State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	01/01/2021	12/31/2021
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 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 (07/01/20 - 06/30/21)
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 07/01/2020 - 06/30/2021** — $ 10,675,274
   (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 07/01/2020 - 06/30/2021**
   (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 Services07/01/2020 - 06/30/2021** — $ 10,675,274

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	SVP & CFO Title	Date
Ruth Fowler Hospital CEO or CFO Printed Name	404-785-7006 Hospital CEO or CFO Telephone Number	ruth.fowler@choa.org Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Sherry Cameron	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 (01/01/2021-12/31/2021 | CHILDREN'S HOSPITAL ATL AT EGLESTON

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 1,721.03		11,297		15,060		229		4,038		661		30,624		67.74%
2	03100 INTENSIVE CARE UNIT	$ 3,161.92		4,080		12,706		156		4,245		279		21,187		90.44%
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	$ 1,590.50		1,381		6,231				2,132		26		9,744		79.63%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	16,758		33,997		385		10,415		966		61,555		68.38%
19	Total Days per PS&R or Exhibit Detail			16,758		33,997		385		10,415		966				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 76,174,292		$ 159,253,306		$ 1,903,185		$ 64,558,681		$ 4,375,019		$ 301,889,463		71.27%
21.01	Calculated Routine Charge Per Dien			$ 4,545.55		$ 4,684.33		$ 4,943.34		$ 6,198.63		$ 4,529.01		$ 4,904.39		
	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		0.357667	1,727,520	3,532,784	4,076,674	15,707,357	16,441	53,981	663,422	2,224,771	263,420	711,093	$ 6,484,056	$ 21,518,892	65.13%
23	5000 OPERATING ROOM		0.135614	38,471,482	19,081,386	72,381,844	50,966,999	909,138	301,310	18,823,370	8,968,849	1,908,613	1,106,749	$ 130,585,835	$ 79,318,545	63.22%
24	5300 ANESTHESIOLOGY		0.082752	9,219,139	7,720,660	16,366,779	15,439,913	209,141	95,220	4,498,944	3,560,185	505,505	444,827	$ 30,294,002	$ 26,815,978	62.34%
25	5400 RADIOLOGY-DIAGNOSTIC		0.100497	7,907,643	8,461,500	19,886,065	27,461,042	168,157	123,653	4,710,468	5,193,581	859,472	1,154,287	$ 32,672,332	$ 41,239,776	56.84%
26	5500 RADIOLOGY-THERAPEUTIC		0.710150	983,740	425,500	1,613,776	2,481,039	-	-	834,185	1,726,116	214,593	132,308	$ 3,431,701	$ 4,632,655	47.39%
27	5600 RADIOISOTOPE		0.302158	115,363	327,976	166,601	366,239	2,006	-	17,339	63,860	14,847	2,021	$ 301,309	$ 758,075	43.71%
28	6000 LABORATORY		0.186651	26,967,463	17,007,321	49,281,323	32,081,379	939,944	1,381,437	14,132,877	9,028,980	2,049,191	1,953,896	$ 91,321,608	$ 59,499,116	63.39%
29	6400 INTRAVENOUS THERAPY		0.360290	875,120	2,430,435	11,638	684,235	2,086	26,379	14,775	522,747	410	45,045	$ 903,618	$ 3,663,795	75.29%
30	6500 RESPIRATORY THERAPY		0.436476	16,334,030	706,115	28,749,723	1,109,486	362,198	1,841	17,776,771	401,697	1,705,686	49,365	$ 63,222,723	$ 2,219,139	72.34%
31	6600 PHYSICAL THERAPY		0.491371	2,748,885	550,620	5,069,057	1,259,260	39,485	1,326	1,664,035	229,013	183,138	28,911	$ 9,521,460	$ 2,040,218	69.89%
32	6900 ELECTROCARDIOLOGY		0.178411	6,572,848	5,937,979	12,743,332	12,394,141	58,416	64,266	3,920,051	3,288,629	351,934	148,076	$ 23,294,646	$ 21,685,014	51.09%
33	7000 ELECTROENCEPHALOGRAPHY		0.152109	2,602,488	1,345,662	6,120,856	3,044,212	51,759	18,406	2,452,968	783,681	264,947	205,965	$ 11,228,069	$ 5,191,960	75.46%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.474438	5,027,396	4,454,146	7,059,261	5,838,015	115,949	122,507	3,061,208	1,530,533	305,592	272,981	$ 15,263,814	$ 11,945,201	63.83%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.488112	7,975,119	3,836,630	12,130,416	5,192,308	-	-	4,091,288	1,358,353	184,549	411,745	$ 24,196,823	$ 10,387,291	60.16%
36	7300 DRUGS CHARGED TO PATIENTS		0.207702	49,839,378	25,490,631	76,029,355	14,472,759	1,779,391	328,213	32,638,592	14,044,230	3,026,814	1,884,516	$ 160,286,715	$ 54,335,833	57.93%
37	7400 RENAL DIALYSIS		0.253331	315,741	1,575	430,221	3,149	23,618	4,724	776,363	35,901	56,017	1,664	$ 1,545,942	$ 45,348	79.14%
38	9000 CLINIC		1.913683	510	1,482,904	29,960	1,387,993	1,580	70,425	48,161	470,237	3,425	60,209	$ 80,211	$ 3,411,558	64.00%
39	9100 EMERGENCY		0.201638	3,826,788	7,272,408	10,264,180	61,407,090	91,817	83,079	1,980,166	4,766,911	756,871	4,513,400	$ 16,162,950	$ 73,529,487	71.93%
40	10500 KIDNEY ACQUISITION		-					-	-			-	-	$ -	$ -	0.00%
41	10600 HEART ACQUISITION		-					-	-					$ -	$ -	0.00%
42	10700 LIVER ACQUISITION		-					-	-					$ -	$ -	0.00%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2021-12/31/2021 | 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		% Survey
64				-											$ -	$ -	
65				-											$ -	$ -	
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67				-											$ -	$ -	
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127				-											$ -	$ -	
					$ 181,510,653	$ 110,066,229	$ 322,411,059	$ 251,296,614	$ 4,771,123	$ 2,676,763	$ 112,104,982	$ 58,198,272	$ 12,655,022	$ 13,127,059			

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

Cost Report Year (01/01/2021-12/31/2021 | 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		% Survey
128	**Total Charges *(includes organ acquisition from Section J)***	$ 258,687,009	$ 110,066,229	$ 484,324,704	$ 251,296,614	$ 6,895,863	$ 2,676,763	$ 176,885,219	$ 58,198,272	$ 17,030,041 (Agrees to Exhibit A)	$ 13,127,059 (Agrees to Exhibit A)	$ 926,792,795	$ 422,237,879	63.92%
129	Total Charges per PS&R or Exhibit Detail	$ 258,687,009	$ 110,066,229	$ 484,324,704	$ 251,296,614	$ 6,895,863	$ 2,676,763	$ 176,885,219	$ 58,198,272	$ 17,030,041	$ 13,127,059			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 76,319,571	$ 25,219,708	$ 148,524,064	$ 51,800,929	$ 2,031,113	$ 642,557	$ 51,360,901	$ 13,117,435	$ 5,056,566	$ 2,873,856	$ 278,235,649	$ 90,780,629	67.51%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 71,834,900	$ 20,437,520	$ 145,748,277	$ 76,569,694							$ 217,583,177	$ 97,007,214	
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)							$ 94,389,524	$ 31,748,919			$ 94,389,524	$ 31,748,919	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 250,125	$ 24,542	$ 557,538	$ 654,532							$ 807,663	$ 679,074	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 72,085,025	$ 20,462,062	$ 146,305,815	$ 77,224,226									
137	Medicaid Cost Settlement Payments (See Note B)		$ (574,566)									$ -	$ (574,566)	
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					$ 52,235	$ 9,716			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 52,235	$ 9,716	
142	Other Medicare Cross-Over Payments (See Note D)					$ 1,558,838	$ 201,539					$ 1,558,838	$ 201,539	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 580,443	$ 1,224,032			
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)**	$ 4,234,546	$ 5,332,212	$ 2,218,249	$ (25,423,297)	$ 420,040	$ 431,302	$ (43,028,623)	$ (18,631,484)	$ 4,476,123	$ 1,649,824	$ (36,155,788)	$ (38,291,267)	
146	**Calculated Payments as a Percentage of Cost**	94%	79%	99%	149%	79%	33%	184%	242%	11%	43%	113%	142%	
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)**					622								
148	**Percent of cross-over days to total Medicare days from the cost report**					62%								

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 s
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 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 payn

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2021

DSH Version 6.01 2/10/2022

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2020	06/30/2021

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	01/01/2021	12/31/2021
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 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 (07/01/20 - 06/30/21)
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 07/01/2020 - 06/30/2021** — $ 799,426
   (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 07/01/2020 - 06/30/2021**
   (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 Services07/01/2020 - 06/30/2021** — $ 799,426

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	SVP & CFO Title	Date
Ruth Fowler Hospital CEO or CFO Printed Name	404-785-7006 Hospital CEO or CFO Telephone Number	ruth.fowler@choa.org Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Sherry Cameron	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 (01/01/2021-12/31/2021 | CHILDREN'S HEALTHCARE-SCOTTISH RITE

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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	$ 1,646.48		10,341		16,084		3		5,435		818		31,863		62.72%
2	03100 INTENSIVE CARE UNIT	$ 2,568.12		4,270		7,433		1		2,283		156		13,987		84.06%
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	$ 1,621.45		1,529		5,738				1,520		5		8,787		79.39%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	16,140		29,255		4		9,238		979		54,637		60.68%
19	Total Days per PS&R or Exhibit Detail			16,140		29,255		4		9,238		979				
20	Unreconciled Days (Explain Variance			-		-		-		-		-				
21	Routine Charges			**Routine Charges** $ 72,288,659		**Routine Charges** $ 124,972,393		**Routine Charges** $ 16,173		**Routine Charges** $ 45,471,774		**Routine Charges** $ 3,569,922		**Routine Charges** $ 242,748,999		69.05%
21.01	Calculated Routine Charge Per Dien			$ 4,478.85		$ 4,271.83		$ 4,043.25		$ 4,922.25		$ 3,646.50		$ 4,442.94		
	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		0.339012	1,631,198	2,652,880	4,504,093	15,256,921	4,010	17,780	1,020,233	2,666,293	287,739	1,008,484	$ 7,159,534	$ 20,593,874	51.36%
23	5000 OPERATING ROOM		0.171618	18,357,447	10,629,281	29,583,579	45,726,970	23,494	63,310	11,396,365	8,370,420	1,232,599	1,337,874	$ 59,360,884	$ 64,789,980	53.39%
24	5100 RECOVERY ROOM		0.455655	639,316	957,606	978,088	3,387,271	-	-	383,212	688,237	42,607	88,025	$ 2,000,615	$ 5,033,113	65.80%
25	5300 ANESTHESIOLOGY		0.112766	5,578,673	4,019,245	8,496,579	14,219,018	9,121	40,629	3,336,181	3,135,300	344,059	382,874	$ 17,420,554	$ 21,414,192	61.41%
26	5400 RADIOLOGY-DIAGNOSTIC		0.126346	3,745,862	4,715,495	7,398,303	20,789,627	3,226	58,597	2,080,433	3,395,369	326,545	1,292,421	$ 13,227,824	$ 28,959,087	45.31%
27	5500 RADIOLOGY-THERAPEUTIC		0.654825	81,140	521,756	709,982	1,999,770	-	-	309,747	2,382,311	18,530	193,453	$ 1,100,869	$ 4,903,837	49.99%
28	5600 RADIOISOTOPE		0.507616	37,492	65,785	55,797	358,102	-	-	34,293	495,745	2,280	5,170	$ 127,581	$ 919,631	55.70%
29	5800 MRI		0.107214	1,859,748	5,460,298	5,065,278	16,779,484	-	-	1,401,739	5,539,550	319,944	301,480	$ 8,326,765	$ 27,779,332	46.21%
30	6000 LABORATORY		0.156731	16,250,610	12,366,243	26,106,742	32,081,769	8,948	32,422	9,297,198	7,527,286	1,214,374	1,928,930	$ 51,663,498	$ 52,007,720	54.79%
31	6500 RESPIRATORY THERAPY		0.402240	25,436,358	389,842	18,394,409	706,296	276	616	12,657,724	273,543	411,022	56,631	$ 56,488,766	$ 1,370,297	79.77%
32	6600 PHYSICAL THERAPY		0.534980	1,671,585	2,218,215	2,430,873	8,883,457	-	31,922	886,597	3,739,386	110,626	196,670	$ 4,989,055	$ 14,872,978	34.98%
33	6800 SPEECH PATHOLOGY		0.474147	388,554	595,683	813,427	2,302,139	-	-	240,548	1,617,732	19,711	31,101	$ 1,442,529	$ 4,515,553	32.81%
34	7000 ELECTROENCEPHALOGRAPHY		0.168283	6,695,263	3,335,231	9,887,152	10,578,434	2,538	4,810	4,116,683	2,427,205	271,480	278,439	$ 20,701,636	$ 16,345,679	64.86%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.982228	3,455,252	1,890,325	2,286,584	1,358,626	123	32,374	2,175,320	935,335	52,948	46,932	$ 7,917,280	$ 4,216,660	69.69%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.397541	6,081,394	2,238,930	9,121,635	3,578,984	-	-	5,247,553	2,038,644	451,477	98,942	$ 20,450,582	$ 7,856,559	46.81%
37	7300 DRUGS CHARGED TO PATIENTS		0.259027	33,835,571	9,792,005	36,970,324	16,868,771	6,993	23,058	28,248,786	10,291,333	2,032,847	1,051,425	$ 99,061,673	$ 36,975,168	65.13%
38	9000 CLINIC		1.580396	180	1,543,102	37,228	1,681,536	-	9,524	91,780	843,489	6,355	67,748	$ 129,188	$ 4,077,650	50.94%
39	9100 EMERGENCY		0.170103	4,783,566	7,247,069	12,843,807	67,689,254	7,261	48,242	2,523,539	5,000,403	690,627	5,977,443	$ 20,158,172	$ 79,984,967	56.17%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (01/01/2021-12/31/2021 | 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		% Survey
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
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127				-											$ -	$ -	
					$ 130,529,205	$ 70,638,988	$ 175,683,878	$ 264,246,426	$ 65,988	$ 363,281	$ 85,447,932	$ 61,367,582	$ 7,835,770	$ 14,344,042			

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

Cost Report Year (01/01/2021-12/31/2021 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		% Survey
128	**Total Charges *(includes organ acquisition from Section J)***	$ 202,817,864	$ 70,638,988	$ 300,656,271	$ 264,246,426	$ 82,161	$ 363,281	$ 130,919,706	$ 61,367,582	$ 11,405,692 (Agrees to Exhibit A)	$ 14,344,042 (Agrees to Exhibit A)	$ 634,476,002	$ 396,616,277	58.39%
129	Total Charges per PS&R or Exhibit Detail	$ 202,817,864	$ 70,638,988	$ 300,656,271	$ 264,246,426	$ 82,161	$ 363,281	$ 130,919,706	$ 61,367,582	$ 11,405,692	$ 14,344,042			
130	Unreconciled Charges (Explain Variance	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 66,213,453	$ 18,249,400	$ 97,386,347	$ 56,318,540	$ 19,442	$ 113,122	$ 40,706,155	$ 16,886,434	$ 3,567,147	$ 2,953,241	$ 204,325,397	$ 91,567,496	60.37%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 53,835,813	$ 16,524,950	$ 94,499,434	$ 87,743,499							$ 148,335,247	$ 104,268,449	
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)							$ 77,351,890	$ 34,617,843			$ 77,351,890	$ 34,617,843	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 357,964	$ 55,187	$ 437,959	$ 2,757,157							$ 795,923	$ 2,812,344	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 54,193,777	$ 16,580,137	$ 94,937,393	$ 90,500,656									
137	Medicaid Cost Settlement Payments (See Note B)		$ (87,950)									$ -	$ (87,950)	
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					$ -	$ -					$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ 16,982	$ 39,611			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 16,982	$ 39,611	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 1,025,928	$ 2,769,118			
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)**	$ 12,019,676	$ 1,757,213	$ 2,448,954	$ (34,182,116)	$ 2,460	$ 73,511	$ (36,645,735)	$ (17,731,409)	$ 2,541,219	$ 184,123	$ (22,174,645)	$ (50,082,801)	
146	**Calculated Payments as a Percentage of Cost**	82%	90%	97%	161%	87%	35%	190%	205%	29%	94%	111%	155%	
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)**					9								
148	**Percent of cross-over days to total Medicare days from the cost report**					44%								

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 s
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 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 payn

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