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 DECATUR

	9/1/2021 through 8/31/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	5/12/2023		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	EMORY DECATUR	Yes	
5. Medicaid Provider Number:	000000536A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110076	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	

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

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (09/01/2021 - 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)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 338,156	$ 1,665,769	$2,003,925
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,730,834	$ 12,055,040	$14,785,874
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$3,068,990	$13,720,809	$16,789,799
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	11.02%	12.14%	11.94%

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)	99,434	**(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	579
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ 579
7.	Inpatient Hospital Charity Care Charges	23,974,852
8.	Outpatient Hospital Charity Care Charges	18,629,212
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 42,604,064

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

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

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$243,610,931.00			$ 174,868,026	$ -	$ -	$ 68,742,905
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$43,770,413.00			$ 31,419,139	$ -	$ -	$ 12,351,274
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	$424,569,774.00	$476,145,719.00		$ 304,763,330	$ 341,785,411	$ -	$ 254,166,752
20.	Outpatient Services		$150,949,200.00			$ 108,353,876	$ -	$ 42,595,324
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	$9,567,674.00	$0.00	$0.00	$ 6,867,837	$ -	$ -	$ 2,699,837
27.	Total	$ 721,518,792	$ 627,094,919	$ -	$ 517,918,333	$ 450,139,287	$ -	$ 380,556,091
28.	Total Hospital and Non Hospital		Total from Above	$ 1,348,613,711		Total from Above	$ 968,057,620	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,348,613,711	Total Contractual Adj. (G-3 Line 2)		966,444,058
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)				+	6,108,512
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)				-	4,494,950
35.	Adjusted Contractual Adjustments					968,057,620
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

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

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 122,105,493	$ 940,016	$ -	$0.00	$ 123,045,509	85,528	$205,700,093.00		$ 1,438.66
2	03100 INTENSIVE CARE UNIT	$ 24,478,828	$ -	$ -		$ 24,478,828	8,307	$54,765,327.00		$ 2,946.77
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ 12,360,529	$ -	$ -		$ 12,360,529	8,239	$26,915,924.00		$ 1,500.25
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II			$ -		$ -				$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,609,923	$ -	$ -		$ 4,609,923	5,218	$9,567,674.00		$ 883.47
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 163,554,773	$ 940,016	$ -	$ -	$ 164,494,789	107,292	$ 296,949,018		
19	Weighted Average									$ 1,533.15

Line #	Observation Data (Non-Distinct)	*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*
20	09200 Observation (Non-Distinct)	7,861	-	-	$ 11,309,306	$6,250,397.00	$8,198,810.00	$ 14,449,207	0.782694

Line #		*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):									
21	5000 OPERATING ROOM	$38,210,513.00	$ 97,593	$ -		$ 38,308,106	$54,327,405.00	$121,284,204.00	$ 175,611,609	0.218141
22	5200 DELIVERY ROOM & LABOR ROOM	$12,241,505.00	$ -	$ -		$ 12,241,505	$19,607,358.00	$205,967.00	$ 19,813,325	0.617842
23	5400 RADIOLOGY-DIAGNOSTIC	$22,652,393.00	$ 37,475	$ -		$ 22,689,868	$28,472,066.00	$81,817,504.00	$ 110,289,570	0.205730
24	5700 CT SCAN	$2,959,880.00	$ -	$ -		$ 2,959,880	$23,426,164.00	$43,228,020.00	$ 66,654,184	0.044407
25	5800 MRI	$1,429,817.00	$ -	$ -		$ 1,429,817	$6,262,618.00	$15,280,579.00	$ 21,543,197	0.066370
26	5900 CARDIAC CATHETERIZATION	$4,969,345.00	$ -	$ -		$ 4,969,345	$10,523,674.00	$16,603,590.00	$ 27,127,264	0.183186
27	5901 CARDIAC IMAGING	$1,035,272.00	$ -	$ -		$ 1,035,272	$26,326.00	$6,514,329.00	$ 6,540,655	0.158283
28	6000 LABORATORY	$19,873,482.00	$ -	$ -		$ 19,873,482	$84,323,306.00	$53,093,591.00	$ 137,416,897	0.144622
29	6500 RESPIRATORY THERAPY	$9,929,859.00	$ -	$ -		$ 9,929,859	$32,850,538.00	$7,357,898.00	$ 40,208,436	0.246960
30	6600 PHYSICAL THERAPY	$12,232,418.00	$ -	$ -		$ 12,232,418	$22,213,356.00	$17,347,692.00	$ 39,561,048	0.309204

G. Cost Report - Cost / Days / Charges

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

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6900	ELECTROCARDIOLOGY	$2,017,136.00	$ -	$ -		$ 2,017,136	$19,904,730.00	$13,853,960.00	$ 33,758,690	0.059752
32	7000	ELECTROENCEPHALOGRAPHY	$265,435.00	$ -	$ -		$ 265,435	$511,412.00	$136,768.00	$ 648,180	0.409508
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$18,324,362.00	$ -	$ -		$ 18,324,362	$15,660,620.00	$16,399,719.00	$ 32,060,339	0.571559
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$25,493,484.00	$ -	$ -		$ 25,493,484	$13,006,023.00	$23,277,752.00	$ 36,283,775	0.702614
35	7300	DRUGS CHARGED TO PATIENTS	$43,719,720.00	$ -	$ -		$ 43,719,720	$83,583,994.00	$58,895,914.00	$ 142,479,908	0.306848
36	7600	NEPHROLOGY	$3,828,294.00	$ -	$ -		$ 3,828,294	$9,870,184.00	$848,232.00	$ 10,718,416	0.357170
37	9001	DIAGNOSTIC TREATMENT CTR	$4,933,498.00	$ -	$ -		$ 4,933,498	$1,929,428.00	$9,624,828.00	$ 11,554,256	0.426985
38	9004	KANN OP CANCER CENTER	$1,840,059.00	$ -	$ -		$ 1,840,059	$7,452.00	$5,563,223.00	$ 5,570,675	0.330312
39	9006	WOUND CARE CLINIC	$2,040,003.00	$ -	$ -		$ 2,040,003	$17,727.00	$8,725,629.00	$ 8,743,356	0.233320
40	9100	EMERGENCY	$27,328,633.00	$ 33,182	$ -		$ 27,361,815	$34,996,024.00	$75,635,683.00	$ 110,631,707	0.247323
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
91		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
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**	$ 255,325,108	$ 168,250	$ -		$ 255,493,358	$ 467,770,802	$ 583,893,892	$ 1,051,664,694	
127	**Weighted Average**									0.253696
128	**Sub Totals**	$ 418,879,881	$ 1,108,266	$ -		$ 419,988,147	$ 764,719,820	$ 583,893,892	$ 1,348,613,712	
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**					$ 419,988,147				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.26%				

* 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 DECATUR

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-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,438.66		6,834		5,283		5,581		9,689		7,589		27,387		45.31%
2	03100 INTENSIVE CARE UNIT	$ 2,946.77		1,391		173		645		1,305		830		3,514		52.32%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ 1,500.25		398		4,026				714		37		5,138		63.11%
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 883.47		234		3,286				534		97		4,054		79.65%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	8,857		12,768		6,226		12,242		8,553		40,093		45.57%
19	Total Days per PS&R or Exhibit Detail			8,857		12,768		6,226		12,242		8,553				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 25,757,117		$ 32,045,675		$ 17,345,982		$ 35,514,579		$ 23,667,560		$ 110,663,353		45.44%
21.01	Calculated Routine Charge Per Diem			$ 2,908.11		$ 2,509.84		$ 2,786.06		$ 2,901.04		$ 2,767.16		$ 2,760.17		
	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)		0.782694	481,880	494,617	1,557,681	736,040	183,229	244,356	891,781	1,652,344	325,832	738,618	$ 3,114,571	$ 3,127,357	50.96%
23	5000 OPERATING ROOM		0.218141	4,677,977	2,756,182	5,594,427	6,643,043	1,844,786	1,872,216	5,737,065	6,588,710	2,241,665	10,262,905	$ 17,854,255	$ 17,860,151	27.51%
24	5200 DELIVERY ROOM & LABOR ROOM		0.617842	202,412	170	5,619,490	21,276	400,847	3,011	2,042,988	12,332	570,645	16,035	$ 8,265,737	$ 36,789	45.01%
25	5400 RADIOLOGY-DIAGNOSTIC		0.205730	1,424,622	1,789,887	3,006,323	4,931,426	1,717,282	1,740,629	3,805,728	5,545,568	1,915,972	4,248,537	$ 9,953,955	$ 14,007,510	27.54%
26	5700 CT SCAN		0.044407	2,124,918	1,123,826	834,426	2,861,911	1,589,650	1,075,067	2,938,074	3,581,978	2,646,024	5,980,362	$ 7,487,068	$ 8,642,782	37.54%
27	5800 MRI		0.066370	614,868	255,793	215,473	477,517	269,519	258,058	640,356	1,213,139	617,881	255,058	$ 1,740,216	$ 2,204,507	22.47%
28	5900 CARDIAC CATHETERIZATION		0.183186	1,868,145	420,149	372,236	219,308	341,654	505,443	1,269,108	1,713,130	1,255,181	259,984	$ 3,851,143	$ 2,858,030	30.55%
29	5901 CARDIAC IMAGING		0.158283	270	17,417	643	87,862	1,295	136,387	3,755	483,952	2,970	113,261	$ 5,963	$ 725,618	13.00%
30	6000 LABORATORY		0.144622	8,683,579	2,812,828	7,530,118	5,296,826	5,398,631	1,320,758	10,500,849	4,439,710	7,221,932	6,170,256	$ 32,113,177	$ 13,870,122	43.55%
31	6500 RESPIRATORY THERAPY		0.246960	2,671,668	126,066	2,628,976	281,993	2,899,457	110,192	5,114,112	313,585	2,612,594	269,807	$ 13,314,213	$ 831,836	42.42%
32	6600 PHYSICAL THERAPY		0.309204	2,391,731	647,208	1,419,949	413,328	1,104,135	380,638	2,309,186	1,312,789	998,696	198,975	$ 7,225,001	$ 2,753,963	28.31%
33	6900 ELECTROCARDIOLOGY		0.059752	650,040	607,315	823,473	784,822	1,333,246	384,822	2,579,678	1,252,792	1,898,412	1,585,449	$ 5,386,437	$ 3,029,751	35.55%
34	7000 ELECTROENCEPHALOGRAPHY		0.409508	66,623	4,384	10,118	3,288	40,840	6,576	60,699	14,464	68,968	4,600	$ 178,280	$ 28,712	43.28%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.571559	960,899	314,137	1,239,686	665,785	902,551	356,911	1,761,826	1,127,952	1,049,667	789,982	$ 4,864,962	$ 2,464,785	28.67%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.702614	700,400	437,831	252,274	502,398	451,406	699,111	1,642,957	1,746,160	507,153	229,879	$ 3,047,037	$ 3,385,500	19.82%
37	7300 DRUGS CHARGED TO PATIENTS		0.306848	8,941,911	1,331,726	5,587,063	1,955,440	5,931,034	1,253,785	10,734,644	7,771,732	7,308,807	2,421,814	$ 31,194,652	$ 12,312,683	37.51%
38	7600 NEPHROLOGY		0.357170	303,321	12,782	455,247	10,956	1,515,528	63,736	1,517,672	143,472	315,946	143,472	$ 3,791,768	$ 230,946	42.23%
39	9001 DIAGNOSTIC TREATMENT CTR		0.426985	166,669	118,243	43,021	258,286	117,448	156,250	264,163	488,174	138,438	240,409	$ 591,301	$ 1,020,953	17.30%
40	9004 KANN OP CANCER CENTER		0.330312	20	20,222	142	297,545	213	146,491	382	696,002	244	468,693	$ 757	$ 1,160,260	29.60%
41	9006 WOUND CARE CLINIC		0.233320	25,006	80,880	975	269,340	850	151,023	1,798	621,731	879	412,943	$ 28,629	$ 1,122,974	17.92%
42	9100 EMERGENCY		0.247323	3,002,264	5,282,100	3,484,578	11,660,450	2,353,401	2,191,268	4,253,699	6,183,505	4,192,254	15,618,108	$ 13,093,942	$ 25,317,323	53.33%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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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 DECATUR

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											$ -	$ -	-
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
69				-											$ -	$ -	
70				-											$ -	$ -	
71				-											$ -	$ -	
72				-											$ -	$ -	
73				-											$ -	$ -	
74				-											$ -	$ -	
75				-											$ -	$ -	
76				-											$ -	$ -	
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81				-											$ -	$ -	
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89				-											$ -	$ -	
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99				-											$ -	$ -	
100				-											$ -	$ -	
101				-											$ -	$ -	
102				-											$ -	$ -	
103				-											$ -	$ -	
104				-											$ -	$ -	
105				-											$ -	$ -	
106				-											$ -	$ -	
107				-											$ -	$ -	
108				-											$ -	$ -	
109				-											$ -	$ -	
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119				-											$ -	$ -	
120				-											$ -	$ -	
121				-											$ -	$ -	
122				-											$ -	$ -	
123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 39,959,223	$ 18,653,763	$ 40,676,319	$ 38,378,840	$ 28,397,002	$ 13,056,728	$ 58,070,520	$ 46,903,221	$ 35,890,160	$ 50,429,147			

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

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

		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)***	$ 65,716,340	$ 18,653,763	$ 72,721,994	$ 38,378,840	$ 45,742,984	$ 13,056,728	$ 93,585,099	$ 46,903,221	$ 59,557,720 (Agrees to Exhibit A)	$ 50,429,147 (Agrees to Exhibit A)	$ 277,766,417	$ 116,992,552	37.66%
129	Total Charges per PS&R or Exhibit Detail	$ 65,716,340	$ 18,653,763	$ 72,721,994	$ 38,378,840	$ 45,742,984	$ 13,056,728	$ 93,585,099	$ 46,903,221	$ 59,557,720	$ 50,429,147			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 24,462,080	$ 4,462,247	$ 29,576,894	$ 8,770,257	$ 16,989,213	$ 3,295,253	$ 34,565,731	$ 12,135,560	$ 21,932,886	$ 10,789,951	$ 105,593,918	$ 28,663,317	39.98%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 11,361,974	$ 2,628,045			$ 1,210,987	$ 157,521	$ 261,468	$ 390,105			$ 12,834,429	$ 3,175,671	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 14,286,009	$ 4,036,867			$ 133,235	$ 34,318			$ 14,419,244	$ 4,071,185	
134	Private Insurance (including primary and third party liability)					$ 49,293	$ 8,747	$ 19,533,873	$ 6,943,555			$ 19,583,166	$ 6,952,302	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 172,419	$ 11,104	$ 771	$ 4,099	$ 2,884	$ 1,877	$ 16,066	$ 19,106			$ 192,140	$ 36,186	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 11,534,393	$ 2,639,149	$ 14,286,780	$ 4,040,966									
137	Medicaid Cost Settlement Payments (See Note B)		$ 651,863									$ -	$ 651,863	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 8,464,536	$ 1,950,855	$ 271,538	$ 3,136			$ 8,736,074	$ 1,953,991	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 3,264,814	$ 1,139,680			$ 3,264,814	$ 1,139,680	
141	Medicare Cross-Over Bad Debt Payments					$ 361,723	$ 86,715					$ 361,723	$ 86,715	
142	Other Medicare Cross-Over Payments (See Note D)					$ 340,484	$ 14,991			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 340,484	$ 14,991	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 338,156	$ 1,665,769			
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)**	$ 12,927,687	$ 1,171,235	$ 15,290,114	$ 4,729,291	$ 6,559,306	$ 1,074,547	$ 11,084,737	$ 3,605,660	$ 21,594,730	$ 9,124,182	$ 45,861,844	$ 10,580,733	
146	**Calculated Payments as a Percentage of Cost**	47%	74%	48%	46%	61%	67%	68%	70%	2%	15%	57%	63%	
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)**					42,039								
148	**Percent of cross-over days to total Medicare days from the cost report**					15%								

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

NOTE: 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 DECATUR

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 Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,438.66		215								215	
2	03100 INTENSIVE CARE UNIT	$ 2,946.77		2								2	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	$ 1,500.25		25								25	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 883.47		5								5	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	247		-		-		-		247	
19	Total Days per PS&R or Exhibit Detail			247		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 596,778								$ 596,778	
21.01	Calculated Routine Charge Per Diem			$ 2,416.11		$ -		$ -		$ -		$ 2,416.11	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.782694	14,809	41,991							$ 14,809	$ 41,991
23	5000 OPERATING ROOM		0.218141	63,062	30,127							$ 63,062	$ 30,127
24	5200 DELIVERY ROOM & LABOR ROOM		0.617842	28,115	49							$ 28,115	$ 49
25	5400 RADIOLOGY-DIAGNOSTIC		0.205730	77,236	175,727							$ 77,236	$ 175,727
26	5700 CT SCAN		0.044407	98,198	165,748							$ 98,198	$ 165,748
27	5800 MRI		0.066370	22,916	-							$ 22,916	$ -
28	5900 CARDIAC CATHETERIZATION		0.183186	62,587	343							$ 62,587	$ 343
29	5901 CARDIAC IMAGING		0.158283	55	2,461							$ 55	$ 2,461
30	6000 LABORATORY		0.144622	210,491	264,245							$ 210,491	$ 264,245
31	6500 RESPIRATORY THERAPY		0.246960	20,223	8,059							$ 20,223	$ 8,059
32	6600 PHYSICAL THERAPY		0.309204	21,799	1,196							$ 21,799	$ 1,196
33	6900 ELECTROCARDIOLOGY		0.059752	49,739	50,464							$ 49,739	$ 50,464
34	7000 ELECTROENCEPHALOGRAPHY		0.409508	-	-							$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.571559	13,909	9,464							$ 13,909	$ 9,464
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.702614	22,774	-							$ 22,774	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.306848	161,425	48,129							$ 161,425	$ 48,129
38	7600 NEPHROLOGY		0.357170	20,878	23,738							$ 20,878	$ 23,738
39	9001 DIAGNOSTIC TREATMENT CTR		0.426985	259	7,175							$ 259	$ 7,175
40	9004 KANN OP CANCER CENTER		0.330312	8	19,072							$ 8	$ 19,072
41	9006 WOUND CARE CLINIC		0.233320	14	1,060							$ 14	$ 1,060
42	9100 EMERGENCY		0.247323	154,677	628,909							$ 154,677	$ 628,909
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

				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	
49			-									$ -	$ -
50			-									$ -	$ -
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -

I. Out-of-State Medicaid Data:

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

				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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,043,174	$ 1,477,957	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ 1,639,952	$ 1,477,957	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,639,952	$ 1,477,957
129	Total Charges per PS&R or Exhibit Detail			$ 1,639,952	$ 1,477,957	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ 597,553	$ 320,835	$ -	$ -	$ -	$ -	$ -	$ -	$ 597,553	$ 320,835
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 50,827	$ 56,659							$ 50,827	$ 56,659
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -
134	Private Insurance (including primary and third party liability)											$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)				$ 1,371							$ -	$ 1,371
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 50,827	$ 58,030	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)											$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -
141	Medicare Cross-Over Bad Debt Payments											$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)											$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ 546,726	$ 262,805	$ -	$ -	$ -	$ -	$ -	$ -	$ 546,726	$ 262,805
144	**Calculated Payments as a Percentage of Cost**			9%	18%	0%	0%	0%	0%	0%	0%	9%	18%

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

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

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

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		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 DECATUR

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							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 DECATUR

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 4,494,950		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	40997.00	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here --------->)		$ 4,494,950		
	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*	Provider Tax Expense in Excess of Revenue	$ 1,224,272	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 1,224,272		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 3,270,678
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	397,876,878
19	Uninsured Hospital	**Charges Sec. G**	109,986,867
20	Total Hospital	**Charges Sec. G**	1,348,613,712
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.50%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		8.16%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 964,937
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 266,742
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 1,231,679**

** 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.*