

GA DSH Payment Results for SFY 2026 - Pool 2
DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

5/7/2026 15:40

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 2026 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:	7/1/2025	-	6/30/2026
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	(A)	(B)	(C)	(D)	(E)
	Cost Report Year Begin	Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	7/1/2023	6/30/2024	\$ 10,349,392	\$ 221,049	\$ 10,572,375

Less: 2024 Net UPL Payments	\$ 1,426,081
Less: 2026 Net DPP Payments	\$ 26,847,385
Less: GME Payments	\$ 174,120
Add: Net OP Settlement (Difference between provider submitted and estimated)	\$ 683,781
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	\$ 588,010
Uncompensated Care Allocation Factor	\$ (16,603,420)
Hospital Specific DSH Limit	\$ (17,913,738)
2026 Eligibility	Not Eligible

Note: If the Hospital Specific DSH Limit (i.e. UCC) is negative, the hospital does not qualify for a DSH payment even if the Uncompensated Care Allocation Factor is positive.

DSH Year Low Income Utilization Ratio (LIUR):	22.44%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	33.03%

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 9.02 4/22/2025

D. General Cost Report Year Information 7/1/2023 - 6/30/2024

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

7/1/2023 through 6/30/2024		
X		

2. Select Cost Report Year Covered by this Survey:

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

3a. Date CMS processed the HCRIS file into the HCRIS database: 12/4/2024

	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	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	Yes	
11. Rural Referral Center (Yes or No)	Yes	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.
12. State Name & Number	Florida	007970100
13. State Name & Number	South Carolina	20996894
14. State Name & Number	Tennessee	1871556621
15. State Name & Number	Illinois	58056622301
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2023 - 06/30/2024)

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)	\$	-	
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	Inpatient	Outpatient	Total
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 500,283	\$ 829,243	\$1,329,526
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	\$ 2,220,331	\$ 8,434,199	\$10,654,530
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	\$2,720,614	\$9,263,442	\$11,984,056
	18.39%	8.95%	11.09%
13. Did your hospital receive any Medicaid managed care payments not paid at the claim level? <i>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.</i>		No	
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 (07/01/2023 - 06/30/2024)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 46,935

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	20,915,801
8. Outpatient Hospital Charity Care Charges	20,099,795
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 41,015,596

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			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 110,868,666	\$ -	\$ -	\$ 82,682,752	\$ -	\$ -	\$ 28,185,914
12. Psych Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
13. Rehab. Subprovider	\$ 10,422,242	\$ -	\$ -	\$ 7,772,617	\$ -	\$ -	\$ 2,649,625
14. Swing Bed - SNF	-	-	-	-	-	-	-
15. Swing Bed - NF	-	-	-	-	-	-	-
16. Skilled Nursing Facility	-	-	-	-	-	-	-
17. Nursing Facility	-	-	-	-	-	-	-
18. Other Long-Term Care	-	-	-	-	-	-	-
19. Ancillary Services	\$ 334,166,075	\$ 499,283,335	\$ -	\$ 249,211,718	\$ 372,351,555	\$ -	\$ 211,886,136
20. Outpatient Services	-	\$ 75,234,628	\$ -	-	\$ 56,107,883	\$ -	\$ 19,126,745
21. Home Health Agency	-	-	-	-	-	-	-
22. Ambulance	-	-	-	-	-	-	-
23. Outpatient Rehab Providers	-	-	-	-	-	-	-
24. ASC	-	-	-	-	-	-	-
25. Hospice	-	-	-	-	-	-	-
26. Other	\$ -	\$ 715,535	\$ -	\$ -	\$ 533,626	\$ -	\$ 181,909
27. Total	\$ 455,456,983	\$ 575,233,498	\$ -	\$ 339,667,087	\$ 428,993,064	\$ -	\$ 262,030,330
28. Total Hospital and Non Hospital		Total from Above	\$ 1,030,690,481		Total from Above	\$ 768,660,151	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 1,030,690,481		Total Contractual Adj. (G-3 Line 2)	\$ 768,660,151	
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						768,660,151	
37. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024) 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	\$ 42,151,020	\$ 2,459,939	\$ -	\$ -	\$ 44,610,959	33,687	\$ 64,330,698	\$ 1,324.28
2	03100	INTENSIVE CARE UNIT	\$ 25,569,292	\$ 777,533	\$ -	\$ -	\$ 26,346,825	10,066	\$ 53,834,781	\$ 2,617.41
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	\$ 1,530,145	\$ -	\$ -	\$ -	\$ 1,530,145	4,208	\$ 3,125,429	\$ 363.63
18		Total Routine	\$ 69,250,457	\$ 3,237,472	\$ -	\$ -	\$ 72,487,929	47,961	\$ 121,290,908	
19		Weighted Average								\$ 1,511.40

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio	
20	09200	Observation (Non-Distinct)	1,299	-	\$ 1,720,240	4,390,451	3,087,511	\$ 7,477,962	0.230041

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	\$ 55,637,734	\$ 1,108,355	\$ -	\$ -	\$ 56,746,089	\$ 95,276,890	\$ 205,378,983	\$ 300,655,873	0.188741
22	5200	DELIVERY ROOM & LABOR ROOM	\$ 3,643,623	\$ -	\$ -	\$ -	\$ 3,643,623	\$ 81,505	\$ 58,764	\$ 140,269	25.975968
23	5400	RADIOLOGY-DIAGNOSTIC	\$ 11,233,768	\$ -	\$ -	\$ -	\$ 11,233,768	\$ 18,514,520	\$ 49,815,812	\$ 68,330,332	0.164404
24	5700	CT SCAN	\$ 1,590,142	\$ -	\$ -	\$ -	\$ 1,590,142	\$ 20,330,468	\$ 26,923,936	\$ 47,254,404	0.033651
25	5800	MRI	\$ 767,066	\$ -	\$ -	\$ -	\$ 767,066	\$ 6,958,110	\$ 7,134,038	\$ 14,092,148	0.054432
26	5900	CARDIAC CATHETERIZATION	\$ 11,278,276	\$ -	\$ -	\$ -	\$ 11,278,276	\$ 23,178,328	\$ 33,068,610	\$ 56,246,938	0.200514
27	6000	LABORATORY	\$ 6,875,410	\$ -	\$ 48,874	\$ -	\$ 6,924,284	\$ 16,913,689	\$ 24,995,986	\$ 41,909,675	0.165219
28	6300	BLOOD STORING PROCESSING & TRANS.	\$ 1,377,148	\$ -	\$ -	\$ -	\$ 1,377,148	\$ 1,402,867	\$ 288,177	\$ 1,691,044	0.814377
29	6400	INTRAVENOUS THERAPY	\$ 952,429	\$ -	\$ -	\$ -	\$ 952,429	\$ 4,491,248	\$ 12,406,385	\$ 16,897,633	0.056365
30	6500	RESPIRATORY THERAPY	\$ 3,036,255	\$ 408,306	\$ -	\$ -	\$ 3,444,561	\$ 14,212,829	\$ 1,318,716	\$ 15,531,545	0.221778
31	6600	PHYSICAL THERAPY	\$ 5,546,920	\$ -	\$ -	\$ -	\$ 5,546,920	\$ 18,196,313	\$ 10,227,289	\$ 28,423,602	0.195152
32	6900	ELECTROCARDIOLOGY	\$ 3,989,768	\$ 533,627	\$ -	\$ -	\$ 4,523,395	\$ 13,993,410	\$ 11,235,181	\$ 25,228,591	0.179296
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 10,793,230	\$ -	\$ -	\$ -	\$ 10,793,230	\$ 12,739,732	\$ 10,700,388	\$ 23,440,120	0.460460
34	7200	IMPL. DEV. CHARGED TO PATIENTS	\$ 10,697,783	\$ -	\$ -	\$ -	\$ 10,697,783	\$ 64,121,369	\$ 54,257,024	\$ 118,378,393	0.090369

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2023-06/30/2024)

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	\$ 15,025,884	\$ -	\$ -	\$ 15,025,884	\$ 21,862,709	\$ 40,217,639	\$ 62,080,348	0.242039
36	7600 CARDIOLOGY	\$ 1,294,612	\$ 266,814	\$ -	\$ 1,561,426	\$ 1,892,089	\$ 11,256,408	\$ 13,148,497	0.118753
37	9000 CLINIC	\$ 2,225,001	\$ -	\$ -	\$ 2,225,001	\$ 20,103	\$ 4,646,096	\$ 4,666,199	0.476834
38	9100 EMERGENCY	\$ 11,480,414	\$ 450,080	\$ 34,539	\$ 11,965,033	\$ 15,619,003	\$ 47,471,464	\$ 63,090,467	0.189649
126	Total Ancillary	\$ 157,445,463	\$ 2,767,182	\$ 83,413	\$ 160,296,058	\$ 354,195,633	\$ 554,488,407	\$ 908,684,040	
127	Weighted Average								0.178298
128	Sub Totals	\$ 226,695,920	\$ 6,004,654	\$ 83,413	\$ 232,783,987	\$ 475,486,541	\$ 554,488,407	\$ 1,029,974,948	
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				\$ 232,783,987				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					2.65%			

* 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 (07/01/2023-06/30/2024) 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		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (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		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
				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	\$ 1,324.28		1,457		1,693		2,271		4,008		9		1,339		9,438		33.49%
2	03100 INTENSIVE CARE UNIT	\$ 2,817.41		432		137		1,094		1,873		-		614		3,336		39.31%
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	\$ 363.63		192		274		214		214		-		155		2,680		67.87%
18	Total Days			2,081		4,104		3,365		5,895		9		2,108		15,454		37.74%
19	Total Days per PS&R or Exhibit Detail				2,081	4,104		3,365		5,895		9		2,108				
20	Unreconciled Days (Explain Variance)				-	-		-		-		-		-		-		
21	Routine Charges				\$ 5,109,848	\$ 9,184,778		\$ 8,647,548		\$ 14,825,645		\$ 16,948		\$ 5,318,499		\$ 37,787,819		35.62%
21.01	Calculated Routine Charge Per Diem				\$ 2,455.48	\$ 2,238.01		\$ 2,569.85		\$ 2,514.95		\$ 1,883.11		\$ 2,523.01		\$ 2,443.89		
Ancillary Cost Centers (from WIS 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	Ancillary Charges
22	09200 Observation (Non-District)	\$ 0.230041	\$ 65,218	\$ 145,298	\$ 125,049	\$ 183,409	\$ 171,159	\$ 1,146,307	\$ 929,821	\$ 664,702	\$ -	\$ -	\$ 95,063	\$ 175,331	\$ 1,291,247	\$ 2,139,716	49.54%	
23	5000 OPERATING ROOM	\$ 0.188741	\$ 3,910,969	\$ 3,759,649	\$ 5,271,312	\$ 4,807,329	\$ 7,616,450	\$ 20,816,716	\$ 13,373,554	\$ 20,739,103	\$ -	\$ -	\$ 4,886,089	\$ 4,283,298	\$ 30,172,285	\$ 50,122,697	29.79%	
24	5200 DELIVERY ROOM & LABOR ROOM	\$ 25.975968	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
25	5400 RADIOLOGY-DIAGNOSTIC	\$ 0.164404	\$ 248,539	\$ 672,758	\$ 293,718	\$ 1,590,361	\$ 794,155	\$ 2,281,542	\$ 1,253,894	\$ 2,697,112	\$ 2,499	\$ -	\$ 410,717	\$ 1,804,943	\$ 2,590,106	\$ 7,241,773	17.69%	
26	5700 CT SCAN	\$ 0.033651	\$ 716,217	\$ 757,208	\$ 303,544	\$ 1,489,304	\$ 1,505,939	\$ 3,155,685	\$ 2,423,172	\$ 3,098,633	\$ 3,540	\$ -	\$ 1,209,520	\$ 2,972,508	\$ 4,948,872	\$ 8,500,830	37.51%	
27	5800 MRI	\$ 0.054432	\$ 219,683	\$ 368,733	\$ 131,699	\$ 354,350	\$ 410,202	\$ 1,402,571	\$ 890,943	\$ 1,368,334	\$ -	\$ -	\$ 407,476	\$ 490,497	\$ 1,646,527	\$ 3,493,988	43.65%	
28	5900 CARDIAC CATHETERIZATION	\$ 0.200514	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
29	6000 LABORATORY	\$ 0.165219	\$ 1,065,451	\$ 814,255	\$ 1,288,218	\$ 1,888,468	\$ 1,457,654	\$ 1,582,734	\$ 2,489,909	\$ 1,973,679	\$ 1,470	\$ -	\$ 1,048,137	\$ 2,545,068	\$ 6,281,232	\$ 6,239,136	38.57%	
30	6300 BLOOD STORING PROCESSING & TRANS.	\$ 0.814377	\$ 51,501	\$ 9,754	\$ 48,460	\$ 16,048	\$ 141,576	\$ 41,291	\$ 176,880	\$ 36,850	\$ -	\$ -	\$ 104,966	\$ 12,693	\$ 417,977	\$ 103,943	38.26%	
31	6400 INTRAVENOUS THERAPY	\$ 0.056365	\$ 297,253	\$ 609,476	\$ 137,385	\$ 932,556	\$ 405,618	\$ 1,233,412	\$ 704,850	\$ 1,509,290	\$ 1,682	\$ -	\$ 333,760	\$ 1,562,895	\$ 1,545,106	\$ 4,284,734	45.96%	
32	6500 RESPIRATORY THERAPY	\$ 0.221778	\$ 859,709	\$ 263,240	\$ 453,375	\$ 84,546	\$ 1,350,098	\$ 216,188	\$ 1,997,509	\$ 198,855	\$ -	\$ -	\$ 580,358	\$ 67,104	\$ 4,660,691	\$ 762,829	39.12%	
33	6600 PHYSICAL THERAPY	\$ 0.195152	\$ 379,029	\$ 81,118	\$ 172,403	\$ 1,067,153	\$ 871,789	\$ 782,884	\$ 1,994,443	\$ 857,287	\$ 11,880	\$ -	\$ 364,141	\$ 224,959	\$ 2,981,663	\$ 2,788,442	22.47%	
34	6900 ELECTROCARDIOLOGY	\$ 0.179295	\$ 365,325	\$ 337,965	\$ 494,990	\$ 595,120	\$ 2,208,177	\$ 3,586,903	\$ 3,272,206	\$ 3,477,031	\$ 446	\$ -	\$ 1,230,534	\$ 740,706	\$ 6,338,698	\$ 7,099,019	64.80%	
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 0.460460	\$ 372,115	\$ 52,331	\$ 152,280	\$ 127,695	\$ 1,300,218	\$ 827,738	\$ 2,210,413	\$ 746,620	\$ -	\$ -	\$ 600,105	\$ 272,620	\$ 4,035,026	\$ 1,754,384	28.46%	
36	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 0.090369	\$ 1,828,736	\$ -	\$ 232,970	\$ 247,819	\$ 4,996,426	\$ 5,710,873	\$ 6,994,523	\$ 4,886,395	\$ -	\$ -	\$ 992,830	\$ 279,020	\$ 14,055,655	\$ 10,845,087	22.11%	
37	7300 DRUGS CHARGED TO PATIENTS	\$ 0.242039	\$ 875,256	\$ 1,377,384	\$ 1,241,295	\$ 821,326	\$ 1,876,068	\$ 3,241,951	\$ 3,243,536	\$ 3,673,789	\$ 458	\$ -	\$ 1,102,191	\$ 839,870	\$ 7,236,155	\$ 9,114,450	29.93%	
38	7600 CARDIOLOGY	\$ 0.118753	\$ 159,568	\$ 144,671	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 527,372	\$ 317,446	\$ 155,588	\$ 144,671	8.72%	
39	9000 CLINIC	\$ 0.476834	\$ 4,828	\$ 8,736	\$ 70,226	\$ 14,768	\$ 142	\$ -	\$ 7,702	\$ 109,890	\$ -	\$ -	\$ 8,236	\$ 15,416	\$ 82,898	\$ 133,364	5.14%	
40	9100 EMERGENCY	\$ 0.189649	\$ 697,213	\$ 2,506,586	\$ 348,752	\$ 6,504,942	\$ 1,206,380	\$ 4,596,577	\$ 2,068,761	\$ 5,310,479	\$ 2,466	\$ -	\$ 881,244	\$ 7,056,642	\$ 4,321,106	\$ 18,918,584	49.73%	
				12,047,170	11,888,662	10,778,676	20,725,194	26,310,050	50,622,772	43,611,916	51,348,019	24,431	-	14,782,769	23,661,074			

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

Cost Report Year (07/01/2023-06/30/2024) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)	Uninsured	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)								
Totals / Payments															
128 Total Charges (includes organ acquisition from Section J)	\$ 17,157,018	\$ 11,888,662	\$ 19,963,454	\$ 20,725,194	\$ 34,957,598	\$ 50,622,772	\$ 58,437,561	\$ 51,348,019	\$ 41,379	\$ -	\$ 20,101,268	\$ 23,661,074	\$ 130,515,631	\$ 134,584,647	30.06%
129 Total Charges per PS&R or Exhibit Detail	\$ 17,157,018	\$ 11,888,662	\$ 19,963,454	\$ 20,725,194	\$ 34,957,598	\$ 50,622,772	\$ 58,437,561	\$ 51,348,019	\$ 41,379	\$ -	\$ 20,101,268	\$ 23,661,074			
130 Unreconciled Charges (Explain Variance)															
131.01 Sampling Cost Adjustment (if applicable)															
131.02 Total Calculated Cost (includes organ acquisition from Section J)	\$ 5,215,934	\$ 2,061,015	\$ 5,492,990	\$ 3,513,034	\$ 10,528,625	\$ 8,512,320	\$ 17,601,421	\$ 8,699,467	\$ 15,761	\$ -	\$ 6,075,536	\$ 3,720,100	\$ 38,838,970	\$ 22,785,836	30.76%
132 Total Medicaid Paid Amount (excludes TPL Co-Pay and Spend-Down)	\$ 3,477,000	\$ 2,506,059	\$ -	\$ 1,097	\$ 199,933	\$ 785,101	\$ 217,617	\$ 673,671					\$ 3,894,550	\$ 3,945,928	
133 Total Medicaid Managed Care Paid Amount (excludes TPL Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 4,633,906	\$ 3,617,782	\$ -	\$ -	\$ 112,109	\$ 168,808					\$ 4,746,015	\$ 3,786,590	
134 Private Insurance (including primary and third party liability)	\$ 63,939	\$ 27,021	\$ 1,248	\$ 3,674	\$ -	\$ -	\$ 1,901,441	\$ 1,351,444					\$ 1,966,628	\$ 1,392,139	
135 Self-Pay (including Co-Pay and Spend-Down)	\$ 100	\$ 990	\$ 47	\$ 3,636	\$ -	\$ -	\$ 1,566	\$ 19,240	\$ -	\$ -			\$ 1,713	\$ 23,866	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,541,039	\$ 2,534,070	\$ 4,635,201	\$ 3,626,189											
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)	\$ -	\$ -	\$ -	\$ -	\$ 8,173,181	\$ 6,430,018	\$ 1,056,175	\$ -	\$ 1,929		\$ -		\$ 9,229,356	\$ 6,430,018	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 11,254,894	\$ 5,824,287					\$ 11,254,894	\$ 5,824,287	
141 Medicare Cross-Over Bad Debt Payments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	
142 Other Medicare Cross-Over Payments (See Note D)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -					\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -			\$ 500,283	\$ 829,243	\$ -	\$ -	
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)	\$ 1,674,895	\$ (473,055)	\$ 857,789	\$ (113,155)	\$ 2,155,511	\$ 1,317,201	\$ 3,057,619	\$ 652,017	\$ 13,832	\$ -	\$ 5,575,253	\$ 2,890,857	\$ 7,745,814	\$ 1,383,008	
146 Calculated Payments as a Percentage of Cost	68%	123%	84%	103%	80%	85%	83%	93%	12%	0%	8%	22%	80%	94%	
147 Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. 1, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)							26,313								13%
148 Percent of cross-over days to total Medicare days from the cost report															

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).

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) 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-Over (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 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)
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
03000	ADULTS & PEDIATRICS	\$ 1,324.28		21		19		-		1		41	
03100	INTENSIVE CARE UNIT	\$ 2,617.41		1		6		-		-		7	
03200	CORONARY CARE UNIT	\$ -		-		-		-		-		-	
03300	BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03400	SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
03500	OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
04000	SUBPROVIDER I	\$ -		-		-		-		-		-	
04100	SUBPROVIDER II	\$ -		-		-		-		-		-	
04200	OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
04300	NURSERY	\$ 363.63		-		-		-		-		-	
	Total Days			22		25		-		1		48	
Total Days per PS&R or Exhibit Detail				22		25		-		1		-	
Unreconciled Days (Explain Variance)				-		-		-		-		-	
	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
	Calculated Routine Charge Per Diem			\$ 48,695		\$ 62,706		\$ -		\$ 2,084		\$ 113,485	
				\$ 2,213.41		\$ 2,508.24		\$ -		\$ 2,084.00		\$ 2,364.27	
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
09200	Observation (Non-Distinct)	0.230041		-	328	-	2,788	-	-	-	-	2,788	328
5000	OPERATING ROOM	0.188741		44,001	-	-	-	-	-	-	-	92,412	-
5200	DELIVERY ROOM & LABOR ROOM	25.975968		-	-	-	-	-	-	21,260	-	-	-
5400	RADIOLOGY-DIAGNOSTIC	0.164404		716	11,951	6,780	13,400	-	2,201	4,948	9,697	30,299	-
5700	CT SCAN	0.033651		-	23,269	14,021	31,512	-	-	22,318	14,021	77,089	-
5800	MRI	0.054432		14,293	-	8,003	2,590	-	-	3,392	22,296	5,982	-
5900	CARDIAC CATHETERIZATION	0.200514		-	-	-	-	-	-	-	-	-	-
6000	LABORATORY	0.165219		8,263	13,222	18,633	22,968	-	-	4,796	28,153	40,984	-
6300	BLOOD STORING PROCESSING & TRANS.	0.814377		1,362	-	4,714	-	-	-	1,362	7,438	-	-
6400	INTRAVENOUS THERAPY	0.056365		295	12,868	8,162	12,545	-	-	1,419	9,876	28,849	-
6500	RESPIRATORY THERAPY	0.221778		3,608	1,073	-	282	-	-	-	3,608	1,355	-
6600	PHYSICAL THERAPY	0.195152		8,061	-	2,514	-	-	-	-	10,575	-	-
6900	ELECTROCARDIOLOGY	0.179296		892	3,122	33,564	3,568	-	-	446	34,902	7,582	-
7100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.460460		1,400	-	6,402	-	-	-	49	7,851	-	-
7200	IMPL. DEV. CHARGED TO PATIENTS	0.090369		-	-	-	-	-	-	-	-	-	-
7300	DRUGS CHARGED TO PATIENTS	0.242039		5,694	2,821	23,118	2,577	-	-	3,981	32,793	6,298	-
7600	CARDIOLOGY	0.118753		-	-	-	-	-	-	-	-	-	-
9000	CLINIC	0.476834		-	-	-	142	-	-	-	-	-	142
9100	EMERGENCY	0.189649		2,466	69,737	12,330	80,663	-	-	2,466	24,068	17,262	174,468
				91,051	138,391	168,180	170,245	-	-	34,441	64,750	-	-
Totals / Payments													
Total Charges (includes organ acquisition from Section K)				\$ 139,746	\$ 138,391	\$ 230,886	\$ 170,245	\$ -	\$ -	\$ 36,525	\$ 64,750	\$ 407,157	\$ 373,386
Total Charges per PS&R or Exhibit Detail				\$ 139,746	\$ 138,391	\$ 230,886	\$ 170,245	\$ -	\$ -	\$ 36,525	\$ 64,750	\$ -	\$ -
Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-	-	-
Sampling Cost Adjustment (if applicable)				-	-	-	-	-	-	-	-	-	-
Total Calculated Cost (includes organ acquisition from Section K)				\$ 47,143	\$ 20,439	\$ 73,421	\$ 24,597	\$ -	\$ -	\$ 8,629	\$ 7,677	\$ 129,193	\$ 52,713
Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ -	\$ 4,299	\$ -	\$ 3,356	\$ -	\$ -	\$ -	\$ 1,226	\$ -	\$ 8,881
Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ -	\$ -	\$ 2,886	\$ 9,191	\$ -	\$ -	\$ 77	\$ -	\$ 2,886	\$ 9,268
Private Insurance (including primary and third party liability)				\$ -	\$ -	\$ -	\$ (91)	\$ -	\$ -	\$ 36,259	\$ 1,464	\$ 36,259	\$ 1,373
Self-Pay (including Co-Pay and Spend-Down)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				\$ -	\$ 4,299	\$ 2,886	\$ 12,456	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicaid Cost Settlement Payments (See Note B)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Other Medicaid Payments Reported on Cost Report Year (See Note C)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,651	\$ -	\$ -	\$ 3,651

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2023-06/30/2024) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
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)	\$ 47,143	\$ 16,140	\$ 70,535	\$ 12,141	\$ -	\$ -	\$ (27,630)	\$ 1,259	\$ 90,048	\$ 29,540
144 Calculated Payments as a Percentage of Cost	0%	21%	4%	51%	0%	0%	420%	84%	30%	44%

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).

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

Cost Report Year (07/01/2023-06/30/2024)

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)	Charges
	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	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
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 (07/01/2023-06/30/2024)

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	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0
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 (07/01/2023-06/30/2024) 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)*	\$ 5,302,485	
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)	\$ 5,302,485	- (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	\$ (5,302,485)	- (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	\$ 5,302,485
Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:	
18 Medicaid Eligible*** Charges Sec. G	265,922,200
19 Uninsured Hospital Charges Sec. G	43,762,342
20 Total Hospital Charges Sec. G	1,029,974,948
21 Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	25.82%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	4.25%
23 Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***	\$ 1,369,012
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 225,296
25 Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***	\$ 1,594,308
Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:	
26 Medicaid Primary*** Charges Sec. G	70,413,596
27 Uninsured Hospital Charges Sec. G	43,803,721
28 Total Hospital Charges Sec. G	1,029,974,948
29 Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***	6.84%
30 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	4.25%
31 Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***	\$ 362,501
32 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 225,509
33 Medicaid Primary Tax Assessment Adjustment to DSH UCC***	\$ 588,010

* 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	7/1/2023	To	6/30/2024

		As-Reported	Adjustments	As-Adjusted	
LIUR					
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	\$ 16,494,682	\$ -	\$ 16,494,682
2	Hospital Cash Subsidies	Survey F-2	\$ 100,000	\$ -	\$ 100,000
3	Total		\$ 16,594,682	\$ -	\$ 16,594,682
4	Net Hospital Patient Revenue	Survey F-3	\$ 262,030,330	\$ -	\$ 262,030,330
5	Medicaid Fraction		6.33%	0.00%	6.33%
6	Inpatient Charity Care Charges	Survey F-2	\$ 20,915,801	\$ -	\$ 20,915,801
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		\$ 20,871,612	\$ -	\$ 20,871,612
10	Inpatient Hospital Charges	Survey F-3	\$ 455,456,983	\$ -	\$ 455,456,983
11	Inpatient Charity Fraction		4.58%	0.00%	4.58%
12	LIUR		10.91%	0.00%	10.91%
MIUR					
13	In-State Medicaid Eligible Days	Survey H	15,454	-	15,454
14	Out-of-State Medicaid Eligible Days	Survey I	48	-	48
15	Total Medicaid Eligible Days		15,502	-	15,502
16	Total Hospital Days (excludes swing-bed)	Survey F-1	46,935	-	46,935
17	MIUR		33.03%	0.00%	33.03%

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 **7/1/2023** To **6/30/2024**

As-Reported:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E		
1 Medicaid Fee for Service	Inpatient	5,145,909	3,477,000	-	63,939	100	-	-	-	-	-	-	-	-	3,541,039	1,604,870	68.81%
2 Medicaid Fee for Service	Outpatient	2,059,811	2,506,059	-	27,021	990	-	-	-	-	-	-	-	-	2,534,070	(474,259)	123.02%
3 Medicaid Managed Care	Inpatient	5,411,215	-	4,633,906	1,248	47	-	-	-	-	-	-	-	-	4,635,201	776,014	85.66%
4 Medicaid Managed Care	Outpatient	3,511,515	1,097	3,617,782	3,674	3,636	-	-	-	-	-	-	-	-	3,626,189	(114,674)	103.27%
5 Medicare Cross-over (FFS)	Inpatient	10,418,903	199,933	-	-	-	-	-	8,173,181	-	-	-	-	-	8,373,114	2,045,789	80.36%
6 Medicare Cross-over (FFS)	Outpatient	8,502,824	765,101	-	-	-	-	-	6,430,018	-	-	-	-	-	7,195,119	1,307,705	84.62%
7 Other Medicaid Eligibles	Inpatient	17,402,577	217,617	112,109	1,901,441	1,566	-	-	1,056,175	11,254,894	-	-	-	-	14,543,802	2,858,775	83.57%
8 Other Medicaid Eligibles	Outpatient	8,693,961	673,671	168,808	1,361,444	19,240	-	-	-	5,824,287	-	-	-	-	8,047,450	646,511	92.56%
9 Uninsured	Inpatient	6,026,223	-	-	-	-	-	-	1,929	-	-	-	500,283	-	502,212	5,524,011	8.33%
10 Uninsured	Outpatient	3,718,648	-	-	-	-	-	-	-	-	-	-	829,243	-	829,243	2,889,405	22.30%
11 In-State Sub-total	Inpatient	44,404,827	3,894,550	4,746,015	1,966,828	1,713	-	-	9,231,285	11,254,894	-	-	500,283	-	31,595,368	12,809,459	71.15%
12 In-State Sub-total	Outpatient	26,486,759	3,945,928	3,786,590	1,392,139	23,866	-	-	6,430,018	5,824,287	-	-	829,243	-	22,232,071	4,254,688	83.94%
13 Out-of-State Medicaid	Inpatient	127,215	-	2,886	36,259	-	-	-	-	-	-	-	-	-	39,145	88,070	30.77%
14 Out-of-State Medicaid	Outpatient	52,710	8,881	9,268	1,373	-	-	-	-	3,651	-	-	-	-	23,173	29,537	43.96%
15 Sub-Total	I/P and O/P	71,071,511	7,849,359	8,544,759	3,396,399	25,579	-	-	15,661,303	17,082,832	-	-	1,329,526	-	53,889,757	17,181,754	75.82%

Adjustments:		A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Service Type		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)
		1 Medicaid Fee for Service	Inpatient	70,025	-	-	-	-	-	-	-	-	-	-	-	-	-
2 Medicaid Fee for Service	Outpatient	1,204	-	-	-	-	-	-	-	-	-	-	-	-	-	1,204	-0.07%
3 Medicaid Managed Care	Inpatient	81,775	-	-	-	-	-	-	-	-	-	-	-	-	-	81,775	-1.28%
4 Medicaid Managed Care	Outpatient	1,519	-	-	-	-	-	-	-	-	-	-	-	-	-	1,519	-0.04%
5 Medicare Cross-over (FFS)	Inpatient	109,722	-	-	-	-	-	-	-	-	-	-	-	-	-	109,722	-0.84%
6 Medicare Cross-over (FFS)	Outpatient	9,496	-	-	-	-	-	-	-	-	-	-	-	-	-	9,496	-0.09%
7 Other Medicaid Eligibles	Inpatient	198,844	-	-	-	-	-	-	-	-	-	-	-	-	-	198,844	-0.94%
8 Other Medicaid Eligibles	Outpatient	5,506	-	-	-	-	-	-	-	-	-	-	-	-	-	5,506	-0.06%
9 Uninsured	Inpatient	65,074	-	-	-	-	-	-	-	-	-	-	-	-	-	65,074	-0.09%
10 Uninsured	Outpatient	1,452	-	-	-	-	-	-	-	-	-	-	-	-	-	1,452	-0.01%
11 In-State Sub-total	Inpatient	525,440	-	-	-	-	-	-	-	-	-	-	-	-	-	525,440	-0.83%
12 In-State Sub-total	Outpatient	19,177	-	-	-	-	-	-	-	-	-	-	-	-	-	19,177	-0.06%
13 Out-of-State Medicaid	Inpatient	1,978	-	-	-	-	-	-	-	-	-	-	-	-	-	1,978	-0.47%
14 Out-of-State Medicaid	Outpatient	3	-	-	-	-	-	-	-	-	-	-	-	-	-	3	0.00%
15 Sub-Total	I/P and O/P	546,598	-	-	-	-	-	-	-	-	-	-	-	-	-	546,598	-0.58%
15.01																1,594,308	

DSH Examination UCC Cost & Payment Summary Georgia

Hospital Name: SAINT MARY'S HOSPITAL
 Hospital Medicaid Number: 000001823A
 Cost Report Period: From 7/1/2023 To 6/30/2024

As-Adjusted:	Service Type	A													M	N	O	P
		Total Costs	Medicaid Basic Rate Payments	Medicaid Managed Care Payments	Private Insurance Payments	Self-Pay Payments (Includes Co-Pay and Spenddown)	Medicaid Cost Settlement Payments	Other Medicaid Payments (Outliers, etc.) **	Medicare Traditional (non-HMO) Payments	Medicare Managed Care (HMO) Payments	Medicare Cross-over Bad Debt	Other Medicare Cross-over Payments (GME, etc.)	Uninsured Payments	Uninsured Payments Not On Exhibit B (1011 Payments)	Total Payments (Col. B through Col. M)	Uncomp. Care Costs (Col. A - Col. N)	Payment to Cost Ratio (Col. N / Col. A)	
		Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey H & I	Survey E				
1	Medicaid Fee for Service	Inpatient	5,215,934	3,477,000	-	63,939	100	-	-	-	-	-	-	-	3,541,039	1,674,895	67.89%	
2	Medicaid Fee for Service	Outpatient	2,061,015	2,506,059	-	27,021	990	-	-	-	-	-	-	-	2,534,070	(473,055)	122.95%	
3	Medicaid Managed Care	Inpatient	5,492,990	-	4,633,906	1,248	47	-	-	-	-	-	-	-	4,635,201	857,789	84.38%	
4	Medicaid Managed Care	Outpatient	3,513,034	1,097	3,617,782	3,674	3,636	-	-	-	-	-	-	-	3,626,189	(113,155)	103.22%	
5	Medicare Cross-over (FFS)	Inpatient	10,528,625	199,933	-	-	-	-	-	-	-	-	-	-	8,373,114	2,155,511	79.53%	
6	Medicare Cross-over (FFS)	Outpatient	8,512,320	765,101	-	-	-	-	8,173,181	-	-	-	-	-	7,195,119	1,317,201	84.53%	
7	Other Medicaid Eligibles	Inpatient	17,601,421	217,617	112,109	1,901,441	1,566	-	1,056,175	11,254,894	-	-	-	-	14,543,802	3,057,619	82.63%	
8	Other Medicaid Eligibles	Outpatient	8,699,467	673,671	168,808	1,361,444	19,240	-	-	5,824,287	-	-	-	-	8,047,450	652,017	92.51%	
9	Uninsured	Inpatient	6,091,297	-	-	-	-	-	1,929	-	-	-	500,283	-	502,212	5,589,085	8.24%	
10	Uninsured	Outpatient	3,720,100	-	-	-	-	-	-	-	-	-	829,243	-	829,243	2,890,857	22.29%	
11	In-State Sub-total	Inpatient	44,930,267	3,894,550	4,746,015	1,966,628	1,713	-	-	9,231,285	11,254,894	-	-	500,283	-	31,595,368	13,334,899	70.32%
12	In-State Sub-total	Outpatient	26,505,936	3,945,928	3,786,590	1,392,139	23,866	-	-	6,430,018	5,824,287	-	-	829,243	-	22,232,071	4,273,865	83.88%
13	Out-of-State Medicaid	Inpatient	129,193	-	2,886	36,259	-	-	-	-	-	-	-	-	39,145	90,048	30.30%	
14	Out-of-State Medicaid	Outpatient	52,713	8,881	9,268	1,373	-	-	-	3,651	-	-	-	-	23,173	29,540	43.96%	
15	Cost Report Year Sub-Total	I/P and O/P	71,618,109	7,849,359	8,544,759	3,396,399	25,579	-	-	15,661,303	17,082,832	-	-	1,329,526	-	53,889,757	17,728,352	75.25%
15.01																	1,594,308	
16																	-	
17																	19,322,660	
18																	1,006,298	
19																	7,155,977	
20																	11,160,385	

Medicaid DSH Survey Adjustments

PROVIDER: SAIN MARY'S HOSPITAL
FROM: 7/1/2023

TO: 6/30/2024

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	G - CR Data	1	ADULTS & PEDIATRICS	3.00	Total Allowable Cost	Adjusted for sub-provider roll up.	\$ 33,482,421.00	\$ 8,668,599	\$ 42,151,020.00	1405.20
1	G - CR Data	8	SUBPROVIDER II	3.00	Total Allowable Cost	Adjusted for sub-provider roll up.	\$ 8,668,599.00	\$ (8,668,599)	\$ -	1405.20
1	G - CR Data	1	ADULTS & PEDIATRICS	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjusted for sub-provider roll up.	28,155	5,532	33,687	1405.20
1	G - CR Data	8	SUBPROVIDER II	8.00	Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others	Adjusted for sub-provider roll up.	5,532	(5,532)	-	1405.20
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)	Adjusted for sub-provider roll up.	\$ 53,908,456.00	\$ 10,422,242	\$ 64,330,698.00	1405.20
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)	Adjusted for sub-provider roll up.	\$ 10,422,242.00	\$ (10,422,242)	\$ -	1405.20
2	L - FRA	1	Hospital Gross Provider Tax Assessment (from general ledger)*	2.00	Dollar Amount	Adjust to hospital's data.	\$ -	\$ 5,302,485	\$ 5,302,485	1705
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.	\$ -	\$ 5,302,485	\$ 5,302,485	1705
2	L - FRA	8	A-8 Adjustment	2.00	Dollar Amount	Adjust to hospital's data.	-	(5,302,485)	(5,302,485)	1705

Medicaid DSH Report Notes

PROVIDER: SAINT MARY'S HOSPITAL

Mcaid Number: 000001823A

FROM: 7/1/2023 TO: 6/30/2024

Mcare Number: 110006

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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