State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided: CHILDREN'S HOSPITAL ATL AT EGLESTON

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	01/01/2019	12/31/2019
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:	000000943A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113300

B. DSH OB 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 (07/01/18 - 06/30/19)
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.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/1/1928

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 7,441,908
   (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 07/01/2018 - 06/30/2019**
   (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 Services07/01/2018 - 06/30/2019** — $ 7,441,908

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
	SVP & CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Ruth Fowler	404-785-7006	Ruth.Fowler@choa.org

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

Hospital Contact:		**Outside Preparer:**	
Name	Sherry.cameron@choa.org	Name	
Title	Reimbursement Manager	Title	
Telephone Number	404-785-7964	Firm Name	
E-Mail Address	Sherry.Cameron@choa.org	Telephone Number	
Mailing Street Address	1575 Northeast Expressway	E-Mail Address	
Mailing City, State, Zip	Atlanta, GA 30329		

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

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HOSPITAL ATL AT EGLESTON

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	$ 1,547.77		14,563		12,648		164		3,060		1,356		30,435		70.16%
2	03100 INTENSIVE CARE UNIT	$ 2,711.61		6,120		13,369		18		1,653		544		21,160		97.55%
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	$ 1,579.47		2,418		7,238				764		69		10,420		83.98%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	23,101		33,255		182		5,477		1,969		62,015		71.94%
19	Total Days per PS&R or Exhibit Detail			23,101		33,255		182		5,477		1,969				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 70,658,179		$ 82,022,480		$ 411,779		$ 19,431,904		$ 7,676,868		$ 172,524,342		64.41%
21.01	Calculated Routine Charge Per Diem			$ 3,058.66		$ 2,466.47		$ 2,262.52		$ 3,547.91		$ 3,898.87		$ 2,781.98		
	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)		0.427484	1,133,546	3,708,035	2,241,605	10,865,948	35,607	122,758	376,667	1,277,599	150,147	886,102	$ 3,787,425	$ 15,974,340	64.58%
23	50 OPERATING ROOM		0.176296	40,366,268	16,514,389	55,429,584	28,730,516	719,796	536,598	12,425,478	5,290,800	2,013,241	872,134	$ 108,941,126	$ 51,072,303	67.13%
24	51 RECOVERY ROOM		-											$ -	$ -	
25	53 ANESTHESIOLOGY		0.064668	11,215,851	8,765,835	15,402,169	13,180,863	222,078	66,792	3,503,423	2,772,179	547,152	273,030	$ 30,343,521	$ 24,785,669	64.87%
26	54 RADIOLOGY-DIAGNOSTIC		0.119337	9,124,173	10,009,094	16,979,371	23,922,103	64,342	216,959	2,456,110	4,153,881	979,522	1,476,130	$ 28,623,996	$ 38,302,037	60.50%
27	55 RADIOLOGY-THERAPEUTIC		0.923001	2,404,214	434,329	1,183,688	2,128,462			781,664	881,720	292,282	166,539	$ 4,369,566	$ 3,444,511	71.87%
28	56 RADIOISOTOPE		0.276359	165,582	546,917	133,538	372,352		3,287	51,591	344,668	33,113	27,742	$ 350,711	$ 1,267,224	61.02%
29	60 LABORATORY		0.153591	46,669,407	18,666,644	61,488,326	27,075,125	410,803	1,765,763	9,854,256	5,906,457	3,540,630	2,679,654	$ 118,422,792	$ 53,503,989	67.26%
30	64 IV THERAPY		0.416973	447,629	1,890,222	14,661	629,493	209	25,210	11,393	203,935	2,478	52,277	$ 473,892	$ 2,748,860	41.79%
31	65 RESPIRATORY THERAPY		0.295716	27,095,345	1,062,427	34,778,231	1,712,350	2,852	2,339	7,253,643	303,761	1,988,124	131,524	$ 69,130,071	$ 3,080,877	72.44%
32	66 PHYSICAL THERAPY		0.492906	3,252,758	529,514	4,305,158	936,957	11,275	1,777	767,521	145,351	278,489	25,039	$ 8,336,712	$ 1,613,599	73.44%
33	69 EKG		0.209619	6,876,743	5,665,372	10,232,149	9,514,700	22,769	97,935	1,758,631	2,785,206	392,614	142,440	$ 18,890,292	$ 18,063,213	51.45%
34	70 ELECTROENCEPHALOGRAPHY		0.134569	3,259,421	1,285,469	4,784,721	2,741,762	30,660	35,160	1,495,353	639,179	205,241	272,462	$ 9,570,155	$ 4,701,570	70.67%
35	71 MEDICAL SUPPLIES CHARGED TO PATIENT		0.190649	16,661,787	9,235,847	18,882,707	13,160,573	448,955	180,042	4,709,006	2,793,787	744,590	510,827	$ 40,702,455	$ 25,370,249	62.91%
36	72 IMPL. DEV. CHARGED TO PATIENTS		0.537557	9,793,273	2,262,129	10,156,041	4,026,663			4,159,424	948,553	177,464	15,771	$ 24,108,738	$ 7,237,345	66.07%
37	73 DRUGS CHARGED TO PATIENTS		0.230620	59,966,141	15,009,471	53,781,880	15,259,336	588,598	2,010,024	14,867,602	7,631,321	5,932,576	1,267,109	$ 129,204,221	$ 39,910,152	64.04%
38	74 Renal		0.387871	140,842	-	312,737	6,427	84,455	4,154	221,478	46,112	60,587	1,385	$ 759,512	$ 56,693	95.54%
39	90 CLINIC		1.922435	986	1,322,846	26,083	1,165,714	1,257	67,396	32,672	323,195	50,359	92,831	$ 60,998	$ 2,879,151	64.79%
40	91 EMERGENCY		0.296314	4,084,522	6,841,726	6,450,115	39,447,148	32,810	80,241	1,043,862	1,850,665	513,183	4,767,768	$ 11,611,309	$ 48,219,780	72.40%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HOSPITAL ATL AT EGLESTON

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
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					$ 242,658,488	$ 103,750,266	$ 296,582,764	$ 194,876,492	$ 2,676,466	$ 5,216,435	$ 65,769,774	$ 38,388,369	$ 17,901,792	$ 13,660,764		

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

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HOSPITAL ATL AT EGLESTON

	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)***	$ 314,782,057	$ 103,750,266	$ 379,920,002	$ 194,876,492	$ 3,277,140	$ 5,216,435	$ 85,569,711	$ 38,388,369	$ 25,578,660 (Agrees to Exhibit A)	$ 13,660,764 (Agrees to Exhibit A)	$ 783,548,910	$ 342,231,562	65.50%
129	Total Charges per PS&R or Exhibit Detail	$ 314,782,057	$ 103,750,266	$ 379,920,002	$ 194,876,492	$ 3,277,140	$ 5,216,435	$ 85,569,711	$ 38,388,369	$ 25,578,660	$ 13,660,764			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 98,184,940	$ 23,409,531	$ 131,411,838	$ 45,362,301	$ 936,842	$ 1,139,570	$ 25,871,805	$ 8,890,372	$ 7,791,039	$ 3,428,714	$ 256,405,425	$ 78,801,774	71.82%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 91,906,302	$ 20,642,455	$ 126,450,560	$ 60,377,924							$ 218,356,862	$ 81,020,379	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)											$ -	$ -	
134	Private Insurance (including primary and third party liability)							$ 52,911,921	$ 21,200,344			$ 52,911,921	$ 21,200,344	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 5,073,869	$ 2,837,327	$ 3,422,955	$ 3,378,917							$ 8,496,824	$ 6,216,244	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 96,980,171	$ 23,479,782	$ 129,873,515	$ 63,756,841									
137	Medicaid Cost Settlement Payments (See Note B)		$ (416,918)									$ -	$ (416,918)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 6,796	$ 16,973			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 6,796	$ 16,973	
142	Other Medicare Cross-Over Payments (See Note D)					$ 588,186	$ 909,985					$ 588,186	$ 909,985	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 528,945	$ 998,435			
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									$ -	$ -			
145	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 1,204,769	$ 346,667	$ 1,538,323	$ (18,394,540)	$ 341,860	$ 212,612	$ (27,040,116)	$ (12,309,972)	$ 7,262,094	$ 2,430,279	$ (23,955,164)	$ (30,145,233)	
146	**Calculated Payments as a Percentage of Cost**	99%	99%	99%	141%	64%	81%	205%	238%	7%	29%	109%	138%	
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)**					395								
148	**Percent of cross-over days to total Medicare days from the cost report**					46%								

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.

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2019

DSH Version 6.00 2/21/2020

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2018	06/30/2019

2. Select Your Facility from the Drop-Down Menu Provided: CHILDREN'S HEALTHCARE-SCOTTISH RITE

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	01/01/2019	12/31/2019
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:	000001636A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113301

B. DSH OB 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 (07/01/18 - 06/30/19)
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.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/1/1915

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 528,080
   (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 07/01/2018 - 06/30/2019**
   (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 Services07/01/2018 - 06/30/2019** — $ 528,080

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
	SVP & CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Ruth Fowler	404-785-7006	Ruth.Fowler@choa.org

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

Hospital Contact:		**Outside Preparer:**	
Name	Sherry.cameron@choa.org	Name	
Title	Reimbursement Manager	Title	
Telephone Number	404-785-7964	Firm Name	
E-Mail Address	Sherry.Cameron@choa.org	Telephone Number	
Mailing Street Address	1575 Northeast Expressway	E-Mail Address	
Mailing City, State, Zip	Atlanta, GA 30329		

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

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HEALTHCARE-SCOTTISH RITE

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	$ 1,369.69		11,365		13,770		5		3,801		776		28,941		59.87%
2	03100 INTENSIVE CARE UNIT	$ 2,486.03		5,064		7,159		16		1,721		141		13,960		86.83%
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	$ 1,453.65		2,235		5,321				1,037		1		8,593		73.64%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	18,664		26,250		21		6,559		918		51,494		57.37%
19	Total Days per PS&R or Exhibit Detail			18,664		26,250		21		6,559		918				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 55,604,871		$ 81,805,633		$ 88,913		$ 22,488,123		$ 2,306,029		$ 159,987,540		65.01%
21.01	Calculated Routine Charge Per Diem			$ 2,979.26		$ 3,116.41		$ 4,233.95		$ 3,428.59		$ 2,512.01		$ 3,106.92		
	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)		0.388795	1,236,752	3,239,577	2,931,525	13,924,383			631,397	1,820,905	186,808	1,140,237	$ 4,799,674	$ 18,984,865	51.65%
23	5000 OPERATING ROOM		0.251022	13,794,640	9,681,375	19,294,271	25,345,562	13,998	14,478	6,056,724	4,960,422	599,064	770,642	$ 39,159,633	$ 40,001,837	51.04%
24	5100 RECOVERY ROOM		0.457323	671,822	1,082,357	835,160	2,754,204			260,481	486,042	47,328	82,574	$ 1,767,463	$ 4,322,603	61.15%
25	5300 ANESTHESIOLOGY		0.093751	5,781,685	5,768,561	7,944,245	13,020,264	5,388	6,820	2,482,293	2,665,526	248,912	349,249	$ 16,213,611	$ 21,461,171	59.64%
26	5400 RADIOLOGY-DIAGNOSTIC		0.139967	4,466,809	5,381,658	6,368,367	18,008,455	13,254	32,267	1,617,513	2,539,840	387,817	1,451,477	$ 12,465,943	$ 25,962,220	36.74%
27	5500 RADIOLOGY-THERAPEUTIC		0.808227	317,106	891,546	919,968	1,448,018			118,030	2,018,797	139,830	57,910	$ 1,355,104	$ 4,358,361	55.56%
28	5600 RADIOISOTOPE		0.396608	46,790	195,045	93,730	575,007			59,852	224,000	-	14,083	$ 200,372	$ 994,052	45.44%
29	5800 MRI		0.140075	1,764,383	5,079,664	3,325,377	12,129,653			697,338	3,333,123	148,429	423,385	$ 5,787,098	$ 20,542,440	67.98%
30	6000 LABORATORY		0.165210	19,659,142	15,533,665	24,803,743	28,139,975	46,558	14,500	8,121,423	5,740,545	1,142,440	2,549,535	$ 52,630,866	$ 49,428,685	58.12%
31	6500 RESPIRATORY THERAPY		0.240349	28,313,113	568,220	25,342,259	998,398	108,238		9,742,120	230,055	611,212	89,306	$ 63,505,730	$ 1,796,673	70.88%
32	6600 PHYSICAL THERAPY		0.520614	1,723,540	2,669,368	2,152,081	7,746,990	7,200	7,814	769,135	3,521,123	59,502	462,443	$ 4,651,956	$ 13,945,295	31.49%
33	6800 SPEECH PATHOLOGY		0.496615	431,297	888,687	650,181	2,138,964			133,275	1,475,814	9,670	129,520	$ 1,214,753	$ 4,503,465	22.30%
34	7000 ELECTROENCEPHALOGRAPHY		0.182577	6,825,073	3,701,362	7,856,722	8,906,669	54,654	6,610	2,683,702	1,792,930	207,004	404,222	$ 17,420,151	$ 14,407,571	64.34%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.203993	9,026,675	4,720,766	9,605,975	10,291,686	22,982	2,598	3,512,910	2,033,631	403,260	714,585	$ 22,168,542	$ 17,048,681	52.57%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.455150	6,503,556	3,202,083	9,309,550	4,737,952			2,919,181	1,757,725	156,273	69,520	$ 18,732,287	$ 9,697,760	51.50%
37	7300 DRUGS CHARGED TO PATIENTS		0.243603	31,090,518	10,709,728	28,922,487	10,241,149	69,399	16,805	13,515,333	9,420,285	1,203,582	1,045,168	$ 73,597,737	$ 30,387,967	65.24%
38	9000 CLINIC		1.819685	200	1,109,729	35,124	1,303,558	865	2,535	59,648	401,708	4,306	99,371	$ 95,837	$ 2,817,530	47.84%
39	9100 EMERGENCY		0.259942	5,251,645	7,113,038	8,376,901	41,497,910	6,386	9,747	1,778,356	2,545,052	634,979	5,607,859	$ 15,413,288	$ 51,165,747	59.71%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
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60			-											$ -	$ -	

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

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HEALTHCARE-SCOTTISH RITE

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											$ -	$ -	
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
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127				-											$ -	$ -	
					$ 136,904,746	$ 81,536,429	$ 158,767,666	$ 203,208,797	$ 348,922	$ 114,174	$ 55,158,711	$ 46,967,523	$ 6,190,416	$ 15,461,086			

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

Cost Report Year (01/01/2019-12/31/2019) CHILDREN'S HEALTHCARE-SCOTTISH RITE

	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)***	$ 192,509,617	$ 81,536,429	$ 240,573,299	$ 203,208,797	$ 437,835	$ 114,174	$ 77,646,834	$ 46,967,523	$ 8,496,445 (Agrees to Exhibit A)	$ 15,461,086 (Agrees to Exhibit A)	$ 511,167,585	$ 331,826,923	56.71%
129	Total Charges per PS&R or Exhibit Detail	$ 192,509,617	$ 81,536,429	$ 240,573,299	$ 203,208,797	$ 437,835	$ 114,174	$ 77,646,834	$ 46,967,523	$ 8,496,445	$ 15,461,086			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 63,495,979	$ 21,095,686	$ 82,191,024	$ 51,394,633	$ 124,761	$ 28,231	$ 24,101,292	$ 13,767,502	$ 2,899,639	$ 3,914,238	$ 169,913,056	$ 86,286,052	57.78%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 57,772,751	$ 18,224,824	$ 77,012,211	$ 62,873,041							$ 134,784,962	$ 81,097,865	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 3,213,579	$ 3,510,857	$ 1,624,300	$ 3,502,485							$ 4,837,879	$ 7,013,342	
134	Private Insurance (including primary and third party liability)			$ -				$ 49,082,827	$ 27,629,296			$ 49,082,827	$ 27,629,296	
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 60,986,330	$ 21,735,681	$ 78,636,511	$ 66,375,526									
137	Medicaid Cost Settlement Payments (See Note B)		$ (390,952)									$ -	$ (390,952)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ 91,352	$ 12,844					$ 91,352	$ 12,844	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,506,402	$ 2,262,660			
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)**	$ 2,509,649	$ (249,043)	$ 3,554,513	$ (14,980,893)	$ 33,409	$ 15,387	$ (24,981,535)	$ (13,861,794)	$ 1,393,237	$ 1,651,578	$ (18,883,964)	$ (29,076,343)	
146	**Calculated Payments as a Percentage of Cost**	96%	101%	96%	129%	73%	45%	204%	201%	52%	58%	111%	134%	
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)**					55								
148	**Percent of cross-over days to total Medicare days from the cost report**					38%								

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.