Georgia DSH Examination Results for 2022 **9/10/2025 14:10**

DSH UCC Cost & Payment Summary

Review Results

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

In order to comply with the December 19, 2008 federal regulation regarding disproportionate share hospital (DSH) payments, surveys were submitted by all facilities that received DSH payments during the 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%	$ 14,310,087	$ 8,556,466	$ 2,016,351	$ 1,046,219	$ 5,753,621	$ 5,753,621
Cost Report Year 2 UCC:	-		0.00%						$ -
Cost Report Year 3 UCC:	-		0.00%						$ -
State DSH Year Sub-Totals:				$ 14,310,087	$ 8,556,466	$ 2,016,351	$ 1,046,219		$ 5,753,621
Less Supplemental Payments (UPL, etc.):									$ 214,817
State DSH Year Adjusted Uncompensated Care Calculation (UCC):									$ 5,538,804
Out-of-State DSH Payments:									$ -
DSH Payments:									$ 4,709,668
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:									**$ -**
DSH Year Low Income Utilization Ratio (LIUR):									16.86%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):									27.97%

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

EXAMINER ADJUSTED SURVEY

Workpaper #:	1302	Reviewer:
Examiner:	KNM	DMH
Date:	10/29/2024	4/22/2025
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 SACRED HEART HOSPITAL

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

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 5/12/2023

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ST. MARYS SACRED HEART HOSPITAL	Yes	
5. Medicaid Provider Number:	000000437A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110027	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	

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

	State Name	Provider No.
9. State Name & Number	South Carolina	413823
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

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

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

	Inpatient		Outpatient		Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 102,616	5203	$ 513,267	5203	$615,883
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 766,339	5203	$ 1,728,697	5203	$2,495,036
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$868,955		$2,241,964		$3,110,919
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.81%		22.89%		19.80%

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

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

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

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

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

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

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	9,775	1505

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

2.	Inpatient Hospital Subsidies	-	
3.	Outpatient Hospital Subsidies	-	
4.	Unspecified I/P and O/P Hospital Subsidies	-	
5.	Non-Hospital Subsidies	-	
6.	Total Hospital Subsidies	$ -	
7.	Inpatient Hospital Charity Care Charges	1,708,894	6001
8.	Outpatient Hospital Charity Care Charges	5,542,545	6001
9.	Non-Hospital Charity Care Charges	6,585	6001
10.	Total Charity Care Charges	$ 7,258,024	6001

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
		1505	1505	1505				
11.	Hospital	$ 7,869,155	$ -	$ -	$ 5,459,719	$ -	$ -	$ 2,409,436
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 37,114,666	$ 63,501,428	$ -	$ 25,750,623	$ 44,058,091	$ -	$ 30,807,379
20.	Outpatient Services		$ 18,685,712	$ -		$ 12,964,383	$ -	$ 5,721,329
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 950,523	$ -	$ -	$ 659,485	$ -
27.	Total	$ 44,983,821	$ 82,187,140	$ 950,523	$ 31,210,342	$ 57,022,474	$ 659,485	$ 38,938,145
28.	Total Hospital and Non Hospital		Total from Above	$ 128,121,484		Total from Above	$ 88,892,301	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 128,121,484	1505	Total Contractual Adj. (G-3 Line 2)	$ 88,892,301	1505
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	$ -	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	$ -	
35.	Adjusted Contractual Adjustments					88,892,301	
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -		Unreconciled Difference (Should be $0)	$ -	

G. Cost Report - Cost / Days / Charges

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

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):		1505	1505	1505	1505		1505	1505		
1	03000	ADULTS & PEDIATRICS	$ 10,283,250	$ -	$ -	-	**$ 10,283,250**	8,617	$ 4,654,820		**$ 1,193.37**
2	03100	INTENSIVE CARE UNIT	$ 3,492,976	$ -	$ -		**$ 3,492,976**	1,907	$ 3,015,363		**$ 1,831.66**
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000	SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100	SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300	NURSERY	$ 544,961	$ -	$ -		**$ 544,961**	647	$ 198,972		**$ 842.29**
18		Total Routine	$ 14,321,187	$ -	$ -	$ -	$ 14,321,187	11,171	$ 7,869,155		
19		Weighted Average									$ 1,282.00

Line #		Observation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
				1505	1505	1505		1505	1505		
20	09200	Observation (Non-Distinct)		1,396	-	-	**$ 1,665,945**	254,276	1,483,892	$ 1,738,168	**0.958449**

Line #		Ancillary Cost Centers (from W/S C excluding Obs	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 Obs	1505	1505	1505			1505	1505		
21	5000	OPERATING ROOM	$ 3,353,745	$ -	$ -		**$ 3,353,745**	$ 1,230,127	$ 7,082,502	$ 8,312,629	**0.403452**
22	5200	DELIVERY ROOM & LABOR ROOM	$ 1,553,059	$ -	$ -		**$ 1,553,059**	$ 2,331,092	$ 123,444	$ 2,454,536	**0.632730**
23	5300	ANESTHESIOLOGY	$ 719,135	$ -	$ -		**$ 719,135**	$ 172,816	$ 1,087,202	$ 1,260,018	**0.570734**
24	5400	RADIOLOGY-DIAGNOSTIC	$ 2,924,899	$ -	$ -		**$ 2,924,899**	$ 1,664,523	$ 8,035,173	$ 9,699,696	**0.301545**
25	5700	CT SCAN	$ 619,744	$ -	$ -		**$ 619,744**	$ 3,556,568	$ 16,343,022	$ 19,899,590	**0.031144**
26	5800	MRI	$ 308,454	$ -	$ -		**$ 308,454**	$ 258,773	$ 2,217,878	$ 2,476,651	**0.124545**
27	6000	LABORATORY	$ 2,643,197	$ -	$ -		**$ 2,643,197**	$ 7,574,069	$ 12,747,382	$ 20,321,451	**0.130069**
28	6500	RESPIRATORY THERAPY	$ 1,449,965	$ -	$ -		**$ 1,449,965**	$ 3,994,929	$ 1,704,450	$ 5,699,379	**0.254408**
29	6600	PHYSICAL THERAPY	$ 1,045,203	$ -	$ -		**$ 1,045,203**	$ 1,556,007	$ 1,598,003	$ 3,154,010	**0.331389**
30	6900	ELECTROCARDIOLOGY	$ 369,584	$ -	$ -		**$ 369,584**	$ 1,012,798	$ 1,997,356	$ 3,010,154	**0.122779**
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 1,364,991	$ -	$ -		**$ 1,364,991**	$ 815,157	$ 489,288	$ 1,304,445	**1.046415**
32	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 1,005,741	$ -	$ -		**$ 1,005,741**	$ 607,612	$ 3,007,717	$ 3,615,329	**0.278188**
33	7300	DRUGS CHARGED TO PATIENTS	$ 3,489,372	$ -	$ -		**$ 3,489,372**	$ 12,340,195	$ 7,068,012	$ 19,408,207	**0.179788**
34	9100	EMERGENCY	$ 4,211,508	$ -	$ -		**$ 4,211,508**	$ 2,327,670	$ 14,619,874	$ 16,947,544	**0.248503**
126		**Total Ancillary**	$ 25,058,597	$ -	$ -		$ 25,058,597	$ 39,696,612	$ 79,605,195	$ 119,301,807	
127		**Weighted Average**									**0.224008**
128		**Sub Totals**	$ 39,379,784	$ -	$ -		$ 39,379,784	$ 47,565,767	$ 79,605,195	$ 127,170,962	
129		NF, SNF, and Swing Bed Cost for Medicaid (Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)					$ -				
130		NF, SNF, and Swing Bed Cost for Medicare (Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)					$ -				
131		NF, SNF, and Swing Bed Cost for Other Payers (Hospital must calculate. Submit support for calculation of cost.)					$ -				
131.01		Other Cost Adjustments (support must be submitted)					$ -				
132		**Grand Total**					**$ 39,379,784**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					**0.00%**				

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

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

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

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,193.37		426		663		-		891		667		1,980		36.73%
2	03100 INTENSIVE CARE UNIT	$ 1,831.66		164		21		-		86		111		271		20.03%
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		-		
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		
10	04300 NURSERY	$ 842.29		38		428		-		12		105		478		90.11%
18			Total Days	628 4103		1,112 4203		-		989 4403		883 5103		2,729		37.00%
19	Total Days per PS&R or Exhibit Detail			628		1,299		-		804		918				
20	Unreconciled Days (Explain Variance)			-		(187)		-		185		(35)				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 570,895 4103		$ 672,618 4203		$ -		$ 800,956 4403		$ 711,486 5103		$ 2,044,469		35.07%
21.01	Calculated Routine Charge Per Diem			$ 909.07		$ 604.87		$ -		$ 809.86		$ 805.76		$ 749.16		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.958449	$ 10,288	$ 26,806	$ 5,200	$ 48,640	$ -	$ -	$ 47,580	$ 362,072	$ 40,768	$ 142,243	$ 63,068	$ 437,518	39.38%
23	5000 OPERATING ROOM		0.403452	$ 44,902	$ 215,754	$ 213,593	$ 325,831	$ -	$ -	$ 133,538	$ 531,090	$ 106,144	$ 302,936	$ 392,033	$ 1,072,675	22.68%
24	5200 DELIVERY ROOM & LABOR ROOM		0.632730	$ 62,999	$ 729	$ 1,115,793	$ 80,467	$ -	$ -	$ 169,117	$ 8,955	$ 95,515	$ 11,817	$ 1,347,909	$ 90,151	62.96%
25	5300 ANESTHESIOLOGY		0.570734	$ 2,480	$ 38,847	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,480	$ 38,847	3.28%
26	5400 RADIOLOGY-DIAGNOSTIC		0.301545	$ 109,785	$ 271,309	$ 161,956	$ 2,094,539	$ -	$ -	$ 144,862	$ 734,437	$ 558,345	$ 808,097	$ 416,603	$ 3,100,285	50.40%
27	5700 CT SCAN		0.031144	$ -	$ 624,067	$ -	$ -	$ -	$ -	$ 387,667	$ 1,369,573	$ 8,811	$ 2,827,370	$ 387,667	$ 1,993,640	26.37%
28	5800 MRI		0.124545	$ 7,759	$ 72,788	$ -	$ -	$ -	$ -	$ 17,022	$ 206,593	$ 36,693	$ 103,091	$ 24,781	$ 279,381	18.27%
29	6000 LABORATORY		0.130069	$ 501,347	$ 635,967	$ 587,692	$ 1,748,614	$ -	$ -	$ 778,976	$ 1,145,965	$ 704,901	$ 2,145,805	$ 1,868,015	$ 3,530,546	40.71%
30	6500 RESPIRATORY THERAPY		0.254408	$ 383,865	$ 109,280	$ 118,259	$ 157,346	$ -	$ -	$ 454,074	$ 325,479	$ 312,714	$ 381,627	$ 956,198	$ 592,105	39.41%
31	6600 PHYSICAL THERAPY		0.331389	$ 80,510	$ 64,855	$ 7,610	$ 156,426	$ -	$ -	$ 177,006	$ 154,151	$ 41,447	$ 73,368	$ 265,126	$ 375,432	23.95%
32	6900 ELECTROCARDIOLOGY		0.122779	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.046415	$ 55,535	$ 17,121	$ 24,616	$ 56,298	$ -	$ -	$ 88,144	$ 45,635	$ 45,392	$ 45,467	$ 168,295	$ 119,054	28.99%
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.278188	$ 16,288	$ 36,031	$ -	$ 1,613	$ -	$ -	$ 79,119	$ 172,297	$ 25,042	$ 33,451	$ 95,407	$ 209,941	10.06%
35	7300 DRUGS CHARGED TO PATIENTS		0.179788	$ 747,431	$ 282,923	$ 918,050	$ 679,262	$ -	$ -	$ 1,179,039	$ 698,770	$ 1,039,298	$ 1,345,823	$ 2,844,520	$ 1,660,955	35.55%
36	9100 EMERGENCY		0.248503	$ 157,019	$ 758,772	$ 80,945	$ 2,589,905	$ -	$ -	$ 245,128	$ 1,007,410	$ 249,273	$ 3,194,443	$ 483,092	$ 4,356,087	49.02%
				2,180,208	3,155,249	3,233,714	7,938,941	-	-	3,901,272	6,762,427	3,264,343	11,415,538			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 2,751,103 4103	$ 3,155,249 4103	$ 3,906,332 4203	$ 7,938,941 4203	$ -	$ -	$ 4,702,228 4403	$ 6,762,427 4403	$ 3,975,829 5103 (Agrees to Exhibit A)	$ 11,415,538 5103 (Agrees to Exhibit A)	$ 11,359,663	$ 17,856,617	35.17%
129	Total Charges per PS&R or Exhibit Detail			$ 2,751,103	$ 3,174,501	$ 4,777,430	$ 9,183,061	$ -	$ -	$ 3,834,805	$ 5,533,831	$ 4,191,008	$ 11,520,028			
130	Unreconciled Charges (Explain Variance)			-	(19,252)	(871,098)	(1,244,120)	-	-	867,423	1,228,596	(215,179)	(104,490)			
131.01	**Sampling Cost Adjustment (if applicable)**											$ (8,419) 5116		$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 1,369,690	$ 645,060	$ 2,356,137	$ 2,004,978	$ -	$ -	$ 2,157,919	$ 1,611,415	$ 1,883,099	$ 2,103,782	$ 5,883,746	$ 4,261,453	35.95%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,007,413 4103	$ 645,724 4103	$ - 4103	$ 78 4203	$ -	$ -	$ 19,559 4403	$ 75,280 4403			$ 1,026,972	$ 721,082	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 1,703,068 4203	$ 1,414,131 4203	$ -	$ -	$ 28,448 4403	$ 6,385 4403			$ 1,731,516	$ 1,420,516	
134	Private Insurance (including primary and third party liability)			$ 3,945 4103	$ 8,015 4103	$ - 4203	$ - 4203	$ -	$ -	$ 452,382 4403	$ 574,806 4403			$ 456,327	$ 582,821	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ 13 4203	$ 17,558 4203	$ -	$ -	$ 6,401 4403	$ 11,967 4403			$ 6,414	$ 29,525	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,011,358	$ 653,739	$ 1,703,081	$ 1,431,767									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (58,012) 4901	$ -	$ -							$ -	$ (58,012)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ -	$ -			$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 1,288,880 4403	$ 721,894 4403			$ 1,288,880	$ 721,894	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -			$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 102,616 5203	$ 513,267 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)**			$ 358,332	$ 49,333	$ 653,056	$ 573,211	$ -	$ -	$ 362,249	$ 221,083	$ 1,780,483	$ 1,590,515	$ 1,373,637	$ 843,627	
146	**Calculated Payments as a Percentage of Cost**			74%	92%	72%	71%	0%	0%	83%	86%	5%	24%	77%	80%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**							5,378 1505								
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 SACRED HEART 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 Inpatient		Out-of-State Medicaid FFS Primary Outpatient		Out-of-State Medicaid Managed Care Primar Inpatient	Out-of-State Medicaid Managed Care Primar Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Include Elsewhere) Inpatient		Out-of-State Other Medicaid Eligibles (Not Include Elsewhere) Outpatient		Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*		*From PS&R Summary (Note A)*		*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		*From PS&R Summary (Note A)*			
	Routine Cost Centers (list below):			**Days**				**Days**		**Days**		**Days**				**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,193.37		5				-		-		-				5	
2	03100 INTENSIVE CARE UNIT	$ 1,831.66		-				-		-		-				-	
3	03200 CORONARY CARE UNIT	$ -		-				-		-		-				-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-				-		-		-				-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-				-		-		-				-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-				-		-		-				-	
7	04000 SUBPROVIDER I	$ -		-				-		-		-				-	
8	04100 SUBPROVIDER II	$ -		-				-		-		-				-	
9	04200 OTHER SUBPROVIDER	$ -		-				-		-		-				-	
10	04300 NURSERY	$ 842.29		-				-		-		-				-	
17		$ -		-				-		-		-				-	
18			**Total Days**	5	4503			-		-		-	4803			5	
19	Total Days per PS&R or Exhibit Detail			5				-		-							
20	Unreconciled Days (Explain Variance			-				-		-							
				Routine Charges				**Routine Charges**		**Routine Charges**		**Routine Charges**				**Routine Charges**	
21	Routine Charges			$ 3,510	4503			$ -		$ -		$ -	4803			$ 3,510	
21.01	Calculated Routine Charge Per Dien			$ 702.00				$ -		$ -		$ -				$ 702.00	
	Ancillary Cost Centers (from W/S C) (list below)			**Ancillary Charges**		**Ancillary Charges**		**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**		**Ancillary Charges**		**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct		0.958449	-		-		-	-	-	-	-		832		$ -	$ 832
23	5000 OPERATING ROOM		0.403452	5,867		-		-	-	-	-	-		5,302		$ 5,867	$ 5,302
24	5200 DELIVERY ROOM & LABOR ROOM		0.632730	-		-		-	-	-	-	-		-		$ -	$ -
25	5300 ANESTHESIOLOGY		0.570734	-		-		-	-	-	-	-		-		$ -	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.301545	2,819		**1,218**		-	-	-	-	-		**1,519**		$ 2,819	$ 2,737
27	5700 CT SCAN		0.031144	-		**16,853**		-	-	-	-	-		**13,942**		$ -	$ 30,795
28	5800 MRI		0.124545	-		-		-	-	-	-	-		**8,423**		$ -	$ 8,423
29	6000 LABORATORY		0.130069	6,440		10,417		-	-	-	-	-		7,358		$ 6,440	$ 17,775
30	6500 RESPIRATORY THERAPY		0.254408	2,504		1,141		-	-	-	-	-		-		$ 2,504	$ 1,141
31	6600 PHYSICAL THERAPY		0.331389	-		-		-	-	-	-	-		-		$ -	$ -
32	6900 ELECTROCARDIOLOGY		0.122779	-		-		-	-	-	-	-		-		$ -	$ -
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.046415	-		-		-	-	-	-	-		-		$ -	$ -
34	7200 IMPL. DEV. CHARGED TO PATIENTS		0.278188	-		-		-	-	-	-	-		-		$ -	$ -
35	7300 DRUGS CHARGED TO PATIENTS		0.179788	1,308		3,461		-	-	-	-	-		5,056		$ 1,308	$ 8,517
36	9100 EMERGENCY		0.248503	873		16,552		-	-	-	-	-		6,830		$ -	$ 23,382
127			-	-		-		-	-	-	-	-		-		$ -	$ -
				19,811		49,642		-	-	-	-	-		49,262			
	Totals / Payments																
128	**Total Charges (includes organ acquisition from Section K)**			**$ 23,321**	4503	**$ 49,642**	4503	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	4803	**$ 49,262**	4803	**$ 23,321**	**$ 98,904**
129	Total Charges per PS&R or Exhibit Detail			$ 23,321		$ 49,372		$ -	$ -	$ -	$ -	$ -		$ 50,262			
130	Unreconciled Charges (Explain Variance			-		270		-	-	-	-	-		(1,000)			
131.01	Sampling Cost Adjustment (if applicable)															$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 11,111**		**$ 7,273**		**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		**$ 8,441**		**$ 11,111**	**$ 15,714**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dow			$ -		$ -		$ -	$ -	$ -	$ -	$ -		$ -		$ -	$ -
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			$ -		$ -		$ -	$ -	$ -	$ -	$ -		$ 7,071	4803	$ -	$ 7,071
135	Self-Pay (including Co-Pay and Spend-Down			$ -		$ -		$ -	$ -	$ -	$ -	$ -		$ -		$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payment			$ -		$ -		$ -	$ -								
137	Medicaid Cost Settlement Payments (See Note E			$ -		$ -										$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note (			$ -		$ -		$ -	$ -							$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductible									$ -	$ -	$ -		$ 1,793	4803	$ -	$ 1,793
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductible									$ -	$ -	$ -		$ 3,784	4803	$ -	$ 3,784
141	Medicare Cross-Over Bad Debt Payment									$ -	$ -	$ -		$ -		$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D									$ -	$ -	$ -		$ -		$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 11,111		$ 7,273		$ -	$ -	$ -	$ -	$ -		$ (4,207)		$ 11,111	$ 3,066
144	**Calculated Payments as a Percentage of Cost**			0%		0%		0%	0%	0%	0%	0%		150%		0%	80%

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

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

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

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

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

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

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

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

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 429,824	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)		$ 429,824	3001	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -			
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)					
4	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -		-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)					
8	*Reason for adjustment*	0	$ (429,824)	3001	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -		-	*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)					
12	*Reason for adjustment*	0	$ -		-	
13	*Reason for adjustment*	0	$ -		-	
14	*Reason for adjustment*	0	$ -		-	
15	*Reason for adjustment*	0	$ -		-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -			

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 429,824
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	29,338,505
19	Uninsured Hospital	**Charges Sec. G**	15,391,367
20	Total Hospital	**Charges Sec. G**	127,170,962
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		23.07%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		12.10%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 99,161
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 52,021
25	Provider Tax Assessment Adjustment to DSH UCC		$ 151,182

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

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

DSH Examination Eligibility Summary

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

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 5,875,638	$ (1,004,033)	$ 4,871,605
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 5,875,638	$ (1,004,033)	$ 4,871,605
4	Net Hospital Patient Revenue	Survey F-3	$ 39,229,183	$ (291,038)	$ 38,938,145
5	Medicaid Fraction		14.98%	-2.47%	12.51%
6	Inpatient Charity Care Charges	Survey F-2	$ 1,708,894	$ -	$ 1,708,894
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 1,708,894	$ -	$ 1,708,894
10	Inpatient Hospital Charges	Survey F-3	$ 45,820,797	$ (836,976)	$ 44,983,821
11	Inpatient Charity Fraction		3.73%	0.07%	3.80%
12	LIUR		18.71%	-2.40%	16.31%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	2,731	(2)	2,729
14	Out-of-State Medicaid Eligible Days	Survey I	5	-	5
15	Total Medicaid Eligible Days		2,736	(2)	2,734
16	Total Hospital Days (excludes swing-bed)	Survey F-1	9,775	-	9,775
17	MIUR		27.99%	-0.02%	27.97%

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

DSH Examination UCC Cost & Payment Summary — Georgia

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

As-Reported:

Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1 Medicaid Fee for Service	Inpatient	1,371,064	1,007,413	-	3,945	-	-	-							1,011,358	359,706	73.76%
2 Medicaid Fee for Service	Outpatient	831,035	634,454	-	3,857	-	-	-							638,311	192,724	76.81%
3 Medicaid Managed Care	Inpatient	2,818,925	-	1,731,516	441,680	6,414	-	-							2,179,610	639,315	77.32%
4 Medicaid Managed Care	Outpatient	2,340,110	78	1,420,516	506,652	22,583	-	-							1,949,829	390,281	83.32%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7 Other Medicaid Eligibles	Inpatient	1,806,286	19,559	1,302	10,702	-			-	1,288,880	-	-			1,320,443	485,843	73.10%
8 Other Medicaid Eligibles	Outpatient	1,686,777	75,280	389	70,978	6,945			-	721,894	-	-			875,486	811,291	51.90%
9 Uninsured	Inpatient	2,004,937	-	-	-	-	-	-	-	-	-	-	116,945	-	116,945	1,887,992	5.83%
10 Uninsured	Outpatient	2,351,861	-	-	-	-	-	-	-	-	-	-	372,697	-	372,697	1,979,164	15.85%
11 In-State Sub-total	Inpatient	8,001,212	1,026,972	1,732,818	456,327	6,414	-	-	-	1,288,880	-	-	116,945	-	4,628,356	3,372,856	57.85%
12 In-State Sub-total	Outpatient	7,209,783	709,812	1,420,905	581,487	29,528	-	-	-	721,894	-	-	372,697	-	3,836,323	3,373,460	53.21%
13 Out-of-State Medicaid	Inpatient	11,111	-	-	-	-	-	-	-	-	-	-			-	11,111	0.00%
14 Out-of-State Medicaid	Outpatient	25,752	-	-	7,071	-	-	-	1,793	3,784	-	-			12,648	13,104	49.11%
15 Sub-Total	I/P and O/P	15,247,858	1,736,784	3,153,723	1,044,885	35,942	-	-	1,793	2,014,558	-	-	489,642	-	8,477,327	6,770,531	55.60%

Adjustments:

Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 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	(1,374)	-	-	-	-	-	-							-	(1,374)	0.07%
2 Medicaid Fee for Service	Outpatient	(185,975)	11,270	-	4,158	-	(58,012)	-							(42,584)	(143,391)	15.54%
3 Medicaid Managed Care	Inpatient	(462,788)	-	(28,448)	(441,680)	(6,401)	-	-							(476,529)	13,741	-5.04%
4 Medicaid Managed Care	Outpatient	(335,132)	-	(6,385)	(506,652)	(5,025)	-	-							(518,062)	182,930	-11.91%
5 Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6 Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7 Other Medicaid Eligibles	Inpatient	351,633	-	27,146	441,680	6,401			-	-	-	-			475,227	(123,594)	10.11%
8 Other Medicaid Eligibles	Outpatient	(75,362)	-	5,996	503,828	5,022			-	-	-	-			514,846	(590,208)	34.38%
9 Uninsured	Inpatient	(121,838)	-	-	-	-	-	-	-	-	-	-	(14,329)	-	(14,329)	(107,509)	-0.38%
10 Uninsured	Outpatient	(248,079)	-	-	-	-	-	-	-	-	-	-	140,570	-	140,570	(388,649)	8.55%
11 In-State Sub-total	Inpatient	(234,367)	-	(1,302)	-	-	-	-	-	-	-	-	(14,329)	-	(15,631)	(218,736)	1.54%
12 In-State Sub-total	Outpatient	(844,548)	11,270	(389)	1,334	(3)	(58,012)	-	-	-	-	-	140,570	-	94,770	(939,318)	8.55%
13 Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14 Out-of-State Medicaid	Outpatient	(10,038)	-	-	-	-	-	-	-	-	-	-			-	(10,038)	31.37%
15 Sub-Total	I/P and O/P	(1,088,953)	11,270	(1,691)	1,334	(3)	(58,012)	-	-	-	-	-	126,241	-	79,139	(1,168,092)	4.83%
15.01																151,182	

DSH Examination UCC Cost & Payment Summary — Georgia

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

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	1,369,690	1,007,413	-	3,945	-	-	-	-	-	-	-			1,011,358	358,332	73.84%
2	Medicaid Fee for Service	Outpatient	645,060	645,724	-	8,015	-	(58,012)	-	-	-	-	-			595,727	49,333	92.35%
3	Medicaid Managed Care	Inpatient	2,356,137	-	1,703,068	-	13	-	-							1,703,081	653,056	72.28%
4	Medicaid Managed Care	Outpatient	2,004,978	78	1,414,131	-	17,558	-	-							1,431,767	573,211	71.41%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	2,157,919	19,559	28,448	452,382	6,401			-	1,288,880	-	-			1,795,670	362,249	83.21%
8	Other Medicaid Eligibles	Outpatient	1,611,415	75,280	6,385	574,806	11,967			-	721,894	-	-			1,390,332	221,083	86.28%
9	Uninsured	Inpatient	1,883,099	-	-	-	-	-	-	-	-	-	-	102,616	-	102,616	1,780,483	5.45%
10	Uninsured	Outpatient	2,103,782	-	-	-	-	-	-	-	-	-	-	513,267	-	513,267	1,590,515	24.40%
11	In-State Sub-total	Inpatient	7,766,845	1,026,972	1,731,516	456,327	6,414	-	-	-	1,288,880	-	-	102,616	-	4,612,725	3,154,120	59.39%
12	In-State Sub-total	Outpatient	6,365,235	721,082	1,420,516	582,821	29,525	(58,012)	-	-	721,894	-	-	513,267	-	3,931,093	2,434,142	61.76%
13	Out-of-State Medicaid	Inpatient	11,111	-	-	-	-	-	-	-	-	-	-			-	11,111	0.00%
14	Out-of-State Medicaid	Outpatient	15,714	-	-	7,071	-	-	-	1,793	3,784	-	-			12,648	3,066	80.49%
15	Cost Report Year Sub-Total	I/P and O/P	14,158,905	1,748,054	3,152,032	1,046,219	35,939	(58,012)	-	1,793	2,014,558	-	-	615,883	-	8,556,466	5,602,439	60.43%
15.01															Provider Tax Assessment Adjustment		151,182	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		5,753,621	

Medicaid DSH Survey Adjustments

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

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	E - Disclosure of Medicaid / Uninsured Payments	9	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	1.00	Amount - Inpatient	Adjust to revised exhibit B.	$ 116,945	$ (14,329)	$ 102,616	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 to revised exhibit B.	$ 402,485	$ 363,854	$ 766,339	5203
1	E - Disclosure of Medicaid / Uninsured Payments	9	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	2.00	Amount - Outpatient	Adjust to revised exhibit B and remove A to B matches.	$ 372,697	$ 140,570	$ 513,267	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 to revised exhibit B and remove A to B matches.	$ 1,826,166	$ (97,469)	$ 1,728,697	5203
2	F - MIUR/LIUR Data	8	Outpatient Hospital Charity Care Charges	1.00	Amount	Adjust to report charity care charges to support.	$ 5,549,130	$ (6,585)	$ 5,542,545	6001
2	F - MIUR/LIUR Data	9	Non-Hospital Charity Care Charges	1.00	Amount	Adjust to report charity care charges to support.	$ -	$ 6,585	$ 6,585	6001
3	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.	$ 836,976	$ (836,976)	$ -	1505
3	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.	$ 113,547	$ (113,547)	$ -	1505
3	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.	$ -	$ 950,523	$ 950,523	1505
3	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 580,705	$ (580,705)	$ -	1505
3	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 78,780	$ (78,780)	$ -	1505
3	F - MIUR/LIUR Data	26	Other	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 659,485	$ 659,485	1505
4	H - In-State	26	RADIOLOGY-DIAGNOSTIC	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 117,544	$ (7,759)	$ 109,785	4103
4	H - In-State	28	MRI	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 7,759	$ 7,759	4103
4	H - In-State	26	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 974,275	$ (702,966)	$ 271,309	4103
4	H - In-State	27	CT SCAN	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 624,067	$ 624,067	4103
4	H - In-State	28	MRI	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 72,788	$ 72,788	4103
4	H - In-State	29	LABORATORY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 641,454	$ (5,487)	$ 635,967	4103
4	H - In-State	30	RESPIRATORY THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 109,756	$ (476)	$ 109,280	4103
4	H - In-State	35	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 284,638	$ (1,715)	$ 282,923	4103
4	H - In-State	36	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 764,235	$ (5,463)	$ 758,772	4103
4	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 remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 634,454	$ 11,270	$ 645,724	4103
4	H - In-State	134	Private Insurance (including primary and third party liability)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids and reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 3,857	$ 4,158	$ 8,015	4103
5	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.	$ -	$ (58,012)	$ (58,012)	4901
6	H - In-State	1	ADULTS & PEDIATRICS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	822	(159)	663	4203
6	H - In-State	2	INTENSIVE CARE UNIT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	40	(19)	21	4203
6	H - In-State	10	NURSERY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	437	(9)	428	4203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
6	H - In-State	21	Routine Charges	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 831,092	$ (158,474)	$ 672,618	4203
6	H - In-State	23	OPERATING ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 261,645	$ (48,052)	$ 213,593	4203
6	H - In-State	24	DELIVERY ROOM & LABOR ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,280,924	$ (165,131)	$ 1,115,793	4203
6	H - In-State	26	RADIOLOGY-DIAGNOSTIC	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 237,414	$ (75,458)	$ 161,956	4203
6	H - In-State	29	LABORATORY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 721,147	$ (133,455)	$ 587,692	4203
6	H - In-State	30	RESPIRATORY THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 153,319	$ (35,060)	$ 118,259	4203
6	H - In-State	31	PHYSICAL THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 11,038	$ (3,428)	$ 7,610	4203
6	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 35,687	$ (11,071)	$ 24,616	4203
6	H - In-State	35	DRUGS CHARGED TO PATIENTS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,134,079	$ (216,029)	$ 918,050	4203
6	H - In-State	36	EMERGENCY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 105,885	$ (24,940)	$ 80,945	4203
6	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,731,516	$ (28,448)	$ 1,703,068	4203
6	H - In-State	134	Private Insurance (including primary and third party liability)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 441,680	$ (441,680)	$ -	4203
6	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 6,414	$ (6,401)	$ 13	4203
6	H - In-State	22	Observation (Non-Distinct)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 62,108	$ (13,468)	$ 48,640	4203
6	H - In-State	23	OPERATING ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 428,181	$ (102,350)	$ 325,831	4203
6	H - In-State	24	DELIVERY ROOM & LABOR ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 89,422	$ (8,955)	$ 80,467	4203
6	H - In-State	26	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 2,466,340	$ (371,801)	$ 2,094,539	4203
6	H - In-State	29	LABORATORY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 2,003,495	$ (254,881)	$ 1,748,614	4203
6	H - In-State	30	RESPIRATORY THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 186,982	$ (29,636)	$ 157,346	4203
6	H - In-State	31	PHYSICAL THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 194,339	$ (37,913)	$ 156,426	4203
6	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 72,981	$ (16,683)	$ 56,298	4203
6	H - In-State	34	IMPL. DEV. CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 20,452	$ (18,839)	$ 1,613	4203
6	H - In-State	35	DRUGS CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 819,256	$ (139,994)	$ 679,262	4203
6	H - In-State	36	EMERGENCY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 2,839,505	$ (249,600)	$ 2,589,905	4203
6	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 1,420,516	$ (6,385)	$ 1,414,131	4203
6	H - In-State	134	Private Insurance (including primary and third party liability)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 506,652	$ (506,652)	$ -	4203
6	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to reclass MCD Secondary claims.	$ 22,583	$ (5,025)	$ 17,558	4203
7	H - In-State	1	ADULTS & PEDIATRICS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	732	159	891	4403
7	H - In-State	2	INTENSIVE CARE UNIT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	67	19	86	4403
7	H - In-State	10	NURSERY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	5	7	12	4403
7	H - In-State	21	Routine Charges	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 643,386	$ 157,570	$ 800,956	4403
7	H - In-State	23	OPERATING ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 85,486	$ 48,052	$ 133,538	4403
7	H - In-State	24	DELIVERY ROOM & LABOR ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 6,498	$ 162,619	$ 169,117	4403
7	H - In-State	26	RADIOLOGY-DIAGNOSTIC	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 474,093	$ (329,231)	$ 144,862	4403
7	H - In-State	27	CT SCAN	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 387,667	$ 387,667	4403
7	H - In-State	28	MRI	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 17,022	$ 17,022	4403
7	H - In-State	29	LABORATORY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 645,609	$ 133,367	$ 778,976	4403
7	H - In-State	30	RESPIRATORY THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 419,014	$ 35,060	$ 454,074	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
7	H - In-State	31	PHYSICAL THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 173,578	$ 3,428	$ 177,006	4403
7	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 77,073	$ 11,071	$ 88,144	4403
7	H - In-State	35	DRUGS CHARGED TO PATIENTS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 963,181	$ 215,858	$ 1,179,039	4403
7	H - In-State	36	EMERGENCY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 220,188	$ 24,940	$ 245,128	4403
7	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,302	$ 27,146	$ 28,448	4403
7	H - In-State	134	Private Insurance (including primary and third party liability)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 10,702	$ 441,680	$ 452,382	4403
7	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 6,401	$ 6,401	4403
7	H - In-State	22	Observation (Non-Distinct)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 348,604	$ 13,468	$ 362,072	4403
7	H - In-State	23	OPERATING ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 428,740	$ 102,350	$ 531,090	4403
7	H - In-State	24	DELIVERY ROOM & LABOR ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 316	$ 8,639	$ 8,955	4403
7	H - In-State	26	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 1,941,632	$ (1,207,195)	$ 734,437	4403
7	H - In-State	27	CT SCAN	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 1,369,573	$ 1,369,573	4403
7	H - In-State	28	MRI	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ -	$ 206,593	$ 206,593	4403
7	H - In-State	29	LABORATORY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 895,170	$ 250,795	$ 1,145,965	4403
7	H - In-State	30	RESPIRATORY THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 297,968	$ 27,511	$ 325,479	4403
7	H - In-State	31	PHYSICAL THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 116,238	$ 37,913	$ 154,151	4403
7	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 28,951	$ 16,684	$ 45,635	4403
7	H - In-State	34	IMPL. DEV. CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 153,458	$ 18,839	$ 172,297	4403
7	H - In-State	35	DRUGS CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 559,711	$ 139,059	$ 698,770	4403
7	H - In-State	36	EMERGENCY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 763,043	$ 244,367	$ 1,007,410	4403
7	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 389	$ 5,996	$ 6,385	4403
7	H - In-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 70,978	$ 503,828	$ 574,806	4403
7	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass MCD Secondary claims and remove duplicate claims.	$ 6,945	$ 5,022	$ 11,967	4403
8	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	686	(19)	667	5103
8	H - In-State	2	INTENSIVE CARE UNIT	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	127	(16)	111	5103
8	H - In-State	21	Routine Charges	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 743,484	$ (31,998)	$ 711,486	5103
8	H - In-State	22	Observation (Non-Distinct)	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 49,348	$ (8,580)	$ 40,768	5103
8	H - In-State	23	OPERATING ROOM	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 118,219	$ (12,075)	$ 106,144	5103
8	H - In-State	26	RADIOLOGY-DIAGNOSTIC	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 645,205	$ (86,860)	$ 558,345	5103
8	H - In-State	27	CT SCAN	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ -	$ 8,811	$ 8,811	5103
8	H - In-State	28	MRI	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ -	$ 36,693	$ 36,693	5103
8	H - In-State	29	LABORATORY	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 739,645	$ (34,744)	$ 704,901	5103
8	H - In-State	30	RESPIRATORY THERAPY	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 338,350	$ (25,636)	$ 312,714	5103
8	H - In-State	31	PHYSICAL THERAPY	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 43,717	$ (2,270)	$ 41,447	5103
8	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 48,354	$ (2,962)	$ 45,392	5103
8	H - In-State	34	IMPL. DEV. CHARGED TO PATIENTS	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 35,224	$ (10,182)	$ 25,042	5103
8	H - In-State	35	DRUGS CHARGED TO PATIENTS	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 1,068,492	$ (29,194)	$ 1,039,298	5103
8	H - In-State	36	EMERGENCY	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 265,455	$ (16,182)	$ 249,273	5103
12	H - In-State	131.01	Sampling Cost Adjustment (if applicable)	13.00	Inpatient Uninsured	Adjust to sample extrapolation.	$ -	$ (8,419)	$ (8,419)	5116
8	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	13.00	Inpatient Uninsured	Adjust to remove duplicate claims.	$ 116,945	$ (14,329)	$ 102,616	5103
8	H - In-State	23	OPERATING ROOM	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 313,279	$ (10,343)	$ 302,936	5103
8	H - In-State	26	RADIOLOGY-DIAGNOSTIC	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 1,257,631	$ (449,534)	$ 808,097	5103
8	H - In-State	27	CT SCAN	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 1,257,631	$ 1,569,739	$ 2,827,370	5103
8	H - In-State	28	MRI	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 1,257,630	$ (1,154,539)	$ 103,091	5103
8	H - In-State	29	LABORATORY	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 2,162,783	$ (16,978)	$ 2,145,805	5103
8	H - In-State	30	RESPIRATORY THERAPY	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 384,796	$ (3,169)	$ 381,627	5103
8	H - In-State	31	PHYSICAL THERAPY	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 85,056	$ (11,688)	$ 73,368	5103
8	H - In-State	33	MEDICAL SUPPLIES CHARGED TO PATIENT	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 45,567	$ (100)	$ 45,467	5103
8	H - In-State	35	DRUGS CHARGED TO PATIENTS	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 1,352,710	$ (6,887)	$ 1,345,823	5103
8	H - In-State	36	EMERGENCY	14.00	Outpatient Uninsured	Adjust to remove duplicate claims.	$ 3,215,434	$ (20,991)	$ 3,194,443	5103
1	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	14.00	Outpatient Uninsured	Adjust to revised exhibit B and remove A to B matches.	$ 372,697	$ 140,570	$ 513,267	5203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.
9	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient Out-of-State Medicaid FFS Primary	Adjust to reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 17,801	$ (16,583)	$ 1,218	4503
9	I - Out-of-State	27	CT SCAN	6.00	Outpatient Out-of-State Medicaid FFS Primary	Adjust to reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 16,853	$ 16,853	4503
10	I - Out-of-State	26	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ 24,884	$ (23,365)	$ 1,519	4803
10	I - Out-of-State	27	CT SCAN	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 13,942	$ 13,942	4803
10	I - Out-of-State	28	MRI	12.00	Outpatient Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass rev codes 350/351 to CC 57 & 611-618 to CC58.	$ -	$ 8,423	$ 8,423	4803
11	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to report provider tax.	$ -	$ 429,824	$ 429,824	3001
11	L - FRA	2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)	2.00	Dollar Amount	Adjust to report provider tax.	$ -	$ 429,824	$ 429,824	3001
11	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to report provider tax.	-	(429,824)	(429,824)	3001

Medicaid DSH Report Notes

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

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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