

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:

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

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

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

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

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

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)	\$ 160,740	\$ 439,866	\$600,606
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	\$ 2,569,330	\$ 10,283,699	\$12,853,029
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)	\$2,730,070	\$10,723,565	\$13,453,635
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.89%	4.10%	4.46%

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

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

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) 46,654 (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	10,951,153
8. Outpatient Hospital Charity Care Charges	10,070,984
9. Non-Hospital Charity Care Charges	
10. Total Charity Care Charges	\$ 21,022,137

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	\$121,113,746.00			\$ 85,141,043	\$ -	\$ -	\$ 35,972,703
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	\$260,798,078.00	\$345,618,783.00		\$ 183,336,914	\$ 242,964,525	\$ -	\$ 180,115,423
20. Outpatient Services		\$78,345,563.00			\$ 55,075,689	\$ -	\$ 23,269,874
21. Home Health Agency			\$0.00			\$ -	
22. Ambulance			\$ -			\$ -	
23. Outpatient Rehab Providers			\$0.00	\$ -	\$ -	\$ -	\$ -
24. ASC	\$0.00	\$0.00		\$ -	\$ -	\$ -	\$ -
25. Hospice			\$0.00			\$ -	
26. Other	\$4,040,758.00	\$0.00	\$0.00	\$ 2,840,589	\$ -	\$ -	\$ 1,200,169
27. Total	\$ 385,952,582	\$ 423,964,346	\$ -	\$ 271,318,546	\$ 298,040,213	\$ -	\$ 240,558,169
28. Total Hospital and Non Hospital		Total from Above	\$ 809,916,928	Total from Above	\$ 569,358,759		

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	809,916,928	Total Contractual Adj. (G-3 Line 2)	569,358,759
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Adjusted Contractual Adjustments				569,358,759
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 JOHNS CREEK

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		<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	\$ 58,929,458	\$ -	\$ -	\$ 0.00	\$ 58,929,458	40,576	\$71,716,367.00	\$ 1,452.32
2	03100	INTENSIVE CARE UNIT	\$ 15,489,759	\$ -	\$ -	\$ -	\$ 15,489,759	6,031	\$36,167,981.00	\$ 2,568.36
3	03200	CORONARY CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
4	03300	BURN INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
6	03500	OTHER SPECIAL CARE UNIT	\$ 5,122,999	\$ -	\$ -	\$ -	\$ 5,122,999	2,176	\$13,229,398.00	\$ 2,354.32
7	04000	SUBPROVIDER I	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
8	04100	SUBPROVIDER II	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
9	04200	OTHER SUBPROVIDER	\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
10	04300	NURSERY	\$ 1,119,926	\$ -	\$ -	\$ -	\$ 1,119,926	2,672	\$4,040,758.00	\$ 419.13
11			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -	\$ -	\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 80,662,142	\$ -	\$ -	\$ -	\$ 80,662,142	51,455	\$ 125,154,504	\$ 1,567.62
19		Weighted Average								

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)	4,801	-	\$ 6,972,588	\$80,655.00	\$7,412,370.00	\$ 7,493,025	0.930544

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	\$25,678,834.00	\$ -	\$ -	\$ 25,678,834	\$33,024,020.00	\$88,194,123.00	\$ 121,218,143	0.211840
22	5100	RECOVERY ROOM	\$2,724,600.00	\$ -	\$ -	\$ 2,724,600	\$4,088,371.00	\$10,463,075.00	\$ 14,551,446	0.187239
23	5200	DELIVERY ROOM & LABOR ROOM	\$6,309,402.00	\$ -	\$ -	\$ 6,309,402	\$15,555,408.00	\$50,000.00	\$ 15,605,408	0.404309
24	5300	ANESTHESIOLOGY	\$1,131,421.00	\$ -	\$ -	\$ 1,131,421	\$6,017,663.00	\$15,768,698.00	\$ 21,786,361	0.051933
25	5400	RADIOLOGY-DIAGNOSTIC	\$12,154,100.00	\$ -	\$ -	\$ 12,154,100	\$19,215,216.00	\$53,792,668.00	\$ 73,007,884	0.166477
26	5700	CT SCAN	\$2,777,637.00	\$ -	\$ -	\$ 2,777,637	\$19,133,334.00	\$41,200,902.00	\$ 60,334,236	0.046037
27	5800	MRI	\$2,684,877.00	\$ -	\$ -	\$ 2,684,877	\$7,162,315.00	\$25,938,616.00	\$ 33,100,931	0.081112
28	5900	CARDIAC CATHETERIZATION	\$4,023,049.00	\$ -	\$ -	\$ 4,023,049	\$7,208,630.00	\$10,660,104.00	\$ 17,868,734	0.225145
29	6000	LABORATORY	\$9,289,829.00	\$ -	\$ -	\$ 9,289,829	\$56,237,073.00	\$35,896,217.00	\$ 92,133,290	0.100830
30	6500	RESPIRATORY THERAPY	\$3,783,777.00	\$ -	\$ -	\$ 3,783,777	\$12,732,205.00	\$2,907,388.00	\$ 15,639,593	0.241936

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6600 PHYSICAL THERAPY	\$5,545,025.00	\$ -	\$ -	\$ 5,545,025	\$11,528,785.00	\$8,763,931.00	\$ 20,292,716	0.273252
32	6900 ELECTROCARDIOLOGY	\$909,263.00	\$ -	\$ -	\$ 909,263	\$10,161,427.00	\$5,890,254.00	\$ 16,051,681	0.056646
33	7000 ELECTROENCEPHALOGRAPHY	\$610,107.00	\$ -	\$ -	\$ 610,107	\$242,503.00	\$1,124,558.00	\$ 1,367,061	0.446291
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	\$8,727,649.00	\$ -	\$ -	\$ 8,727,649	\$9,251,655.00	\$11,818,601.00	\$ 21,070,256	0.414217
35	7200 IMPL. DEV. CHARGED TO PATIENTS	\$13,062,509.00	\$ -	\$ -	\$ 13,062,509	\$5,317,714.00	\$10,454,010.00	\$ 15,771,724	0.828223
36	7300 DRUGS CHARGED TO PATIENTS	\$19,683,029.00	\$ -	\$ -	\$ 19,683,029	\$42,241,778.00	\$22,518,710.00	\$ 64,760,488	0.303936
37	7400 RENAL DIALYSIS	\$736,052.00	\$ -	\$ -	\$ 736,052	\$1,679,982.00	\$176,928.00	\$ 1,856,910	0.396385
38	9100 EMERGENCY	\$16,477,836.00	\$ -	\$ -	\$ 16,477,836	\$21,382,640.00	\$49,469,898.00	\$ 70,852,538	0.232565
39		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$ -	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

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

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (if Applicable)	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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	\$ 136,308,996	\$ -	\$ -	\$ 136,308,996	\$ 282,261,374	\$ 402,501,051	\$ 684,762,425	
127	Weighted Average								0.209243
128	Sub Totals	\$ 216,971,138	\$ -	\$ -	\$ 216,971,138	\$ 407,415,878	\$ 402,501,051	\$ 809,916,929	
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				\$ 216,971,138				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					0.00%			

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

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

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

			In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%	
													\$	\$		
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																
98																
99																
100																
101																
102																
103																
104																
105																
106																
107																
108																
109																
110																
111																
112																
113																
114																
115																
116																
117																
118																
119																
120																
121																
122																
123																
124																
125																
126																
127																
			\$ 10,340,436	\$ 4,268,916	\$ 7,228,647	\$ 10,311,788	\$ 8,808,936	\$ 4,897,865	\$ 10,705,332	\$ 9,849,429	\$ 10,658,021	\$ 12,323,064				

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

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

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
Totals / Payments													
128 Total Charges (includes organ acquisition from Section J)	\$ 15,514,347	\$ 4,268,916	\$ 13,031,918	\$ 10,311,788	\$ 12,709,551	\$ 4,897,865	\$ 15,571,512	\$ 9,849,429	\$ 15,083,520	\$ 12,323,064	\$ 56,827,328	\$ 29,327,998	14.20%
									(Agrees to Exhibit A)	(Agrees to Exhibit A)			
129 Total Charges per PS&R or Exhibit Detail	\$ 15,514,347	\$ 4,268,916	\$ 13,031,918	\$ 10,311,788	\$ 12,709,551	\$ 4,897,865	\$ 15,571,512	\$ 9,849,429	\$ 15,083,520	\$ 12,323,064			
130 Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 5,329,719	\$ 933,079	\$ 4,824,149	\$ 2,177,970	\$ 4,011,331	\$ 1,084,131	\$ 5,149,978	\$ 2,112,636	\$ 4,939,844	\$ 2,492,715	\$ 19,315,177	\$ 6,307,816	15.41%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 3,207,337	\$ 650,963									\$ 3,207,337	\$ 650,963	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			\$ 2,571,626	\$ 1,368,156							\$ 2,571,626	\$ 1,368,156	
134 Private Insurance (including primary and third party liability)	\$ 167,393	\$ 6,352					\$ 3,943,593	\$ 1,945,034			\$ 4,110,986	\$ 1,951,386	
135 Self-Pay (including Co-Pay and Spend-Down)				\$ 1,895	\$ 10		\$ 10	\$ 1,675			\$ 20	\$ 3,570	
136 Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 3,374,730	\$ 657,315	\$ 2,571,626	\$ 1,370,051									
137 Medicaid Cost Settlement Payments (See Note B)		\$ 113,780									\$ -	\$ 113,780	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)											\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 2,635,343	\$ 752,365					\$ 2,635,343	\$ 752,365	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											\$ -	\$ -	
141 Medicare Cross-Over Bad Debt Payments					\$ 22,849	\$ 34,032					\$ 22,849	\$ 34,032	
142 Other Medicare Cross-Over Payments (See Note D)									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									\$ 160,740	\$ 439,866			
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)	\$ 1,954,989	\$ 161,984	\$ 2,252,523	\$ 807,919	\$ 1,353,129	\$ 297,734	\$ 1,206,375	\$ 165,927	\$ 4,779,104	\$ 2,052,849	\$ 6,767,016	\$ 1,433,564	
146 Calculated Payments as a Percentage of Cost	63%	83%	53%	63%	66%	73%	77%	92%	3%	18%	65%	77%	
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)					20,554								
148 Percent of cross-over days to total Medicare days from the cost report					7%								

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.

I. Out-of-State Medicaid Data:

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

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 PS&R Summary (Note A)	From PS&R Summary (Note A)
		From Section G	From Section G										
Routine Cost Centers (list below):				Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	\$ 1,452.32			63			1		8		72	
2	03100 INTENSIVE CARE UNIT	\$ 2,568.36			1					3		4	
3	03200 CORONARY CARE UNIT	\$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	\$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	\$ -										-	
6	03500 OTHER SPECIAL CARE UNIT	\$ 2,354.32			7							7	
7	04000 SUBPROVIDER I	\$ -										-	
8	04100 SUBPROVIDER II	\$ -										-	
9	04200 OTHER SUBPROVIDER	\$ -										-	
10	04300 NURSERY	\$ 419.13			5							5	
11		\$ -										-	
12		\$ -										-	
13		\$ -										-	
14		\$ -										-	
15		\$ -										-	
16		\$ -										-	
17		\$ -										-	
18		\$ -										-	
					Total Days							88	
19	Total Days per PS&R or Exhibit Detail				76			1		11			
20	Unreconciled Days (Explain Variance)				-			-		-			
21				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21.01				\$ 175,375		\$ -		\$ 1,807.00		\$ 37,607		\$ 214,789	
				Calculated Routine Charge Per Diem	\$ 2,307.57			\$ 1,807.00		\$ 3,418.82		\$ 2,440.78	
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)		0.930544	62	18,823				1,368		3,724	62	23,915
23	5000 OPERATING ROOM		0.211840	15,162	65,052						62,634	15,162	127,686
24	5100 RECOVERY ROOM		0.187239	2,046	4,983						6,204	2,046	11,187
25	5200 DELIVERY ROOM & LABOR ROOM		0.404309	26,820								26,820	
26	5300 ANESTHESIOLOGY		0.051933	1,872	12,921						12,702	1,872	25,623
27	5400 RADIOLOGY-DIAGNOSTIC		0.166477	16,829	53,580		1,788	10,237	846	9,337		19,463	73,154
28	5700 CT SCAN		0.046037	21,152	82,586		4,947	6,537	8,814	3,582		34,913	92,705
29	5800 MRI		0.081112		12,216		2,296	11,436		3,812		2,296	25,948
30	5900 CARDIAC CATHETERIZATION		0.225145										
31	6000 LABORATORY		0.100830	83,293	75,501		2,292	12,031	14,708	7,948		100,293	95,480
32	6500 RESPIRATORY THERAPY		0.241936	15,135	2,824							15,135	2,824
33	6600 PHYSICAL THERAPY		0.273252	12,374	775		2,512	8,287	9,701	5,351		24,587	14,413
34	6900 ELECTROCARDIOLOGY		0.056646	34,477	5,487		4,636	4,867	3,395	3,749		42,508	14,103
35	7000 ELECTROENCEPHALOGRAPHY		0.446291		1,794								1,794
36	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.414217	5,298	8,336					2,441		5,298	10,777
37	7200 IMPL. DEV. CHARGED TO PATIENTS		0.828223	1,586	11,042					6,976		1,586	18,018
38	7300 DRUGS CHARGED TO PATIENTS		0.303936	47,207	73,127		1,989	2,371	12,276	3,706		61,472	79,204
39	7400 RENAL DIALYSIS		0.396385	1,826				1,826				1,826	1,826
40	9100 EMERGENCY		0.232565	21,471	185,949		2,228	13,013	8,405	11,227		32,104	210,189
41													
42													
43													
44													
45													
46													
47													
48													

I. Out-of-State Medicaid Data:

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

		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
112										\$ -	\$ -
113										\$ -	\$ -
114										\$ -	\$ -
115										\$ -	\$ -
116										\$ -	\$ -
117										\$ -	\$ -
118										\$ -	\$ -
119										\$ -	\$ -
120										\$ -	\$ -
121										\$ -	\$ -
122										\$ -	\$ -
123										\$ -	\$ -
124										\$ -	\$ -
125										\$ -	\$ -
126										\$ -	\$ -
127										\$ -	\$ -
		\$ 306,610	\$ 614,996	\$ -	\$ -	\$ 22,688	\$ 71,973	\$ 61,957	\$ 141,877		
Totals / Payments											
128	Total Charges (includes organ acquisition from Section K)	\$ 481,985	\$ 614,996	\$ -	\$ -	\$ 24,495	\$ 71,973	\$ 99,564	\$ 141,877	\$ 606,044	\$ 828,846
129	Total Charges per PS&R or Exhibit Detail	\$ 481,985	\$ 614,996	\$ -	\$ -	\$ 24,495	\$ 71,973	\$ 99,564	\$ 141,877		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	Total Calculated Cost (includes organ acquisition from Section K)	\$ 171,977	\$ 134,302	\$ -	\$ -	\$ 4,467	\$ 12,430	\$ 30,191	\$ 33,463	\$ 206,635	\$ 180,195
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 22,290	\$ 9,316							\$ 22,290	\$ 9,316
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)							\$ 20,008	\$ 26,391	\$ 20,008	\$ 26,391
135	Self-Pay (including Co-Pay and Spend-Down)									\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ 22,290	\$ 9,316	\$ -	\$ -						
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)					\$ 6,374	\$ 8,794			\$ 6,374	\$ 8,794
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)	\$ 149,687	\$ 124,986	\$ -	\$ -	\$ (1,907)	\$ 3,636	\$ 10,183	\$ 7,072	\$ 157,963	\$ 135,694
144	Calculated Payments as a Percentage of Cost	13%	7%	0%	0%	143%	71%	66%	79%	24%	25%

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 JOHNS CREEK

	Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-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)
						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	\$ -	\$ -											
2	Kidney Acquisition	\$0.00	\$ -	\$ -											
3	Liver Acquisition	\$0.00	\$ -	\$ -											
4	Heart Acquisition	\$0.00	\$ -	\$ -											
5	Pancreas Acquisition	\$0.00	\$ -	\$ -											
6	Intestinal Acquisition	\$0.00	\$ -	\$ -											
7	Islet Acquisition	\$0.00	\$ -	\$ -											
8		\$0.00	\$ -	\$ -											
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 JOHNS CREEK

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

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 2,794,800	
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)	\$ 2,794,800	5.00 (Where is the cost included on w/s A?)
3 Difference (Explain Here ----->)	\$ -	
Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)		
4 Reclassification Code		(Reclassified to / (from))
5 Reclassification Code		(Reclassified to / (from))
6 Reclassification Code		(Reclassified to / (from))
7 Reclassification Code		(Reclassified to / (from))
DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)		
8 Reason for adjustment	\$ (2,061,560)	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	\$ 733,240	

DSH UCC Provider Tax Assessment Adjustment:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 2,061,560
Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:	
18 Medicaid Hospital Charges Sec. G	87,590,216
19 Uninsured Hospital Charges Sec. G	27,406,584
20 Total Hospital Charges Sec. G	809,916,929
21 Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC	10.81%
22 Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC	3.38%
23 Medicaid Provider Tax Assessment Adjustment to DSH UCC	\$ 222,952
24 Uninsured Provider Tax Assessment Adjustment to DSH UCC	\$ 69,761
25 Provider Tax Assessment Adjustment to DSH UCC	\$ 292,713

* 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.