State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	07/01/2020	06/30/2021
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 Qualifying Information

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

	DSH Examination Year (07/01/20 - 06/30/21)
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 07/01/2020 - 06/30/2021** — $ 1,045,986
   (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 07/01/2020 - 06/30/2021** — $ -
   (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 Services07/01/2020 - 06/30/2021** — $ 1,045,986

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	Title	Date
	CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Allen Butcher	912-819-6162	butcheral@sjchs.org

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

Hospital Contact:

Name	Allen Butcher
Title	CFO
Telephone Number	912-819-6162
E-Mail Address	butcheral@sjchs.org
Mailing Street Address	5353 Reynolds St.,
Mailing City, State, Zip	Savannah, GA 31405

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 7/1/2020 - 6/30/2021

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		
	7/1/2020 through 6/30/2021		
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):	5 - Amended		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/22/2022		

	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	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
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: (07/01/2020 - 06/30/2021

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)	$ 966,069	$ 719,424	$1,685,493
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,755,497	$ 8,640,908	$10,396,405
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)	$2,721,566	$9,360,332	$12,081,898
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	35.50%	7.69%	13.95%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
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 (07/01/2020 - 06/30/2021)

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)	65,052 (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	26,993,503
8.	Outpatient Hospital Charity Care Charges	27,848,858
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 54,842,361

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	$125,827,712.00			$ 98,290,894	$ -	$ -	$ 27,536,818
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			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$497,495,869.00	$557,329,726.00		$ 388,621,178	$ 435,360,670	$ -	$ 230,843,747
20.	Outpatient Services		$81,005,428.00			$ 63,277,761	$ -	$ 17,727,667
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	$ 623,323,581	$ 638,335,154	$ -	$ 486,912,072	$ 498,638,431	$ -	$ 276,108,232
28.	Total Hospital and Non Hospital		Total from Above	$ 1,261,658,735		Total from Above	$ 985,550,503	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,261,658,735	Total Contractual Adj. (G-3 Line 2)		987,766,155
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)				-	2,215,652
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					985,550,503
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) | 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	$ 42,745,938	$ -	$ -	$0.00	$ 42,745,938	58,778	$80,364,290.00		$ 727.24
2	03100 INTENSIVE CARE UNIT	$ 10,487,001	$ -	$ -		$ 10,487,001	5,492	$26,772,123.00		$ 1,909.50
3	03200 CORONARY CARE UNIT	$ 8,795,234	$ -	$ -		$ 8,795,234	4,942	$19,972,581.00		$ 1,779.69
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	$ 62,028,173	$ -	$ -	$ -	$ 62,028,173	69,212	$ 127,108,994		
19	Weighted Average									$ 896.20

		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)	4,160	-	-	$ 3,025,318	$89,972.00	$4,049,942.00	$ 4,139,914	0.730768

Line #	Cost Center Description	*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	$24,983,902.00	$ -	$ -		$ 24,983,902	$80,516,580.00	$93,652,111.00	$ 174,168,691	0.143447
22	5100 RECOVERY ROOM	$4,484,376.00	$ -	$ -		$ 4,484,376	$8,406,162.00	$10,905,649.00	$ 19,311,811	0.232209
23	5300 ANESTHESIOLOGY	$1,488,939.00	$ -	$ -		$ 1,488,939	$16,587,636.00	$23,204,636.00	$ 39,792,272	0.037418
24	5400 RADIOLOGY-DIAGNOSTIC	$12,128,342.00	$ -	$ 16,984		$ 12,145,326	$31,802,087.00	$91,928,912.00	$ 123,730,999	0.098159
25	5700 CT SCAN	$2,172,265.00	$ -	$ -		$ 2,172,265	$28,007,048.00	$63,125,416.00	$ 91,132,464	0.023836
26	5800 MRI	$766,049.00	$ -	$ -		$ 766,049	$6,541,610.00	$13,802,564.00	$ 20,344,174	0.037654
27	6000 LABORATORY	$9,384,195.00	$ -	$ 1,580		$ 9,385,775	$58,556,763.00	$26,605,922.00	$ 85,162,685	0.110210
28	6500 RESPIRATORY THERAPY	$4,922,845.00	$ -	$ 1,933		$ 4,924,778	$25,548,257.00	$633,679.00	$ 26,181,936	0.188098
29	6600 PHYSICAL THERAPY	$4,799,813.00	$ -	$ -		$ 4,799,813	$13,694,884.00	$16,161,649.00	$ 29,856,533	0.160763
30	6700 OCCUPATIONAL THERAPY	$1,077,520.00	$ -	$ -		$ 1,077,520	$6,329,634.00	$1,343,319.00	$ 7,672,953	0.140431
31	6800 SPEECH PATHOLOGY	$383,627.00	$ -	$ -		$ 383,627	$2,803,933.00	$173,252.00	$ 2,977,185	0.128856

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) | 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
32	6900	ELECTROCARDIOLOGY	$4,395,655.00	$ -	$ 1,281		$ 4,396,936	$33,667,000.00	$64,172,384.00	$ 97,839,384	0.044940
33	7000	ELECTROENCEPHALOGRAPHY	$1,000,279.00	$ -	$ -		$ 1,000,279	$868,450.00	$3,761,917.00	$ 4,630,367	0.216026
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$27,889,087.00	$ -	$ -		$ 27,889,087	$20,856,706.00	$23,465,712.00	$ 44,322,418	0.629232
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$44,076,539.00	$ -	$ -		$ 44,076,539	$71,598,628.00	$81,298,010.00	$ 152,896,638	0.288277
36	7300	DRUGS CHARGED TO PATIENTS	$21,737,589.00	$ -	$ -		$ 21,737,589	$85,652,348.00	$31,313,494.00	$ 116,965,842	0.185846
37	7400	RENAL DIALYSIS	$1,885,708.00	$ -	$ -		$ 1,885,708	$6,591,711.00	$1,328,986.00	$ 7,920,697	0.238073
38	9100	EMERGENCY	$13,769,589.00	$ -	$ -		$ 13,769,589	$20,824,410.00	$53,455,219.00	$ 74,279,629	0.185375
39	9300	WOUND CARE	$1,299,424.00	$ -	$ 7,537		$ 1,306,961	$771,035.00	$10,452,114.00	$ 11,223,149	0.116452
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2020-06/30/2021) | 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
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 182,645,743	$ -	$ 29,315		$ 182,675,058	$ 519,714,854	$ 614,834,887	$ 1,134,549,741	
127	**Weighted Average**									0.163678
128	**Sub Totals**	$ 244,673,916	$ -	$ 29,315		$ 244,703,231	$ 646,823,848	$ 614,834,887	$ 1,261,658,735	
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)*					$0.00				
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**					$ 244,703,231				
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 (07/01/2020-06/30/2021 | St. Joseph Hospital Savannah

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 727.24		2,229		519		4,928		3,444		2,616		11,120		25.57%
2	03100 INTENSIVE CARE UNIT	$ 1,909.50		1,919		37		421		476		456		2,853		61.14%
3	03200 CORONARY CARE UNIT	$ 1,779.69		307		13		299		311		389		930		27.07%
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**	4,455		569		5,648		4,231		3,461		14,903		26.96%
19	Total Days per PS&R or Exhibit Detail			4,455		569		5,648		4,231		3,461				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 8,749,461		$ 898,966		$ 9,851,146		$ 8,101,313		$ 7,036,762		$ 27,600,886		27.72%
21.01	Calculated Routine Charge Per Dien			$ 1,963.96		$ 1,579.91		$ 1,744.18		$ 1,914.75		$ 2,033.16		$ 1,852.04		
	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		0.730768	86,471	91,652	-	25,705	7,880	462,792	6,844	163,141	1,829	259,450	$ 101,195	$ 743,290	27.06%
23	5000 OPERATING ROOM		0.143447	4,802,639	2,045,258	956,624	3,212,773	5,817,906	7,738,387	3,191,079	1,597,602	3,378,634	4,657,493	$ 14,768,248	$ 14,594,020	21.57%
24	5100 RECOVERY ROOM		0.232209	373,633	188,748	93,806	411,727	609,559	674,151	280,636	191,889	307,025	438,229	$ 1,357,634	$ 1,466,515	18.51%
25	5300 ANESTHESIOLOGY		0.037418	783,420	450,771	198,894	973,829	1,179,909	1,564,365	609,406	393,510	652,770	1,400,324	$ 2,771,629	$ 3,382,475	20.69%
26	5400 RADIOLOGY-DIAGNOSTIC		0.098159	1,172,274	862,267	209,224	1,704,458	2,217,122	5,038,150	1,516,337	1,154,519	1,493,139	4,127,670	$ 5,114,957	$ 8,759,394	15.97%
27	5700 CT SCAN		0.023836	1,700,257	1,453,286	324,267	2,199,358	2,407,227	3,905,984	1,328,454	1,031,008	2,235,852	6,999,921	$ 5,760,205	$ 8,589,636	26.46%
28	5800 MRI		0.037654	414,677	215,405	134,117	438,585	538,610	714,288	395,020	162,902	577,652	478,966	$ 1,482,424	$ 1,531,180	20.14%
29	6000 LABORATORY		0.110210	3,998,319	771,937	471,645	1,135,207	4,760,938	1,964,295	3,584,672	570,982	3,995,051	3,179,449	$ 12,815,574	$ 4,442,421	29.21%
30	6500 RESPIRATORY THERAPY		0.188098	2,005,064	308,866	88,377	17,351	1,931,126	172,467	2,100,837	22,054	1,657,022	47,162	$ 6,125,404	$ 520,738	32.44%
31	6600 PHYSICAL THERAPY		0.160763	524,924	94,564	57,918	818,718	786,551	470,180	528,241	694,330	352,600	457,163	$ 1,897,634	$ 2,077,792	16.13%
32	6700 OCCUPATIONAL THERAPY		0.140431	116,104	9,637	6,660	88,656	180,585	80,992	126,102	105,422	86,597	52,300	$ 429,451	$ 284,707	11.19%
33	6800 SPEECH PATHOLOGY		0.128856	154,684	1,101	3,128	1,101	209,808	31,451	170,100	6,105	111,521	8,319	$ 537,720	$ 39,758	23.59%
34	6900 ELECTROCARDIOLOGY		0.044940	1,183,185	694,817	235,982	569,236	2,348,364	4,342,040	1,002,782	882,670	2,065,264	2,202,327	$ 4,770,313	$ 6,488,763	16.03%
35	7000 ELECTROENCEPHALOGRAPHY		0.216026	58,059	97,172	9,326	485,521	59,815	147,722	51,458	79,873	92,019	83,018	$ 178,658	$ 810,288	25.45%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.629232	995,957	390,303	185,800	411,736	1,401,314	1,691,731	772,424	386,899	1,028,446	593,978	$ 3,355,495	$ 2,880,669	17.83%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.288277	2,582,405	1,078,619	481,870	942,472	4,033,385	5,469,215	1,786,899	1,346,444	1,837,080	1,400,588	$ 8,884,559	$ 8,836,750	13.74%
38	7300 DRUGS CHARGED TO PATIENTS		0.185846	6,036,504	1,093,331	757,423	738,407	7,054,802	2,130,028	5,501,965	544,685	5,478,395	1,859,726	$ 19,350,694	$ 4,506,451	27.03%
39	7400 RENAL DIALYSIS		0.238073	397,146	-	16,456	3,126	986,818	458,501	748,888	49,773	127,423	10,366	$ 2,149,308	$ 511,400	36.63%
40	9100 EMERGENCY		0.185375	903,355	1,456,911	282,306	3,931,328	1,921,619	3,895,397	1,311,425	1,423,900	1,850,325	10,443,949	$ 4,418,705	$ 10,707,536	37.92%
41	9300 WOUND CARE		0.116452	-	-	15,016	76,063	96,678	2,039,623	86,658	393,041	31,909	186,875	$ 198,352	$ 2,508,727	26.07%
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
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63			-											$ -	$ -	

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

Cost Report Year (07/01/2020-06/30/2021 | 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		% Survey
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
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127			-											$ -	$ -	
				$ 28,289,077	$ 11,304,645	$ 4,528,839	$ 18,185,357	$ 38,550,016	$ 42,991,759	$ 25,100,227	$ 11,200,749	$ 27,360,553	$ 38,887,273			

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

Cost Report Year (07/01/2020-06/30/2021 | 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		% Survey
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 37,038,538	$ 11,304,645	$ 5,427,805	$ 18,185,357	$ 48,401,162	$ 42,991,759	$ 33,201,540	$ 11,200,749	$ 34,397,315 (Agrees to Exhibit A)	$ 38,887,273 (Agrees to Exhibit A)	$ 124,069,045	$ 83,682,510	22.58%
129	Total Charges per PS&R or Exhibit Detail	$ 37,038,538	$ 11,304,645	$ 5,427,805	$ 18,185,357	$ 48,401,162	$ 42,991,759	$ 33,201,540	$ 11,200,749	$ 34,397,315	$ 38,887,273			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 10,630,261	$ 1,790,334	$ 1,217,450	$ 2,657,364	$ 11,384,418	$ 6,950,624	$ 8,139,243	$ 1,857,321	$ 7,788,609	$ 5,243,415	$ 31,371,372	$ 13,255,643	23.87%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 7,202,742	$ 1,426,239		$ 78	$ 1,050,870	$ 290,913	$ 141,726	$ 26,162			$ 8,395,338	$ 1,743,392	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 1,164,062	$ 2,110,312			$ 1,894	$ 37,218			$ 1,165,956	$ 2,147,530	
134	Private Insurance (including primary and third party liability)	$ 108,233	$ 3,827	$ 14,725	$ 19,447	$ 1,172	$ 2,453	$ 1,281,462	$ 659,078			$ 1,405,592	$ 684,805	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 3	$ 15,116			$ 2,114	$ 9,960			$ 2,117	$ 25,076	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,310,975	$ 1,430,066	$ 1,178,790	$ 2,144,953									
137	Medicaid Cost Settlement Payments (See Note B)		$ 9,854									$ -	$ 9,854	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				$ 97							$ -	$ 97	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 7,840,466	$ 5,609,456	$ 2,565,664	$ 273,725			$ 10,406,130	$ 5,883,181	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 2,266,474	$ 635,128			$ 2,266,474	$ 635,128	
141	Medicare Cross-Over Bad Debt Payments					$ 34,809	$ 147,607					$ 34,809	$ 147,607	
142	Other Medicare Cross-Over Payments (See Note D)					$ (58,112)	$ (6,099)	$ (13,678)	$ (140)	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (71,790)	$ (6,239)	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 966,069	$ 719,424			
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)**	$ 3,319,286	$ 350,414	$ 38,660	$ 512,314	$ 2,515,213	$ 906,294	$ 1,893,587	$ 216,190	$ 6,822,540	$ 4,523,991	$ 7,766,746	$ 1,985,212	
146	**Calculated Payments as a Percentage of Cost**	69%	80%	97%	81%	78%	87%	77%	88%	12%	14%	75%	85%	
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)**					42,987								
148	**Percent of cross-over days to total Medicare days from the cost report**					13%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with s
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 pay
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 payn

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) St. Joseph Hospital Savannah

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 727.24		231								231	
2	03100 INTENSIVE CARE UNIT	$ 1,909.50		49								49	
3	03200 CORONARY CARE UNIT	$ 1,779.69		19								19	
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**	299		-		-		-		299	
19	Total Days per PS&R or Exhibit Detail			299		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 598,121								$ 598,121	
21.01	Calculated Routine Charge Per Diem			$ 2,000.40		$ -		$ -		$ -		$ 2,000.40	
	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)		0.730768	-	14,434							$ -	$ 14,434
23	5000 OPERATING ROOM		0.143447	150,877	27,580							$ 150,877	$ 27,580
24	5100 RECOVERY ROOM		0.232209	5,434	-							$ 5,434	$ -
25	5300 ANESTHESIOLOGY		0.037418	25,833	1,302							$ 25,833	$ 1,302
26	5400 RADIOLOGY-DIAGNOSTIC		0.098159	91,431	168,192							$ 91,431	$ 168,192
27	5700 CT SCAN		0.023836	98,867	425,884							$ 98,867	$ 425,884
28	5800 MRI		0.037654	27,055	-							$ 27,055	$ -
29	6000 LABORATORY		0.110210	271,939	167,501							$ 271,939	$ 167,501
30	6500 RESPIRATORY THERAPY		0.188098	139,212	4,125							$ 139,212	$ 4,125
31	6600 PHYSICAL THERAPY		0.160763	28,654	1,108							$ 28,654	$ 1,108
32	6700 OCCUPATIONAL THERAPY		0.140431	5,767	-							$ 5,767	$ -
33	6800 SPEECH PATHOLOGY		0.128856	4,865	-							$ 4,865	$ -
34	6900 ELECTROCARDIOLOGY		0.044940	87,144	70,450							$ 87,144	$ 70,450
35	7000 ELECTROENCEPHALOGRAPHY		0.216026	10,885	3,438							$ 10,885	$ 3,438
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.629232	35,872	7,440							$ 35,872	$ 7,440
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.288277	36,835	17,762							$ 36,835	$ 17,762
38	7300 DRUGS CHARGED TO PATIENTS		0.185846	325,385	95,418							$ 325,385	$ 95,418
39	7400 RENAL DIALYSIS		0.238073	13,411	89,585							$ 13,411	$ 89,585
40	9100 EMERGENCY		0.185375	83,384	659,272							$ 83,384	$ 659,272
41	9300 WOUND CARE		0.116452	-	-							$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) 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	
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			-									$ -	$ -
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108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2020-06/30/2021) 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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,442,850	$ 1,753,491	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 2,040,971	$ 1,753,491	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,040,971	$ 1,753,491
129	Total Charges per PS&R or Exhibit Detail	$ 2,040,971	$ 1,753,491	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 512,372	$ 235,612	$ -	$ -	$ -	$ -	$ -	$ -	$ 512,372	$ 235,612
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 399,738	$ 185,781							$ 399,738	$ 185,781
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ 1							$ -	$ 1
134	Private Insurance (including primary and third party liability)		$ 13,060							$ -	$ 13,060
135	Self-Pay (including Co-Pay and Spend-Down)	$ 3								$ 3	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 399,741	$ 198,842	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		$ 988							$ -	$ 988
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)**	$ 112,631	$ 35,782	$ -	$ -	$ -	$ -	$ -	$ -	$ 112,631	$ 35,782
144	**Calculated Payments as a Percentage of Cost**	78%	85%	0%	0%	0%	0%	0%	0%	78%	85%

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 (07/01/2020-06/30/2021) 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)*		$ 2,215,652		
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 ---------->)		$ 2,215,652		
	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	$ 2,215,652	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		$ 2,215,652		

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**	211,546,017
19	Uninsured Hospital	**Charges Sec. G**	73,284,588
20	Total Hospital	**Charges Sec. G**	1,261,658,735
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		16.77%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.81%
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.*