State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

A. General DSH Year Information

DSH Version 6.02 2/10/2023

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

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	07/01/2022	06/30/2023
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.

During the DSH Examination Year:

	DSH Examination Year (07/01/24 - 06/30/25)
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 07/01/2024 - 06/30/2025** — $ 2,523,743
   (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 07/01/2024 - 06/30/2025** — $ 876,817
   (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 Services07/01/2024 - 06/30/2025** — $ 3,400,560

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	1/13/2025

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

DSH Version 9.00 9/11/2024

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

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

1. Select Your Facility from the Drop-Down Menu Provided:	St. Joseph Hospital Savannah		
	7/1/2022 through 6/30/2023		
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:	5/9/2024		

	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	

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

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 179,232	$ 852,841	$1,032,073
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,927,211	$ 11,370,734	$13,297,945
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)	$2,106,443	$12,223,575	$14,330,018
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.51%	6.98%	7.20%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 876,817	***<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.***
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	$876,817	

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (07/01/2022 - 06/30/2023)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	58,120 (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	27,670,001
8.	Outpatient Hospital Charity Care Charges	27,674,387
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 55,344,388

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	$122,084,422.00			$ 95,939,126	$ -	$ -	$ 26,145,296
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	$518,029,597.00	$673,863,235.00		$ 407,089,670	$ 529,550,364	$ -	$ 255,252,798
20.	Outpatient Services		$96,239,841.00			$ 75,629,357	$ -	$ 20,610,484
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	$ 640,114,019	$ 770,103,076	$ -	$ 503,028,796	$ 605,179,721	$ -	$ 302,008,578
28.	Total Hospital and Non Hospital		Total from Above	$ 1,410,217,095		Total from Above	$ 1,108,208,517	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,410,217,095	Total Contractual Adj. (G-3 Line 2)		1,109,661,784
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)				+	2,130,344
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)				-	3,583,611
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"				-	
36.	Adjusted Contractual Adjustments					1,108,208,517
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) | 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	$ 50,964,177	$ -	$ -	$0.00	$ 50,964,177	52,571	$71,590,139.00		$ 969.44
2	03100 INTENSIVE CARE UNIT	$ 13,762,152	$ -	$ -		$ 13,762,152	6,324	$27,712,685.00		$ 2,176.18
3	03200 CORONARY CARE UNIT	$ 11,145,197	$ -	$ -		$ 11,145,197	4,525	$20,198,005.00		$ 2,463.03
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	$ 75,871,526	$ -	$ -	$ -	$ 75,871,526	63,420	$ 119,500,829		
19	Weighted Average									$ 1,196.34

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)	5,300	-	-	$ 5,138,032	$162,000.00	$5,177,709.00	$ 5,339,709	0.962231

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below)	*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*
21	5000 OPERATING ROOM	$36,807,932.00	$ -	$ -		$ 36,807,932	$112,975,487.00	$122,062,498.00	$ 235,037,985	0.156604
22	5100 RECOVERY ROOM	$5,679,851.00	$ -	$ -		$ 5,679,851	$9,676,328.00	$14,725,929.00	$ 24,402,257	0.232759
23	5300 ANESTHESIOLOGY	$1,915,838.00	$ -	$ -		$ 1,915,838	$17,885,941.00	$35,312,921.00	$ 53,198,862	0.036013
24	5400 RADIOLOGY-DIAGNOSTIC	$16,840,943.00	$ -	$ 18,529		$ 16,859,472	$22,891,864.00	$88,479,912.00	$ 111,371,776	0.151380
25	5700 CT SCAN	$2,777,332.00	$ -	$ -		$ 2,777,332	$26,191,284.00	$63,308,129.00	$ 89,499,413	0.031032
26	5800 MRI	$1,043,649.00	$ -	$ -		$ 1,043,649	$6,153,732.00	$15,834,967.00	$ 21,988,699	0.047463
27	6000 LABORATORY	$15,122,251.00	$ -	$ -		$ 15,122,251	$60,194,422.00	$67,805,496.00	$ 127,999,918	0.118143
28	6500 RESPIRATORY THERAPY	$5,636,374.00	$ -	$ 1,691		$ 5,638,065	$23,396,585.00	$916,870.00	$ 24,313,455	0.231891
29	6600 PHYSICAL THERAPY	$4,748,617.00	$ -	$ -		$ 4,748,617	$14,197,128.00	$16,057,447.00	$ 30,254,575	0.156955
30	6700 OCCUPATIONAL THERAPY	$1,445,898.00	$ -	$ -		$ 1,445,898	$6,910,452.00	$1,914,195.00	$ 8,824,647	0.163848
31	6800 SPEECH PATHOLOGY	$674,942.00	$ -	$ -		$ 674,942	$2,919,257.00	$613,556.00	$ 3,532,813	0.191049

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2022-06/30/2023) | 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	$5,963,308.00	$ -	$ 1,288		$ 5,964,596	$38,842,129.00	$72,112,246.00	$ 110,954,375	0.053757
33	7000	ELECTROENCEPHALOGRAPHY	$1,259,520.00	$ -	$ -		$ 1,259,520	$982,573.00	$2,620,624.00	$ 3,603,197	0.349556
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$33,795,450.00	$ -	$ -		$ 33,795,450	$27,362,076.00	$32,087,352.00	$ 59,449,428	0.568474
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$50,355,893.00	$ -	$ -		$ 50,355,893	$77,397,804.00	$101,719,084.00	$ 179,116,888	0.281134
36	7300	DRUGS CHARGED TO PATIENTS	$21,834,429.00	$ -	$ -		$ 21,834,429	$64,635,717.00	$32,252,331.00	$ 96,888,048	0.225357
37	7400	RENAL DIALYSIS	$1,837,793.00	$ -	$ -		$ 1,837,793	$6,222,210.00	$1,819,169.00	$ 8,041,379	0.228542
38	9100	EMERGENCY	$20,454,253.00	$ -	$ -		$ 20,454,253	$25,275,965.00	$66,369,511.00	$ 91,645,476	0.223189
39	9300	WOUND CARE	$1,480,359.00	$ -	$ 7,537		$ 1,487,896	$1,032,857.00	$4,220,509.00	$ 5,253,366	0.283227
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 (07/01/2022-06/30/2023) | 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**	$ 229,674,632	$ -	$ 29,045		$ 229,703,677	$ 545,305,811	$ 745,410,455	$ 1,290,716,266	
127	**Weighted Average**									0.181947
128	**Sub Totals**	$ 305,546,158	$ -	$ 29,045		$ 305,575,203	$ 664,806,640	$ 745,410,455	$ 1,410,217,095	
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**					$ 305,575,203				
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 (07/01/2022-06/30/2023) | 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		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From 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 Hospital's Own Internal	From Hospital's Own Internal			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 969.44		1,627		325		1,657		4,467				2,736		8,076		23.64%
2	03100 INTENSIVE CARE UNIT	$ 2,176.18		1,233		88		222		653				348		2,196		40.73%
3	03200 CORONARY CARE UNIT	$ 2,463.03		208		29		78		300				294		615		20.77%
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	3,068		442		1,957		5,420		-		3,378		10,887		23.17%
19	Total Days per PS&R or Exhibit Detail			3,068		442		1,957		5,420		-		3,378				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 6,281,433		$ 978,483		$ 3,828,409		$ 10,862,919				$ 6,829,952		$ 21,951,244		24.76%
21.01	Calculated Routine Charge Per Diem			$ 2,047.40		$ 2,213.76		$ 1,956.26		$ 2,004.23		$ -		$ 2,021.89		$ 2,016.28		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.962231	178,114	118,722	-	31,143	2,587	70,198	5,991	764,367			11,348	154,211	$ 186,692	$ 984,430	25.86%
23	5000 OPERATING ROOM		0.156604	3,322,607	2,430,689	579,253	8,579,920	1,998,426	2,079,482	6,653,984	9,116,146			3,300,705	6,402,523	$ 12,554,270	$ 22,206,237	
24	5100 RECOVERY ROOM		0.232759	318,363	209,176	62,822	1,097,147	193,711	167,985	716,951	891,847			380,837	551,140	$ 1,291,847	$ 2,366,155	
25	5300 ANESTHESIOLOGY		0.036013	539,940	490,418	113,191	2,833,220	396,140	408,836	1,388,980	2,010,679			686,953	2,092,447	$ 2,438,251	$ 5,743,153	
26	5400 RADIOLOGY-DIAGNOSTIC		0.151380	1,006,522	903,104	191,645	1,893,751	946,103	1,308,428	2,053,249	5,641,085			1,282,320	3,824,915	$ 4,197,520	$ 9,746,368	8.32%
27	5700 CT SCAN		0.031032	1,257,231	1,145,160	342,144	2,228,709	1,126,924	1,116,971	1,964,627	3,996,753			1,754,588	5,926,958	$ 4,690,926	$ 8,487,593	88.57%
28	5800 MRI		0.047463	202,691	320,543	92,456	311,226	159,648	227,365	564,568	892,272			458,999	436,445	$ 1,019,363	$ 1,751,406	7.04%
29	6000 LABORATORY		0.118143	3,405,252	1,207,963	572,678	3,782,692	2,360,929	967,816	5,600,799	4,144,369			3,492,142	6,776,298	$ 11,939,658	$ 10,102,840	29.84%
30	6500 RESPIRATORY THERAPY		0.231891	1,866,979	120,995	187,041	35,473	798,912	11,187	2,547,864	119,498			1,190,186	55,663	$ 5,400,796	$ 287,153	7.93%
31	6600 PHYSICAL THERAPY		0.156955	370,399	64,722	55,285	407,132	346,571	173,881	1,023,466	929,452			320,404	365,054	$ 1,795,721	$ 1,575,187	18.80%
32	6700 OCCUPATIONAL THERAPY		0.163848	120,673	2,580	12,522	103,097	77,845	13,008	387,616	194,650			91,012	32,859	$ 598,656	$ 313,335	0.83%
33	6800 SPEECH PATHOLOGY		0.191049	125,848	699	24,752	2,069	126,268	9,293	335,120	52,472			112,749	15,212	$ 611,988	$ 64,533	3.36%
34	6900 ELECTROCARDIOLOGY		0.053757	814,401	445,479	196,502	557,703	1,049,108	834,821	2,528,290	4,432,717			2,210,938	1,688,950	$ 4,588,300	$ 6,270,720	50.11%
35	7000 ELECTROENCEPHALOGRAPHY		0.349556	85,553	37,214	10,562	431,035	27,233	14,261	99,797	130,601			72,328	71,361	$ 223,145	$ 613,111	11.32%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.568474	691,512	354,638	121,762	765,653	729,440	392,592	2,112,408	2,159,501			1,144,353	482,116	$ 3,655,122	$ 3,672,384	260.78%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.281134	1,350,806	1,247,252	223,105	1,484,255	1,718,210	1,116,512	5,585,040	6,870,514			1,247,133	1,451,030	$ 8,877,161	$ 10,718,533	20.83%
38	7300 DRUGS CHARGED TO PATIENTS		0.225357	4,340,415	896,687	783,010	1,271,376	2,401,025	471,379	6,858,748	2,162,200			3,924,259	1,879,170	$ 14,383,198	$ 4,801,642	709.89%
39	7400 RENAL DIALYSIS		0.228542	298,247	-	4,114	2,057	378,644	171,819	917,251	473,702			134,842	111,764	$ 1,598,256	$ 647,578	4.32%
40	9100 EMERGENCY		0.223189	789,823	1,396,673	293,702	4,990,025	1,139,577	1,219,105	2,163,198	5,086,766			2,004,935	9,327,667	$ 4,386,300	$ 12,692,569	16.41%
41	9300 WOUND CARE		0.283227	-	-	18,173	303,500	71,087	378,227	79,144	1,100,718			34,075	464,499	$ 168,404	$ 1,782,445	2.57%
42																$ -	$ -	0.00%
43			-													$ -	$ -	0.00%
44			-													$ -	$ -	0.00%
45			-													$ -	$ -	
46			-													$ -	$ -	
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73			-													$ -	$ -	

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

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report
74				-													$ -	$ -
75				-													$ -	$ -
76				-													$ -	$ -
77				-													$ -	$ -
78				-													$ -	$ -
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124				-													$ -	$ -
125				-													$ -	$ -
126				-													$ -	$ -
127				-													$ -	$ -
					$ 21,085,377	$ 11,392,716	$ 3,884,719	$ 31,111,183	$ 16,048,388	$ 11,153,165	$ 43,587,090	$ 51,170,309	$ -	$ -	$ 23,855,107	$ 42,110,283		

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

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 27,366,810	$ 11,392,716	$ 4,863,202	$ 31,111,183	$ 19,876,797	$ 11,153,165	$ 54,450,009	$ 51,170,309	$ -	$ -	$ 30,685,059 (Agrees to Exhibit A)	$ 42,110,283 (Agrees to Exhibit A)	$ 106,556,818	$ 104,827,373	20.71%
129	Total Charges per PS&R or Exhibit Detail	$ 27,366,810	$ 11,392,716	$ 4,863,202	$ 31,111,183	$ 19,876,797	$ 11,153,165	$ 54,450,009	$ 51,170,309	$ -	$ -	$ 30,685,059	$ 42,110,283			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 8,765,416	$ 2,033,190	$ 1,252,209	$ 5,157,784	$ 5,263,356	$ 1,950,323	$ 14,896,731	$ 9,654,270	$ -	$ -	$ 8,338,283	$ 6,477,569	$ 30,177,712	$ 18,795,567	21.46%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 5,557,782	$ 1,454,046			$ 795,416	$ 80,710	$ 805,097	$ 246,415					$ 7,158,295	$ 1,781,171	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 866,394	$ 3,549,277			$ (1,227)	$ 106,100					$ 865,167	$ 3,655,377	
134	Private Insurance (including primary and third party liability)	$ 59,293	$ 1,285	$ 4	$ 27,477		$ 642	$ 1,685,373	$ 1,246,622					$ 1,744,670	$ 1,276,026	
135	Self-Pay (including Co-Pay and Spend-Down)					$ 1,749	$ 5,916	$ 4,501	$ 26,890					$ 6,250	$ 32,806	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 5,617,075	$ 1,455,331	$ 866,398	$ 3,576,754											
137	Medicaid Cost Settlement Payments (See Note B)		$ 179,469											$ -	$ 179,469	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 3,400,015	$ 1,398,322	$ 433,522	$ 153,383					$ 3,833,537	$ 1,551,705	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 4,277		$ 7,427,968	$ 5,726,674					$ 7,432,245	$ 5,726,674	
141	Medicare Cross-Over Bad Debt Payments					$ 14,417	$ 86,811							$ 14,417	$ 86,811	
142	Other Medicare Cross-Over Payments (See Note D)					$ 27,128	$ 182,273	$ (70,070)	$ (9,635)			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ (42,942)	$ 172,638	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 179,232	$ 852,841			
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)**	$ 3,148,341	$ 398,390	$ 385,811	$ 1,581,030	$ 1,020,354	$ 195,649	$ 4,611,567	$ 2,157,821	$ -	$ -	$ 8,159,051	$ 5,624,728	$ 9,166,073	$ 4,332,890	
146	**Calculated Payments as a Percentage of Cost**	64%	80%	69%	69%	81%	90%	69%	78%	0%	0%	2%	13%	70%	77%	
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**					38,894										
148	**Percent of cross-over days to total Medicare days from the cost report**					5%										

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 surve
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 payment
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) 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	$ 969.44		116						248		364	
2	03100 INTENSIVE CARE UNIT	$ 2,176.18		12						20		32	
3	03200 CORONARY CARE UNIT	$ 2,463.03		23						8		31	
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**	151		-		-		276		427	
19	Total Days per PS&R or Exhibit Detail			151		-		-		276			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 321,801						$ 482,224		$ 804,025	
21.01	Calculated Routine Charge Per Diem			$ 2,131.13		$ -		$ -		$ 1,747.19		$ 1,882.96	
	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)		0.962231	-	13,771					-	30,273	$ -	$ 44,044
23	5000 OPERATING ROOM		0.156604	439,023	39,850					345,548	194,178	$ 784,571	$ 234,028
24	5100 RECOVERY ROOM		0.232759	8,940	4,470					22,653	18,919	$ 31,593	$ 23,389
25	5300 ANESTHESIOLOGY		0.036013	81,525	8,808					62,527	37,588	$ 144,052	$ 46,396
26	5400 RADIOLOGY-DIAGNOSTIC		0.151380	148,123	166,546					103,660	90,275	$ 251,783	$ 256,821
27	5700 CT SCAN		0.031032	97,196	307,259					160,376	187,830	$ 257,572	$ 495,089
28	5800 MRI		0.047463	22,058	4,509					39,036	11,485	$ 61,094	$ 15,994
29	6000 LABORATORY		0.118143	308,766	208,086					263,915	144,451	$ 572,681	$ 352,537
30	6500 RESPIRATORY THERAPY		0.231891	77,880	2,997					81,006	1,999	$ 158,886	$ 4,996
31	6600 PHYSICAL THERAPY		0.156955	14,878	2,483					52,477	6,664	$ 67,355	$ 9,147
32	6700 OCCUPATIONAL THERAPY		0.163848	7,463	1,493					17,924	2,893	$ 25,387	$ 4,386
33	6800 SPEECH PATHOLOGY		0.191049	1,040	1,217					7,287	2,637	$ 8,327	$ 3,854
34	6900 ELECTROCARDIOLOGY		0.053757	115,128	29,785					144,887	111,470	$ 260,015	$ 141,255
35	7000 ELECTROENCEPHALOGRAPHY		0.349556	-	1,236					18,071	-	$ 18,071	$ 1,236
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.568474	154,115	2,553					66,500	35,828	$ 220,615	$ 38,381
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.281134	398,269	13,128					256,364	154,042	$ 654,633	$ 167,170
38	7300 DRUGS CHARGED TO PATIENTS		0.225357	215,907	55,672					270,936	47,920	$ 486,843	$ 103,592
39	7400 RENAL DIALYSIS		0.228542	20,570	6,171					47,311	2,057	$ 67,881	$ 8,228
40	9100 EMERGENCY		0.223189	74,388	589,541					114,813	210,611	$ 189,201	$ 800,152
41	9300 WOUND CARE		0.283227	6,815	-					22,715	6,493	$ 29,530	$ 6,493
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
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110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2022-06/30/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 2,192,084	$ 1,459,575	$ -	$ -	$ -	$ -	$ 2,098,006	$ 1,297,613		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 2,513,885	$ 1,459,575	$ -	$ -	$ -	$ -	$ 2,580,230	$ 1,297,613	$ 5,094,115	$ 2,757,188
129	Total Charges per PS&R or Exhibit Detail	$ 2,513,885	$ 1,459,575	$ -	$ -	$ -	$ -	$ 2,580,230	$ 1,297,613		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 631,426	$ 234,666	$ -	$ -	$ -	$ -	$ 678,249	$ 234,669	$ 1,309,675	$ 469,335
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 417,133	$ 130,795					$ 139,700	$ 8,181	$ 556,833	$ 138,976
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)								$ 484	$ -	$ 484
134	Private Insurance (including primary and third party liability)							$ 158,699	$ 29,766	$ 158,699	$ 29,766
135	Self-Pay (including Co-Pay and Spend-Down)	$ 50	$ 909					$ 600		$ 650	$ 909
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 417,183	$ 131,704	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)							$ 53,833	$ 25,009	$ 53,833	$ 25,009
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 169,376	$ 120,638	$ 169,376	$ 120,638
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)**	$ 214,243	$ 102,962	$ -	$ -	$ -	$ -	$ 156,041	$ 50,591	$ 370,284	$ 153,553
144	**Calculated Payments as a Percentage of Cost**	66%	56%	0%	0%	0%	0%	77%	78%	72%	67%

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 (07/01/2022-06/30/2023) | 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)*		$ 3,583,611		
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 ---------->)		$ 3,583,611		
	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	$ 3,583,611	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		$ 3,583,611		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	219,235,494
19	Uninsured Hospital	**Charges Sec. G**	72,795,341
20	Total Hospital	**Charges Sec. G**	1,410,217,095
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		15.55%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.16%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	78,707,371
27	Uninsured Hospital	**Charges Sec. G**	72,795,341
28	Total Hospital	**Charges Sec. G**	1,410,217,095
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		5.58%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		5.16%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ -
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
33	Medicaid Primary 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.*

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