State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: ST. JOSEPH HOSPITAL SAVANNAH

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	07/01/2016	06/30/2017
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	000001801A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110043

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	8/30/1946

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

Wilfredo A. Negron, M.D.
Nhi Phan, M.D.

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
6. Is the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017** *(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)*	$ 472,358

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CFO Title	12/5/18 Date
Greg Schaack Hospital CEO or CFO Printed Name	912-819-6162 Hospital CEO or CFO Telephone Number	schaackg@sjchs.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Greg Schaack
Title	CFO
Telephone Number	912-819-6162
E-Mail Address	schaackg@sjchs.org
Mailing Street Address	11705 Mercy Blvd
Mailing City, State, Zip	Savannah, GA 31419

Outside Preparer:

Name	Bert Bennett
Title:	Partner
Firm Name:	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bbennett@draffin-tucker.com

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 7/1/2016 - 6/30/2017

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

1. Select Your Facility from the Drop-Down Menu Provided:	ST. JOSEPH HOSPITAL SAVANNAH		
	7/1/2016 through 6/30/2017		
2. Select Cost Report Year Covered by this Survey (enter "X"):	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:	12/20/2017		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ST. JOSEPH HOSPITAL SAVANNAH	Yes	
5. Medicaid Provider Number:	000001801A	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:	110043	Yes	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
8b. DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	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		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (07/01/2016 - 06/30/2017)

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)	$ 18,745	$ 216,959	$235,704
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,641,287	$ 5,195,248	$6,836,535
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$1,660,032	$5,412,207	$7,072,239
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	1.13%	4.01%	3.33%

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 (07/01/2016 - 06/30/2017)

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, 15, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	59,348 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	29,643,075
8.	Outpatient Hospital Charity Care Charges	27,814,785
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 57,457,860

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$93,029,829.00			$ 72,550,779	$ -	$ -	$ 20,479,050
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$2,879,370.00			$ 2,245,522	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$500,794,945.00	$291,507,299.00		$ 390,552,834	$ 227,336,563	$ -	$ 174,412,846
20.	Outpatient Services		$45,601,130.00			$ 35,562,760	$ -	$ 10,038,370
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$0.00	$ -	$ -	$ -	$ -
27.	Total	$ 593,824,774	$ 337,108,429	$ 2,879,370	$ 463,103,613	$ 262,899,324	$ 2,245,522	$ 204,930,266
28.	Total Hospital and Non Hospital		Total from Above	$ 933,812,573		Total from Above	$ 728,248,459	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	933,812,573	Total Contractual Adj. (G-3 Line 2)	730,902,454
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)			+	
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)			-	(2,653,995)
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)"			-	
35.	Adjusted Contractual Adjustments				728,248,459

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total 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	$ 30,442,739	$ -	$ -	$0.00	$ 30,442,739	48,767	$54,052,224.00		$ 624.25
2	03100 INTENSIVE CARE UNIT	$ 9,275,883	$ -	$ -		$ 9,275,883	6,894	$23,267,265.00		$ 1,345.50
3	03200 CORONARY CARE UNIT	$ 7,164,886	$ -	$ -		$ 7,164,886	4,911	$16,417,821.00		$ 1,458.95
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ -	$ -	$ -		$ -	-	$0.00		$ -
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 46,883,508	$ -	$ -	$ -	$ 46,883,508	60,572	$ 93,737,310		
19	Weighted Average									$ 774.01

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	1,224	-	-	$ 764,082	$66,008.00	$1,069,043.00	$ 1,135,051	0.673170

Line #			*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	$20,080,404.00	$ -	$13,699.00		$ 20,094,103	$83,850,332.00	$40,656,884.00	$ 124,507,216	0.161389
22	5100	RECOVERY ROOM	$2,977,767.00	$ -	$0.00		$ 2,977,767	$9,355,667.00	$5,465,333.00	$ 14,821,000	0.200915
23	5300	ANESTHESIOLOGY	$1,401,457.00	$ -	$0.00		$ 1,401,457	$18,677,875.00	$11,660,346.00	$ 30,338,221	0.046194
24	5400	RADIOLOGY-DIAGNOSTIC	$7,167,389.00	$ -	$0.00		$ 7,167,389	$22,667,236.00	$39,125,016.00	$ 61,792,252	0.115992
25	5700	CT SCAN	$1,719,338.00	$ -	$0.00		$ 1,719,338	$21,434,090.00	$34,006,084.00	$ 55,440,174	0.031012
26	5800	MRI	$667,377.00	$ -	$0.00		$ 667,377	$6,971,860.00	$7,411,070.00	$ 14,382,930	0.046401
27	6000	LABORATORY	$8,526,816.00	$ -	$0.00		$ 8,526,816	$49,626,356.00	$17,088,846.00	$ 66,715,202	0.127809
28	6500	RESPIRATORY THERAPY	$4,006,794.00	$ -	$0.00		$ 4,006,794	$20,750,890.00	$511,728.00	$ 21,262,618	0.188443
29	6600	PHYSICAL THERAPY	$3,525,773.00	$ -	$0.00		$ 3,525,773	$11,032,899.00	$6,245,438.00	$ 17,278,337	0.204057
30	6700	OCCUPATIONAL THERAPY	$1,118,627.00	$ -	$0.00		$ 1,118,627	$5,675,368.00	$882,397.00	$ 6,557,765	0.170581

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report*	RCE and Therapy Add-Back (If Applicable)		Total 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
31	6800	SPEECH PATHOLOGY	$336,298.00	$ -	$0.00		$ 336,298	$2,462,711.00	$53,897.00	$ 2,516,608	0.133631
32	6900	ELECTROCARDIOLOGY	$4,599,708.00	$ -	$6,353.00		$ 4,606,061	$26,824,708.00	$41,765,900.00	$ 68,590,608	0.067153
33	7000	ELECTROENCEPHALOGRAPHY	$1,158,670.00	$ -	$0.00		$ 1,158,670	$1,712,318.00	$4,576,010.00	$ 6,288,328	0.184257
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$23,325,443.00	$ -	$0.00		$ 23,325,443	$30,152,588.00	$15,563,678.00	$ 45,716,266	0.510222
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$38,996,692.00	$ -	$0.00		$ 38,996,692	$95,836,543.00	$38,823,000.00	$ 134,659,543	0.289595
36	7300	DRUGS CHARGED TO PATIENTS	$21,303,443.00	$ -	$0.00		$ 21,303,443	$87,524,974.00	$18,569,752.00	$ 106,094,726	0.200796
37	7400	RENAL DIALYSIS	$1,442,255.00	$ -	$0.00		$ 1,442,255	$5,745,375.00	$982,459.00	$ 6,727,834	0.214371
38	9100	EMERGENCY	$8,661,868.00	$ -	$0.00		$ 8,661,868	$10,853,458.00	$32,959,879.00	$ 43,813,337	0.197699
39	9300	WOUND CARE	$1,249,699.00	$ -	$7,537.00		$ 1,257,236	$492,322.00	$8,065,555.00	$ 8,557,877	0.146910
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total 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
91		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 152,265,818	$ -	$ 27,589		$ 152,293,407	$ 511,713,578	$ 325,482,315	$ 837,195,893	
127	**Weighted Average**									0.182822
128	**Sub Totals**	$ 199,149,326	$ -	$ 27,589		$ 199,176,915	$ 605,450,888	$ 325,482,315	$ 930,933,203	
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)*					$0.00				
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)*					$384,229.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 198,792,686				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%				

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

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

Cost Report Year (07/01/2016-06/30/2017) | ST. JOSEPH HOSPITAL SAVANNAH

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 624.25		1,365		298		3,044		2,881		2,324		7,566		21.36%
2	03100 INTENSIVE CARE UNIT	$ 1,345.50		1,642		95		682		568		380		2,947		48.61%
3	03200 CORONARY CARE UNIT	$ 1,458.95		370		54		259		279		262		956		24.62%
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	$ -						-		-		-		-		
11		$ -						-		-		-		-		
12		$ -						-		-		-		-		
13		$ -						-		-		-		-		
14		$ -						-		-		-		-		
15		$ -						-		-		-		-		
16		$ -						-		-		-		-		
17		$ -						-		-		-		-		
18			Total Days	3,377		407		3,985		3,722		2,966		11,491		24.33%
19	Total Days per PS&R or Exhibit Detail			3,377		407		3,985		3,722		2,966				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			Routine Charges $ 6,064,033		Routine Charges $ 699,042		Routine Charges $ 7,704,095		Routine Charges $ 6,169,483		Routine Charges $ 4,739,186		Routine Charges $ 20,636,623		27.47%
21.01	Calculated Routine Charge Per Diem			$ 1,795.68		$ 1,717.55		$ 1,933.27		$ 1,657.57		$ 1,597.84		$ 1,795.69		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.573170	48,126	63,972	-	16,348	335	84,551	2,605	29,322	1,160	44,300	$ 51,066	$ 196,193	26.09%
23	5000 OPERATING ROOM		0.161389	3,012,645	1,190,207	681,754	817,339	6,274,424	3,170,604	2,767,643	659,259	2,490,843	1,140,205	$ 12,736,666	$ 5,837,409	16.01%
24	5100 RECOVERY ROOM		0.200915	302,576	174,467	85,709	131,523	717,443	371,590	279,440	99,752	235,514	159,066	$ 1,385,268	$ 773,332	17.44%
25	5300 ANESTHESIOLOGY		0.046194	568,742	317,508	145,449	262,304	1,373,345	636,014	598,962	163,907	497,772	303,406	$ 2,686,519	$ 1,573,733	18.80%
26	5400 RADIOLOGY-DIAGNOSTIC		0.115992	900,221	670,005	119,816	869,882	1,975,238	2,925,031	1,168,435	427,412	1,073,369	2,365,670	$ 4,163,710	$ 4,892,330	20.44%
27	5700 CT SCAN		0.031012	1,030,400	750,880	207,257	1,090,156	1,607,111	2,341,398	888,729	348,118	1,487,462	4,344,959	$ 4,833,497	$ 4,530,542	25.83%
28	5800 MRI		0.046401	332,934	162,404	87,665	168,835	546,189	436,674	302,419	102,685	533,378	201,237	$ 1,269,267	$ 871,596	20.09%
29	6000 LABORATORY		0.127609	3,198,677	678,551	347,408	513,710	4,333,810	1,263,735	3,175,609	417,743	2,732,808	2,345,350	$ 11,055,504	$ 2,971,739	26.88%
30	6500 RESPIRATORY THERAPY		0.186443	1,901,445	24,034	157,533	24,509	1,946,596	47,585	1,562,748	5,985	888,470	88,634	$ 5,568,324	$ 102,113	31.37%
31	6600 PHYSICAL THERAPY		0.204057	284,676	17,917	24,576	47,663	576,318	212,009	586,149	134,677	181,479	277,800	$ 1,451,719	$ 412,266	14.07%
32	6700 OCCUPATIONAL THERAPY		0.170581	106,053	8,021	3,541	6,227	184,231	20,315	392,777	19,475	90,389	21,177	$ 656,602	$ 54,038	12.97%
33	6800 SPEECH PATHOLOGY		0.133631	132,440	507	5,011	-	157,761	3,248	219,859	2,032	106,560	391	$ 505,871	$ 5,787	25.03%
34	6900 ELECTROCARDIOLOGY		0.067153	740,111	678,424	132,830	390,200	1,896,569	3,047,912	961,924	269,001	1,646,248	783,346	$ 3,731,434	$ 4,385,537	15.54%
35	7000 ELECTROENCEPHALOGRAPHY		0.184257	81,130	98,675	45,472	280,181	126,525	171,926	119,405	79,433	46,200	35,506	$ 352,532	$ 630,215	17.34%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.510222	853,186	307,795	154,306	283,354	2,161,605	1,193,205	846,150	184,128	629,475	302,008	$ 4,015,247	$ 1,968,486	15.08%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.289595	2,291,623	791,335	806,209	342,973	6,547,336	3,823,541	2,083,784	290,223	1,245,744	1,095,296	$ 11,728,952	$ 5,248,072	14.11%
38	7300 DRUGS CHARGED TO PATIENTS		0.200796	5,417,440	1,347,106	753,963	476,518	7,117,226	2,017,807	5,538,750	309,991	4,500,032	1,095,296	$ 18,827,379	$ 4,151,424	27.35%
39	7400 RENAL DIALYSIS		0.214371	469,230	-	18,513	-	752,002	400,675	921,393	59,795	142,821	10,410	$ 2,151,138	$ 460,470	41.31%
40	9100 EMERGENCY		0.197999	320,404	1,198,256	123,878	2,247,284	896,564	2,443,770	614,896	480,647	980,366	7,042,916	$ 1,955,742	$ 6,369,957	38.00%
41	9300 WOUND CARE		0.146919	-	-	11,675	68,522	50,010	99,210	58,343	123,711	34,641	199,724	$ 120,028	$ 291,443	7.55%
42														$ -	$ -	
43														$ -	$ -	
44														$ -	$ -	
45														$ -	$ -	
46														$ -	$ -	
47														$ -	$ -	
48														$ -	$ -	
49														$ -	$ -	
50														$ -	$ -	
51														$ -	$ -	
52														$ -	$ -	
53														$ -	$ -	
54														$ -	$ -	
55														$ -	$ -	
56														$ -	$ -	
57														$ -	$ -	
58														$ -	$ -	
59														$ -	$ -	
60														$ -	$ -	
61														$ -	$ -	
62														$ -	$ -	
63														$ -	$ -	
64														$ -	$ -	
65														$ -	$ -	
66														$ -	$ -	
67														$ -	$ -	
68														$ -	$ -	
69														$ -	$ -	
70														$ -	$ -	
71														$ -	$ -	
72														$ -	$ -	
73														$ -	$ -	
74														$ -	$ -	
75														$ -	$ -	
76														$ -	$ -	
77														$ -	$ -	
78														$ -	$ -	
79														$ -	$ -	
80														$ -	$ -	
81														$ -	$ -	
82														$ -	$ -	

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

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

Line	Description			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		
83			-											$ -	$ -	
84			-											$ -	$ -	
85			-											$ -	$ -	
86			-											$ -	$ -	
87			-											$ -	$ -	
88			-											$ -	$ -	
89			-											$ -	$ -	
90			-											$ -	$ -	
91			-											$ -	$ -	
92			-											$ -	$ -	
93			-											$ -	$ -	
94			-											$ -	$ -	
95			-											$ -	$ -	
96			-											$ -	$ -	
97			-											$ -	$ -	
98			-											$ -	$ -	
99			-											$ -	$ -	
100			-											$ -	$ -	
101			-											$ -	$ -	
102			-											$ -	$ -	
103			-											$ -	$ -	
104			-											$ -	$ -	
105			-											$ -	$ -	
106			-											$ -	$ -	
107			-											$ -	$ -	
108			-											$ -	$ -	
109			-											$ -	$ -	
110			-											$ -	$ -	
111			-											$ -	$ -	
112			-											$ -	$ -	
113			-											$ -	$ -	
114			-											$ -	$ -	
115			-											$ -	$ -	
116			-											$ -	$ -	
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 21,972,159	$ 8,478,070	$ 3,912,565	$ 8,140,528	$ 39,240,641	$ 24,910,790	$ 23,131,040	$ 4,203,296	$ 19,764,731	$ 21,316,720			
	Totals / Payments															
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 28,036,162	$ 8,478,070	$ 4,611,607	$ 8,140,528	$ 46,944,736	$ 24,910,790	$ 29,300,523	$ 4,203,296	$ 24,503,917 **(Agrees to Exhibit A)**	$ 21,316,720 **(Agrees to Exhibit A)**	$ 108,893,028	$ 45,732,684	21.80%
129	Total Charges per PS&R or Exhibit Detail			$ 28,036,162	$ 8,478,070	$ 4,611,607	$ 8,140,528	$ 46,944,736	$ 24,910,790	$ 29,300,523	$ 4,203,296	$ 24,503,917	$ 21,316,720			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 7,631,402	$ 1,446,838	$ 1,088,818	$ 1,290,995	$ 10,735,840	$ 4,272,892	$ 7,141,002	$ 702,631	$ 5,636,324	$ 3,073,035	$ 26,596,862	$ 7,713,356	21.93%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 6,559,836	$ 1,204,434	$ -	$ 170	$ 823,950	$ 207,244	$ 301,117	$ 19,380			$ 7,684,903	$ 1,431,228	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 975,410	$ 948,613	$ -	$ -	$ 2,216	$ 12,752			$ 977,626	$ 961,365	
134	Private Insurance (including primary and third party liability)			$ 101,971	$ 7,626	$ -	$ 2,107	$ 2,623	$ 4,050	$ 463,433	$ 383,224			$ 568,027	$ 397,009	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ 2,666	$ 53	$ 1,568	$ -	$ -	$ 647	$ 2,606			$ 700	$ 6,840	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 6,661,807	$ 1,214,728	$ 975,463	$ 952,458									
137	Medicaid Cost Settlement Payments (See Note B)			$ -	$ (17,151)	$ -	$ -							$ -	$ (17,151)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)			$ -		$ -	$ -							$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)							$ 8,238,496	$ 3,584,102	$ 4,060,095	$ 224,903			$ 12,298,591	$ 3,809,005	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 1,272,705	$ 107,919			$ 1,272,705	$ 107,919	
141	Medicare Cross-Over Bad Debt Payments							$ 116,324	$ 199,700			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 116,324	$ 199,700	
142	Other Medicare Cross-Over Payments (See Note D)							$ 107,681	$ 9,651	$ 41,060	$ 363			$ 148,741	$ 10,014	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 18,745	$ 216,959			
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)**			$ 969,585	$ 249,261	$ 113,155	$ 338,537	$ 1,445,766	$ 268,145	$ 999,729	$ (48,516)	$ 5,617,579	$ 2,856,076	$ 3,529,245	$ 807,427	
146	**Calculated Payments as a Percentage of Cost**			87%	83%	90%	74%	87%	94%	86%	107%	0%	7%	87%	90%	
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)**							40,160								
148	**Percent of cross-over days to total Medicare days from the cost report**							10%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 624.25		251								251	
2	03100 INTENSIVE CARE UNIT	$ 1,345.50		24								24	
3	03200 CORONARY CARE UNIT	$ 1,458.95		6								6	
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	$ -										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	281		-		-		-		281	
19	Total Days per PS&R or Exhibit Detail			281		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
21	Routine Charges			Routine Charges $ 374,351		Routine Charges $ -		Routine Charges $ -		Routine Charges $ -		Routine Charges $ 374,351	
21.01	Calculated Routine Charge Per Diem			$ 1,332.21								$ 1,332.21	
	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)		0.673170	-	3,458							$ -	$ 3,458
23	5000 OPERATING ROOM		0.161389	171,317	44,835							$ 171,317	$ 44,835
24	5100 RECOVERY ROOM		0.200915	26,071	5,199							$ 26,071	$ 5,199
25	5300 ANESTHESIOLOGY		0.046194	36,024	10,749							$ 36,024	$ 10,749
26	5400 RADIOLOGY-DIAGNOSTIC		0.115992	55,631	78,792							$ 55,631	$ 78,792
27	5700 CT SCAN		0.031012	45,514	134,809							$ 45,514	$ 134,809
28	5800 MRI		0.046401	12,689	-							$ 12,689	$ -
29	6000 LABORATORY		0.127809	148,405	81,178							$ 148,405	$ 81,178
30	6500 RESPIRATORY THERAPY		0.168443	20,867	1,122							$ 20,867	$ 1,122
31	6600 PHYSICAL THERAPY		0.204057	35,937	61,749							$ 35,937	$ 61,749
32	6700 OCCUPATIONAL THERAPY		0.170581	24,408	4,164							$ 24,408	$ 4,164
33	6800 SPEECH PATHOLOGY		0.133631	11,278	-							$ 11,278	$ -
34	6900 ELECTROCARDIOLOGY		0.067153	46,124	57,507							$ 46,124	$ 57,507
35	7000 ELECTROENCEPHALOGRAPHY		0.184257	2,106	23,763							$ 2,106	$ 23,763
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.510222	39,555	12,624							$ 39,555	$ 12,624
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.289595	212,201	4,163							$ 212,201	$ 4,163
38	7300 DRUGS CHARGED TO PATIENTS		0.200796	406,860	37,800							$ 406,860	$ 37,800
39	7400 RENAL DIALYSIS		0.214371	4,380	-							$ 4,380	$ -
40	9100 EMERGENCY		0.197699	35,348	253,502							$ 35,348	$ 253,502
41	9300 WOUND CARE		0.146910	-	-							$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

			Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
81		-									$ -	$ -
82		-									$ -	$ -
83		-									$ -	$ -
84		-									$ -	$ -
85		-									$ -	$ -
86		-									$ -	$ -
87		-									$ -	$ -
88		-									$ -	$ -
89		-									$ -	$ -
90		-									$ -	$ -
91		-									$ -	$ -
92		-									$ -	$ -
93		-									$ -	$ -
94		-									$ -	$ -
95		-									$ -	$ -
96		-									$ -	$ -
97		-									$ -	$ -
98		-									$ -	$ -
99		-									$ -	$ -
100		-									$ -	$ -
101		-									$ -	$ -
102		-									$ -	$ -
103		-									$ -	$ -
104		-									$ -	$ -
105		-									$ -	$ -
106		-									$ -	$ -
107		-									$ -	$ -
108		-									$ -	$ -
109		-									$ -	$ -
110		-									$ -	$ -
111		-									$ -	$ -
112		-									$ -	$ -
113		-									$ -	$ -
114		-									$ -	$ -
115		-									$ -	$ -
116		-									$ -	$ -
117		-									$ -	$ -
118		-									$ -	$ -
119		-									$ -	$ -
120		-									$ -	$ -
121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
	Totals / Payments		$ 1,334,715	$ 825,624	$ -	$ -	$ -	$ -	$ -	$ -		
128	**Total Charges (includes organ acquisition from Section K)**		$ 1,709,066	$ 825,624	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,709,066	$ 825,624
129	Total Charges per PS&R or Exhibit Detail		$ 1,709,066	$ 825,624	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 451,383	$ 122,621	$ -	$ -	$ -	$ -	$ -	$ -	$ 451,383	$ 122,621
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 212,854	$ 73,651							$ 212,854	$ 73,651
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 10,000							$ -	$ 10,000
134	Private Insurance (including primary and third party liability)		$ 13,075	$ 683							$ 13,075	$ 683
135	Self-Pay (including Co-Pay and Spend-Down)			$ 10,587							$ -	$ 10,587
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		$ 225,929	$ 94,921	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)										$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)										$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
141	Medicare Cross-Over Bad Debt Payments										$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)										$ -	$ -
143	**Calculated Payment Shortfall / (Longfall)**		$ 225,454	$ 27,700	$ -	$ -	$ -	$ -	$ -	$ -	$ 225,454	$ 27,700
144	**Calculated Payments as a Percentage of Cost**		50%	77%	0%	0%	0%	0%	0%	0%	50%	77%

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

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

Cost Report Year (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

		Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
Organ Acquisition Cost Centers (list below):																
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		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 H 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 (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

		Total Organ Acquisition Cost	Additional Add-in Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4 Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
Organ Acquisition Cost Centers (list below):														
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	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 I 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 (07/01/2016-06/30/2017) ST. JOSEPH HOSPITAL SAVANNAH

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 2,653,995		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	001.5515.4000	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ———>)	The provider tax is included in Contracutal Adjustments and not reported on W/S A.	$ 2,653,995		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Added to expense through A-8(41) for cost report purposes	$ 2,653,995	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(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*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 2,653,995		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	$ -

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