State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2025

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2024	06/30/2025

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)	
3. Cost Report Year 1	01/01/2023	12/31/2023	Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES
4. Cost Report Year 2 (if applicable)			
5. Cost Report Year 3 (if applicable)			

	Data
6. Medicaid Provider Number:	000000855A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110079

B. DSH Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:	DSH Examination Year (07/01/24 - 06/30/25)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	06/02/1892

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2024 - 06/30/2025** — $91,061,021
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2024 - 06/30/2025**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2024 - 06/30/2025** — $ 91,061,021

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	COO/CFO Title	11-21-24 Date
Anthony Saul Hospital CEO or CFO Printed Name	404-616-1767 Hospital CEO or CFO Telephone Number	asaul@gmh.edu Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Felicia Wofford
Title	Executive Director of Reimbursement
Telephone Number	404-616-0606
E-Mail Address	fasims@gmh.edu
Mailing Street Address	80 Jesse Hill Jr. Dr.
Mailing City, State, Zip	Atlanta, GA 30303

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

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D. General Cost Report Year Information 1/1/2023 - 12/31/2023

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: GRADY MEMORIAL HOSPITAL

	1/1/2023 through 12/31/2023		
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:	6/6/2024		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	GRADY MEMORIAL HOSPITAL		
5. Medicaid Provider Number:	000000855A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110079		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		

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	ALABAMA	1992799050
10. State Name & Number	ARKANSAS	206845105
11. State Name & Number	CONNECTICUT	1992799050
12. State Name & Number	DELAWARE	1992799050
13. State Name & Number	FLORIDA	913008000
14. State Name & Number	HAWAII	1992799050
15. State Name & Number	ILLINOIS	262037695-001

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2023 - 12/31/2023)

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)	$ 820,291	$ 2,523,671	$3,343,962
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,489,445	$ 3,068,267	$4,557,712
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)	$2,309,736	$5,591,938	$7,901,674
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	35.51%	45.13%	42.32%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** Yes
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	$ 294,523,796
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	$294,523,796

<--These payments do NOT flow to Section H, and therefore do not impact the UCC. If these payments are not already considered in the UCC and should be, include the amount reported here on line 133 of Section H.

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 (01/01/2023 - 12/31/2023)

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)	259,253 **(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	63,010,403
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 63,010,403
7.	Inpatient Hospital Charity Care Charges	258,981,614
8.	Outpatient Hospital Charity Care Charges	444,543,228
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 703,524,842

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	$1,044,577,516.00			$ 893,416,898	$ -	$ -	$ 151,160,618
12.	Subprovider I (Psych or Rehab)	$22,211,883.00			$ 18,997,606	$ -	$ -	$ 3,214,277
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$47,992,836.00			$ 28,772,336	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$3,954,165,823.00	$2,454,059,381.00		$ 3,381,959,221	$ 2,098,932,904	$ -	$ 927,333,079
20.	Outpatient Services		$318,382,695.00			$ 272,309,594	$ -	$ 46,073,101
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 227,608,818	-	-	$ 181,980,870	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$592,430,385.00	$ -	$ -	$ 367,208,687	$ -
27.	Total	$ 5,020,955,222	$ 2,772,442,076	$ 868,032,039	$ 4,294,373,725	$ 2,371,242,498	$ 577,961,893	$ 1,127,781,075
28.	Total Hospital and Non Hospital		Total from Above	$ 8,661,429,337		Total from Above	$ 7,243,578,116	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	8,661,429,337	Total Contractual Adj. (G-3 Line 2)	7,243,578,116
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.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
36.	Adjusted Contractual Adjustments				7,243,578,116
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2023-12/31/2023) | GRADY MEMORIAL HOSPITAL

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	$ 178,175,035	$ 47,666,254	$ 1,415,550	$0.00	$ 227,256,839	171,895	$472,708,272.00		$ 1,322.07
2	03100 INTENSIVE CARE UNIT	$ 104,881,314	$ 9,255,005	$ -		$ 114,136,319	49,903	$325,109,770.00		$ 2,287.16
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 55,448,175	$ 3,108,824	$ 129,496		$ 58,686,495	16,762	$177,631,827.00		$ 3,501.16
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ 22,377,245	$ 131,023	$ 59,660		$ 22,567,928	7,533	$22,211,883.00		$ 2,995.88
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 9,056,210	$ 1,141,093	$ -		$ 10,197,303	6,156	$8,680,312.00		$ 1,656.48
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 27,803,259	$ 2,303,626	$ 39,378		$ 30,146,263	12,418	$64,397,542.00		$ 2,427.63
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 397,741,238	$ 63,605,825	$ 1,644,084	$ -	$ 462,991,147	264,667	$ 1,070,739,606		
19	Weighted Average									$ 1,749.34

Line #			*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*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	5,414	-	-	$ 7,157,687	$4,006,926.00	$14,305,705.00	$ 18,312,631	0.390861

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	$95,859,280.00	$ 6,434,432	$ 547,097		$ 102,840,809	$1,096,391,060.00	$396,179,842.00	$ 1,492,570,902	0.068902
22	5200	DELIVERY ROOM & LABOR ROOM	$24,558,694.00	$ 986,248	$ -		$ 25,544,942	$78,203,530.00	$12,428,156.00	$ 90,631,686	0.281854
23	5300	ANESTHESIOLOGY	$10,333,802.00	$ 4,045,045	$ 143,898		$ 14,522,745	$201,536,924.00	$80,360,518.00	$ 281,897,442	0.051518
24	5400	RADIOLOGY-DIAGNOSTIC	$37,980,771.00	$ 5,653,057	$ 63,284		$ 43,697,112	$149,730,047.00	$153,149,337.00	$ 302,879,384	0.144272
25	5600	RADIOISOTOPE	$9,254,592.00	$ 135,787	$ 28,493		$ 9,418,872	$43,572,040.00	$102,194,173.00	$ 145,766,213	0.064616
26	5700	CT SCAN	$10,024,058.00	$ 745,641	$ 153,015		$ 10,922,714	$442,998,188.00	$360,309,137.00	$ 803,307,325	0.013597
27	5800	MRI	$5,720,423.00	$ 97,671	$ 20,170		$ 5,838,264	$57,536,966.00	$48,756,275.00	$ 106,293,241	0.054926
28	6000	LABORATORY	$59,335,949.00	$ 1,948,672	$ 216,448		$ 61,501,069	$466,025,432.00	$403,944,634.00	$ 869,970,066	0.070693
29	6001	LABORATORY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
30	6200	WHOLE BLOOD & PACKED RED BLOOD CELL	$13,014,133.00	$ -	$ -		$ 13,014,133	$83,518,880.00	$30,240,933.00	$ 113,759,813	0.114400

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
31	6500	RESPIRATORY THERAPY	$25,286,637.00	$ -	$ -		$ 25,286,637	$294,416,765.00	$14,313,200.00	$ 308,729,965	0.081905
32	6501	RESPIRATORY THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
33	6600	PHYSICAL THERAPY	$19,334,175.00	$ 474,066	$ 43,143		$ 19,851,384	$81,957,843.00	$29,718,546.00	$ 111,676,389	0.177758
34	6601	PHYSICAL THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
35	6900	ELECTROCARDIOLOGY	$6,435,270.00	$ -	$ -		$ 6,435,270	$117,314,476.00	$48,450,453.00	$ 165,764,929	0.038822
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$44,935,282.00	$ -	$ -		$ 44,935,282	$90,271,846.00	$20,927,028.00	$ 111,198,874	0.404098
37	7101	MEDICAL SUPPLIES CHARGED CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
38	7200	IMPL. DEV. CHARGED TO PATIENTS	$37,809,530.00	$ -	$ -		$ 37,809,530	$57,743,237.00	$12,793,203.00	$ 70,536,440	0.536028
39	7300	DRUGS CHARGED TO PATIENTS	$94,302,695.00	$ -	$ -		$ 94,302,695	$228,652,233.00	$206,791,284.00	$ 435,443,517	0.216567
40	7301	DRUGS CHARGED TO PATIENTS-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41	7302	OUTPATIENT PHARMACY	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42	7400	RENAL DIALYSIS	$8,503,920.00	$ -	$ -		$ 8,503,920	$21,028,384.00	$32,424,834.00	$ 53,453,218	0.159091
43	7601	PULMONARY FUNCTION TESTING	$1,244,986.00	$ -	$ 253,406		$ 1,498,392	$5,123,133.00	$13,533,710.00	$ 18,656,843	0.080313
44	7602	CARDIOVASCULAR LAB	$10,014,319.00	$ 1,257,823	$ 412,234		$ 11,684,376	$26,973,054.00	$9,383,169.00	$ 36,356,223	0.321386
45	9000	CLINIC	$144,722,146.00	$ 11,751,593	$ 520,808		$ 156,994,547	$44,273,391.00	$286,077,913.00	$ 330,351,304	0.475235
46	9001	SATELLITE CLINICS	$44,218,549.00	$ -	$ -		$ 44,218,549	$177,638.00	$56,877,023.00	$ 57,054,661	0.775021
47	9100	EMERGENCY	$109,595,156.00	$ 9,748,128	$ 1,114,122		$ 120,457,406	$380,356,915.00	$651,290,247.00	$ 1,031,647,162	0.116762
48	9201	OBSERVATION BEDS (DISTINCT PART)	$6,623,104.00	$ -	$ -		$ 6,623,104	$2,859,146.00	$19,951,456.00	$ 22,810,602	0.290352
49		HUGHES SPALDING COST-SEE SUPPORT	($57,626,256.00)	$ -	$ -		$ (57,626,256)	$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 (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
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**	$ 761,481,215	$ 43,278,163	$ 3,516,118		$ 808,275,496	$ 3,974,668,054	$ 3,004,400,776	$ 6,979,068,830	
127		**Weighted Average**									0.125097
128		**Sub Totals**	$ 1,159,222,453	$ 106,883,988	$ 5,160,202		$ 1,271,266,643	$ 5,045,407,660	$ 3,004,400,776	$ 8,049,808,436	
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)*					$134,373.00				
131		NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01		Other Cost Adjustments (support must be submitted)									
132		**Grand Total**					$ 1,271,132,270				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					9.18%				

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

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

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	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 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**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,322.07		29,347		8,852		4,545		36,000		132		31,830		78,876		68.20%
2	03100 INTENSIVE CARE UNIT	$ 2,287.16		8,955		1,096		1,360		10,728		6		8,344		22,145		62.25%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,501.16		819		1,469		279		3,914		52		4,731		6,533		69.11%
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ 2,995.88														-		0.00%
8	04100 SUBPROVIDER II	$ -														-		
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 1,656.48		1,539		3,693				496				107		5,728		95.09%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,427.63		3,047		7,383				1,159				96		11,589		94.63%
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	43,707		22,493		6,184		52,297		190		45,108		124,871		65.67%
19	Total Days per PS&R or Exhibit Detail			43,707		22,493		6,184		52,297		190		45,108				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 158,146,972		$ 92,600,001		$ 24,250,771		$ 206,565,287		$ 811,806		$ 180,209,148		$ 481,563,031		63.15%
21.01	Calculated Routine Charge Per Diem			$ 3,618.34		$ 4,116.84		$ 3,921.53		$ 3,949.85		$ 4,272.66		$ 3,995.06		$ 3,856.48		
	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**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.390861	659,045	737,437	67,650	236,556	236,550	350,700	973,914	3,294,255			359,850	2,058,732	$ 1,937,159	$ 4,618,948	50.27%
23	5000 OPERATING ROOM		0.068902	106,280,158	30,518,329	66,503,885	22,236,260	12,358,485	10,755,653	151,115,747	45,879,385	150,932	81,390	289,313,740	120,983,756	$ 336,258,274	$ 109,389,628	
24	5200 DELIVERY ROOM & LABOR ROOM		0.281854	15,616,227	1,363,705	40,932,742	5,798,007	319,288	58,512	10,320,673	1,183,643	-	-	2,937,448	2,166,667	$ 67,188,930	$ 8,403,866	
25	5300 ANESTHESIOLOGY		0.051518	22,327,190	6,231,325	22,226,775	4,380,434	2,211,094	2,158,949	28,794,761	10,238,266	23,410	11,021	46,500,053	24,017,395	$ 75,559,820	$ 23,008,974	
26	5400 RADIOLOGY-DIAGNOSTIC		0.144272	17,079,286	10,014,057	8,248,228	9,962,617	2,757,662	3,214,446	24,951,273	16,459,311	57,410	-	28,910,907	42,550,044	$ 53,036,449	$ 39,650,431	11.20%
27	5600 RADIOISOTOPE		0.064616	6,143,618	12,181,422	2,452,577	4,921,073	1,098,228	5,148,813	7,851,888	24,552,219	-	-	9,252,398	21,958,491	$ 17,546,311	$ 46,803,527	106.29%
28	5700 CT SCAN		0.013597	46,627,718	25,396,694	18,957,675	22,423,726	9,473,787	10,076,475	77,781,027	42,519,214	167,345	-	94,403,627	115,581,834	$ 152,840,207	$ 100,416,109	167.18%
29	5800 MRI		0.054926	7,715,638	4,901,096	2,222,826	2,163,221	1,218,716	1,885,515	10,685,482	8,154,758	5,561	-	11,367,381	13,801,113	$ 21,842,663	$ 17,104,590	21.43%
30	6000 LABORATORY		0.070693	69,248,294	44,126,565	26,675,184	36,763,273	12,035,137	9,496,001	93,794,540	47,280,536	210,000	1,331	87,416,310	122,874,290	$ 201,753,155	$ 137,668,374	383.15%
31	6001 LABORATORY-CRESTVIEW		-													$ -	$ -	0.00%
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.114400	13,247,740	6,098,425	9,230,650	2,408,611	1,776,101	651,466	16,129,781	4,022,339	28,159	1,593	21,448,287	4,188,841	$ 40,384,271	$ 13,180,841	75.77%
33	6500 RESPIRATORY THERAPY		0.081905	50,126,918	218,277	22,233,396	83,775	8,027,559	77,185	60,494,675	507,290	293,125		42,151,230	925,374	$ 140,882,548	$ 886,527	21.69%
34	6501 RESPIRATORY THERAPY-CRESTVIEW		-													$ -	$ -	
35	6600 PHYSICAL THERAPY		0.177758	10,120,737	2,594,245	5,016,896	1,128,147	1,323,537	1,018,757	15,538,472	3,554,412	53,161		13,602,643	9,927,792	$ 31,999,642	$ 8,295,561	57.07%
36	6601 PHYSICAL THERAPY-CRESTVIEW		-													$ -	$ -	0.00%
37	6900 ELECTROCARDIOLOGY		0.038822	16,264,759	4,296,573	3,729,057	2,391,781	3,865,044	1,762,297	25,058,004	7,820,310	80,256		19,076,948	13,224,982	$ 48,916,864	$ 16,270,961	
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.404098	12,330,352	1,323,476	5,434,098	612,906	1,750,404	585,501	15,316,765	2,554,964	39,004	2,471	16,924,490	4,433,920	$ 34,831,619	$ 5,076,847	56.05%
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-													$ -	$ -	
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.536028	5,692,445	1,006,895	2,868,298	584,222	342,230	416,658	9,392,144	2,102,107	4,280		13,937,304	3,223,781	$ 18,295,117	$ 4,109,881	24.23%
41	7300 DRUGS CHARGED TO PATIENTS		0.216567	37,308,169	25,065,037	12,675,480	14,171,435	6,294,048	12,588,150	44,622,065	46,189,710	131,623	797	43,218,267	23,590,254	$ 100,899,762	$ 98,014,332	243.33%
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-													$ -	$ -	
43	7302 OUTPATIENT PHARMACY		-													$ -	$ -	0.00%
44	7400 RENAL DIALYSIS		0.159091	3,492,323	2,059,446	268,458	762,340	981,120	414,813	7,276,445	875,051			2,001,152	22,269,221	$ 12,018,346	$ 4,111,650	9.48%
45	7601 PULMONARY FUNCTION TESTING		0.080313	1,063,128	1,585,354	149,722	450,640	206,379	745,400	1,081,958	3,355,270			998,704	2,706,949	$ 2,501,187	$ 6,136,664	
46	7602 CARDIOVASCULAR LAB		0.321386	3,842,749	673,307	470,747	143,038	122,724	208,631	5,411,009	2,338,722			6,030,373	1,936,112	$ 9,847,229	$ 3,363,698	
47	9000 CLINIC		0.475235	8,633,517	31,091,021	2,956,518	22,711,059	1,140,817	7,485,885	8,870,009	44,327,987	40,206		6,826,236	60,874,003	$ 21,600,861	$ 105,615,952	369.48%
48	9001 SATELLITE CLINICS		0.775021	43,990	4,722,761	37,367	4,753,130	5,759	1,280,705	36,326	6,240,956			9,304	17,969,125	$ 123,442	$ 16,997,552	188.61%
49	9100 EMERGENCY		0.116762	38,384,686	41,733,098	19,477,818	39,112,366	7,494,298	12,196,891	63,745,605	49,429,298	86,663		90,000,937	193,300,985	$ 129,102,406	$ 142,471,654	1558.61%
50	9201 OBSERVATION BEDS (DISTINCT PART)		0.290352	419,371	1,156,976	65,850	651,150	79,950	369,573	526,782	1,784,310			342,303	5,662,425	$ 1,091,953	$ 3,962,009	3.42%
51	HUGHES SPALDING COST-SEE SUPPORT		-													$ -	$ -	0.00%
52			-													$ -	$ -	0.00%
53			-													$ -	$ -	0.00%
54			-													$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
71				-													$ -	$ -	
72				-													$ -	$ -	
73				-													$ -	$ -	
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126				-													$ -	$ -	
127				-													$ -	$ -	
					$ 492,668,057	$ 259,097,519	$ 272,901,896	$ 198,849,766	$ 75,118,919	$ 82,946,975	$ 679,769,343	$ 374,664,314	$ 1,371,135	$ 98,603	$ 847,029,891	$ 830,226,086			

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

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 650,815,029	$ 259,097,519	$ 365,501,897	$ 198,849,766	$ 99,369,690	$ 82,946,975	$ 886,334,630	$ 374,664,314	$ 2,182,941	$ 98,603	$ 1,027,239,039 (Agrees to Exhibit A)	$ 830,226,086 (Agrees to Exhibit A)	$ 2,002,021,245	$ 915,558,575	60.37%
129	Total Charges per PS&R or Exhibit Detail	$ 650,815,029	$ 259,097,519	$ 365,501,897	$ 198,849,766	$ 99,369,690	$ 82,946,975	$ 886,334,630	$ 374,664,314	$ 2,182,941	$ 98,603	$ 1,027,239,039	$ 830,226,086			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 128,822,545	$ 41,224,550	$ 78,623,845	$ 31,904,278	$ 17,916,277	$ 12,505,154	$ 163,282,997	$ 60,591,859	$ 523,193	$ 7,623	$ 163,225,141	$ 112,476,815	$ 388,645,664	$ 146,225,841	64.92%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 84,987,764	$ 31,441,900		$ 3,436	$ 89,050	$ 1,297,489	$ 70,499	$ 2,758,058					$ 85,147,313	$ 35,500,883	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 53,488,228	$ 23,096,002		$ 943	$ 1,282,289	$ 623,274					$ 54,770,517	$ 23,720,219	
134	Private Insurance (including primary and third party liability)	$ 1,046,120	$ 256,784	$ 272,438	$ 59,872		$ 730	$ 65,982,368	$ 9,405,922					$ 67,300,927	$ 9,723,308	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 7,092	$ 23,808	$ 2,043	$ 12,233			$ 370,530	$ 29,024					$ 379,665	$ 65,065	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 86,040,976	$ 31,722,492	$ 53,762,709	$ 23,171,544											
137	Medicaid Cost Settlement Payments (See Note B)		$ (1,773,124)											$ -	$ (1,773,124)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)													$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)					$ 20,336,697	$ 7,009,774	$ 31,973,447	$ 2,713,647					$ 52,310,143	$ 9,723,421	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 72,587		$ 61,420,640	$ 22,140,968					$ 61,493,227	$ 22,140,968	
141	Medicare Cross-Over Bad Debt Payments					$ 1,563,984	$ 727,208							$ 1,563,984	$ 727,208	
142	Other Medicare Cross-Over Payments (See Note D)					$ 2,689,263		$ 1,740,059	$ 1,095,529			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 4,429,322	$ 1,095,529	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 820,291	$ 2,523,671			
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)**	$ 42,781,569	$ 11,275,181	$ 24,861,136	$ 8,732,734	$ (6,835,304)	$ 3,469,010	$ 443,165	$ 21,825,437	$ 523,193	$ 7,623	$ 162,404,850	$ 109,953,144	$ 61,250,566	$ 45,302,363	
146	**Calculated Payments as a Percentage of Cost**	67%	73%	68%	73%	138%	72%	100%	64%	0%	0%	1%	2%	84%	69%	
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)**					81,277										
148	**Percent of cross-over days to total Medicare days from the cost report**					8%										

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 F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		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	$ 1,322.07		1,821		14		114		888		2,837	
2	03100 INTENSIVE CARE UNIT	$ 2,287.16		334				28		216		578	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -								-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,501.16		136				13		172		321	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ 2,995.88										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,656.48		18						1		19	
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,427.63		64						2		66	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	2,373		14		155		1,279		3,821	
19	Total Days per PS&R or Exhibit Detail			2,373		14		155		1,279			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 8,521,205		$ 37,674		$ 565,583		$ 5,312,905		$ 14,437,367	
21.01	Calculated Routine Charge Per Diem			$ 3,590.90		$ 2,691.00		$ 3,648.92		$ 4,153.95		$ 3,778.43	
	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)		0.390861	25,950	148,389					26,250	31,350	$ 52,200	$ 179,739
23	5000 OPERATING ROOM		0.068902	10,757,242	1,062,111	-		442,417	-	3,198,698	526,298	$ 14,398,357	$ 1,588,409
24	5200 DELIVERY ROOM & LABOR ROOM		0.281854	399,885	117,163	-		-	-	224,193	17,200	$ 624,078	$ 134,363
25	5300 ANESTHESIOLOGY		0.051518	1,782,962	220,063	-		96,282	-	540,666	75,977	$ 2,419,910	$ 296,040
26	5400 RADIOLOGY-DIAGNOSTIC		0.144272	1,137,645	704,239	4,092		244,238	9,294	603,842	296,092	$ 1,989,817	$ 1,009,625
27	5600 RADIOISOTOPE		0.064616	286,043	357,725	-		17,918	-	103,053	8,191	$ 407,014	$ 365,916
28	5700 CT SCAN		0.013597	3,122,327	1,845,115	21,636		185,949	3,998	1,800,141	892,670	$ 5,130,053	$ 2,741,783
29	5800 MRI		0.054926	350,662	95,398	5,792		9,582	6,121	289,167	26,533	$ 655,203	$ 128,052
30	6000 LABORATORY		0.070693	3,338,540	1,910,607	17,083		252,633	19,091	2,233,743	802,620	$ 5,841,998	$ 2,732,318
31	6001 LABORATORY-CRESTVIEW		-									$ -	$ -
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.114400	725,608	53,985			63,848		369,903	87,823	$ 1,159,359	$ 141,808
33	6500 RESPIRATORY THERAPY		0.081905	1,308,865	3,426			187,046	-	2,030,806	-	$ 3,526,717	$ 3,426
34	6501 RESPIRATORY THERAPY-CRESTVIEW		-									$ -	$ -
35	6600 PHYSICAL THERAPY		0.177758	579,393	91,332	5,839		61,921	6,035	281,018	20,898	$ 928,171	$ 118,265
36	6601 PHYSICAL THERAPY-CRESTVIEW		-									$ -	$ -
37	6900 ELECTROCARDIOLOGY		0.038822	644,103	234,693	5,577		92,728	2,428	476,014	107,700	$ 1,218,422	$ 344,821
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.404098	631,272	77,059			39,987	202	526,592	14,628	$ 1,197,850	$ 91,889
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-									$ -	$ -
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.536028	396,512	57,320			3,784		128,589	7,023	$ 528,885	$ 64,343
41	7300 DRUGS CHARGED TO PATIENTS		0.216567	2,127,587	405,264	3,279		148,529	663	1,836,415	201,442	$ 4,115,810	$ 607,369
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-									$ -	$ -
43	7302 OUTPATIENT PHARMACY		-									$ -	$ -
44	7400 RENAL DIALYSIS		0.159091	777,238	82,122					25,970	4,420	$ 803,208	$ 86,542
45	7601 PULMONARY FUNCTION TESTING		0.080313	9,836	18,207				-	50,757	-	$ 60,593	$ 18,207
46	7602 CARDIOVASCULAR LAB		0.321386	121,225	24,713				-	26,329	-	$ 147,554	$ 24,713
47	9000 CLINIC		0.475235	566,613	1,027,132	3,443		7,963	3,925	430,209	502,875	$ 1,008,228	$ 1,533,932
48	9001 SATELLITE CLINICS		0.775021	-	68,454			-	384	-	19,662	$ -	$ 88,500

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
49	9100	EMERGENCY		0.116762	3,050,879	4,571,016	26,890		156,051	34,222	1,528,087	2,322,236	$ 4,761,907	$ 6,927,474
50	9201	OBSERVATION BEDS (DISTINCT PART)		0.290352	22,350	135,750			1,200	1,200	6,300	83,850	$ 29,850	$ 220,800
51		HUGHES SPALDING COST-SEE SUPPORT		-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
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I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2023-12/31/2023) GRADY MEMORIAL HOSPITAL

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)		Total Out-Of-State Medicaid	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 32,162,737	$ 13,311,283	$ 93,631	$ -	$ 2,012,076	$ 87,563	$ 16,736,741	$ 6,049,488		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 40,683,942	$ 13,311,283	$ 131,305	$ -	$ 2,577,659	$ 87,563	$ 22,049,646	$ 6,049,488	$ 65,442,552	$ 19,448,334
129	Total Charges per PS&R or Exhibit Detail	$ 40,683,942	$ 13,311,283	$ 131,305	$ -	$ 2,577,659	$ 87,563	$ 22,049,646	$ 6,049,488		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 7,310,989	$ 1,783,874	$ 27,660	$ -	$ 462,962	$ 10,980	$ 4,248,366	$ 792,525	$ 12,049,977	$ 2,587,379
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 646,330	$ 196,840			$ 32,800	$ 2,608		$ 4,665	$ 679,130	$ 204,113
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 14,645				$ 163,368	$ 11,181	$ 178,013	$ 11,181
134	Private Insurance (including primary and third party liability)		$ 2,092				$ 9,509	$ 2,935,244	$ 686,254	$ 2,935,244	$ 697,855
135	Self-Pay (including Co-Pay and Spend-Down)		$ 290				$ 187		$ 218	$ -	$ 695
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 646,330	$ 199,222	$ 14,645	$ -						
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) (See Note F)					$ 373,897	$ 6,900	$ 605,919	$ 35,344	$ 979,816	$ 42,244
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)		$ 2,310					$ 586,991	$ 7,815	$ 586,991	$ 7,815
141	Medicare Cross-Over Bad Debt Payments									$ -	#REF!
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 6,664,659	$ 1,584,652	$ 13,015	$ -	$ 56,265	$ (8,224)	$ (43,156)	$ 47,048	$ 6,690,784	#REF!
144	**Calculated Payments as a Percentage of Cost**	9%	11%	53%	0%	88%	175%	101%	94%	44%	#REF!

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 (01/01/2023-12/31/2023) | GRADY MEMORIAL HOSPITAL

		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 & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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 (01/01/2023-12/31/2023) | GRADY MEMORIAL HOSPITAL

		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 & with Medicaid Secondary)	
							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.

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Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 11,968,902		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	60534.00	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 11,968,902		*(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*	Removed from Medicare, allowable on Medicaid DSH	$ (11,968,902)	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*	Account number 60534, Dept 16108			*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 11,968,902
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	3,004,752,251
19	Uninsured Hospital	**Charges Sec. G**	1,857,465,126
20	Total Hospital	**Charges Sec. G**	8,049,808,436
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		37.33%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		23.07%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 4,467,632
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,761,782
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 7,229,414**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	1,528,390,740
27	Uninsured Hospital	**Charges Sec. G**	1,859,746,670
28	Total Hospital	**Charges Sec. G**	8,049,808,436
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		18.99%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		23.10%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 2,272,496
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,765,175
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 5,037,671**

** 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.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*