

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 MIDTOWN

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 MIDTOWN

5. Medicaid Provider Number:

000000503A

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

0

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

0

8. Medicare Provider Number:

110078

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

Private

Data	Correct?	If Incorrect, Proper Information
EMORY UNIVERSITY HOSPITAL MIDTOWN	Yes	
000000503A	Yes	
0	Yes	
0	Yes	
110078	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
\$ 138,412	\$ 707,844	\$846,256
\$ 3,455,751	\$ 16,943,791	\$20,399,542
\$3,594,163	\$17,651,635	\$21,245,798
3.85%	4.01%	3.98%

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) 165,970 (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	74,828,185
8. Outpatient Hospital Charity Care Charges	54,549,930
9. Non-Hospital Charity Care Charges	256,537
10. Total Charity Care Charges	\$ 129,634,652

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	\$444,808,748.00			\$ 302,775,771	-	-	\$ 142,032,977
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	-	-	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	-	-	\$ -
14. Swing Bed - SNF			\$0.00			-	
15. Swing Bed - NF			\$0.00			-	
16. Skilled Nursing Facility			\$0.00			-	
17. Nursing Facility			\$0.00			-	
18. Other Long-Term Care			\$0.00			-	
19. Ancillary Services	\$1,169,498,600.00	\$53,489,982.00		\$ 796,063,121	\$ 36,409,964	-	\$ 390,515,497
20. Outpatient Services		\$2,178,247,304.00			\$ 1,482,705,791	-	\$ 695,541,513
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	\$0.00	\$0.00	\$0.00	\$ -	\$ -	-	\$ -
27. Total	\$ 1,614,307,348	\$ 2,231,737,286	\$ -	\$ 1,098,838,891	\$ 1,519,115,755	\$ -	\$ 1,228,089,988
28. Total Hospital and Non Hospital		Total from Above	\$ 3,846,044,634		Total from Above	\$ 2,617,954,646	
29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)			Total Contractual Adj. (G-3 Line 2)			
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)	3,846,044,634			2,628,436,035			
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)				+			4,005,515
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				-			14,486,904
36. Unreconciled Difference	Unreconciled Difference (Should be \$0)			Unreconciled Difference (Should be \$0)			2,617,954,646
	\$ -			\$ -			

G. Cost Report - Cost / Days / Charges

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

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. 1, 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	\$ 175,241,247	\$ 14,982,070	\$ -	\$0.00	\$ 190,223,317	109,962	\$237,966,878.00	\$ 1,729.90
2	03100 INTENSIVE CARE UNIT	\$ 26,523,488	\$ -	\$ -		\$ 26,523,488	13,817	\$79,566,808.00	\$ 1,919.63
3	03200 CORONARY CARE UNIT	\$ 7,682,491	\$ -	\$ -		\$ 7,682,491	3,583	\$27,762,165.00	\$ 2,144.15
4	03300 BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 17,259,995	\$ -	\$ -		\$ 17,259,995	3,844	\$56,466,802.00	\$ 4,490.11
6	03500 OTHER SPECIAL CARE UNIT	\$ 21,447,969	\$ -	\$ -		\$ 21,447,969	13,498	\$52,527,260.00	\$ 1,588.97
7	04000 SUBPROVIDER I	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
8	04100 SUBPROVIDER II	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
9	04200 OTHER SUBPROVIDER	\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
10	04300 NURSERY	\$ 15,699,311	\$ -	\$ -		\$ 15,699,311	21,266	\$26,000,381.00	\$ 738.24
11		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17		\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18	Total Routine	\$ 263,854,501	\$ 14,982,070	\$ -	\$ -	\$ 278,836,571	165,970	\$ 480,290,294	
19	Weighted Average								\$ 1,680.04

Observation Data (Non-Distinct)

20	09200 Observation (Non-Distinct)								
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Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
-	-	-	\$ -	\$0.00	\$0.00	\$ -	-

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

21	5000 OPERATING ROOM	\$48,249,076.00	\$ -	\$ -	\$ 48,249,076	\$186,181,102.00	\$148,106,180.00	\$ 334,287,282	0.144334
22	5100 RECOVERY ROOM	\$16,220,489.00	\$ -	\$ -	\$ 16,220,489	\$12,804,567.00	\$21,198,762.00	\$ 34,003,329	0.477026
23	5200 DELIVERY ROOM & LABOR ROOM	\$28,055,883.00	\$ -	\$ -	\$ 28,055,883	\$65,693,697.00	\$2,875,710.00	\$ 68,569,407	0.409160
24	5300 ANESTHESIOLOGY	\$5,084,252.00	\$ -	\$ -	\$ 5,084,252	\$62,037,627.00	\$31,358,815.00	\$ 93,396,442	0.054437
25	5400 RADIOLOGY-DIAGNOSTIC	\$23,861,318.00	\$ -	\$ -	\$ 23,861,318	\$22,521,877.00	\$79,308,649.00	\$ 101,830,526	0.234324
26	5401 EP LAB	\$4,156,820.00	\$ -	\$ -	\$ 4,156,820	\$5,721,821.00	\$14,411,296.00	\$ 20,133,117	0.206467
27	5402 PET CENTER	\$3,500,120.00	\$ -	\$ -	\$ 3,500,120	\$8,764,124.00	\$44,764,508.00	\$ 53,528,632	0.065388
28	5500 RADIOLOGY-THERAPEUTIC	\$10,315,363.00	\$ -	\$ -	\$ 10,315,363	\$2,218,649.00	\$49,016,482.00	\$ 51,235,131	0.201334
29	5600 RADIOISOTOPE	\$1,495,758.00	\$ -	\$ -	\$ 1,495,758	\$1,263,642.00	\$18,452,718.00	\$ 19,716,360	0.075864

G. Cost Report - Cost / Days / Charges

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

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	5700 CT SCAN	\$5,308,808.00	\$ -	\$ -	\$ 5,308,808	\$42,073,124.00	\$69,761,171.00	\$ 111,834,295	0.047470
31	5800 MRI	\$6,038,530.00	\$ -	\$ -	\$ 6,038,530	\$24,853,438.00	\$59,038,002.00	\$ 83,891,440	0.071980
32	5900 CARDIAC CATHETERIZATION	\$15,444,230.00	\$ -	\$ -	\$ 15,444,230	\$36,516,033.00	\$49,826,658.00	\$ 86,342,691	0.178871
33	6000 LABORATORY	\$39,620,284.00	\$ -	\$ -	\$ 39,620,284	\$199,605,798.00	\$226,570,177.00	\$ 426,175,975	0.092967
34	6001 VASCULAR LAB	\$840,111.00	\$ -	\$ -	\$ 840,111	\$7,869,437.00	\$5,398,677.00	\$ 13,268,114	0.063318
35	6002 ENDOSCOPY	\$4,966,344.00	\$ -	\$ -	\$ 4,966,344	\$8,048,157.00	\$12,604,222.00	\$ 20,652,379	0.240473
36	6500 RESPIRATORY THERAPY	\$13,626,740.00	\$ -	\$ -	\$ 13,626,740	\$85,817,565.00	\$2,636,726.00	\$ 88,454,291	0.154054
37	6501 PULMONARY FUNCTION TESTING	\$1,197,689.00	\$ -	\$ -	\$ 1,197,689	\$32,493,127.00	\$5,321,407.00	\$ 37,814,534	0.031673
38	6600 PHYSICAL THERAPY	\$6,561,717.00	\$ -	\$ -	\$ 6,561,717	\$23,310,977.00	\$4,443,294.00	\$ 27,754,271	0.236422
39	6900 ELECTROCARDIOLOGY	\$622,544.00	\$ -	\$ -	\$ 622,544	\$4,668,829.00	\$5,288,546.00	\$ 9,957,375	0.062521
40	7000 ELECTROENCEPHALOGRAPHY	\$1,261,299.00	\$ -	\$ -	\$ 1,261,299	\$2,980,998.00	\$124,738.00	\$ 3,105,736	0.406119
41	7001 CARDIOLOGY	\$9,091,391.00	\$ -	\$ -	\$ 9,091,391	\$38,944,150.00	\$43,703,988.00	\$ 82,648,138	0.110001
42	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$27,047,543.00	\$ -	\$ -	\$ 27,047,543	\$37,341,680.00	\$21,985,606.00	\$ 59,327,286	0.455904
43	7200 IMPL. DEV. CHARGED TO PATIENTS	\$74,180,157.00	\$ -	\$ -	\$ 74,180,157	\$51,740,019.00	\$31,504,376.00	\$ 83,244,395	0.891113
44	7300 DRUGS CHARGED TO PATIENTS	\$523,004,884.00	\$ -	\$ -	\$ 523,004,884	\$123,551,321.00	\$973,171,622.00	\$ 1,096,722,943	0.476880
45	7400 RENAL DIALYSIS	\$4,743,209.00	\$ -	\$ -	\$ 4,743,209	\$14,340,636.00	\$2,763,700.00	\$ 17,104,336	0.277310
46	9000 CLINIC	\$97,617,951.00	\$ -	\$ -	\$ 97,617,951	\$6,905,731.00	\$203,838,189.00	\$ 210,743,920	0.463206
47	9100 EMERGENCY	\$34,876,136.00	\$ -	\$ -	\$ 34,876,136	\$45,939,981.00	\$84,068,955.00	\$ 130,008,936	0.268260
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

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

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	\$ 1,006,988,646	\$ -	\$ -	\$ 1,006,988,646	\$ 1,154,208,107	\$ 2,211,543,174	\$ 3,365,751,281	
127	Weighted Average								0.299187
128	Sub Totals	\$ 1,270,843,147	\$ 14,982,070	\$ -	\$ 1,285,825,217	\$ 1,634,498,401	\$ 2,211,543,174	\$ 3,846,041,575	
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)				\$20,549,612.00				
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)				\$202,602,499.00				
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				\$ 1,062,673,106				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					1.18%			

* 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 MIDTOWN

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													
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	\$ 1,729.90		12,640		8,895		11,415		7,819		6,976		40,769		43.90%
2	03100 INTENSIVE CARE UNIT	\$ 1,919.63		333		333		1,304		491		765		3,350		30.28%
3	03200 CORONARY CARE UNIT	\$ 2,144.15		340		64		429		152		135		985		31.54%
4	03300 BURN INTENSIVE CARE UNIT	\$ -														
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 4,490.11		856		234		913		344		536		2,347		75.55%
6	03500 OTHER SPECIAL CARE UNIT	\$ 1,588.97		223		5,407				1,355		41		6,985		52.12%
7	04000 SUBPROVIDER I	\$ -														
8	04100 SUBPROVIDER II	\$ -														
9	04200 OTHER SUBPROVIDER	\$ -														
10	04300 NURSERY	\$ 738.24		1,417		5,728				82		275		7,227		35.28%
11		\$ -														
12		\$ -														
13		\$ -														
14		\$ -														
15		\$ -														
16		\$ -														
17		\$ -														
18		\$ -														
	Total Days			16,698		20,661		14,061		10,243		8,728		61,663		42.79%
19	Total Days per PS&R or Exhibit Detail			16,698		20,661		14,061		10,243		8,728				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21.01	Calculated Routine Charge Per Diem			\$ 46,424.834		\$ 50,170.896		\$ 40,120.536		\$ 28,958.573		\$ 23,694.376		\$ 163,674.839		39.37%
				\$ 2,780.26		\$ 2,428.29		\$ 2,853.32		\$ 2,631.90		\$ 2,714.75		\$ 2,654.34		
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	0.144334		12,278.377	3,244.228	6,478.877	6,134.685	14,361.407	9,442.385	5,560.868	3,474.760	9,870.051	2,055.340	\$ 38,679.529	\$ 22,296.059	22.03%
24	5100 RECOVERY ROOM	0.477026		727.929	973.626	475.863	931.081	1,299.032	356.701	497.337	548.769	300.289	2,491.514	\$ 3,236.638	\$ 19,474	19.47%
25	5200 DELIVERY ROOM & LABOR ROOM	0.409160		90.847	167.397	23,810.199	167.397	7,806	6,920.716	262.257	387.115	28,896	\$ 31,731.110	\$ 1,598.401	\$ 49,33%	49.33%
26	5300 ANESTHESIOLOGY	0.054437		2,433.152	650.816	10,511.200	3,268.076	3,230.215	2,471.336	4,312.580	1,128.142	2,448.542	1,161.883	\$ 20,487.147	\$ 7,518.370	34.09%
27	5400 RADIOLOGY-DIAGNOSTIC	0.234324		1,445.353	1,693.104	702.999	1,441.411	1,813.344	4,197.906	1,014.179	1,506.235	1,261.092	2,743.214	\$ 4,975.875	\$ 8,838.656	17.84%
28	5401 EP LAB	0.206467		550.699	344.295	178.601	293.135	690.933	853.715	257.658	306.318	320.388	557.879	\$ 1,677.891	\$ 1,797.463	21.77%
29	5402 PET CENTER	0.085388		592.624	915.580	273.564	779.526	743.535	2,270.260	394.656	814.584	490.739	1,483.551	\$ 2,004.379	\$ 4,779.950	16.57%
30	5500 RADIOLOGY-THERAPEUTIC	0.201334		162.037	737.301	69.253	203.299	1,828.254	99.908	655.989	124.231	1,194.713	\$ 534.497	\$ 3,849.301	\$ 11,26%	11.26%
31	5600 RADIOISOTOPE	0.075864		82.152	612.983	39.443	521.885	103.071	1,519.917	56.903	545.356	70.756	993.223	\$ 281.569	\$ 3,200.141	23.30%
32	5700 CT SCAN	0.047470		4,047.793	2,572.007	1,513.061	3,619.888	4,788.901	6,587.051	2,348.051	1,922.154	3,954.968	6,316.843	\$ 12,677.806	\$ 14,701.100	34.18%
33	5800 MRI	0.071980		1,705.252	1,123.988	614.310	1,727.029	1,474.207	3,070.528	653.532	1,161.426	1,055.381	1,032.444	\$ 4,447.301	\$ 7,082.971	16.44%
34	5900 CARDIAC CATHETERIZATION	0.178871		-	-	-	10,710	543.498	425.048	499.514	88.833	1,055.209	1,043.012	\$ 524.591	\$ 3,25%	3.25%
35	6000 LABORATORY	0.092967		22,619.420	8,322.089	15,815.175	8,917.618	21,579.950	18,494.077	11,618.276	7,461.753	13,791.908	11,556.087	\$ 71,632.821	\$ 43,195.538	33.23%
36	6001 VASCULAR LAB	0.063318		3,651.416	1,506.064	547.771	196.178	345.473	376.401	236.307	287.060	102.556	4,780.967	\$ 2,231.555	\$ 55,92%	55.92%
37	6002 ENDOSCOPY	0.240473		562.220	83.948	162.242	235.970	656.147	795.769	308.673	362.965	424.269	226.058	\$ 1,689.282	\$ 1,478.652	18.73%
38	6500 RESPIRATORY THERAPY	0.154054		10,753.624	361.289	5,935.832	520.043	8,993.914	736.162	4,596.086	826.669	3,627.662	709.232	\$ 30,279.458	\$ 2,464.163	42.27%
39	6501 PULMONARY FUNCTION TESTING	0.031673		2,753.255	126.904	777.187	210.993	2,510.002	423.938	136.933	1,023.628	215.137	\$ 6,962.713	\$ 898.768	\$ 24,16%	24.16%
40	6600 PHYSICAL THERAPY	0.236422		2,071.959	87.023	1,496.635	25.837	2,364.298	642.378	1,114.419	167.101	1,010.482	103.972	\$ 7,047.311	\$ 922.339	33.02%
41	6800 ELECTROCARDIOLOGY	0.062521		419.246	155.746	111.671	209.690	382.205	520.287	132.518	136.088	147.082	213.808	\$ 1,045.640	\$ 1,021.811	25.26%
42	7000 ELECTROENCEPHALOGRAPHY	0.406119		237.781	2.884	7.152	4.946	216.773	9.635	8.487	3.210	9.419	5.043	\$ 470.193	\$ 20.675	16.37%
43	7001 CARDIOLOGY	0.110001		2,847.116	1,156.560	931.485	1,732.858	2,595.570	3,863.616	1,105.372	1,124.615	1,226.853	1,766.888	\$ 7,479.543	\$ 7,877.649	22.41%
44	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.455994		3,015.417	552.271	2,338.849	857.449	2,978.641	1,919.244	1,616.226	420.337	2,058.056	429.031	\$ 9,949.133	\$ 2,749.301	25.85%
45	7200 IMPL. DEV. CHARGED TO PATIENTS	0.891133		2,330.131	345.303	823.346	569.465	2,873.281	1,937.898	1,450.317	426.104	1,213.108	248.492	\$ 7,477.075	\$ 3,278.770	14.88%
46	7300 DRUGS CHARGED TO PATIENTS	0.476880		15,068.050	12,120.826	6,535.032	9,350.703	10,857.944	59,055.306	6,158.671	11,962.578	7,405.907	16,691.787	\$ 38,619.697	\$ 92,489.413	14.21%
47	7400 RENAL DIALYSIS	0.277310		1,273.551	-	195.508	74.864	2,563.589	635.635	1,765.538	602.048	392.978	91.298	\$ 5,798.186	\$ 1,312.547	44.54%
48	9000 CLINIC	0.463206		1,224.428	2,689.377	444.034	1,847.985	609.228	2,031.110	57.217	321.710	12.122	547.170	\$ 2,334.907	\$ 6,890.182	47.40%
49	9100 EMERGENCY	0.268260		4,123.463	8,717.941	1,190.132	8,568.791	3,615.656	10,273.360	2,285.162	3,889.993	3,468.600	17,400.377	\$ 11,214.413	\$ 31,450.085	49.59%
50				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
51				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
52				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
53				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
54				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
55				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
56				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
57				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
58				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
59				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	
60				-	-	-	-	-	-	-	-	-	-	\$ -	\$ -	

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

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

					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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121				-											\$ -	\$ -	-
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123				-											\$ -	\$ -	-
124				-											\$ -	\$ -	-
125				-											\$ -	\$ -	-
126				-											\$ -	\$ -	-
127				-											\$ -	\$ -	-
					\$ 97,809,242	\$ 48,807,001	\$ 81,979,361	\$ 53,851,627	\$ 92,173,559	\$ 134,688,055	\$ 55,850,806	\$ 40,358,407	\$ 57,686,374	\$ 68,297,223			

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

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

	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		%		
Totals / Payments															
128	Total Charges (includes organ acquisition from Section J)		\$ 144,234,076	\$ 48,807,001	\$ 132,150,257	\$ 53,851,627	\$ 132,294,095	\$ 134,688,055	\$ 82,809,379	\$ 40,358,407	\$ 81,380,750 (Agrees to Exhibit A)	\$ 68,297,223 (Agrees to Exhibit A)	\$ 491,487,807	\$ 277,705,089	24.11%
129	Total Charges per PS&R or Exhibit Detail		\$ 144,234,076	\$ 48,807,001	\$ 132,150,257	\$ 53,851,627	\$ 132,294,095	\$ 134,688,055	\$ 82,809,379	\$ 40,358,407	\$ 81,380,750	\$ 68,297,223			
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-	-	-			
131	Total Calculated Cost (includes organ acquisition from Section J)		\$ 51,424,422	\$ 12,774,888	\$ 50,308,553	\$ 12,626,195	\$ 46,792,006	\$ 41,377,741	\$ 31,579,551	\$ 10,472,055	\$ 28,331,890	\$ 16,891,077	\$ 180,104,532	\$ 77,250,879	28.72%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		\$ 29,514,347	\$ 10,193,907			\$ 1,482,048	\$ 3,434,227	\$ 84,914	\$ 42,586			\$ 31,081,309	\$ 13,670,720	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)				\$ 29,774,280	\$ 7,855,380							\$ 29,774,280	\$ 7,855,380	
134	Private Insurance (including primary and third party liability)		\$ 485,912	\$ 8,059				\$ 361	\$ 15,143,561	\$ 6,897,498			\$ 15,629,473	\$ 6,905,918	
135	Self-Pay (including Co-Pay and Spend-Down)					\$ 1,555			\$ 5,632	\$ 5,839			\$ 5,632	\$ 7,394	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)		\$ 30,000,259	\$ 10,201,966	\$ 29,774,280	\$ 7,856,935									
137	Medicaid Cost Settlement Payments (See Note B)			\$ 1,035,514										\$ 1,035,514	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													\$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)						\$ 27,138,860	\$ 23,002,433	\$ 4,448,606	\$ 1,196,674			\$ 31,587,466	\$ 24,199,107	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							\$ 5,259,199	\$ 2,560,333				\$ 5,259,199	\$ 2,560,333	
141	Medicare Cross-Over Bad Debt Payments						\$ 455,022	\$ 393,196					\$ 455,022	\$ 393,196	
142	Other Medicare Cross-Over Payments (See Note D)						\$ 8,960,033	\$ 856,497					\$ 8,960,033	\$ 856,497	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										(Agrees to Exhibit B and B-1)	(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)										\$ 138,412	\$ 707,844			
											\$ -	\$ -			
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)		\$ 21,424,163	\$ 1,537,408	\$ 20,534,273	\$ 4,769,260	\$ 8,756,043	\$ 13,691,027	\$ 6,637,639	\$ (230,875)	\$ 28,193,478	\$ 16,183,233	\$ 57,352,118	\$ 19,766,820	
146	Calculated Payments as a Percentage of Cost		58%	88%	59%	62%	81%	67%	79%	102%	0%	4%	68%	74%	
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)						69,831								
148	Percent of cross-over days to total Medicare days from the cost report						20%								

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.
NOTE: Outpatient 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 MIDTOWN

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	\$ 1,729.90		437				44		44		525	
2	03100 INTENSIVE CARE UNIT	\$ 1,919.63		24				6		39		69	
3	03200 CORONARY CARE UNIT	\$ 2,144.15		9				1				10	
4	03300 BURN INTENSIVE CARE UNIT	\$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ 4,490.11		17				4				21	
6	03500 OTHER SPECIAL CARE UNIT	\$ 1,588.97		9								9	
7	04000 SUBPROVIDER I	\$ -										-	
8	04100 SUBPROVIDER II	\$ -										-	
9	04200 OTHER SUBPROVIDER	\$ -										-	
10	04300 NURSERY	\$ 738.24		1								1	
11		\$ -										-	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
18		\$ -										-	
	Total Days			497		-		55		83		635	
19	Total Days per PS&R or Exhibit Detail			497		-		55		83		-	
20	Unreconciled Days (Explain Variance)			-		-		-		-		-	
	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges	\$ 1,169,941		\$ 1,169,941		\$ 164,395		\$ 380,471		\$ 1,714,807		\$ 1,714,807	
21.01	Calculated Routine Charge Per Diem	\$ 2,354.01		\$ -		\$ 2,989.00		\$ 4,583.99		\$ 2,700.48		\$ 2,700.48	
	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	0.144334		263,293	97,870			190,058	33,891	153,912	-	\$ 607,263	\$ 131,761
24	5100 RECOVERY ROOM	0.477026		17,687	14,529			6,754	3,103	2,291	-	\$ 26,732	\$ 17,632
25	5200 DELIVERY ROOM & LABOR ROOM	0.409160		74,767	4,116			-	-	1,476	-	\$ 74,767	\$ 5,592
26	5300 ANESTHESIOLOGY	0.054437		90,609	69,311			27,480	8,837	22,979	1,356	\$ 141,068	\$ 79,504
27	5400 RADIOLOGY-DIAGNOSTIC	0.234324		72,241	166,439			12,226	95,370	4,788	1,321	\$ 89,255	\$ 263,130
28	5401 EP LAB	0.206467		3,513	-			4,658	19,395	1,824	269	\$ 9,995	\$ 19,664
29	5402 PET CENTER	0.065388		20,612	31,127			5,013	51,577	1,963	714	\$ 27,588	\$ 83,418
30	5500 RADIOLOGY-THERAPEUTIC	0.201334		-	23,345			1,371	41,535	537	575	\$ 1,908	\$ 65,455
31	5600 RADIOISOTOPE	0.075864		6,309	5,462			695	34,530	272	478	\$ 7,276	\$ 40,470
32	5700 CT SCAN	0.047470		186,482	293,027			31,751	23,042	26,449	13,254	\$ 244,682	\$ 329,323
33	5800 MRI	0.071980		83,736	64,848			3,812	3,812	13,732	3,812	\$ 101,280	\$ 72,472
34	5900 CARDIAC CATHETERIZATION	0.178871		-	-			64,914	-	-	-	\$ 64,914	\$ -
35	6000 LABORATORY	0.092967		709,218	408,492			157,149	27,929	147,510	8,817	\$ 1,013,877	\$ 445,238
36	6001 VASCULAR LAB	0.063318		11,186	2,851			983	2,506	500	-	\$ 12,669	\$ 5,357
37	6002 ENDOSCOPY	0.240473		32,015	7,904			6,769	-	3,201	-	\$ 41,985	\$ 7,904
38	6500 RESPIRATORY THERAPY	0.154054		141,466	32,646			33,119	1,042	97,601	647	\$ 272,186	\$ 34,335
39	6501 PULMONARY FUNCTION TESTING	0.031673		0.031673				24,407	2,170	9,604	125	\$ 34,011	\$ 2,295
40	6600 PHYSICAL THERAPY	0.236422		21,913	9,353			12,022	1,194	34,975	-	\$ 68,910	\$ 10,547
41	6900 ELECTROCARDIOLOGY	0.062521		23,895	54,782			3,716	2,663	1,462	153	\$ 29,073	\$ 57,598
42	7000 ELECTROENCEPHALOGRAPHY	0.406119		-	-			2,108	49	829	3	\$ 2,937	\$ 52
43	7001 CARDIOLOGY	0.110001		90,677	25,349			25,239	19,778	9,931	1,136	\$ 125,847	\$ 46,263
44	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.455904		63,192	27,370			16,598	3,566	40,406	136	\$ 120,196	\$ 31,072
45	7200 IMPL. DEV. CHARGED TO PATIENTS	0.891113		86,924	439			75,803	8	5,541	-	\$ 168,268	\$ 447
46	7300 DRUGS CHARGED TO PATIENTS	0.476880		396,314	119,531			49,425	36,688	48,967	2,567	\$ 494,706	\$ 158,786
47	7400 RENAL DIALYSIS	0.277310		10,616	3,478			-	8,782	-	-	\$ 10,616	\$ 12,260

I. Out-of-State Medicaid Data:

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

				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	9000	CLINIC	0.463206	55,738	65,423			-	8,393	-	-	\$ 55,738	\$ 73,816
49	9100	EMERGENCY	0.268260	159,602	704,023			10,962	36,169	11,568	16,786	\$ 182,132	\$ 756,978
50			-									\$ -	\$ -
51			-									\$ -	\$ -
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Cost Report Year (09/01/2021-08/31/2022)	EMORY UNIVERSITY HOSPITAL MIDTOWN
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Totals / Payments

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 MIDTOWN

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
						Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
	Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost	Sum of Cost Report Organ Acquisition Cost and the Add-On Cost	Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.	Cost Report Worksheet D-4, Pt. III, Line 62	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Paid Claims Data or Provider Logs (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis
Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	\$0.00	\$ -	\$ -	0										
2	Kidney Acquisition	\$0.00	\$ -	\$ -	0										
3	Liver Acquisition	\$0.00	\$ -	\$ -	0										
4	Heart Acquisition	\$0.00	\$ -	\$ -	0										
5	Pancreas Acquisition	\$0.00	\$ -	\$ -	0										
6	Intestinal Acquisition	\$0.00	\$ -	\$ -	0										
7	Islet Acquisition	\$0.00	\$ -	\$ -	0										
8		\$0.00	\$ -	\$ -	0										
9	Totals	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-	\$ -	-
10	Total Cost						-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.

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

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

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

EMORY UNIVERSITY HOSPITAL MIDTOWN

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-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	\$ -	\$ -	\$ -	0								
12	Kidney Acquisition	\$ -	\$ -	\$ -	0								
13	Liver Acquisition	\$ -	\$ -	\$ -	0								
14	Heart Acquisition	\$ -	\$ -	\$ -	0								
15	Pancreas Acquisition	\$ -	\$ -	\$ -	0								
16	Intestinal Acquisition	\$ -	\$ -	\$ -	0								
17	Islet Acquisition	\$ -	\$ -	\$ -	0								
18		\$ -	\$ -	\$ -	0								
19	Totals	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$ -	-	\$ -	-	\$ -	-
20	Total Cost						-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).

Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

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

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line
1	Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 14,486,904	
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment	Contractual Adjustment	489000-40997 (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 ----->)	\$ 14,486,904	
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	\$ 14,486,904
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital Charges Sec. G	777,688,952
19	Uninsured Hospital Charges Sec. G	149,677,973
20	Total Hospital Charges Sec. G	3,846,041,575
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	20.22%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	3.89%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 2,929,325
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 563,793
25	Provider Tax Assessment Adjustment to DSH UCC	\$ 3,493,118

* 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.