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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: 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	01/01/2022	12/31/2022
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	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 (07/01/21 - 06/30/22)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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 07/01/2021 - 06/30/2022** — $ 11,264,901
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06/30/2022** — $ 11,264,901

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:	
Name	Sherry Cameron
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

Outside Preparer:	
Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

DSH Version 8.11 2/10/2023

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

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

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

	1/1/2022 through 12/31/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 6/13/2023

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	CHILDREN'S HOSPITAL ATL AT EGLESTON	Yes	
5. Medicaid Provider Number:	000000943A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	113300	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: (01/01/2022 - 12/31/2022)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 341,484	$ 848,679	$1,190,163
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,096,564	$ 9,105,886	$10,202,450
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$1,438,048	$9,954,565	$11,392,613
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	23.75%	8.53%	10.45%

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

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	85,084 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	21,862,948
8.	Outpatient Hospital Charity Care Charges	20,405,416
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 42,268,364

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$455,476,443.00			$ 269,260,272	$ -	$ -	$ 186,216,171
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$1,019,306,892.00	$663,614,329.00		$ 602,575,292	$ 392,303,438	$ -	$ 688,042,491
20.	Outpatient Services		$145,064,674.00			$ 85,756,693	$ -	$ 59,307,981
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 14,760,183	-	-	$ 8,725,656	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$5,607,241.00	$0.00	$0.00	$ 3,314,787	$ -	$ -	$ 2,292,454
27.	Total	$ 1,480,390,576	$ 808,679,003	$ 14,760,183	$ 875,150,350	$ 478,060,131	$ 8,725,656	$ 935,859,098
28.	Total Hospital and Non Hospital		Total from Above	$ 2,303,829,762		Total from Above	$ 1,361,936,137	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,303,829,762	Total Contractual Adj. (G-3 Line 2)	1,361,936,137
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				1,361,936,137
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 96,261,287	$ -	$ -	$0.00	$ 96,261,287	58,932	$138,580,111.00		$ 1,633.43
2	03100 INTENSIVE CARE UNIT	$ 90,980,852	$ -	$ -		$ 90,980,852	24,765	$239,276,845.00		$ 3,673.77
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 24,220,448	$ -	$ -		$ 24,220,448	11,356	$77,619,487.00		$ 2,132.83
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 211,462,587	$ -	$ -	$ -	$ 211,462,587	95,053	$ 455,476,443		
19	Weighted Average									$ 2,224.68

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	9,969	-	-	$ 16,283,664	$10,713,286.00	$38,951,851.00	$ 49,665,137	0.327869

Line #			*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	$41,568,490.00	$ -	$ -		$ 41,568,490	$197,895,959.00	$129,938,325.00	$ 327,834,284	0.126797
22	5300	ANESTHESIOLOGY	$7,722,911.00	$ -	$ -		$ 7,722,911	$47,381,398.00	$44,312,521.00	$ 91,693,919	0.084225
23	5400	RADIOLOGY-DIAGNOSTIC	$17,143,864.00	$ -	$ -		$ 17,143,864	$58,925,944.00	$84,696,905.00	$ 143,622,849	0.119367
24	5500	RADIOLOGY-THERAPEUTIC	$11,602,175.00	$ -	$ -		$ 11,602,175	$9,408,311.00	$9,695,705.00	$ 19,104,016	0.607316
25	5600	RADIOISOTOPE	$716,437.00	$ -	$ -		$ 716,437	$509,490.00	$1,881,182.00	$ 2,390,672	0.299680
26	6000	LABORATORY	$52,528,670.00	$ -	$ -		$ 52,528,670	$146,207,524.00	$116,235,414.00	$ 262,442,938	0.200153
27	6400	INTRAVENOUS THERAPY	$2,553,494.00	$ -	$ -		$ 2,553,494	$1,265,568.00	$6,128,443.00	$ 7,394,011	0.345346
28	6500	RESPIRATORY THERAPY	$50,610,870.00	$ -	$ -		$ 50,610,870	$104,524,524.00	$5,775,130.00	$ 110,299,654	0.458849
29	6600	PHYSICAL THERAPY	$9,452,013.00	$ -	$ -		$ 9,452,013	$14,515,124.00	$2,944,387.00	$ 17,459,511	0.541368
30	6900	ELECTROCARDIOLOGY	$15,020,287.00	$ -	$ -		$ 15,020,287	$39,364,501.00	$47,241,386.00	$ 86,605,887	0.173433
31	7000	ELECTROENCEPHALOGRAPHY	$5,753,314.00	$ -	$ -		$ 5,753,314	$16,713,272.00	$6,940,357.00	$ 23,653,629	0.243232

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$15,608,428.00	$ -	$ -		$ 15,608,428	$23,707,459.00	$18,603,287.00	$ 42,310,746	0.368900
33	7200	IMPL. DEV. CHARGED TO PATIENTS	$32,227,904.00	$ -	$ -		$ 32,227,904	$36,728,360.00	$18,329,606.00	$ 55,057,966	0.585345
34	7300	DRUGS CHARGED TO PATIENTS	$85,503,551.00	$ -	$ -		$ 85,503,551	$280,742,575.00	$132,011,160.00	$ 412,753,735	0.207154
35	7400	RENAL DIALYSIS	$1,548,477.00	$ -	$ -		$ 1,548,477	$3,927,528.00	$106,575.00	$ 4,034,103	0.383847
36	9000	CLINIC	$9,681,739.00	$ -	$ -		$ 9,681,739	$129,834.00	$5,885,134.00	$ 6,014,968	1.609608
37	9100	EMERGENCY	$41,566,731.00	$ -	$ -		$ 41,566,731	$26,646,235.00	$139,179,540.00	$ 165,825,775	0.250665
38	10500	KIDNEY ACQUISITION	$2,547,222.00	$ -	$ -		$ 2,547,222	$1,145,157.00	$0.00	$ 1,145,157	-
39	10600	HEART ACQUISITION	$1,572,868.00	$ -	$ -		$ 1,572,868	$2,413,323.00	$0.00	$ 2,413,323	-
40	10700	LIVER ACQUISITION	$1,706,439.00	$ -	$ -		$ 1,706,439	$2,048,761.00	$0.00	$ 2,048,761	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 406,635,884	$ -	$ -		$ 406,635,884	$ 1,024,914,133	$ 808,856,908	$ 1,833,771,041	
127	**Weighted Average**									0.228149
128	**Sub Totals**	$ 618,098,471	$ -	$ -		$ 618,098,471	$ 1,480,390,576	$ 808,856,908	$ 2,289,247,484	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 618,098,471				
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 (01/01/2022-12/31/2022) 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	$ 1,633.43		12,644		17,216		323		5,207		763		35,390		73.84%
2	03100 INTENSIVE CARE UNIT	$ 3,673.77		4,619		10,324		73		4,087		303		19,103		78.36%
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	$ 2,132.83		1,537		5,578				1,653		38		8,768		77.54%
11		$ -		-										-		
12		$ -		-										-		
13		$ -		-										-		
14		$ -		-										-		
15		$ -		-										-		
16		$ -		-										-		
17		$ -		-										-		
18			**Total Days**	18,800		33,118		396		10,947		1,104		63,261		67.71%
19	Total Days per PS&R or Exhibit Detail			18,800		33,118		396		10,947		1,104				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 88,702,535		$ 187,495,975		$ 1,498,022		$ 64,640,161		$ 5,014,851		$ 342,336,693		76.26%
21.01	Calculated Routine Charge Per Diem			$ 4,718.22		$ 5,661.45		$ 3,782.88		$ 5,904.83		$ 4,542.44		$ 5,411.50		
	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)		0.327869	1,620,998	3,676,066	4,853,019	19,646,816	74,842	114,668	921,037	2,561,775	140,546	551,042	$ 7,469,896	$ 25,999,325	68.78%
23	5000 OPERATING ROOM		0.126797	39,808,561	17,012,816	68,778,154	49,841,630	459,138	416,829	23,898,890	9,002,948	2,352,146	1,164,078	$ 132,944,743	$ 76,274,223	64.89%
24	5300 ANESTHESIOLOGY		0.084225	8,820,956	7,280,815	15,794,699	15,411,841	185,752	79,989	5,822,639	3,741,633	555,290	352,856	$ 30,624,046	$ 26,514,278	63.30%
25	5400 RADIOLOGY-DIAGNOSTIC		0.119367	9,985,335	8,776,037	21,910,474	30,498,721	241,699	121,974	5,944,511	6,610,517	786,543	1,205,512	$ 38,082,019	$ 46,007,249	59.94%
26	5500 RADIOLOGY-THERAPEUTIC		0.607316	2,417,205	294,625	2,268,972	3,058,174	663	61,266	957,804	1,597,437	80,004	76,168	$ 5,644,644	$ 5,011,502	56.60%
27	5600 RADIOISOTOPE		0.299680	65,874	452,973	174,546	457,961	23,983	43,952	54,215	464,894	28,852	6,519	$ 318,618	$ 1,419,780	74.20%
28	6000 LABORATORY		0.200153	34,506,785	17,593,168	50,872,599	39,451,011	867,518	2,218,475	19,294,181	11,264,152	1,519,687	1,859,570	$ 105,541,083	$ 70,526,806	68.38%
29	6400 INTRAVENOUS THERAPY		0.345346	1,176,064	2,397,628	24,047	1,124,407	-	-	15,106	574,154	1,518	37,567	$ 1,215,217	$ 4,096,189	72.36%
30	6500 RESPIRATORY THERAPY		0.458849	23,002,494	800,740	39,882,166	1,969,224	197,814	1,831	17,872,301	489,438	1,342,685	41,390	$ 80,954,775	$ 3,261,233	77.61%
31	6600 PHYSICAL THERAPY		0.541368	3,105,450	459,166	5,532,253	1,347,340	33,959	1,419	1,751,737	276,508	270,052	27,041	$ 10,423,399	$ 2,084,433	73.34%
32	6900 ELECTROCARDIOLOGY		0.173433	6,507,036	4,497,516	14,318,235	14,376,458	-	-	4,404,503	4,647,997	311,399	407,923	$ 25,229,774	$ 23,521,971	57.12%
33	7000 ELECTROENCEPHALOGRAPHY		0.243232	2,962,265	1,143,343	8,747,266	5,481,603	228,205	98,637	2,817,910	970,157	457,235	206,589	$ 14,755,646	$ 7,693,740	97.72%
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.368900	4,422,002	3,352,246	8,534,158	5,616,123	60,538	72,976	3,453,287	1,572,920	250,218	204,942	$ 16,469,985	$ 10,614,265	65.09%
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.585345	7,027,266	3,186,012	10,411,871	6,284,239	20,232	7,386	4,501,773	1,523,406	402,469	208,268	$ 21,961,142	$ 11,001,043	60.98%
36	7300 DRUGS CHARGED TO PATIENTS		0.207154	73,608,042	29,965,408	84,879,355	37,158,129	1,557,753	589,937	41,909,842	11,784,194	2,312,854	948,243	$ 201,954,992	$ 79,497,668	68.98%
37	7400 RENAL DIALYSIS		0.383847	405,846	2,986	805,397	15,157	-	-	341,508	417	149,356	2,136	$ 1,552,751	$ 18,560	42.71%
38	9000 CLINIC		1.609608	1,696	1,522,305	319,831	1,549,369	12,167	84,652	55,192	676,021	13,646	58,978	$ 388,886	$ 3,832,347	71.39%
39	9100 EMERGENCY		0.250665	4,258,418	8,557,746	11,771,352	79,234,831	96,957	117,916	2,095,854	6,360,232	445,241	5,016,061	$ 18,222,581	$ 94,270,725	71.13%
40	10500 KIDNEY ACQUISITION		-					-	-	-	-	-	-	$ -	$ -	0.00%
41	10600 HEART ACQUISITION		-					-	-					$ -	$ -	0.00%
42	10700 LIVER ACQUISITION		-					-	-					$ -	$ -	0.00%
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
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61			-											$ -	$ -	
62			-											$ -	$ -	

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

Cost Report Year (01/01/2022-12/31/2022) 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
63			-											$ -	$ -	
64			-											$ -	$ -	
65			-											$ -	$ -	
66			-											$ -	$ -	
67			-											$ -	$ -	
68			-											$ -	$ -	
69			-											$ -	$ -	
70			-											$ -	$ -	
71			-											$ -	$ -	
72			-											$ -	$ -	
73			-											$ -	$ -	
74			-											$ -	$ -	
75			-											$ -	$ -	
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124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 223,702,293	$ 110,971,596	$ 349,878,394	$ 312,523,034	$ 4,061,220	$ 4,031,907	$ 136,112,290	$ 64,118,800	$ 11,419,741	$ 12,374,883			

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

Cost Report Year (01/01/2022-12/31/2022) 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)***	$ 314,384,228	$ 110,971,596	$ 538,523,053	$ 312,523,034	$ 5,559,242	$ 4,031,907	$ 200,752,451	$ 64,118,800	$ 16,434,592 (Agrees to Exhibit A)	$ 12,374,883 (Agrees to Exhibit A)	$ 1,059,218,974	$ 491,645,337	69.00%
129	Total Charges per PS&R or Exhibit Detail	$ 314,384,228	$ 110,971,596	$ 538,523,053	$ 312,523,034	$ 5,559,242	$ 4,031,907	$ 200,752,451	$ 64,118,800	$ 16,434,592	$ 12,374,883			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 94,901,209	$ 25,266,966	$ 161,243,669	$ 69,247,443	$ 1,669,676	$ 951,025	$ 59,977,150	$ 14,660,042	$ 5,212,832	$ 2,836,946	$ 317,791,704	$ 110,125,476	70.53%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 80,329,336	$ 20,866,043	$ 173,563,910	$ 91,880,041	$ -	$ -					$ 253,893,246	$ 112,746,084	
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)					$ -	$ -	$ 122,374,618	$ 34,292,183			$ 122,374,618	$ 34,292,183	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 331,626	$ 35,437			$ -	$ -					$ 331,626	$ 35,437	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 80,660,962	$ 20,901,480	$ 173,563,910	$ 91,880,041									
137	Medicaid Cost Settlement Payments (See Note B)		$ (106,010)									$ -	$ (106,010)	
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					$ 15,560	$ 4,631					$ 15,560	$ 4,631	
142	Other Medicare Cross-Over Payments (See Note D)					$ 1,760,191	$ 292,964			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 1,760,191	$ 292,964	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 341,484	$ 848,679			
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)**	$ 14,240,247	$ 4,471,496	$ (12,320,241)	$ (22,632,598)	$ (106,075)	$ 653,430	$ (62,397,468)	$ (19,632,141)	$ 4,871,348	$ 1,988,267	$ (60,583,537)	$ (37,139,813)	
146	**Calculated Payments as a Percentage of Cost**	85%	82%	108%	133%	106%	31%	204%	234%	7%	30%	119%	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)**					639								
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 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.

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,633.43										-	
2	03100 INTENSIVE CARE UNIT	$ 3,673.77										-	
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	$ 2,132.83										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		0.327869									$ -	$ -
23	5000 OPERATING ROOM		0.126797									$ -	$ -
24	5300 ANESTHESIOLOGY		0.084225									$ -	$ -
25	5400 RADIOLOGY-DIAGNOSTIC		0.119367									$ -	$ -
26	5500 RADIOLOGY-THERAPEUTIC		0.607316									$ -	$ -
27	5600 RADIOISOTOPE		0.299680									$ -	$ -
28	6000 LABORATORY		0.200153									$ -	$ -
29	6400 INTRAVENOUS THERAPY		0.345346									$ -	$ -
30	6500 RESPIRATORY THERAPY		0.458849									$ -	$ -
31	6600 PHYSICAL THERAPY		0.541368									$ -	$ -
32	6900 ELECTROCARDIOLOGY		0.173433									$ -	$ -
33	7000 ELECTROENCEPHALOGRAPHY		0.243232									$ -	$ -
34	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.368900									$ -	$ -
35	7200 IMPL. DEV. CHARGED TO PATIENTS		0.585345									$ -	$ -
36	7300 DRUGS CHARGED TO PATIENTS		0.207154									$ -	$ -
37	7400 RENAL DIALYSIS		0.383847									$ -	$ -
38	9000 CLINIC		1.609608									$ -	$ -
39	9100 EMERGENCY		0.250665									$ -	$ -
40	10500 KIDNEY ACQUISITION		-									$ -	$ -
41	10600 HEART ACQUISITION		-									$ -	$ -
42	10700 LIVER ACQUISITION		-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
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101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -				
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-				
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)									$ -	$ -		
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)									$ -	$ -		
135	Self-Pay (including Co-Pay and Spend-Down)									$ -	$ -		
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -								
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)									$ -	$ -		
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)									$ -	$ -		
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&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0	$ -	0								
2	Kidney Acquisition	$2,744,778.00	$ -	$ 2,744,778		23	$ 239,192	3	$ 170,750	2						
3	Liver Acquisition	$1,779,456.00	$ -	$ 1,779,456		22	$ 862,636	8	$ 539,148	6						
4	Heart Acquisition	$1,698,894.00	$ -	$ 1,698,894		18	$ 877,572	4	$ 438,786	2						
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ 6,223,128	$ -	$ 6,223,128	$ -	63	$ 1,979,400	15	$ 1,148,684	10	$ -	-	$ -	-	$ -	-
10	**Total Cost**							1,382,621		912,749		-		-		-

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

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ 2,744,778	$ -	$ 2,744,778	$ -	23								
13	Liver Acquisition	$ 1,779,456	$ -	$ 1,779,456	$ -	22								
14	Heart Acquisition	$ 1,698,894	$ -	$ 1,698,894	$ -	18								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ 6,223,128	$ -	$ 6,223,128	$ -	63	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HOSPITAL ATL AT EGLESTON

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	1,550,864,311
19	Uninsured Hospital	**Charges Sec. G**	28,809,475
20	Total Hospital	**Charges Sec. G**	2,289,247,484
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		67.75%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		1.26%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** 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.*

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

DSH Version 6.02 2/10/2023

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: 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	01/01/2022	12/31/2022
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

Must also complete a separate survey file for each cost report period listed - SEE DSH SURVEY PART II FILES

	Data
6. Medicaid Provider Number:	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 (07/01/21 - 06/30/22)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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 07/01/2021 - 06/30/2022** — $ 901,925
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2021 - 06/30/2022** — $ -
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2021 - 06/30/2022** — $ 901,925

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		

DSH Version 8.11 2/10/2023

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

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

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

	1/1/2022 through 12/31/2022		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		

3. Status of Cost Report Used for this Survey (Should be audited if available): 1 - As Submitted

3a. Date CMS processed the HCRIS file into the HCRIS database: 6/8/2023

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	CHILDREN'S HEALTHCARE-SCOTTISH RITE	Yes	
5. Medicaid Provider Number:	000001636A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	113301	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: (01/01/2022 - 12/31/2022)

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

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 928,201	$ 2,437,384	$3,365,585
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 3,150,981	$ 30,286,035	$33,437,016
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$4,079,182	$32,723,419	$36,802,601
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	22.75%	7.45%	9.14%

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

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

1.	Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	85,373 (See Note in Section F-3, below)

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

2.	Inpatient Hospital Subsidies	
3.	Outpatient Hospital Subsidies	
4.	Unspecified I/P and O/P Hospital Subsidies	
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	17,532,645
8.	Outpatient Hospital Charity Care Charges	25,488,790
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 43,021,435

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

		Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$389,895,529.00			$ 216,958,037	$ -	$ -	$ 172,937,492
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$0.00			$ -	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$680,841,108.00	$764,781,332.00		$ 378,855,205	$ 425,563,886	$ -	$ 641,203,349
20.	Outpatient Services		$206,127,598.00			$ 114,700,056	$ -	$ 91,427,542
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ -	-	-	$ -	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$526.00	$ -	$ -	$ 293	$ -
27.	Total	$ 1,070,736,637	$ 970,908,930	$ 526	$ 595,813,242	$ 540,263,943	$ 293	$ 905,568,383
28.	Total Hospital and Non Hospital		Total from Above	$ 2,041,646,093		Total from Above	$ 1,136,077,477	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	2,041,646,093	Total Contractual Adj. (G-3 Line 2)	1,136,077,477
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Adjusted Contractual Adjustments				1,136,077,477
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
		Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):									
1	03000 ADULTS & PEDIATRICS	$ 116,723,958	$ -	$ -	$0.00	$ 116,723,958	67,944	$163,072,848.00		$ 1,717.94
2	03100 INTENSIVE CARE UNIT	$ 59,771,173	$ -	$ -		$ 59,771,173	19,484	$167,652,781.00		$ 3,067.71
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 17,811,757	$ -	$ -		$ 17,811,757	9,846	$59,169,900.00		$ 1,809.03
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 194,306,888	$ -	$ -	$ -	$ 194,306,888	97,274	$ 389,895,529		
19	Weighted Average									$ 1,997.52

Line #			*Hospital Observation Days - Cost Report W/S S-3, Pt. I, Line 28, Col. 8*	*Subprovider I Observation Days - Cost Report W/S S-3, Pt. I, Line 28.01, Col. 8*	*Subprovider II Observation Days - Cost Report W/S S-3, Pt. I, Line 28.02, Col. 8*	*Calculated (Per Diems Above Multiplied by Days)*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Observation Data (Non-Distinct)									
20	09200	Observation (Non-Distinct)	11,901	-	-	$ 20,445,204	$13,620,439.00	$48,156,357.00	$ 61,776,796	0.330953

Line #			*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	$34,220,223.00	$ -	$ -		$ 34,220,223	$111,589,750.00	$136,137,557.00	$ 247,727,307	0.138137
22	5100	RECOVERY ROOM	$5,174,535.00	$ -	$ -		$ 5,174,535	$3,561,576.00	$7,955,787.00	$ 11,517,363	0.449281
23	5300	ANESTHESIOLOGY	$11,356,187.00	$ -	$ -		$ 11,356,187	$32,159,021.00	$41,652,740.00	$ 73,811,761	0.153853
24	5400	RADIOLOGY-DIAGNOSTIC	$13,162,064.00	$ -	$ -		$ 13,162,064	$26,350,862.00	$82,027,760.00	$ 108,378,622	0.121445
25	5500	RADIOLOGY-THERAPEUTIC	$7,872,144.00	$ -	$ -		$ 7,872,144	$3,053,926.00	$11,023,356.00	$ 14,077,282	0.559209
26	5600	RADIOISOTOPE	$680,306.00	$ -	$ -		$ 680,306	$268,563.00	$1,400,934.00	$ 1,669,497	0.407492
27	5800	MRI	$8,643,626.00	$ -	$ -		$ 8,643,626	$16,925,790.00	$68,292,747.00	$ 85,218,537	0.101429
28	6000	LABORATORY	$41,346,167.00	$ -	$ -		$ 41,346,167	$92,235,581.00	$119,630,803.00	$ 211,866,384	0.195152
29	6500	RESPIRATORY THERAPY	$38,146,287.00	$ -	$ -		$ 38,146,287	$85,886,311.00	$3,620,826.00	$ 89,507,137	0.426182
30	6600	PHYSICAL THERAPY	$28,808,415.00	$ -	$ -		$ 28,808,415	$7,830,029.00	$50,297,096.00	$ 58,127,125	0.495611
31	6800	SPEECH PATHOLOGY	$9,746,990.00	$ -	$ -		$ 9,746,990	$2,908,707.00	$16,548,352.00	$ 19,457,059	0.500949

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
32	7000	ELECTROENCEPHALOGRAPHY	$9,440,823.00	$ -	$ -		$ 9,440,823	$34,247,952.00	$27,435,334.00	$ 61,683,286	0.153053
33	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$15,175,185.00	$ -	$ -		$ 15,175,185	$11,890,038.00	$6,633,697.00	$ 18,523,735	0.819229
34	7200	IMPL. DEV. CHARGED TO PATIENTS	$30,279,342.00	$ -	$ -		$ 30,279,342	$47,234,838.00	$15,766,704.00	$ 63,001,542	0.480613
35	7300	DRUGS CHARGED TO PATIENTS	$68,402,833.00	$ -	$ -		$ 68,402,833	$149,766,815.00	$100,990,734.00	$ 250,757,549	0.272785
36	9000	CLINIC	$9,182,438.00	$ -	$ -		$ 9,182,438	$31,993.00	$7,807,586.00	$ 7,839,579	1.171292
37	9100	EMERGENCY	$48,618,748.00	$ -	$ -		$ 48,618,748	$41,278,561.00	$198,320,012.00	$ 239,598,573	0.202918
38			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
92		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125		$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126	**Total Ancillary**	$ 380,256,313	$ -	$ -		$ 380,256,313	$ 680,840,752	$ 943,698,382	$ 1,624,539,134	
127	**Weighted Average**									0.246656
128	**Sub Totals**	$ 574,563,201	$ -	$ -		$ 574,563,201	$ 1,070,736,281	$ 943,698,382	$ 2,014,434,663	
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*					$0.00				
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*					$0.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 574,563,201				
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 (01/01/2022-12/31/2022) 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	$ 1,717.94		10,587		17,914		4		6,035		1,071		34,540		63.54%
2	03100 INTENSIVE CARE UNIT	$ 3,067.71		3,598		7,159		14		3,195		212		13,966		72.77%
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	$ 1,809.03		1,224		3,578				2,653		26		7,455		75.98%
11		$ -		-		-								-		
12		$ -		-		-								-		
13		$ -		-		-								-		
14		$ -		-		-								-		
15		$ -		-		-								-		
16		$ -		-		-								-		
17		$ -		-		-								-		
18			**Total Days**	15,409		28,651		18		11,883		1,309		55,961		58.87%
19	Total Days per PS&R or Exhibit Detail			15,409		28,651		18		11,883		1,309				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 67,120,731		$ 136,031,100		$ 130,859		$ 63,077,514		$ 5,139,271		$ 266,360,204		69.63%
21.01	Calculated Routine Charge Per Diem			$ 4,355.94		$ 4,747.87		$ 7,269.94		$ 5,308.21		$ 3,926.10		$ 4,759.75		
	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)		0.330953	1,312,417	2,673,861	8,765,535	16,517,288	-	7,021	1,231,575	3,043,704	303,219	947,449	$ 11,309,527	$ 22,241,874	56.34%
23	5000 OPERATING ROOM		0.138137	14,873,601	10,869,627	34,906,872	45,100,841	-	23,478	15,277,145	9,155,667	1,673,455	1,657,706	$ 65,057,618	$ 65,149,613	53.91%
24	5100 RECOVERY ROOM		0.449281	585,609	1,011,818	1,324,656	3,690,783	-	2,998	508,772	802,324	74,143	114,159	$ 2,419,037	$ 5,507,923	70.46%
25	5300 ANESTHESIOLOGY		0.153853	4,417,586	4,263,286	9,981,252	14,403,340	-	8,055	4,437,964	3,534,231	487,175	369,342	$ 18,836,802	$ 22,208,912	56.77%
26	5400 RADIOLOGY-DIAGNOSTIC		0.121445	3,850,285	5,439,938	9,573,890	25,858,605	8,426	20,840	3,317,797	4,229,368	441,968	1,370,588	$ 16,750,396	$ 35,548,751	49.93%
27	5500 RADIOLOGY-THERAPEUTIC		0.559209	58,610	405,083	701,635	2,466,378	-	-	645,756	2,356,768	23,392	140,361	$ 1,406,001	$ 5,228,229	48.29%
28	5600 RADIOISOTOPE		0.407492	41,388	132,542	58,539	357,160	-	-	44,119	291,557	-	-	$ 144,046	$ 781,259	55.42%
29	5800 MRI		0.101429	1,900,531	6,062,969	6,177,998	18,603,383	-	-	2,000,158	6,318,121	166,018	396,212	$ 10,078,687	$ 30,984,473	48.85%
30	6000 LABORATORY		0.195152	15,959,154	13,195,593	30,659,103	47,097,821	17,460	7,918	12,874,284	8,706,836	1,321,466	2,075,194	$ 59,510,001	$ 69,008,168	62.26%
31	6500 RESPIRATORY THERAPY		0.426182	24,616,850	342,704	25,303,144	877,448	23,928	98	17,177,552	309,441	810,072	46,818	$ 67,121,474	$ 1,529,691	77.66%
32	6600 PHYSICAL THERAPY		0.495611	1,520,908	2,373,231	2,649,743	11,638,128	3,851	34,167	1,319,497	3,645,180	115,649	401,966	$ 5,493,999	$ 17,690,706	40.78%
33	6800 SPEECH PATHOLOGY		0.500949	421,499	568,429	972,952	4,537,699	-	1,557	250,505	1,318,491	27,960	133,408	$ 1,644,956	$ 6,426,176	42.31%
34	7000 ELECTROENCEPHALOGRAPHY		0.153053	6,680,461	3,164,069	11,772,194	13,296,072	-	7,002	4,759,480	2,928,734	336,410	372,851	$ 23,212,135	$ 19,395,877	70.23%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.819229	2,854,521	1,750,197	2,915,775	1,453,815	1,817	1,283	1,915,180	917,503	107,584	42,682	$ 7,687,293	$ 4,122,798	64.57%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.480613	6,433,881	2,026,193	11,694,176	3,970,137	-	334	6,735,532	2,040,328	493,575	184,812	$ 24,863,589	$ 8,036,992	53.30%
37	7300 DRUGS CHARGED TO PATIENTS		0.272785	29,047,674	14,139,186	42,719,566	29,772,651	29,696	11,031	27,005,460	18,050,516	1,831,369	1,154,577	$ 98,802,396	$ 61,973,384	65.31%
38	9000 CLINIC		1.171292	1,812	1,666,138	162,450	1,931,738	-	4,986	64,527	1,031,833	6,721	93,558	$ 228,789	$ 4,634,695	63.32%
39	9100 EMERGENCY		0.202918	4,984,409	8,298,997	16,318,363	91,687,031	14,535	14,971	3,251,133	7,471,113	859,257	7,523,226	$ 24,568,440	$ 107,472,112	58.61%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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60			-											$ -	$ -	
61			-											$ -	$ -	
62			-											$ -	$ -	

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

Cost Report Year (01/01/2022-12/31/2022) 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
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
69				-											$ -	$ -	
70				-											$ -	$ -	
71				-											$ -	$ -	
72				-											$ -	$ -	
73				-											$ -	$ -	
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75				-											$ -	$ -	
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120				-											$ -	$ -	
121				-											$ -	$ -	
122				-											$ -	$ -	
123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 119,561,196	$ 78,383,861	$ 216,657,843	$ 333,260,318	$ 99,713	$ 145,739	$ 102,816,436	$ 76,151,715	$ 9,079,433	$ 17,024,909			

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

Cost Report Year (01/01/2022-12/31/2022) 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)***	$ 186,681,927	$ 78,383,861	$ 352,688,943	$ 333,260,318	$ 230,572	$ 145,739	$ 165,893,950	$ 76,151,715	$ 14,218,704 (Agrees to Exhibit A)	$ 17,024,909 (Agrees to Exhibit A)	$ 705,495,392	$ 487,941,633	60.80%
129	Total Charges per PS&R or Exhibit Detail	$ 186,681,927	$ 78,383,861	$ 352,688,943	$ 333,260,318	$ 230,572	$ 145,739	$ 165,893,950	$ 76,151,715	$ 14,218,704	$ 17,024,909			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 65,542,560	$ 19,619,639	$ 114,802,089	$ 73,852,366	$ 78,895	$ 44,155	$ 53,631,900	$ 19,894,628	$ 4,793,772	$ 3,758,764	$ 234,055,444	$ 113,410,788	61.96%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 52,258,758	$ 21,200,150	$ 118,582,635	$ 111,185,953	$ -	$ -					$ 170,841,393	$ 132,386,103	
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)					$ -	$ -	$ 100,468,473	$ 41,965,662			$ 100,468,473	$ 41,965,662	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 421,515	$ 85,397			$ -	$ -					$ 421,515	$ 85,397	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 52,680,273	$ 21,285,547	$ 118,582,635	$ 111,185,953									
137	Medicaid Cost Settlement Payments (See Note B)		$ (2,129,673)									$ -	$ (2,129,673)	
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)					$ 133,197	$ 18,810			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 133,197	$ 18,810	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 928,201	$ 2,437,384			
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)**	$ 12,862,287	$ 463,765	$ (3,780,546)	$ (37,333,587)	$ (54,302)	$ 25,345	$ (46,836,573)	$ (22,071,034)	$ 3,865,571	$ 1,321,380	$ (37,809,134)	$ (58,915,511)	
146	**Calculated Payments as a Percentage of Cost**	80%	98%	103%	151%	169%	43%	187%	211%	19%	65%	116%	152%	
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)**					18								
148	**Percent of cross-over days to total Medicare days from the cost report**					100%								

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

Line #	Cost Center Description	Diem Cost for Routine Cost Centers	Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary Inpatient	Out-of-State Medicaid FFS Primary Outpatient	Out-of-State Medicaid Managed Care Primary Inpatient	Out-of-State Medicaid Managed Care Primary Outpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Inpatient	Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary) Outpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Inpatient	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) Outpatient	Total Out-Of-State Medicaid Inpatient	Total Out-Of-State Medicaid Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 1,717.94										-	
2	03100 INTENSIVE CARE UNIT	$ 3,067.71										-	
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	$ 1,809.03										-	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges											$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	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)		0.330953									$ -	$ -
23	5000 OPERATING ROOM		0.138137									$ -	$ -
24	5100 RECOVERY ROOM		0.449281									$ -	$ -
25	5300 ANESTHESIOLOGY		0.153853									$ -	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.121445									$ -	$ -
27	5500 RADIOLOGY-THERAPEUTIC		0.559209									$ -	$ -
28	5600 RADIOISOTOPE		0.407492									$ -	$ -
29	5800 MRI		0.101429									$ -	$ -
30	6000 LABORATORY		0.195152									$ -	$ -
31	6500 RESPIRATORY THERAPY		0.426182									$ -	$ -
32	6600 PHYSICAL THERAPY		0.495611									$ -	$ -
33	6800 SPEECH PATHOLOGY		0.500949									$ -	$ -
34	7000 ELECTROENCEPHALOGRAPHY		0.153053									$ -	$ -
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.819229									$ -	$ -
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.480613									$ -	$ -
37	7300 DRUGS CHARGED TO PATIENTS		0.272785									$ -	$ -
38	9000 CLINIC		1.171292									$ -	$ -
39	9100 EMERGENCY		0.202918									$ -	$ -
40			-									$ -	$ -
41			-									$ -	$ -
42			-									$ -	$ -
43			-									$ -	$ -
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -
48			-									$ -	$ -
49			-									$ -	$ -
50			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
51			-									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
57			-									$ -	$ -
58			-									$ -	$ -
59			-									$ -	$ -
60			-									$ -	$ -
61			-									$ -	$ -
62			-									$ -	$ -
63			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
80			-									$ -	$ -
81			-									$ -	$ -
82			-									$ -	$ -
83			-									$ -	$ -
84			-									$ -	$ -
85			-									$ -	$ -
86			-									$ -	$ -
87			-									$ -	$ -
88			-									$ -	$ -
89			-									$ -	$ -
90			-									$ -	$ -
91			-									$ -	$ -
92			-									$ -	$ -
93			-									$ -	$ -
94			-									$ -	$ -
95			-									$ -	$ -
96			-									$ -	$ -
97			-									$ -	$ -
98			-									$ -	$ -
99			-									$ -	$ -
100			-									$ -	$ -
101			-									$ -	$ -
102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

				Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)											$ -	$ -
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)											$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)											$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ -	$ -	$ -	$ -						
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)											$ -	$ -
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)											$ -	$ -
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&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*
	Organ Acquisition Cost Centers (list below):															
1	Lung Acquisition	$0.00	$ -	$ -		0										
2	Kidney Acquisition	$0.00	$ -	$ -		0										
3	Liver Acquisition	$0.00	$ -	$ -		0										
4	Heart Acquisition	$0.00	$ -	$ -		0										
5	Pancreas Acquisition	$0.00	$ -	$ -		0										
6	Intestinal Acquisition	$0.00	$ -	$ -		0										
7	Islet Acquisition	$0.00	$ -	$ -		0										
8		$0.00	$ -	$ -		0										
9	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
10	**Total Cost**							-		-		-		-		-

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

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	
							Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)	Charges	Useable Organs (Count)
		Cost Report Worksheet D-4, Pt. III, Col. 1, Ln 61	*Add-On Cost Factor on Section G, Line 133 x Total Cost Report Organ Acquisition Cost*	*Sum of Cost Report Organ Acquisition Cost and the Add-On Cost*	*Similar to Instructions from Cost Report W/S D-4 Pt. III, Col. 1, Ln 66 (substitute Medicare with Medicaid/ Cross-Over & uninsured). See Note C below.*	*Cost Report Worksheet D-4, Pt. III, Line 62*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*	*From Paid Claims Data or Provider Logs (Note A)*
	Organ Acquisition Cost Centers (list below):													
11	Lung Acquisition	$ -	$ -	$ -	$ -	0								
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0								
13	Liver Acquisition	$ -	$ -	$ -	$ -	0								
14	Heart Acquisition	$ -	$ -	$ -	$ -	0								
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0								
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0								
17	Islet Acquisition	$ -	$ -	$ -	$ -	0								
18		$ -	$ -	$ -	$ -	0								
19	**Totals**	$ -	$ -	$ -	$ -	-	$ -	-	$ -	-	$ -	-	$ -	-
20	**Total Cost**							-		-		-		-

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2022-12/31/2022) CHILDREN'S HEALTHCARE-SCOTTISH RITE

Worksheet A Provider Tax Assessment Reconciliation:

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

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	1,193,437,025
19	Uninsured Hospital	**Charges Sec. G**	31,243,613
20	Total Hospital	**Charges Sec. G**	2,014,434,663
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		59.24%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		1.55%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** 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.*