,440	$ 148,620	$ 1,159,166	$ -	$ -	$ 1,657,718	$ 1,357,346	$ 365,655	$ 1,194,992	$ 2,343,133	$ 3,027,952	24.56%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 435,755 4103	$ 373,664 4103	$ -	$ -	$ -	$ -	$ 55,890 4403	$ 43,973 4403			$ 491,645	$ 417,637	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 73,688 4203	$ 675,765 4203	$ -	$ -	$ -	$ 2,235 4403			$ 73,688	$ 678,000	
134	Private Insurance (including primary and third party liability)	$ -	$ 3,558 4103	$ -	$ -	$ -	$ -	$ 22,816 4403	$ 207,715 4403			$ 22,816	$ 211,273	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ 4,961 4203	$ -	$ -	$ -	$ 1,628 4403			$ -	$ 6,589	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 435,755	$ 377,222	$ 73,688	$ 680,726									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 39,134 4901	$ -	$ -							$ -	$ 39,134	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -			$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 757,541 4403	$ 812,103 4403			$ 757,541	$ 812,103	
141	Medicare Cross-Over Bad Debt Payments					$ 3,634 1405	$ 32,761 1405	$ -	$ -			$ 3,634	$ 32,761	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									(Agrees to Exhibit B and B-1) $ 10,677 5203	(Agrees to Exhibit B and B-1) $ 246,049 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)**	$ 101,040	$ 95,084	$ 74,932	$ 478,440	$ (3,634)	$ (32,761)	$ 821,471	$ 289,692	$ 354,978	$ 948,943	$ 993,809	$ 830,455	
146	**Calculated Payments as a Percentage of Cost**	81%	81%	50%	59%	0%	0%	50%	79%	3%	21%	58%	73%	
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)**					2,770								
148	**Percent of cross-over days to total Medicare days from the cost report**					0%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

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	$ 1,378.14		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
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	$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		1.262317	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.302726	-	-	-	-	-	-	-	-	$ -	$ -
24	5400 RADIOLOGY-DIAGNOSTIC		0.163270	-	8,719	-	-	-	-	-	-	$ -	$ 8,719
25	6000 LABORATORY		0.193561	-	5,424	-	-	-	-	-	-	$ -	$ 5,424
26	6500 RESPIRATORY THERAPY		0.585491	-	447	-	-	-	-	-	-	$ -	$ 447
27	6600 PHYSICAL THERAPY		0.456741	-	-	-	-	-	-	-	-	$ -	$ -
28	6900 ELECTROCARDIOLOGY		0.112214	-	-	-	-	-	-	-	-	$ -	$ -
29	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.439894	-	-	-	-	-	-	-	-	$ -	$ -
30	7200 IMPL. DEV. CHARGED TO PATIENTS		0.291013	-	-	-	-	-	-	-	-	$ -	$ -
31	7300 DRUGS CHARGED TO PATIENTS		0.287200	-	1,946	-	-	-	-	-	-	$ -	$ 1,946
32	9100 EMERGENCY		0.400261	-	11,683	-	-	-	-	-	-	$ -	$ 11,683
				-	28,219	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ 28,219	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 28,219
129	Total Charges per PS&R or Exhibit Detail			$ -	$ 28,219	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ 7,970	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 7,970
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ 298	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 298
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)			$ -	$ 260	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 260
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 892	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 892
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 1,450	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -	$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ 6,520	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,520
144	**Calculated Payments as a Percentage of Cost**			0%	18%	0%	0%	0%	0%	0%	0%	0%	18%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

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

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

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

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

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

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section E as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (07/01/2021-06/30/2022) ST. MARYS GOOD SAMARITAN

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ -	3001		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -		0	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -		-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -			
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)					
4	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)					
8	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)					
12	*Reason for adjustment*	0	$ -		-	
13	*Reason for adjustment*	0	$ -		-	
14	*Reason for adjustment*	0	$ -		-	
15	*Reason for adjustment*	0	$ -		-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -			

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	14,536,279
19	Uninsured Hospital	**Charges Sec. G**	4,932,897
20	Total Hospital	**Charges Sec. G**	90,366,329
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		16.09%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.46%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		$ -

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

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

DSH Examination Eligibility Summary

Hospital Name	**ST. MARYS GOOD SAMARITAN**
Hospital Medicaid Number	**000001328A**
Cost Report Period	From **7/1/2021** To **6/30/2022**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 1,826,353	$ (116,280)	$ 1,710,073
2	Hospital Cash Subsidies	Survey F-2	$ 200,000	$ -	$ 200,000
3	Total		$ 2,026,353	$ (116,280)	$ 1,910,073
4	Net Hospital Patient Revenue	Survey F-3	$ 30,060,816	$ (293,933)	$ 29,766,883
5	Medicaid Fraction		6.70%	-0.33%	6.37%
6	Inpatient Charity Care Charges	Survey F-2	$ 186,815	$ -	$ 186,815
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ 200,000	$ -	$ 200,000
9	Adjusted Inpatient Charity Care		$ 144,864	$ -	$ 144,451
10	Inpatient Hospital Charges	Survey F-3	$ 19,142,005	$ (408)	$ 19,141,597
11	Inpatient Charity Fraction		0.76%	-0.01%	0.75%
12	LIUR		7.46%	-0.34%	7.12%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	1,131	-	1,131
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		1,131	-	1,131
16	Total Hospital Days (excludes swing-bed)	Survey F-1	4,038	-	4,038
17	MIUR		28.01%	0.00%	28.01%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: ST. MARYS GOOD SAMARITAN
Hospital Medicaid Number: 000001328A
Cost Report Period: From 7/1/2021 To 6/30/2022

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 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	536,795	435,755	-	-	-	-	-	-	-	-	-			435,755	101,040	81.18%
2	Medicaid Fee for Service	Outpatient	511,440	373,664	-	3,558	-	-	-	-	-	-	-			377,222	134,218	73.76%
3	Medicaid Managed Care	Inpatient	148,620	-	73,688	-	-	-	-							73,688	74,932	49.58%
4	Medicaid Managed Care	Outpatient	1,232,720	-	678,000	155,414	4,961	-	-							838,375	394,345	68.01%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	1,657,718	55,890	-	22,816	-			-	757,541	-	-			836,247	821,471	50.45%
8	Other Medicaid Eligibles	Outpatient	1,283,792	43,973	-	52,300	1,628			-	812,103	-	-			910,004	373,788	70.88%
9	Uninsured	Inpatient	365,655	-	-	-	-	-	-	-	-	-	-	10,677	-	10,677	354,978	2.92%
10	Uninsured	Outpatient	1,194,992	-	-	-	-	-	-	-	-	-	-	233,013	-	233,013	961,979	19.50%
11	In-State Sub-total	Inpatient	2,708,788	491,645	73,688	22,816	-	-	-	-	757,541	-	-	10,677	-	1,356,367	1,352,421	50.07%
12	In-State Sub-total	Outpatient	4,222,944	417,637	678,000	211,272	6,589	-	-	-	812,103	-	-	233,013	-	2,358,614	1,864,330	55.85%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	7,970	298	-	260	892	-	-	-	-	-	-			1,450	6,520	18.19%
15	Sub-Total	I/P and O/P	6,939,702	909,580	751,688	234,348	7,481	-	-	-	1,569,644	-	-	243,690	-	3,716,431	3,223,271	53.55%

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	39,134	-	-	-	-	-			39,134	(39,134)	7.65%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-							-	-	0.00%
4	Medicaid Managed Care	Outpatient	(73,554)	-	(2,235)	(155,414)	-	-	-							(157,649)	84,095	-9.28%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	3,634	-			3,634	(3,634)	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	32,761	-			32,761	(32,761)	0.00%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	73,554	-	2,235	155,415	-			-	-	-	-			157,650	(84,096)	7.77%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	13,036	-	13,036	(13,036)	1.09%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	3,634	-	-	-	3,634	(3,634)	0.13%
12	In-State Sub-total	Outpatient	-	-	-	1	-	39,134	-	-	-	32,761	-	13,036	-	84,932	(84,932)	2.01%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	1	-	39,134	-	-	-	36,395	-	13,036	-	88,566	(88,566)	1.28%

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: ST. MARYS GOOD SAMARITAN
Hospital Medicaid Number: 000001328A
Cost Report Period: From 7/1/2021 To 6/30/2022
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 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	536,795	435,755	-	-	-	-	-	-	-	-	-			435,755	101,040	81.18%
2	Medicaid Fee for Service	Outpatient	511,440	373,664	-	3,558	-	39,134	-	-	-	-	-			416,356	95,084	81.41%
3	Medicaid Managed Care	Inpatient	148,620	-	73,688	-	-	-	-							73,688	74,932	49.58%
4	Medicaid Managed Care	Outpatient	1,159,166	-	675,765	-	4,961	-	-							680,726	478,440	58.73%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	3,634	-			3,634	(3,634)	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	32,761	-			32,761	(32,761)	n/a
7	Other Medicaid Eligibles	Inpatient	1,657,718	55,890	-	22,816	-			-	757,541	-	-			836,247	821,471	50.45%
8	Other Medicaid Eligibles	Outpatient	1,357,346	43,973	2,235	207,715	1,628			-	812,103	-	-			1,067,654	289,692	78.66%
9	Uninsured	Inpatient	365,655	-	-	-	-	-	-	-	-	-	-	10,677	-	10,677	354,978	2.92%
10	Uninsured	Outpatient	1,194,992	-	-	-	-	-	-	-	-	-	-	246,049	-	246,049	948,943	20.59%
11	In-State Sub-total	Inpatient	2,708,788	491,645	73,688	22,816	-	-	-	-	757,541	3,634	-	10,677	-	1,360,001	1,348,787	50.21%
12	In-State Sub-total	Outpatient	4,222,944	417,637	678,000	211,273	6,589	39,134	-	-	812,103	32,761	-	246,049	-	2,443,546	1,779,398	57.86%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	7,970	298	-	260	892	-	-	-	-	-	-			1,450	6,520	18.19%
15	Cost Report Year Sub-Total	I/P and O/P	6,939,702	909,580	751,688	234,349	7,481	39,134	-	-	1,569,644	36,395	-	256,726	-	3,804,997	3,134,705	54.83%

16	Less: Out of State DSH Payments from Adjusted Survey	-
17	Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments	3,134,705

Medicaid DSH Survey Adjustments

PROVIDER: ST. MARYS GOOD SAMARITAN
FROM: 7/1/2021 TO: 6/30/2022
Mcaid Number: 000001328A
Mcare Number: 111329

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)	2.00	Amount - Outpatient	Adjust for A to B matches.	$ 233,013	$ 13,036	$ 246,049	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 for A to B matches.	$ 2,294,594	$ (36,120)	$ 2,258,474	5203
2	F - MIUR/LIUR Data	26	Other	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 408	$ (408)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	2.00	Outpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 891,914	$ (891,914)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ -	$ 892,322	$ 892,322	1405
2	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 274	$ (274)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 598,115	$ (598,115)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 598,389	$ 598,389	1405
3	H - In-State	137	Medicaid Cost Settlement Payments (See Note B)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to Medicaid cost settlement per state's listing.	$ -	$ 39,134	$ 39,134	4901
4	H - In-State	23	OPERATING ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 233,847	$ (22,586)	$ 211,261	4203
4	H - In-State	24	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 1,118,355	$ (76,704)	$ 1,041,651	4203
4	H - In-State	25	LABORATORY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 1,000,644	$ (62,229)	$ 938,415	4203
4	H - In-State	26	RESPIRATORY THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 52,618	$ (1,986)	$ 50,632	4203
4	H - In-State	27	PHYSICAL THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 4,010	$ (1,156)	$ 2,854	4203
4	H - In-State	29	MEDICAL SUPPLIES CHARGED TO PATIENT	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 69,395	$ (8,407)	$ 60,988	4203
4	H - In-State	30	IMPL. DEV. CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 31,751	$ (1,725)	$ 30,026	4203
4	H - In-State	31	DRUGS CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 265,410	$ (18,444)	$ 246,966	4203
4	H - In-State	32	EMERGENCY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 1,550,744	$ (77,349)	$ 1,473,395	4203
4	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 678,000	$ (2,235)	$ 675,765	4203
4	H - In-State	134	Private Insurance (including primary and third party liability)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to move Medicaid secondary claims from MCO to OME.	$ 155,414	$ (155,414)	$ -	4203
2	H - In-State	141	Medicare Cross-Over Bad Debt Payments	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to 65% of bad debts.	$ -	$ 3,634	$ 3,634	1405
2	H - In-State	141	Medicare Cross-Over Bad Debt Payments	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to 65% of bad debts.	$ -	$ 32,761	$ 32,761	1405
7	H - In-State	23	OPERATING ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 494,356	$ 22,586	$ 516,942	4403
7	H - In-State	24	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 1,582,728	$ 76,704	$ 1,659,432	4403
7	H - In-State	25	LABORATORY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 810,112	$ 62,229	$ 872,341	4403
7	H - In-State	26	RESPIRATORY THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 96,845	$ 1,986	$ 98,831	4403
7	H - In-State	27	PHYSICAL THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 131,383	$ 1,156	$ 132,539	4403
7	H - In-State	29	MEDICAL SUPPLIES CHARGED TO PATIENT	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 64,630	$ 8,407	$ 73,037	4403
7	H - In-State	30	IMPL. DEV. CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 161,158	$ 1,725	$ 162,883	4403
7	H - In-State	31	DRUGS CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 317,998	$ 18,444	$ 336,442	4403
7	H - In-State	32	EMERGENCY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 696,986	$ 77,349	$ 774,335	4403
7	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ -	$ 2,235	$ 2,235	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
7	H - In-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims to OME from MCO.	$ 52,300	$ 155,415	$ 207,715	4403
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	14.00	Outpatient Uninsured	Adjust for A to B matches.	$ 233,013	$ 13,036	$ 246,049	5203

Medicaid DSH Report Notes

PROVIDER: ST. MARYS GOOD SAMARITAN Mcaid Number: 000001328A
FROM: 7/1/2021 TO: 6/30/2022 Mcare Number: 111329

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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