

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2021	06/30/2022

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

Identification of cost reports needed to cover the DSH Year:

3. Cost Report Year 1
4. Cost Report Year 2 (if applicable)
5. Cost Report Year 3 (if applicable)

Cost Report Begin Date(s)	Cost Report End Date(s)
09/01/2021	08/31/2022

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

6. Medicaid Provider Number:
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):
9. Medicare Provider Number:

Data
000000712A
000000712B
0
110010

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:

- 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.)
- Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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 (07/01/21 -
06/30/22)

Yes

No

No

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

Yes

3b. What date did the hospital open?

3/1/1904

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2021 - 06/30/2022 \$ 17,568,709
(Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)
2. Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022 \$ -
(Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.
3. Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services 07/01/2021 - 06/30/2022 \$ 17,568,709

Certification:

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.

Answer

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

Liz Daunt-Samford
Hospital CEO or CFO Printed Name

VP & CFO
Title

404-686-4918
Hospital CEO or CFO Telephone Number

10/20/2023
Date
liz.duant@emoryhealthcare.org
Hospital CEO or CFO E-Mail

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

Hospital Contact:
Name Ronda Mitchell-Wise
Title Manager of Budgets and Reimbursement
Telephone Number 404-686-6019
E-Mail Address ronda.mitchell-wise@emoryhealthcare.org
Mailing Street Address 1 Baltimore Place, Suite 300
Mailing City, State, Zip Atlanta, GA 30309

Outside Preparer:
Name Jeff Askey
Title Partner
Firm Name Draffin Tucker
Telephone Number 229-883-7878
E-Mail Address JAskey@draffin-tucker.com

GA DSH Payment Results for SFY 2024 - Pool 2
DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

4/8/2024 7:46

Provider Name	EMORY UNIVERSITY HOSPITAL
Mcaid Provider Number	000000712A
Mcare Provider Number	110010

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2023 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year:					7/1/2023 - 6/30/2024
	(A)	(B)	(C)	(D)	(E)
	Cost Report Year Begin	Cost Report Year End	As-Filed DSH Uncompensated Care Cost (UCC)	Total Adjustments	Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	9/1/2021	8/31/2022	\$ 90,607,630	\$ (12,962)	\$ 90,594,603
Less: 2022 Net UPL Payments					\$ 15,915,417
Less: 2024 Net DPP Payments					\$ 24,795,813
Plus: 2023 Net DPP Recoupments					\$ -
Less: GME Payments					\$ 1,653,292
Add: Net OP Settlement (Difference between provider submitted and estimated)					\$ 209,109
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)					\$ 1,884,830
Uncompensated Care Allocation Factor					\$ 50,324,020
Hospital Specific DSH Limit					\$ 50,324,020
2024 Eligibility					Eligible
DSH Year Low Income Utilization Ratio (LIUR):					9.05%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):					21.17%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail: gadsh@mslc.com
Fax: 816-945-5301
Web Portal Address: <https://DSH.MSLC.com>
Phone Inquiries: 800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	8.11	2/10/2023

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

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

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

EMORY UNIVERSITY HOSPITAL

9/1/2021 through 8/31/2022		
X		

2. Select Cost Report Year Covered by this Survey:

3. Status of Cost Report Used for this Survey (Should be audited if available):

1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database:

5/12/2023

4. Hospital Name:

EMORY UNIVERSITY HOSPITAL

5. Medicaid Provider Number:

000000712A

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

000000712B

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

0

8. Medicare Provider Number:

110010

Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):

Private

Correct?

Yes

Yes

Yes

Yes

Yes

Yes

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

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

\$	-
\$	-
\$	-
\$	\$-
\$	-
\$	-
\$	\$-

8. **Out-of-State DSH Payments (See Note 2)**

\$	-
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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)

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

Inpatient	Outpatient	Total
\$ 268,761	\$ 1,510,849	\$1,779,610
\$ 3,188,572	\$ 13,847,826	\$17,036,398
\$3,457,333	\$15,358,675	\$18,816,008
7.77%	9.84%	9.46%

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.

No

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services

\$	-
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15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services

\$	-
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16. Total Medicaid managed care non-claims payments (see question 13 above) received

\$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (09/01/2021 - 08/31/2022)

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

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6) 206,476

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	104,551,738
8. Outpatient Hospital Charity Care Charges	26,058,731
9. Non-Hospital Charity Care Charges	1,730,431
10. Total Charity Care Charges	\$ 132,340,900

F-3. Calculation of Net Hospital Revenue from Patient Services (Used for LIUR) (W/S G-2 and G-3 of Cost Report)

	Total Patient Revenues (Charges)			Contractual Adjustments			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$ 758,997,775	\$ -	\$ -	\$ 497,769,224	\$ -	\$ -	\$ 261,228,551
12. Psych Subprovider	\$ 21,256,896	\$ -	\$ -	\$ 13,940,790	\$ -	\$ -	\$ 7,316,106
13. Rehab. Subprovider	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$ -			\$ -	
15. Swing Bed - NF			\$ -			\$ -	
16. Skilled Nursing Facility			\$ -			\$ -	
17. Nursing Facility			\$ -			\$ -	
18. Other Long-Term Care			\$ -			\$ -	
19. Ancillary Services	\$ 1,958,462,531	\$ 1,026,422,123	\$ -	\$ 1,284,407,421	\$ 673,152,624	\$ -	\$ 1,027,324,609
20. Outpatient Services		\$ 94,365,857	\$ -		\$ 61,887,427	\$ -	\$ 32,478,430
21. Home Health Agency			\$ -			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
24. ASC	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
25. Hospice			\$ -			\$ -	
26. Other	\$ 48,023,467	\$ 125,404	\$ -	\$ 31,494,959	\$ 82,243	\$ -	\$ 16,571,669
27. Total	\$ 2,786,740,669	\$ 1,120,913,384	\$ -	\$ 1,827,612,395	\$ 735,122,294	\$ -	\$ 1,344,919,364
28. Total Hospital and Non Hospital		Total from Above	\$ 3,907,654,053		Total from Above	\$ 2,562,734,689	
29. Total Per Cost Report		Total Patient Revenues (G-3 Line 1)	\$ 3,907,654,053		Total Contractual Adj. (G-3 Line 2)	\$ 2,568,140,890	
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)						\$ -	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)						\$ 5,406,201	
35. Adjusted Contractual Adjustments						2,562,734,689	
36. Unreconciled Difference		Unreconciled Difference (Should be \$0)	\$ -		Unreconciled Difference (Should be \$0)	\$ -	

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net 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 Curve 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	\$ 232,128,332	\$ 13,139,721	\$ -	\$ -	\$ 245,268,053	138,516	\$ 335,813,734	\$ 1,770.68
2	03100 INTENSIVE CARE UNIT	\$ 106,181,358	\$ 3,446,430	\$ -	\$ -	\$ 109,627,788	38,147	\$ 297,640,956	\$ 2,873.82
3	03200 CORONARY CARE UNIT	\$ 16,249,771	\$ 596,049	\$ -	\$ -	\$ 16,845,820	5,108	\$ 51,350,189	\$ 3,297.93
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
10	04300 NURSERY	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
11	3101 BMT	\$ 34,443,573	\$ 2,234,352	\$ -	\$ -	\$ 36,677,925	24,705	\$ 95,131,635	\$ 1,484.64
18	Total Routine	\$ 389,003,034	\$ 19,416,552	\$ -	\$ -	\$ 408,419,586	206,476	\$ 779,936,514	\$ 1,978.05
19	Weighted Average								

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)								
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$ 83,676,393	\$ 3,662,872	\$ -	\$ -	\$ 87,339,265	\$ 361,360,557	\$ 165,598,325	\$ 526,958,882	0.165742
22	5100 RECOVERY ROOM	\$ 11,032,410	\$ 299,690	\$ -	\$ -	\$ 11,332,100	\$ 24,605,012	\$ 30,141,164	\$ 54,746,176	0.206993
23	5300 ANESTHESIOLOGY	\$ 6,035,406	\$ 2,750,484	\$ -	\$ -	\$ 8,785,890	\$ 66,359,324	\$ 34,459,913	\$ 100,819,237	0.087145
24	5400 RADIOLOGY-DIAGNOSTIC	\$ 39,108,892	\$ 3,506,368	\$ -	\$ -	\$ 42,615,260	\$ 76,302,548	\$ 91,377,130	\$ 167,679,678	0.254147
25	5401 ELECTRO PYSIOLOGY	\$ 1,078,893	\$ -	\$ -	\$ -	\$ 1,078,893	\$ 6,716,577	\$ 17,002,638	\$ 23,719,215	0.045486
26	5402 PET SCANNER	\$ 3,732,325	\$ -	\$ -	\$ -	\$ 3,732,325	\$ 788,337	\$ 33,098,746	\$ 33,887,083	0.110140
27	5500 RADIOLOGY-THERAPEUTIC	\$ 14,882,661	\$ 379,607	\$ -	\$ -	\$ 15,262,268	\$ 4,800,430	\$ 69,557,386	\$ 74,357,816	0.205254
28	5600 RADIOISOTOPE	\$ 7,334,947	\$ -	\$ -	\$ -	\$ 7,334,947	\$ 4,886,437	\$ 28,498,324	\$ 33,384,761	0.219709
29	5700 CT SCAN	\$ 8,418,105	\$ -	\$ -	\$ -	\$ 8,418,105	\$ 63,567,941	\$ 84,280,330	\$ 147,848,271	0.056937
30	5800 MRI	\$ 14,798,236	\$ -	\$ -	\$ -	\$ 14,798,236	\$ 51,144,203	\$ 93,545,255	\$ 144,689,458	0.102276
31	5900 CARDIAC CATHETERIZATION	\$ 7,221,244	\$ -	\$ -	\$ -	\$ 7,221,244	\$ 18,028,482	\$ 20,337,938	\$ 38,366,420	0.188218
32	6000 LABORATORY	\$ 80,062,080	\$ 1,748,189	\$ -	\$ -	\$ 81,810,269	\$ 350,604,243	\$ 141,003,982	\$ 491,608,225	0.166414
33	6001 PATHOLOGY	\$ 9,771,431	\$ 1,535,076	\$ -	\$ -	\$ 11,306,507	\$ 9,427,364	\$ 8,345,287	\$ 17,772,651	0.636174
34	6002 HEMAPHERESIS	\$ 5,712,490	\$ -	\$ -	\$ -	\$ 5,712,490	\$ 14,664,167	\$ 3,570,088	\$ 18,234,255	0.313283
35	6003 GI LAB	\$ 5,105,467	\$ -	\$ -	\$ -	\$ 5,105,467	\$ 14,770,133	\$ 14,194,432	\$ 28,964,565	0.176266
36	6500 RESPIRATORY THERAPY	\$ 27,228,956	\$ -	\$ -	\$ -	\$ 27,228,956	\$ 112,031,784	\$ 1,217,755	\$ 113,249,539	0.240433
37	6501 PULMONARY FUNCTION	\$ 1,189,406	\$ -	\$ -	\$ -	\$ 1,189,406	\$ 89,466,453	\$ 4,827,325	\$ 94,293,778	0.012614

G. Cost Report - Cost / Days / Charges

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Net 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
38	6600 PHYSICAL THERAPY	\$ 10,598,450	\$ -	\$ -	\$ 10,598,450	\$ 32,080,143	\$ 4,331,359	\$ 36,411,502	0.291074
39	6900 ELECTROCARDIOLOGY	\$ 710,457	\$ -	\$ -	\$ 710,457	\$ 6,346,623	\$ 3,527,372	\$ 9,873,995	0.071952
40	7000 ELECTROENCEPHALOGRAPHY	\$ 3,576,396	\$ -	\$ -	\$ 3,576,396	\$ 12,257,592	\$ 345,333	\$ 12,602,925	0.283775
41	7001 ECHO CARDIOLOGY	\$ 10,380,329	\$ -	\$ -	\$ 10,380,329	\$ 46,982,285	\$ 39,714,236	\$ 86,696,521	0.119732
42	7002 ELECTROSHOCK THERAPY	\$ 1,746,388	\$ -	\$ -	\$ 1,746,388	\$ 521,785	\$ 2,726,142	\$ 3,247,927	0.537693
43	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 118,633,797	\$ -	\$ -	\$ 118,633,797	\$ 55,390,853	\$ 23,672,505	\$ 79,063,358	1.500490
44	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 42,814,487	\$ -	\$ -	\$ 42,814,487	\$ 84,644,102	\$ 50,317,590	\$ 134,961,692	0.317234
45	7300 DRUGS CHARGED TO PATIENTS	\$ 113,030,167	\$ -	\$ -	\$ 113,030,167	\$ 325,187,044	\$ 40,686,906	\$ 365,873,950	0.308932
46	7400 RENAL DIALYSIS	\$ 4,434,869	\$ -	\$ -	\$ 4,434,869	\$ 11,788,769	\$ 1,980,642	\$ 13,769,411	0.322081
47	7700 ALLOGENEIC HSCT ACQUISITION	\$ 28,107,239	\$ -	\$ -	\$ 28,107,239	\$ 71,833,761	\$ 17,488,405	\$ 89,322,166	0.314673
48	9100 EMERGENCY	\$ 45,274,208	\$ -	\$ -	\$ 45,274,208	\$ 41,905,582	\$ 94,365,857	\$ 136,271,439	0.332235
49	10500 KIDNEY ACQUISITION	\$ 18,124,586	\$ -	\$ -	\$ 18,124,586	\$ 23,944,113	\$ 70,000	\$ 24,014,113	-
50	10600 HEART ACQUISITION	\$ 5,210,913	\$ -	\$ -	\$ 5,210,913	\$ 7,980,856	\$ -	\$ 7,980,856	-
51	10700 LIVER ACQUISITION	\$ 9,480,452	\$ -	\$ -	\$ 9,480,452	\$ 9,815,859	\$ -	\$ 9,815,859	-
52	10800 LUNG ACQUISITION	\$ 2,914,277	\$ -	\$ -	\$ 2,914,277	\$ 2,075,248	\$ 389,109	\$ 2,464,357	-
53	10900 PANCREAS ACQUISITION	\$ 601,628	\$ -	\$ -	\$ 601,628	\$ 779,868	\$ -	\$ 779,868	-
126	Total Ancillary	\$ 742,027,985	\$ 13,882,286	\$ -	\$ 755,910,271	\$ 2,003,058,475	\$ 1,120,671,474	\$ 3,123,729,949	
127	Weighted Average								0.233730
128	Sub Totals	\$ 1,131,031,019	\$ 33,298,838	\$ -	\$ 1,164,329,857	\$ 2,782,994,989	\$ 1,120,671,474	\$ 3,903,666,463	
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)				\$ -				
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)				\$ -				
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				\$ 1,164,329,857				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				2.94%				

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

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

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

		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		
Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)		Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
Routine Cost Centers (from Section G):																
				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,770.68		11,299		2,651		8,714		4,735		5,395		27,399	24.13%	
2	03100 INTENSIVE CARE UNIT	\$ 2,873.82		5,421		1,236		2,710		1,744		2,643		11,111	36.52%	
3	03200 CORONARY CARE UNIT	\$ 3,297.93		270		121		143		194		120		728	17.19%	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-		-		
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-		-		
10	04300 NURSERY	\$ -		-		-		-		-		-		-		
11	3101 BMT	\$ 1,484.64		-		767		1,683		1,082		1,641		3,532	21.39%	
18			Total Days	16,990		4,775		13,250		7,755		9,799		42,770	25.92%	
19	Total Days per PS&R or Exhibit Detail															
20	Unreconciled Days (Explain Variance)															
				16,990		4,775		13,250		7,755		9,799				
				-		-		-		-		-				
21	Routine Charges	\$ 58,295,460		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		24.74%
21.01	Calculated Routine Charge Per Dien	\$ 3,431.16		\$ 3,885.13		\$ 4,451,207		\$ 3,430.28		\$ 3,741.90		\$ 3,921.66		\$ 3,537.92		
				\$ 3,885.13		\$ 4,451,207		\$ 3,430.28		\$ 3,741.90		\$ 3,921.66		\$ 3,537.92		
Ancillary Cost Centers (from W/S C) (from Section G):																
				Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)			-		-		-		-		-		-		
23	5000 OPERATING ROOM	\$ 0.165742		\$ 20,219,195	\$ 4,721,039	\$ 10,492,584	\$ 6,619,998	\$ 20,633,252	\$ 9,516,479	\$ 9,909,752	\$ 3,820,329	\$ 13,741,409	\$ 2,589,401	\$ 61,254,783	\$ 24,677,846	19.65%
24	5100 RECOVERY ROOM	\$ 0.006993		\$ 1,005,807	\$ 872,939	\$ 642,186	\$ 979,666	\$ 1,313,829	\$ 1,622,085	\$ 543,269	\$ 633,834	\$ 568,906	\$ 368,998	\$ 3,505,091	\$ 4,108,524	15.72%
25	5300 ANESTHESIOLOGY	\$ 0.087145		\$ 2,897,597	\$ 920,476	\$ 1,615,034	\$ 1,166,212	\$ 3,571,254	\$ 1,679,332	\$ 1,554,409	\$ 696,364	\$ 1,905,435	\$ 456,753	\$ 9,638,294	\$ 4,462,384	16.51%
26	5400 RADIOLOGY-DIAGNOSTIC	\$ 0.254147		\$ 4,722,714	\$ 3,006,199	\$ 1,031,066	\$ 1,201,995	\$ 2,274,721	\$ 2,159,398	\$ 1,198,988	\$ 981,990	\$ 2,214,386	\$ 1,216,863	\$ 9,227,489	\$ 7,349,582	12.04%
27	5401 ELECTROPHYSIOLOGY	\$ 0.045486		\$ -	\$ -	\$ 149,216	\$ 99,947	\$ 294,730	\$ 404,736	\$ 219,587	\$ 251,459	\$ 357,970	\$ 155,548	\$ 663,533	\$ 756,142	8.23%
28	5402 PET SCANNER	\$ 0.110140		\$ -	\$ -	\$ 69,183	\$ 393,155	\$ 170,401	\$ 1,320,728	\$ 147,714	\$ 469,410	\$ 237,717	\$ 1,029,028	\$ 387,298	\$ 2,183,293	11.35%
29	5500 RADIOLOGY-THERAPEUTIC	\$ 0.205254		\$ 342,860	\$ 1,583,042	\$ 344,191	\$ 2,353,611	\$ 141,428	\$ 3,332,947	\$ 184,600	\$ 1,243,680	\$ 207,671	\$ 2,021,321	\$ 1,013,079	\$ 8,513,280	15.84%
30	5600 RADIOISOTOPE	\$ 0.219709		\$ 59,896	\$ 162,202	\$ 22,051	\$ 151,194	\$ 95,062	\$ 639,954	\$ 45,800	\$ 198,172	\$ 71,476	\$ 373,043	\$ 222,809	\$ 1,151,522	5.48%
31	5700 CT SCAN	\$ 0.056937		\$ 4,391,727	\$ 1,573,342	\$ 1,670,909	\$ 2,207,976	\$ 3,948,272	\$ 4,795,845	\$ 2,499,418	\$ 1,543,993	\$ 3,929,624	\$ 3,359,872	\$ 12,510,326	\$ 10,121,156	20.53%
32	5800 MRI	\$ 0.102276		\$ -	\$ -	\$ 1,497,063	\$ 3,674,532	\$ 2,551,393	\$ 4,315,393	\$ 1,515,094	\$ 1,482,028	\$ 2,966,725	\$ 1,881,318	\$ 5,563,550	\$ 9,471,953	13.90%
33	5900 CARDIAC CATHETERIZATION	\$ 0.188218		\$ -	\$ -	\$ 36,018	\$ 8,908	\$ 291,525	\$ 846,433	\$ 386,124	\$ 347,111	\$ 720,624	\$ 326,946	\$ 713,667	\$ 1,202,452	7.93%
34	6000 LABORATORY	\$ 0.166414		\$ 33,349,910	\$ 5,106,642	\$ 10,180,770	\$ 2,286,297	\$ 21,102,913	\$ 6,537,162	\$ 12,900,662	\$ 4,375,717	\$ 18,016,004	\$ 4,372,794	\$ 77,534,254	\$ 18,305,818	24.41%
35	6001 PATHOLOGY	\$ 0.636174		\$ 999,036	\$ 162,893	\$ 195,048	\$ 199,724	\$ 408,431	\$ 354,033	\$ 178,723	\$ 137,571	\$ 287,280	\$ 137,684	\$ 1,781,238	\$ 854,221	17.42%
36	6002 HEMAPHERESIS	\$ 0.313283		\$ -	\$ -	\$ 387,654	\$ 352,257	\$ 537,980	\$ 243,505	\$ 317,440	\$ 376,958	\$ 393,414	\$ 458,942	\$ 1,243,074	\$ 972,720	17.12%
37	6003 GLAB	\$ 0.176266		\$ 625,701	\$ 149,202	\$ 186,310	\$ 176,623	\$ 518,257	\$ 666,724	\$ 261,784	\$ 219,220	\$ 449,279	\$ 137,241	\$ 1,592,052	\$ 1,211,769	11.87%
38	6500 RESPIRATORY THERAPY	\$ 0.240433		\$ 8,256,668	\$ 40,119	\$ 1,827,178	\$ 29,332	\$ 6,289,046	\$ 166,244	\$ 4,285,700	\$ 75,110	\$ 4,112,226	\$ 45,898	\$ 20,658,592	\$ 310,805	22.53%
39	6501 PULMONARY FUNCTION	\$ 0.012614		\$ -	\$ -	\$ 1,906,539	\$ 165,267	\$ 3,651,341	\$ 580,254	\$ 2,320,331	\$ 216,934	\$ 3,070,331	\$ 309,831	\$ 7,878,211	\$ 962,455	13.27%
40	6600 PHYSICAL THERAPY	\$ 0.291074		\$ 1,989,177	\$ 146,179	\$ 611,622	\$ 81,075	\$ 1,927,682	\$ 336,087	\$ 893,624	\$ 70,465	\$ 1,364,559	\$ 25,378	\$ 5,422,105	\$ 633,806	20.79%
41	6900 ELECTROCARDIOLOGY	\$ 0.071952		\$ 491,965	\$ 154,344	\$ 148,489	\$ 133,724	\$ 474,957	\$ 272,226	\$ 256,313	\$ 113,811	\$ 354,270	\$ 280,014	\$ 1,371,724	\$ 674,105	27.53%
42	7000 ELECTROENCEPHALOGRAPHY	\$ 0.283775		\$ 666,352	\$ 8,551	\$ 352,363	\$ 367,605	\$ 454,628	\$ 95,969	\$ 332,993	\$ 481,375	\$ 599,201	\$ 127,427	\$ 1,806,336	\$ 953,500	27.97%
43	7001 ECHO CARDIOLOGY	\$ 0.119732		\$ 4,376,626	\$ 1,077,899	\$ 1,412,142	\$ 791,197	\$ 3,511,074	\$ 2,790,870	\$ 1,729,442	\$ 949,469	\$ 2,567,258	\$ 665,176	\$ 11,029,284	\$ 5,609,435	23.15%
44	7002 ELECTROSHOCK THERAPY	\$ 0.537693		\$ 76,254	\$ -	\$ 172,175	\$ 334,104	\$ 211,387	\$ 178,755	\$ 68,978	\$ 324,202	\$ 2,044	\$ 67,423	\$ 528,794	\$ 837,061	45.56%
45	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$ 1.500490		\$ 4,855,981	\$ 560,241	\$ 2,484,222	\$ 607,928	\$ 3,766,733	\$ 1,189,381	\$ 2,580,885	\$ 407,376	\$ 2,986,190	\$ 298,373	\$ 13,687,822	\$ 2,764,926	25.30%
46	7200 IMPL. DEV. CHARGED TO PATIENTS	\$ 0.317234		\$ 3,890,334	\$ 930,460	\$ 1,213,190	\$ 1,038,085	\$ 3,449,360	\$ 2,771,493	\$ 1,941,584	\$ 1,553,718	\$ 2,192,326	\$ 429,191	\$ 10,494,466	\$ 6,293,756	14.53%
47	7300 DRUGS CHARGED TO PATIENTS	\$ 0.306932		\$ 24,806,201	\$ 1,333,187	\$ 7,623,977	\$ 1,324,982	\$ 29,155,011	\$ 4,893,310	\$ 10,488,213	\$ 1,647,249	\$ 15,590,739	\$ 1,998,127	\$ 72,273,402	\$ 9,198,728	27.47%
48	7400 RENAL DIALYSIS	\$ 0.322081		\$ 1,080,673	\$ -	\$ 235,849	\$ 6,966	\$ 1,471,803	\$ 333,282	\$ 1,063,224	\$ 164,365	\$ 555,733	\$ 487,859	\$ 3,851,549	\$ 504,603	39.45%
49	7700 ALLOGENEIC HSCT ACQUISITION	\$ 0.314673		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
50	9100 EMERGENCY	\$ 0.332235		\$ 2,865,828	\$ 3,472,534	\$ 882,703	\$ 3,222,754	\$ 2,383,578	\$ 3,677,450	\$ 1,530,420	\$ 2,608,836	\$ 2,333,290	\$ 6,835,319	\$ 7,662,529	\$ 12,981,574	22.22%
51	10500 KIDNEY ACQUISITION	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
52	10600 HEART ACQUISITION	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
53	10700 LIVER ACQUISITION	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
54	10800 LUNG ACQUISITION	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
55	10900 PANCREAS ACQUISITION	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
				121,970,501	25,961,491	47,589,732	29,975,104	114,600,048	55,720,076	59,355,072	25,390,746	81,796,087	30,455,768			

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

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

		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		Total In-State Medicaid		% Survey
Totals / Payments														
128	Total Charges (includes organ acquisition from Section J)	\$ 189,656,266	\$ 25,981,491	\$ 67,893,480	\$ 29,975,104	\$ 171,608,615	\$ 55,720,076	\$ 98,222,159	\$ 25,390,746	\$ 120,224,426	\$ 30,455,768	\$ 527,380,521	\$ 137,067,416	21.17%
129	Total Charges per PS&R or Exhibit Detail	\$ 189,656,266	\$ 25,981,491	\$ 67,893,480	\$ 29,975,104	\$ 171,608,615	\$ 55,720,076	\$ 98,222,159	\$ 25,390,746	(Agrees to Exhibit A)	(Agrees to Exhibit A)			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131.01	Sampling Cost Adjustment (if applicable)													
131.02	Total Calculated Cost (includes organ acquisition from Section J)	\$ 70,563,978	\$ 6,133,443	\$ 22,492,604	\$ 6,568,331	\$ 57,725,322	\$ 12,104,311	\$ 32,719,487	\$ 5,720,675	\$ 40,126,940	\$ 6,724,125	\$ 183,501,391	\$ 30,526,760	22.74%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 40,070,304	\$ 5,060,817	\$ -	\$ -	\$ 1,944,991	\$ 919,241	\$ -	\$ -			\$ 42,015,295	\$ 5,980,058	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 13,094,674	\$ 4,207,476	\$ -	\$ -	\$ 219,458	\$ 87,769			\$ 13,314,132	\$ 4,295,245	
134	Private Insurance (including primary and third party liability)	\$ 334,139	\$ 26,183	\$ -	\$ -	\$ -	\$ 1,786	\$ 5,813,226	\$ 1,696,905			\$ 6,147,365	\$ 1,724,674	
135	Self-Pay (including Co-Pay and Spend-Down)	\$ -	\$ -	\$ -	\$ 9	\$ -	\$ -	\$ 67,071	\$ 113,156			\$ 67,071	\$ 113,165	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 40,404,443	\$ 5,087,000	\$ 13,094,674	\$ 4,207,485									
137	Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ 354,680	\$ -	\$ -							\$ -	\$ 354,680	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 29,904,968	\$ 8,643,258	\$ 7,920,223	\$ 800,685			\$ 37,825,191	\$ 9,443,943	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ 11,537,881	\$ 2,903,262			\$ 11,537,881	\$ 2,903,262	
141	Medicare Cross-Over Bad Debt Payments					\$ 215,322	\$ 272,822	\$ -	\$ -	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ 215,322	\$ 272,822	
142	Other Medicare Cross-Over Payments (See Note D)					\$ 16,878,972	\$ 1,791,240	\$ -	\$ -			\$ 16,878,972	\$ 1,791,240	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 268,761	\$ 1,510,649			
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)	\$ 30,159,535	\$ 691,763	\$ 9,397,930	\$ 2,360,846	\$ 8,781,069	\$ 475,964	\$ 7,161,628	\$ 118,898	\$ 39,858,179	\$ 5,213,276	\$ 55,500,162	\$ 3,647,471	
146	Calculated Payments as a Percentage of Cost	57%	89%	58%	64%	85%	96%	78%	98%	1%	22%	70%	88%	
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)					96,267								
148	Percent of cross-over days to total Medicare days from the cost report					14%								

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 :
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 P:
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 si
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 pay
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 pay

NOTE: Inpatient uninsured payment rate is outside normal ranges, please verify this is correct.

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From 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 Section G	From Section G										
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,770.68		498		-		106		22		626	
2	03100 INTENSIVE CARE UNIT	\$ 2,873.82		155		-		19		2		176	
3	03200 CORONARY CARE UNIT	\$ 3,297.93		24		-		6		-		30	
4	03300 BURN INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	\$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	\$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	\$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	\$ -		-		-		-		-		-	
10	04300 NURSERY	\$ -		-		-		-		-		-	
11	3101 BMT	\$ 1,484.64		97		-		12		2		111	
18	Total Days			774		-		143		26		943	
19	Total Days per PS&R or Exhibit Detail			774		-		143		26		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
Routine Charges				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			\$ 2,621,257		\$ -		\$ 503,167		\$ 79,229		\$ 3,203,653	
21.01	Calculated Routine Charge Per Diem			\$ 3,386.64		\$ -		\$ 3,518.65		\$ 3,047.27		\$ 3,397.30	
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)			-		-		-		-		\$ -	\$ -
23	5000 OPERATING ROOM	0.165742		986,327	56,145	-	-	147,524	104	72,272	-	\$ 1,206,123	\$ 56,249
24	5100 RECOVERY ROOM	0.206993		40,482	3,730	-	-	11,544	-	-	-	\$ 52,026	\$ 3,730
25	5300 ANESTHESIOLOGY	0.087145		138,988	7,830	-	-	24,882	-	6,032	-	\$ 169,902	\$ 7,830
26	5400 RADIOLOGY-DIAGNOSTIC	0.254147		100,967	39,270	-	-	38,624	966	3,096	2,554	\$ 142,687	\$ 42,810
27	5401 ELECTRO PYSIOLOGY	0.045486		15,420	-	-	-	4,613	-	-	-	\$ 20,033	\$ -
28	5402 PET SCANNER	0.110140		-	10,022	-	-	-	-	-	-	\$ -	\$ 10,022
29	5500 RADIOLOGY-THERAPEUTIC	0.205254		6,384	14,539	-	-	260	121	238	-	\$ 6,882	\$ 14,660
30	5600 RADIOISOTOPE	0.219709		4,322	6,302	-	-	-	-	-	-	\$ 4,322	\$ 6,302
31	5700 CT SCAN	0.056937		222,076	127,357	-	-	57,184	15,412	8,007	3,582	\$ 287,267	\$ 146,351
32	5800 MRI	0.102276		143,488	38,621	-	-	31,751	30	8,752	1,549	\$ 183,991	\$ 40,200
33	5900 CARDIAC CATHETERIZATION	0.188218		10,535	46,195	-	-	8,687	13,302	-	-	\$ 19,222	\$ 59,497
34	6000 LABORATORY	0.166414		1,376,286	141,557	-	-	146,873	15,473	81,966	2,265	\$ 1,605,125	\$ 159,295
35	6001 PATHOLOGY	0.636174		26,034	1,155	-	-	9,010	-	-	-	\$ 35,044	\$ 1,155
36	6002 HEMAPHERESIS	0.313283		45,170	2,289	-	-	928	1,514	4,308	42	\$ 50,406	\$ 3,845
37	6003 GI LAB	0.176266		39,921	-	-	-	8,493	-	-	-	\$ 48,414	\$ -
38	6500 RESPIRATORY THERAPY	0.240433		346,421	1,138	-	-	15,152	-	23,382	-	\$ 384,955	\$ 1,138
39	6501 PULMONARY FUNCTION	0.012614		242,922	11,125	-	-	28,663	628	12,546	86	\$ 284,131	\$ 11,839
40	6600 PHYSICAL THERAPY	0.291074		101,897	-	-	-	20,858	-	1,333	-	\$ 124,088	\$ -
41	6900 ELECTROCARDIOLOGY	0.071952		19,320	14,160	-	-	3,009	1,416	531	177	\$ 22,860	\$ 15,753
42	7000 ELECTROENCEPHALOGRAPHY	0.283775		25,032	3,517	-	-	8,731	-	1,687	-	\$ 35,450	\$ 3,517
43	7001 ECHO CARDIOLOGY	0.119732		136,630	24,292	-	-	27,080	-	9,123	-	\$ 172,833	\$ 24,292
44	7002 ELECTROSHOCK THERAPY	0.537693		16,096	20,819	-	-	7,518	-	-	-	\$ 23,614	\$ 20,819
45	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.500490		201,061	7,140	-	-	21,335	1,076	33,524	-	\$ 255,920	\$ 8,216
46	7200 IMPL. DEV. CHARGED TO PATIENTS	0.317234		106,169	40,341	-	-	39,759	8,303	71	-	\$ 145,999	\$ 48,644
47	7300 DRUGS CHARGED TO PATIENTS	0.308932		1,182,281	36,443	-	-	182,336	3,426	38,094	742	\$ 1,402,711	\$ 40,611
48	7400 RENAL DIALYSIS	0.322081		27,876	5,012	-	-	-	-	-	-	\$ 27,876	\$ 5,012
49	7700 ALLOGENEIC HSCT ACQUISITION	0.314673		-	-	-	-	-	-	-	-	\$ -	\$ -
50	9100 EMERGENCY	0.332235		109,491	302,060	-	-	20,029	22,219	4,362	11,279	\$ 133,882	\$ 335,558
51	10500 KIDNEY ACQUISITION	-		-	-	-	-	-	-	-	-	\$ -	\$ -
52	10600 HEART ACQUISITION	-		-	-	-	-	-	-	-	-	\$ -	\$ -
53	10700 LIVER ACQUISITION	-		-	-	-	-	-	-	-	-	\$ -	\$ -
54	10800 LUNG ACQUISITION	-		-	-	-	-	-	-	-	-	\$ -	\$ -
55	10900 PANCREAS ACQUISITION	-		-	-	-	-	-	-	-	-	\$ -	\$ -
				5,671,596	961,059	-	-	864,843	84,010	309,324	22,276		
Totals / Payments													
Total Charges (includes organ acquisition from Section K)				\$ 8,292,853	\$ 961,059	\$ -	\$ -	\$ 1,368,010	\$ 84,010	\$ 388,553	\$ 22,276	\$ 10,049,416	\$ 1,067,345

I. Out-of-State Medicaid Data:

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

		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)		Total Out-Of-State Medicaid	
129	Total Charges per PS&R or Exhibit Detail	\$ 8,292,853	\$ 961,059	\$ -	\$ -	\$ 1,368,010	\$ 84,010	\$ 388,553	\$ 22,276		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)									\$ -	\$ -
131.02	Total Calculated Cost (includes organ acquisition from Section K)	\$ 2,954,568	\$ 224,390	\$ -	\$ -	\$ 486,750	\$ 19,525	\$ 148,672	\$ 5,392	\$ 3,589,990	\$ 249,307
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 228,778	\$ 11,795	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 228,778	\$ 11,795
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)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 290,427	\$ 8,339	\$ 290,427	\$ 8,339
135	Self-Pay (including Co-Pay and Spend-Down)	\$ 21,866	\$ 3,445	\$ -	\$ -	\$ -	\$ 21	\$ -	\$ -	\$ 21,866	\$ 3,466
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 250,644	\$ 15,240	\$ -	\$ -						
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)					\$ 97,692	\$ 5,483	\$ -	\$ -	\$ 97,692	\$ 5,483
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 208,641	\$ 15,669	\$ -	\$ 107	\$ 208,641	\$ 15,776
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)	\$ 2,703,924	\$ 209,150	\$ -	\$ -	\$ 180,417	\$ (1,648)	\$ (141,755)	\$ (3,054)	\$ 2,742,586	\$ 204,448
144	Calculated Payments as a Percentage of Cost	8%	7%	0%	0%	63%	108%	195%	157%	24%	18%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).

Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).

Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.

Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).

Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (09/01/2021-08/31/2022)

EMORY UNIVERSITY HOSPITAL

Total 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	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61		Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below)															
1	Lung Acquisition	\$ 3,254,919	\$ 95,829	\$ 3,350,748	\$ -	23	\$ 1,952,230	2	\$ -	0	\$ -	0	\$ -	0	\$ -
2	Kidney Acquisition	\$ 24,459,224	\$ 720,107	\$ 25,179,331	\$ -	391	\$ 1,943,296	11	\$ -	0	\$ 7,595,235	33	\$ 4,146,913	23	\$ -
3	Liver Acquisition	\$ 10,077,605	\$ 296,696	\$ 10,374,301	\$ -	115	\$ 1,476,307	2	\$ 364,273	1	\$ -	0	\$ 1,212,757	2	\$ -
4	Heart Acquisition	\$ 5,747,002	\$ 169,198	\$ 5,916,200	\$ -	52	\$ 3,725,207	3	\$ 1,387,975	1	\$ 3,962,125	3	\$ 4,488,947	1	\$ -
5	Pancreas Acquisition	\$ 675,240	\$ 19,880	\$ 695,120	\$ -	8	\$ 293,265	1	\$ -	0	\$ -	0	\$ -	0	\$ -
6	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
7	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
8		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
9	Totals	\$ 44,213,990	\$ 1,301,710	\$ 45,515,700	\$ -	589	\$ 9,390,305	19	\$ 1,752,248	2	\$ 11,557,360	36	\$ 9,848,617	26	\$ -
10	Total Cost					1,608,371		203,984		2,466,429		1,775,333			-

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 D as part of your In-State Medicaid total payments

Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (09/01/2021-08/31/2022)

EMORY UNIVERSITY HOSPITAL

Total 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-Over (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61		Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below)													
11	Lung Acquisition	\$ 3,254,919	\$ 95,829	\$ 3,350,748	\$ -	23	\$ -	0	\$ -	0	\$ -	0	\$ -
12	Kidney Acquisition	\$ 24,459,224	\$ 720,107	\$ 25,179,331	\$ -	391	\$ -	0	\$ -	0	\$ -	0	\$ -
13	Liver Acquisition	\$ 10,077,605	\$ 296,696	\$ 10,374,301	\$ -	115	\$ -	0	\$ -	0	\$ -	0	\$ -
14	Heart Acquisition	\$ 5,747,002	\$ 169,198	\$ 5,916,200	\$ -	52	\$ -	0	\$ -	0	\$ -	0	\$ -
15	Pancreas Acquisition	\$ 675,240	\$ 19,880	\$ 695,120	\$ -	8	\$ -	0	\$ -	0	\$ -	0	\$ -
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
18		\$ -	\$ -	\$ -	\$ -	0	\$ -	0	\$ -	0	\$ -	0	\$ -
19	Totals	\$ 44,213,990	\$ 1,301,710	\$ 45,515,700	\$ -	589	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
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 E as part of your Out-of-State Medicaid total payments

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (09/01/2021-08/31/2022) EMORY UNIVERSITY HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 15,541,017		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	389000-40997	(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 ----->)	\$ 15,541,017		
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	Reclassification Code	0	-	(Reclassified to / (from))
5	Reclassification Code	0	-	(Reclassified to / (from))
6	Reclassification Code	0	-	(Reclassified to / (from))
7	Reclassification Code	0	-	(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	Reason for adjustment	0	-	(Adjusted to / (from))
9	Reason for adjustment	0	-	(Adjusted to / (from))
10	Reason for adjustment	0	-	(Adjusted to / (from))
11	Reason for adjustment	0	-	(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	0	-	
13	Reason for adjustment	0	-	
14	Reason for adjustment	0	-	
15	Reason for adjustment	0	-	
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	\$ 15,541,017
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital Charges Sec. G	675,564,699
19	Uninsured Hospital Charges Sec. G	150,680,193
20	Total Hospital Charges Sec. G	3,903,666,463
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	17.31%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	3.86%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 2,689,513
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 599,878
25	Provider Tax Assessment Adjustment to DSH UCC	\$ 3,289,391

* 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.