State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2022

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2021	06/30/2022

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	01/01/2022	12/31/2022
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:	000030855A
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 (07/01/21 - 06/30/22)
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 07/01/2021 - 06/30/2022** — $ 88,627,640
   (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 07/01/2021 - 06/30/2022**
   (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 Services07/01/2021 - 06/30/2022** — $ 88,627,640

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	Title	Date
	CFO	10-16-23

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Anthony Saul	404-616-1767	asaul@gmh.edu

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	

DSH Version 8.11 2/10/2023

D. General Cost Report Year Information 1/1/2022 - 12/31/2022

The following information is provided based on the information we received from the state. Please review this information for items 4 through 8 and select "Yes" or "No" to either agree or disagree with the accuracy of the information. If you disagree with one of these items, please provide the correct information along with supporting documentation when you submit your survey.

1. Select Your Facility from the Drop-Down Menu Provided:	GRADY MEMORIAL HOSPITAL		
	1/1/2022 through 12/31/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	6/13/2023		

	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: (01/01/2022 - 12/31/2022)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 1,570,785	$ 2,178,552	$3,749,337
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,196,688	$ 2,177,550	$3,374,238
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)	$2,767,473	$4,356,102	$7,123,575
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	56.76%	50.01%	52.63%

NOTE: According to the payment data entered above, uninsured patient payments account for more than half of all patient payments. Please verify this is correct.

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?**
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ 106,485,903	***<--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	$106,485,903	

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 (01/01/2022 - 12/31/2022)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	241,767 **(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	58,254,716
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 58,254,716
7.	Inpatient Hospital Charity Care Charges	479,189,641
8.	Outpatient Hospital Charity Care Charges	548,343,995
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 1,027,533,636

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	$920,700,750.00			$ 786,386,162	$ -	$ -	$ 134,314,588
12.	Subprovider I (Psych or Rehab)	$19,380,669.00			$ 16,553,359	$ -	$ -	$ 2,827,310
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$42,594,303.00			$ 24,389,399	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$3,334,751,962.00	$2,030,765,095.00		$ 2,848,268,340	$ 1,734,510,990	$ -	$ 782,737,727
20.	Outpatient Services		$278,197,696.00			$ 237,613,380	$ -	$ 40,584,316
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 200,142,190	-	-	$ 161,475,125	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$475,453,220.00	$ -	$ -	$ 306,852,801	$ -
27.	Total	$ 4,274,833,381	$ 2,308,962,791	$ 718,189,713	$ 3,651,207,861	$ 1,972,124,370	$ 492,717,325	$ 960,463,941
28.	Total Hospital and Non Hospital		Total from Above	$ 7,301,985,885		Total from Above	$ 6,116,049,556	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	7,301,985,885	Total Contractual Adj. (G-3 Line 2)		6,116,049,556
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)				+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)				-	
35.	Adjusted Contractual Adjustments					6,116,049,556
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) | 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	$ 191,251,443	$ 48,394,670	$ 1,791,981	$0.00	$ 241,438,094	163,379	$425,032,370.00		$ 1,477.78
2	03100 INTENSIVE CARE UNIT	$ 117,028,291	$ 9,337,441	$ -		$ 126,365,732	48,211	$283,215,132.00		$ 2,621.10
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 58,069,626	$ 3,659,201	$ 173,566		$ 61,902,393	15,887	$155,153,994.00		$ 3,896.42
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ 17,735,707	$ 186,948	$ 66,025		$ 17,988,680	7,024	$19,380,669.00		$ 2,561.03
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 9,025,372	$ 902,337	$ -		$ 9,927,709	4,821	$6,418,082.00		$ 2,059.26
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 24,512,092	$ 2,113,762	$ -		$ 26,625,854	11,228	$54,139,910.00		$ 2,371.38
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 417,622,531	$ 64,594,359	$ 2,031,572	$ -	$ 484,248,462	250,550	$ 943,340,157		
19	Weighted Average									$ 1,932.74

		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)	6,845	-	-	$ 10,115,404	$3,410,644.00	$18,760,942.00	$ 22,171,586	0.456233

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) | 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
		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	$68,315,230.00	$ 6,533,218	$ 803,215		$ 75,651,663	$927,402,958.00	$315,995,726.00	$ 1,243,398,684	0.060843
22	5200 DELIVERY ROOM & LABOR ROOM	$25,524,982.00	$ 653,072	$ -		$ 26,178,054	$53,577,226.00	$8,207,597.00	$ 61,784,823	0.423697
23	5300 ANESTHESIOLOGY	$5,918,809.00	$ 4,449,368	$ 136,295		$ 10,504,472	$167,753,863.00	$67,005,908.00	$ 234,759,771	0.044746
24	5400 RADIOLOGY-DIAGNOSTIC	$30,833,274.00	$ 5,541,146	$ 34,201		$ 36,408,621	$136,776,626.00	$141,399,849.00	$ 278,176,475	0.130883
25	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
26	5600 RADIOISOTOPE	$8,892,072.00	$ 147,066	$ 13,723		$ 9,052,861	$35,582,338.00	$80,997,714.00	$ 116,580,052	0.077654
27	5700 CT SCAN	$8,021,962.00	$ 795,153	$ 71,106		$ 8,888,221	$342,457,835.00	$287,677,338.00	$ 630,135,173	0.014105
28	5800 MRI	$4,369,991.00	$ 112,169	$ 9,922		$ 4,492,082	$48,817,878.00	$39,728,896.00	$ 88,546,774	0.050731
29	6000 LABORATORY	$47,390,380.00	$ 2,081,357	$ 73,490		$ 49,545,227	$420,241,583.00	$371,064,911.00	$ 791,306,494	0.062612
30	6001 LABORATORY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
31	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	$13,969,865.00	$ -	$ -		$ 13,969,865	$79,720,641.00	$24,238,044.00	$ 103,958,685	0.134379
32	6500 RESPIRATORY THERAPY	$26,863,353.00	$ -	$ -		$ 26,863,353	$273,624,809.00	$11,858,931.00	$ 285,483,740	0.094098
33	6501 RESPIRATORY THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
34	6600 PHYSICAL THERAPY	$15,433,969.00	$ 498,529	$ 40,222		$ 15,972,720	$79,508,139.00	$26,994,341.00	$ 106,502,480	0.149975
35	6601 PHYSICAL THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
36	6900 ELECTROCARDIOLOGY	$5,623,189.00	$ -	$ -		$ 5,623,189	$107,638,714.00	$45,026,788.00	$ 152,665,502	0.036833
37	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$39,908,716.00	$ -	$ -		$ 39,908,716	$75,229,786.00	$19,439,404.00	$ 94,669,190	0.421560
38	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39	7200 IMPL. DEV. CHARGED TO PATIENTS	$33,294,446.00	$ -	$ -		$ 33,294,446	$52,313,661.00	$10,738,349.00	$ 63,052,010	0.528047
40	7300 DRUGS CHARGED TO PATIENTS	$76,145,445.00	$ -	$ -		$ 76,145,445	$196,589,337.00	$167,883,587.00	$ 364,472,924	0.208919
41	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42	7302 OUTPATIENT PHARMACY	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43	7400 RENAL DIALYSIS	$9,174,585.00	$ -	$ -		$ 9,174,585	$23,290,839.00	$36,386,059.00	$ 59,676,898	0.153738
44	7601 PULMONARY FUNCTION TESTING	$1,656,763.00	$ -	$ 212,648		$ 1,869,411	$3,686,346.00	$9,807,296.00	$ 13,493,642	0.138540
45	7602 CARDIOVASCULAR LAB	$6,415,817.00	$ 1,403,359	$ 355,805		$ 8,174,981	$30,907,803.00	$9,859,145.00	$ 40,766,948	0.200530
46	9000 CLINIC	$111,087,306.00	$ 12,592,834	$ 679,624		$ 124,359,764	$32,286,809.00	$248,325,080.00	$ 280,611,889	0.443174
47	9001 SATELLITE CLINICS	$33,135,476.00	$ -	$ 105,845		$ 33,241,321	$121,390.00	$48,308,961.00	$ 48,430,351	0.686374
48	9100 EMERGENCY	$103,125,543.00	$ 12,400,901	$ 781,860		$ 116,308,304	$259,147,701.00	$510,475,861.00	$ 769,623,562	0.151124
49	9201 OBSERVATION BEDS (DISTINCT PART)	$6,554,671.00	$ -	$ -		$ 6,554,671	$2,563,852.00	$19,096,641.00	$ 21,660,493	0.302610
50	HUGHES SPLADING COST-SEE SUPPORT	($64,160,209.00)	$ -	$ -		$ (64,160,209)	$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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) 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
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) | 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
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	$ -	-
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) 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
126	**Total Ancillary**	$ 617,495,635	$ 47,208,172	$ 3,317,956	$ 668,021,763	$ 3,352,650,778	$ 2,519,277,368	$ 5,871,928,146	
127	**Weighted Average**								0.126415
128	**Sub Totals**	$ 1,035,118,166	$ 111,802,531	$ 5,349,528	$ 1,152,270,225	$ 4,295,990,935	$ 2,519,277,368	$ 6,815,268,303	
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)*				$114,432.00				
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**				$ 1,152,155,793				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				10.75%				

* 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 (01/01/2022-12/31/2022) 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)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):			**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,477.78		33,468		8,166		5,494		27,764		34,245		74,892		71.19%
2	03100 INTENSIVE CARE UNIT	$ 2,621.10		9,306		1,200		1,668		7,802		8,353		19,976		59.87%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,896.42		3,153		1,336		292		2,270		4,022		7,051		71.63%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ 2,561.03												-		0.00%
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 2,059.26		1,122		3,182		3		165		65		4,472		94.38%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,371.38		3,468		6,098				297		36		9,863		88.78%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	50,517		19,982		7,457		38,298		46,721		116,254		66.33%
19	Total Days per PS&R or Exhibit Detail			50,517		19,982		7,457		38,298		46,721				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 179,443,771		$ 78,562,358		$ 27,553,233		$ 140,780,743		$ 169,488,004		$ 426,340,104		64.44%
21.01	Calculated Routine Charge Per Diem			$ 3,552.15		$ 3,931.66		$ 3,694.95		$ 3,675.93		$ 3,627.66		$ 3,667.32		
	Ancillary Cost Centers (from W/S C) (from Section G):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.456233	682,551	2,556,219	61,053	285,525	119,709	1,350,921	717,162	5,416,878	644,907	2,472,012	$ 1,580,475	$ 9,609,543	65.25%
23	5000 OPERATING ROOM		0.060843	116,979,940	31,140,155	59,371,527	21,536,543	14,066,290	8,536,434	88,018,974	29,884,609	293,583,917	111,927,960	$ 278,436,731	$ 91,097,741	63.42%
24	5200 DELIVERY ROOM & LABOR ROOM		0.423697	10,199,735	1,093,117	32,790,717	4,887,082	150,549	32,872	4,917,812	552,877	1,300,111	1,156,374	$ 48,058,813	$ 6,565,948	92.88%
25	5300 ANESTHESIOLOGY		0.044746	22,312,624	6,873,406	19,048,472	4,110,084	2,548,309	1,855,770	16,538,251	7,139,948	47,200,744	23,743,674	$ 60,447,656	$ 19,979,208	65.43%
26	5400 RADIOLOGY-DIAGNOSTIC		0.130883	19,687,435	11,407,215	8,202,871	10,086,862	3,275,519	3,099,494	16,792,249	12,443,184	30,715,362	49,043,980	$ 47,958,074	$ 37,036,755	59.97%
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-											$ -	$ -	
28	5600 RADIOISOTOPE		0.077654	6,669,246	13,418,582	1,620,547	4,334,630	1,033,844	3,599,965	5,507,786	14,532,751	8,870,104	19,547,665	$ 14,831,423	$ 35,885,927	68.38%
29	5700 CT SCAN		0.014105	44,028,488	25,145,476	15,454,991	20,621,705	8,823,320	8,826,128	41,514,641	28,319,279	86,077,977	106,281,345	$ 109,821,440	$ 82,912,589	62.00%
30	5800 MRI		0.050731	7,536,012	5,077,121	1,589,593	1,943,266	1,442,598	1,342,406	6,279,020	5,251,510	11,847,890	13,718,859	$ 16,847,223	$ 13,614,303	64.13%
31	6000 LABORATORY		0.062612	77,756,358	47,477,802	24,207,086	36,598,287	13,771,070	9,564,280	65,624,257	38,186,769	87,674,312	134,354,436	$ 181,358,772	$ 131,827,138	68.41%
32	6001 LABORATORY-CRESTVIEW		-											$ -	$ -	
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.134379	15,031,598	5,925,718	8,626,133	2,545,071	2,353,652	573,225	13,318,781	3,310,990	21,861,629	4,829,468	$ 39,330,164	$ 12,355,004	76.57%
34	6500 RESPIRATORY THERAPY		0.094098	53,912,946	287,621	17,828,912	106,614	7,246,660	81,286	40,520,498	429,489	38,661,287	943,738	$ 119,509,016	$ 905,010	57.13%
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-											$ -	$ -	
36	6600 PHYSICAL THERAPY		0.149975	12,661,864	3,613,222	4,522,253	1,239,353	1,903,434	897,257	11,534,454	1,967,251	15,054,679	11,047,550	$ 30,622,005	$ 7,717,083	61.43%
37	6601 PHYSICAL THERAPY-CRESTVIEW		-											$ -	$ -	
38	6900 ELECTROCARDIOLOGY		0.036833	16,052,558	4,982,388	3,315,174	2,352,943	3,705,860	1,572,826	18,515,482	6,179,385	19,181,212	15,320,339	$ 41,589,074	$ 15,087,542	60.73%
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.421560	13,779,608	1,785,775	4,346,973	608,571	1,781,760	566,093	10,170,897	1,918,186	15,438,827	5,014,311	$ 30,079,238	$ 4,878,626	59.48%
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-											$ -	$ -	
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.528047	7,352,220	1,294,341	2,349,470	441,090	970,287	280,808	4,807,809	1,286,930	12,393,807	3,025,557	$ 15,479,787	$ 3,303,169	55.34%
42	7300 DRUGS CHARGED TO PATIENTS		0.208919	39,096,873	27,085,592	10,476,446	14,136,193	5,757,069	9,318,335	30,687,776	32,032,522	36,625,031	20,713,109	$ 86,018,163	$ 82,572,643	62.85%
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-											$ -	$ -	
44	7302 OUTPATIENT PHARMACY		-											$ -	$ -	
45	7400 RENAL DIALYSIS		0.153738	5,258,006	2,455,013	312,170	910,210	1,194,818	211,155	7,060,522	1,359,753	2,180,894	28,641,795	$ 13,825,516	$ 4,936,131	83.50%
46	7601 PULMONARY FUNCTION TESTING		0.138540	959,225	1,621,645	57,037	232,757	144,274	752,387	599,401	1,712,198	864,972	2,487,895	$ 1,759,937	$ 4,318,987	70.04%
47	7602 CARDIOVASCULAR LAB		0.200530	5,093,278	1,322,277	771,874	197,602	784,525	197,450	4,272,590	1,437,823	7,513,397	2,917,533	$ 10,922,267	$ 3,155,152	60.70%
48	9000 CLINIC		0.443174	7,022,285	34,371,657	1,669,310	19,281,181	1,089,181	7,763,652	5,608,223	30,529,694	5,730,522	63,818,109	$ 15,388,999	$ 91,946,184	63.37%
49	9001 SATELLITE CLINICS		0.686374	33,324	5,099,666	18,263	4,521,206	6,466	1,519,270	16,553	4,959,143	15,922	19,052,894	$ 74,606	$ 16,099,285	72.79%
50	9100 EMERGENCY		0.151124	33,554,108	36,679,648	15,195,412	31,644,268	6,076,250	8,866,913	27,965,788	30,637,560	73,944,579	165,612,609	$ 82,791,557	$ 107,828,389	56.58%

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

Cost Report Year (01/01/2022-12/31/2022) 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)		Uninsured		Total In-State Medicaid		%
51	9201	OBSERVATION BEDS (DISTINCT PART)	0.302610	525,878	1,692,185	115,080	843,453	113,097	238,995	395,739	1,962,501	643,638	9,695,415	$ 1,149,794	$ 4,737,134	75.57%
52		HUGHES SPLADING COST-SEE SUPPORT	-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
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114			-											$ -	$ -	
115			-											$ -	$ -	
116			-											$ -	$ -	

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

Cost Report Year (01/01/2022-12/31/2022) 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)		Uninsured		Total In-State Medicaid		%
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 516,186,161	$ 272,405,841	$ 231,951,363	$ 183,464,497	$ 78,358,540	$ 71,047,924	$ 421,384,665	$ 261,451,230	$ 818,025,719	$ 815,366,626			

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

Cost Report Year (01/01/2022-12/31/2022) GRADY MEMORIAL HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 695,629,932	$ 272,405,841	$ 310,513,721	$ 183,464,497	$ 105,911,773	$ 71,047,924	$ 562,165,408	$ 261,451,230	$ 987,513,723 (Agrees to Exhibit A)	$ 815,366,626 (Agrees to Exhibit A)	$ 1,674,220,834	$ 788,369,492	63.49%
129	Total Charges per PS&R or Exhibit Detail	$ 695,629,932	$ 272,405,841	$ 310,513,721	$ 183,464,497	$ 105,911,773	$ 71,047,924	$ 562,165,408	$ 261,451,230	$ 987,513,723	$ 815,366,626			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 156,155,536	$ 44,250,684	$ 75,024,605	$ 28,997,677	$ 21,978,982	$ 11,392,269	$ 117,632,869	$ 42,737,994	$ 167,350,955	$ 113,687,210	$ 370,791,992	$ 127,378,624	68.63%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 86,692,132	$ 32,950,154		$ 3,511	$ 105,152	$ 1,178,983	$ 446,223	$ 2,594,869			$ 87,243,507	$ 36,727,517	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 48		$ 49,684,366	$ 21,725,619			$ 340,750	$ 371,346			$ 50,025,164	$ 22,096,966	
134	Private Insurance (including primary and third party liability)	$ 1,118,229	$ 37,366	$ 23,099	$ 76,006	$ 5,450	$ 6,716	$ 23,764,215	$ 5,612,969			$ 24,910,993	$ 5,733,057	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 1,160	$ 17,319		$ 28,120		$ 677	$ 5,674	$ 23,255			$ 6,834	$ 69,371	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 87,811,569	$ 33,004,839	$ 49,707,465	$ 21,833,256									
137	Medicaid Cost Settlement Payments (See Note B)		$ (3,404,368)									$ -	$ (3,404,368)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 22,291,059	$ 5,977,419	$ 26,126,763	$ 2,328,205			$ 48,417,822	$ 8,305,624	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 54,178,103	$ 18,714,810			$ 54,178,103	$ 18,714,810	
141	Medicare Cross-Over Bad Debt Payments					$ 1,132,819	$ 405,830					$ 1,132,819	$ 405,830	
142	Other Medicare Cross-Over Payments (See Note D)					$ 3,364,950	$ 679,593	$ 2,606,834	$ 870,795	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 5,971,784	$ 1,550,388	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,570,785	$ 2,178,552			
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)**	$ 68,343,967	$ 14,650,213	$ 25,317,140	$ 7,164,421	$ (4,920,447)	$ 3,143,050	$ 10,164,306	$ 12,221,745	$ 165,780,170	$ 111,508,658	$ 98,904,965	$ 37,179,429	
146	**Calculated Payments as a Percentage of Cost**	56%	67%	66%	75%	122%	72%	91%	71%	1%	2%	73%	71%	

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)**	81,423
148	**Percent of cross-over days to total Medicare days from the cost report**	9%

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) 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)		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	$ 1,477.78		365		133		127		1,676		2,301	
2	03100 INTENSIVE CARE UNIT	$ 2,621.10		23		8		83		422		536	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,896.42		87		13				207		307	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ 2,561.03										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 2,059.26								13		13	
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,371.38				2				67		69	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	475		156		210		2,385		3,226	
19	Total Days per PS&R or Exhibit Detail			475		156		210		2,385			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 1,733,890		$ 534,030		$ 934,979		$ 8,840,386		$ 12,043,285	
21.01	Calculated Routine Charge Per Diem			$ 3,650.29		$ 3,423.27		$ 4,452.28		$ 3,706.66		$ 3,733.19	
	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)		0.456233	6,627	1,974					12,267	139,449	$ 18,894	$ 141,423
23	5000 OPERATING ROOM		0.060843	3,690,674	191,827	1,324,355		345,652		7,720,729	228,279	$ 13,081,410	$ 420,106
24	5200 DELIVERY ROOM & LABOR ROOM		0.423697	90,212	29,863	6,989		-		174,209	1,672	$ 271,410	$ 31,535
25	5300 ANESTHESIOLOGY		0.044746	590,532	35,730	194,972		45,803		1,324,320	35,650	$ 2,155,627	$ 71,380
26	5400 RADIOLOGY-DIAGNOSTIC		0.130883	250,884	139,532	68,745		73,215	4,880	1,341,132	202,097	$ 1,733,976	$ 346,509
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-									$ -	$ -
28	5600 RADIOISOTOPE		0.077654	90,421	85,813	-		19,643	-	338,640	52,964	$ 448,704	$ 138,777
29	5700 CT SCAN		0.014105	838,401	429,092	204,309		184,316	15,938	3,140,925	783,975	$ 4,367,951	$ 1,229,005
30	5800 MRI		0.050731	77,761	40,747	20,568		35,152	-	562,715	19,069	$ 696,196	$ 59,816
31	6000 LABORATORY		0.062612	683,503	336,365	218,424		313,782	16,122	4,056,962	528,977	$ 5,272,671	$ 881,464
32	6001 LABORATORY-CRESTVIEW		-									$ -	$ -
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.134379	176,064	30,917	66,232		106,155		818,248	28,386	$ 1,166,699	$ 59,303
34	6500 RESPIRATORY THERAPY		0.094098	363,796	-	174,595		387,378		2,137,298	983	$ 3,063,067	$ 983
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-									$ -	$ -
36	6600 PHYSICAL THERAPY		0.149975	156,163	140,902	47,141		42,655		576,820	14,343	$ 822,779	$ 155,245
37	6601 PHYSICAL THERAPY-CRESTVIEW		-									$ -	$ -
38	6900 ELECTROCARDIOLOGY		0.036833	99,017	54,884	24,110		399,658	1,212	871,184	81,131	$ 1,393,969	$ 137,227
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.421560	159,036	7,030	67,717		52,492		606,570	6,305	$ 885,815	$ 13,335
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-									$ -	$ -
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.528047	109,609	20,173	50,069		32,807		475,791	1,560	$ 668,275	$ 21,733
42	7300 DRUGS CHARGED TO PATIENTS		0.208919	262,746	43,944	74,527		213,748	336	2,457,579	100,534	$ 3,008,600	$ 144,814
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-									$ -	$ -
44	7302 OUTPATIENT PHARMACY		-									$ -	$ -
45	7400 RENAL DIALYSIS		0.153738	3,267	11,330			158,777		59,097	14,328	$ 221,141	$ 25,658

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) 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)		Total Out-Of-State Medicaid	
46	7601	PULMONARY FUNCTION TESTING	0.138540	-	2,330					14,513	2,330	$ 14,513	$ 4,660
47	7602	CARDIOVASCULAR LAB	0.200530	31,610	-					206,204	-	$ 237,814	$ -
48	9000	CLINIC	0.443174	133,085	116,247	9,589		17,371	576	480,295	181,814	$ 640,340	$ 298,637
49	9001	SATELLITE CLINICS	0.686374	-	2,844	-		-	838	410	7,957	$ 410	$ 11,639
50	9100	EMERGENCY	0.151124	559,451	811,117	224,890		23,366	25,887	2,407,981	1,190,612	$ 3,215,688	$ 2,027,616
51	9201	OBSERVATION BEDS (DISTINCT PART)	0.302610	5,781	46,107			282		36,411	53,298	$ 42,474	$ 99,405
52		HUGHES SPLADING COST-SEE SUPPORT	-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
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105			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) 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)		Total Out-Of-State Medicaid	
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
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118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 8,378,640	$ 2,578,768	$ 2,777,233	$ -	$ 2,452,251	$ 65,789	$ 29,820,300	$ 3,675,713		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 10,112,530	$ 2,578,768	$ 3,311,263	$ -	$ 3,387,230	$ 65,789	$ 38,660,686	$ 3,675,713	$ 55,471,709	$ 6,320,270
129	Total Charges per PS&R or Exhibit Detail	$ 10,112,530	$ 2,578,768	$ 3,311,263	$ -	$ 3,387,230	$ 65,789	$ 38,660,686	$ 3,675,713		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 1,746,200	$ 323,100	$ 533,851	$ -	$ 655,114	$ 6,730	$ 7,802,738	$ 473,676	$ 10,737,903	$ 803,506
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,288,274	$ 268,055			$ 35,275	$ 1,043	$ 86,137	$ 7,344	$ 1,409,686	$ 276,442
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ 4,954	$ 388,611				$ 205,675	$ 36,118	$ 594,286	$ 41,072
134	Private Insurance (including primary and third party liability)	$ (18,122)	$ 1,701				$ 50	$ 2,999,681	$ 216,410	$ 2,981,559	$ 218,161
135	Self-Pay (including Co-Pay and Spend-Down)		$ 230	$ 1,873					$ 660	$ 1,873	$ 890
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,270,152	$ 274,940	$ 390,484	$ -						
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)					$ 416,820	$ 2,423	$ 685,145	$ 30,226	$ 1,101,965	$ 32,649
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 327,017	$ 21,362	$ 327,017	$ 21,362
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)**	$ 476,048	$ 48,160	$ 143,367	$ -	$ 203,019	$ 3,214	$ 3,499,084	$ 161,556	$ 4,321,517	$ 212,930
144	**Calculated Payments as a Percentage of Cost**	73%	85%	73%	0%	69%	52%	55%	66%	60%	73%

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 (01/01/2022-12/31/2022) 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)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section H as part of your In-State Medicaid total payments.
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (01/01/2022-12/31/2022) 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)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary, if available (if not, use hospital's logs and submit with survey).
Note B: Enter Organ Acquisition Payments in Section I as part of your Out-of-State Medicaid total payments.

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2022-12/31/2022) GRADY MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 11,239,950		
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)	$ 11,239,950		*(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	$ (11,239,950)	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		$ 11,239,950
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	2,524,382,305
19	Uninsured Hospital	**Charges Sec. G**	1,802,880,348
20	Total Hospital	**Charges Sec. G**	6,815,268,303
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		37.04%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		26.45%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 4,163,289
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,973,366
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 7,136,655**

** 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.*