State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2022

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2021	06/30/2022

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	09/01/2021	08/31/2022
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 (07/01/21 - 06/30/22)
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 07/01/2021 - 06/30/2022** — $ 1,976,428
   (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 07/01/2021 - 06/30/2022** — $ -
   (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 Services07/01/2021 - 06/30/2022** — $ 1,976,428

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	Title	Date
	CFO	10/17/2023

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

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

DSH Version 8.11 2/10/2023

D. General Cost Report Year Information 9/1/2021 - 8/31/2022

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

	9/1/2021 through 8/31/2022		
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:	5/12/2023		

	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	

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: (09/01/2021 - 08/31/2022)

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)	$ 834,726	$ 541,663	$1,376,389
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 13,694,127	$ 19,820,235	$33,514,362
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)	$14,528,853	$20,361,898	$34,890,751
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.75%	2.66%	3.94%

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 (09/01/2021 - 08/31/2022)

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)	103,585 **(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	32,269,163
8.	Outpatient Hospital Charity Care Charges	19,244,433
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 51,513,596

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	$289,692,339.00			$ 206,847,446	$ -	$ -	$ 82,844,893
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	$826,795,014.00	$638,047,379.00		$ 590,351,950	$ 455,581,502	$ -	$ 418,908,940
20.	Outpatient Services		$171,700,102.00			$ 122,598,091	$ -	$ 49,102,011
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	$ 1,116,487,353	$ 809,747,481	$ -	$ 797,199,397	$ 578,179,593	$ -	$ 550,855,844
28.	Total Hospital and Non Hospital		Total from Above	$ 1,926,234,834		Total from Above	$ 1,375,378,990	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,926,234,834	Total Contractual Adj. (G-3 Line 2)	1,375,378,990
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.	Adjusted Contractual Adjustments				1,375,378,990
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2021-08/31/2022) | 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	$ 130,030,567	$ 395,000	$ -	$0.00	$ 130,425,567	94,665	$171,855,132.00		$ 1,377.76
2	03100 INTENSIVE CARE UNIT	$ 29,292,433	$ 140,956	$ -		$ 29,433,389	10,174	$79,186,067.00		$ 2,893.00
3	03200 CORONARY CARE UNIT	$ 13,090,161	$ -	$ -		$ 13,090,161	4,996	$38,651,140.00		$ 2,620.13
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	$ 172,413,161	$ 535,956	$ -	$ -	$ 172,949,117	109,835	$ 289,692,339		
19	Weighted Average									$ 1,574.63

		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
	Observation Data (Non-Distinct)								
20	09200 Observation (Non-Distinct)	6,250	-	-	$ 8,611,000	$2,786,035.00	$8,384,081.00	$ 11,170,116	0.770896

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*		*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	$47,479,549.00	$ 1,265,896	$ -		$ 48,745,445	$182,403,350.00	$134,779,249.00	$ 317,182,599	0.153683
22	5100 RECOVERY ROOM	$12,131,425.00	$ -	$ -		$ 12,131,425	$11,369,292.00	$17,594,680.00	$ 28,963,972	0.418845
23	5300 ANESTHESIOLOGY	$3,379,421.00	$ -	$ -		$ 3,379,421	$37,363,009.00	$29,519,926.00	$ 66,882,935	0.050527
24	5400 RADIOLOGY-DIAGNOSTIC	$10,858,924.00	$ -	$ -		$ 10,858,924	$29,415,029.00	$25,200,496.00	$ 54,615,525	0.198825
25	5401 ELECTRO-PHYSIOLOGY	$469,655.00	$ -	$ -		$ 469,655	$6,241,611.00	$30,496,200.00	$ 36,737,811	0.012784
26	5402 CARDIOLOGY	$2,169,741.00	$ 98,750	$ -		$ 2,268,491	$172,974.00	$29,109,098.00	$ 29,282,072	0.077470
27	5500 RADIOLOGY-THERAPEUTIC	$11,366,116.00	$ 274,065	$ -		$ 11,640,181	$3,129,020.00	$72,106,083.00	$ 75,235,103	0.154717
28	5600 RADIOISOTOPE	$4,632,951.00	$ -	$ -		$ 4,632,951	$2,694,606.00	$24,580,312.00	$ 27,274,918	0.169861
29	5700 CT SCAN	$3,596,109.00	$ -	$ -		$ 3,596,109	$29,774,036.00	$29,921,219.00	$ 59,695,255	0.060241
30	5800 MRI	$5,802,857.00	$ -	$ -		$ 5,802,857	$17,492,649.00	$22,673,824.00	$ 40,166,473	0.144470

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2021-08/31/2022) 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	$7,571,605.00	$ -	$ -		$ 7,571,605	$31,964,700.00	$24,714,408.00	$ 56,679,108	0.133587
32	6000	LABORATORY	$19,052,867.00	$ -	$ -		$ 19,052,867	$144,115,578.00	$37,691,275.00	$ 181,806,853	0.104797
33	6001	BLOOD LABORATORY	$7,053,842.00	$ -	$ -		$ 7,053,842	$6,567,606.00	$8,907,860.00	$ 15,475,466	0.455808
34	6002	ENDOSCOPY	$6,081,090.00	$ -	$ -		$ 6,081,090	$8,992,354.00	$21,593,325.00	$ 30,585,679	0.198821
35	6500	RESPIRATORY THERAPY	$10,641,059.00	$ -	$ -		$ 10,641,059	$62,071,318.00	$5,694,758.00	$ 67,766,076	0.157026
36	6600	PHYSICAL THERAPY	$4,652,519.00	$ -	$ -		$ 4,652,519	$13,387,106.00	$2,343,620.00	$ 15,730,726	0.295760
37	6700	OCCUPATIONAL THERAPY	$917,607.00	$ -	$ -		$ 917,607	$2,226,390.00	$299,041.00	$ 2,525,431	0.363347
38	7000	ELECTROENCEPHALOGRAPHY	$428,153.00	$ 16,774	$ -		$ 444,927	$1,708,865.00	$231,267.00	$ 1,940,132	0.229328
39	7001	ECHOCARDIOGRAPHY	$6,839,321.00	$ -	$ -		$ 6,839,321	$36,457,948.00	$17,315,920.00	$ 53,773,868	0.127187
40	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$26,732,845.00	$ -	$ -		$ 26,732,845	$43,790,714.00	$20,625,386.00	$ 64,416,100	0.415003
41	7200	IMPL. DEV. CHARGED TO PATIENTS	$77,946,147.00	$ -	$ -		$ 77,946,147	$43,529,286.00	$41,509,976.00	$ 85,039,262	0.916590
42	7300	DRUGS CHARGED TO PATIENTS	$36,628,055.00	$ -	$ -		$ 36,628,055	$103,045,149.00	$38,549,604.00	$ 141,594,753	0.258682
43	7400	RENAL DIALYSIS	$3,132,273.00	$ -	$ -		$ 3,132,273	$8,882,424.00	$2,589,852.00	$ 11,472,276	0.273030
44	9002	OUTPATIENT IMAGING CENTER	$5,858,875.00	$ -	$ -		$ 5,858,875	$647,377.00	$65,547,155.00	$ 66,194,532	0.088510
45	9004	OP VASCULAR LAB	$1,110,871.00	$ -	$ -		$ 1,110,871	$108,924.00	$12,683,807.00	$ 12,792,731	0.086836
46	9100	EMERGENCY	$25,344,153.00	$ -	$ -		$ 25,344,153	$32,923,652.00	$48,619,071.00	$ 81,542,723	0.310808
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 (09/01/2021-08/31/2022) 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**	$ 341,878,030	$ 1,655,485	$ -		$ 343,533,515	$ 863,261,002	$ 773,281,493	$ 1,636,542,495	
127	**Weighted Average**									0.215176
128	**Sub Totals**	$ 514,291,191	$ 2,191,441	$ -		$ 516,482,632	$ 1,152,953,341	$ 773,281,493	$ 1,926,234,834	

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**	$ 516,482,632
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.43%

* 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 (09/01/2021-08/31/2022) 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	$ 1,377.76		4,507		1,037		2,677		4,507		3,550		12,728		18.68%
2	03100 INTENSIVE CARE UNIT	$ 2,893.00		769		110		315		374		449		1,568		20.25%
3	03200 CORONARY CARE UNIT	$ 2,620.13		249		26		143		235		173		653		16.77%
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ -												-		
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	5,525		1,173		3,135		5,116		4,172		14,949		17.67%
19	Total Days per PS&R or Exhibit Detail			5,525		1,173		3,135		5,116		4,172				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 15,320,295		$ 2,971,613		$ 8,526,536		$ 13,299,609		$ 11,803,321		$ 40,118,053		18.23%
21.01	Calculated Routine Charge Per Diem			$ 2,772.90		$ 2,533.34		$ 2,719.79		$ 2,599.61		$ 2,829.18		$ 2,683.66		
	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)		0.770896		226,240	532	111,975	1,216	63,612	2,660	319,849		784,290	$ 4,408	$ 721,676	13.70%
23	5000 OPERATING ROOM		0.153683	3,692,927	915,480	1,681,569	2,296,836	1,571,973	1,120,889	5,237,700	3,138,616	4,300,226	1,714,983	$ 12,184,169	$ 7,471,822	8.27%
24	5100 RECOVERY ROOM		0.418845	227,482	124,560	145,047	312,728	137,532	140,980	359,071	374,629	244,013	237,651	$ 869,132	$ 952,897	8.04%
25	5300 ANESTHESIOLOGY		0.050527	765,483	202,123	343,945	476,402	317,236	201,109	1,067,891	608,961	874,160	350,234	$ 2,494,555	$ 1,488,595	7.94%
26	5400 RADIOLOGY-DIAGNOSTIC		0.198825	1,037,859	159,919	367,280	231,819	698,496	382,847	1,522,406	1,018,886	912,819	812,625	$ 3,626,041	$ 1,793,471	13.36%
27	5401 ELECTRO-PHYSIOLOGY		0.012784	59,369	68,955	44,085	102,778	78,776	54,766	288,882	162,778	142,941	935	$ 471,112	$ 389,277	2.74%
28	5402 CARDIOLOGY		0.077470	2,791	217,537		198,415	3,041	329,248	10,825	523,930		140,779	$ 16,657	$ 1,269,130	4.93%
29	5500 RADIOLOGY-THERAPEUTIC		0.154717	38,261	291,039	72,223	794,789	3,104	334,099	227,818	1,018,434	23,958	777,102	$ 341,406	$ 2,438,361	4.76%
30	5600 RADIOISOTOPE		0.169861	107,967	438,294	26,628	286,604	70,340	217,735	114,330	689,027	88,171	330,759	$ 319,265	$ 1,631,660	8.71%
31	5700 CT SCAN		0.060241	1,406,381	309,568	423,237	552,501	779,125	326,771	1,389,817	834,631	1,921,580	2,466,428	$ 3,998,560	$ 2,023,471	17.74%
32	5800 MRI		0.144470	567,078	150,734	315,266	458,140	326,376	88,138	808,539	422,821	1,018,915	945,931	$ 2,017,259	$ 1,119,833	12.98%
33	5900 CARDIAC CATHETERIZATION		0.133587	659,233	48,363	93,803	38,046	405,008	278,828	1,134,252	758,435	1,049,671	524,551	$ 2,292,296	$ 1,123,672	9.16%
34	6000 LABORATORY		0.104797	5,802,083	893,393	1,623,109	739,439	3,672,224	342,145	6,355,949	1,082,188	5,906,253	2,605,660	$ 17,453,364	$ 3,057,165	16.28%
35	6001 BLOOD LABORATORY		0.455808	112,169	7,032	69,094	162,982	90,869	79,757	209,905	243,854	224,086	149,719	$ 482,037	$ 493,625	8.80%
36	6002 ENDOSCOPY		0.198821	231,273	190,930	61,885	191,007	167,128	188,410	376,382	757,857	517,860	246,544	$ 836,668	$ 1,328,204	9.63%
37	6500 RESPIRATORY THERAPY		0.157026	6,092,813	70,138	510,080	68,032	2,259,201	41,963	2,976,041	182,269	2,013,894	296,327	$ 11,838,135	$ 362,402	21.73%
38	6600 PHYSICAL THERAPY		0.295760	488,181	-	97,906	2,582	357,523	9,711	575,236	67,674	338,827	8,999	$ 1,518,846	$ 79,967	12.50%
39	6700 OCCUPATIONAL THERAPY		0.363347	107,184	-	6,678		86,118	2,994	102,528	4,794	66,617	1,194	$ 302,508	$ 7,788	15.16%
40	7000 ELECTROENCEPHALOGRAPHY		0.229328	66,912	-	8,272	4,418	82,792	5,131	95,660	13,235	43,694	8,171	$ 253,636	$ 22,784	17.71%
41	7001 ECHOCARDIOGRAPHY		0.127187	1,290,191	31,034	357,147	76,820	756,433	99,569	1,608,185	369,206	1,298,430	238,775	$ 4,011,956	$ 576,629	11.63%
42	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.415003	1,033,967	153,509	689,658	246,628	494,949	128,475	1,181,607	487,083	1,321,584	293,292	$ 3,400,181	$ 1,015,695	9.57%
43	7200 IMPL. DEV. CHARGED TO PATIENTS		0.916590	954,062	85,288	324,456	180,307	440,729	291,425	1,382,327	738,794	774,394	309,668	$ 3,101,574	$ 1,295,813	6.55%
44	7300 DRUGS CHARGED TO PATIENTS		0.259682	5,129,560	585,483	1,229,483	539,986	2,699,531	360,446	4,385,540	926,452	4,479,012	1,111,244	$ 13,444,114	$ 2,412,367	15.42%
45	7400 RENAL DIALYSIS		0.273030	504,272	17,390	72,870		420,438	32,520	816,510	139,556	160,311	1,621,618	$ 1,814,090	$ 189,466	33.49%
46	9002 OUTPATIENT IMAGING CENTER		0.088510	11,311	590,684	6,252	1,075,112	11,955	572,843	8,542	1,550,583	3,812	786,778	$ 38,060	$ 3,789,222	7.04%
47	9004 OP VASCULAR LAB		0.086836		-									$ -	$ -	0.00%
48	9100 EMERGENCY		0.310808	1,097,153	1,202,320	494,867	1,718,019	851,154	635,422	1,267,254	1,570,020	1,648,954	7,452,329	$ 3,710,428	$ 5,125,781	22.36%
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (09/01/2021-08/31/2022) 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				-											$ -	$ -	
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124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 31,485,962	$ 6,980,010	$ 9,065,372	$ 10,866,365	$ 16,783,267	$ 6,329,833	$ 33,505,857	$ 18,004,561	$ 29,374,183	$ 24,216,585			

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

Cost Report Year (09/01/2021-08/31/2022) 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)***	$ 46,806,257	$ 6,980,010	$ 12,036,985	$ 10,866,365	$ 25,309,803	$ 6,329,833	$ 46,805,466	$ 18,004,561	$ 41,177,504 (Agrees to Exhibit A)	$ 24,216,585 (Agrees to Exhibit A)	$ 130,958,510	$ 42,180,770	12.60%
129	Total Charges per PS&R or Exhibit Detail	$ 46,806,257	$ 6,980,010	$ 12,036,985	$ 10,866,365	$ 25,309,803	$ 6,329,833	$ 46,805,466	$ 18,004,561	$ 41,177,504	$ 24,216,585			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 15,409,334	$ 1,467,184	$ 3,773,520	$ 2,181,763	$ 8,345,688	$ 1,355,989	$ 14,879,762	$ 3,907,039	$ 12,469,108	$ 5,683,461	$ 42,408,304	$ 8,911,975	13.68%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 9,523,755	$ 1,066,992			$ 202,021	$ 80,856	$ 710,976	$ 160,396			$ 10,436,751	$ 1,308,244	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,523,837	$ 1,296,815	$ 1,556	$ 1,206	$ 59,531	$ 24,963			$ 2,584,924	$ 1,322,984	
134	Private Insurance (including primary and third party liability)	$ 244,296	$ 2,419					$ 1,691,704	$ 792,844			$ 1,936,000	$ 795,262	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 150	$ 2,735	$ 3,158		$ 24,235	$ 13,082			$ 27,544	$ 15,817	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 9,768,052	$ 1,069,410	$ 2,523,987	$ 1,299,550									
137	Medicaid Cost Settlement Payments (See Note B)		$ 167,991									$ -	$ 167,991	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 5,043,607	$ 1,003,370	$ 819,058	$ 271,828			$ 5,862,665	$ 1,275,198	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 6,915,238	$ 1,971,381			$ 6,915,238	$ 1,971,381	
141	Medicare Cross-Over Bad Debt Payments					$ 42,850	$ 62,968					$ 42,850	$ 62,968	
142	Other Medicare Cross-Over Payments (See Note D)					$ 22,967	$ 2,085			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 22,967	$ 2,085	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 834,726	$ 541,663			
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)**	$ 5,641,282	$ 229,783	$ 1,249,533	$ 882,213	$ 3,029,529	$ 205,504	$ 4,659,020	$ 672,544	$ 11,634,382	$ 5,141,798	$ 14,579,364	$ 1,990,044	
146	**Calculated Payments as a Percentage of Cost**	63%	84%	67%	60%	64%	85%	69%	83%	7%	10%	66%	78%	
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)**					59,176								
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 (09/01/2021-08/31/2022) 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	$ 1,377.76		139				56		41		236	
2	03100 INTENSIVE CARE UNIT	$ 2,893.00		27				14		2		43	
3	03200 CORONARY CARE UNIT	$ 2,620.13		1				6		5		12	
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**	167		-		76		48		291	
19	Total Days per PS&R or Exhibit Detail			167		-		76		48			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 530,262				$ 241,906		$ 116,286		$ 888,454	
21.01	Calculated Routine Charge Per Diem			$ 3,175.22		$ -		$ 3,182.97		$ 2,422.63		$ 3,053.11	
	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)		0.770896	152	17,708						1,596	$ 152	$ 19,304
23	5000 OPERATING ROOM		0.153683	348,360	126,982			3,621	13,029	49,232	5,589	$ 401,213	$ 145,600
24	5100 RECOVERY ROOM		0.418845	9,035	6,873			62	3,625	5,017		$ 14,114	$ 10,498
25	5300 ANESTHESIOLOGY		0.050527	66,479	25,207				2,929	9,599		$ 76,078	$ 28,136
26	5400 RADIOLOGY-DIAGNOSTIC		0.198825	20,167	59,567			18,080	32,636	21,932	633	$ 60,179	$ 92,836
27	5401 ELECTRO-PHYSIOLOGY		0.012784					2,371				$ 2,371	$ -
28	5402 CARDIOLOGY		0.077470		7,500				4,459		4,459	$ -	$ 16,418
29	5500 RADIOLOGY-THERAPEUTIC		0.154717									$ -	$ -
30	5600 RADIOISOTOPE		0.169861	5,414	1,527							$ 5,414	$ 1,527
31	5700 CT SCAN		0.060241	87,021	50,646			27,161	4,947	6,252	1,289	$ 120,434	$ 56,882
32	5800 MRI		0.144470	61,061	17,996			15,276	9,377	5,443	2,296	$ 81,780	$ 29,669
33	5900 CARDIAC CATHETERIZATION		0.133587	59,405				29,790	29,268	81,209		$ 170,404	$ 29,268
34	6000 LABORATORY		0.104797	314,921	120,675			84,471	3,728	50,290	2,182	$ 449,682	$ 126,585
35	6001 BLOOD LABORATORY		0.455808	3,500	2,664			4,054	1,382	388	766	$ 7,942	$ 4,812
36	6002 ENDOSCOPY		0.198821	5,186	5,621						6,161	$ 5,186	$ 11,782
37	6500 RESPIRATORY THERAPY		0.157026	124,782	14,228			73,559	708	4,711	177	$ 203,052	$ 15,113
38	6600 PHYSICAL THERAPY		0.295760	8,897	1,402			6,461		3,193		$ 18,551	$ 1,402
39	6700 OCCUPATIONAL THERAPY		0.363347	1,194				1,993		1,598		$ 4,785	$ -
40	7000 ELECTROENCEPHALOGRAPHY		0.229328	15,336								$ 15,336	$ -
41	7001 ECHOCARDIOGRAPHY		0.127187	85,746	12,408			13,089	12,453	5,041		$ 103,876	$ 24,861
42	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.415003	98,137	12,095			9,345	4,452	6,877	847	$ 114,359	$ 17,394
43	7200 IMPL. DEV. CHARGED TO PATIENTS		0.916590	16,910	21,328			8,387	5,157	39,264		$ 64,561	$ 26,485
44	7300 DRUGS CHARGED TO PATIENTS		0.258682	170,834	47,381			119,499	29,212	22,516	3,303	$ 312,848	$ 79,895
45	7400 RENAL DIALYSIS		0.273030	3,652				47,476		5,478		$ 56,606	$ -
46	9002 OUTPATIENT IMAGING CENTER		0.088510		29,977				3,501		11,198	$ -	$ 44,676
47	9004 OP VASCULAR LAB		0.086836									$ -	$ -
48	9100 EMERGENCY		0.310808	82,292	203,253			2,228	5,148	2,228	2,838	$ 86,748	$ 211,239

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2021-08/31/2022) 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			-									$ -	$ -
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109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2021-08/31/2022) 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			-									$ -	$ -
				$ 1,588,481	$ 785,037	$ -	$ -	$ 466,923	$ 166,011	$ 320,268	$ 43,334		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 2,118,743	$ 785,037	$ -	$ -	$ 708,829	$ 166,011	$ 436,554	$ 43,334	$ 3,264,126	$ 994,382
129	Total Charges per PS&R or Exhibit Detail	$ 2,118,743	$ 785,037	$ -	$ -	$ 708,829	$ 166,011	$ 436,554	$ 43,334		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 559,670	$ 177,509	$ -	$ -	$ 228,091	$ 34,822	$ 157,108	$ 7,880	$ 944,869	$ 220,211
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 51,251	$ 11,613							$ 51,251	$ 11,613
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)							$ 111,048	$ 13,324	$ 111,048	$ 13,324
135	Self-Pay (including Co-Pay and Spend-Down)		$ 1,559							$ -	$ 1,559
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 51,251	$ 13,172	$ -	$ -						
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)					$ 143,887	$ 28,934		$ 137	$ 143,887	$ 29,071
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 58,947	$ 1,268	$ 58,947	$ 1,268
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)**	$ 508,419	$ 164,337	$ -	$ -	$ 84,204	$ 5,888	$ (12,887)	$ (6,849)	$ 579,736	$ 163,376
144	**Calculated Payments as a Percentage of Cost**	9%	7%	0%	0%	63%	83%	108%	187%	39%	26%

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 (09/01/2021-08/31/2022) 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 (09/01/2021-08/31/2022) 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 (09/01/2021-08/31/2022) 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)*		$ 6,637,350		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	40997.00	*(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 ---------->)		$ 6,637,350		
	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	$ 5,087,106	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		$ 5,087,106		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 1,550,244
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	177,397,787
19	Uninsured Hospital	**Charges Sec. G**	65,394,089
20	Total Hospital	**Charges Sec. G**	1,926,234,834
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		9.21%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		3.39%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 142,771
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 52,629
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 195,400**

** 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.*