State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

2. Select Your Facility from the Drop-Down Menu Provided: EMORY DECATUR

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	09/01/2019	08/31/2020
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:	000000536A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110076

B. DSH CB 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 (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/1/1966

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** $ 6,625,884
   (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 07/01/2019 - 06/30/2020** $ -
   (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 Services07/01/2019 - 06/30/2020** $ 6,625,884

Certification:

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

Explanation for "No" answers:

Other Protested Item: "New Hampshire Hospital Association v. Azar" We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospitals Specific limit for Medicaid DSH and the payment calculation reduction of Uncompensated Care Cost.

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	Chief Financial Officer Title	10/22/2021 Date
Liz Daunt-Samford Hospital CEO or CFO Printed Name	404-501-5025 Hospital CEO or CFO Telephone Number	liz.daunt@emoryhealthcare.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Liz Daunt-Samford
Title	Chief Financial Officer
Telephone Number	404-501-5025
E-Mail Address	liz.daunt@emoryhealthcare.org
Mailing Street Address	2701 N Decatur Rd
Mailing City, State, Zip	Decatur, GA 30033

Outside Preparer:

Name	Tim Beatty
Title	Senior Director
Firm Name	Southeast Reimbursement Group
Telephone Number	770-923-3352
E-Mail Address	tim.beatty@srgllc.org

DSH Version 8.00 1/28/2021

D. General Cost Report Year Information 9/1/2019 - 8/31/2020

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:	EMORY DECATUR		
	9/1/2019 through 8/31/2020		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	2/2/2021		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	EMORY DECATUR	Yes	
5. Medicaid Provider Number:	000000536A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	No	11T076
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110076	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: (09/01/2019 - 08/31/2020)

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)	$ 1,146,108	$ 1,316,886	$2,462,994
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,893,522	$ 10,574,024	$13,467,546
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)	$4,039,630	$11,890,910	$15,930,540
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	28.37%	11.07%	15.46%

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 (09/01/2019 - 08/31/2020)

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)	92,266	**(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	9,222
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 9,222
7.	Inpatient Hospital Charity Care Charges	23,486,826
8.	Outpatient Hospital Charity Care Charges	28,032,643
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 51,519,469

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	$158,959,321.00			$ 116,886,052	$ -	$ -	$ 42,073,269
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$34,623,078.00			$ 25,459,060	$ -	$ -	$ 9,164,018
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	$381,999,858.00	$431,380,076.00		$ 280,892,337	$ 317,202,625	$ -	$ 215,284,973
20.	Outpatient Services		$152,437,023.00			$ 112,090,072	$ -	$ 40,346,951
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	$7,131,708.00	$284.00	$0.00	$ 5,244,091	$ 209	$ -	$ 1,887,692
27.	Total	$ 582,713,965	$ 583,817,383	$ -	$ 428,481,540	$ 429,292,905	$ -	$ 308,756,903
28.	Total Hospital and Non Hospital		Total from Above	$ 1,166,531,348		Total from Above	$ 857,774,445	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,166,531,348	Total Contractual Adj. (G-3 Line 2)		857,397,816
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)				+	4,935,622
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)				-	4,558,993
35.	Adjusted Contractual Adjustments					857,774,445
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

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	$ 83,733,836	$ 927,771	$ -	$0.00	$ 84,661,607	79,501	$141,788,552.00		$ 1,064.91
2	03100 INTENSIVE CARE UNIT	$ 16,831,719	$ -	$ -		$ 16,831,719	8,098	$28,321,719.00		$ 2,078.50
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ 9,328,353	$ -	$ -		$ 9,328,353	7,212	$23,472,128.00		$ 1,293.45
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II		$ -	$ -		$ -				$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 3,650,179	$ -	$ -		$ 3,650,179	6,015	$7,111,908.00		$ 606.85
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 113,544,087	$ 927,771	$ -	$ -	$ 114,471,858	100,826	$ 200,694,307		
19	Weighted Average									$ 1,135.34

Line #			*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)	8,567	-	-	$ 9,123,084	$7,654,430.00	$11,320,536.00	$ 18,974,966	0.480796

Line #		Cost Center Description	*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	$34,199,427.00	$ 26,627	$0.00		$ 34,226,054	$52,562,915.00	$104,853,991.00	$ 157,416,906	0.217423
22	5200	DELIVERY ROOM & LABOR ROOM	$13,184,509.00	$ -	$0.00		$ 13,184,509	$28,543,088.00	$5,053,445.00	$ 33,596,533	0.392437
23	5400	RADIOLOGY-DIAGNOSTIC	$21,201,973.00	$ 11,127	$0.00		$ 21,213,100	$32,443,804.00	$88,795,525.00	$ 121,239,329	0.174969
24	5700	CT SCAN	$2,170,013.00	$ -	$0.00		$ 2,170,013	$20,374,663.00	$35,364,746.00	$ 55,739,409	0.038931
25	5800	MRI	$1,412,316.00	$ -	$0.00		$ 1,412,316	$4,701,299.00	$9,304,460.00	$ 14,005,759	0.100838
26	5900	CARDIAC CATHETERIZATION	$3,294,808.00	$ -	$0.00		$ 3,294,808	$9,029,407.00	$12,563,851.00	$ 21,593,258	0.152585
27	6000	LABORATORY	$18,509,738.00	$ 11,326	$0.00		$ 18,521,064	$60,610,731.00	$44,318,298.00	$ 104,929,029	0.176510
28	6500	RESPIRATORY THERAPY	$7,866,692.00	$ -	$0.00		$ 7,866,692	$33,902,207.00	$9,129,297.00	$ 43,031,504	0.182812
29	6600	PHYSICAL THERAPY	$8,619,205.00	$ -	$0.00		$ 8,619,205	$21,476,283.00	$14,340,443.00	$ 35,816,726	0.240647
30	6900	ELECTROCARDIOLOGY	$1,356,465.00	$ -	$0.00		$ 1,356,465	$12,685,781.00	$11,857,469.00	$ 24,543,250	0.055268
31	7000	ELECTROENCEPHALOGRAPHY	$215,051.00	$ -	$0.00		$ 215,051	$1,047,078.00	$362,746.00	$ 1,409,824	0.152537

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

	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	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$14,945,492.00	$ -	$0.00	$ 14,945,492	$13,867,446.00	$13,128,854.00	$ 26,996,300	0.553613
33	7200	IMPL. DEV. CHARGED TO PATIENTS	$20,218,838.00	$ -	$0.00	$ 20,218,838	$12,047,660.00	$12,047,660.00	$ 24,095,320	0.839119
34	7300	DRUGS CHARGED TO PATIENTS	$43,382,012.00	$ -	$0.00	$ 43,382,012	$74,664,268.00	$69,835,192.00	$ 144,499,460	0.300223
35	7600	NEPHROLOGY	$2,626,518.00	$ -	$0.00	$ 2,626,518	$4,043,227.00	$424,100.00	$ 4,467,327	0.587939
36	9001	DIAGNOSTIC TREATMENT CTR	$3,126,894.00	$ -	$0.00	$ 3,126,894	$1,993,975.00	$5,974,824.00	$ 7,968,799	0.392392
37	9004	KANN OP CANCER CENTER	$1,688,544.00	$ -	$0.00	$ 1,688,544	$24,861.00	$8,449,771.00	$ 8,474,632	0.199247
38	9006	WOUND CARE CLINIC	$1,740,875.00	$ -	$0.00	$ 1,740,875	$75,092.00	$8,473,255.00	$ 8,548,347	0.203650
39	9100	EMERGENCY	$17,434,400.00	$ 13,910	$0.00	$ 17,448,310	$31,406,034.00	$77,064,246.00	$ 108,470,280	0.160858
40			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

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	$0.00	$ -	-
93		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 217,193,770	$ 62,990	$ -		$ 217,256,760	$ 423,154,249	$ 542,662,709	$ 965,816,958	
127	**Weighted Average**									0.234392
128	**Sub Totals**	$ 330,737,857	$ 990,761	$ -		$ 331,728,618	$ 623,848,556	$ 542,662,709	$ 1,166,511,265	
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**					$ 331,728,618				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.30%				

* 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 (09/01/2019-08/31/2020) EMORY DECATUR

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) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid Inpatient	Total In-State Medicaid Outpatient	% Survey to Cost Report Totals
		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	$ 1,064.91		7,273		7,765		5,390		6,247		6,501		26,675		46.97%
2	03100 INTENSIVE CARE UNIT	$ 2,078.50		1,633		145		923		814		812		3,515		53.52%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,293.45		870		4,492						45		5,362		74.97%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 606.85		641		4,269				451		53		5,361		90.04%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	10,417		16,671		6,313		7,512		7,411		40,913		48.08%
19	Total Days per PS&R or Exhibit Detail			10,417		16,671		6,313		7,512		7,411				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 19,395,562		$ 30,365,784		$ 11,355,891		$ 13,530,111		$ 13,011,176		$ 74,647,348		43.80%
21.01	Calculated Routine Charge Per Diem			$ 1,861.91		$ 1,821.47		$ 1,798.81		$ 1,801.13		$ 1,755.66		$ 1,824.54		
	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)		0.480796	967,380	807,232	2,097,364	775,988	343,602	520,561	855,248	1,118,258	297,310	1,095,865	$ 4,263,594	$ 3,222,039	46.96%
23	5000 OPERATING ROOM		0.217423	5,482,978	3,009,809	13,093,108	5,700,596	3,131,552	3,139,318	6,177,770	6,256,362	3,586,677	7,205,578	$ 27,885,408	$ 18,106,085	36.12%
24	5200 DELIVERY ROOM & LABOR ROOM		0.392437	340,216	-	3,144,511	9,712	8,240	-	483,203	1,806	80,554	-	$ 3,976,170	$ 11,518	12.13%
25	5400 RADIOLOGY-DIAGNOSTIC		0.174969	2,224,539	2,699,299	1,842,035	5,329,490	1,921,150	2,405,441	1,990,710	4,523,287	1,983,416	5,843,093	$ 7,978,434	$ 14,957,517	25.51%
26	5700 CT SCAN		0.038931	2,076,697	1,800,466	609,242	1,768,240	1,629,719	1,328,682	1,599,376	2,246,049	2,419,862	5,950,856	$ 5,915,034	$ 7,143,437	38.69%
27	5800 MRI		0.100838	510,293	235,629	176,348	306,776	273,766	263,150	288,076	584,215	556,059	291,733	$ 1,248,483	$ 1,389,770	25.03%
28	5900 CARDIAC CATHETERIZATION		0.152585	910,706	284,908	213,528	108,312	237,320	403,459	539,198	732,812	871,788	186,544	$ 1,900,752	$ 1,529,491	20.81%
29	6000 LABORATORY		0.176510	7,889,530	3,149,518	6,037,124	4,381,588	5,182,328	1,546,184	5,352,172	2,667,374	5,979,372	7,468,413	$ 24,461,154	$ 11,744,664	47.59%
30	6500 RESPIRATORY THERAPY		0.182812	3,581,324	163,637	2,860,352	698,137	2,948,057	88,914	2,915,821	329,705	1,835,051	476,449	$ 12,305,554	$ 1,280,393	37.02%
31	6600 PHYSICAL THERAPY		0.240647	3,495,250	495,607	2,116,353	307,063	2,820,385	458,038	2,560,149	1,167,638	1,393,934	209,114	$ 10,992,137	$ 2,428,346	42.00%
32	6900 ELECTROCARDIOLOGY		0.055268	686,855	780,531	542,843	622,290	1,019,054	503,766	1,049,134	918,933	1,247,293	1,981,757	$ 3,297,886	$ 2,825,520	38.42%
33	7000 ELECTROENCEPHALOGRAPHY		0.152537	118,392	12,230	44,028	14,676	96,378	17,122	98,185	19,814	116,002	14,676	$ 356,983	$ 63,842	39.47%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.553613	988,145	268,298	1,235,213	419,604	685,807	363,656	1,154,966	846,470	758,498	541,914	$ 4,064,131	$ 1,898,028	26.95%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.839119	700,767	367,705	212,309	283,201	496,440	478,033	1,120,872	1,119,775	351,227	190,696	$ 2,530,388	$ 2,248,714	22.09%
36	7300 DRUGS CHARGED TO PATIENTS		0.300223	8,802,309	2,495,745	5,441,338	1,993,244	5,291,640	1,546,663	5,592,882	4,119,795	5,870,090	2,558,090	$ 25,128,169	$ 10,155,447	30.34%
37	7600 NEPHROLOGY		0.587939	76,272	10,896	16,344	3,632	730,940	49,799	196,128	13,620	108,052	113,500	$ 1,019,684	$ 77,947	29.75%
38	9001 DIAGNOSTIC TREATMENT CTR		0.392392	211,974	40,895	30,126	22,678	147,444	56,590	144,079	130,498	159,583	45,358	$ 533,623	$ 250,661	12.44%
39	9004 KANN OP CANCER CENTER		0.199247	82,944	26,374	373,249	146,351	439,145	188,434	512,764	300,812	285,696	149,970	$ 1,408,102	$ 661,971	29.71%
40	9006 WOUND CARE CLINIC		0.203650	52,644	1,751	-	-	-	47,760	-	54,116	-	-	$ 52,644	$ 103,627	1.83%
41	9100 EMERGENCY		0.160858	3,172,382	6,145,278	3,828,404	11,734,569	2,579,098	2,985,333	2,682,380	5,047,569	4,297,147	22,395,446	$ 12,262,264	$ 25,912,749	60.39%
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
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61			-											$ -	$ -	
62			-											$ -	$ -	

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

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

				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
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
71			-											$ -	$ -	
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126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 42,371,597	$ 22,795,808	$ 43,913,819	$ 34,626,147	$ 29,982,065	$ 16,390,903	$ 35,313,113	$ 32,198,908	$ 32,197,611	$ 56,719,052			

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

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

	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		% Survey
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 61,767,159	$ 22,795,808	$ 74,279,603	$ 34,626,147	$ 41,337,956	$ 16,390,903	$ 48,843,224	$ 32,198,908	$ 45,208,787 (Agrees to Exhibit A)	$ 56,719,052 (Agrees to Exhibit A)	$ 226,227,942	$ 106,011,766	37.38%
129	Total Charges per PS&R or Exhibit Detail	$ 61,767,159	$ 22,795,808	$ 74,279,603	$ 34,626,147	$ 41,337,956	$ 16,390,903	$ 48,843,224	$ 32,198,908	$ 45,208,787	$ 56,719,052			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 22,492,549	$ 4,625,186	$ 27,798,536	$ 6,672,836	$ 14,549,333	$ 3,569,161	$ 17,215,366	$ 7,401,345	$ 15,450,049	$ 9,917,821	$ 82,055,784	$ 22,268,528	39.24%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 14,389,771	$ 3,198,599	$ 1,758	$ 1,055	$ 1,653,327	$ 218,075	$ 160,696	$ 334,421			$ 16,205,552	$ 3,752,150	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 19,029,100	$ 4,391,499			$ 108,832	$ 34,356			$ 19,137,932	$ 4,425,855	
134	Private Insurance (including primary and third party liability)			$ 82,767	$ 27,600	$ 74,176	$ 9,568	$ 10,803,618	$ 4,033,058			$ 10,960,561	$ 4,070,226	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 182,316	$ 10,680	$ 370	$ 9,279	$ 25	$ 3,772	$ 8,135	$ 11,076			$ 190,846	$ 34,807	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 14,572,087	$ 3,209,279	$ 19,113,995	$ 4,429,433									
137	Medicaid Cost Settlement Payments (See Note B)		$ (7,209)									$ -	$ (7,209)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 10,794,382	$ 2,314,665	$ 155,499				$ 10,949,881	$ 2,314,665	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 8,506	$ 2,243	$ 3,131,012	$ 1,100,517			$ 3,139,518	$ 1,102,760	
141	Medicare Cross-Over Bad Debt Payments					$ 392,837	$ 194,201					$ 392,837	$ 194,201	
142	Other Medicare Cross-Over Payments (See Note D)					$ 312,443	$ 18,600			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 312,443	$ 18,600	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,146,108	$ 1,316,886			
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)**	$ 7,920,462	$ 1,423,116	$ 8,684,541	$ 2,243,403	$ 1,313,637	$ 808,037	$ 2,847,574	$ 1,887,917	$ 14,303,941	$ 8,600,935	$ 20,766,214	$ 6,362,473	
146	**Calculated Payments as a Percentage of Cost**	65%	69%	69%	66%	91%	77%	83%	74%	7%	13%	75%	71%	
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)**					37,281								
148	**Percent of cross-over days to total Medicare days from the cost report**					17%								

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:

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Line #	Cost Center Description	Diem Cost for Routine Cost Centers	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	$ 1,064.91		145								145	
2	03100 INTENSIVE CARE UNIT	$ 2,078.50		7								7	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,293.45										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 606.85		2								2	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	154		-		-		-		154	
19	Total Days per PS&R or Exhibit Detail			154		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 250,737								$ 250,737	
21.01	Calculated Routine Charge Per Diem			$ 1,628.16		$ -		$ -		$ -		$ 1,628.16	
	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)		0.480796	7,776	23,976							$ 7,776	$ 23,976
23	5000 OPERATING ROOM		0.217423	54,271	13,483							$ 54,271	$ 13,483
24	5200 DELIVERY ROOM & LABOR ROOM		0.392437	5,418	-							$ 5,418	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.174969	51,063	110,571							$ 51,063	$ 110,571
26	5700 CT SCAN		0.038931	42,030	94,320							$ 42,030	$ 94,320
27	5800 MRI		0.100838	16,406	2,754							$ 16,406	$ 2,754
28	5900 CARDIAC CATHETERIZATION		0.152585	5,454	-							$ 5,454	$ -
29	6000 LABORATORY		0.176510	110,394	167,977							$ 110,394	$ 167,977
30	6500 RESPIRATORY THERAPY		0.182812	22,116	8,640							$ 22,116	$ 8,640
31	6600 PHYSICAL THERAPY		0.240647	18,867	-							$ 18,867	$ -
32	6900 ELECTROCARDIOLOGY		0.055268	31,371	45,825							$ 31,371	$ 45,825
33	7000 ELECTROENCEPHALOGRAPHY		0.152537	2,446	2,446							$ 2,446	$ 2,446
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.553613	10,766	1,167							$ 10,766	$ 1,167
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.839119	1,638	-							$ 1,638	$ -
36	7300 DRUGS CHARGED TO PATIENTS		0.300223	92,104	36,829							$ 92,104	$ 36,829
37	7600 NEPHROLOGY		0.587939	8,172	1,816							$ 8,172	$ 1,816
38	9001 DIAGNOSTIC TREATMENT CTR		0.392392	1,756	-							$ 1,756	$ -
39	9004 KANN OP CANCER CENTER		0.199247	10,752	1,536							$ 10,752	$ 1,536
40	9006 WOUND CARE CLINIC		0.203650	-	-							$ -	$ -
41	9100 EMERGENCY		0.160858	119,349	520,978							$ 119,349	$ 520,978
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -

I. Out-of-State Medicaid Data:

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				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	
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			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2019-08/31/2020) EMORY DECATUR

				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	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 612,149	$ 1,032,318	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 862,886	$ 1,032,318	$ -	$ -	$ -	$ -	$ -	$ -	$ 862,886	$ 1,032,318
129	Total Charges per PS&R or Exhibit Detail			$ 862,886	$ 1,032,318	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 292,894	$ 168,770	$ -	$ -	$ -	$ -	$ -	$ -	$ 292,894	$ 168,770
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 91,891	$ 111,678							$ 91,891	$ 111,678
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)											$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)				$ 1,112							$ -	$ 1,112
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 91,891	$ 112,790	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 201,003	$ 55,980	$ -	$ -	$ -	$ -	$ -	$ -	$ 201,003	$ 55,980
144	**Calculated Payments as a Percentage of Cost**			31%	67%	0%	0%	0%	0%	0%	0%	31%	67%

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

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

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		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 (09/01/2019-08/31/2020) EMORY DECATUR

		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.

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Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 4,558,993		
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 ---------->)		$ 4,558,993		
	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*	Provider Tax Expense in Excess of Revenue	$ 1,028,331	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		$ 1,028,331		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 3,530,662
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	334,134,912
19	Uninsured Hospital	**Charges Sec. G**	101,927,839
20	Total Hospital	**Charges Sec. G**	1,166,511,265
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		28.64%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.74%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 1,011,321
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 308,503
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,319,824**

** 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.*