State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

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	07/01/2019	06/30/2020	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	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.

	DSH Examination Year (07/01/19 - 06/30/20)
During the DSH Examination Year:	
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	8/30/1946

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 786,753
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2019 - 06/30/2020** — $ 786,753

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	11/9/21 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

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D. General Cost Report Year Information 7/1/2019 - 6/30/2020

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

	7/1/2019 through 6/30/2020		
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: 12/3/2020

	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	

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: (07/01/2019 - 06/30/2020)

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)	$ 85,231	$ 466,804	$552,035
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,112,317	$ 7,489,221	$9,601,538
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)	$2,197,548	$7,956,025	$10,153,573
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	3.88%	5.87%	5.44%

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 (07/01/2019 - 06/30/2020)

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)	60,327 **(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	34,198,385
8.	Outpatient Hospital Charity Care Charges	33,282,634
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 67,481,019

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	$112,430,949.00			$ 88,316,348	$ -	$ -	$ 24,114,601
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			$8,611,703.00			$ 6,764,633	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$506,715,706.00	$465,680,920.00		$ 398,033,470	$ 365,799,974	$ -	$ 208,563,182
20.	Outpatient Services		$78,152,994.00			$ 61,390,454	$ -	$ 16,762,540
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	$ 619,146,655	$ 543,833,914	$ 8,611,703	$ 486,349,818	$ 427,190,429	$ 6,764,633	$ 249,440,322
28.	Total Hospital and Non Hospital		Total from Above	$ 1,171,592,272		Total from Above	$ 920,304,880	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,171,592,272	Total Contractual Adj. (G-3 Line 2)		922,961,515
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)				-	2,656,635
35.	Adjusted Contractual Adjustments					920,304,880
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) 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	$ 39,488,419	$ -	$ -	$0.00	$ 39,488,419	53,235	$67,722,974.00		$ 741.78
2	03100 INTENSIVE CARE UNIT	$ 9,869,202	$ -	$ -		$ 9,869,202	6,428	$25,501,296.00		$ 1,535.35
3	03200 CORONARY CARE UNIT	$ 8,187,667	$ -	$ -		$ 8,187,667	4,553	$17,379,509.00		$ 1,798.30
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	$ 57,545,288	$ -	$ -	$ -	$ 57,545,288	64,216	$ 110,603,779		
19	Weighted Average									$ 896.12

Line #	Observation Data (Non-Distinct)		*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
20	09200	Observation (Non-Distinct)	3,889	-	-	$ 2,884,782	$82,309.00	$3,829,438.00	$ 3,911,747	0.737466

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	$24,021,455.00	$ -	$0.00		$ 24,021,455	$93,882,816.00	$75,067,495.00	$ 168,950,311	0.142181
22	5100	RECOVERY ROOM	$4,320,851.00	$ -	$0.00		$ 4,320,851	$9,443,316.00	$8,678,601.00	$ 18,121,917	0.238432
23	5300	ANESTHESIOLOGY	$1,485,935.00	$ -	$0.00		$ 1,485,935	$18,938,972.00	$20,402,330.00	$ 39,341,302	0.037770
24	5400	RADIOLOGY-DIAGNOSTIC	$11,438,911.00	$ -	$15,440.00		$ 11,454,351	$23,946,722.00	$66,448,973.00	$ 90,395,695	0.126713
25	5700	CT SCAN	$2,097,128.00	$ -	$0.00		$ 2,097,128	$25,867,805.00	$56,367,647.00	$ 82,235,452	0.025502
26	5800	MRI	$732,841.00	$ -	$0.00		$ 732,841	$6,188,580.00	$13,714,730.00	$ 19,903,310	0.036820
27	6000	LABORATORY	$9,358,676.00	$ -	$5,185.00		$ 9,363,861	$53,571,578.00	$27,959,912.00	$ 81,531,490	0.114850
28	6500	RESPIRATORY THERAPY	$4,598,325.00	$ -	$2,223.00		$ 4,600,548	$22,004,624.00	$850,799.00	$ 22,855,423	0.201289
29	6600	PHYSICAL THERAPY	$4,268,712.00	$ -	$0.00		$ 4,268,712	$13,557,345.00	$11,496,599.00	$ 25,053,944	0.170381

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) 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
30	6700	OCCUPATIONAL THERAPY	$1,256,278.00	$ -	$0.00		$ 1,256,278	$7,142,999.00	$1,523,000.00	$ 8,665,999	0.144966
31	6800	SPEECH PATHOLOGY	$361,574.00	$ -	$0.00		$ 361,574	$2,704,860.00	$147,081.00	$ 2,851,941	0.126782
32	6900	ELECTROCARDIOLOGY	$4,546,764.00	$ -	$4,399.00		$ 4,551,163	$32,951,500.00	$61,149,930.00	$ 94,101,430	0.048364
33	7000	ELECTROENCEPHALOGRAPHY	$953,530.00	$ -	$0.00		$ 953,530	$1,680,041.00	$4,241,085.00	$ 5,921,126	0.161039
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$25,756,975.00	$ -	$0.00		$ 25,756,975	$24,324,430.00	$19,504,541.00	$ 43,828,971	0.587670
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$42,501,944.00	$ -	$0.00		$ 42,501,944	$89,168,415.00	$59,090,118.00	$ 148,258,533	0.286675
36	7300	DRUGS CHARGED TO PATIENTS	$20,136,039.00	$ -	$0.00		$ 20,136,039	$79,777,927.00	$27,596,857.00	$ 107,374,784	0.187530
37	7400	RENAL DIALYSIS	$1,898,074.00	$ -	$0.00		$ 1,898,074	$7,106,570.00	$1,488,560.00	$ 8,595,130	0.220831
38	9100	EMERGENCY	$12,059,915.00	$ -	$0.00		$ 12,059,915	$21,134,494.00	$53,671,798.00	$ 74,806,292	0.161215
39	9300	WOUND CARE	$1,135,200.00	$ -	$6,909.00		$ 1,142,109	$680,946.00	$9,949,372.00	$ 10,630,318	0.107439
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) 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
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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**	$ 172,929,127	$ -	$ 34,156		$ 172,963,283	$ 534,156,249	$ 523,178,866	$ 1,057,335,115	
127		**Weighted Average**									0.166313
128		**Sub Totals**	$ 230,474,415	$ -	$ 34,156		$ 230,508,571	$ 644,760,028	$ 523,178,866	$ 1,167,938,894	
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)*					$241,298.00				
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**					$ 230,267,273				
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 (07/01/2019-06/30/2020) 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	$ 741.78		1,818		327		3,875		2,318		2,704		8,338		22.60%
2	03100 INTENSIVE CARE UNIT	$ 1,535.35		1,771		55		641		358		327		2,825		49.38%
3	03200 CORONARY CARE UNIT	$ 1,798.30		312		25		364		180		263		881		25.74%
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**	3,901		407		4,880		2,856		3,294		12,044		24.14%
19	Total Days per PS&R or Exhibit Detail			3,901		407		4,880		2,856		3,294				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 7,735,566		$ 760,880		$ 9,160,479		$ 5,286,729		$ 6,003,339		$ 22,943,654		26.49%
21.01	Calculated Routine Charge Per Diem			$ 1,982.97		$ 1,869.48		$ 1,877.15		$ 1,851.10		$ 1,822.51		$ 1,904.99		
	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)		0.737466	33,562	126,071	-	39,559	6,720	502,922	4,709	161,603	-	196,516	$ 44,991	$ 830,155	27.66%
23	5000 OPERATING ROOM		0.142181	4,186,766	1,902,237	818,775	1,811,672	6,713,395	6,275,271	2,790,213	1,621,444	2,985,321	2,981,451	$ 14,509,149	$ 11,610,624	19.04%
24	5100 RECOVERY ROOM		0.238432	335,045	154,457	73,385	229,694	622,418	562,660	264,298	156,317	360,721	283,620	$ 1,295,146	$ 1,103,128	16.83%
25	5300 ANESTHESIOLOGY		0.037770	695,316	365,671	163,022	497,083	1,418,017	1,247,100	558,924	342,209	631,590	863,724	$ 2,835,279	$ 2,452,063	17.28%
26	5400 RADIOLOGY-DIAGNOSTIC		0.126713	1,307,169	1,006,209	170,580	1,589,142	1,838,095	4,779,752	1,029,381	1,130,034	1,285,874	3,761,430	$ 4,345,225	$ 8,505,137	19.98%
27	5700 CT SCAN		0.025502	1,534,841	1,382,385	261,271	1,742,819	1,949,821	3,622,033	999,003	877,619	2,099,912	6,420,734	$ 4,744,936	$ 7,624,856	25.66%
28	5800 MRI		0.036820	351,549	294,049	45,760	317,189	371,794	763,714	215,011	251,690	507,794	511,812	$ 984,114	$ 1,626,642	18.29%
29	6000 LABORATORY		0.114850	4,134,932	993,598	445,021	1,207,764	4,406,114	1,960,459	2,662,328	624,548	3,327,877	3,454,175	$ 11,648,395	$ 4,786,369	28.81%
30	6500 RESPIRATORY THERAPY		0.201289	2,022,299	150,263	78,203	27,031	2,063,362	244,220	1,268,527	37,690	790,686	90,141	$ 5,432,391	$ 459,204	30.13%
31	6600 PHYSICAL THERAPY		0.170381	433,640	65,758	35,477	375,686	684,810	452,121	307,096	524,559	247,781	325,599	$ 1,461,023	$ 1,418,124	13.81%
32	6700 OCCUPATIONAL THERAPY		0.144966	122,331	15,462	9,848	120,216	205,113	61,404	86,785	53,246	73,943	68,787	$ 424,077	$ 250,328	9.45%
33	6800 SPEECH PATHOLOGY		0.126782	150,443	1,138	5,068	1,567	188,488	14,159	110,757	2,401	61,462	5,031	$ 454,756	$ 19,265	19.11%
34	6900 ELECTROCARDIOLOGY		0.048364	1,275,208	783,490	107,559	429,223	2,055,563	4,261,489	819,251	756,873	1,885,573	1,856,508	$ 4,257,581	$ 6,231,075	15.18%
35	7000 ELECTROENCEPHALOGRAPHY		0.161039	83,987	112,474	11,142	427,796	91,480	176,583	78,669	112,001	44,693	86,488	$ 265,278	$ 828,854	20.75%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.587670	918,624	277,318	156,787	293,562	1,705,605	1,487,182	614,164	451,494	829,368	363,314	$ 3,395,180	$ 2,509,556	16.22%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.286675	2,160,063	1,006,854	638,310	637,242	5,995,310	4,339,758	1,865,236	1,118,096	1,523,236	1,086,451	$ 10,658,919	$ 7,101,950	13.75%
38	7300 DRUGS CHARGED TO PATIENTS		0.187530	6,664,104	1,351,652	650,211	569,743	6,427,794	1,951,998	3,405,462	616,516	4,379,620	1,635,487	$ 17,147,571	$ 4,489,909	26.00%
39	7400 RENAL DIALYSIS		0.220831	352,916	-	19,923	2,057	910,459	522,485	669,809	77,613	85,129	30,737	$ 1,953,107	$ 602,155	31.49%
40	9100 EMERGENCY		0.161215	824,763	1,499,461	230,457	3,830,435	1,762,480	3,522,799	1,051,424	1,224,713	1,893,745	10,764,253	$ 3,869,124	$ 10,077,408	36.16%
41	9300 WOUND CARE		0.107439	-	-	12,054	242,414	88,806	1,221,489	76,563	187,225	17,395	109,786	$ 177,423	$ 1,651,128	18.41%
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (07/01/2019-06/30/2020) ST. JOSEPH HOSPITAL SAVANNAH

				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		%
61			-											$ -	$ -	
62			-											$ -	$ -	
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
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126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 27,587,558	$ 11,488,547	$ 3,932,853	$ 14,391,894	$ 39,505,643	$ 37,969,597	$ 18,877,610	$ 10,327,891	$ 23,031,720	$ 34,896,044			

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

Cost Report Year (07/01/2019-06/30/2020) ST. JOSEPH HOSPITAL SAVANNAH

	Totals / Payments	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		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 35,323,124	$ 11,488,547	$ 4,693,733	$ 14,391,894	$ 48,666,122	$ 37,969,597	$ 24,164,339	$ 10,327,891	$ 29,035,059 (Agrees to Exhibit A)	$ 34,896,044 (Agrees to Exhibit A)	$ 112,847,319	$ 74,177,929	21.67%
129	Total Charges per PS&R or Exhibit Detail	$ 35,323,124	$ 11,488,547	$ 4,693,733	$ 14,391,894	$ 48,666,122	$ 37,969,597	$ 24,164,339	$ 10,327,891	$ 29,035,059	$ 34,896,044			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 9,260,185	$ 1,748,432	$ 1,063,867	$ 2,039,294	$ 11,597,909	$ 6,065,778	$ 5,793,201	$ 1,742,277	$ 6,522,119	$ 4,498,555	$ 27,715,162	$ 11,595,781	22.04%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 7,425,649	$ 1,653,965			$ 916,642	$ 300,244	$ 156,182	$ 42,712			$ 8,498,473	$ 1,996,921	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 891,318	$ 1,742,009	$ -	$ -	$ 2,530	$ 29,643			$ 893,848	$ 1,771,652	
134	Private Insurance (including primary and third party liability)	$ 118,523	$ 2,745		$ 23,535	$ 1,091	$ 852	$ 986,443	$ 547,221			$ 1,106,057	$ 574,353	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 225	$ 2,853	$ 5,273	$ 8,098	$ 488	$ 3,272		$ 5,259			$ 5,986	$ 19,482	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,544,397	$ 1,659,563	$ 896,591	$ 1,773,642									
137	Medicaid Cost Settlement Payments (See Note B)		$ (139,571)									$ -	$ (139,571)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				$ 201							$ -	$ 201	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 7,783,090	$ 4,694,503	$ 2,372,241	$ 458,723			$ 10,155,331	$ 5,153,226	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,269,730	$ 477,513			$ 1,269,730	$ 477,513	
141	Medicare Cross-Over Bad Debt Payments					$ 36,702	$ 185,969			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 36,702	$ 185,969	
142	Other Medicare Cross-Over Payments (See Note D)					$ (1,910)	$ (9,184)	$ (354)	$ (121)			$ (2,264)	$ (9,305)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 85,231	$ 466,804			
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)**	$ 1,715,788	$ 228,440	$ 167,276	$ 265,451	$ 2,861,806	$ 890,122	$ 1,006,429	$ 181,327	$ 6,436,888	$ 4,031,751	$ 5,751,299	$ 1,565,340	
146	**Calculated Payments as a Percentage of Cost**	81%	87%	84%	87%	75%	85%	83%	90%	1%	10%	79%	87%	
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)**					40,614								
148	**Percent of cross-over days to total Medicare days from the cost report**					12%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&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 (07/01/2019-06/30/2020) 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	$ 741.78								111		111	
2	03100 INTENSIVE CARE UNIT	$ 1,535.35								22		22	
3	03200 CORONARY CARE UNIT	$ 1,798.30								28		28	
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**	-		-		-		161		161	
19	Total Days per PS&R or Exhibit Detail			-		-		-		161			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 355,496		$ 355,496	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 2,208.05		$ 2,208.05	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.737466							1,198	9,054	$ 1,198	$ 9,054
23	5000 OPERATING ROOM		0.142181							55,550	22,635	$ 55,550	$ 22,635
24	5100 RECOVERY ROOM		0.238432							6,135	2,045	$ 6,135	$ 2,045
25	5300 ANESTHESIOLOGY		0.037770							6,930	8,520	$ 6,930	$ 8,520
26	5400 RADIOLOGY-DIAGNOSTIC		0.126713							53,291	110,083	$ 53,291	$ 110,083
27	5700 CT SCAN		0.025502							44,457	169,758	$ 44,457	$ 169,758
28	5800 MRI		0.036820							7,401	2,487	$ 7,401	$ 2,487
29	6000 LABORATORY		0.114850							146,472	127,451	$ 146,472	$ 127,451
30	6500 RESPIRATORY THERAPY		0.201289							109,935	3,024	$ 109,935	$ 3,024
31	6600 PHYSICAL THERAPY		0.170381							7,904	593	$ 7,904	$ 593
32	6700 OCCUPATIONAL THERAPY		0.144966							1,984	-	$ 1,984	$ -
33	6800 SPEECH PATHOLOGY		0.126782							4,472	-	$ 4,472	$ -
34	6900 ELECTROCARDIOLOGY		0.048364							14,763	36,334	$ 14,763	$ 36,334
35	7000 ELECTROENCEPHALOGRAPHY		0.161039							-	3,526	$ -	$ 3,526
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.587670							8,972	2,835	$ 8,972	$ 2,835
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.286675							6,133	13,142	$ 6,133	$ 13,142
38	7300 DRUGS CHARGED TO PATIENTS		0.187530							222,113	41,807	$ 222,113	$ 41,807
39	7400 RENAL DIALYSIS		0.220831							32,912	2,868	$ 32,912	$ 2,868
40	9100 EMERGENCY		0.161215							82,862	360,639	$ 82,862	$ 360,639
41	9300 WOUND CARE		0.107439							-	1,722	$ -	$ 1,722
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2019-06/30/2020) 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	
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			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2019-06/30/2020) 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ 813,484	$ 918,523		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,168,980	$ 918,523	$ 1,168,980	$ 918,523
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,168,980	$ 918,523		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 296,309	$ 118,979	$ 296,309	$ 118,979
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)							$ 268,912	$ 92,986	$ 268,912	$ 92,986
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)								$ 668	$ -	$ 668
134	Private Insurance (including primary and third party liability)								$ 5,173	$ -	$ 5,173
135	Self-Pay (including Co-Pay and Spend-Down)							$ 25	$ 6,300	$ 25	$ 6,300
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 27,372	$ 13,852	$ 27,372	$ 13,852
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	91%	88%	91%	88%

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.

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 (07/01/2019-06/30/2020) 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)*		$ 2,656,635		
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 ---------->)		$ 2,656,635		
	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*	Addback	$ 2,656,635	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		$ 2,656,635		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	189,112,751
19	Uninsured Hospital	**Charges Sec. G**	63,931,103
20	Total Hospital	**Charges Sec. G**	1,167,938,894
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		16.19%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.47%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** 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.*