

**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 EGGLESTON

**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 Services 07/01/2018 - 06/30/2019** \$ 7,441,908

**Certification:**

1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year?** Answer  
**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:

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

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

<p><b>Hospital Contact:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="font-size: small;">Name</td><td style="border: 1px solid blue;">Sherry.cameron@choa.org</td></tr> <tr><td style="font-size: small;">Title</td><td style="border: 1px solid blue;">Reimbursement Manager</td></tr> <tr><td style="font-size: small;">Telephone Number</td><td style="border: 1px solid blue;">404-785-7964</td></tr> <tr><td style="font-size: small;">E-Mail Address</td><td style="border: 1px solid blue;">Sherry.Cameron@choa.org</td></tr> <tr><td style="font-size: small;">Mailing Street Address</td><td style="border: 1px solid blue;">1575 Northeast Expressway</td></tr> <tr><td style="font-size: small;">Mailing City, State, Zip</td><td style="border: 1px solid blue;">Atlanta, GA 30329</td></tr> </table>	Name	Sherry.cameron@choa.org	Title	Reimbursement Manager	Telephone Number	404-785-7964	E-Mail Address	Sherry.Cameron@choa.org	Mailing Street Address	1575 Northeast Expressway	Mailing City, State, Zip	Atlanta, GA 30329	<p><b>Outside Preparer:</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr><td style="font-size: small;">Name</td><td style="border: 1px solid blue;"> </td></tr> <tr><td style="font-size: small;">Title</td><td style="border: 1px solid blue;"> </td></tr> <tr><td style="font-size: small;">Firm Name</td><td style="border: 1px solid blue;"> </td></tr> <tr><td style="font-size: small;">Telephone Number</td><td style="border: 1px solid blue;"> </td></tr> <tr><td style="font-size: small;">E-Mail Address</td><td style="border: 1px solid blue;"> </td></tr> </table>	Name		Title		Firm Name		Telephone Number		E-Mail Address	
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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

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-Over (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 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			
<b>Routine Cost Centers (from Section G):</b>				<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>	<b>Days</b>			
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		\$ -														
19	<b>Total Days per PS&amp;R or Exhibit Detail</b>			<b>23,101</b>	<b>33,255</b>	<b>182</b>	<b>5,477</b>	<b>1,969</b>	<b>62,015</b>							<b>71.94%</b>
20	<b>Unreconciled Days (Explain Variance)</b>															
21	<b>Routine Charges</b>			<b>\$ 70,658,179</b>	<b>\$ 82,022,480</b>	<b>\$ 411,773</b>	<b>\$ 19,431,904</b>	<b>\$ 7,676,868</b>	<b>\$ 172,524,342</b>							<b>64.41%</b>
21.01	Calculated Routine Charge Per Diem			\$ 3,058.66	\$ 2,486.47	\$ 2,262.52	\$ 3,547.91	\$ 3,898.87	\$ 2,761.96							
<b>Ancillary Cost Centers (from W/S C) (from Section G):</b>				<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	<b>Ancillary Charges</b>	
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			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	5,996,457	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	1,962,427	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		0.492908	3,252,758	529,514	4,305,158	936,957	1,777	787,521	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	16,661,787	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	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 EGGLESTON

			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		%
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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 EGGLESTON

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Over (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
<b>Totals / Payments</b>													
128 <b>Total Charges (includes organ acquisition from Section J)</b>	\$ 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 <b>Total Calculated Cost (includes organ acquisition from Section J)</b>	\$ 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					\$ 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 (Agrees to Exhibit B and B-1)	\$ 998,435 (Agrees to Exhibit B and B-1)			
144 Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)									\$ -	\$ -			
145 <b>Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)</b>	\$ 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 <b>Calculated Payments as a Percentage of Cost</b>	99%	99%	99%	141%	64%	81%	205%	238%	7%	29%	109%	138%	
147 <b>Total Medicare Days from WIS S-3 of the Cost Report Excluding Swing-Bed (C/R, WIS S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 &amp; 6)</b>					395								
148 <b>Percent of cross-over days to total Medicare days from the cost report</b>					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 Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.