GA DSH Payment Results for SFY 2025 - Pool 2

3/25/2025 9:50

DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

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

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2025 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2024 - 6/30/2025

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	7/1/2022	-	6/30/2023	$ 17,618,988	$ 217,316	$ 17,836,979

Less: 2023 Net UPL Payments	$ 1,452,378
Less: 2025 Net DPP Payments	$ 16,833,921
Plus: 2024 Net DPP Recoupments	$ -
Less: GME Payments	$ 180,412
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ (114,428)
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 377,901
Uncompensated Care Allocation Factor	$ (366,259)
Hospital Specific DSH Limit	$ (2,562,320)
2025 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	11.41%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	30.05%

If you disagree with the findings presented above please respond within five 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
Web Portal Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	9.00	9/11/2024

D. General Cost Report Year Information 7/1/2022 - 6/30/2023

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

	7/1/2022 through 6/30/2023		
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: 5/9/2024

	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: (07/01/2022 - 06/30/2023)

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)	$ 119,646	$ 403,498	$523,144
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,651,211	$ 4,442,779	$6,093,990
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$1,770,857	$4,846,277	$6,617,134
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.76%	8.33%	7.91%

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 (07/01/2022 - 06/30/2023)

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)	44,190

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

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	100,000
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 100,000
7.	Inpatient Hospital Charity Care Charges	18,377,799
8.	Outpatient Hospital Charity Care Charges	18,255,774
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 36,633,573

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
11.	Hospital	$ 92,106,391	$ -	$ -	$ 68,852,616	$ -	$ -	$ 23,253,775
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ 8,930,413	$ -	$ -	$ 6,675,783	$ -	$ -	$ 2,254,630
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 301,724,819	$ 495,304,033	$ -	$ 225,549,419	$ 370,256,373	$ -	$ 201,223,060
20.	Outpatient Services		$ 72,925,159	$ -		$ 54,514,002	$ -	$ 18,411,157
21.	Home Health Agency			$ 7,580,128			$ 5,666,400	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ 5,790,899			$ 4,328,891	
26.	Other	$ -	$ (2,378,655)	$ -	$ -	$ (1,778,124)	$ -	$ (600,531)
27.	Total	$ 402,761,623	$ 565,850,537	$ 13,371,027	$ 301,077,818	$ 422,992,250	$ 9,995,291	$ 244,542,092
28.	Total Hospital and Non Hospital		Total from Above	$ 981,983,187		Total from Above	$ 734,065,359	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 981,983,187	Total Contractual Adj. (G-3 Line 2)	$ 734,065,359
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	$ -
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	$ -
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	$ -
36.	Adjusted Contractual Adjustments				734,065,359
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023 | SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 40,420,331	$ 2,196,116	$ -	-	$ 42,616,447	31,620	$ 45,353,477		$ 1,347.77
2	03100 INTENSIVE CARE UNIT	$ 26,496,217	$ 694,144	$ -		$ 27,190,361	9,683	$ 45,978,579		$ 2,808.05
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	$ 1,461,261	$ -	$ -		$ 1,461,261	4,311	$ 2,838,971		$ 338.96
11	0	$ -	$ -	$ -		$ -	-	$ -		$ -
12	0	$ -	$ -	$ -		$ -	-	$ -		$ -
13	0	$ -	$ -	$ -		$ -	-	$ -		$ -
14	0	$ -	$ -	$ -		$ -	-	$ -		$ -
15	0	$ -	$ -	$ -		$ -	-	$ -		$ -
16	0	$ -	$ -	$ -		$ -	-	$ -		$ -
17	0	$ -	$ -	$ -		$ -	-	$ -		$ -
18	Total Routine	$ 68,377,809	$ 2,890,260	$ -	$ -	$ 71,268,069	45,614	$ 94,171,027		
19	Weighted Average									$ 1,562.42

		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)	1,729	-	-	$ 2,330,294	1,781,644	4,897,003	$ 6,678,647	**0.348917**

		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	$ 55,580,874	$ 989,486	$ -		$ 56,570,360	$ 80,590,850	$ 196,275,736	$ 276,866,586	**0.204324**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 3,838,327	$ -	$ -		$ 3,838,327	$ 9,251,393	$ 95,210	$ 9,346,603	**0.410665**
23	5400 RADIOLOGY-DIAGNOSTIC	$ 10,141,277	$ -	$ -		$ 10,141,277	$ 14,992,334	$ 42,623,359	$ 57,615,693	**0.176016**
24	5700 CT SCAN	$ 1,751,894	$ -	$ -		$ 1,751,894	$ 15,581,227	$ 27,410,024	$ 42,991,251	**0.040750**
25	5800 MRI	$ 854,462	$ -	$ -		$ 854,462	$ 5,742,426	$ 8,262,112	$ 14,004,538	**0.061013**
26	5900 CARDIAC CATHETERIZATION	$ 11,038,941	$ -	$ -		$ 11,038,941	$ 16,509,801	$ 28,977,283	$ 45,487,084	**0.242683**
27	6000 LABORATORY	$ 7,020,585	$ -	$ 5,478		$ 7,026,063	$ 16,262,792	$ 25,322,556	$ 41,585,348	**0.168955**
28	6300 BLOOD STORING PROCESSING & TRANS.	$ 1,397,582	$ -	$ -		$ 1,397,582	$ 1,327,306	$ 363,747	$ 1,691,053	**0.826457**
29	6400 INTRAVENOUS THERAPY	$ 2,681,454	$ -	$ -		$ 2,681,454	$ 4,634,145	$ 18,087,037	$ 22,721,182	**0.118016**
30	6500 RESPIRATORY THERAPY	$ 3,373,233	$ 364,516	$ -		$ 3,737,749	$ 12,250,338	$ 1,715,037	$ 13,965,375	**0.267644**
31	6600 PHYSICAL THERAPY	$ 5,459,500	$ -	$ -		$ 5,459,500	$ 15,822,541	$ 8,934,171	$ 24,756,712	**0.220526**
32	6900 ELECTROCARDIOLOGY	$ 3,702,407	$ 476,397	$ -		$ 4,178,804	$ 12,139,400	$ 11,913,377	$ 24,052,777	**0.173735**
33	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 12,666,103	$ -	$ -		$ 12,666,103	$ 16,753,972	$ 18,513,169	$ 35,267,141	**0.359147**
34	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 10,818,372	$ -	$ -		$ 10,818,372	$ 59,352,269	$ 64,500,092	$ 123,852,361	**0.087349**
35	7300 DRUGS CHARGED TO PATIENTS	$ 15,846,232	$ -	$ -		$ 15,846,232	$ 25,769,522	$ 32,031,318	$ 57,800,840	**0.274152**
36	7600 CARDIOLOGY	$ 998,759	$ 238,198	$ -		$ 1,236,957	$ 1,610,282	$ 10,279,804	$ 11,890,086	**0.104033**
37	9000 CLINIC	$ 634,663	$ -	$ -		$ 634,663	$ -	$ 21,741	$ 21,741	**29.191987**
38	9001 WOUND CARE CENTER	$ 1,413,764	$ -	$ -		$ 1,413,764	$ 15,248	$ 4,583,917	$ 4,599,165	**0.307396**
39	9100 EMERGENCY	$ 11,464,611	$ 401,809	$ -		$ 11,866,420	$ 13,402,120	$ 48,223,486	$ 61,625,606	**0.192557**
126	**Total Ancillary**	$ 160,683,040	$ 2,470,406	$ 5,478		$ 163,158,924	$ 323,789,610	$ 553,030,179	$ 876,819,789	
127	**Weighted Average**									**0.188738**
128	**Sub Totals**	$ 229,060,849	$ 5,360,666	$ 5,478		$ 234,426,993	$ 417,960,637	$ 553,030,179	$ 970,990,816	
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**					**$ 234,426,993**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					**2.34%**				

* 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 (07/01/2022-06/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Inpatient	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Outpatient	% Survey to Cost Report Totals (Includes all payers)
		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 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**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,347.77		1,240		1,228		2,189		4,074		-		2,685		**8,731**		38.24%
2	03100 INTENSIVE CARE UNIT	$ 2,808.05		511		38		1,037		812		-		414		**2,398**		29.10%
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	$ 338.96		396		1,560		-		267		-		133		**2,133**		52.56%
18			**Total Days**	2,057		2,826		3,226		5,153		-		3,232		13,262		37.63%
19	Total Days per PS&R or Exhibit Detail			2,057		2,826		3,226		5,153		-		3,232				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 4,685,398		$ 5,325,629		$ 7,354,973		$ 11,386,161		$ -		$ 7,090,162		**$ 28,752,161**		38.10%
21.01	Calculated Routine Charge Per Diem			$ 2,277.78		$ 1,884.51		$ 2,279.90		$ 2,209.62		$ -		$ 2,193.74		$ 2,168.01		
	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**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.348917	$ 45,199	$ 124,285	$ 51,776	$ 113,943	$ 99,022	$ 259,375	$ 531,675	$ 832,483	$ -	$ -	$ 62,842	$ 301,972	$ 727,672	$ 1,330,086	36.48%
23	5000 OPERATING ROOM		0.204324	$ 2,592,431	$ 3,939,914	$ 1,825,498	$ 3,502,836	$ 6,759,522	$ 8,367,054	$ 8,564,673	$ 16,138,729	$ -	$ -	$ 5,858,671	$ 5,410,682	$ 19,742,125	$ 31,948,533	22.75%
24	5200 DELIVERY ROOM & LABOR ROOM		0.410865	$ 133,672	$ 470	$ 2,400,942	$ 15,030	$ 14,091	$ -	$ 817,526	$ 940	$ -	$ -	$ 146,803	$ 1,729	$ 3,366,631	$ 16,440	37.78%
25	5400 RADIOLOGY-DIAGNOSTIC		0.176016	$ 264,179	$ 658,880	$ 229,850	$ 1,741,670	$ 644,149	$ 980,001	$ 863,401	$ 2,375,748	$ -	$ -	$ 577,035	$ 2,146,850	$ 2,001,579	$ 5,756,299	18.22%
26	5700 CT SCAN		0.040750	$ 392,667	$ 874,185	$ 181,759	$ 1,678,955	$ 1,380,105	$ 1,519,028	$ 1,892,011	$ 2,922,671	$ -	$ -	$ 1,533,283	$ 3,194,385	$ 3,846,562	$ 6,994,839	36.29%
27	5800 MRI		0.081013	$ 174,166	$ 242,143	$ 97,499	$ 292,019	$ 451,324	$ 567,178	$ 701,143	$ 1,060,513	$ -	$ -	$ 570,095	$ 612,110	$ 1,424,132	$ 2,191,853	34.33%
28	5900 CARDIAC CATHETERIZATION		0.242683	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	6000 LABORATORY		0.168955	$ 963,962	$ 863,103	$ 1,000,121	$ 1,538,649	$ 1,469,766	$ 844,795	$ 2,219,241	$ 1,906,998	$ -	$ -	$ 1,430,127	$ 3,718,533	$ 5,653,090	$ 5,153,545	38.43%
30	6300 BLOOD STORING, PROCESSING & TRANS.		0.826457	$ 80,539	$ 12,588	$ 36,767	$ 20,870	$ 136,722	$ 7,548	$ 155,358	$ 38,963	$ -	$ -	$ 111,460	$ 41,169	$ 409,386	$ 79,969	38.40%
31	6400 INTRAVENOUS THERAPY		0.118016	$ 310,315	$ 688,004	$ 124,105	$ 1,005,717	$ 520,662	$ 723,206	$ 616,299	$ 1,680,013	$ -	$ -	$ 436,940	$ 1,722,190	$ 1,571,381	$ 4,096,940	34.54%
32	6500 RESPIRATORY THERAPY		0.267644	$ 783,725	$ 37,866	$ 238,805	$ 100,781	$ 1,069,583	$ 128,142	$ 1,664,168	$ 464,326	$ -	$ -	$ 612,504	$ 157,992	$ 3,756,281	$ 731,115	37.65%
33	6600 PHYSICAL THERAPY		0.220526	$ 301,113	$ 99,180	$ 48,623	$ 803,273	$ 842,310	$ 302,182	$ 1,415,365	$ 711,854	$ -	$ -	$ 675,876	$ 264,499	$ 2,607,411	$ 1,916,489	22.09%
34	6900 ELECTROCARDIOLOGY		0.173735	$ 456,322	$ 299,219	$ 354,825	$ 509,841	$ 2,141,513	$ 1,322,814	$ 2,825,550	$ 2,838,252	$ -	$ -	$ 1,448,276	$ 1,070,036	$ 5,778,210	$ 4,970,126	55.29%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.359147	$ 629,288	$ 360,849	$ 372,036	$ 247,578	$ 1,726,353	$ 837,067	$ 2,264,222	$ 1,397,088	$ -	$ -	$ 1,190,387	$ 704,871	$ 4,991,899	$ 2,842,582	27.60%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.087349	$ 1,153,090	$ 107,726	$ 149,344	$ 475,938	$ 4,607,250	$ 3,220,390	$ 5,444,950	$ 5,100,462	$ -	$ -	$ 1,229,455	$ 803,147	$ 11,354,634	$ 8,904,516	18.00%
37	7300 DRUGS CHARGED TO PATIENTS		0.274152	$ 1,216,033	$ 1,091,749	$ 1,334,500	$ 1,096,619	$ 2,216,891	$ 1,834,006	$ 3,198,834	$ 3,367,685	$ -	$ -	$ 2,264,625	$ 976,980	$ 7,966,258	$ 7,390,059	32.20%
38	7600 CARDIOLOGY		0.104033	$ 195,566	$ 128,237	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 620,690	$ 458,587	$ 195,566	$ 128,237	11.80%
39	9000 CLINIC		29.191987	$ 4,619	$ 4,439	$ -	$ -	$ -	$ -	$ 5,129	$ -	$ -	$ -	$ 6,274	$ -	$ 9,748	$ 4,439	94.11%
40	9001 WOUND CARE CENTER		0.307396	$ -	$ 39,950	$ -	$ -	$ 1,358	$ -	$ -	$ -	$ -	$ -	$ 165	$ 79,948	$ 1,358	$ 39,950	2.64%
41	9100 EMERGENCY		0.192557	$ 647,875	$ 2,658,027	$ 356,976	$ 6,729,625	$ 1,216,263	$ 2,266,552	$ 1,639,171	$ 5,174,174	$ -	$ -	$ 1,073,902	$ 7,893,384	$ 3,860,285	$ 16,828,378	48.24%
				10,344,781	12,230,814	8,803,427	19,873,344	25,296,884	23,179,338	34,819,116	46,040,899	-	-	19,849,410	29,559,064			
	Totals / Payments																	
128	**Total Charges** *(includes organ acquisition from Section J)*			**$ 15,030,179**	**$ 12,230,814**	**$ 14,129,056**	**$ 19,873,344**	**$ 32,651,857**	**$ 23,179,338**	**$ 46,205,277**	**$ 46,040,899**	**$ -**	**$ -**	**$ 26,939,592** (Agrees to Exhibit A)	**$ 29,559,064** (Agrees to Exhibit A)	**$ 108,016,369**	**$ 101,324,395**	27.41%
129	Total Charges per PS&R or Exhibit Detail			$ 15,030,179	$ 12,230,814	$ 14,129,056	$ 19,873,344	$ 32,651,857	$ 23,179,338	$ 46,205,277	$ 46,040,899	$ -	$ -	$ 26,939,592	$ 29,559,064			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**															$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			**$ 5,444,893**	**$ 2,441,702**	**$ 4,652,945**	**$ 3,569,999**	**$ 10,612,518**	**$ 4,155,331**	**$ 14,860,311**	**$ 8,386,075**	**$ -**	**$ -**	**$ 8,864,728**	**$ 5,092,413**	$ 35,570,667	$ 18,553,107	29.08%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 3,605,233	$ 1,866,386	$ -	$ -	$ 176,508	$ 219,490	$ 203,319	$ 256,612	[redacted]	[redacted]			$ 3,985,060	$ 2,342,488	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 3,452,444	$ 2,727,611	$ -	$ -	$ 52,757	$ 90,585					$ 3,505,201	$ 2,818,196	
134	Private Insurance (including primary and third party liability)			$ 22,363	$ 42,415	$ -	$ 12,723	$ -	$ -	$ 1,319,774	$ 1,300,758					$ 1,342,137	$ 1,355,896	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ 9,503	$ 39,670	$ -	$ -	$ 15,715	$ 18,072	$ -	$ -			$ 25,218	$ 57,742	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 3,627,596	$ 1,908,801	$ 3,461,947	$ 2,780,004									[redacted]	[redacted]	
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) (See Note F)			$ -	[redacted]	$ -	[redacted]	$ 7,240,942	$ 3,077,652	$ 597,113	$ 162,389	$ -	[redacted]	$ -	[redacted]	$ 7,838,055	$ 3,240,041	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 8,615,228	$ 5,143,913					$ 8,615,228	$ 5,143,913	
141	Medicare Cross-Over Bad Debt Payments							$ -	$ -	$ -	$ -					$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													$ 119,646	$ 403,498			
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)**			$ 1,817,297	$ 532,901	$ 1,190,998	$ 789,995	$ 3,195,068	$ 858,189	$ 4,056,405	$ 1,413,746	$ -	$ -	$ 8,745,079	$ 4,688,915	$ 10,259,768	$ 3,594,831	
146	**Calculated Payments as a Percentage of Cost**			67%	78%	74%	78%	70%	79%	73%	83%	0%	0%	1%	8%	71%	81%	
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)**							24,418										
148	**Percent of cross-over days to total Medicare days from the cost report**							13%										

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.

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) SAINT MARY'S HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,347.77		13		-		-		-		13	
2	03100 INTENSIVE CARE UNIT	$ 2,808.05		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	$ 338.96		-		-		-		-		-	
18			**Total Days**	19		-		-		-		19	
19	Total Days per PS&R or Exhibit Detail			19		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 41,269		$ -		$ -		$ -		$ 41,269	
21.01	Calculated Routine Charge Per Diem			$ 2,172.05		$ -		$ -		$ -		$ 2,172.05	
	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)		0.348917	-	13,783	-	-	-	-	-	-	$ -	$ 13,783
23	5000 OPERATING ROOM		0.204324	36,719	-	-	-	-	-	-	-	$ 36,719	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.410665	-	-	-	-	-	-	-	-	$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.176016	6,154	12,504	-	-	-	-	-	-	$ 6,154	$ 12,504
26	5700 CT SCAN		0.040750	12,333	21,484	-	-	-	-	-	-	$ 12,333	$ 21,484
27	5800 MRI		0.061013	4,507	5,643	-	-	-	-	-	-	$ 4,507	$ 5,643
28	5900 CARDIAC CATHETERIZATION		0.242683	-	-	-	-	-	-	-	-	$ -	$ -
29	6000 LABORATORY		0.168955	11,460	16,110	-	-	-	-	-	-	$ 11,460	$ 16,110
30	6300 BLOOD STORING, PROCESSING & TRANS.		0.826457	7,302	-	-	-	-	-	-	-	$ 7,302	$ -
31	6400 INTRAVENOUS THERAPY		0.118016	2,653	17,120	-	-	-	-	-	-	$ 2,653	$ 17,120
32	6500 RESPIRATORY THERAPY		0.267644	-	266	-	-	-	-	-	-	$ -	$ 266
33	6600 PHYSICAL THERAPY		0.220526	543	3,256	-	-	-	-	-	-	$ 543	$ 3,256
34	6900 ELECTROCARDIOLOGY		0.173735	18,935	12,522	-	-	-	-	-	-	$ 18,935	$ 12,522
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.359147	5,455	-	-	-	-	-	-	-	$ 5,455	$ -
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.087349	-	-	-	-	-	-	-	-	$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.274152	7,204	4,107	-	-	-	-	-	-	$ 7,204	$ 4,107
38	7600 CARDIOLOGY		0.104033	-	-	-	-	-	-	-	-	$ -	$ -
39	9000 CLINIC		29.191987	-	-	-	-	-	-	-	-	$ -	$ -
40	9001 WOUND CARE CENTER		0.307396	-	-	-	-	-	-	-	-	$ -	$ -
41	9100 EMERGENCY		0.192557	13,060	61,973	-	-	-	-	-	-	$ 13,060	$ 61,973
				126,325	168,768	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			**$ 167,594**	**$ 168,768**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 167,594**	**$ 168,768**
129	Total Charges per PS&R or Exhibit Detail			$ 167,594	$ 168,768	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			**$ 61,875**	**$ 28,996**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 61,875**	**$ 28,996**
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ -	$ 3,376	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 3,376
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E			$ 621	$ 227	$ -	$ -	$ -	$ -	$ -	$ -	$ 621	$ 227
134	Private Insurance (including primary and third party liability)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments			$ 621	$ 3,603	$ -	$ -						
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) (See Note F			$ 14,853		$ -		$ -	$ -	$ -	$ -	$ 14,853	$ -
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)**			$ 46,401	$ 25,393	$ -	$ -	$ -	$ -	$ -	$ -	$ 46,401	$ 25,393
144	**Calculated Payments as a Percentage of Cost**			25%	12%	0%	0%	0%	0%	0%	0%	25%	12%

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&F
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the surve
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payment
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	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 Medicai

Cost Report Year (07/01/2022-06/30/2023) 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)		Included Elsewhere & with Medicaid Secondary)	
							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 (07/01/2022-06/30/2023) 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)*		$ 3,107,059		
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)		$ 5,231,597	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ (2,124,538)		
	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	$ (5,231,597)	-	*(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		$ 3,107,059
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	209,677,126
19	Uninsured Hospital	**Charges Sec. G**	56,498,656
20	Total Hospital	**Charges Sec. G**	970,990,816
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		21.59%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.82%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 670,943
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 180,789
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 851,732**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	61,599,755
27	Uninsured Hospital	**Charges Sec. G**	56,498,656
28	Total Hospital	**Charges Sec. G**	970,990,816
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		6.34%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.82%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 197,112
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 180,789
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 377,901**

** 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.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*

DSH Examination Eligibility Summary

Hospital Name	**SAINT MARY'S HOSPITAL**
Hospital Medicaid Number	**000001823A**
Cost Report Period	From **7/1/2022** To **6/30/2023**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 12,781,843	$ -	$ 12,781,843
2	Hospital Cash Subsidies	Survey F-2	$ 100,000	$ -	$ 100,000
3	Total		$ 12,881,843	$ -	$ 12,881,843
4	Net Hospital Patient Revenue	Survey F-3	$ 244,542,092	$ -	$ 244,542,092
5	Medicaid Fraction		5.27%	0.00%	5.27%
6	Inpatient Charity Care Charges	Survey F-2	$ 18,377,799	$ -	$ 18,377,799
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		$ 18,336,218	$ -	$ 18,336,218
10	Inpatient Hospital Charges	Survey F-3	$ 402,761,623	$ -	$ 402,761,623
11	Inpatient Charity Fraction		4.55%	0.00%	4.55%
12	LIUR		9.82%	0.00%	9.82%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	13,262	-	13,262
14	Out-of-State Medicaid Eligible Days	Survey I	19	-	19
15	Total Medicaid Eligible Days		13,281	-	13,281
16	Total Hospital Days (excludes swing-bed)	Survey F-1	44,190	-	44,190
17	MIUR		30.05%	0.00%	30.05%

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 **7/1/2022** To **6/30/2023**

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	5,393,899	3,605,233	-	22,363	-	-	-	-	-	-	-			3,627,596	1,766,303	67.25%
2	Medicaid Fee for Service	Outpatient	2,440,391	1,866,386	-	42,415	-	-	-	-	-	-	-			1,908,801	531,590	78.22%
3	Medicaid Managed Care	Inpatient	4,602,370	-	3,452,444	-	9,503	-	-	-						3,461,947	1,140,423	75.22%
4	Medicaid Managed Care	Outpatient	3,568,798	-	2,727,611	12,723	39,670	-	-							2,780,004	788,794	77.90%
5	Medicare Cross-over (FFS)	Inpatient	10,522,294	176,508	-	-	-		-	7,240,942	-	-	-			7,417,450	3,104,844	70.49%
6	Medicare Cross-over (FFS)	Outpatient	4,152,596	219,490	-	-	-		-	3,077,652	-	-	-			3,297,142	855,454	79.40%
7	Other Medicaid Eligibles	Inpatient	14,688,728	203,319	52,757	1,319,774	15,715			597,113	8,615,228	-	-			10,803,906	3,884,822	73.55%
8	Other Medicaid Eligibles	Outpatient	8,377,295	256,612	90,585	1,300,758	18,072			162,389	5,143,913	-	-			6,972,329	1,404,966	83.23%
9	Uninsured	Inpatient	8,754,675	-	-	-	-	-	-	-	-	-	-	119,646	-	119,646	8,635,029	1.37%
10	Uninsured	Outpatient	5,089,228	-	-	-	-	-	-	-	-	-	-	403,498	-	403,498	4,685,730	7.93%
11	In-State Sub-total	Inpatient	43,961,966	3,985,060	3,505,201	1,342,137	25,218	-	-	7,838,055	8,615,228	-	-	119,646	-	25,430,545	18,531,421	57.85%
12	In-State Sub-total	Outpatient	23,628,308	2,342,488	2,818,196	1,355,896	57,742	-	-	3,240,041	5,143,913	-	-	403,498	-	15,361,774	8,266,534	65.01%
13	Out-of-State Medicaid	Inpatient	61,345	-	621	-	-	-	-	14,853	-	-	-			15,474	45,871	25.22%
14	Out-of-State Medicaid	Outpatient	28,851	3,376	227	-	-	-	-	-	-	-	-			3,603	25,248	12.49%
15	Sub-Total	I/P and O/P	67,680,470	6,330,924	6,324,245	2,698,033	82,960	-	-	11,092,949	13,759,141	-	-	523,144	-	40,811,396	26,869,074	60.30%

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	50,994	-	-	-	-	-	-	-	-	-	-			-	50,994	-0.63%
2	Medicaid Fee for Service	Outpatient	1,311	-	-	-	-	-	-	-	-	-	-			-	1,311	-0.04%
3	Medicaid Managed Care	Inpatient	50,575	-	-	-	-	-	-	-						-	50,575	-0.82%
4	Medicaid Managed Care	Outpatient	1,201	-	-	-	-	-	-							-	1,201	-0.03%
5	Medicare Cross-over (FFS)	Inpatient	90,224	-	-	-	-		-	-	-	-	-			-	90,224	-0.60%
6	Medicare Cross-over (FFS)	Outpatient	2,735	-	-	-	-		-	-	-	-	-			-	2,735	-0.05%
7	Other Medicaid Eligibles	Inpatient	171,583	-	-	-	-			-	-	-	-			-	171,583	-0.85%
8	Other Medicaid Eligibles	Outpatient	8,780	-	-	-	-			-	-	-	-			-	8,780	-0.09%
9	Uninsured	Inpatient	110,050	-	-	-	-	-	-	-	-	-	-	-	-	-	110,050	-0.02%
10	Uninsured	Outpatient	3,185	-	-	-	-	-	-	-	-	-	-	-	-	-	3,185	0.00%
11	In-State Sub-total	Inpatient	473,426	-	-	-	-	-	-	-	-	-	-	-	-	-	473,426	-0.62%
12	In-State Sub-total	Outpatient	17,212	-	-	-	-	-	-	-	-	-	-	-	-	-	17,212	-0.05%
13	Out-of-State Medicaid	Inpatient	530	-	-	-	-	-	-	-	-	-	-			-	530	-0.22%
14	Out-of-State Medicaid	Outpatient	145	-	-	-	-	-	-	-	-	-	-			-	145	-0.06%
15	Sub-Total	I/P and O/P	491,313	-	-	-	-	-	-	-	-	-	-	-	-	-	491,313	-0.43%
15.01																	851,732	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: SAINT MARY'S HOSPITAL
Hospital Medicaid Number: 000001823A
Cost Report Period: From 7/1/2022 To 6/30/2023
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	5,444,893	3,605,233	-	22,363	-	-	-	-	-	-	-			3,627,596	1,817,297	66.62%
2	Medicaid Fee for Service	Outpatient	2,441,702	1,866,386	-	42,415	-	-	-	-	-	-	-			1,908,801	532,901	78.18%
3	Medicaid Managed Care	Inpatient	4,652,945	-	3,452,444	-	9,503	-	-	-						3,461,947	1,190,998	74.40%
4	Medicaid Managed Care	Outpatient	3,569,999	-	2,727,611	12,723	39,670	-	-							2,780,004	789,995	77.87%
5	Medicare Cross-over (FFS)	Inpatient	10,612,518	176,508	-	-	-		-	7,240,942	-	-	-			7,417,450	3,195,068	69.89%
6	Medicare Cross-over (FFS)	Outpatient	4,155,331	219,490	-	-	-		-	3,077,652	-	-	-			3,297,142	858,189	79.35%
7	Other Medicaid Eligibles	Inpatient	14,860,311	203,319	52,757	1,319,774	15,715			597,113	8,615,228	-	-			10,803,906	4,056,405	72.70%
8	Other Medicaid Eligibles	Outpatient	8,386,075	256,612	90,585	1,300,758	18,072			162,389	5,143,913	-	-			6,972,329	1,413,746	83.14%
9	Uninsured	Inpatient	8,864,725	-	-	-	-	-	-	-	-	-	-	119,646	-	119,646	8,745,079	1.35%
10	Uninsured	Outpatient	5,092,413	-	-	-	-	-	-	-	-	-	-	403,498	-	403,498	4,688,915	7.92%
11	In-State Sub-total	Inpatient	44,435,392	3,985,060	3,505,201	1,342,137	25,218	-	-	7,838,055	8,615,228	-	-	119,646	-	25,430,545	19,004,847	57.23%
12	In-State Sub-total	Outpatient	23,645,520	2,342,488	2,818,196	1,355,896	57,742	-	-	3,240,041	5,143,913	-	-	403,498	-	15,361,774	8,283,746	64.97%
13	Out-of-State Medicaid	Inpatient	61,875	-	621	-	-	-	-	14,853	-	-	-			15,474	46,401	25.01%
14	Out-of-State Medicaid	Outpatient	28,996	3,376	227	-	-	-	-	-	-	-	-			3,603	25,393	12.43%
15	Cost Report Year Sub-Total	I/P and O/P	68,171,783	6,330,924	6,324,245	2,698,033	82,960	-	-	11,092,949	13,759,141	-	-	523,144	-	40,811,396	27,360,387	59.87%
15.01																	851,732	
16																	-	
17																	28,212,119	
18																	473,831	
19																	9,523,408	
20																	18,214,880	

15.01 Provider Tax Assessment Adjustment to UCC Including all Medicaid Eligibles
16 Less: Out of State DSH Payments from Adjusted Survey
17 Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments
18 Less: Non-Medicaid Primary Provider Tax Assessment Adjustment to UCC
19 Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments
20 Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments

Medicaid DSH Survey Adjustments

PROVIDER: SAINT MARY'S HOSPITAL
Mcaid Number: 000001823A
FROM: 7/1/2022 TO: 6/30/2023
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	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Sub-provider Roll-up.	$ 32,352,480.00	$ 8,067,851	$ 40,420,331.00	1505.20
1	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Sub-provider Roll-up.	$ 8,067,851.00	$ (8,067,851)	$ -	1505.20
1	G - CR Data	1	ADULTS & PEDIATRICS	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	Sub-provider Roll-up.	26,433	5,187	31,620	1505.20
1	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	Sub-provider Roll-up.	5,187	(5,187)	-	1505.20
1	G - CR Data	1	ADULTS & PEDIATRICS	9.00	Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)	Sub-provider Roll-up.	$ 36,423,064.00	$ 8,930,413	$ 45,353,477.00	1505.20
1	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)	Sub-provider Roll-up.	$ 8,930,413.00	$ (8,930,413)	$ -	1505.20
2	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to hospital's data.	$ -	$ 3,107,059	$ 3,107,059	N/A
2	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 hospital's data.	$ -	$ 5,231,597	$ 5,231,597	N/A
2	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to hospital's data.	-	(5,231,597)	(5,231,597)	N/A

Medicaid DSH Report Notes

PROVIDER: SAINT MARY'S HOSPITAL
Mcaid Number: 000001823A
FROM: 7/1/2022 TO: 6/30/2023
Mcare Number: 110006

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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