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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

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

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	09/01/2022	08/31/2023
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	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 Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/24 - 06/30/25)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	No
3b. What date did the hospital open?	4/4/2017

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** — $ 772,426
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

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

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** — $ 772,426

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:

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

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

Hospital Contact:

Name	Dawn Stone
Title	Director of Reimbursement
Telephone Number	404-782-2224
E-Mail Address	dawn.stone@emoryhealthcare.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.willlis@srgllc.org

DSH Version 9.00 9/11/2024

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

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

1. Select Your Facility from the Drop-Down Menu Provided: EMORY JOHNS CREEK

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

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	EMORY JOHNS CREEK	Yes	
5. Medicaid Provider Number:	344886600A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110230	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (09/01/2022 - 08/31/2023)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 475,791	$ 850,459	$1,326,250
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,685,410	$ 8,818,694	$11,504,104
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)	$3,161,201	$9,669,153	$12,830,354
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	15.05%	8.80%	10.34%

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

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	49,108 **(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	13,541,325
8.	Outpatient Hospital Charity Care Charges	13,214,701
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 26,756,026

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	$122,316,084.00			$ 85,835,477	$ -	$ -	$ 36,480,607
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	$308,245,048.00	$361,758,818.00		$ 216,311,378	$ 253,864,738	$ -	$ 199,827,750
20.	Outpatient Services		$101,964,674.00			$ 71,553,847	$ -	$ 30,410,827
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	$4,351,435.00	$0.00	$0.00	$ 3,053,625	$ -	$ -	$ 1,297,810
27.	Total	$ 434,912,567	$ 463,723,492	$ -	$ 305,200,480	$ 325,418,585	$ -	$ 268,016,994
28.	Total Hospital and Non Hospital		Total from Above	$ 898,636,059		Total from Above	$ 630,619,065	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	898,636,059	Total Contractual Adj. (G-3 Line 2)	629,568,124
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)			+	1,050,941
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36.	Adjusted Contractual Adjustments				630,619,065
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) EMORY JOHNS CREEK

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	$ 60,887,306	$ -	$ -	$0.00	$ 60,887,306	45,290	$76,553,944.00		$ 1,344.39
2	03100 INTENSIVE CARE UNIT	$ 12,692,050	$ -	$ -		$ 12,692,050	5,327	$36,804,096.00		$ 2,382.59
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	$ 5,191,822	$ -	$ -		$ 5,191,822	1,765	$8,958,044.00		$ 2,941.54
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 1,623,697	$ -	$ -		$ 1,623,697	2,690	$4,351,435.00		$ 603.60
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 80,394,875	$ -	$ -	$ -	$ 80,394,875	55,072	$ 126,667,519		
19	Weighted Average									$ 1,459.82

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)	5,964	-	-	$ 8,017,942	$2,538,392.00	$9,023,317.00	$ 11,561,709	0.693491

Line #			*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$29,491,990.00	$ -	$ -		$ 29,491,990	$44,345,487.00	$86,701,794.00	$ 131,047,281	0.225048
22	5100	RECOVERY ROOM	$2,891,335.00	$ -	$ -		$ 2,891,335	$5,112,633.00	$13,283,098.00	$ 18,395,731	0.157174
23	5200	DELIVERY ROOM & LABOR ROOM	$7,989,297.00	$ -	$ -		$ 7,989,297	$16,450,489.00	$5,392.00	$ 16,455,881	0.485498
24	5300	ANESTHESIOLOGY	$1,218,709.00	$ -	$ -		$ 1,218,709	$13,347,319.00	$19,220,416.00	$ 32,567,735	0.037421
25	5400	RADIOLOGY-DIAGNOSTIC	$14,836,931.00	$ -	$ -		$ 14,836,931	$21,953,403.00	$63,007,634.00	$ 84,961,037	0.174632
26	5700	CT SCAN	$2,904,958.00	$ -	$ -		$ 2,904,958	$20,706,417.00	$37,963,789.00	$ 58,670,206	0.049513
27	5800	MRI	$2,459,511.00	$ -	$ -		$ 2,459,511	$7,976,219.00	$22,719,973.00	$ 30,696,192	0.080124
28	5900	CARDIAC CATHETERIZATION	$4,798,502.00	$ -	$ -		$ 4,798,502	$11,404,718.00	$15,095,626.00	$ 26,500,344	0.181073
29	6000	LABORATORY	$11,691,455.00	$ -	$ -		$ 11,691,455	$61,807,149.00	$39,996,169.00	$ 101,803,318	0.114844
30	6500	RESPIRATORY THERAPY	$3,913,296.00	$ -	$ -		$ 3,913,296	$14,557,229.00	$2,662,639.00	$ 17,219,868	0.227255
31	6600	PHYSICAL THERAPY	$6,136,446.00	$ -	$ -		$ 6,136,446	$12,345,513.00	$8,770,214.00	$ 21,115,727	0.290610

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) 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
32	6900	ELECTROCARDIOLOGY	$1,000,339.00	$ -	$ -		$ 1,000,339	$14,704,442.00	$9,406,506.00	$ 24,110,948	0.041489
33	7000	ELECTROENCEPHALOGRAPHY	$724,395.00	$ -	$ -		$ 724,395	$303,015.00	$2,756,588.00	$ 3,059,603	0.236761
34	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$9,435,657.00	$ -	$ -		$ 9,435,657	$12,514,948.00	$14,651,338.00	$ 27,166,286	0.347330
35	7200	IMPL. DEV. CHARGED TO PATIENTS	$19,762,888.00	$ -	$ -		$ 19,762,888	$10,214,859.00	$10,787,370.00	$ 21,002,229	0.940990
36	7300	DRUGS CHARGED TO PATIENTS	$18,750,387.00	$ -	$ -		$ 18,750,387	$38,131,002.00	$14,402,376.00	$ 52,533,378	0.356923
37	7400	RENAL DIALYSIS	$1,075,878.00	$ -	$ -		$ 1,075,878	$2,370,206.00	$327,896.00	$ 2,698,102	0.398754
38	9100	EMERGENCY	$14,380,550.00	$ -	$ -		$ 14,380,550	$27,166,457.00	$63,236,508.00	$ 90,402,965	0.159072
39			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2022-08/31/2023) 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
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 153,462,524	$ -	$ -		$ 153,462,524	$ 337,949,897	$ 434,018,643	$ 771,968,540	
127		**Weighted Average**									0.209180
128		**Sub Totals**	$ 233,857,399	$ -	$ -		$ 233,857,399	$ 464,617,416	$ 434,018,643	$ 898,636,059	
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**					$ 233,857,399				
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 (09/01/2022-08/31/2023) EMORY JOHNS CREEK

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	In-State Medicaid FFS Primary Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Inpatient	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Outpatient	% Survey to Cost Report Totals (Includes all payers)
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,344.39		1,670		1,092		1,043		2,354		168		1,578		6,327		20.53%
2	03100 INTENSIVE CARE UNIT	$ 2,382.59		232		49		159		245		8		133		693		15.69%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -														-		
6	03500 OTHER SPECIAL CARE UNIT	$ 2,941.54		5		356				90		11		42		462		28.56%
7	04000 SUBPROVIDER I	$ -														-		
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 603.60		219		250				51		52		201		572		28.74%
11		$ -														-		
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	2,126		1,747		1,202		2,740		239		1,954		8,054		18.50%
19	Total Days per PS&R or Exhibit Detail			2,126		1,747		1,202		2,740		239		1,954				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 5,579,339		$ 4,515,213		$ 3,269,256		$ 6,833,683		$ 485,885		$ 4,425,141		$ 20,197,491		19.74%
21.01	Calculated Routine Charge Per Diem			$ 2,624.34		$ 2,584.55		$ 2,719.85		$ 2,494.04		$ 2,032.99		$ 2,264.66		$ 2,507.76		
Ancillary Cost Centers (from W/S C) (from Section G):				**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.693491	299,170	105,094	90,543	215,970	30,628	128,364	89,555	463,551	2,812	37,392	117,349	450,148	$ 509,896	$ 912,979	17.77%
23	5000 OPERATING ROOM		0.225048	1,469,726	351,213	1,381,761	2,332,071	1,143,288	956,489	2,924,814	2,985,111	157,282	160,846	1,519,093	4,785,385	$ 6,919,589	$ 6,624,884	15.45%
24	5100 RECOVERY ROOM		0.157174	141,826	94,524	106,578	344,719	70,235	202,145	258,698	423,695	23,919	11,355	149,538	398,346	$ 577,337	$ 1,065,083	12.10%
25	5200 DELIVERY ROOM & LABOR ROOM		0.485498	87,689	891	1,482,543	46,502	10,623		670,929	19,632	51,535	1,862	449,749	7,827	$ 2,251,784	$ 67,025	17.20%
26	5300 ANESTHESIOLOGY		0.037421	219,033	105,869	519,594	488,975	188,711	207,708	624,732	607,900	40,727	31,681	347,686	1,055,395	$ 1,552,070	$ 1,410,452	13.67%
27	5400 RADIOLOGY-DIAGNOSTIC		0.174632	538,542	306,343	316,716	1,265,530	304,756	650,760	944,530	1,489,135	51,946	129,245	581,270	1,270,108	$ 2,104,544	$ 3,711,768	9.38%
28	5700 CT SCAN		0.049513	703,169	269,337	364,924	1,105,522	349,850	584,485	1,078,334	1,291,920	84,353	141,295	974,878	2,200,086	$ 2,496,277	$ 3,251,264	15.87%
29	5800 MRI		0.080124	203,414	86,204	131,864	433,698	171,990	337,858	541,996	727,434	30,754	63,254	306,330	363,404	$ 1,049,264	$ 1,585,194	11.17%
30	5900 CARDIAC CATHETERIZATION		0.181073	520,617	114,105	50,599	81,653	66,166	356,339	339,369	558,766	68,355		609,878	99,695	$ 976,751	$ 1,110,863	10.81%
31	6000 LABORATORY		0.114844	3,058,882	480,808	1,762,843	1,421,555	1,629,572	603,581	3,487,487	1,626,763	261,108	161,543	3,038,806	1,982,667	$ 9,938,784	$ 4,132,707	19.53%
32	6500 RESPIRATORY THERAPY		0.227255	546,121	39,742	316,215	60,224	414,613	37,408	734,103	117,586	58,844	1,728	252,518	65,570	$ 2,011,052	$ 254,960	15.61%
33	6600 PHYSICAL THERAPY		0.290610	519,243	4,101	119,573	143,041	293,674	194,705	713,414	314,146	20,297	64,454	239,316	63,789	$ 1,645,904	$ 655,993	12.88%
34	6900 ELECTROCARDIOLOGY		0.041489	315,661	41,412	280,603	229,980	281,208	186,596	779,074	427,009	81,629	55,020	626,878	325,672	$ 1,656,546	$ 884,997	15.31%
35	7000 ELECTROENCEPHALOGRAPHY		0.236761	5,289	133,158	6,737	95,515	12,956	41,411	15,703	122,450		16,418	9,997	13,283	$ 40,685	$ 392,534	15.46%
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.347330	350,652	94,715	387,304	736,211	243,496	115,370	552,565	532,166	40,844	19,422	354,928	507,239	$ 1,534,017	$ 1,478,462	14.55%
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.940990	232,978	24,277	92,650	113,378	126,697	124,627	431,218	359,463	24,689	20,775	165,868	58,335	$ 883,543	$ 621,745	8.46%
38	7300 DRUGS CHARGED TO PATIENTS		0.356923	1,669,762	178,913	954,123	629,714	1,210,503	163,903	2,110,300	501,567	178,943	76,655	1,387,251	733,217	$ 5,944,688	$ 1,474,097	19.09%
39	7400 RENAL DIALYSIS		0.398754	159,010		31,042		158,862	18,260	324,529	88,082	5,478		44,482	12,782	$ 673,443	$ 106,342	32.31%
40	9100 EMERGENCY		0.159072	840,725	709,236	428,538	3,100,585	445,659	809,843	1,149,309	2,190,776	80,984	406,406	1,217,688	5,289,326	$ 2,864,231	$ 6,810,440	18.78%
41			-													$ -	$ -	
42			-													$ -	$ -	
43			-													$ -	$ -	
44			-													$ -	$ -	
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72			-													$ -	$ -	

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

Cost Report Year (09/01/2022-08/31/2023) 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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)	% Survey to Cost Report
73				-													$ -	$ -
74				-													$ -	$ -
75				-													$ -	$ -
76				-													$ -	$ -
77				-													$ -	$ -
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127				-													$ -	$ -
					$ 11,881,509	$ 3,139,942	$ 8,824,750	$ 12,844,843	$ 7,153,487	$ 5,719,852	$ 17,770,659	$ 14,847,152	$ 1,264,499	$ 1,399,351	$ 12,393,503	$ 19,682,274		

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

Cost Report Year (09/01/2022-08/31/2023) EMORY JOHNS CREEK

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Total
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 17,460,848	$ 3,139,942	$ 13,339,963	$ 12,844,843	$ 10,422,743	$ 5,719,852	$ 24,604,342	$ 14,847,152	$ 1,750,384	$ 1,399,351	$ 16,818,644 (Agrees to Exhibit A)	$ 19,682,274 (Agrees to Exhibit A)	$ 65,827,896	$ 36,551,789	15.67%
129	Total Charges per PS&R or Exhibit Detail	$ 17,460,848	$ 3,139,942	$ 13,339,963	$ 12,844,843	$ 10,422,743	$ 5,719,852	$ 24,604,342	$ 14,847,152	$ 1,750,384	$ 1,399,351	$ 16,818,644	$ 19,682,274			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 5,570,299	$ 596,679	$ 4,970,833	$ 2,425,971	$ 3,330,665	$ 1,081,895	$ 7,951,118	$ 3,012,886	$ 573,400	$ 262,786	$ 5,136,304	$ 3,489,970	$ 21,822,915	$ 7,117,431	16.29%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 2,729,103	$ 549,195											$ 2,729,103	$ 549,195	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 2,445,062	$ 1,632,780									$ 2,445,062	$ 1,632,780	
134	Private Insurance (including primary and third party liability)	$ 21,351	$ 5,663											$ 21,351	$ 5,663	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 332	$ 8,858	$ 7,452	$ 4,942	$ 4,840	$ 13,935		$ 18			$ 12,624	$ 27,735	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 2,750,454	$ 554,858	$ 2,445,394	$ 1,641,638											
137	Medicaid Cost Settlement Payments (See Note B)		$ (36,205)											$ -	$ (36,205)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 1,965,666	$ 836,130							$ 1,965,666	$ 836,130	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 5,974,685	$ 2,825,936					$ 5,974,685	$ 2,825,936	
141	Medicare Cross-Over Bad Debt Payments					$ 6,271	$ 11,490							$ 6,271	$ 11,490	
142	Other Medicare Cross-Over Payments (See Note D)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 475,791	$ 850,459			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)											$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 2,819,845	$ 78,026	$ 2,525,439	$ 784,333	$ 1,351,276	$ 229,333	$ 1,971,593	$ 173,015	$ 573,400	$ 262,768	$ 4,660,513	$ 2,639,511	$ 8,668,153	$ 1,264,707	
146	**Calculated Payments as a Percentage of Cost**	49%	87%	49%	68%	59%	79%	75%	94%	0%	0%	9%	24%	60%	82%	
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)**					22,880										
148	**Percent of cross-over days to total Medicare days from the cost report**					5%										

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

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) EMORY JOHNS CREEK

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 & with Medicaid Secondary)		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	$ 1,344.39		144				8		17		169	
2	03100 INTENSIVE CARE UNIT	$ 2,382.59		8						2		10	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 2,941.54										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 603.60										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	152		-		8		19		179	
19	Total Days per PS&R or Exhibit Detail			152		-		8		19			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 325,336				$ 14,456		$ 47,001		$ 386,793	
21.01	Calculated Routine Charge Per Diem			$ 2,140.37		$ -		$ 1,807.00		$ 2,473.74		$ 2,160.85	
	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)		0.693491	6,384	10,868		1,064		988		4,864	$ 6,384	$ 17,784
23	5000 OPERATING ROOM		0.225048	66,794	1,618			4,549	808	3,666	1,429	$ 75,009	$ 3,855
24	5100 RECOVERY ROOM		0.157174									$ -	$ -
25	5200 DELIVERY ROOM & LABOR ROOM		0.485498		1,400							$ -	$ 1,400
26	5300 ANESTHESIOLOGY		0.037421	9,724				3,386				$ 13,110	$ -
27	5400 RADIOLOGY-DIAGNOSTIC		0.174632	37,991	36,220		1,590	5,474	16,958	9,845	14,740	$ 53,310	$ 69,508
28	5700 CT SCAN		0.049513	87,263	38,375			2,293	16,371	2,578	17,195	$ 92,134	$ 71,941
29	5800 MRI		0.080124	29,760	2,296							$ 29,760	$ 2,296
30	5900 CARDIAC CATHETERIZATION		0.181073									$ -	$ -
31	6000 LABORATORY		0.114844	247,119	47,755		1,185	13,781	5,883	37,362	11,737	$ 298,262	$ 66,560
32	6500 RESPIRATORY THERAPY		0.227255	26,547	641			3,767	2,665	9,924	547	$ 40,238	$ 3,853
33	6600 PHYSICAL THERAPY		0.290610	19,440				5,652		4,984		$ 30,076	$ -
34	6900 ELECTROCARDIOLOGY		0.041489	33,657	4,080			4,517	1,428	9,441	7,434	$ 47,615	$ 12,942
35	7000 ELECTROENCEPHALOGRAPHY		0.236761									$ -	$ -
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.347330	13,237	984			196	84	2,112	84	$ 15,545	$ 1,152
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.940990	1,626	63			270				$ 1,896	$ 63
38	7300 DRUGS CHARGED TO PATIENTS		0.356923	192,928	21,344		861	2,963	2,679	8,864	4,838	$ 204,755	$ 29,722
39	7400 RENAL DIALYSIS		0.398754	20,086	1,826				3,652		3,652	$ 20,086	$ 9,130
40	9100 EMERGENCY		0.159072	94,840	145,141		1,419	8,445	16,153	7,967	31,948	$ 111,252	$ 194,661
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) EMORY JOHNS CREEK

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
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66				-									$ -	$ -
67				-									$ -	$ -
68				-									$ -	$ -
69				-									$ -	$ -
70				-									$ -	$ -
71				-									$ -	$ -
72				-									$ -	$ -
73				-									$ -	$ -
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108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -
112				-									$ -	$ -
113				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2022-08/31/2023) EMORY JOHNS CREEK

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 887,396	$ 312,611	$ -	$ 6,119	$ 55,293	$ 67,669	$ 96,743	$ 98,468		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 1,212,732	$ 312,611	$ -	$ 6,119	$ 69,749	$ 67,669	$ 143,744	$ 98,468	$ 1,426,225	$ 484,867
129	Total Charges per PS&R or Exhibit Detail			$ 1,212,732	$ 312,611	$ -	$ 6,119	$ 69,749	$ 67,669	$ 143,744	$ 98,468		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 385,358	$ 54,624	$ -	$ 1,685	$ 19,967	$ 10,991	$ 43,843	$ 17,195	$ 449,168	$ 84,495
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 82,154	$ 7,081							$ 82,154	$ 7,081
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)										$ 100	$ -	$ 100
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 82,154	$ 7,081	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)							$ 19,741	$ 7,968			$ 19,741	$ 7,968
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)									$ 46,846	$ 12,614	$ 46,846	$ 12,614
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)**			$ 303,204	$ 47,543	$ -	$ 1,685	$ 226	$ 3,023	$ (3,003)	$ 4,481	$ 300,427	$ 56,732
144	**Calculated Payments as a Percentage of Cost**			21%	13%	0%	0%	99%	72%	107%	74%	33%	33%

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

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

Cost Report Year (09/01/2022-08/31/2023) 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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):																	
1	Lung Acquisition	$0.00	$ -	$ -		0												
2	Kidney Acquisition	$0.00	$ -	$ -		0												
3	Liver Acquisition	$0.00	$ -	$ -		0												
4	Heart Acquisition	$0.00	$ -	$ -		0												
5	Pancreas Acquisition	$0.00	$ -	$ -		0												
6	Intestinal Acquisition	$0.00	$ -	$ -		0												
7	Islet Acquisition	$0.00	$ -	$ -		0												
8		$0.00	$ -	$ -		0												
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-		-

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

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

Cost Report Year (09/01/2022-08/31/2023) 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)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (09/01/2022-08/31/2023) 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)*		$ 2,770,387		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	458900-40997	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -	5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 2,770,387		
	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*		$ 2,198,385	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		$ 2,198,385		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 572,002
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	107,440,512
19	Uninsured Hospital	**Charges Sec. G**	36,500,918
20	Total Hospital	**Charges Sec. G**	898,636,059
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		11.96%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		4.06%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 68,388
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 23,234
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 91,622**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	48,317,058
27	Uninsured Hospital	**Charges Sec. G**	39,650,653
28	Total Hospital	**Charges Sec. G**	898,636,059
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		5.38%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		4.41%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 30,755
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 25,239
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 55,994**

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

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

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