GA DSH Payment Results for SFY 2025 - Pool 1

3/25/2025 9:31

DSH Uncompensated Care Cost & Allocation Factor Summary
Preliminary Results

Provider Name	ADVENTHEALTH MURRAY MEDICAL CENTER
Mcaid Provider Number	000001383A
Mcare Provider Number	110050

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2025 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2024 - 6/30/2025

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	1/1/2023	-	12/31/2023	$ 1,678,449	$ -	$ 1,678,449

Less: 2023 Gross UPL Payments	$ 530,157
Less: 2025 Gross DPP Payments	$ 534,130
Less: GME Payments	$ -
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ 234,897
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 152,625
Hospital Specific DSH Limit (Total UCC)	$ 1,001,684
2025 Eligibility	**Eligible**
DSH Year Low Income Utilization Ratio (LIUR):	11.11%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	27.02%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail: gadsh@mslc.com

Fax: 816-945-5301

Web Portal Address: https://DSH.MSLC.com

Phone Inquiries: 800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	9.00	9/11/2024

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

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

1. Select Your Facility from the Drop-Down Menu Provided: ADVENTHEALTH MURRAY MEDICAL CENTER

	1/1/2023 through 12/31/2023		
2. Select Cost Report Year Covered by this Survey:	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: 6/18/2024

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	ADVENTHEALTH MURRAY MEDICAL CENTER	Yes	
5. Medicaid Provider Number:	000001383A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110050	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Private	Yes	

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

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

(List additional states on a separate attachment)

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

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 7,099	$ 133,067	$140,166
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 79,751	$ 1,495,395	$1,575,146
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$86,850	$1,628,463	$1,715,312
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	8.17%	8.17%	8.17%

13. **Did your hospital receive any Medicaid managed care payments not paid at the claim level?** No
Should include all non-claim-specific payments such as lump sum payments for full Medicaid pricing, supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

14. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to hospital services	$ -
15. Total Medicaid managed care non-claims payments (see question 13 above) received applicable to non-hospital services	$ -
16. Total Medicaid managed care non-claims payments (see question 13 above) received	$-

Note 1: Subtitle B - Miscellaneous Provision, Section 1011 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 provides federal reimbursement for emergency health services furnished to undocumented aliens. If your hospital received these funds during any cost report year covered by the survey, they must be reported here. If you can document that a portion of the payment received is related to non-hospital services (physician or ambulance services), report that amount in the section titled "Section 1011 Payments Related to Non-Hospital Services." Otherwise report 100 percent of the funds you received in the section related to hospital services.

Note 2: Report any DSH payments your hospital received from a state Medicaid program (other than your home state). In-state DSH payments will be reported directly from the Medicaid program and should not be included in this section of the survey.

F. MIUR / LIUR Qualifying Data from the Cost Report (01/01/2023 - 12/31/2023)

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	2,354

F-2. Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges (Used in Low-Income Utilization Ratio (LIUR) Calculation):

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	-
8.	Outpatient Hospital Charity Care Charges	-
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ -

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 6,256,056	$ -	$ -	$ 5,150,095	$ -	$ -	$ 1,105,961
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 23,166,100	$ 153,176,006	$ -	$ 19,070,741	$ 126,097,185	$ -	$ 31,174,180
20.	Outpatient Services		$ 58,854,043	$ -		$ 48,449,684	$ -	$ 10,404,359
21.	Home Health Agency			$ -			$ -	
22.	Ambulance			$ -			$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ -	$ -	$ -	$ -	$ -
27.	Total	$ 29,422,156	$ 212,030,049	$ -	$ 24,220,837	$ 174,546,869	$ -	$ 42,684,499
28.	Total Hospital and Non Hospital		Total from Above	$ 241,452,205		Total from Above	$ 198,767,706	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 241,452,205	Total Contractual Adj. (G-3 Line 2)	$ 198,767,706
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				198,767,706
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2023-12/31/2023) | ADVENTHEALTH MURRAY MEDICAL CENTER

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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	$ 2,797,954	$ -	$ -	-	**$ 2,797,954**	2,991	$ 6,900,899		**$ 935.46**
2	03100 INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
18	Total Routine	$ 2,797,954	$ -	$ -	$ -	$ 2,797,954	2,991	$ 6,900,899		
19	Weighted Average									$ 935.46

Line #	Observation Data (Non-Distinct)		Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200	Observation (Non-Distinct)	637	-	-	**$ 595,888**	264,444	2,320,947	$ 2,585,391	**0.230483**

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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	$ 1,310,341	$ -	$ -		**$ 1,310,341**	$ 40,368	$ 5,930,225	$ 5,970,593	**0.219466**
22	5400 RADIOLOGY-DIAGNOSTIC	$ 1,961,957	$ -	$ -		**$ 1,961,957**	$ 3,305,882	$ 13,038,063	$ 16,343,945	**0.120042**
23	5401 ULTRASOUND	$ 354,957	$ -	$ -		**$ 354,957**	$ 338,078	$ 2,387,369	$ 2,725,447	**0.130238**
24	5700 CT SCAN	$ 210,229	$ -	$ -		**$ 210,229**	$ 2,699,334	$ 29,705,132	$ 32,404,466	**0.006488**
25	5800 MRI	$ 209,183	$ -	$ -		**$ 209,183**	$ 704,307	$ 5,894,303	$ 6,598,610	**0.031701**
26	6000 LABORATORY	$ 1,972,597	$ -	$ -		**$ 1,972,597**	$ 6,599,729	$ 30,745,023	$ 37,344,752	**0.052821**
27	6500 RESPIRATORY THERAPY	$ 799,111	$ -	$ -		**$ 799,111**	$ 2,976,850	$ 1,378,303	$ 4,355,153	**0.183486**
28	6600 PHYSICAL THERAPY	$ 3,460,104	$ -	$ -		**$ 3,460,104**	$ 364,330	$ 25,472,648	$ 25,836,978	**0.133921**
29	6800 SPEECH PATHOLOGY	$ 48,285	$ -	$ -		**$ 48,285**	$ 9,670	$ 379,680	$ 389,350	**0.124014**
30	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$ 189,702	$ -	$ -		**$ 189,702**	$ 49,648	$ 499,151	$ 548,799	**0.345668**
31	7200 IMPL. DEV. CHARGED TO PATIENTS	$ 161,109	$ -	$ -		**$ 161,109**	$ 7,794	$ 237,995	$ 245,789	**0.655477**
32	7300 DRUGS CHARGED TO PATIENTS	$ 1,483,899	$ -	$ -		**$ 1,483,899**	$ 6,118,770	$ 10,980,233	$ 17,099,003	**0.086783**
33	9100 EMERGENCY	$ 5,329,934	$ -	$ -		**$ 5,329,934**	$ 3,251,867	$ 55,440,818	$ 58,692,685	**0.090811**
126	**Total Ancillary**	$ 17,491,408	$ -	$ -		$ 17,491,408	$ 26,731,071	$ 184,409,890	$ 211,140,961	
127	**Weighted Average**									**0.085665**
128	**Sub Totals**	$ 20,289,362	$ -	$ -		$ 20,289,362	$ 33,631,970	$ 184,409,890	$ 218,041,860	
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)					$ -				
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)					$ -				
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**					**$ 20,289,362**				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					**0.00%**				

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

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

Cost Report Year (01/01/2023-12/31/2023) ADVENTHEALTH MURRAY MEDICAL CENTER

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 Inpatient	In-State Medicaid FFS Primary Outpatient	In-State Medicaid Managed Care Primary Inpatient	In-State Medicaid Managed Care Primary Outpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	In-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Inpatient	In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered) Outpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Inpatient	Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere) Outpatient	Uninsured Inpatient (See Exhibit A)	Uninsured Outpatient (See Exhibit A)	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Inpatient	Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered) Outpatient	% Survey to Cost Report Totals (Includes all payers)
		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	$ 935.46		169		55		379		33		-		194		636		35.26%
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		-		-		
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		-		
8	04100 SUBPROVIDER I	$ -		-		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		-		
10	04300 NURSERY	$ -		-		-		-		-		-		-		-		
18			**Total Days**	169		55		379		33		-		194		636		35.26%
19	Total Days per PS&R or Exhibit Detai			169		55		379		33		-		194				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 393,397		$ 188,840		$ 1,041,328		$ 828,958		$ -		$ 583,790		$ 2,452,523		44.00%
21.01	Calculated Routine Charge Per Diem			$ 2,327.79		$ 3,433.45		$ 2,747.57		$ 25,119.94		$ -		$ 3,009.23		$ 3,856.17		
	Ancillary Cost Centers (from W/S C) (from Section G):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	
22	09200 Observation (Non-Distinct)		0.230483	$ -	$ 86,284	$ 1,607	$ -	$ 55,037	$ 89,171	$ 36,963	$ 732,606	$ -	$ -	$ 18,560	$ 185,780	$ 93,607	$ 908,061	46.65%
23	5000 OPERATING ROOM		0.219466	$ 5,423	$ -	$ -	$ -	$ 6,055	$ 275,106	$ 19,481	$ 581,707	$ -	$ -	$ 6,096	$ 56,637	$ 30,958	$ 856,812	
24	5400 RADIOLOGY-DIAGNOSTIC		0.120042	$ 49,540	$ 433,506	$ 119,128	$ 6,342,203	$ 530,305	$ 525,539	$ 315,233	$ 1,737,933	$ -	$ -	$ 295,905	$ 1,549,713	$ 1,014,256	$ 9,039,181	
25	5401 ULTRASOUND		0.130238	$ -	$ -	$ -	$ -	$ 39,384	$ 65,324	$ 35,551	$ 280,251	$ -	$ -	$ 33,229	$ 203,942	$ 74,935	$ 345,576	
26	5700 CT SCAN		0.006488	$ 189,636	$ 1,602,824	$ 83,517	$ 644,103	$ 388,588	$ 1,069,594	$ 322,143	$ 4,047,337	$ -	$ -	$ 251,547	$ 4,462,869	$ 983,883	$ 7,363,856	218.77%
27	5800 MRI		0.031701	$ 20,369	$ 133,399	$ -	$ -	$ 91,667	$ 174,803	$ 63,039	$ 677,357	$ -	$ -	$ 86,206	$ 290,873	$ 175,075	$ 985,559	9.40%
28	6000 LABORATORY		0.052821	$ 556,023	$ 2,354,660	$ 173,580	$ 4,207,612	$ 1,082,865	$ 994,091	$ 803,424	$ 4,280,752	$ -	$ -	$ 606,378	$ 4,338,607	$ 2,615,895	$ 11,837,116	711.74%
29	6500 RESPIRATORY THERAPY		0.183486	$ 535,468	$ 421,561	$ 24,348	$ -	$ 511,805	$ 37,201	$ 290,090	$ 192,299	$ -	$ -	$ 112,966	$ 105,439	$ 1,361,712	$ 651,060	6.89%
30	6600 PHYSICAL THERAPY		0.133921	$ 14,064	$ 1,000,000	$ -	$ 2,595,277	$ 63,690	$ 400,288	$ 60,019	$ 1,873,106	$ -	$ -	$ 7,830	$ 361,961	$ 137,773	$ 5,868,674	96.63%
31	6800 SPEECH PATHOLOGY		0.124014	$ 2,015	$ 3,429	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 2,015	$ 3,429	0.01%
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.345668	$ 1,444	$ -	$ -	$ -	$ -	$ -	$ -	$ 8,227	$ -	$ -	$ -	$ 378	$ 1,444	$ 8,227	0.23%
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.655477	$ -	$ -	$ -	$ -	$ 1,444	$ -	$ 4,906	$ 85,217	$ -	$ -	$ -	$ -	$ 6,350	$ 85,217	0.35%
34	7300 DRUGS CHARGED TO PATIENTS		0.086783	$ 542,723	$ 1,509,824	$ 134,910	$ 249,204	$ 1,341,456	$ 258,070	$ 681,006	$ 1,889,986	$ -	$ -	$ 433,849	$ 1,441,009	$ 2,700,095	$ 3,907,084	2178.51%
35	9100 EMERGENCY		0.090811	$ 204,865	$ 2,815,425	$ 76,066	$ 11,246,891	$ 386,092	$ 1,800,274	$ 249,405	$ -	$ -	$ -	$ 251,747	$ 9,701,302	$ 916,428	$ 15,862,590	4871.01%
				2,121,569	10,360,913	613,157	25,285,290	4,498,390	5,689,461	2,881,259	16,386,779	-	-	2,103,313	22,698,508			
	Totals / Payments																	
128	**Total Charges** *(includes organ acquisition from Section J)*			$ 2,514,966	$ 10,360,913	$ 801,997	$ 25,285,290	$ 5,539,719	$ 5,689,461	$ 3,710,217	$ 16,386,779	$ -	$ -	$ 2,687,103 (Agrees to Exhibit A)	$ 22,698,508 (Agrees to Exhibit A)	$ 12,566,898	$ 57,722,443	43.88%
129	Total Charges per PS&R or Exhibit Detail			$ 2,514,966	$ 10,360,913	$ 801,997	$ 25,285,290	$ 5,539,719	$ 5,689,461	$ 3,710,217	$ 16,386,779	$ -	$ -	$ 2,687,103	$ 22,698,506			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**															$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 363,062	$ 809,325	$ 98,915	$ 2,378,290	$ 754,828	$ 463,827	$ 278,892	$ 1,324,341	$ -	$ -	$ 345,595	$ 1,609,177	$ 1,495,697	$ 4,975,783	41.53%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 467,772	$ 876,306	$ -	$ -	$ 105,976	$ 55,401	$ 91,508	$ 126,536					$ 665,256	$ 1,058,243	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ -	$ -	$ 163,929	$ 2,272,144	$ -	$ -	$ -	$ 41,274					$ 163,929	$ 2,313,418	
134	Private Insurance (including primary and third party liability)			$ -	$ -	$ -	$ 3,765	$ -	$ -	$ 3,200	$ 1,154,566					$ 3,200	$ 1,158,355	
135	Self-Pay (including Co-Pay and Spend-Down)			$ -	$ -	$ -	$ 1,808	$ -	$ -	$ 107	$ 9,916	$ -	$ -			$ 107	$ 11,724	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 467,772	$ 876,306	$ 163,929	$ 2,277,742											
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)			$ -		$ -		$ 943,940	$ 369,072	$ 343,113	$ 552,252	$ -		$ -		$ 1,287,053	$ 921,324	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ -	$ -	$ 130,643	$ 1,043,777					$ 130,643	$ 1,043,777	
141	Medicare Cross-Over Bad Debt Payments							$ 14,331	$ 12,821	$ -	$ -					$ 14,331	$ 12,821	
142	Other Medicare Cross-Over Payments (See Note D)							$ -	$ -	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)													$ 7,099	$ 133,067			
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)**			$ (104,710)	$ (66,981)	$ (65,014)	$ 100,548	$ (309,419)	$ 26,533	$ (289,678)	$ (1,603,980)	$ -	$ -	$ 338,496	$ 1,476,110	$ (768,821)	$ (1,543,880)	
146	**Calculated Payments as a Percentage of Cost**			129%	108%	166%	96%	141%	94%	204%	221%	0%	0%	2%	8%	151%	131%	
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**							1,538										
148	**Percent of cross-over days to total Medicare days from the cost report**							25%										

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with surve
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 surv
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 payment
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 paymen

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).

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2023-12/31/2023) ADVENTHEALTH MURRAY MEDICAL CENTER

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	$ 935.46		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ -		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Deta			-		-		-		-			
20	Unreconciled Days (Explain Variance			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Dien			$ -		$ -		$ -		$ -		$ -	
	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		0.230483	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.219466	-	-	-	-	-	-	-	-	$ -	$ -
24	5400 RADIOLOGY-DIAGNOSTIC		0.120042	-	-	-	-	-	-	-	-	$ -	$ -
25	5401 ULTRASOUND		0.130238	-	-	-	-	-	-	-	-	$ -	$ -
26	5700 CT SCAN		0.006488	-	-	-	-	-	-	-	-	$ -	$ -
27	5800 MRI		0.031701	-	-	-	-	-	-	-	-	$ -	$ -
28	6000 LABORATORY		0.052821	-	-	-	-	-	-	-	-	$ -	$ -
29	6500 RESPIRATORY THERAPY		0.183486	-	-	-	-	-	-	-	-	$ -	$ -
30	6600 PHYSICAL THERAPY		0.133921	-	-	-	-	-	-	-	-	$ -	$ -
31	6800 SPEECH PATHOLOGY		0.124014	-	-	-	-	-	-	-	-	$ -	$ -
32	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.345668	-	-	-	-	-	-	-	-	$ -	$ -
33	7200 IMPL. DEV. CHARGED TO PATIENTS		0.655477	-	-	-	-	-	-	-	-	$ -	$ -
34	7300 DRUGS CHARGED TO PATIENTS		0.086783	-	-	-	-	-	-	-	-	$ -	$ -
35	9100 EMERGENCY		0.090811	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Deta			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Dow			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liabilit			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payment			$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note E			$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note I			$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note			$ -		$ -		$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductible							$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payment							$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D							$ -	$ -	$ -	$ -	$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**			0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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
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 su
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 pay
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 pa
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).

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

Cost Report Year (01/01/2023-12/31/2023) ADVENTHEALTH MURRAY MEDICAL CENTER

		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	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 D as part of your In-State Medicaid total payments
Note C: Enter the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicaid / non-Uninsured patients (but where organs were included in the Medicaid and Uninsured organ counts above). Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicaid/non-Uninsured patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered must also include an amount representing the acquisition cost of the organs transplanted into such patients.

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

Cost Report Year (01/01/2023-12/31/2023) ADVENTHEALTH MURRAY MEDICAL CENTER

		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)		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	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 E 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 (01/01/2023-12/31/2023) ADVENTHEALTH MURRAY MEDICAL CENTER

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 517,160		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		Expense	677700766600	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 517,160	LINE 4	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Medicaid Provider Tax	$ (517,160)	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ 0		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ 517,160
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	70,289,341
19	Uninsured Hospital	**Charges Sec. G**	25,385,611
20	Total Hospital	**Charges Sec. G**	218,041,860
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		32.24%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.64%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 166,715
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 60,211
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 226,926**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	38,963,165
27	Uninsured Hospital	**Charges Sec. G**	25,385,611
28	Total Hospital	**Charges Sec. G**	218,041,860
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		17.87%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		11.64%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 92,414
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 60,211
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 152,625**

** 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.*

DSH Examination Eligibility Summary

Hospital Name	**ADVENTHEALTH MURRAY MEDICAL CENTER**
Hospital Medicaid Number	**000001383A**
Cost Report Period	From **1/1/2023** To **12/31/2023**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 4,206,444	$ -	$ 4,206,444
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 4,206,444	$ -	$ 4,206,444
4	Net Hospital Patient Revenue	Survey F-3	$ 42,684,499	$ -	$ 42,684,499
5	Medicaid Fraction		9.85%	0.00%	9.85%
6	Inpatient Charity Care Charges	Survey F-2	$ -	$ -	$ -
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ -	$ -	$ -
10	Inpatient Hospital Charges	Survey F-3	$ 29,422,156	$ -	$ 29,422,156
11	Inpatient Charity Fraction		0.00%	0.00%	0.00%
12	LIUR		9.85%	0.00%	9.85%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	636	-	636
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		636	-	636
16	Total Hospital Days (excludes swing-bed)	Survey F-1	2,354	-	2,354
17	MIUR		27.02%	0.00%	27.02%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: ADVENTHEALTH MURRAY MEDICAL CENTER
Hospital Medicaid Number: 000001383A
Cost Report Period: From 1/1/2023 To 12/31/2023

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	363,062	467,772	-	-	-	-	-	-	-	-	-			467,772	(104,710)	128.84%
2	Medicaid Fee for Service	Outpatient	809,325	876,306	-	-	-	-	-	-	-	-	-			876,306	(66,981)	108.28%
3	Medicaid Managed Care	Inpatient	98,915	-	163,929	-	-	-	-	-						163,929	(65,014)	165.73%
4	Medicaid Managed Care	Outpatient	2,378,290	-	2,272,144	3,789	1,808	-	-							2,277,742	100,548	95.77%
5	Medicare Cross-over (FFS)	Inpatient	754,828	105,976	-	-	-		-	943,940	-	14,331	-			1,064,247	(309,419)	140.99%
6	Medicare Cross-over (FFS)	Outpatient	463,827	55,401	-	-	-		-	369,072	-	12,821	-			437,294	26,533	94.28%
7	Other Medicaid Eligibles	Inpatient	278,892	91,508	-	3,200	107			343,113	130,643	-	-			568,570	(289,678)	203.87%
8	Other Medicaid Eligibles	Outpatient	1,324,341	126,536	41,274	1,154,566	9,916			552,252	1,043,777	-	-			2,928,321	(1,603,980)	221.12%
9	Uninsured	Inpatient	345,595	-	-	-	-	-	-	-	-	-	-	7,099	-	7,099	338,496	2.05%
10	Uninsured	Outpatient	1,609,177	-	-	-	-	-	-	-	-	-	-	133,067	-	133,067	1,476,110	8.27%
11	In-State Sub-total	Inpatient	1,841,292	665,256	163,929	3,200	107	-	-	1,287,053	130,643	14,331	-	7,099	-	2,271,617	(430,325)	123.37%
12	In-State Sub-total	Outpatient	6,584,960	1,058,243	2,313,418	1,158,355	11,724	-	-	921,324	1,043,777	12,821	-	133,067	-	6,652,730	(67,770)	101.03%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	8,426,252	1,723,499	2,477,347	1,161,555	11,831	-	-	2,208,377	1,174,420	27,152	-	140,166	-	8,924,347	(498,095)	105.91%
15.01	Provider Tax Assessment Adjustment to UCC																226,926	

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-						-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01	Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: ADVENTHEALTH MURRAY MEDICAL CENTER
Hospital Medicaid Number: 000001383A
Cost Report Period: From 1/1/2023 To 12/31/2023
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	363,062	467,772	-	-	-	-	-	-	-	-	-			467,772	(104,710)	128.84%
2	Medicaid Fee for Service	Outpatient	809,325	876,306	-	-	-	-	-	-	-	-	-			876,306	(66,981)	108.28%
3	Medicaid Managed Care	Inpatient	98,915	-	163,929	-	-	-	-	-						163,929	(65,014)	165.73%
4	Medicaid Managed Care	Outpatient	2,378,290	-	2,272,144	3,789	1,808	-	-							2,277,742	100,548	95.77%
5	Medicare Cross-over (FFS)	Inpatient	754,828	105,976	-	-	-			943,940	-	14,331	-			1,064,247	(309,419)	140.99%
6	Medicare Cross-over (FFS)	Outpatient	463,827	55,401	-	-	-			369,072	-	12,821	-			437,294	26,533	94.28%
7	Other Medicaid Eligibles	Inpatient	278,892	91,508	-	3,200	107			343,113	130,643	-	-			568,570	(289,678)	203.87%
8	Other Medicaid Eligibles	Outpatient	1,324,341	126,536	41,274	1,154,566	9,916			552,252	1,043,777	-	-			2,928,321	(1,603,980)	221.12%
9	Uninsured	Inpatient	345,595	-	-	-	-	-	-	-	-	-	-	7,099	-	7,099	338,496	2.05%
10	Uninsured	Outpatient	1,609,177	-	-	-	-	-	-	-	-	-	-	133,067	-	133,067	1,476,110	8.27%
11	In-State Sub-total	Inpatient	1,841,292	665,256	163,929	3,200	107	-	-	1,287,053	130,643	14,331	-	7,099	-	2,271,617	(430,325)	123.37%
12	In-State Sub-total	Outpatient	6,584,960	1,058,243	2,313,418	1,158,355	11,724	-	-	921,324	1,043,777	12,821	-	133,067	-	6,652,730	(67,770)	101.03%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	8,426,252	1,723,499	2,477,347	1,161,555	11,831	-	-	2,208,377	1,174,420	27,152	-	140,166	-	8,924,347	(498,095)	105.91%
15.01																	226,926	
16																	-	
17																	(271,169)	
18																	74,301	
19																	(2,176,544)	
20																	1,831,074	

15.01 Provider Tax Assessment Adjustment to UCC Including all Medicaid Eligibles
16 Less: Out of State DSH Payments from Adjusted Survey
17 Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments
18 Less: Non-Medicaid Primary Provider Tax Assessment Adjustment to UCC
19 Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments
20 Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments

Medicaid DSH Survey Adjustments

PROVIDER: ADVENTHEALTH MURRAY MEDICAL CENTER
Mcaid Number: 000001383A
FROM: 1/1/2023
TO: 12/31/2023
Mcare Number: 110050

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustmen	Original Amount	Adjustment	Adjusted Total	W/P Ref.

Medicaid DSH Report Notes

PROVIDER: ADVENTHEALTH MURRAY MEDICAL CENTER Mcaid Number: 000001383A
FROM: 1/1/2023 TO: 12/31/2023 Mcare Number: 110050

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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