State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

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	01/01/2024	12/31/2024
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	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 (07/01/25 - 06/30/26)
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?	6/2/1892

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** — $ 97,933,472
   (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 07/01/2025 - 06/30/2026** — $ 156,808,364
   (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 Services07/01/2025 - 06/30/2026** — $ 254,741,836

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

Billy Wright
Hospital CEO or CFO Printed Name

COO/CFO
Title

404-616-1767
Hospital CEO or CFO Telephone Number

11/13/2025
Date

BWRIGHT1@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 1/1/2024 - 12/31/2024

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

	1/1/2024 through 12/31/2024		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 5/29/2025

	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		
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2		
11. Rural Referral Center (Yes or No)	No		

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

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2024 - 12/31/2024)

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)	$ 584,468	$ 2,987,187	$3,571,655
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,662,553	$ 3,256,527	$4,919,079
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)	$2,247,021	$6,243,713	$8,490,734
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	26.01%	47.84%	42.07%

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	$ 389,065,448	***<--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.***
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	$389,065,448	

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 (01/01/2024 - 12/31/2024)

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)	286,498 (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	79,688,767
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 79,688,767
7.	Inpatient Hospital Charity Care Charges	419,562,479
8.	Outpatient Hospital Charity Care Charges	700,460,664
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 1,120,023,143

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	$1,313,077,753.00			$ 1,121,379,064	$ -	$ -	$ 191,698,689
12.	Subprovider I (Psych or Rehab)	$40,688,575.00			$ 34,748,374	$ -	$ -	$ 5,940,201
13.	Subprovider II (Psych or Rehab)	$8,753,487.00			$ 7,475,549	$ -	$ -	$ 1,277,938
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$49,139,918.00			$ 28,909,028	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$4,515,476,144.00	$2,868,898,911.00		$ 3,856,253,295	$ 2,450,062,967	$ -	$ 1,078,058,793
20.	Outpatient Services		$416,686,731.00			$ 355,853,852	$ -	$ 60,832,879
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 221,616,471	-	-	$ 177,123,867	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$601,590,604.00	$ -	$ -	$ 344,403,853	$ -
27.	Total	$ 5,877,995,959	$ 3,285,585,642	$ 872,346,993	$ 5,019,856,282	$ 2,805,916,819	$ 550,436,748	$ 1,337,808,500
28.	Total Hospital and Non Hospital		Total from Above	$ 10,035,928,594		Total from Above	$ 8,376,209,849	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	10,035,928,594	Total Contractual Adj. (G-3 Line 2)	8,376,209,849
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				8,376,209,849
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) | 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	$ 214,427,004	$ 49,147,744	$ 1,801,593	$0.00	$ 265,376,341	177,894	$572,053,768.00		$ 1,491.77
2	03100 INTENSIVE CARE UNIT	$ 126,538,641	$ 7,584,205	$ -		$ 134,122,846	60,489	$421,720,764.00		$ 2,217.31
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 69,616,097	$ 2,872,125	$ 130,152		$ 72,618,374	19,181	$227,806,506.00		$ 3,785.95
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ 30,964,135	$ 82,274	$ 14,653		$ 31,061,062	12,123	$40,688,575.00		$ 2,562.16
8	04100 SUBPROVIDER II	$ 5,452,960	$ -	$ -		$ 5,452,960	2,005	$8,753,487.00		$ 2,719.68
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 10,550,492	$ 1,209,184	$ -		$ 11,759,676	7,053	$11,445,106.00		$ 1,667.33
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 30,296,279	$ 2,375,985	$ 80,537		$ 32,752,801	13,872	$84,158,357.00		$ 2,361.07
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 487,845,608	$ 63,271,517	$ 2,026,935	$ -	$ 553,144,060	292,617	$ 1,366,626,563		
19	Weighted Average									$ 1,890.34

			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)		6,119	-	-	$ 9,128,141	$4,853,131.00	$15,772,196.00	$ 20,625,327	0.442570

		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	$97,346,289.00	$ 7,242,641	$ 722,503		$ 105,311,433	$1,172,654,282.00	$481,323,334.00	$ 1,653,977,616	0.063672
22	5200 DELIVERY ROOM & LABOR ROOM	$29,217,487.00	$ 1,104,471	$ -		$ 30,321,958	$111,350,887.00	$29,927,011.00	$ 141,277,898	0.214626
23	5300 ANESTHESIOLOGY	$8,525,299.00	$ 3,792,103	$ 210,677		$ 12,528,079	$221,991,202.00	$93,627,653.00	$ 315,618,855	0.039694
24	5400 RADIOLOGY-DIAGNOSTIC	$43,044,054.00	$ 5,230,658	$ 72,085		$ 48,346,797	$167,239,612.00	$167,424,598.00	$ 334,664,210	0.144464
25	5600 RADIOISOTOPE	$11,104,950.00	$ 137,124	$ 35,950		$ 11,278,024	$51,957,110.00	$124,934,982.00	$ 176,892,092	0.063757
26	5700 CT SCAN	$10,637,434.00	$ 645,730	$ 170,276		$ 11,453,440	$491,476,097.00	$371,780,855.00	$ 863,256,952	0.013268
27	5800 MRI	$5,671,208.00	$ 94,740	$ 25,749		$ 5,791,697	$68,621,393.00	$56,879,505.00	$ 125,500,898	0.046149
28	6000 LABORATORY	$72,599,047.00	$ 2,031,929	$ 435,151		$ 75,066,127	$561,146,751.00	$459,181,815.00	$ 1,020,328,566	0.073571
29	6001 LABORATORY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
30	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	$15,555,728.00	$ -	$ -		$ 15,555,728	$88,208,166.00	$34,237,652.00	$ 122,445,818	0.127042

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) 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	$26,966,990.00	$ -	$ -		$ 26,966,990	$359,499,736.00	$11,632,946.00	$ 371,132,682	0.072661
32	6501	RESPIRATORY THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
33	6600	PHYSICAL THERAPY	$24,577,904.00	$ 461,235	$ 37,175		$ 25,076,314	$97,122,707.00	$35,497,817.00	$ 132,620,524	0.189083
34	6601	PHYSICAL THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
35	6900	ELECTROCARDIOLOGY	$7,349,936.00	$ -	$ -		$ 7,349,936	$146,525,398.00	$55,534,925.00	$ 202,060,323	0.036375
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$49,612,865.00	$ -	$ -		$ 49,612,865	$97,968,031.00	$23,663,134.00	$ 121,631,165	0.407896
37	7101	MEDICAL SUPPLIES CHARGED CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
38	7200	IMPL. DEV. CHARGED TO PATIENTS	$43,571,070.00	$ -	$ -		$ 43,571,070	$67,815,408.00	$14,074,635.00	$ 81,890,043	0.532068
39	7300	DRUGS CHARGED TO PATIENTS	$117,379,592.00	$ -	$ -		$ 117,379,592	$234,923,809.00	$272,069,870.00	$ 506,993,679	0.231521
40	7301	DRUGS CHARGED TO PATIENTS-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41	7302	OUTPATIENT PHARMACY	$134,821,362.00	$ -	$ -		$ 134,821,362	$14,509.00	$240,467,885.00	$ 240,482,394	0.560629
42	7400	RENAL DIALYSIS	$8,953,874.00	$ -	$ -		$ 8,953,874	$22,370,149.00	$30,616,906.00	$ 52,987,055	0.168982
43	7601	PULMONARY FUNCTION TESTING	$1,379,567.00	$ -	$ 320,489		$ 1,700,056	$5,011,886.00	$14,156,557.00	$ 19,168,443	0.088690
44	7602	CARDIOVASCULAR LAB	$11,330,351.00	$ 1,131,896	$ 420,296		$ 12,882,543	$40,011,868.00	$10,648,014.00	$ 50,659,882	0.254295
45	9000	CLINIC	$167,064,520.00	$ 12,540,615	$ 759,333		$ 180,364,468	$67,051,604.00	$349,264,680.00	$ 416,316,284	0.433239
46	9001	SATELLITE CLINICS	$47,311,050.00	$ -	$ 81,208		$ 47,392,258	$142,697.00	$94,508,227.00	$ 94,650,924	0.500706
47	9100	EMERGENCY	$117,845,854.00	$ 10,254,384	$ 1,174,081		$ 129,274,319	$454,897,227.00	$767,068,835.00	$ 1,221,966,062	0.105792
48	9201	OBSERVATION BEDS (DISTINCT PART)	$6,616,446.00	$ -	$ -		$ 6,616,446	$2,211,672.00	$17,791,497.00	$ 20,003,169	0.330770
49		HUGHES SPALDING COST-SEE SUPPORT	($63,214,672.00)	$ -	$ -		$ (63,214,672)	$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	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) | 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
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**	$ 995,268,205	$ 44,667,526	$ 4,464,973		$ 1,044,400,704	$ 4,535,065,332	$ 3,772,085,529	$ 8,307,150,861	
127	**Weighted Average**									0.134432
128	**Sub Totals**	$ 1,483,113,813	$ 107,939,043	$ 6,491,908		$ 1,597,544,764	$ 5,901,691,895	$ 3,772,085,529	$ 9,673,777,424	
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)*					$48,684.00				
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**					$ 1,597,496,080				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					7.25%				

* 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 (01/01/2024-12/31/2024) 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	$ 1,491.77		26,452		5,920		3,764		45,473		479		27,770		82,088		65.07%
2	03100 INTENSIVE CARE UNIT	$ 2,217.31		8,653		757		1,590		15,855		30		8,464		26,885		59.06%
3	03200 CORONARY CARE UNIT	$ -														-		
4	03300 BURN INTENSIVE CARE UNIT	$ -														-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,785.95		605		571		274		4,400		97		3,655		5,947		51.51%
6	03500 OTHER SPECIAL CARE UNIT	$ -														-		
7	04000 SUBPROVIDER I	$ 2,562.16														-		0.00%
8	04100 SUBPROVIDER II	$ 2,719.68														-		0.00%
9	04200 OTHER SUBPROVIDER	$ -														-		
10	04300 NURSERY	$ 1,667.33		1,381		3,418				1,348		22		174		6,169		90.27%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,361.07		2,794		5,620				3,736				170		12,150		89.09%
12		$ -														-		
13		$ -														-		
14		$ -														-		
15		$ -														-		
16		$ -														-		
17		$ -														-		
18			**Total Days**	39,885		16,286		5,628		70,812		628		40,233		133,239		60.18%
19	Total Days per PS&R or Exhibit Detail			39,885		16,286		5,628		70,812		628		40,233				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
21	Routine Charges			**Routine Charges** $ 144,091,151		**Routine Charges** $ 73,008,099		**Routine Charges** $ 26,288,014		**Routine Charges** $ 324,082,335		**Routine Charges** $ 2,718,244		**Routine Charges** $ 182,413,916		**Routine Charges** $ 567,469,598		55.71%
21.01	Calculated Routine Charge Per Diem			$ 3,612.67		$ 4,482.87		$ 4,670.93		$ 4,576.66		$ 4,328.41		$ 4,533.94		$ 4,259.04		
	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)		0.442570	501,566	573,388	69,750	91,050	109,950	776,700	1,450,572	3,298,326	4,500	15,000	576,000	2,722,494	$ 2,131,838	$ 4,739,464	52.01%
23	5000 OPERATING ROOM		0.063672	95,627,476	17,004,729	31,970,918	20,504,075	14,895,159	10,056,160	186,170,880	56,172,188	868,678		255,062,386	147,007,243	$ 328,664,433	$ 103,737,151	51.15%
24	5200 DELIVERY ROOM & LABOR ROOM		0.214626	16,174,937	2,253,207	42,422,002	10,754,061	315,511	80,048	31,603,372	5,071,044	29,993		4,561,421	6,257,661	$ 90,515,822	$ 18,158,360	85.72%
25	5300 ANESTHESIOLOGY		0.039694	20,097,332	3,895,810	16,112,928	3,731,244	2,525,114	2,296,166	39,974,196	11,439,884	132,644		41,703,486	27,361,280	$ 78,709,570	$ 21,363,104	54.30%
26	5400 RADIOLOGY-DIAGNOSTIC		0.144464	16,276,443	7,235,718	4,948,022	6,303,119	2,562,285	3,261,913	34,125,852	17,237,707	191,586		25,640,117	48,193,957	$ 57,912,602	$ 34,038,457	50.22%
27	5600 RADIOISOTOPE		0.063757	6,393,894	10,982,119	2,223,789	3,890,751	627,267	5,394,342	11,258,799	23,425,307	-		9,162,274	20,179,018	$ 20,503,749	$ 43,692,519	53.42%
28	5700 CT SCAN		0.013268	44,795,160	16,851,990	9,896,173	14,359,016	9,454,974	10,711,114	100,882,809	43,067,381	383,639	9,691	83,554,041	120,357,855	$ 165,029,116	$ 84,989,501	53.31%
29	5800 MRI		0.046149	7,579,684	2,891,032	1,326,323	1,572,504	1,236,401	1,841,059	16,229,748	9,461,923	52,216		11,246,033	15,046,184	$ 26,372,156	$ 15,766,518	55.14%
30	6000 LABORATORY		0.073571	71,743,226	37,038,351	19,086,296	27,016,618	11,927,475	10,404,514	134,699,818	55,193,128	609,557	10,806	84,383,118	144,138,076	$ 237,456,814	$ 129,652,611	59.12%
31	6001 LABORATORY-CRESTVIEW		-													$ -	$ -	
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.127042	13,780,535	6,166,198	6,543,768	1,987,709	1,281,815	526,157	19,172,797	4,806,235	121,191		16,371,500	5,439,128	$ 40,778,915	$ 13,486,299	63.12%
33	6500 RESPIRATORY THERAPY		0.072661	49,817,503	141,588	11,555,077	59,487	7,314,646	106,872	86,068,187	646,369	1,068,911		39,026,150	1,454,188	$ 154,755,413	$ 954,316	53.53%
34	6501 RESPIRATORY THERAPY-CRESTVIEW		-													$ -	$ -	
35	6600 PHYSICAL THERAPY		0.189083	9,384,530	1,755,449	3,048,812	726,578	1,337,370	976,225	22,215,081	4,916,527	30,982		13,088,981	10,523,837	$ 35,985,793	$ 8,374,779	51.88%
36	6601 PHYSICAL THERAPY-CRESTVIEW		-													$ -	$ -	
37	6900 ELECTROCARDIOLOGY		0.036375	17,466,723	3,065,839	2,742,894	1,795,524	3,510,898	1,693,189	35,834,768	7,824,132	94,744	607	18,289,824	14,682,439	$ 59,555,283	$ 14,378,684	53.51%
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.407896	10,523,143	859,735	3,081,550	462,748	1,757,802	569,618	21,359,636	2,692,480	100,158		16,678,623	5,387,076	$ 36,722,131	$ 4,584,581	52.71%
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-													$ -	$ -	
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.532068	5,172,905	641,422	1,455,899	310,957	898,248	425,823	11,260,600	2,278,345	45,274		11,964,088	4,033,220	$ 18,787,652	$ 3,656,546	47.56%
41	7300 DRUGS CHARGED TO PATIENTS		0.231521	27,518,287	12,758,035	7,967,249	15,899,528	3,889,926	11,448,663	51,743,619	37,345,172	404,670	14,528	35,545,199	41,778,142	$ 91,119,082	$ 77,451,398	48.99%
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-													$ -	$ -	
43	7302 OUTPATIENT PHARMACY		0.560629													$ -	$ -	0.00%
44	7400 RENAL DIALYSIS		0.168982	2,842,112	1,248,446	166,765	109,573	961,883	96,508	7,668,316	1,404,951			2,669,233	23,475,987	$ 11,639,076	$ 2,859,478	77.35%
45	7601 PULMONARY FUNCTION TESTING		0.088690	785,874	1,184,235	37,453	179,404	96,314	593,395	1,448,499	3,482,706			749,936	2,442,213	$ 2,368,140	$ 5,439,740	57.41%
46	7602 CARDIOVASCULAR LAB		0.254295	3,917,213	889,219	152,767	113,839	457,249	458,528	8,954,711	1,629,449	13,836		6,250,761	2,286,224	$ 13,481,940	$ 3,091,035	49.78%
47	9000 CLINIC		0.433239	9,593,884	25,453,252	2,107,743	19,750,700	1,349,529	9,709,521	16,033,433	54,994,983	74,355	5,070	7,866,776	74,159,592	$ 29,084,588	$ 109,908,456	53.61%
48	9001 SATELLITE CLINICS		0.500706	35,024	5,109,484	19,559	5,922,773	6,663	2,201,089	43,853	11,268,605	-	-	5,079	27,333,401	$ 105,099	$ 24,501,951	54.97%
49	9100 EMERGENCY		0.105792	37,879,513	29,797,869	11,103,158	29,887,762	7,790,767	14,988,215	89,297,582	62,664,006	269,213	7,696	91,993,386	236,228,777	$ 146,071,020	$ 137,337,852	50.89%
50	9201 OBSERVATION BEDS (DISTINCT PART)		0.330770	304,049	651,214	39,300	409,376	32,250	387,438	533,088	1,886,758	2,250		356,700	7,079,592	$ 908,687	$ 3,334,786	59.41%
51	HUGHES SPALDING COST-SEE SUPPORT		-													$ -	$ -	
52			-													$ -	$ -	
53			-													$ -	$ -	
54			-													$ -	$ -	
55			-													$ -	$ -	
56			-													$ -	$ -	
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58			-													$ -	$ -	
59			-													$ -	$ -	
60			-													$ -	$ -	

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

Cost Report Year (01/01/2024-12/31/2024) 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
61			-													$ -	$ -	
62			-													$ -	$ -	
63			-													$ -	$ -	
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119			-													$ -	$ -	
120			-													$ -	$ -	
121			-													$ -	$ -	
122			-													$ -	$ -	
123			-													$ -	$ -	
124			-													$ -	$ -	
125			-													$ -	$ -	
126			-													$ -	$ -	
127			-													$ -	$ -	
				$ 468,211,014	$ 188,448,330	$ 178,078,194	$ 165,838,395	$ 74,339,496	$ 89,003,257	$ 928,030,216	$ 422,207,606	$ 4,498,397	$ 63,398	$ 776,745,112	$ 987,567,585			

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

Cost Report Year (01/01/2024-12/31/2024) 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)***	$ 612,302,164	$ 188,448,330	$ 251,086,293	$ 165,838,395	$ 100,627,510	$ 89,003,257	$ 1,252,112,551	$ 422,207,606	$ 7,216,641	$ 63,398	$ 959,159,028 (Agrees to Exhibit A)	$ 987,567,585 (Agrees to Exhibit A)	$ 2,216,128,518	$ 865,497,588	52.63%
129	Total Charges per PS&R or Exhibit Detail	$ 612,302,164	$ 188,448,330	$ 251,086,293	$ 165,838,395	$ 100,627,510	$ 89,003,257	$ 1,252,112,551	$ 422,207,606	$ 7,216,641	$ 63,398	$ 959,159,028	$ 987,567,585			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 120,422,089	$ 29,180,576	$ 54,308,268	$ 26,589,233	$ 17,693,761	$ 13,538,339	$ 230,398,345	$ 66,142,042	$ 1,659,981	$ 13,958	$ 150,798,555	$ 129,387,872	$ 422,822,463	$ 135,450,190	53.16%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 84,745,167	$ 27,163,398		$ 1,254	$ 167,262	$ 1,124,885	$ 2,461,120	$ 2,700,025					$ 87,373,550	$ 30,989,562	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 36,932,022	$ 18,390,529			$ 1,200,640	$ 477,638					$ 38,132,661	$ 18,868,167	
134	Private Insurance (including primary and third party liability)	$ 1,760,806	$ 265,210	$ 88,992	$ 64,254	$ 106,690		$ 81,022,028	$ 11,638,960					$ 82,978,516	$ 11,968,424	
135	Self-Pay (including Co-Pay and Spend-Down)			$ 120	$ 22,363	$ 117	$ 6,213	$ 46,625	$ 57,033	$ 100				$ 46,862	$ 85,609	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 86,505,973	$ 27,428,608	$ 37,021,134	$ 18,478,399											
137	Medicaid Cost Settlement Payments (See Note B)		$ (2,527,036)											$ -	$ (2,527,036)	
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)					$ 18,529,331	$ 8,432,886	$ 35,942,097	$ 1,473,032					$ 54,471,428	$ 9,905,918	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ 115,777	$ 682	$ 79,129,901	$ 20,873,941					$ 79,245,678	$ 20,874,623	
141	Medicare Cross-Over Bad Debt Payments					$ 882,342	$ 596,809							$ 882,342	$ 596,809	
142	Other Medicare Cross-Over Payments (See Note D)					$ 600,134	$ 650,191	$ 1,943,856	$ 991,469			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 2,543,990	$ 1,641,660	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 584,468	$ 2,987,187			
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)**	$ 33,916,116	$ 4,279,004	$ 17,287,134	$ 8,110,834	$ (2,707,892)	$ 2,726,673	$ 28,652,079	$ 27,929,944	$ 1,659,881	$ 13,958	$ 150,214,087	$ 126,400,685	$ 77,147,437	$ 43,046,455	
146	**Calculated Payments as a Percentage of Cost**	72%	85%	68%	69%	115%	80%	88%	58%	0%	0%	0%	2%	82%	68%	
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)**					94,602										
148	**Percent of cross-over days to total Medicare days from the cost report**					6%										

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 (01/01/2024-12/31/2024) 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	$ 1,491.77		1,495				16		413		1,924	
2	03100 INTENSIVE CARE UNIT	$ 2,217.31		265				2		106		373	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,785.95		213				39		27		279	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ 2,562.16										-	
8	04100 SUBPROVIDER II	$ 2,719.68										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,667.33		24				-				24	
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,361.07		39				-				39	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	2,036		-		57		546		2,639	
19	Total Days per PS&R or Exhibit Detail			2,036		-		57		546			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 8,865,020				$ 401,946		$ 2,246,946		$ 11,513,912	
21.01	Calculated Routine Charge Per Diem			$ 4,354.14		$ -		$ 7,051.68		$ 4,115.29		$ 4,362.98	
	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)		0.442570	469,893	36,900			-		14,850	16,800	$ 484,743	$ 53,700
23	5000 OPERATING ROOM		0.063672	7,512,588	705,968			256,380	510	1,800,721	332,585	$ 9,569,689	$ 1,039,063
24	5200 DELIVERY ROOM & LABOR ROOM		0.214626	1,006,964	310,667			-		217,390	50,230	$ 1,224,354	$ 360,897
25	5300 ANESTHESIOLOGY		0.039694	1,473,495	143,439			36,014		393,122	52,899	$ 1,902,631	$ 196,338
26	5400 RADIOLOGY-DIAGNOSTIC		0.144464	956,014	569,976			50,380		395,863	128,276	$ 1,402,257	$ 698,252
27	5600 RADIOISOTOPE		0.063757	307,837	525,701			-		123,842	-	$ 431,679	$ 525,701
28	5700 CT SCAN		0.013268	2,900,144	1,639,771			96,289		955,628	309,327	$ 3,952,061	$ 1,949,098
29	5800 MRI		0.046149	400,578	119,015			-		163,700	31,833	$ 564,278	$ 150,848
30	6000 LABORATORY		0.073571	3,628,100	1,825,508			169,948	7,838	930,845	406,452	$ 4,728,893	$ 2,239,798
31	6001 LABORATORY-CRESTVIEW		-									$ -	$ -
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.127042	639,076	84,496			20,116		114,322	230,357	$ 773,514	$ 314,853
33	6500 RESPIRATORY THERAPY		0.072661	740,496	8,844			371,146		305,315		$ 1,416,957	$ 8,844
34	6501 RESPIRATORY THERAPY-CRESTVIEW		-									$ -	$ -
35	6600 PHYSICAL THERAPY		0.189083	551,154	51,135			17,713		169,188	5,527	$ 738,055	$ 56,662
36	6601 PHYSICAL THERAPY-CRESTVIEW		-									$ -	$ -
37	6900 ELECTROCARDIOLOGY		0.036375	598,140	235,368			21,922	607	183,816	78,377	$ 803,878	$ 314,352
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.407896	436,900	18,813			22,494		148,749	9,058	$ 608,143	$ 27,871
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-									$ -	$ -
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.532068	331,827	3,080			11,306		115,634	886	$ 458,767	$ 3,966
41	7300 DRUGS CHARGED TO PATIENTS		0.231521	1,211,867	381,863			65,456	1,078	281,021	142,809	$ 1,558,344	$ 525,751
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-									$ -	$ -
43	7302 OUTPATIENT PHARMACY		0.560629									$ -	$ -
44	7400 RENAL DIALYSIS		0.168982	136,174	123,196			-		68,919	14,730	$ 205,093	$ 137,926
45	7601 PULMONARY FUNCTION TESTING		0.088690	633	-			-		-	3,227	$ 633	$ 3,227
46	7602 CARDIOVASCULAR LAB		0.254295	94,448	-			-		-	-	$ 94,448	$ -
47	9000 CLINIC		0.433239	737,833	1,029,977			27,034	1,806	73,899	202,466	$ 838,765	$ 1,234,249
48	9001 SATELLITE CLINICS		0.500706	1,040	71,571			-	1,020	-	11,676	$ 1,040	$ 84,267
49	9100 EMERGENCY		0.105792	3,209,157	4,635,387			88,896	1,400	860,531	1,142,942	$ 4,158,584	$ 5,779,729

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) 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	
50	9201	OBSERVATION BEDS (DISTINCT PART)		0.330770	19,650	149,100			-		12,600	19,800	$ 32,250	$ 168,900
51		HUGHES SPALDING COST-SEE SUPPORT		-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
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I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) 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	
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 27,364,008	$ 12,669,775	$ -	$ -	$ 1,255,095	$ 14,259	$ 7,329,954	$ 3,190,257		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 36,229,028	$ 12,669,775	$ -	$ -	$ 1,657,041	$ 14,259	$ 9,576,900	$ 3,190,257	$ 47,462,969	$ 15,874,291
129	Total Charges per PS&R or Exhibit Detail	$ 36,229,028	$ 12,669,775	$ -	$ -	$ 1,657,041	$ 14,259	$ 9,576,900	$ 3,190,257		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 6,808,394	$ 1,580,977	$ -	$ -	$ 299,900	$ 2,322	$ 1,692,160	$ 389,691	$ 8,800,454	$ 1,972,990
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 764,222	$ 118,551			$ 3,273	$ 288	$ 6,454	$ 709	$ 773,949	$ 119,548
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 8,105	$ 18,204							$ 8,105	$ 18,204
134	Private Insurance (including primary and third party liability)	$ 658,680	$ 135,044					$ 1,354,488	$ 274,221	$ 2,013,168	$ 409,265
135	Self-Pay (including Co-Pay and Spend-Down)		$ 1,977						$ 80	$ -	$ 2,057
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,431,007	$ 273,776	$ -	$ -						
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)					$ 265,320	$ 1,057	$ 390,736	$ 77,397	$ 656,056	$ 78,454
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 278,932	$ 23,328	$ 278,932	$ 23,328
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)**	$ 5,377,387	$ 1,307,201	$ -	$ -	$ 31,307	$ 977	$ (338,450)	$ 13,956	$ 5,070,244	$ 1,322,134
144	**Calculated Payments as a Percentage of Cost**	21%	17%	0%	0%	90%	58%	120%	96%	42%	33%

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 (01/01/2024-12/31/2024) 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 (01/01/2024-12/31/2024) 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)*		$ 13,970,922		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*			60534.00	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 13,970,922		*(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	$ (13,970,922)	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		$ 13,970,922
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	3,152,243,405
19	Uninsured Hospital	**Charges Sec. G**	1,946,726,613
20	Total Hospital	**Charges Sec. G**	9,673,777,424
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		32.59%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		20.12%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 4,552,487
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,811,473
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 7,363,960**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	1,266,573,986
27	Uninsured Hospital	**Charges Sec. G**	1,954,006,651
28	Total Hospital	**Charges Sec. G**	9,673,777,424
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		13.09%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		20.20%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 1,829,193
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,821,987
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 4,651,180**

** 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.*