State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

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	07/01/2018	06/30/2019
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

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

B. DSH OB Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/18 - 06/30/19)
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 07/01/2018 - 06/30/2019** — $ 473,872
   (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 07/01/2018 - 06/30/2019**
   (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 Services07/01/2018 - 06/30/2019** — $ 473,872

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CFO Title	11/2/20 Date
Greg Schaack Hospital CEO or CFO Printed Name	912-819-6162 Hospital CEO or CFO Telephone Number	schaackg@sjchs.org Hospital CEO or CFO E-Mail

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

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

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

DSH Version 8.00 3/31/2020

D. General Cost Report Year Information 7/1/2018 - 6/30/2019

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 c 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		
	7/1/2018 through 6/30/2019		
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:	5/13/2020		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ST. JOSEPH HOSPITAL SAVANNAH	Yes	
5. Medicaid Provider Number:	000001801A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110043	Yes	
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 yea

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. 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: (07/01/2018 - 06/30/2019)

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)	$ 148,869	$ 381,949	$530,818
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,028,592	$ 7,457,764	$9,486,356
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)	$2,177,461	$7,839,713	$10,017,174
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.84%	4.87%	5.30%

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 thes 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 (07/01/2018 - 06/30/2019)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	60,278 (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	40,972,795
8.	Outpatient Hospital Charity Care Charges	28,569,210
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 69,542,005

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)			
11.	Hospital	$107,385,963.00			$ 84,661,546	$ -	$ -	$ 22,724,417
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$8,968,233.00			$ 7,070,426	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$527,641,232.00	$432,238,352.00		$ 415,984,746	$ 340,770,490	$ -	$ 203,124,347
20.	Outpatient Services		$75,452,459.00			$ 59,485,632	$ -	$ 15,966,827
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	$2,062,517.00	$ -	$ -	$ 1,626,059	$ -
27.	Total	$ 635,027,195	$ 507,690,811	$ 11,030,750	$ 500,646,293	$ 400,256,122	$ 8,696,484	$ 241,815,591

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,153,748,756	Total Contractual Adj. (G-3 Line 2)	908,656,957
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)			+	941,942
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				909,598,899
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) 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	$ 36,204,188	$ -	$ -	$0.00	$ 36,204,188	52,609	$64,439,641.00		$ 688.17
2	03100 INTENSIVE CARE UNIT	$ 9,537,467	$ -	$ -		$ 9,537,467	6,592	$25,157,759.00		$ 1,446.82
3	03200 CORONARY CARE UNIT	$ 8,104,723	$ -	$ -		$ 8,104,723	4,640	$17,788,563.00		$ 1,746.71
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	$ 53,846,378	$ -	$ -	$ -	$ 53,846,378	63,841	$ 107,385,963		
19	Weighted Average									$ 843.44

Line #	Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200 Observation (Non-Distinct)	3,563	-	-	$ 2,451,950	$116,167.00	$3,092,857.00	$ 3,209,024	0.764080

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	$24,128,983.00	$ -	$0.00		$ 24,128,983	$99,220,418.00	$71,418,516.00	$ 170,638,934	0.141404
22	5100 RECOVERY ROOM	$3,887,234.00	$ -	$0.00		$ 3,887,234	$10,253,197.00	$8,490,682.00	$ 18,743,879	0.207387
23	5300 ANESTHESIOLOGY	$1,570,595.00	$ -	$0.00		$ 1,570,595	$20,789,905.00	$18,269,367.00	$ 39,059,272	0.040211
24	5400 RADIOLOGY-DIAGNOSTIC	$8,956,274.00	$ -	$6,176.00		$ 8,962,450	$24,390,636.00	$63,164,853.00	$ 87,555,489	0.102363
25	5700 CT SCAN	$1,853,020.00	$ -	$0.00		$ 1,853,020	$24,121,658.00	$49,829,688.00	$ 73,951,346	0.025057
26	5800 MRI	$685,698.00	$ -	$0.00		$ 685,698	$6,974,980.00	$9,035,224.00	$ 16,010,204	0.042829
27	6000 LABORATORY	$8,635,775.00	$ -	$5,913.00		$ 8,641,688	$51,143,537.00	$24,686,618.00	$ 75,830,155	0.113961
28	6500 RESPIRATORY THERAPY	$4,216,037.00	$ -	$435.00		$ 4,216,472	$22,064,728.00	$974,838.00	$ 23,039,566	0.183010
29	6600 PHYSICAL THERAPY	$4,004,778.00	$ -	$0.00		$ 4,004,778	$12,825,291.00	$11,207,967.00	$ 24,033,258	0.166635

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	6700	OCCUPATIONAL THERAPY	$1,260,242.00	$ -	$0.00		$ 1,260,242	$6,818,929.00	$1,649,944.00	$ 8,468,873	0.148809
31	6800	SPEECH PATHOLOGY	$338,860.00	$ -	$0.00		$ 338,860	$2,370,255.00	$124,271.00	$ 2,494,526	0.135841
32	6900	ELECTROCARDIOLOGY	$4,328,178.00	$ -	$676.00		$ 4,328,854	$33,535,850.00	$58,707,829.00	$ 92,243,679	0.046928
33	7000	ELECTROENCEPHALOGRAPHY	$1,050,854.00	$ -	$0.00		$ 1,050,854	$1,907,791.00	$4,649,166.00	$ 6,556,957	0.160266
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$25,516,137.00	$ -	$0.00		$ 25,516,137	$27,320,895.00	$19,011,428.00	$ 46,332,323	0.550720
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$43,607,731.00	$ -	$0.00		$ 43,607,731	$103,831,400.00	$56,926,224.00	$ 160,757,624	0.271264
36	7300	DRUGS CHARGED TO PATIENTS	$19,547,359.00	$ -	$0.00		$ 19,547,359	$78,451,874.00	$24,544,952.00	$ 102,996,826	0.189786
37	7400	RENAL DIALYSIS	$1,832,329.00	$ -	$0.00		$ 1,832,329	$6,419,351.00	$1,351,037.00	$ 7,770,388	0.235809
38	9100	EMERGENCY	$11,381,706.00	$ -	$0.00		$ 11,381,706	$20,678,928.00	$54,773,531.00	$ 75,452,459	0.150846
39	9300	WOUND CARE	$962,072.00	$ -	$7,537.00		$ 969,609	$477,363.00	$7,122,570.00	$ 7,599,933	0.127581
40			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 167,763,862	$ -	$ 20,737		$ 167,784,599	$ 553,713,153	$ 489,031,562	$ 1,042,744,715	
127		**Weighted Average**									0.163258
128		**Sub Totals**	$ 221,610,240	$ -	$ 20,737		$ 221,630,977	$ 661,099,116	$ 489,031,562	$ 1,150,130,678	
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)*					$303,375.00				
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**					$ 221,327,602				
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 (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 688.17		1,575		320		3,463		3,490		2,796		8,848		24.03%
2	03100 INTENSIVE CARE UNIT	$ 1,446.82		2,070		34		625		386		479		3,115		54.92%
3	03200 CORONARY CARE UNIT	$ 1,746.71		227		57		-		362		340		646		22.28%
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	3,872		411		4,088		4,238		3,615		12,609		25.75%
19	Total Days per PS&R or Exhibit Detail			3,872		411		4,088		4,238		3,615				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 7,224,911		$ 759,522		$ 6,552,178		$ 7,344,512		$ 6,797,360		$ 21,881,123		27.13%
21.01	Calculated Routine Charge Per Diem			$ 1,865.94		$ 1,847.99		$ 1,602.78		$ 1,733.01		$ 1,880.32		$ 1,735.36		
	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)		0.764080	61,356	115,302	-	100,697	4,825	101,244	3,785	296,196	865	202,408	$ 69,966	$ 613,439	28.21%
23	5000 OPERATING ROOM		0.141404	3,912,155	1,835,847	573,984	1,330,711	3,474,870	3,151,519	4,801,903	2,964,664	4,041,136	2,313,809	$ 12,762,912	$ 9,282,741	16.79%
24	5100 RECOVERY ROOM		0.207387	342,226	168,184	55,253	200,231	314,321	369,575	488,155	312,226	307,486	299,158	$ 1,199,955	$ 1,050,216	15.30%
25	5300 ANESTHESIOLOGY		0.040211	652,301	355,233	95,610	371,944	558,285	488,588	977,589	679,424	708,794	674,098	$ 2,283,785	$ 1,895,189	14.34%
26	5400 RADIOLOGY-DIAGNOSTIC		0.102363	1,153,885	957,124	141,380	1,588,661	1,661,271	5,029,355	1,646,633	2,707,161	1,556,555	3,638,873	$ 4,603,169	$ 10,282,301	23.26%
27	5700 CT SCAN		0.025057	1,204,689	1,241,312	136,366	1,668,353	1,506,173	2,431,705	1,519,079	1,955,996	2,195,040	6,454,238	$ 4,366,307	$ 7,297,366	27.99%
28	5800 MRI		0.042829	402,345	259,660	54,827	287,508	218,797	480,940	423,484	319,609	537,147	394,377	$ 1,099,453	$ 1,347,717	21.22%
29	6000 LABORATORY		0.113961	3,396,972	902,496	510,791	1,211,629	3,586,087	2,489,598	3,446,983	927,659	3,574,072	3,187,985	$ 10,940,833	$ 5,531,382	31.18%
30	6500 RESPIRATORY THERAPY		0.183010	1,774,169	27,422	201,258	53,304	1,607,930	67,917	1,805,931	77,943	1,280,333	117,881	$ 5,389,288	$ 226,586	30.91%
31	6600 PHYSICAL THERAPY		0.166635	387,439	51,912	34,910	255,736	348,100	145,940	602,865	372,402	302,616	314,487	$ 1,373,314	$ 825,990	11.79%
32	6700 OCCUPATIONAL THERAPY		0.148809	122,340	21,924	8,400	76,607	86,096	36,422	250,099	70,767	132,480	51,968	$ 466,935	$ 205,720	10.20%
33	6800 SPEECH PATHOLOGY		0.135841	126,435	1,022	9,446	1,022	94,525	7,376	147,392	13,946	100,822	3,976	$ 377,798	$ 23,366	20.55%
34	6900 ELECTROCARDIOLOGY		0.046928	1,143,770	663,040	131,111	565,053	341,611	288,825	1,897,509	2,923,900	2,372,569	1,980,982	$ 3,514,001	$ 4,440,818	13.50%
35	7000 ELECTROENCEPHALOGRAPHY		0.160266	124,150	166,725	17,387	544,268	26,935	-	73,934	174,845	66,023	117,085	$ 242,406	$ 885,838	20.61%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.550720	936,043	353,090	259,406	247,595	652,245	358,496	1,284,494	891,960	1,106,510	416,116	$ 3,132,188	$ 1,851,141	14.15%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.271264	1,626,952	592,281	352,571	699,558	352,939	387,691	4,769,684	2,790,365	2,246,444	992,660	$ 7,102,146	$ 4,469,895	9.29%
38	7300 DRUGS CHARGED TO PATIENTS		0.189786	5,802,887	1,411,810	604,698	715,499	5,208,275	9,995,527	5,009,405	1,143,222	5,102,816	1,501,434	$ 16,625,265	$ 13,266,058	35.81%
39	7400 RENAL DIALYSIS		0.235809	372,636	-	11,048	6,745	803,319	140,176	509,532	121,075	142,258	13,490	$ 1,696,535	$ 267,996	28.34%
40	9100 EMERGENCY		0.150846	813,084	1,687,662	198,524	4,404,549	1,592,335	3,646,685	1,421,791	2,282,194	1,846,990	10,644,229	$ 4,025,734	$ 12,021,090	38.66%
41	9300 WOUND CARE		0.127581	-	-	15,040	85,764	89,866	1,138,642	48,980	375,777	27,854	83,900	$ 153,886	$ 1,600,183	24.55%
42			-	-										$ -	$ -	
43			-	-										$ -	$ -	
44			-											$ -	$ -	
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60			-											$ -	$ -	

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

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
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125				-											$ -	$ -
126				-											$ -	$ -
127				-											$ -	$ -
					$ 24,355,834	$ 10,812,046	$ 3,412,010	$ 14,415,434	$ 22,528,805	$ 30,756,221	$ 31,129,227	$ 21,401,331	$ 27,648,810	$ 33,403,154		

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

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 31,580,745	$ 10,812,046	$ 4,171,532	$ 14,415,434	$ 29,080,983	$ 30,756,221	$ 38,473,739	$ 21,401,331	$ 34,446,170 (Agrees to Exhibit A)	$ 33,403,154 (Agrees to Exhibit A)	$ 103,306,999	$ 77,385,032	21.91%
129	Total Charges per PS&R or Exhibit Detail	$ 31,580,745	$ 10,812,046	$ 4,171,532	$ 14,415,434	$ 29,080,983	$ 30,756,221	$ 38,473,739	$ 21,401,331	$ 34,446,170	$ 33,403,154			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 8,492,085	$ 1,592,450	$ 985,739	$ 1,992,912	$ 6,778,683	$ 4,484,098	$ 8,914,443	$ 3,322,980	$ 7,463,022	$ 4,082,283	$ 25,170,950	$ 11,392,440	22.03%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 7,045,333	$ 1,627,051		$ 67	$ 892,200	$ 386,246	$ 457,632	$ 150,146			$ 8,395,165	$ 2,163,510	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ 858,079	$ 1,851,206			$ 16,352	$ 24,548			$ 874,431	$ 1,875,754	
134	Private Insurance (including primary and third party liability)	$ 98,523	$ 6,472		$ 7,087		$ 2,087	$ 641,955	$ 409,000			$ 740,478	$ 424,646	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 3,043	$ 24	$ 2,328	$ 25	$ 13,026	$ 1,965	$ 9,674			$ 2,014	$ 28,071	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 7,143,856	$ 1,636,566	$ 858,103	$ 1,860,688									
137	Medicaid Cost Settlement Payments (See Note B)		$ (193,460)									$ -	$ (193,460)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,766,078	$ 3,909,964	$ 800,190	$ 220,310			$ 6,566,268	$ 4,130,274	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,060,667	$ 2,384,466			$ 5,060,667	$ 2,384,466	
141	Medicare Cross-Over Bad Debt Payments					$ 15,362	$ 214,402			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 15,362	$ 214,402	
142	Other Medicare Cross-Over Payments (See Note D)					$ (197)	$ 629					$ (197)	$ 629	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 148,869	$ 381,949			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 1,348,229	$ 149,344	$ 127,636	$ 132,224	$ 105,215	$ (42,256)	$ 1,935,682	$ 124,836	$ 7,314,153	$ 3,700,334	$ 3,516,762	$ 364,148	
146	**Calculated Payments as a Percentage of Cost**	84%	91%	87%	93%	98%	101%	78%	96%	2%	9%	86%	97%	
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)**					39,580								
148	**Percent of cross-over days to total Medicare days from the cost report**					10%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 688.17		141								141	
2	03100 INTENSIVE CARE UNIT	$ 1,446.82		26								26	
3	03200 CORONARY CARE UNIT	$ 1,746.71		48								48	
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**	215		-		-		-		215	
19	Total Days per PS&R or Exhibit Detail			215		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 459,447								$ 459,447	
21.01	Calculated Routine Charge Per Diem			$ 2,136.96		$ -		$ -		$ -		$ 2,136.96	
	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)		0.764080	-	18,428							$ -	$ 18,428
23	5000 OPERATING ROOM		0.141404	221,416	26,509							$ 221,416	$ 26,509
24	5100 RECOVERY ROOM		0.207387	9,830	1,966							$ 9,830	$ 1,966
25	5300 ANESTHESIOLOGY		0.040211	36,518	2,960							$ 36,518	$ 2,960
26	5400 RADIOLOGY-DIAGNOSTIC		0.102363	74,636	207,457							$ 74,636	$ 207,457
27	5700 CT SCAN		0.025057	125,783	256,760							$ 125,783	$ 256,760
28	5800 MRI		0.042829	18,114	-							$ 18,114	$ -
29	6000 LABORATORY		0.113961	243,897	168,313							$ 243,897	$ 168,313
30	6500 RESPIRATORY THERAPY		0.183010	99,770	7,685							$ 99,770	$ 7,685
31	6600 PHYSICAL THERAPY		0.166635	15,446	544							$ 15,446	$ 544
32	6700 OCCUPATIONAL THERAPY		0.148809	6,537	-							$ 6,537	$ -
33	6800 SPEECH PATHOLOGY		0.135841	6,680	-							$ 6,680	$ -
34	6900 ELECTROCARDIOLOGY		0.046928	56,739	85,356							$ 56,739	$ 85,356
35	7000 ELECTROENCEPHALOGRAPHY		0.160266	36,684	3,593							$ 36,684	$ 3,593
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.550720	43,739	8,369							$ 43,739	$ 8,369
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.271264	117,458	-							$ 117,458	$ -
38	7300 DRUGS CHARGED TO PATIENTS		0.189786	336,919	55,552							$ 336,919	$ 55,552
39	7400 RENAL DIALYSIS		0.235809	49,368	32,816							$ 49,368	$ 32,816
40	9100 EMERGENCY		0.150846	109,491	524,829							$ 109,491	$ 524,829
41	9300 WOUND CARE		0.127581	-	-							$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2018-06/30/2019) ST. JOSEPH HOSPITAL SAVANNAH

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,609,025	$ 1,401,137	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 2,068,472	$ 1,401,137	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,068,472	$ 1,401,137
129	Total Charges per PS&R or Exhibit Detail			$ 2,068,472	$ 1,401,137	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 471,975	$ 173,344	$ -	$ -	$ -	$ -	$ -	$ -	$ 471,975	$ 173,344
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 251,177	$ 136,583							$ 251,177	$ 136,583
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				$ 761							$ -	$ 761
134	Private Insurance (including primary and third party liability)				$ 744							$ -	$ 744
135	Self-Pay (including Co-Pay and Spend-Down)			$ 24	$ 4,146							$ 24	$ 4,146
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 251,201	$ 142,234	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 220,774	$ 31,110	$ -	$ -	$ -	$ -	$ -	$ -	$ 220,774	$ 31,110
144	**Calculated Payments as a Percentage of Cost**			53%	82%	0%	0%	0%	0%	0%	0%	53%	82%

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.