MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

August 7, 2025

Janice Dunn
Saint Mary's Hospital
1230 Baxter Street
Athens, Georgia 30606

RE: DSH Medicaid Provider Examination

Provider Number:	110006
Provider Name:	Saint Mary's Hospital
DSH Year(s) under Examination:	June 30, 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 **8/6/2025 16:47**

DSH UCC Cost & Payment Summary

Review Results

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

In order to comply with the December 19, 2008 federal regulation regarding disproportionate share hospital (DSH) payments, surveys were submitted by all facilities that received DSH payments during the 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%	$ 59,153,535	$ 18,559,654	$ 13,887,504	$ 2,778,159	$ 23,928,217	$ 23,928,217
Cost Report Year 2 UCC:	-		0.00%						$ -
Cost Report Year 3 UCC:	-		0.00%						$ -
State DSH Year Sub-Totals:				$ 59,153,535	$ 18,559,654	$ 13,887,504	$ 2,778,159		$ 23,928,217

Less Supplemental Payments (UPL, etc.):	$ 2,867,766
State DSH Year Adjusted Uncompensated Care Calculation (UCC):	$ 21,060,451
Out-of-State DSH Payments:	$ -
DSH Payments:	$ 3,281,303
In-State DSH Payments In Excess of State DSH Year Adjusted UCC:	**$ -**
DSH Year Low Income Utilization Ratio (LIUR):	12.86%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	24.51%

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:	KJP	DMH
				Date:	10/11/2024	11/21/2024
2.	Select Your Facility from the Drop-Down Menu Provided:	SAINT MARY'S HOSPITAL				

Identification of cost reports needed to cover the DSH Year:

		Cost Report Begin Date(s)	Cost Report End Date(s)
3.	Cost Report Year 1	07/01/2021	06/30/2022
4.	Cost Report Year 2 (if applicable)		
5.	Cost Report Year 3 (if applicable)		

		Data
6.	Medicaid Provider Number:	000001823A
7.	Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8.	Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9.	Medicare Provider Number:	110006

B. DSH Qualifying Information

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

		DSH Examination Year (07/01/21 - 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?	Yes
3b.	What date did the hospital open?	7/1/1966

C. Disclosure of Supplemental Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022** $ 2,867,766 **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** $ 2,867,766

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: SAINT MARY'S HOSPITAL
FROM: 7/1/2021 TO: 6/30/2022
Mcaid Number: 000001823A
Mcare Number: 110006

Myers and Stauffer DSH Survey Adjustments

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

EXAMINER ADJUSTED SURVEY

Workpaper #:	1301	Reviewer:
Examiner:	KJP	DMH
Date:	10/11/2024	12/9/2024
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: SAINT MARY'S 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:	SAINT MARY'S HOSPITAL	Yes	
5. Medicaid Provider Number:	000001823A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110006	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2021 - 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)	$ 417,615	5203	$ 1,396,649	5203	$1,814,265
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,653,369	5203	$ 9,007,603	5203	$11,660,972
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$3,070,985		$10,404,252		$13,475,237
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	13.60%		13.42%		13.46%

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)	47,798	1405

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

2.	Inpatient Hospital Subsidies	-	
3.	Outpatient Hospital Subsidies	-	
4.	Unspecified I/P and O/P Hospital Subsidies	100,000	6001
5.	Non-Hospital Subsidies	-	
6.	Total Hospital Subsidies	$ 100,000	
7.	Inpatient Hospital Charity Care Charges	18,802,569	6001
8.	Outpatient Hospital Charity Care Charges	19,888,899	6001
9.	Non-Hospital Charity Care Charges	-	
10.	Total Charity Care Charges	$ 38,691,468	

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

		1405 Inpatient Hospital	1405 Outpatient Hospital	1405 Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
		Total Patient Revenues (Charges)			Contractual Adjustments			
11.	Hospital	$ 86,665,348	$ -	$ -	$ 64,661,813	$ -	$ -	$ 22,003,535
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ 8,267,085	$ -	$ -	$ 6,168,148	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 311,083,400	$ 495,919,997	$ -	$ 232,102,185	$ 370,010,470	$ -	$ 204,890,742
20.	Outpatient Services		$ 66,589,626	$ -		$ 49,683,132	$ -	$ 16,906,494
21.	Home Health Agency			$ 8,259,854			$ 6,162,753	
22.	Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 6,572,826			$ 4,904,046	
26.	Other	$ -	$ -	$ 2,302,528	$ -	$ -	$ 1,717,937	$ -
27.	Total	$ 397,748,748	$ 562,509,623	$ 25,402,293	$ 296,763,998	$ 419,693,602	$ 18,952,884	$ 243,800,770
28.	Total Hospital and Non Hospital		Total from Above	$ 985,660,664		Total from Above	$ 735,410,485	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 985,660,664	1405	Total Contractual Adj. (G-3 Line 2)	$ 735,410,485	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					735,410,485	
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) | SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		1405	1405	1405	1405		1405	1405		
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 34,322,273	$ 2,027,221	$ -	-	**$ 36,349,494**	26,015	$ 39,360,074		**$ 1,397.25**
2	03100 INTENSIVE CARE UNIT	$ 25,306,123	$ 640,760	$ 14,832		**$ 25,961,715**	12,309	$ 44,555,787		**$ 2,109.17**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 1,301,253	$ -	$ -		**$ 1,301,253**	4,632	$ 2,749,487		**$ 280.93**
18	Total Routine	$ 60,929,649	$ 2,667,981	$ 14,832	$ -	$ 63,612,462	42,956	$ 86,665,348		
19	Weighted Average									$ 1,480.88

		1405	1405	1405		1405	1405		
		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	1,248	-	-	**$ 1,743,768**	43,428	5,406,733	$ 5,450,161	**0.319948**

		1405	1405	1405		1405	1405		
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):								
21	5000 OPERATING ROOM	$ 52,660,243	$ 913,388	$ -	**$ 53,573,631**	$ 66,935,087	$ 178,456,960	$ 245,392,047	**0.218319**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 4,227,593	$ -	$ -	**$ 4,227,593**	$ 6,925,670	$ 699,004	$ 7,624,674	**0.554462**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 9,961,870	$ -	$ -	**$ 9,961,870**	$ 14,559,506	$ 40,329,521	$ 54,889,027	**0.181491**
24	5700 CT SCAN	$ 1,564,309	$ -	$ -	**$ 1,564,309**	$ 13,365,861	$ 28,579,432	$ 41,945,293	**0.037294**
25	5800 MRI	$ 708,581	$ -	$ -	**$ 708,581**	$ 5,084,787	$ 8,128,832	$ 13,213,619	**0.053625**
26	5900 CARDIAC CATHETERIZATION	$ 9,254,392	$ -	$ -	**$ 9,254,392**	$ 15,081,340	$ 27,156,027	$ 42,237,367	**0.219104**
27	6000 LABORATORY	$ 7,428,055	$ -	$ 5,478	**$ 7,433,533**	$ 18,392,596	$ 31,225,754	$ 49,618,350	**0.149814**
28	6300 BLOOD STORING PROCESSING & TRANS.	$ 1,403,056	$ -	$ -	**$ 1,403,056**	$ 1,469,583	$ 476,385	$ 1,945,968	**0.721007**
29	6400 INTRAVENOUS THERAPY	$ 6,584,328	$ -	$ -	**$ 6,584,328**	$ 4,546,344	$ 24,703,784	$ 29,250,128	**0.225104**
30	6500 RESPIRATORY THERAPY	$ 3,307,920	$ 336,482	$ -	**$ 3,644,402**	$ 17,183,251	$ 2,107,094	$ 19,290,345	**0.188924**
31	6600 PHYSICAL THERAPY	$ 4,814,419	$ -	$ -	**$ 4,814,419**	$ 14,705,325	$ 8,257,206	$ 22,962,531	**0.209664**
32	6900 ELECTROCARDIOLOGY	$ 3,373,241	$ 439,759	$ -	**$ 3,813,000**	$ 10,735,135	$ 14,106,533	$ 24,841,668	**0.153492**
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 12,712,303	$ -	$ -	**$ 12,712,303**	$ 21,550,577	$ 25,197,077	$ 46,747,654	**0.271935**
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 11,024,405	$ -	$ -	**$ 11,024,405**	$ 54,009,241	$ 70,505,706	$ 124,514,947	**0.088539**

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
35	7300	DRUGS CHARGED TO PATIENTS	$ 15,628,813	$ -	$ -		**$ 15,628,813**	$ 44,686,126	$ 26,372,561	$ 71,058,687	**0.219942**
36	7600	CARDIOLOGY	$ 798,552	$ 219,879	$ -		**$ 1,018,431**	$ 1,852,970	$ 9,618,122	$ 11,471,092	**0.088782**
37	9000	CLINIC	$ 749,657	$ -	$ -		**$ 749,657**	$ 1,596	$ 84,668	$ 86,264	**8.690265**
38	9001	WOUND CARE CENTER	$ 1,418,110	$ -	$ -		**$ 1,418,110**	$ 15,338	$ 4,244,662	$ 4,260,000	**0.332890**
39	9100	EMERGENCY	$ 10,407,336	$ 370,908	$ 47,062		**$ 10,825,306**	$ 12,023,347	$ 44,769,854	$ 56,793,201	**0.190609**
126		**Total Ancillary**	$ 158,027,183	$ 2,280,416	$ 52,540		$ 160,360,139	$ 323,167,108	$ 550,425,915	$ 873,593,023	
127		**Weighted Average**									**0.185560**
128		**Sub Totals**	$ 218,956,832	$ 4,948,397	$ 67,372		$ 223,972,601	$ 409,832,456	$ 550,425,915	$ 960,258,371	
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**					**$ 223,972,601**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					**2.26%**				

* 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) SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,397.25		1,348		1,833		-		3,197		2,155		6,378		34.48%
2	03100 INTENSIVE CARE UNIT	$ 2,109.17		850		288		-		1,436		1,037		2,574		29.39%
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	$ 280.93		185		2,406		-		161		84		2,752		61.23%
18			**Total Days**	2,383	4103	4,527	4203	-	4303	4,794	4403	3,276	5103	11,704		35.95%
19	Total Days per PS&R or Exhibit Detail			2,210		5,114		-		4,389		3,390				
20	Unreconciled Days (Explain Variance)			173		(587)		-		405		(114)				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 4,775,568	4103	$ 7,560,512	4203	-	4303	$ 8,712,888	4403	$ 6,184,051	5103	$ 21,048,968		31.45%
21.01	Calculated Routine Charge Per Diem			$ 2,004.02		$ 1,670.09		$ -		$ 1,817.46		$ 1,887.68		$ 1,798.44		
	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)		0.319948	$ 5,544	$ 132,290	$ 1,386	$ 133,060	-	$ -	$ 12,166	$ 996,940	$ 5,929	$ 220,111	$ 19,096	$ 1,262,290	27.66%
23	5000 OPERATING ROOM		0.218319	$ 2,977,219	$ 3,523,880	$ 3,010,299	$ 5,482,361	-	$ -	$ 7,939,278	$ 11,876,712	$ 5,324,751	$ 5,758,467	$ 13,926,796	$ 20,882,953	18.72%
24	5200 DELIVERY ROOM & LABOR ROOM		0.554462	$ 153,220	$ 3,664	$ 3,729,769	$ 106,051	-	$ -	$ 1,081,030	$ 44,507	$ 174,647	$ 3,206	$ 4,964,019	$ 154,222	69.46%
25	5400 RADIOLOGY-DIAGNOSTIC		0.181491	$ 395,970	$ 720,963	$ 368,576	$ 2,386,428	-	$ -	$ 856,399	$ 2,287,112	$ 776,101	$ 2,396,884	$ 1,620,945	$ 5,394,503	18.60%
26	5700 CT SCAN		0.037294	$ 11,086	$ 805,998	$ 402,753	$ 1,854,052	-	$ -	$ 1,535,936	$ 2,397,252	$ 1,527,587	$ 3,331,374	$ 1,949,775	$ 5,057,302	28.32%
27	5800 MRI		0.053625	$ 187,216	$ 269,786	$ 172,285	$ 413,327	-	$ -	$ 463,981	$ 962,982	$ 630,311	$ 623,761	$ 823,482	$ 1,646,095	28.18%
28	5900 CARDIAC CATHETERIZATION		0.219104	$ -	$ -	$ -	$ -	-	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	6000 LABORATORY		0.149814	$ 1,287,576	$ 1,042,950	$ 1,775,447	$ 2,552,656	-	$ -	$ 2,146,932	$ 1,992,213	$ 1,776,459	$ 6,131,853	$ 5,209,955	$ 5,587,819	37.75%
30	6300 BLOOD STORING PROCESSING & TRANS.		0.721007	$ 92,512	$ 41,850	$ 112,377	$ 21,335	-	$ -	$ 152,716	$ 41,955	$ 160,124	$ 37,844	$ 357,605	$ 105,140	33.95%
31	6400 INTRAVENOUS THERAPY		0.225104	$ 373,197	$ 685,218	$ 161,824	$ 1,116,639	-	$ -	$ 553,122	$ 1,327,740	$ 469,874	$ 1,656,281	$ 1,088,143	$ 3,129,597	21.71%
32	6500 RESPIRATORY THERAPY		0.188924	$ 1,240,401	$ 40,408	$ 452,506	$ 97,766	-	$ -	$ 1,705,212	$ 355,928	$ 1,154,189	$ 108,423	$ 3,398,119	$ 494,102	26.75%
33	6600 PHYSICAL THERAPY		0.209664	$ 394,999	$ 35,703	$ 259,502	$ 1,034,874	-	$ -	$ 1,144,793	$ 756,097	$ 654,724	$ 300,218	$ 1,799,294	$ 1,826,674	19.96%
34	6900 ELECTROCARDIOLOGY		0.153492	$ 459,656	$ 347,616	$ 278,318	$ 512,819	-	$ -	$ 1,809,886	$ 2,154,207	$ 1,578,503	$ 1,119,661	$ 2,547,860	$ 3,014,642	33.27%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.271935	$ 797,191	$ 351,246	$ 775,961	$ 402,461	-	$ -	$ 2,158,523	$ 1,631,626	$ 1,411,231	$ 724,973	$ 3,731,675	$ 2,385,332	17.66%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.088539	$ 1,043,437	$ 107,726	$ 730,914	$ 261,772	-	$ -	$ 6,206,388	$ 4,769,411	$ 1,688,359	$ 610,228	$ 7,980,739	$ 5,138,909	12.38%
37	7300 DRUGS CHARGED TO PATIENTS		0.219942	$ 1,992,767	$ 1,001,481	$ 2,689,033	$ 1,245,261	-	$ -	$ 4,351,272	$ 2,730,362	$ 4,403,622	$ 1,702,599	$ 9,003,072	$ 4,977,104	28.30%
38	7600 CARDIOLOGY		0.088782	$ 196,995	$ 148,978	$ 119,279	$ 219,779	-	$ -	$ 775,666	$ 923,232	$ 676,501	$ 479,855	$ 1,091,940	$ 1,291,989	30.87%
39	9000 CLINIC		8.690265	$ 783	$ 45,469	$ 633	$ 18,114	-	$ -	$ 1,219	$ 18,636	$ 539	$ -	$ 2,635	$ 82,219	99.28%
40	9001 WOUND CARE CENTER		0.332890	$ -	$ 45,469	$ 435	$ 60,675	-	$ -	$ 1,454	$ 129,365	$ -	$ 88,807	$ 1,889	$ 235,509	7.66%
41	9100 EMERGENCY		0.190609	$ 730,853	$ 2,551,581	$ 565,059	$ 8,620,546	-	$ -	$ 1,334,027	$ 4,014,767	$ 1,062,377	$ 7,381,621	$ 2,629,939	$ 15,186,894	46.36%
				12,340,622	11,902,275	15,576,355	26,539,976	-	-	34,230,001	39,411,045	23,475,828	32,676,165			

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

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 17,116,190 4103	$ 11,902,275 4103	$ 23,136,867 4203	$ 26,539,976 4203	$ - 4303	$ - 4303	$ 42,942,889 4403	$ 39,411,045 4403	$ 29,659,879 5103 (Agrees to Exhibit A)	$ 32,676,165 5103 (Agrees to Exhibit A)	$ 83,195,946	$ 77,853,295	23.29%
129	Total Charges per PS&R or Exhibit Detail	$ 17,321,234	$ 12,081,612	$ 26,030,630	$ 29,263,908	$ -	$ -	$ 40,315,392	$ 36,690,730	$ 29,847,073	$ 32,689,380			
130	Unreconciled Charges (Explain Variance)	(205,044)	(179,337)	(2,893,763)	(2,723,932)	-	-	2,627,497	2,720,315	(187,194)	(13,215)			
131.01	**Sampling Cost Adjustment (if applicable)**											$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 6,189,672	$ 2,633,382	$ 8,211,889	$ 5,032,813	$ -	$ -	$ 13,939,148	$ 7,195,435	$ 9,568,740	$ 5,600,949	$ 28,340,709	$ 14,861,630	26.09%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 3,901,621 4103	$ 2,165,140 4103	$ -	$ -	$ - 4303	$ - 4303	$ 245,582 4403	$ 331,268 4403			$ 4,147,203	$ 2,496,408	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 5,407,034 4203	$ 4,137,073 4203	$ -	$ -	$ 78,550 4403	$ 83,268 4403			$ 5,485,584	$ 4,220,341	
134	Private Insurance (including primary and third party liability)	$ 67,749 4103	$ 61,611 4103	$ 33,103 4203	$ -	$ - 4303	$ - 4303	$ 1,381,339 4403	$ 1,234,065 4403			$ 1,482,190	$ 1,295,676	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ 2,013 4203	$ 21,291 4203	$ -	$ -	$ 19,559 4403	$ 9,540 4403			$ 21,572	$ 30,832	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 3,969,370	$ 2,226,751	$ 5,442,149	$ 4,158,364									
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ 343,198 4901	$ -	$ -							$ -	$ 343,198	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ - 4303	$ - 4303	$ 1,232 4403	$ -			$ 1,232	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 8,869,872 4403	$ 4,798,500 4403			$ 8,869,872	$ 4,798,500	
141	Medicare Cross-Over Bad Debt Payments					$ 152,718 1405	$ 65,182 1405	$ -	$ -			$ 152,718	$ 65,182	
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) $ 417,615 5203	(Agrees to Exhibit B and B-1) $ 1,396,649 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)**	$ 2,220,302	$ 63,433	$ 2,769,740	$ 874,449	$ (152,718)	$ (65,182)	$ 3,343,014	$ 738,794	$ 9,151,125	$ 4,204,300	$ 8,180,338	$ 1,611,494	
146	**Calculated Payments as a Percentage of Cost**	64%	98%	66%	83%	0%	0%	76%	90%	4%	25%	71%	89%	
147	**Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)**					24,645 1405								
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) SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,397.25		7		-		-		-		7	
2	03100 INTENSIVE CARE UNIT	$ 2,109.17		6		-		-		-		6	
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	$ 280.93		-		-		-		-		-	
18			**Total Days**	13 4503		-		-		- 4803		13	
19	Total Days per PS&R or Exhibit Detail			13		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 23,536 4503		$ -		$ -		$ - 4803		$ 23,536	
21.01	Calculated Routine Charge Per Diem			$ 1,810.46		$ -		$ -		$ -		$ 1,810.46	
	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)		0.319948	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.218319	48,858	-	-	-	-	-	-	-	$ 48,858	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.554462	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.181491	4,283	15,306	-	-	-	-	-	-	$ 4,283	$ 15,306
26	5700 CT SCAN		0.037294	8,132	4,435	-	-	-	-	-	-	$ 8,132	$ 4,435
27	5800 MRI		0.053625	-	-	-	-	-	-	-	-	$ -	$ -
28	5900 CARDIAC CATHETERIZATION		0.219104	-	-	-	-	-	-	-	-	$ -	$ -
29	6000 LABORATORY		0.149814	8,184	15,636	-	-	-	-	-	-	$ 8,184	$ 15,636
30	6300 BLOOD STORING PROCESSING & TRANS.		0.721007	-	-	-	-	-	-	-	-	$ -	$ -
31	6400 INTRAVENOUS THERAPY		0.225104	1,264	6,318	-	-	-	-	-	-	$ 1,264	$ 6,318
32	6500 RESPIRATORY THERAPY		0.188924	5,628	244	-	-	-	-	-	-	$ 5,628	$ 244
33	6600 PHYSICAL THERAPY		0.209664	3,011	-	-	-	-	-	-	-	$ 3,011	$ -
34	6900 ELECTROCARDIOLOGY		0.153492	-	2,972	-	-	-	-	-	-	$ -	$ 2,972
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.271935	1,374	105	-	-	-	-	-	-	$ 1,374	$ 105
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.088539	-	-	-	-	-	-	-	-	$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.219942	18,086	3,439	-	-	-	-	-	-	$ 18,086	$ 3,439
38	7600 CARDIOLOGY		0.088782	-	1,274	-	-	-	-	-	-	$ -	$ 1,274
39	9000 CLINIC		8.690265	-	246	-	-	-	-	-	-	$ -	$ 246
40	9001 WOUND CARE CENTER		0.332890	-	-	-	-	-	-	-	-	$ -	$ -
41	9100 EMERGENCY		0.190609	3,878	66,622	-	-	-	-	-	-	$ 3,878	$ 66,622
				102,698	116,597	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ 126,234 4503	$ 116,597 4503	$ -	$ -	$ -	$ -	$ - 4803	$ - 4803	$ 126,234	$ 116,597
129	Total Charges per PS&R or Exhibit Detail			$ 126,234	$ 116,597	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 42,479	$ 22,945	$ -	$ -	$ -	$ -	$ -	$ -	$ 42,479	$ 22,945
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ 252 4503	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 252
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)			$ -	$ 293 4503	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 293
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ 545	$ -	$ -						
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)**			$ 42,479	$ 22,400	$ -	$ -	$ -	$ -	$ -	$ -	$ 42,479	$ 22,400
144	**Calculated Payments as a Percentage of Cost**			0%	2%	0%	0%	0%	0%	0%	0%	0%	2%

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

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

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

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

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

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

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

Cost Report Year (07/01/2021-06/30/2022) SAINT MARY'S HOSPITAL

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

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount		W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 3,074,857	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)		$ 3,074,857	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	$ (3,074,857)	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		$ 3,074,857
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	161,292,072
19	Uninsured Hospital	**Charges Sec. G**	62,336,044
20	Total Hospital	**Charges Sec. G**	960,258,371
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		16.80%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.49%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 516,476
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 199,607
25	Provider Tax Assessment Adjustment to DSH UCC		$ 716,083

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

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

DSH Examination Eligibility Summary

Hospital Name	**SAINT MARY'S HOSPITAL**
Hospital Medicaid Number	**000001823A**
Cost Report Period	From **7/1/2021** 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)	$ 18,516,888	$ (1,637,843)	$ 16,879,045
2	Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
3	Total		$ 18,616,888	$ (1,637,843)	$ 16,979,045
4	Net Hospital Patient Revenue	Survey F-3	$ 246,484,298	$ (2,683,528)	$ 243,800,770
5	Medicaid Fraction		7.55%	-0.59%	6.96%
6	Inpatient Charity Care Charges	Survey F-2	$ 18,802,569	$ -	$ 18,802,569
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
9	Adjusted Inpatient Charity Care		$ 18,760,747	$ -	$ 18,761,148
10	Inpatient Hospital Charges	Survey F-3	$ 406,017,129	$ (8,268,381)	$ 397,748,748
11	Inpatient Charity Fraction		4.62%	0.10%	4.72%
12	LIUR		12.17%	-0.49%	11.68%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	11,713	(9)	11,704
14	Out-of-State Medicaid Eligible Days	Survey I	13	-	13
15	Total Medicaid Eligible Days		11,726	(9)	11,717
16	Total Hospital Days (excludes swing-bed)	Survey F-1	47,798	-	47,798
17	MIUR		24.53%	-0.02%	24.51%

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

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: SAINT MARY'S HOSPITAL
Hospital Medicaid Number: 000001823A
Cost Report Period: From 7/1/2021 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	6,201,948	3,882,108	-	79,302	-	-	-	-	-	-	-			3,961,410	2,240,538	63.87%
2	Medicaid Fee for Service	Outpatient	2,668,893	2,159,205	-	42,789	-	-	-	-	-	-	-			2,201,994	466,899	82.51%
3	Medicaid Managed Care	Inpatient	9,725,849	-	5,485,584	1,109,287	3,877	-	-							6,598,748	3,127,101	67.85%
4	Medicaid Managed Care	Outpatient	5,575,810	-	4,205,590	945,442	26,309	-	-							5,177,341	398,469	92.85%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
7	Other Medicaid Eligibles	Inpatient	12,679,488	245,582	-	305,155	17,695			1,232	8,869,872	-	-			9,439,536	3,239,952	74.45%
8	Other Medicaid Eligibles	Outpatient	6,653,083	331,268	-	286,810	4,270			-	4,798,500	-	-			5,420,848	1,232,235	81.48%
9	Uninsured	Inpatient	9,732,418	-	-	-	-	-	-	-	-	-	-	402,966	-	402,966	9,329,452	4.14%
10	Uninsured	Outpatient	5,603,582	-	-	-	-	-	-	-	-	-	-	1,317,878	-	1,317,878	4,285,704	23.52%
11	In-State Sub-total	Inpatient	38,339,703	4,127,690	5,485,584	1,493,744	21,572	-	-	1,232	8,869,872	-	-	402,966	-	20,402,660	17,937,043	53.22%
12	In-State Sub-total	Outpatient	20,501,368	2,490,473	4,205,590	1,275,041	30,579	-	-	-	4,798,500	-	-	1,317,878	-	14,118,061	6,383,307	68.86%
13	Out-of-State Medicaid	Inpatient	42,479	-	-	-	-	-	-	-	-	-	-			-	42,479	0.00%
14	Out-of-State Medicaid	Outpatient	22,945	252	-	293	-	-	-	-	-	-	-			545	22,400	2.38%
15	Sub-Total	I/P and O/P	58,906,495	6,618,415	9,691,174	2,769,078	52,151	-	-	1,232	13,668,372	-	-	1,720,844	-	34,521,266	24,385,229	58.60%

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	(12,276)	19,513	-	(11,553)	-	-	-	-	-	-	-			7,960	(20,236)	0.26%
2	Medicaid Fee for Service	Outpatient	(35,511)	5,935	-	18,822	-	343,198	-	-	-	-	-			367,955	(403,466)	15.09%
3	Medicaid Managed Care	Inpatient	(1,513,960)	-	(78,550)	(1,076,184)	(1,864)	-	-							(1,156,599)	(357,361)	-1.58%
4	Medicaid Managed Care	Outpatient	(542,997)	-	(68,517)	(945,442)	(5,018)	-	-							(1,018,977)	475,980	-10.23%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	152,718	-			152,718	(152,718)	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	65,182	-			65,182	(65,182)	0.00%
7	Other Medicaid Eligibles	Inpatient	1,259,660	-	78,550	1,076,184	1,864			-	-	-	-			1,156,598	103,062	1.57%
8	Other Medicaid Eligibles	Outpatient	542,352	-	83,268	947,255	5,270			-	-	-	-			1,035,793	(493,441)	8.25%
9	Uninsured	Inpatient	(163,678)	-	-	-	-	-	-	-	-	-	-	14,649	-	14,649	(178,327)	0.22%
10	Uninsured	Outpatient	(2,633)	-	-	-	-	-	-	-	-	-	-	78,771	-	78,771	(81,404)	1.42%
11	In-State Sub-total	Inpatient	(430,254)	19,513	(0)	(11,554)	(0)	-	-	-	-	152,718	-	14,649	-	175,327	(605,581)	1.07%
12	In-State Sub-total	Outpatient	(38,789)	5,935	14,751	20,635	253	343,198	-	-	-	65,182	-	78,771	-	528,725	(567,514)	2.71%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	(469,043)	25,448	14,751	9,081	253	343,198	-	-	-	217,900	-	93,421	-	704,052	(1,173,095)	1.68%
15.01																	716,083	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: SAINT MARY'S HOSPITAL
Hospital Medicaid Number: 000001823A
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	6,189,672	3,901,621	-	67,749	-	-	-	-	-	-	-			3,969,370	2,220,302	64.13%
2	Medicaid Fee for Service	Outpatient	2,633,382	2,165,140	-	61,611	-	343,198	-	-	-	-	-			2,569,949	63,433	97.59%
3	Medicaid Managed Care	Inpatient	8,211,889	-	5,407,034	33,103	2,013	-	-							5,442,149	2,769,740	66.27%
4	Medicaid Managed Care	Outpatient	5,032,813	-	4,137,073	-	21,291	-	-							4,158,364	874,449	82.63%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	152,718	-			152,718	(152,718)	n/a
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	65,182	-			65,182	(65,182)	n/a
7	Other Medicaid Eligibles	Inpatient	13,939,148	245,582	78,550	1,381,339	19,559			1,232	8,869,872	-	-			10,596,134	3,343,014	76.02%
8	Other Medicaid Eligibles	Outpatient	7,195,435	331,268	83,268	1,234,065	9,540			-	4,798,500	-	-			6,456,641	738,794	89.73%
9	Uninsured	Inpatient	9,568,740	-	-	-	-	-	-	-	-	-	-	417,615	-	417,615	9,151,125	4.36%
10	Uninsured	Outpatient	5,600,949	-	-	-	-	-	-	-	-	-	-	1,396,649	-	1,396,649	4,204,300	24.94%
11	In-State Sub-total	Inpatient	37,909,449	4,147,203	5,485,584	1,482,190	21,572	-	-	1,232	8,869,872	152,718	-	417,615	-	20,577,987	17,331,462	54.28%
12	In-State Sub-total	Outpatient	20,462,579	2,496,408	4,220,341	1,295,676	30,832	343,198	-	-	4,798,500	65,182	-	1,396,649	-	14,646,786	5,815,793	71.58%
13	Out-of-State Medicaid	Inpatient	42,479	-	-	-	-	-	-	-	-	-	-			-	42,479	0.00%
14	Out-of-State Medicaid	Outpatient	22,945	252	-	293	-	-	-	-	-	-	-			545	22,400	2.38%
15	Cost Report Year Sub-Total	I/P and O/P	58,437,452	6,643,863	9,705,925	2,778,159	52,404	343,198	-	1,232	13,668,372	217,900	-	1,814,265	-	35,225,318	23,212,134	60.28%
15.01															Provider Tax Assessment Adjustment (		716,083	
16															Less: Out of State DSH Payments from Adjusted Survey		-	
17															Adjusted Sub-Total UCC Prior to Supplemental Medicaid Payments		23,928,217	

Medicaid DSH Survey Adjustments

PROVIDER: SAINT MARY'S HOSPITAL
FROM: 7/1/2021 TO: 6/30/2022
Mcaid Number: 000001823A
Mcare Number: 110006

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
1	E - Disclosure of Medicaid / Uninsured Payments	9	Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	1.00	Amount - Inpatient	Adjust to A to B matches.	$ 402,966	$ 14,649	$ 417,615	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 A to B matches.	$ 2,668,032	$ (14,663)	$ 2,653,369	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 A to B matches.	$ 1,317,878	$ 78,771	$ 1,396,649	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 A to B matches.	$ 9,087,515	$ (79,912)	$ 9,007,603	5203
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	1.00	Inpatient Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ 8,267,085	$ (8,267,085)	$ -	1405
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.	$ 1,296	$ (1,296)	$ -	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.	$ 2,301,232	$ (2,301,232)	$ -	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	3.00	Non-Hospital Total Patient Revenues (Total Charges)	Adjust hospital revenues to the hospital cost report worksheet G-2.	$ -	$ 8,267,085	$ 8,267,085	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.	$ -	$ 2,302,528	$ 2,302,528	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 6,168,148	$ (6,168,148)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	4.00	Inpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 967	$ (967)	$ -	1405
2	F - MIUR/LIUR Data	26	Other	5.00	Outpatient Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ 1,716,970	$ (1,716,970)	$ -	1405
2	F - MIUR/LIUR Data	13	Rehab. Subprovider	6.00	Non-Hospital Contractuals	Adjust hospital contractuals to the hospital cost report worksheet G-3 total.	$ -	$ 6,168,148	$ 6,168,148	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.	$ -	$ 1,717,937	$ 1,717,937	1405
2	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Adjust to exlcude Subprovider IRF amounts.	$ 7,385,711.00	$ (7,385,711)	$ -	1405
2	G - CR Data	8	SUBPROVIDER II	8.00	Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjust to exlcude Subprovider IRF amounts.	5,623	(5,623)	-	1405
2	G - CR Data	8	SUBPROVIDER II	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Adjust to exlcude Subprovider IRF amounts.	$ 8,267,085.00	$ (8,267,085)	$ -	1405
2	G - CR Data	8	SUBPROVIDER II	12.00	Title XVIII Days - Cost Report W/S S-3, Pt. I, Column 6	Adjust to exlcude Subprovider IRF amounts.	3,465	(3,465)	-	1405
3	H - In-State	1	ADULTS & PEDIATRICS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	1,360	(12)	1,348	4103
3	H - In-State	10	NURSERY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to include nursery days.	-	185	185	4103
3	H - In-State	21	Routine Charges	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 4,793,436	$ (17,868)	$ 4,775,568	4103
3	H - In-State	23	OPERATING ROOM	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 3,063,075	$ (85,856)	$ 2,977,219	4103
3	H - In-State	24	DELIVERY ROOM & LABOR ROOM	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 167,304	$ (14,084)	$ 153,220	4103
3	H - In-State	25	RADIOLOGY-DIAGNOSTIC	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 396,308	$ (338)	$ 395,970	4103
3	H - In-State	29	LABORATORY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 1,294,098	$ (6,522)	$ 1,287,576	4103
3	H - In-State	31	INTRAVENOUS THERAPY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 374,752	$ (1,555)	$ 373,197	4103
3	H - In-State	32	RESPIRATORY THERAPY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 1,246,833	$ (6,432)	$ 1,240,401	4103
3	H - In-State	34	ELECTROCARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 462,145	$ (2,489)	$ 459,656	4103
3	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 853,816	$ (56,625)	$ 797,191	4103
3	H - In-State	37	DRUGS CHARGED TO PATIENTS	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 1,996,940	$ (4,173)	$ 1,992,767	4103

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
3	H - In-State	38	CARDIOLOGY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 198,062	$ (1,067)	$ 196,995	4103
3	H - In-State	41	EMERGENCY	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 738,888	$ (8,035)	$ 730,853	4103
3	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 3,882,108	$ 19,513	$ 3,901,621	4103
3	H - In-State	134	Private Insurance (including primary and third party liability)	5.00	Inpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 79,302	$ (11,553)	$ 67,749	4103
3	H - In-State	22	Observation (Non-Distinct)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 133,676	$ (1,386)	$ 132,290	4103
3	H - In-State	23	OPERATING ROOM	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 3,533,634	$ (9,754)	$ 3,523,880	4103
3	H - In-State	25	RADIOLOGY-DIAGNOSTIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 731,668	$ (10,705)	$ 720,963	4103
3	H - In-State	26	CT SCAN	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 810,538	$ (4,540)	$ 805,998	4103
3	H - In-State	29	LABORATORY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 1,060,349	$ (17,399)	$ 1,042,950	4103
3	H - In-State	31	INTRAVENOUS THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 722,529	$ (37,311)	$ 685,218	4103
3	H - In-State	32	RESPIRATORY THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 42,085	$ (1,677)	$ 40,408	4103
3	H - In-State	33	PHYSICAL THERAPY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 36,098	$ (395)	$ 35,703	4103
3	H - In-State	34	ELECTROCARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 351,518	$ (3,902)	$ 347,616	4103
3	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 352,550	$ (1,305)	$ 351,246	4103
3	H - In-State	37	DRUGS CHARGED TO PATIENTS	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 1,014,823	$ (13,342)	$ 1,001,481	4103
3	H - In-State	38	CARDIOLOGY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 150,651	$ (1,673)	$ 148,978	4103
3	H - In-State	39	CLINIC	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 45,574	$ (105)	$ 45,469	4103
3	H - In-State	40	WOUND CARE CENTER	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 45,573	$ (104)	$ 45,469	4103
3	H - In-State	41	EMERGENCY	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to remove zero paids claims.	$ 2,627,320	$ (75,740)	$ 2,551,581	4103
3	H - In-State	132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 2,159,205	$ 5,935	$ 2,165,140	4103
3	H - In-State	134	Private Insurance (including primary and third party liability)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to updated MMIS data.	$ 42,789	$ 18,822	$ 61,611	4103
4	H - In-State	137	Medicaid Cost Settlement Payments (See Note B)	6.00	Outpatient In-State Medicaid FFS Primary	Adjust to Medicaid cost settlement per state's listing.	$ -	$ 343,198	$ 343,198	4901
5	H - In-State	1	ADULTS & PEDIATRICS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to remove days in non-covered rev codes and reclass Medicaid secondary claims.	2,354	(521)	1,833	4203
5	H - In-State	2	INTENSIVE CARE UNIT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to remove days in non-covered rev codes and reclass Medicaid secondary claims.	289	(1)	288	4203
5	H - In-State	10	NURSERY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to remove days in non-covered rev codes and reclass Medicaid secondary claims.	2,471	(65)	2,406	4203
5	H - In-State	21	Routine Charges	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to remove days in non-covered rev codes and reclass Medicaid secondary claims.	$ 8,442,990	$ (882,478)	$ 7,560,512	4203
5	H - In-State	23	OPERATING ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 3,308,634	$ (298,335)	$ 3,010,299	4203
5	H - In-State	24	DELIVERY ROOM & LABOR ROOM	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 4,745,566	$ (1,015,797)	$ 3,729,769	4203
5	H - In-State	25	RADIOLOGY-DIAGNOSTIC	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 387,093	$ (18,517)	$ 368,576	4203
5	H - In-State	26	CT SCAN	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 415,655	$ (12,902)	$ 402,753	4203
5	H - In-State	27	MRI	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 175,221	$ (2,936)	$ 172,285	4203
5	H - In-State	29	LABORATORY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 1,980,152	$ (204,705)	$ 1,775,447	4203
5	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 113,739	$ (1,362)	$ 112,377	4203
5	H - In-State	31	INTRAVENOUS THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 169,698	$ (7,874)	$ 161,824	4203
5	H - In-State	32	RESPIRATORY THERAPY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 465,731	$ (13,225)	$ 452,506	4203
5	H - In-State	34	ELECTROCARDIOLOGY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 281,875	$ (3,557)	$ 278,318	4203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
5	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 832,376	$ (56,415)	$ 775,961	4203
5	H - In-State	37	DRUGS CHARGED TO PATIENTS	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 2,975,787	$ (316,754)	$ 2,659,033	4203
5	H - In-State	38	CARDIOLOGY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 120,804	$ (1,525)	$ 119,279	4203
5	H - In-State	39	CLINIC	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 718	$ (85)	$ 633	4203
5	H - In-State	41	EMERGENCY	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 622,354	$ (57,295)	$ 565,059	4203
5	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 5,485,584	$ (78,550)	$ 5,407,034	4203
5	H - In-State	134	Private Insurance (including primary and third party liability)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 1,109,287	$ (1,076,184)	$ 33,103	4203
5	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	7.00	Inpatient In-State Medicaid Managed Care Primary	Adjust to reclass Medicaid secondary claims.	$ 3,877	$ (1,864)	$ 2,013	4203
5	H - In-State	22	Observation (Non-Distinct)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 159,398	$ (26,338)	$ 133,060	4203
5	H - In-State	23	OPERATING ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 6,255,226	$ (772,865)	$ 5,482,361	4203
5	H - In-State	24	DELIVERY ROOM & LABOR ROOM	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 150,558	$ (44,507)	$ 106,051	4203
5	H - In-State	25	RADIOLOGY-DIAGNOSTIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 2,585,398	$ (198,970)	$ 2,386,428	4203
5	H - In-State	26	CT SCAN	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 2,042,433	$ (188,381)	$ 1,854,052	4203
5	H - In-State	27	MRI	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 427,392	$ (14,065)	$ 413,327	4203
5	H - In-State	29	LABORATORY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 2,766,766	$ (214,110)	$ 2,552,656	4203
5	H - In-State	31	INTRAVENOUS THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 1,229,493	$ (112,854)	$ 1,116,639	4203
5	H - In-State	32	RESPIRATORY THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 118,843	$ (21,077)	$ 97,766	4203
5	H - In-State	33	PHYSICAL THERAPY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 1,173,024	$ (138,150)	$ 1,034,874	4203
5	H - In-State	34	ELECTROCARDIOLOGY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 560,616	$ (47,797)	$ 512,819	4203
5	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 500,411	$ (97,950)	$ 402,461	4203
5	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 310,879	$ (49,107)	$ 261,772	4203
5	H - In-State	37	DRUGS CHARGED TO PATIENTS	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 1,375,573	$ (130,312)	$ 1,245,261	4203
5	H - In-State	38	CARDIOLOGY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 240,264	$ (20,485)	$ 219,779	4203
5	H - In-State	39	CLINIC	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 19,834	$ (1,720)	$ 18,114	4203
5	H - In-State	40	WOUND CARE CENTER	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 61,420	$ (745)	$ 60,675	4203
5	H - In-State	41	EMERGENCY	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate charges, non-covered rev codes, and reclass Medicaid secondary claims.	$ 9,265,045	$ (644,499)	$ 8,620,546	4203
5	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate payments, reclass Medicaid secondary claims and formula error on exhibit.	$ 4,205,590	$ (68,517)	$ 4,137,073	4203

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
5	H - In-State	134	Private Insurance (including primary and third party liability)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate payments, reclass Medicaid secondary claims and formula error on exhibit.	$ 945,442	$ (945,442)	$ -	4203
5	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	8.00	Outpatient In-State Medicaid Managed Care Primary	Adjust to remove duplicate payments, reclass Medicaid secondary claims and formula error on exhibit.	$ 26,309	$ (5,018)	$ 21,291	4203
7	H - In-State	141	Medicare Cross-Over Bad Debt Payments	9.00	Inpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to bad debt calculation.	$ -	$ 152,718	$ 152,718	1405
7	H - In-State	141	Medicare Cross-Over Bad Debt Payments	10.00	Outpatient In-State Medicare FFS Cross-Overs (with Medicaid Secondary)	Adjust to bad debt calculation.	$ -	$ 65,182	$ 65,182	1405
9	H - In-State	1	ADULTS & PEDIATRICS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to remove non-covered rev codes and reclass Medicaid secondary claims.	2,858	339	3,197	4403
9	H - In-State	2	INTENSIVE CARE UNIT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to remove non-covered rev codes and reclass Medicaid secondary claims.	1,435	1	1,436	4403
9	H - In-State	10	NURSERY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to remove non-covered rev codes and reclass Medicaid secondary claims.	96	65	161	4403
9	H - In-State	21	Routine Charges	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to remove non-covered rev codes and reclass Medicaid secondary claims.	$ 8,096,676	$ 616,212	$ 8,712,888	4403
9	H - In-State	23	OPERATING ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 7,640,943	$ 298,335	$ 7,939,278	4403
9	H - In-State	24	DELIVERY ROOM & LABOR ROOM	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 65,233	$ 1,015,797	$ 1,081,030	4403
9	H - In-State	25	RADIOLOGY-DIAGNOSTIC	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 837,882	$ 18,517	$ 856,399	4403
9	H - In-State	26	CT SCAN	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,523,034	$ 12,902	$ 1,535,936	4403
9	H - In-State	27	MRI	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 461,045	$ 2,936	$ 463,981	4403
9	H - In-State	29	LABORATORY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,942,227	$ 204,705	$ 2,146,932	4403
9	H - In-State	30	BLOOD STORING PROCESSING & TRANS.	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 151,354	$ 1,362	$ 152,716	4403
9	H - In-State	31	INTRAVENOUS THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 545,248	$ 7,874	$ 553,122	4403
9	H - In-State	32	RESPIRATORY THERAPY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,691,987	$ 13,225	$ 1,705,212	4403
9	H - In-State	34	ELECTROCARDIOLOGY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,806,329	$ 3,557	$ 1,809,886	4403
9	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 2,102,108	$ 56,415	$ 2,158,523	4403
9	H - In-State	37	DRUGS CHARGED TO PATIENTS	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 4,034,518	$ 316,754	$ 4,351,272	4403
9	H - In-State	38	CARDIOLOGY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 774,141	$ 1,525	$ 775,666	4403
9	H - In-State	39	CLINIC	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,134	$ 85	$ 1,219	4403
9	H - In-State	41	EMERGENCY	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,276,732	$ 57,295	$ 1,334,027	4403
9	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ -	$ 78,550	$ 78,550	4403
9	H - In-State	134	Private Insurance (including primary and third party liability)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 305,155	$ 1,076,184	$ 1,381,339	4403
9	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	11.00	Inpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 17,695	$ 1,864	$ 19,559	4403
9	H - In-State	22	Observation (Non-Distinct)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 970,602	$ 26,338	$ 996,940	4403
9	H - In-State	23	OPERATING ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 11,103,847	$ 772,865	$ 11,876,712	4403
9	H - In-State	24	DELIVERY ROOM & LABOR ROOM	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ -	$ 44,507	$ 44,507	4403
9	H - In-State	25	RADIOLOGY-DIAGNOSTIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 2,088,862	$ 198,250	$ 2,287,112	4403
9	H - In-State	26	CT SCAN	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 2,208,871	$ 188,381	$ 2,397,252	4403
9	H - In-State	27	MRI	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 948,917	$ 14,065	$ 962,982	4403
9	H - In-State	29	LABORATORY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,778,522	$ 213,691	$ 1,992,213	4403

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.
9	H - In-State	31	INTRAVENOUS THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,214,886	$ 112,854	$ 1,327,740	4403
9	H - In-State	32	RESPIRATORY THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 334,851	$ 21,077	$ 355,928	4403
9	H - In-State	33	PHYSICAL THERAPY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 617,947	$ 138,150	$ 756,097	4403
9	H - In-State	34	ELECTROCARDIOLOGY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 2,106,680	$ 47,527	$ 2,154,207	4403
9	H - In-State	35	MEDICAL SUPPLIES CHARGED TO PATIENT	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 1,533,676	$ 97,950	$ 1,631,626	4403
9	H - In-State	36	IMPL. DEV. CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 4,720,304	$ 49,107	$ 4,769,411	4403
9	H - In-State	37	DRUGS CHARGED TO PATIENTS	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 2,600,063	$ 130,299	$ 2,730,362	4403
9	H - In-State	38	CARDIOLOGY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 902,863	$ 20,369	$ 923,232	4403
9	H - In-State	39	CLINIC	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 16,916	$ 1,720	$ 18,636	4403
9	H - In-State	40	WOUND CARE CENTER	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 128,620	$ 745	$ 129,365	4403
9	H - In-State	41	EMERGENCY	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 3,372,348	$ 642,419	$ 4,014,767	4403
9	H - In-State	133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ -	$ 83,268	$ 83,268	4403
9	H - In-State	134	Private Insurance (including primary and third party liability)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 286,810	$ 947,255	$ 1,234,065	4403
9	H - In-State	135	Self-Pay (including Co-Pay and Spend-Down)	12.00	Outpatient In-State Other Medicaid Eligibles (Not Included Elsewhere)	Adjust to reclass Medicaid secondary claims.	$ 4,270	$ 5,270	$ 9,540	4403
10	H - In-State	1	ADULTS & PEDIATRICS	13.00	Inpatient Uninsured	Adjust to duplicate days and non-covered rev codes.	2,269	(114)	2,155	5103
10	H - In-State	21	Routine Charges	13.00	Inpatient Uninsured	Adjust to duplicate charges and non-covered rev codes	$ 6,350,273	$ (166,222)	$ 6,184,051	5103
10	H - In-State	23	OPERATING ROOM	13.00	Inpatient Uninsured	Adjust to duplicate charges.	$ 5,336,600	$ (11,849)	$ 5,324,751	5103
10	H - In-State	25	RADIOLOGY-DIAGNOSTIC	13.00	Inpatient Uninsured	Adjust to duplicate charges.	$ 777,763	$ (1,662)	$ 776,101	5103
10	H - In-State	29	LABORATORY	13.00	Inpatient Uninsured	Adjust to duplicate charges.	$ 1,778,221	$ (1,762)	$ 1,776,459	5103
10	H - In-State	33	PHYSICAL THERAPY	13.00	Inpatient Uninsured	Adjust to duplicate charges.	$ 656,103	$ (1,379)	$ 654,724	5103
10	H - In-State	37	DRUGS CHARGED TO PATIENTS	13.00	Inpatient Uninsured	Adjust to duplicate charges.	$ 4,407,942	$ (4,320)	$ 4,403,622	5103
11	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	13.00	Inpatient Uninsured	Adjust to A to B matches.	$ 402,966	$ 14,649	$ 417,615	5203
10	H - In-State	25	RADIOLOGY-DIAGNOSTIC	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 2,398,111	$ (1,227)	$ 2,396,884	5103
10	H - In-State	29	LABORATORY	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 6,132,722	$ (869)	$ 6,131,853	5103
10	H - In-State	33	PHYSICAL THERAPY	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 309,040	$ (8,822)	$ 300,218	5103
10	H - In-State	37	DRUGS CHARGED TO PATIENTS	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 1,701,757	$ 841	$ 1,702,599	5103
10	H - In-State	40	WOUND CARE CENTER	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 88,930	$ (123)	$ 88,807	5103
10	H - In-State	41	EMERGENCY	14.00	Outpatient Uninsured	Adjust to duplicate charges and formula error on exhibit.	$ 7,384,636	$ (3,015)	$ 7,381,621	5103
11	H - In-State	143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	14.00	Outpatient Uninsured	Adjust to A to B matches.	$ 1,317,878	$ 78,771	$ 1,396,649	5203
12	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to provider's tax assessment.	$ -	$ 3,074,857	$ 3,074,857	3001
12	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 provider's tax assessment.	$ -	$ 3,074,857	$ 3,074,857	3001
12	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to provider's tax assessment.	-	(3,074,857)	(3,074,857)	3001

Medicaid DSH Report Notes

PROVIDER: SAINT MARY'S HOSPITAL
Mcaid Number: 000001823A
FROM: 7/1/2021 TO: 6/30/2022
Mcare Number: 110006

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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