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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

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

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	09/01/2022	08/31/2023
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	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 (07/01/24 - 06/30/25)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	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 07/01/2024 - 06/30/2025** — $ 3,210,292
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** — $ 3,210,292

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	11/22/24 Date
Lisa Urbistondo Hospital CEO or CFO Printed Name	404-501-5025 Hospital CEO or CFO Telephone Number	lisa.urbistondo@emoryhealthcare.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Dawn Stone
Title	Director of Hospital Budgets
Telephone Number	404-782-2224
E-Mail Address	dawn.stone@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 9.00 9/11/2024

D. General Cost Report Year Information 9/1/2022 - 8/31/2023

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

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

	9/1/2022 through 8/31/2023		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	5/9/2024		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	St. Joseph Hospital-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: (09/01/2022 - 08/31/2023)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 679,251	$ 443,752	$1,123,003
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 11,285,751	$ 2,608,647	$13,894,398
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)	$11,965,002	$3,052,399	$15,017,401
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.68%	14.54%	7.48%

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 (09/01/2022 - 08/31/2023)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	96,738 **(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	32,875,327
8.	Outpatient Hospital Charity Care Charges	19,535,124
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 52,410,451

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	$287,982,995.00			$ 208,967,031	$ -	$ -	$ 79,015,964
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	$834,956,124.00	$677,811,263.00		$ 605,863,211	$ 491,835,315	$ -	$ 415,068,861
20.	Outpatient Services		$211,302,645.00			$ 153,326,020	$ -	$ 57,976,625
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	$ 1,122,939,119	$ 889,113,908	$ -	$ 814,830,242	$ 645,161,334	$ -	$ 552,061,451
28.	Total Hospital and Non Hospital		Total from Above	$ 2,012,053,027		Total from Above	$ 1,459,991,576	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,012,053,027	Total Contractual Adj. (G-3 Line 2)		1,459,575,021
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)				+	416,555
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)"				-	
36.	Adjusted Contractual Adjustments					1,459,991,576
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) | 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	$ 119,805,278	$ 403,465	$ -	$0.00	$ 120,208,743	90,408	$176,798,455.00		$ 1,329.63
2	03100 INTENSIVE CARE UNIT	$ 25,652,733	$ 117,171	$ -		$ 25,769,904	9,888	$81,158,980.00		$ 2,606.18
3	03200 CORONARY CARE UNIT	$ 10,943,839	$ -	$ -		$ 10,943,839	4,547	$35,462,175.00		$ 2,406.83
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	$ 156,401,850	$ 520,636	$ -	$ -	$ 156,922,486	104,843	$ 293,419,610		
19	Weighted Average									$ 1,496.74

		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)	8,105	-	-	$ 10,776,651	$1,400,000.00	$13,948,917.00	$ 15,348,917	0.702111

		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	$45,804,191.00	$ 1,489,226	$ -		$ 47,293,417	$192,916,250.00	$140,001,543.00	$ 332,917,793	0.142057
22	5100 RECOVERY ROOM	$11,980,564.00	$ -	$ -		$ 11,980,564	$9,715,832.00	$16,434,210.00	$ 26,150,042	0.458147
23	5300 ANESTHESIOLOGY	$3,375,135.00	$ -	$ -		$ 3,375,135	$40,061,348.00	$37,392,467.00	$ 77,453,815	0.043576
24	5400 RADIOLOGY-DIAGNOSTIC	$11,822,936.00	$ -	$ -		$ 11,822,936	$31,194,146.00	$25,808,913.00	$ 57,003,059	0.207409
25	5401 ELECTRO-PHYSIOLOGY	$493,373.00	$ -	$ -		$ 493,373	$6,941,640.00	$27,579,060.00	$ 34,520,700	0.014292
26	5402 CARDIOLOGY	$2,295,883.00	$ 100,866	$ -		$ 2,396,749	$35,214.00	$10,949,885.00	$ 10,985,099	0.218182
27	5500 RADIOLOGY-THERAPEUTIC	$12,100,315.00	$ 242,079	$ -		$ 12,342,394	$2,839,479.00	$70,679,074.00	$ 73,518,553	0.167881
28	5600 RADIOISOTOPE	$5,451,896.00	$ -	$ -		$ 5,451,896	$3,079,814.00	$33,606,680.00	$ 36,686,494	0.148608
29	5700 CT SCAN	$4,053,506.00	$ -	$ -		$ 4,053,506	$31,395,326.00	$31,409,732.00	$ 62,805,058	0.064541
30	5800 MRI	$6,109,755.00	$ -	$ -		$ 6,109,755	$17,515,165.00	$24,251,190.00	$ 41,766,355	0.146284
31	5900 CARDIAC CATHETERIZATION	$9,607,187.00	$ -	$ -		$ 9,607,187	$37,831,068.00	$29,544,263.00	$ 67,375,331	0.142592

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) 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
32	6000	LABORATORY	$18,529,464.00	$ -	$ -		$ 18,529,464	$135,999,897.00	$40,198,025.00	$ 176,197,922	0.105163
33	6001	BLOOD LABORATORY	$7,130,175.00	$ -	$ -		$ 7,130,175	$5,798,046.00	$9,042,500.00	$ 14,840,546	0.480452
34	6002	ENDOSCOPY	$6,640,465.00	$ -	$ -		$ 6,640,465	$9,408,644.00	$23,058,197.00	$ 32,466,841	0.204531
35	6500	RESPIRATORY THERAPY	$8,881,578.00	$ -	$ -		$ 8,881,578	$61,802,467.00	$6,141,189.00	$ 67,943,656	0.130720
36	6600	PHYSICAL THERAPY	$5,104,039.00	$ -	$ -		$ 5,104,039	$12,963,353.00	$2,460,141.00	$ 15,423,494	0.330926
37	6700	OCCUPATIONAL THERAPY	$951,126.00	$ -	$ -		$ 951,126	$2,670,485.00	$234,815.00	$ 2,905,300	0.327376
38	6900	ELECTROCARDIOLOGY	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39	7000	ELECTROENCEPHALOGRAPHY	$479,769.00	$ 83,733	$ -		$ 563,502	$1,792,765.00	$228,640.00	$ 2,021,405	0.278767
40	7001	ECHOCARDIOGRAPHY	$7,442,674.00	$ -	$ -		$ 7,442,674	$44,101,036.00	$46,579,098.00	$ 90,680,134	0.082076
41	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$28,744,350.00	$ -	$ -		$ 28,744,350	$46,530,737.00	$28,055,118.00	$ 74,585,855	0.385386
42	7200	IMPL. DEV. CHARGED TO PATIENTS	$81,823,095.00	$ -	$ -		$ 81,823,095	$44,076,813.00	$43,542,040.00	$ 87,618,853	0.933853
43	7300	DRUGS CHARGED TO PATIENTS	$33,775,610.00	$ -	$ -		$ 33,775,610	$86,948,832.00	$26,853,423.00	$ 113,802,255	0.296792
44	7400	RENAL DIALYSIS	$3,461,896.00	$ -	$ -		$ 3,461,896	$9,358,748.00	$3,768,161.00	$ 13,126,909	0.263725
45	9002	OUTPATIENT IMAGING CENTER	$6,092,868.00	$ -	$ -		$ 6,092,868	$222,478.00	$62,181,681.00	$ 62,404,159	0.097636
46	9004	OP VASCULAR LAB	$1,248,097.00	$ -	$ -		$ 1,248,097	$108,606.00	$15,534,724.00	$ 15,643,330	0.079785
47	9100	EMERGENCY	$24,334,492.00	$ -	$ -		$ 24,334,492	$39,862,021.00	$72,579,522.00	$ 112,441,543	0.216419
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) 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
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**	$ 347,734,439	$ 1,915,904	$ -		$ 349,650,343	$ 876,570,210	$ 842,063,208	$ 1,718,633,418	
127		**Weighted Average**									0.209717
128		**Sub Totals**	$ 504,136,289	$ 2,436,540	$ -		$ 506,572,829	$ 1,169,989,820	$ 842,063,208	$ 2,012,053,028	
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**					$ 506,572,829				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.48%				

* 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 (09/01/2022-08/31/2023) St. Joseph Hospital-Atlanta

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Inpatient	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Outpatient	% Survey to Cost Report Totals (Includes all payers)
		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 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		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,329.63		3,156		764		2,598		5,043		364		3,567		11,925		19.11%
2	03100 INTENSIVE CARE UNIT	$ 2,606.18		730		94		395		676		33		437		1,928		24.02%
3	03200 CORONARY CARE UNIT	$ 2,406.83		38		83		208		252		20		214		601		18.03%
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ -														-		
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	3,924		941		3,201		5,971		417		4,218		14,454		18.05%
19	Total Days per PS&R or Exhibit Detail			3,924		941		3,201		5,971		417		4,218				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 11,240,240		$ 2,993,085		$ 9,778,500		$ 17,448,085		$ 1,078,385		$ 12,549,171		$ 41,459,910		18.59%
21.01	Calculated Routine Charge Per Diem			$ 2,864.49		$ 3,180.75		$ 3,054.83		$ 2,922.14		$ 2,586.06		$ 2,975.15		$ 2,868.40		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.702111	13,680	187,420	39,319	186,156	49,579	155,724	274,088	661,389	58,444	58,444	170,451	986,974	$ 376,666	$ 1,190,689	18.55%
23	5000 OPERATING ROOM		0.142057	3,707,011	864,016	1,784,620	3,078,935	2,246,665	884,819	6,400,822	3,405,706	384,315	116,365	5,445,289	1,517,961	$ 14,138,918	$ 8,033,475	8.98%
24	5100 RECOVERY ROOM		0.458147	140,870	144,047	120,951	350,284	107,451	87,871	356,183	519,134	25,381	19,148	236,763	243,825	$ 725,456	$ 1,101,336	9.06%
25	5300 ANESTHESIOLOGY		0.043576	694,430	319,569	386,371	715,078	523,747	215,546	1,358,308	982,379	93,762	35,058	1,097,698	395,958	$ 2,962,856	$ 2,232,572	8.94%
26	5400 RADIOLOGY-DIAGNOSTIC		0.207409	528,896	119,024	234,983	274,977	826,261	414,956	1,738,752	1,034,959	67,525	30,089	1,021,988	741,897	$ 3,328,892	$ 1,843,916	12.44%
27	5401 ELECTRO-PHYSIOLOGY		0.014292	40,729	215	16,666	51,307	152,581	201,497	250,199	465,801	7,385	19,044	144,250	85,240	$ 460,175	$ 718,820	4.19%
28	5402 CARDIOLOGY		0.218182	-	37,636	-	42,921	1,141	208,872	980	263,322	-	11,473	9,655	28,804	$ 2,121	$ 552,751	5.52%
29	5500 RADIOLOGY-THERAPEUTIC		0.167881	33,971	230,949	36,189	794,403	59,735	701,657	43,876	1,543,984	-	104,943	41,656	540,546	$ 173,771	$ 3,270,992	5.66%
30	5600 RADIOISOTOPE		0.148608	87,594	334,820	8,187	411,346	76,583	462,838	148,226	1,237,673	6,477	185,445	99,197	514,294	$ 320,590	$ 2,446,676	9.79%
31	5700 CT SCAN		0.064541	1,149,338	292,831	478,415	757,351	883,957	363,291	1,586,695	1,111,287	125,820	97,798	1,859,981	2,484,699	$ 4,098,405	$ 2,524,760	18.09%
32	5800 MRI		0.146284	392,568	60,349	219,557	561,934	369,582	247,504	774,468	755,462	41,935	59,998	1,032,847	1,039,794	$ 1,756,175	$ 1,625,249	13.43%
33	5900 CARDIAC CATHETERIZATION		0.142592	260,346	3,659	97,745	139,548	504,332	231,671	1,128,745	707,082	32,258	19,622	1,403,075	149,089	$ 1,991,167	$ 1,081,960	7.13%
34	6000 LABORATORY		0.105163	4,701,690	956,212	1,508,892	958,913	4,285,922	547,131	8,433,600	1,573,366	484,865	152,071	6,719,776	3,065,567	$ 18,930,103	$ 4,035,622	19.17%
35	6001 BLOOD LABORATORY		0.480452	46,477	-	93,209	175,778	95,294	67,804	257,484	238,651	19,538	14,897	192,302	118,546	$ 492,464	$ 482,233	8.98%
36	6002 ENDOSCOPY		0.204531	290,020	123,645	93,121	141,255	252,386	259,854	344,233	635,947	41,284	54,188	409,130	160,504	$ 979,761	$ 1,160,701	8.76%
37	6500 RESPIRATORY THERAPY		0.130720	4,214,796	81,615	692,611	94,906	2,543,710	74,158	4,443,863	240,564	395,219	13,820	2,397,118	366,301	$ 11,894,980	$ 491,243	23.02%
38	6600 PHYSICAL THERAPY		0.330926	412,865	-	54,257	3,784	319,401	12,604	749,406	75,701	23,403	3,336	313,713	16,315	$ 1,535,929	$ 92,089	13.00%
39	6700 OCCUPATIONAL THERAPY		0.327376	91,995	-	6,251	-	86,083	5,786	150,118	13,556	4,583	597	58,150	2,985	$ 334,447	$ 19,342	14.56%
40	6900 ELECTROCARDIOLOGY		-			-	-	-	-	-	-	-	-	-	-	$ -	$ -	
41	7000 ELECTROENCEPHALOGRAPHY		0.278767	74,282	1,260	33,428	1,260	53,112	3,244	146,880	15,186	-	-	58,792	8,945	$ 307,702	$ 20,950	19.61%
42	7001 ECHOCARDIOGRAPHY		0.082076	1,709,322	262,162	244,306	252,363	1,023,634	505,356	1,792,611	1,283,781	86,282	140,274	1,496,856	624,639	$ 4,769,873	$ 2,303,662	10.50%
43	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.385386	989,396	221,524	522,274	462,351	1,031,844	172,239	1,594,050	663,659	92,991	40,493	1,269,654	350,454	$ 4,137,564	$ 1,519,774	10.00%
44	7200 IMPL. DEV. CHARGED TO PATIENTS		0.933853	670,690	14,929	156,388	159,755	544,783	248,291	1,322,727	932,692	17,748	42,516	1,115,023	191,276	$ 2,694,588	$ 1,355,667	6.25%
45	7300 DRUGS CHARGED TO PATIENTS		0.296792	3,404,857	242,960	858,114	360,782	2,742,104	268,503	5,127,701	794,800	347,835	51,101	3,754,866	937,546	$ 12,132,777	$ 1,667,045	16.77%
46	7400 RENAL DIALYSIS		0.263725	381,623	-	73,369	-	911,413	58,692	1,311,775	108,428	21,912	71,386	461,374	2,915,000	$ 2,678,180	$ 167,120	48.11%
47	9002 OUTPATIENT IMAGING CENTER		0.097636	3,373	322,380	-	1,203,989	9,691	867,699	7,254	2,030,827	1,908	178,706	-	776,785	$ 20,318	$ 4,424,895	8.77%
48	9004 OP VASCULAR LAB		0.079785		-	-	102,420	5,226	253,485	4,261	501,700	416	15,420	-	94,363	$ 9,487	$ 857,604	6.33%
49	9100 EMERGENCY		0.216419	1,272,743	1,211,048	440,306	2,114,983	979,756	1,066,441	1,685,755	2,826,694	134,140	366,448	1,906,397	9,099,515	$ 4,378,560	$ 7,219,167	20.88%
50			-													$ -	$ -	
51			-													$ -	$ -	
52			-													$ -	$ -	
53			-													$ -	$ -	
54			-													$ -	$ -	
55			-													$ -	$ -	
56			-													$ -	$ -	
57			-													$ -	$ -	
58			-													$ -	$ -	
59			-													$ -	$ -	
60			-													$ -	$ -	
61			-													$ -	$ -	
62			-													$ -	$ -	
63			-													$ -	$ -	
64			-													$ -	$ -	
65			-													$ -	$ -	
66			-													$ -	$ -	
67			-													$ -	$ -	
68			-													$ -	$ -	
69			-													$ -	$ -	
70			-													$ -	$ -	
71			-													$ -	$ -	
72			-													$ -	$ -	

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

Cost Report Year (09/01/2022-08/31/2023) | 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report
73				-													$ -	$ -
74				-													$ -	$ -
75				-													$ -	$ -
76				-													$ -	$ -
77				-													$ -	$ -
78				-													$ -	$ -
79				-													$ -	$ -
80				-													$ -	$ -
81				-													$ -	$ -
82				-													$ -	$ -
83				-													$ -	$ -
84				-													$ -	$ -
85				-													$ -	$ -
86				-													$ -	$ -
87				-													$ -	$ -
88				-													$ -	$ -
89				-													$ -	$ -
90				-													$ -	$ -
91				-													$ -	$ -
92				-													$ -	$ -
93				-													$ -	$ -
94				-													$ -	$ -
95				-													$ -	$ -
96				-													$ -	$ -
97				-													$ -	$ -
98				-													$ -	$ -
99				-													$ -	$ -
100				-													$ -	$ -
101				-													$ -	$ -
102				-													$ -	$ -
103				-													$ -	$ -
104				-													$ -	$ -
105				-													$ -	$ -
106				-													$ -	$ -
107				-													$ -	$ -
108				-													$ -	$ -
109				-													$ -	$ -
110				-													$ -	$ -
111				-													$ -	$ -
112				-													$ -	$ -
113				-													$ -	$ -
114				-													$ -	$ -
115				-													$ -	$ -
116				-													$ -	$ -
117				-													$ -	$ -
118				-													$ -	$ -
119				-													$ -	$ -
120				-													$ -	$ -
121				-													$ -	$ -
122				-													$ -	$ -
123				-													$ -	$ -
124				-													$ -	$ -
125				-													$ -	$ -
126				-													$ -	$ -
127				-													$ -	$ -
					$ 25,313,563	$ 6,032,270	$ 8,199,529	$ 13,396,779	$ 20,685,975	$ 8,387,531	$ 41,432,858	$ 24,623,731	$ 2,483,430	$ 1,902,680	$ 32,716,002	$ 27,457,821		

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

Cost Report Year (09/01/2022-08/31/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 36,553,803	$ 6,032,270	$ 11,192,614	$ 13,396,779	$ 30,464,475	$ 8,387,531	$ 58,880,943	$ 24,623,731	$ 3,561,815	$ 1,902,680	$ 45,265,173 (Agrees to Exhibit A)	$ 27,457,821 (Agrees to Exhibit A)	$ 137,091,834	$ 52,440,311	13.18%
129	Total Charges per PS&R or Exhibit Detail	$ 36,553,803	$ 6,032,270	$ 11,192,614	$ 13,396,779	$ 30,464,475	$ 8,387,531	$ 58,880,943	$ 24,623,731	$ 3,561,815	$ 1,902,680	$ 45,265,173	$ 27,457,821			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 10,968,399	$ 1,107,306	$ 3,026,219	$ 2,439,138	$ 9,076,042	$ 1,600,609	$ 17,398,536	$ 5,055,819	$ 1,068,417	$ 376,083	$ 12,792,787	$ 5,633,413	$ 40,469,196	$ 10,202,872	13.79%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 6,559,576	$ 968,717			$ 260,973	$ 96,081	$ 291,271	$ 129,693					$ 7,111,820	$ 1,194,490	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,115,490	$ 1,451,516			$ 13,663	$ 42,552					$ 2,129,153	$ 1,494,068	
134	Private Insurance (including primary and third party liability)	$ 15,827	$ 6,190					$ 3,021,528	$ 1,378,594					$ 3,037,355	$ 1,384,785	
135	Self-Pay (including Co-Pay and Spend-Down)													$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 6,575,403	$ 974,908	$ 2,115,490	$ 1,451,516											
137	Medicaid Cost Settlement Payments (See Note B)		$ 37,231											$ -	$ 37,231	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ 210,037				$ 5,499,401	$ 1,207,641							$ 5,709,438	$ 1,207,641	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 9,141,104	$ 2,942,512					$ 9,141,104	$ 2,942,512	
141	Medicare Cross-Over Bad Debt Payments					$ 25,930	$ 22,537							$ 25,930	$ 22,537	
142	Other Medicare Cross-Over Payments (See Note D)					$ 26,503	$ 2,660					(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 26,503	$ 2,660	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 679,251	$ 443,752			
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)**	$ 4,182,959	$ 95,168	$ 910,729	$ 987,622	$ 3,263,235	$ 271,690	$ 4,930,970	$ 562,468	$ 1,068,417	$ 376,083	$ 12,113,536	$ 5,189,661	$ 13,287,893	$ 1,916,948	
146	**Calculated Payments as a Percentage of Cost**	62%	91%	70%	60%	64%	83%	72%	89%	0%	0%	5%	8%	67%	81%	
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)**					54,817										
148	**Percent of cross-over days to total Medicare days from the cost report**					6%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) St. Joseph Hospital-Atlanta

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,329.63		164				37		33		234	
2	03100 INTENSIVE CARE UNIT	$ 2,606.18		9				1				10	
3	03200 CORONARY CARE UNIT	$ 2,406.83		5								5	
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**	178		-		38		33		249	
19	Total Days per PS&R or Exhibit Detail			178		-		38		33			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 407,168				$ 77,264		$ 59,631		$ 544,063	
21.01	Calculated Routine Charge Per Diem			$ 2,287.46		$ -		$ 2,033.26		$ 1,807.00		$ 2,184.99	
	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)		0.702111	9,831	14,744			1,596	8,360	-	3,268	$ 11,427	$ 26,372
23	5000 OPERATING ROOM		0.142057	103,055	38			2,611	36,611	106,323	23,139	$ 211,989	$ 59,788
24	5100 RECOVERY ROOM		0.458147	10	2,809			8	5,363	4,870	3,893	$ 4,888	$ 12,065
25	5300 ANESTHESIOLOGY		0.043576	18,822	5,211			2,038	8,688	67,508	6,284	$ 88,368	$ 20,183
26	5400 RADIOLOGY-DIAGNOSTIC		0.207409	22,941	12,158			5,595	3,194	11,106	4,042	$ 39,642	$ 19,393
27	5401 ELECTRO-PHYSIOLOGY		0.014292	1,991	4,772			3,037	1,127	293	734	$ 5,320	$ 6,632
28	5402 CARDIOLOGY		0.218182	-	217			27	927	4	893	$ 31	$ 2,037
29	5500 RADIOLOGY-THERAPEUTIC		0.167881	-	568			26,648	40	0	264	$ 26,648	$ 871
30	5600 RADIOISOTOPE		0.148608	1,704	2,808			1,723	12,275	4	488	$ 3,431	$ 15,572
31	5700 CT SCAN		0.064541	76,853	39,995			17,245	7,685	16,010	9,680	$ 110,109	$ 57,360
32	5800 MRI		0.146284	27,931	7,838			10,650	1,624	453	2,688	$ 39,033	$ 12,150
33	5900 CARDIAC CATHETERIZATION		0.142592	22,290	1,154			65,294	19,776	5,758	12,461	$ 93,342	$ 33,391
34	6000 LABORATORY		0.105163	222,027	63,349			46,347	8,609	31,253	10,151	$ 299,628	$ 82,108
35	6001 BLOOD LABORATORY		0.480452	4,087	133			11	1,893	6,022	819	$ 10,121	$ 2,846
36	6002 ENDOSCOPY		0.204531	4,103	34,995			7	520	167	177	$ 4,277	$ 35,691
37	6500 RESPIRATORY THERAPY		0.130720	48,192	12,651			15,219	1,526	3,551	1,997	$ 66,962	$ 16,173
38	6600 PHYSICAL THERAPY		0.330926	10,675	-			3,745	1,654	3,807	-	$ 18,227	$ 1,654
39	6700 OCCUPATIONAL THERAPY		0.327376	1,598	-			1,400	-	11	-	$ 3,009	$ -
40	6900 ELECTROCARDIOLOGY		-	-	-			-	-	-	-	$ -	$ -
41	7000 ELECTROENCEPHALOGRAPHY		0.278767	-	-			-	-	-	-	$ -	$ -
42	7001 ECHOCARDIOGRAPHY		0.082076	40,315	13,602			25,878	7,052	13,876	591	$ 80,069	$ 21,245
43	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.385386	21,606	4,158			3,058	8,901	10,876	867	$ 35,540	$ 13,926
44	7200 IMPL. DEV. CHARGED TO PATIENTS		0.933853	37,478	4,644			10,202	719	577	1,765	$ 48,256	$ 7,128
45	7300 DRUGS CHARGED TO PATIENTS		0.296792	106,303	28,226			13,456	7,270	27,591	13,060	$ 147,350	$ 48,556
46	7400 RENAL DIALYSIS		0.263725	-	-			30	-	22	-	$ 51	$ -
47	9002 OUTPATIENT IMAGING CENTER		0.097636	1,156	35,340			334	24,212	72	8,888	$ 1,561	$ 68,440
48	9004 OP VASCULAR LAB		0.079785	180	5,661			97	4,156	47	2,877	$ 324	$ 12,694
49	9100 EMERGENCY		0.216419	99,660	185,070			22,385	26,555	6,836	33,023	$ 128,881	$ 244,649
50			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
64				-									$ -	$ -
65				-									$ -	$ -
66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
74				-									$ -	$ -
75				-									$ -	$ -
76				-									$ -	$ -
77				-									$ -	$ -
78				-									$ -	$ -
79				-									$ -	$ -
80				-									$ -	$ -
81				-									$ -	$ -
82				-									$ -	$ -
83				-									$ -	$ -
84				-									$ -	$ -
85				-									$ -	$ -
86				-									$ -	$ -
87				-									$ -	$ -
88				-									$ -	$ -
89				-									$ -	$ -
90				-									$ -	$ -
91				-									$ -	$ -
92				-									$ -	$ -
93				-									$ -	$ -
94				-									$ -	$ -
95				-									$ -	$ -
96				-									$ -	$ -
97				-									$ -	$ -
98				-									$ -	$ -
99				-									$ -	$ -
100				-									$ -	$ -
101				-									$ -	$ -
102				-									$ -	$ -
103				-									$ -	$ -
104				-									$ -	$ -
105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -
112				-									$ -	$ -
113				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) 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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 882,809	$ 480,140	$ -	$ -	$ 278,640	$ 198,736	$ 317,036	$ 142,048		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 1,289,977	$ 480,140	$ -	$ -	$ 355,904	$ 198,736	$ 376,667	$ 142,048	$ 2,022,548	$ 820,924
129	Total Charges per PS&R or Exhibit Detail			$ 1,289,977	$ 480,140	$ -	$ -	$ 355,904	$ 198,736	$ 376,667	$ 142,048		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 429,567	$ 93,839	$ -	$ -	$ 101,591	$ 38,120	$ 91,880	$ 27,504	$ 623,038	$ 159,463
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 21,648	$ 3,937			$ 1,568			$ 92	$ 23,216	$ 4,029
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)										$ 59,956	$ -	$ 59,956
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 21,648	$ 3,937	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)							$ 72,478	$ 24,924			$ 72,478	$ 24,924
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 45,724	$ 361	$ 45,724	$ 361
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)**			$ 407,919	$ 89,902	$ -	$ -	$ 27,545	$ 13,196	$ 46,156	$ (32,905)	$ 481,620	$ 70,193
144	**Calculated Payments as a Percentage of Cost**			5%	4%	0%	0%	73%	65%	50%	220%	23%	56%

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 (09/01/2022-08/31/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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 (09/01/2022-08/31/2023) 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 & with Medicaid Secondary)	
							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 (09/01/2022-08/31/2023) 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)*		$ 6,673,350		
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 ---------->)		$ 6,673,350		
	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	$ 5,956,047	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		$ 5,956,047		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 717,303
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	197,840,112
19	Uninsured Hospital	**Charges Sec. G**	72,722,994
20	Total Hospital	**Charges Sec. G**	2,012,053,028
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		9.83%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		3.61%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 70,531
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 25,926
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 96,457**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	68,945,583
27	Uninsured Hospital	**Charges Sec. G**	78,187,489
28	Total Hospital	**Charges Sec. G**	2,012,053,028
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		3.43%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		3.89%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 24,579
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 27,874
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 52,453**

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*

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