

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2019	06/30/2020

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

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:	344886600A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110230

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

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.)
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
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?

DSH Examination Year (07/01/19 - 06/30/20)
Yes

No

No

3a. Was the hospital open as of December 22, 1987?

No

3b. What date did the hospital open?

4/1/2017

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020

\$ 200,364

(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 Services 07/01/2019 - 06/30/2020

\$ 200,364

Certification:

1. Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?

Answer

Yes

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:

Other Protest Item: "New Hampshire Hospital Association v. Azar" We protest the inclusion of Commercial and Medicare payments for Dual Eligibles toward the Hospital 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

Joann Manning

Hospital CEO or CFO Printed Name

CFO

Title

678-474-7001

Hospital CEO or CFO Telephone Number

Date

joann.manning@emoryhealth.org

Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name Dana Laster
Title Controller
Telephone Number 678-474-7001
E-Mail Address dana.laster@emoryhealth.org
Mailing Street Address 6325 Hospital Parkway
Mailing City, State, Zip Johns Creek, GA 30097

Outside Preparer:

Name Dennis Willis
Title Senior Manager
Firm Name Southeast Reimbursement Group
Telephone Number 615-333-0655 ext 205
E-Mail Address dennis.willis@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 JOHNS CREEK

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:

2/19/2021

4. Hospital Name:

EMORY JOHNS CREEK

5. Medicaid Provider Number:

344886600A

6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):

0

7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):

0

8. Medicare Provider Number:

110230

Correct?

If Incorrect, Proper Information

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

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)

State Name

Provider No.

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)**

9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)

10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)

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)

12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

\$-
\$-

Inpatient	Outpatient	Total
\$ 358,668	\$ 521,155	\$879,823
\$ 2,543,499	\$ 8,779,118	\$11,322,617
\$2,902,167	\$9,300,273	\$12,202,440
12.36%	5.60%	7.21%

13. Did your hospital receive any Medicaid managed care payments not paid at the claim level?

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)

37,237

(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
8. Outpatient Hospital Charity Care Charges
9. Non-Hospital Charity Care Charges
10. Total Charity Care Charges

10,361,303
10,759,221
\$ 21,120,524

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)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$85,106,758.00			\$ 59,170,129	\$ -	\$ -	\$ 25,936,629
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	\$218,056,430.00	\$251,414,670.00		\$ 151,602,849	\$ 174,795,030	\$ -	\$ 143,073,221
20. Outpatient Services		\$49,991,787.00			\$ 34,756,587	\$ -	\$ 15,235,200
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	\$2,889,718.00	\$0.00	\$0.00	\$ 2,009,065	\$ -	\$ -	\$ 880,653
27. Total	\$ 306,052,906	\$ 301,406,457	\$ -	\$ 212,782,042	\$ 209,551,618	\$ -	\$ 185,125,703
28. Total Hospital and Non Hospital		Total from Above	\$ 607,459,363		Total from Above	\$ 422,333,660	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)			
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)	607,459,363			422,333,660			
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+			
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+			
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+			
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-			
35. Adjusted Contractual Adjustments				422,333,660			
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 JOHNS CREEK

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

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 39,734,432	\$ -	\$ -	\$0.00	\$ 39,734,432	33,698	\$51,093,415.00	\$ 1,179.13
2	03100	INTENSIVE CARE UNIT	\$ 8,545,394	\$ -	\$ -		\$ 8,545,394	3,900	\$26,657,341.00	\$ 2,191.13
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	\$ 3,176,902	\$ -	\$ -		\$ 3,176,902	1,594	\$7,356,002.00	\$ 1,993.04
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 986,861	\$ -	\$ -		\$ 986,861	2,098	\$2,889,718.00	\$ 470.38
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine		\$ 52,443,589	\$ -	\$ -	\$ -	\$ 52,443,589	41,290	\$ 87,996,476	
19	Weighted Average									\$ 1,270.13

Observation Data (Non-Distinct)

20	09200	Observation (Non-Distinct)		4,053	-	-	\$ 4,779,014	\$83,380.00	\$7,603,213.00	\$ 7,686,593	0.621734
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		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
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$18,261,219.00	\$ -	\$0.00	\$ 18,261,219	\$40,407,090.00	\$61,102,564.00	\$ 101,509,654	0.179896
22	5100	RECOVERY ROOM	\$2,139,186.00	\$ -	\$0.00	\$ 2,139,186	\$4,471,471.00	\$7,134,526.00	\$ 11,605,997	0.184317
23	5200	DELIVERY ROOM & LABOR ROOM	\$4,572,899.00	\$ -	\$0.00	\$ 4,572,899	\$11,089,516.00	\$9,918.00	\$ 11,099,434	0.411994
24	5300	ANESTHESIOLOGY	\$622,374.00	\$ -	\$0.00	\$ 622,374	\$6,804,156.00	\$9,743,400.00	\$ 16,547,556	0.037611
25	5400	RADIOLOGY-DIAGNOSTIC	\$8,555,480.00	\$ -	\$0.00	\$ 8,555,480	\$9,310,559.00	\$33,881,669.00	\$ 43,192,228	0.198079
26	5700	CT SCAN	\$2,036,740.00	\$ -	\$0.00	\$ 2,036,740	\$14,170,724.00	\$34,429,827.00	\$ 48,600,551	0.041908
27	5800	MRI	\$1,847,846.00	\$ -	\$0.00	\$ 1,847,846	\$5,945,844.00	\$20,535,238.00	\$ 26,481,082	0.069780
28	5900	CARDIAC CATHETERIZATION	\$2,978,347.00	\$ -	\$0.00	\$ 2,978,347	\$6,290,944.00	\$8,665,272.00	\$ 14,956,216	0.199138
29	6000	LABORATORY	\$6,516,631.00	\$ -	\$0.00	\$ 6,516,631	\$45,008,852.00	\$26,073,248.00	\$ 71,082,100	0.091678
30	6500	RESPIRATORY THERAPY	\$2,753,375.00	\$ -	\$0.00	\$ 2,753,375	\$6,321,288.00	\$1,421,719.00	\$ 7,743,007	0.355595

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6600 PHYSICAL THERAPY	\$4,153,259.00	\$ -	\$0.00	\$ 4,153,259	\$9,176,138.00	\$6,042,873.00	\$ 15,219,011	0.272899
32	6900 ELECTROCARDIOLOGY	\$794,064.00	\$ -	\$0.00	\$ 794,064	\$6,354,411.00	\$5,622,867.00	\$ 11,977,278	0.066298
33	7000 ELECTROENCEPHALOGRAPHY	\$458,309.00	\$ -	\$0.00	\$ 458,309	\$108,996.00	\$1,499,589.00	\$ 1,608,585	0.284914
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$9,344,030.00	\$ -	\$0.00	\$ 9,344,030	\$9,838,875.00	\$8,816,243.00	\$ 18,655,118	0.500883
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$14,645,021.00	\$ -	\$0.00	\$ 14,645,021	\$7,255,266.00	\$7,521,647.00	\$ 14,776,913	0.991074
36	7300 DRUGS CHARGED TO PATIENTS	\$15,412,297.00	\$ -	\$0.00	\$ 15,412,297	\$33,941,158.00	\$18,796,228.00	\$ 52,737,386	0.292246
37	7400 RENAL DIALYSIS	\$583,948.00	\$ -	\$0.00	\$ 583,948	\$1,561,142.00	\$117,842.00	\$ 1,678,984	0.347798
38	9100 EMERGENCY	\$9,822,634.00	\$ -	\$0.00	\$ 9,822,634	\$11,652,392.00	\$30,652,802.00	\$ 42,305,194	0.232185
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ -	-

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 105,497,659	\$ -	\$ -	\$ 105,497,659	\$ 229,792,202	\$ 289,670,685	\$ 519,462,887	
127	Weighted Average								0.212290
128	Sub Totals	\$ 157,941,248	\$ -	\$ -	\$ 157,941,248	\$ 317,788,678	\$ 289,670,685	\$ 607,459,363	
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				\$ 157,941,248				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

* Note A - Final cost-to-charge ratios should include teaching cost. Only enter Intern & Resident costs if it was removed in Column 25 of Worksheet B, Pt. I of the cost report you are using.

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

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

Medicaid Per Diem Cost for Routine Cost Centers			Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient		
Line #	Cost Center Description			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				
From Section G			From Section G														
Routine Cost Centers (from Section G):																	
1	03000 ADULTS & PEDIATRICS	\$	1,179.13	Days	1,181	Days	850	Days	904	Days	567	Days	1,274	Days	3,502	16.11%	
2	03100 INTENSIVE CARE UNIT	\$	2,191.13		280		60		257		86		300		683	25.21%	
3	03200 CORONARY CARE UNIT	\$	-												-		
4	03300 BURN INTENSIVE CARE UNIT	\$	-												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	\$	-												-		
6	03500 OTHER SPECIAL CARE UNIT	\$	1,993.04	105		432				4		19		541	35.13%		
7	04000 SUBPROVIDER I	\$	-												-		
8	04100 SUBPROVIDER II	\$	-												-		
9	04200 OTHER SUBPROVIDER	\$	-												-		
10	04300 NURSERY	\$	470.38	120		394				25		96		539	30.36%		
11		\$	-												-		
12		\$	-												-		
13		\$	-												-		
14		\$	-												-		
15		\$	-												-		
16		\$	-												-		
17		\$	-												-		
18		\$	-												-		
Total Days				1,686		1,736		1,161		682		1,689		5,265	16.85%		
Total Days per PS&R or Exhibit Detail				1,686		1,736		1,161		682		1,689					
Unreconciled Days (Explain Variance)				-		-		-		-		-					
Routine Charges				\$ 4,341,539		\$ 4,408,539		\$ 3,084,851		\$ 1,483,365		\$ 4,009,300		\$ 13,318,294	19.69%		
Calculated Routine Charge Per Diem				\$ 2,575.05		\$ 2,539.48		\$ 2,657.06		\$ 2,175.02		\$ 2,373.77		\$ 2,529.59			
Ancillary Cost Centers (from WIS C) (from Section G):																	
22	09200 Observation (Non-Distinct)		0.621734	Ancillary Charges	9.085	Ancillary Charges	213.228	Ancillary Charges	6.376	Ancillary Charges	3.876	Ancillary Charges	236.302	Ancillary Charges	47	Ancillary Charges	103.416
23	5000 OPERATING ROOM		0.179896		1,131.735		443.798		734.370		944.370		925.212		732.774		677.219
24	5100 RECOVERY ROOM		0.184317		134.523		94.795		79.616		145.971		121.925		75.567		77.404
25	5200 DELIVERY ROOM & LABOR ROOM		0.411994		74.438		1.125		1,764.679		24.607		22.155		81.037		1.064
26	5300 ANESTHESIOLOGY		0.037611		162.560		128.500		124.120		168.335		140.590		168.215		115.690
27	5400 RADIOLOGY-DIAGNOSTIC		0.198079		293.354		215.260		221.709		469.938		420.909		567.884		467.055
28	5700 CT SCAN		0.041908		520.877		334.291		191.216		766.037		489.633		486.771		512.472
29	5800 MRI		0.069780		267.061		146.375		82.995		247.649		271.866		428.824		134.480
30	5900 CARDIAC CATHETERIZATION		0.199138		395.509		98.594		10.218		147.278		154.577		106.075		191.093
31	6000 LABORATORY		0.091678		2,195.456		437.968		1,229.601		675.905		1,678.400		542.303		923.267
32	6500 RESPIRATORY THERAPY		0.355595		442.914		33.718		254.794		50.623		343.990		38.020		126.636
33	6600 PHYSICAL THERAPY		0.272899		330.217		61.235		83.842		131.819		362.019		104.515		209.621
34	6900 ELECTROCARDIOLOGY		0.066298		51.700		34.594		96.161		123.332		268.339		100.843		140.099
35	7000 ELECTROENCEPHALOGRAPHY		0.284914		4.699		39.940		1.821		33.156		7.352		15.198		39.639
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.500883		313.221		117.326		251.685		168.074		224.974		111.752		178.047
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.991074		160.163		36.222		61.048		63.768		161.386		127.644		127.644
38	7300 DRUGS CHARGED TO PATIENTS		0.292246		1,791.222		259.837		885.107		500.715		1,090.575		295.801		603.613
39	7400 RENAL DIALYSIS		0.347798		188.078		1.826		33.197		3.652		245.841		11.784		39.174
40	9100 EMERGENCY		0.232185		483.262		562.817		144.664		1,229.854		427.701		469.670		271.362
41			-		-		-		-		-		-		-		-
42			-		-		-		-		-		-		-		-
43			-		-		-		-		-		-		-		-
44			-		-		-		-		-		-		-		-
45			-		-		-		-		-		-		-		-
46			-		-		-		-		-		-		-		-
47			-		-		-		-		-		-		-		-
48			-		-		-		-		-		-		-		-
49			-		-		-		-		-		-		-		-
50			-		-		-		-		-		-		-		-
51			-		-		-		-		-		-		-		-
52			-		-		-		-		-		-		-		-
53			-		-		-		-		-		-		-		-
54			-		-		-		-		-		-		-		-
55			-		-		-		-		-		-		-		-
56			-		-		-		-		-		-		-		-
57			-		-		-		-		-		-		-		-
58			-		-		-		-		-		-		-		-
59			-		-		-		-		-		-		-		-
60			-		-		-		-		-		-		-		-

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

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

EMORY JOHNS CREEK

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61				-										\$	-	-
62				-										\$	-	-
63				-										\$	-	-
64				-										\$	-	-
65				-										\$	-	-
66				-										\$	-	-
67				-										\$	-	-
68				-										\$	-	-
69				-										\$	-	-
70				-										\$	-	-
71				-										\$	-	-
72				-										\$	-	-
73				-										\$	-	-
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124				-										\$	-	-
125				-										\$	-	-
126				-										\$	-	-
127				-										\$	-	-
					\$ 8,950,074	\$ 3,260,449	\$ 6,259,601	\$ 5,802,041	\$ 7,351,618	\$ 4,949,562	\$ 4,336,906	\$ 4,025,767	\$ 10,863,659	\$ 12,793,180		

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

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

	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		%				
Totals / Payments																	
128	Total Charges (includes organ acquisition from Section J)				\$ 13,291,613	\$ 3,260,449	\$ 10,668,140	\$ 5,802,041	\$ 10,436,469	\$ 4,949,562	\$ 5,820,271	\$ 4,025,767	\$ 14,872,959	\$ 12,793,180	\$ 40,216,493	\$ 18,037,819	14.16%
129	Total Charges per PS&R or Exhibit Detail				\$ 13,291,613	\$ 3,260,449	\$ 10,668,140	\$ 5,802,041	\$ 10,436,469	\$ 4,949,562	\$ 5,820,271	\$ 4,025,767	\$ 14,872,959	\$ 12,793,180			
130	Unreconciled Charges (Explain Variance)				-	-	-	-	-	-	-	-	-	-			
131	Total Calculated Cost (includes organ acquisition from Section J)				\$ 4,190,309	\$ 705,829	\$ 3,846,212	\$ 1,130,230	\$ 3,156,064	\$ 1,055,565	\$ 1,801,370	\$ 823,321	\$ 4,476,790	\$ 2,564,919	\$ 12,993,955	\$ 3,714,945	15.05%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)				\$ 2,983,360	\$ 465,120									\$ 2,983,360	\$ 465,120	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)						\$ 2,462,148	\$ 722,689							\$ 2,462,148	\$ 722,689	
134	Private Insurance (including primary and third party liability)				\$ 129,097	\$ 916					\$ 1,414,931	\$ 920,657			\$ 1,544,028	\$ 921,573	
135	Self-Pay (including Co-Pay and Spend-Down)				\$ 125	\$ 906									\$ 125	\$ 906	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)				\$ 3,112,582	\$ 466,942	\$ 2,462,148	\$ 722,689									
137	Medicaid Cost Settlement Payments (See Note B)					\$ 52,255									\$ -	\$ 52,255	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)														\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)								\$ 2,112,869	\$ 805,297					\$ 2,112,869	\$ 805,297	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)														\$ -	\$ -	
141	Medicare Cross-Over Bad Debt Payments								\$ 25,042	\$ 42,930					\$ 25,042	\$ 42,930	
142	Other Medicare Cross-Over Payments (See Note D)														\$ -	\$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)												\$ 358,668	\$ 521,155			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)												\$ -	\$ -			
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)				\$ 1,077,727	\$ 186,632	\$ 1,384,064	\$ 407,541	\$ 1,018,153	\$ 207,338	\$ 386,439	\$ (97,336)	\$ 4,118,122	\$ 2,043,764	\$ 3,866,383	\$ 704,175	
146	Calculated Payments as a Percentage of Cost				74%	74%	64%	64%	68%	80%	79%	112%	8%	20%	70%	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)				16,509												
148	Percent of cross-over days to total Medicare days from the cost report				7%												

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.

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

EMORY JOHNS CREEK

					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-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured							
					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			Charges		Useable Organs (Count)		Charges		Useable Organs (Count)		Charges		Useable Organs (Count)		Charges		Useable Organs (Count)	
					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)

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		Total			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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
		Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost			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 (09/01/2019-08/31/2020) EMORY JOHNS CREEK

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 2,571,413	
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 ----->)	\$ 2,571,413	
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		(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	\$ -	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 2,571,413
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	58,322,910
19 Uninsured Hospital Charges Sec. G	27,666,139
20 Total Hospital Charges Sec. G	607,459,363
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	9.60%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	4.55%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 246,884
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 117,112
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 363,996

* 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.