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

DSH Version 6.01 2/10/2022

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: St. Joseph Hospital-Atlanta

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	09/01/2020	08/31/2021
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001812A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110082

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 (07/01/20 - 06/30/21)
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.)	No
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?	Yes
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	5/1/1976

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** — $ 1,263,253
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2020 - 06/30/2021** — $ 1,263,253

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.**	

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	11/18/2022 Date
Divya Matai Hospital CEO or CFO Printed Name	678-843-5928 Hospital CEO or CFO Telephone Number	divya.matai@emoryhealthcare.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Hunter Hatcher
Title	Controller
Telephone Number	404-272-6959
E-Mail Address	james.hunter.hatcher@emoryhealthcare.org
Mailing Street Address	5665 Peachtree Dunwoody Rd.
Mailing City, State, Zip	Atlanta, GA 30342

Outside Preparer:

Name	Lewis Cantrell
Title	Director
Firm Name	Southeast Reimbursement Group
Telephone Number	615-333-0655
E-Mail Address	lewis.cantrell@srgllc.org

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D. General Cost Report Year Information 9/1/2020 - 8/31/2021

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

1. Select Your Facility from the Drop-Down Menu Provided:	St. Joseph Hospital-Atlanta		
	9/1/2020 through 8/31/2021		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	2/2/2022		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	St. Joseph Hospital-Atlanta	Yes	
5. Medicaid Provider Number:	000001812A	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:	110082	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number		
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (09/01/2020 - 08/31/2021)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 532,467	$ 958,577	$1,491,044
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 9,459,523	$ 15,944,698	$25,404,222
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)	$9,991,990	$16,903,276	$26,895,266
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.33%	5.67%	5.54%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

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

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

F. MIUR / LIUR Qualifying Data from the Cost Report (09/01/2020 - 08/31/2021)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	105,728	**(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	35,247,651
8.	Outpatient Hospital Charity Care Charges	17,655,161
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 52,902,812

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	$302,732,303.00			$ 219,530,535	$ -	$ -	$ 83,201,768
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	$847,954,268.00	$604,386,854.00		$ 614,905,818	$ 438,279,524	$ -	$ 399,155,781
20.	Outpatient Services		$165,020,171.00			$ 119,666,670	$ -	$ 45,353,501
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	$ 1,150,686,571	$ 769,407,025	$ -	$ 834,436,353	$ 557,946,193	$ -	$ 527,711,050
28.	Total Hospital and Non Hospital		Total from Above	$ 1,920,093,596		Total from Above	$ 1,392,382,546	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,920,093,596	Total Contractual Adj. (G-3 Line 2)	1,392,382,546
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
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				1,392,382,546
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2020-08/31/2021) | St. Joseph Hospital-Atlanta

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	$ 109,993,729	$ 453,578	$ -	$0.00	$ 110,447,307	96,546	$179,314,919.00		$ 1,143.99
2	03100 INTENSIVE CARE UNIT	$ 26,333,552	$ 124,700	$ -		$ 26,458,252	11,548	$83,798,234.00		$ 2,291.15
3	03200 CORONARY CARE UNIT	$ 11,520,179	$ -	$ -		$ 11,520,179	5,528	$39,619,150.00		$ 2,083.97
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	$ 147,847,460	$ 578,278	$ -	$ -	$ 148,425,738	113,622	$ 302,732,303		
19	Weighted Average									$ 1,306.31

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)	7,894	-	-	$ 9,030,657	$2,529,953.00	$10,789,116.00	$ 13,319,069	0.678025

Line #		*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$32,480,692.00	$ 1,109,417	$ -		$ 33,590,109	$174,627,744.00	$114,708,786.00	$ 289,336,530	0.116094
22	5100 RECOVERY ROOM	$9,358,372.00	$ -	$ -		$ 9,358,372	$13,089,663.00	$18,513,032.00	$ 31,602,695	0.296126
23	5300 ANESTHESIOLOGY	$2,210,388.00	$ -	$ -		$ 2,210,388	$34,958,337.00	$25,555,519.00	$ 60,513,856	0.036527
24	5400 RADIOLOGY-DIAGNOSTIC	$8,700,027.00	$ -	$ -		$ 8,700,027	$30,649,429.00	$27,679,279.00	$ 58,328,708	0.149155
25	5401 ELECTRO-PHYSIOLOGY	$3,216,391.00	$ -	$ -		$ 3,216,391	$6,631,479.00	$38,790,391.00	$ 45,421,870	0.070812
26	5402 CARDIOLOGY	$2,014,775.00	$ -	$ -		$ 2,014,775	$128,785.00	$28,588,098.00	$ 28,716,883	0.070160
27	5500 RADIOLOGY-THERAPEUTIC	$11,440,893.00	$ 117,026	$ -		$ 11,557,919	$2,203,729.00	$54,885,848.00	$ 57,089,577	0.202452
28	5600 RADIOISOTOPE	$3,911,020.00	$ -	$ -		$ 3,911,020	$3,072,825.00	$23,150,914.00	$ 26,223,739	0.149140
29	5700 CT SCAN	$2,841,904.00	$ -	$ -		$ 2,841,904	$30,266,188.00	$27,465,299.00	$ 57,731,487	0.049226
30	5800 MRI	$5,273,075.00	$ -	$ -		$ 5,273,075	$16,695,013.00	$22,879,020.00	$ 39,574,033	0.133246

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	5900	CARDIAC CATHETERIZATION	$5,397,929.00	$ -	$ -		$ 5,397,929	$34,308,916.00	$27,824,604.00	$ 62,133,520	0.086876
32	6000	LABORATORY	$19,647,081.00	$ -	$ -		$ 19,647,081	$148,558,410.00	$33,771,103.00	$ 182,329,513	0.107756
33	6001	BLOOD LABORATORY	$3,202,867.00	$ -	$ -		$ 3,202,867	$8,427,673.00	$10,133,791.00	$ 18,561,464	0.172555
34	6002	ENDOSCOPY	$5,755,288.00	$ -	$ -		$ 5,755,288	$9,350,925.00	$17,803,511.00	$ 27,154,436	0.211947
35	6500	RESPIRATORY THERAPY	$10,304,469.00	$ -	$ -		$ 10,304,469	$60,672,819.00	$5,280,742.00	$ 65,953,561	0.156238
36	6600	PHYSICAL THERAPY	$4,012,217.00	$ -	$ -		$ 4,012,217	$12,961,599.00	$2,208,282.00	$ 15,169,881	0.264486
37	6700	OCCUPATIONAL THERAPY	$866,128.00	$ -	$ -		$ 866,128	$2,356,469.00	$286,487.00	$ 2,642,956	0.327712
38	7000	ELECTROENCEPHALOGRAPHY	$480,864.00	$ -	$ -		$ 480,864	$1,621,935.00	$375,154.00	$ 1,997,089	0.240782
39	7001	ECHOCARDIOGRAPHY	$6,219,514.00	$ -	$ -		$ 6,219,514	$33,015,525.00	$13,654,096.00	$ 46,669,621	0.133267
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$33,582,423.00	$ -	$ -		$ 33,582,423	$53,726,927.00	$25,100,917.00	$ 78,827,844	0.426022
41	7200	IMPL. DEV. CHARGED TO PATIENTS	$79,089,808.00	$ -	$ -		$ 79,089,808	$43,135,733.00	$41,055,001.00	$ 84,190,734	0.939412
42	7300	DRUGS CHARGED TO PATIENTS	$38,387,502.00	$ -	$ -		$ 38,387,502	$118,335,385.00	$42,934,133.00	$ 161,269,518	0.238033
43	7400	RENAL DIALYSIS	$2,571,350.00	$ -	$ -		$ 2,571,350	$9,158,759.00	$1,742,847.00	$ 10,901,606	0.235869
44	9002	OUTPATIENT IMAGING CENTER	$5,422,664.00	$ -	$ -		$ 5,422,664	$399,680.00	$68,086,682.00	$ 68,486,362	0.079179
45	9004	OP VASCULAR LAB	$1,071,463.00	$ -	$ -		$ 1,071,463	$127,472.00	$11,154,879.00	$ 11,282,351	0.094968
46	9100	EMERGENCY	$19,579,027.00	$ -	$ -		$ 19,579,027	$29,301,858.00	$42,630,531.00	$ 71,932,389	0.272187
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
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**	$ 317,038,131	$ 1,226,443	$ -		$ 318,264,574	$ 880,313,230	$ 737,048,062	$ 1,617,361,292	
127	**Weighted Average**									0.202364
128	**Sub Totals**	$ 464,885,591	$ 1,804,721	$ -		$ 466,690,312	$ 1,183,045,533	$ 737,048,062	$ 1,920,093,595	

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**	$ 466,690,312
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.39%

* 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 (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

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	$ 1,143.99		3,730		767		2,674		3,316		3,115		10,487		15.55%
2	03100 INTENSIVE CARE UNIT	$ 2,291.15		555		84		323		338		353		1,300		14.89%
3	03200 CORONARY CARE UNIT	$ 2,083.97		510		55		181		271		249		1,017		23.55%
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	4,795		906		3,178		3,925		3,717		12,804		14.79%
19	Total Days per PS&R or Exhibit Detail			4,795		906		3,178		3,925		3,717				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 12,544,389		$ 2,459,921		$ 8,765,598		$ 10,755,751		$ 10,322,949		$ 34,525,659		15.17%
21.01	Calculated Routine Charge Per Diem			$ 2,616.14		$ 2,715.14		$ 2,758.21		$ 2,740.32		$ 2,777.23		$ 2,696.47		
	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)		0.678025		229,232	-	136,924	1,322	148,130		311,202		756,006	$ 1,322	$ 825,488	12.00%
23	5000 OPERATING ROOM		0.116094	3,153,714	810,316	1,221,339	2,149,018	2,188,983	972,134	3,942,212	1,983,174	3,756,294	1,695,780	$ 10,506,249	$ 5,914,642	7.64%
24	5100 RECOVERY ROOM		0.296126	258,761	182,518	154,224	374,462	156,406	173,708	325,581	373,380	226,492	267,324	$ 894,972	$ 1,104,068	7.95%
25	5300 ANESTHESIOLOGY		0.036527	608,774	200,317	246,553	463,370	450,860	219,737	796,164	451,062	766,755	362,338	$ 2,102,351	$ 1,334,486	7.62%
26	5400 RADIOLOGY-DIAGNOSTIC		0.149155	942,857	213,289	219,940	256,927	788,519	532,085	1,101,438	1,005,941	986,397	786,067	$ 3,052,754	$ 2,008,242	11.84%
27	5401 ELECTRO-PHYSIOLOGY		0.070812	93,674	168,339	60,038	271,625	214,583	261,685	211,621	793,979	172,608	121,404	$ 579,916	$ 1,495,628	5.37%
28	5402 CARDIOLOGY		0.070160	10,422	223,316		212,705	3,877	347,877	(1,742)	451,396	2,644	187,463	$ 12,557	$ 1,235,294	5.02%
29	5500 RADIOLOGY-THERAPEUTIC		0.202452	71,845	443,406	56,196	811,154	14,155	671,747	41,376	739,636	82,387	547,783	$ 183,572	$ 2,665,943	6.12%
30	5600 RADIOISOTOPE		0.149140	82,863	456,430	39,274	231,791	101,581	357,113	84,195	475,746	123,803	514,162	$ 307,913	$ 1,521,080	9.50%
31	5700 CT SCAN		0.049226	1,138,988	326,696	248,417	511,626	769,549	388,592	1,124,541	589,119	1,774,114	2,301,862	$ 3,281,495	$ 1,816,033	16.15%
32	5800 MRI		0.133246	575,646	169,221	175,348	393,262	345,002	249,326	520,951	399,880	878,475	830,462	$ 1,616,947	$ 1,211,689	11.65%
33	5900 CARDIAC CATHETERIZATION		0.086876	681,438	138,404	61,005	95,034	520,596	639,002	750,157	530,128	1,389,229	309,552	$ 2,013,196	$ 1,402,568	8.36%
34	6000 LABORATORY		0.107756	5,034,791	866,205	1,093,104	556,506	3,814,943	501,348	4,895,294	832,141	5,549,295	2,374,527	$ 14,838,132	$ 2,756,200	14.25%
35	6001 BLOOD LABORATORY		0.172555	187,604	8,507	80,823	189,823	154,442	122,246	247,204	228,577	284,875	166,363	$ 670,073	$ 549,153	9.12%
36	6002 ENDOSCOPY		0.211947	346,583	160,272	80,192	170,849	176,412	266,030	274,490	421,589	447,961	174,472	$ 877,677	$ 1,018,740	9.35%
37	6500 RESPIRATORY THERAPY		0.156238	3,660,247	69,106	500,401	62,254	1,955,547	84,674	2,487,157	132,744	1,719,881	302,205	$ 8,603,352	$ 348,778	17.06%
38	6600 PHYSICAL THERAPY		0.264486	410,181	1,746	77,894	4,799	354,680	13,019	447,702	40,418	262,727	12,791	$ 1,290,457	$ 59,982	10.87%
39	6700 OCCUPATIONAL THERAPY		0.327712	89,461		11,261		88,088	799	96,346	8,174	62,660	4,776	$ 285,156	$ 8,973	14.16%
40	7000 ELECTROENCEPHALOGRAPHY		0.240782	55,398		14,373	9,439	32,985	1,999	34,111	7,375	36,798	13,796	$ 136,867	$ 18,813	10.87%
41	7001 ECHOCARDIOGRAPHY		0.133267	1,058,274	74,092	230,010	95,991	924,338	160,601	1,001,117	263,338	1,151,145	270,219	$ 3,213,739	$ 594,022	11.40%
42	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.426022	1,040,564	171,126	400,740	312,077	867,280	217,219	1,361,877	451,317	1,157,980	402,839	$ 3,670,461	$ 1,151,739	8.24%
43	7200 IMPL. DEV. CHARGED TO PATIENTS		0.939412	728,712	69,237	182,782	229,601	551,972	454,444	788,368	866,805	1,009,248	269,083	$ 2,251,833	$ 1,620,087	6.22%
44	7300 DRUGS CHARGED TO PATIENTS		0.238033	4,611,474	645,487	933,875	540,724	2,984,671	646,458	3,805,490	769,671	4,076,868	1,168,742	$ 12,335,510	$ 2,602,340	12.69%
45	7400 RENAL DIALYSIS		0.235869	643,887	18,144	38,514	4,850	656,488	46,674	620,688	53,292	267,704	972,134	$ 1,959,577	$ 122,960	31.44%
46	9002 OUTPATIENT IMAGING CENTER		0.079179	10,827	645,368	9,274	1,249,981	2,532	666,159	7,628	1,229,819		655,253	$ 30,261	$ 3,791,327	6.58%
47	9004 OP VASCULAR LAB		0.094968		6,024	1,423	70,134	2,015	192,456	6,617	237,112		132,478	$ 10,055	$ 505,726	5.75%
48	9100 EMERGENCY		0.272187	980,595	986,104	306,257	1,220,988	791,886	779,063	888,314	1,190,527	1,489,987	6,668,399	$ 2,967,052	$ 4,176,682	21.58%
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
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58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											$ -	$ -	-
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
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123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 26,477,582	$ 7,282,902	$ 6,443,257	$ 10,625,915	$ 18,913,712	$ 9,114,325	$ 25,858,897	$ 14,837,542	$ 27,676,327	$ 22,268,280			

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

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

	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)***	$ 39,021,971	$ 7,282,902	$ 8,903,178	$ 10,625,915	$ 27,679,310	$ 9,114,325	$ 36,614,648	$ 14,837,542	$ 37,999,276 (Agrees to Exhibit A)	$ 22,268,280 (Agrees to Exhibit A)	$ 112,219,106	$ 41,860,684	11.35%
129	Total Charges per PS&R or Exhibit Detail	$ 39,021,971	$ 7,282,902	$ 8,903,178	$ 10,625,915	$ 27,679,310	$ 9,114,325	$ 36,614,648	$ 14,837,542	$ 37,999,276	$ 22,268,280			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 11,590,943	$ 1,344,616	$ 2,419,521	$ 1,898,710	$ 7,777,943	$ 1,829,914	$ 10,030,399	$ 3,090,964	$ 10,085,753	$ 4,603,755	$ 31,818,806	$ 8,164,204	11.91%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 9,169,809	$ 1,034,913			$ 381,491	$ 104,166	$ 581,436	$ 109,006			$ 10,132,736	$ 1,248,086	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,160,427	$ 1,333,822				$ 1,277			$ 2,160,427	$ 1,335,098	
134	Private Insurance (including primary and third party liability)	$ 203,623	$ 3,684					$ 1,935,310	$ 687,532			$ 2,138,932	$ 691,216	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 11,202	$ 20,756	$ 1,391	$ 1,979	$ 2,066	$ 2,496	$ 9,233			$ 25,231	$ 23,892	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 9,373,431	$ 1,049,799	$ 2,181,183	$ 1,335,212									
137	Medicaid Cost Settlement Payments (See Note B)		$ 7,097									$ -	$ 7,097	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,392,046	$ 1,542,110					$ 5,392,046	$ 1,542,110	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 84	$ -	$ 6,310,698	$ 2,078,907			$ 6,310,782	$ 2,078,907	
141	Medicare Cross-Over Bad Debt Payments					$ 54,794	$ 84,265					$ 54,794	$ 84,265	
142	Other Medicare Cross-Over Payments (See Note D)					$ 26,861	$ 4,308			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 26,861	$ 4,308	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 532,467	$ 958,577			
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)**	$ 2,217,512	$ 287,720	$ 238,338	$ 563,498	$ 1,920,688	$ 92,998	$ 1,200,459	$ 205,008	$ 9,553,286	$ 3,645,178	$ 5,576,997	$ 1,149,224	
146	**Calculated Payments as a Percentage of Cost**	81%	79%	90%	70%	75%	95%	88%	93%	5%	21%	82%	86%	
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)**					60,119								
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 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.

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

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	$ 1,143.99		132		-		7		40		179	
2	03100 INTENSIVE CARE UNIT	$ 2,291.15		40		-		16		10		66	
3	03200 CORONARY CARE UNIT	$ 2,083.97		18		-		2		16		36	
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	190		-		25		66		281	
19	Total Days per PS&R or Exhibit Detail			190		-		25		66			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 659,658		$ -		$ 141,807		$ 286,336		$ 1,087,801	
21.01	Calculated Routine Charge Per Diem			$ 3,471.88		$ -		$ 5,672.28		$ 4,338.42		$ 3,871.18	
	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)		0.678025		8,928	-	-	2,082	4,316		216	$ 2,082	$ 13,460
23	5000 OPERATING ROOM		0.116094	14,748	41,310	-	-		16,380	133,081	13,542	$ 147,829	$ 71,232
24	5100 RECOVERY ROOM		0.296126		12,090	-	-		3,718	2,210	1,092	$ 2,210	$ 16,900
25	5300 ANESTHESIOLOGY		0.036527	3,120	8,606	-	-		3,640	26,806	4,496	$ 29,926	$ 16,742
26	5400 RADIOLOGY-DIAGNOSTIC		0.149155	17,720	14,146	-	-	6,099	694	33,183	1,689	$ 57,002	$ 16,529
27	5401 ELECTRO-PHYSIOLOGY		0.070812	20,169		-	-				50,602	$ 20,169	$ 50,602
28	5402 CARDIOLOGY		0.070160			-	-		680		3,877	$ -	$ 4,557
29	5500 RADIOLOGY-THERAPEUTIC		0.202452			-	-		16,500			$ -	$ 16,500
30	5600 RADIOISOTOPE		0.149140	1,575		-	-	5,378			17,327	$ 6,953	$ 17,327
31	5700 CT SCAN		0.049226	81,931	47,538	-	-	1,725	4,404	12,380	2,578	$ 96,036	$ 54,520
32	5800 MRI		0.133246	44,527	14,227	-	-	9,042		3,812	1,202	$ 57,381	$ 15,429
33	5900 CARDIAC CATHETERIZATION		0.086876	44,717		-	-	16,841		16,202		$ 77,760	$ -
34	6000 LABORATORY		0.107756	240,857	68,676	-	-	52,706	3,554	97,201	5,146	$ 390,764	$ 77,376
35	6001 BLOOD LABORATORY		0.172555	8,822	1,627	-	-	2,106	6,139	3,548	429	$ 14,476	$ 8,195
36	6002 ENDOSCOPY		0.211947	7,770		-	-	7,534	3,632			$ 15,304	$ 3,632
37	6500 RESPIRATORY THERAPY		0.156238	138,842	8,479	-	-	62,487	177	67,019	531	$ 268,348	$ 9,187
38	6600 PHYSICAL THERAPY		0.264486	15,769	417	-	-	1,736		5,470		$ 22,975	$ 417
39	6700 OCCUPATIONAL THERAPY		0.327712	9,549		-	-			3,209		$ 12,758	$ -
40	7000 ELECTROENCEPHALOGRAPHY		0.240782	3,376		-	-	6,114		1,340		$ 10,830	$ -
41	7001 ECHOCARDIOGRAPHY		0.133267	49,631	15,616	-	-	13,220		12,201		$ 75,052	$ 15,616
42	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.426022	24,788	8,225	-	-	8,859	3,109	57,262	7,450	$ 90,909	$ 18,784
43	7200 IMPL. DEV. CHARGED TO PATIENTS		0.939412	31,064		-	-	36,135	336	4,287	14,648	$ 71,486	$ 14,984
44	7300 DRUGS CHARGED TO PATIENTS		0.238033	137,001	20,801	-	-	64,979	2,092	57,507	7,321	$ 259,487	$ 30,215
45	7400 RENAL DIALYSIS		0.235869	56,606		-	-	1,327		47,476		$ 105,409	$ -
46	9002 OUTPATIENT IMAGING CENTER		0.079179		9,753	-	-				16,437	$ -	$ 26,190
47	9004 OP VASCULAR LAB		0.094968			-	-				560	$ -	$ 560
48	9100 EMERGENCY		0.272187	51,249	159,520	-	-			3,473	8,782	$ 54,722	$ 168,302

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

				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	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
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65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
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109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,003,831	$ 439,959	$ -	$ -	$ 298,370	$ 69,371	$ 587,667	$ 157,925		

Totals / Payments

		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	
128	**Total Charges (includes organ acquisition from Section K)**	$ 1,663,489	$ 439,959	$ -	$ -	$ 440,177	$ 69,371	$ 874,003	$ 157,925	$ 2,977,669	$ 667,256
129	Total Charges per PS&R or Exhibit Detail	$ 1,663,489	$ 439,959	$ -	$ -	$ 440,177	$ 69,371	$ 874,003	$ 157,925		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 465,343	$ 84,934	$ -	$ -	$ 129,306	$ 14,148	$ 206,831	$ 32,318	$ 801,480	$ 131,400
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 20,768	$ 5,684	$ -	$ -					$ 20,768	$ 5,684
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -					$ -	$ -
134	Private Insurance (including primary and third party liability)								$ 22,459	$ -	$ 22,459
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 20,768	$ 5,684	$ -	$ -						
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)					$ 135,642	$ 10,173			$ 135,642	$ 10,173
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 173,301	$ 4,654	$ 173,301	$ 4,654
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)**	$ 444,575	$ 79,250	$ -	$ -	$ (6,336)	$ 3,975	$ 33,530	$ 5,206	$ 471,769	$ 88,431
144	**Calculated Payments as a Percentage of Cost**	4%	7%	0%	0%	105%	72%	84%	84%	41%	33%

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

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

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

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

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

K. Transplant Facilities Only: Organ Acquisition Cost Out-of-State Medicaid

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

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

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

An adjustment is necessary to properly reflect the Medicaid and uninsured share of the provider tax assessment for some hospitals. The Medicaid and uninsured share of the provider tax assessment collected is an allowable cost in determining hospital-specific DSH limits and, therefore, can be included in the DSH examination survey. However, depending on how your hospital reports it on the Medicare cost report, an adjustment may be necessary to ensure the cost is properly reflected in determining your hospital-specific DSH limit. For instance, if your hospital removed part or all of the provider tax assessment on the Medicare cost report, the full amount of the provider tax assessment would not have been apportioned to the various payers through the step down allocation process, resulting in the Medicaid and uninsured share being understated in determining the hospital-specific DSH limit. If your hospital needs to make an adjustment for the Medicaid and uninsured share of the provider tax assessment, please fill out the reconciliation below, and submit the supporting general ledger entries and other supporting documentation to Myers and Stauffer, LC along with your hospital's DSH examination surveys.

Cost Report Year (09/01/2020-08/31/2021) St. Joseph Hospital-Atlanta

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 5,638,032		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	40977.00	*(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 ---------->)		$ 5,638,032		
	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*	Allowable Provider Tax Adjustment	$ 4,180,390	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		$ 4,180,390		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 1,457,642
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	157,724,714
19	Uninsured Hospital	**Charges Sec. G**	60,267,556
20	Total Hospital	**Charges Sec. G**	1,920,093,595
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		8.21%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		3.14%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 119,737
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 45,752
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 165,489**

** 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.*