

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

2. Select Cost Report Year Covered by this Survey (enter "X"):

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

5/12/2023

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

Data	Correct?	If Incorrect, Proper Information
EMORY UNIVERSITY HOSPITAL	Yes	
000000712A	Yes	
000000712B	Yes	
0	Yes	
110010	Yes	
Private	Yes	

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)**

\$ -

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

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%

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

11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)

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

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

No

Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

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

\$ -

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

\$ -

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

\$-

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

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

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$758,997,775.00			\$ 497,769,224	\$ -	\$ -	\$ 261,228,551
12. Subprovider I (Psych or Rehab)	\$21,256,896.00			\$ 13,940,790	\$ -	\$ -	\$ 7,316,106
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	\$1,958,462,531.00	\$1,026,422,123.00		\$ 1,284,407,421	\$ 673,152,624	\$ -	\$ 1,027,324,609
20. Outpatient Services		\$94,365,857.00			\$ 61,887,427	\$ -	\$ 32,478,430
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	\$48,023,467.00	\$125,404.00	\$0.00	\$ 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)							-
35. Adjusted Contractual Adjustments							5,406,201
36. Unreconciled Difference	Unreconciled Difference (Should be \$0) \$ -			Unreconciled Difference (Should be \$0) \$ -			2,562,734,689

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)	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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>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</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Routine Cost Centers (list below):

1	03000 ADULTS & PEDIATRICS	\$ 220,323,385	\$ 11,697,881	\$ -	\$0.00	\$ 232,021,266	130,957	\$314,874,995.00	\$ 1,771.74
2	03100 INTENSIVE CARE UNIT	\$ 106,181,358	\$ 3,446,430	\$ -		\$ 109,627,788	38,147	\$297,640,956.00	\$ 2,873.82
3	03200 CORONARY CARE UNIT	\$ 16,249,771	\$ 596,049	\$ -		\$ 16,845,820	5,108	\$51,350,189.00	\$ 3,297.93
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
6	03500 OTHER SPECIAL CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
7	04000 SUBPROVIDER I	\$ 11,804,947	\$ 1,441,840	\$ -		\$ 13,246,787	7,559	\$20,938,739.00	\$ 1,752.45
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300 NURSERY	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
11	3101 BMT	\$ 34,443,573	\$ 2,234,352	\$ -		\$ 36,677,925	24,705	\$95,131,635.00	\$ 1,484.64
12		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine	\$ 389,003,034	\$ 19,416,552	\$ -	\$ -	\$ 408,419,586	206,476	\$ 779,936,514	
19	Weighted Average								\$ 1,978.05

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)					\$ -	\$0.00	\$0.00	\$ -	-
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	<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>		<i>Calculated</i>	<i>Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6</i>	<i>Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7</i>	<i>Total Charges - Cost Report Worksheet C, Pt. I, Col. 8</i>	<i>Medicaid Calculated Cost-to-Charge Ratio</i>
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000 OPERATING ROOM	\$83,676,393.00	\$ 3,662,872	\$ -		\$ 87,339,265	\$361,360,557.00	\$165,598,325.00	\$ 526,958,882	0.165742
22	5100 RECOVERY ROOM	\$11,032,410.00	\$ 299,690	\$ -		\$ 11,332,100	\$24,605,012.00	\$30,141,164.00	\$ 54,746,176	0.206993
23	5300 ANESTHESIOLOGY	\$6,035,406.00	\$ 2,750,484	\$ -		\$ 8,785,890	\$66,359,324.00	\$34,459,913.00	\$ 100,819,237	0.087145
24	5400 RADIOLOGY-DIAGNOSTIC	\$39,108,892.00	\$ 3,506,368	\$ -		\$ 42,615,260	\$76,302,548.00	\$91,377,130.00	\$ 167,679,678	0.254147
25	5401 ELECTRO PYSIOLOGY	\$1,078,893.00	\$ -	\$ -		\$ 1,078,893	\$6,716,577.00	\$17,002,638.00	\$ 23,719,215	0.045486
26	5402 PET SCANNER	\$3,732,325.00	\$ -	\$ -		\$ 3,732,325	\$788,337.00	\$33,098,746.00	\$ 33,887,083	0.110140
27	5500 RADIOLOGY-THERAPEUTIC	\$14,882,661.00	\$ 379,607	\$ -		\$ 15,262,268	\$4,800,430.00	\$69,557,386.00	\$ 74,357,816	0.205254
28	5600 RADIOISOTOPE	\$7,334,947.00	\$ -	\$ -		\$ 7,334,947	\$4,886,437.00	\$28,498,324.00	\$ 33,384,761	0.219709
29	5700 CT SCAN	\$8,418,105.00	\$ -	\$ -		\$ 8,418,105	\$63,567,941.00	\$84,280,330.00	\$ 147,848,271	0.056937

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)	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
30	5800 MRI	\$14,798,236.00	\$ -	\$ -	\$ 14,798,236	\$51,144,203.00	\$93,545,255.00	\$ 144,689,458	0.102276
31	5900 CARDIAC CATHETERIZATION	\$7,221,244.00	\$ -	\$ -	\$ 7,221,244	\$18,028,482.00	\$20,337,938.00	\$ 38,366,420	0.188218
32	6000 LABORATORY	\$80,062,080.00	\$ 1,748,189	\$ -	\$ 81,810,269	\$350,604,243.00	\$141,003,982.00	\$ 491,608,225	0.166414
33	6001 PATHOLOGY	\$9,771,431.00	\$ 1,535,076	\$ -	\$ 11,306,507	\$9,427,364.00	\$8,345,287.00	\$ 17,772,651	0.636174
34	6002 HEMAPHERESIS	\$5,712,490.00	\$ -	\$ -	\$ 5,712,490	\$14,664,167.00	\$3,570,088.00	\$ 18,234,255	0.313283
35	6003 GI LAB	\$5,105,467.00	\$ -	\$ -	\$ 5,105,467	\$14,770,133.00	\$14,194,432.00	\$ 28,964,565	0.176266
36	6500 RESPIRATORY THERAPY	\$27,228,956.00	\$ -	\$ -	\$ 27,228,956	\$112,031,784.00	\$1,217,755.00	\$ 113,249,539	0.240433
37	6501 PULMONARY FUNCTION	\$1,189,406.00	\$ -	\$ -	\$ 1,189,406	\$89,466,453.00	\$4,827,325.00	\$ 94,293,778	0.012614
38	6600 PHYSICAL THERAPY	\$10,598,450.00	\$ -	\$ -	\$ 10,598,450	\$32,080,143.00	\$4,331,359.00	\$ 36,411,502	0.291074
39	6900 ELECTROCARDIOLOGY	\$710,457.00	\$ -	\$ -	\$ 710,457	\$6,346,623.00	\$3,527,372.00	\$ 9,873,995	0.071952
40	7000 ELECTROENCEPHALOGRAPHY	\$3,576,396.00	\$ -	\$ -	\$ 3,576,396	\$12,257,592.00	\$345,333.00	\$ 12,602,925	0.283775
41	7001 ECHO CARDIOLOGY	\$10,380,329.00	\$ -	\$ -	\$ 10,380,329	\$46,982,285.00	\$39,714,236.00	\$ 86,696,521	0.119732
42	7002 ELECTROSHOCK THERAPY	\$1,746,388.00	\$ -	\$ -	\$ 1,746,388	\$521,785.00	\$2,726,142.00	\$ 3,247,927	0.537693
43	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$118,633,797.00	\$ -	\$ -	\$ 118,633,797	\$55,390,853.00	\$23,672,505.00	\$ 79,063,358	1.500490
44	7200 IMPL. DEV. CHARGED TO PATIENTS	\$42,814,487.00	\$ -	\$ -	\$ 42,814,487	\$84,644,102.00	\$50,317,590.00	\$ 134,961,692	0.317234
45	7300 DRUGS CHARGED TO PATIENTS	\$113,030,167.00	\$ -	\$ -	\$ 113,030,167	\$325,187,044.00	\$40,686,906.00	\$ 365,873,950	0.308932
46	7400 RENAL DIALYSIS	\$4,434,869.00	\$ -	\$ -	\$ 4,434,869	\$11,788,769.00	\$1,980,642.00	\$ 13,769,411	0.322081
47	7700 ALLOGENEIC HSCT ACQUISITION	\$28,107,239.00	\$ -	\$ -	\$ 28,107,239	\$71,833,761.00	\$17,488,405.00	\$ 89,322,166	0.314673
48	9100 EMERGENCY	\$45,274,208.00	\$ -	\$ -	\$ 45,274,208	\$41,905,582.00	\$94,365,857.00	\$ 136,271,439	0.332235
49	10500 KIDNEY ACQUISITION	\$18,124,586.00	\$ -	\$ -	\$ 18,124,586	\$23,944,113.00	\$70,000.00	\$ 24,014,113	-
50	10600 HEART ACQUISITION	\$5,210,913.00	\$ -	\$ -	\$ 5,210,913	\$7,980,856.00	\$0.00	\$ 7,980,856	-
51	10700 LIVER ACQUISITION	\$9,480,452.00	\$ -	\$ -	\$ 9,480,452	\$9,815,859.00	\$0.00	\$ 9,815,859	-
52	10800 LUNG ACQUISITION	\$2,914,277.00	\$ -	\$ -	\$ 2,914,277	\$2,075,248.00	\$389,109.00	\$ 2,464,357	-
53	10900 PANCREAS ACQUISITION	\$601,628.00	\$ -	\$ -	\$ 601,628	\$779,868.00	\$0.00	\$ 779,868	-
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	\$ -	-

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)	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
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
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	\$ 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)				\$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				\$ 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

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
					From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
		From Section G		From Section G													
					Days		Days		Days		Days		Days		Days		
Routine Cost Centers (from Section G):																	
1	03000	ADULTS & PEDIATRICS	\$ 1,771.74		11,299		2,532		8,290		4,505		5,133		26,616		24.70%
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	\$ 1,752.45			129		424		230		262		783			14.22%
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%
12			\$ -												-		
13			\$ -												-		
14			\$ -												-		
15			\$ -												-		
16			\$ -												-		
17			\$ -												-		
18			\$ -												-		
Total Days					16,990		4,775		13,250		7,755		9,799		42,770		25.92%
Total Days per PS&R or Exhibit Detail					16,990		4,775		13,250		7,755		9,799				
Unreconciled Days (Explain Variance)					-		-		-		-		-				
Routine Charges					\$ 58,295,460		\$ 18,551,500		\$ 45,451,207		\$ 29,018,470		\$ 38,428,339		\$ 151,316,637		24.74%
Calculated Routine Charge Per Diem					\$ 3,431.16		\$ 3,885.13		\$ 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	0.206993		1,005,807	872,939	642,186	979,666	1,313,825	1,822,085	543,269	633,834	668,906	3,505,091	\$ 4,108,524	\$ 4,108,524	15.72%
25	5300	ANESTHESIOLOGY	0.087145		2,897,597	920,476	1,615,034	1,679,332	3,571,254	1,679,332	1,554,409	1,905,435	456,753	\$ 9,638,294	\$ 4,462,384	\$ 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	ELECTRO PYSIOLOGY	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	1,013,079	\$ 8,513,280	\$ 8,513,280	15.84%
30	5600	RADIOISOTOPE	0.219709		59,896	162,202	22,051	151,194	639,954	45,800	198,172	373,043	71,476	222,809	\$ 1,151,522	\$ 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	\$ 12,610,326	\$ 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	2,968,725	1,881,318	\$ 5,963,550	\$ 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	GI LAB	0.176266		625,701	149,202	186,310	176,623	518,257	666,724	261,784	219,220	449,279	157,241	\$ 1,592,052	\$ 1,211,769	11.87%
38	6500	RESPIRATORY THERAPY	0.240433		8,256,668	40,119	1,827,178	6,289,046	166,244	4,285,700	75,110	4,112,226	45,898	\$ 20,658,592	\$ 310,805	\$ 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	27.93%
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	4.855361		560,241		2,484,222	607,928	3,766,733	1,189,381	2,580,885	407,376	298,373	13,887,822	\$ 2,764,926	\$ 2,764,926	25.59%
46	7200	IMPL - DEV. CHARGED TO PATIENTS	0.317234		3,890,334	930,460	1,038,085	3,449,960	2,771,493	1,941,584	1,553,718	2,192,326	429,191	10,494,469	\$ 6,293,756	\$ 6,293,756	14.53%
47	7300	DRUGS CHARGED TO PATIENTS	0.308932		24,806,201	1,333,187	7,823,977	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	6,956	1,471,803	333,282	1,063,224	164,365	555,733	487,859	\$ 3,851,549	\$ 504,603	38.41%
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%
56			-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
57			-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
58			-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
59			-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
60			-		-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	

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	%
61				-											\$ -	\$ -
62				-											\$ -	\$ -
63				-											\$ -	\$ -
64				-											\$ -	\$ -
65				-											\$ -	\$ -
66				-											\$ -	\$ -
67				-											\$ -	\$ -
68				-											\$ -	\$ -
69				-											\$ -	\$ -
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124				-											\$ -	\$ -
125				-											\$ -	\$ -
126				-											\$ -	\$ -
127				-											\$ -	\$ -
					\$ 121,970,501	\$ 25,981,491	\$ 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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%		
Totals / Payments																											
128	Total Charges (includes organ acquisition from Section J)														\$ 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 (Agrees to Exhibit A)	\$ 30,455,768 (Agrees to Exhibit A)	\$ 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	\$ 120,224,426	\$ 30,455,768			
130	Unreconciled Charges (Explain Variance)														-	-	-	-	-	-	-	-	-	-	-	-	
131	Total Calculated Cost (includes organ acquisition from Section J)														\$ 70,575,955	\$ 6,133,443	\$ 22,492,925	\$ 6,568,331	\$ 57,726,380	\$ 12,104,311	\$ 32,720,070	\$ 5,720,675	\$ 40,127,604	\$ 6,724,125	\$ 183,515,330	\$ 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	\$ 1,724,874	
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					\$ 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 (Agrees to Exhibit B and B-1)	\$ 1,510,849 (Agrees to Exhibit B and B-1)		
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)														\$ 30,171,512	\$ 691,763	\$ 9,398,251	\$ 2,360,846	\$ 8,782,127	\$ 475,964	\$ 7,162,211	\$ 118,898	\$ 39,858,843	\$ 5,213,276	\$ 55,514,101	\$ 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 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 Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
				From 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	Days	Days	Days	Days	Days
1	03000 ADULTS & PEDIATRICS	\$ 1,771.74		474				101		21		596	
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	\$ 1,752.45		24				5		1		30	
8	04100 SUBPROVIDER II	\$ -										-	
9	04200 OTHER SUBPROVIDER	\$ -										-	
10	04300 NURSERY	\$ -										-	
11	3101 BMT	\$ 1,484.64		97				12		2		111	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
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			\$ 2,621,257		\$ -		\$ 503,167		\$ 79,229		\$ 3,203,653	
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	986	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 GLI 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

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-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
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	-									\$ -	\$ -
56			-									\$ -	\$ -
57			-									\$ -	\$ -
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Cost Report Year (09/01/2021-08/31/2022)	EMORY UNIVERSITY HOSPITAL
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Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
 Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
 Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
 Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
 Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

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

EMORY UNIVERSITY HOSPITAL

				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	
Total Organ Acquisition Cost			Additional Add-In Intern/Resident Cost			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	\$ 3,254,919.00	\$ 95,829	\$ 3,350,748	23	\$ 1,952,230	2								
2	Kidney Acquisition	\$24,459,224.00	\$ 720,107	\$ 25,179,331	391	\$ 1,943,296	11			\$ 7,595,235	33	\$ 4,146,913	23		
3	Liver Acquisition	\$10,077,605.00	\$ 296,696	\$ 10,374,301	115	\$ 1,476,307	2	\$ 364,273	1			\$ 1,212,757	2		
4	Heart Acquisition	\$5,747,002.00	\$ 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	\$675,240.00	\$ 19,880	\$ 695,120	8	\$ 293,265	1								
6	Intestinal Acquisition	\$ 0.00	\$ -	\$ -	0										
7	Islet Acquisition	\$ 0.00	\$ -	\$ -	0										
8		\$ 0.00	\$ -	\$ -	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 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 (09/01/2021-08/31/2022)

EMORY UNIVERSITY HOSPITAL

				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)	
Total Organ Acquisition Cost			Additional Add-In Intern/Resident Cost			Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost											
				Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)
Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	\$ 3,254,919	\$ 95,829	\$ 3,350,748	\$ -	23							
12	Kidney Acquisition	\$ 24,459,224	\$ 720,107	\$ 25,179,331	\$ -	391							
13	Liver Acquisition	\$ 10,077,605	\$ 296,696	\$ 10,374,301	\$ -	115							
14	Heart Acquisition	\$ 5,747,002	\$ 169,198	\$ 5,916,200	\$ -	52							
15	Pancreas Acquisition	\$ 675,240	\$ 19,880	\$ 695,120	\$ -	8							
16	Intestinal Acquisition	\$ -	\$ -	\$ -	\$ -	0							
17	Islet Acquisition	\$ -	\$ -	\$ -	\$ -	0							
18		\$ -	\$ -	\$ -	\$ -	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 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 (09/01/2021-08/31/2022) 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		(Reclassified to / (from))
5	Reclassification Code		(Reclassified to / (from))
6	Reclassification Code		(Reclassified to / (from))
7	Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
8	Reason for adjustment		(Adjusted to / (from))
9	Reason for adjustment		(Adjusted to / (from))
10	Reason for adjustment		(Adjusted to / (from))
11	Reason for adjustment		(Adjusted to / (from))
DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)			
12	Reason for adjustment		
13	Reason for adjustment		
14	Reason for adjustment		
15	Reason for adjustment		
16	Total Net Provider Tax Assessment Expense Included in the Cost Report	\$ -	

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report	\$ 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.