State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2017

DSH Version 5.20 11/1/2017

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2016	06/30/2017

2. Select Your Facility from the Drop-Down Menu Provided: CHILDREN'S HLTHCRE-HUGHES SPALDING

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	01/01/2017	12/31/2017
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:	000679808A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110079

B. DSH OB Qualifying Information

Questions 1-3, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the DSH Examination Year:

	DSH Examination Year (07/01/16 - 06/30/17)
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.)	Yes
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?	1952

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

	DSH Payment Year (07/01/18 - 06/30/19)
4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)	Yes

List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:

5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
6. Is 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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017**
   (Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

$ 687,401

Certification:

Answer
Yes

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.**

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.

Ruth Fowler

Hospital CEO or CFO Signature

Chief Financial Officer
Title

10/28/2018
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:

Name	Art Kutner
Title	Reimbursement Manager
Telephone Number	404-785-7963
E-Mail Address	art.kutner@choa.org
Mailing Street Address	3375 NE Expressway Suite 100
Mailing City, State, Zip	Atlanta, GA 30341-4007

Outside Preparer:

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

General Instructions and Identification of Cost Reports that Cover the DSH Year:

Macro Settings for Microsoft Excel 2007 Software

1. Please make sure Macros are enabled under the Excel options. If Macros are disabled, the DSH survey will not have full functionality. Macros can be enabled for Microsoft Excel 2007 software by first selecting "Excel Options" under the Microsoft Office File Menu Button (upper left hand corner of the screen). Then under the Excel Options dialog box select the "Trust Center" option. Under the Trust Center Dialog box select the "Trust Center Settings" button. Then select "Macro Settings" and click the "Enable all macros" button. Then press the OK button. After the Macro settings have been enabled it will be necessary to save changes and close the Excel program and re-open the DSH Survey Part II Excel workbook so the setting changes can take place.

   OR

   Select the Developer tab on the Excel Ribbon Menu. If the Developer tab is not displayed, click the Microsoft Office File Menu Button (upper left hand corner of the screen), then select the "Excel Options" button. Under Excel Options, Select the "Popular" category, then under "Top Options for working with Excel" select the "Show Developer Tab in The Ribbon" option. Once the Developer tab is available select the "Macro Security" option under the Code Group. Under Macro Security settings select the "Enable All Macros" option or the option that allows you to disable macros with notification (if the notification option is chosen, you will see a "SECURITY WARNING" message). Then close and re-open the Excel workbook so the settings changes can take place.

Macro Settings for Older Versions of Microsoft Excel Software

For older versions of Microsoft Excel software (before Microsoft Excel 2007) select the "Tools" menu. Under the Tools Menu select "Macro" - "Security". Then select "Low" or "Medium" security. Then close and re-open the Excel workbook for the settings changes to take place.

2. DSH Survey Sections A, B, and C are part of a separate Excel workbook titled DSH Survey Part I and should be submitted along with the completed DSH Survey Part II Excel workbook. DSH Survey sections A, B, and C contain DSH eligibility and certification questions.

3. Select the "Survey - Sec. D, E, F CR Data" tab in the Excel workbook. On Line 1, select your facility from the drop-down menu provided. When your facility is selected, the following Lines will be populated with your facility specific information: Line 2 - applicable cost report years, Line 4 - Hospital Name, Line 5 - in-state Medicaid provider number, Line 6 - Medicaid Subprovider Number 1 (Psychiatric or Rehab), Line 7 - Medicaid Provider Number 2 (Psychiatric or Rehab), and Line 8 -Medicare provider number. The provider must manually select the appropriate option from the drop down menu for Line 3 - Status of Cost Report Used for the Survey. Review the information and indicate whether it is correct or incorrect. If incorrect, provide correct information in the provided space and submit supporting documentation when you submit your survey.

4. You must complete a separate DSH Survey Part II Excel workbook for each cost report year needed to cover the State DSH year and not previously submitted for a DSH examination. To indicate the proper time period for the current survey select an "X" from the drop down menu on the appropriate box of Line 2 of the "Survey - Sec. D, E, F CR Data" tab in this Excel workbook. If two cost report years are selected at the same time the survey will generate an error message as only one cost report year may be selected per Excel workbook.

NOTE: For the 2014 DSH Survey, if your hospital completed the DSH survey for 2013, the first cost report year should follow the last cost report year reported on the 2013 DSH survey. The last cost report year on the 2014 survey must end on or after the end of the 2014 DSH year. If your hospital did not complete the 2013 survey, you must report data for each cost report year that covers the 2014 DSH year.

5. Supporting documentation for all data elements provided within the DSH survey must be maintained for a minimum of five years.

Exhibit A - Support of Uninsured I/P and O/P Hospital Services:

1. See Exhibit A for an example format of the information that needs to be available to support the data reported in Section H of the survey related to uninsured services provided in each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit A for each cost reporting period included in the survey.

2. Complete Exhibit A based on your individual state Medicaid hospital reimbursement methodology (if your state reimburses based on discharge date then only include claims in Exhibit A that were discharged during the cost reporting period for which you are pulling the data).

3. Exhibit A population should include all uninsured patients whose dates of service (see above) fall within the cost report period.

4. The total inpatient and outpatient *hospital (excluding professional fees, and other non-hospital items)* charges from Exhibit A, column N should tie to Section H, line 128 of the DSH survey.

Exhibit B - Support for Self-Pay I/P and O/P Hospital Payments Received:

1. See Exhibit B for an example format of the information that needs to be available to support the data reported in Section E of the survey related to ALL patient payments received during each cost reporting year needed to completely cover the DSH year. This information must be maintained by the facility in accordance with the documentation retention requirements outlined in the general instructions section. Submit a separate Exhibit B for each cost reporting period included in the survey.

   Note: Include Section 1011 payments received related to undocumented aliens if they are applied at a patient level.

2. Exhibit B population should include all payments received from patients during the cost report year regardless of dates of service and insurance status.

3. Only the payments received from uninsured patients should be included on Section H of the DSH survey, line 143. Payments from both the uninsured and insured patients should be reported on Section E of the DSH survey, lines 9 and 10, respectively. The total payments from Section H, line 143 should reconcile to Section E, line 9.

Section D - General Cost Report Year Information

1. For Lines 1 through 8 of Section D, please refer to the instructions listed above in the "General Information and Identification of Cost Reports that Cover the DSH Year" section.

2. For Lines 9 through 15, provide the name and Medicaid provider number for each state (other than your home state) where you had a current Medicaid provider agreement during the term of the DSH year. Per federal regulation, the DSH examination must review both in-state Medicaid services as well as out-of-state Medicaid services when determining the Medicaid shortfall or longfall.

Section E - Disclosure of Medicaid / Uninsured Payments Received

1. Please read "Note 1" located at the bottom of Section E before entering information for Lines 1 through 7. After reading through Note 1, please provide the applicable Section 1011 payment information as indicated.

2. Please read "Note 2" located at the bottom of Section E before entering information for Line 8. After reading through Note 2, please provide the total Out-of-State DSH payments as indicated.

3. Lines 9 and 10 should reconcile to the Exhibit B information provided by the facility.

4. Line 13 is a drop-down menu. Please answer 'Yes' or 'No' to the question.

5. Lines 14 and 15 should be completed if you answered 'Yes' to line 13. Please provide the amount of lump sum (non-claims-based) payments received from Medicaid Managed Care plans. Please also provide supporting documentation for the amounts reported in the form of cancelled checks, general ledger records, or some other financial records.

Section F - MIUR / LIUR Qualifying Data from the Cost Report

Section F-1 Total Hospital Days Used in Medicaid Inpatient Utilization Ration (MIUR)

1. Section F-1 is required to calculate the Medicaid Inpatient Utilization Rate (MIUR). The MIUR is a federal DSH eligibility criteria that must be met in order to receive DSH payments.

Section F-2 Cash Subsidies for Patient Services Received from State or Local Governments and Charity Care Charges

2. For Lines 2 through 6 report all state or local government cash subsidies received for patient care services. If the subsidies are directed specifically for inpatient or outpatient services, record the subsidies in the appropriate cell. If the subsidies do not specify inpatient or outpatient services, record the subsidies in the unspecified cell. If any subsidies are directed toward non-hospital services, record the subsidies in the non-hospital cell.

3. The unspecified subsidies will be allocated between inpatient and outpatient using your hospital volume statistics. State and local subsidies do not include regular Medicaid payments, supplemental (UPL) Medicaid payments or Medicaid/Medicare DSH payments. Subsidies are funds the hospital received from state or local government sources to assist hospitals to provide care to uninsured or underinsured patients.

4. Cash subsidies are used to calculate Medicaid DSH eligibility under the federal low-income utilization rate formula. They are NOT used to reduce your net uninsured cost for DSH payment programs.

5. For Lines 7 through 10 report the applicable charity care charges. Charity care charges are used in the calculation of the low-income utilization rate. Report the hospital's inpatient and outpatient charity care charges for the applicable cost reporting period. Any charity care charges related to non-hospital services should be reported on the non-hospital charity care charges line. Total charity care charges must reconcile to the charity care charges reported in your financial statements and/or annual audit or they must be in compliance with the definition of charity per your state's DSH payment program.

Section F-3 Calculation of Net Hospital Revenue from Patient Services (Used for LIUR)

6. For purposes of the low-income utilization rate (LIUR) calculation, it is necessary to calculate net hospital revenue from patient services. This section of the survey requests a breakdown of charges reported on cost report Worksheet G-2 between hospital and non-hospital services. The form directs you to allocate your total contractual adjustments, as reported on cost report Worksheet G-3, Line 2, between hospital and non-hospital services. The form provides space for an allocation of contractual allowances among service types. If contractual adjustment amounts are not maintained by service type in your accounting system, a reasonable allocation method must be used. This will allow for the calculation of net "hospital" revenue. Total charges and contractual adjustments must agree to your cost report. Contractuals may have been spread on the survey using formulas but you can overwrite those amounts with actual contractuals if you have the data.

7. A separate Excel workbook must be used for each cost reporting period needed to completely cover the DSH year as indicated in the "General Information and Identification of Cost Reports that Cover the DSH Year" section of the instructions.

Section G - CR Data

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.

1. The provider should enter all applicable Routine and Ancillary Cost Centers not currently provided in Section G. Once the Routine and Ancillary Cost Centers have been entered into Section G of the DSH survey, they will populate the Routine and Ancillary Cost Centers on DSH survey "Sec. H - In-State", "Sec. I - Out-of-State.

2. If your teaching hospital removed intern and resident costs in Column 25 of Worksheet B, Part I, you will need to enter those amounts in the column provided so the amounts can be added back to your total cost per diems and CCRs for Medicaid/Uninsured. If intern and resident cost was not removed in Column 25 of Worksheet B, Part I then no entry is needed. Teaching costs should be included in the final cost per diems and CCRs.

3. After the Routine and Ancillary Cost Centers have been identified, it will be necessary for the provider to fill in the remaining information required by Section G. The location of the specific cost report information required by Schedule G for both Routine and Ancillary Cost Centers is identified in each column heading. The provider will NOT need to enter data into the "Net Cost", or "Medicaid Per Diem/Cost-to-Charge Ratios" columns as these are calculated columns.

4. Once the "Medicaid Per Diem/Cost-to-Charge Ratios" column has been calculated, the values will also populate on DSH Survey "Sec. H - In-State", and "Sec. I - Out-of-State".

Section H - Calculation of In-State Medicaid and Uninsured I/P and O/P Costs:

1. This section of the survey is used to collect information to calculate the hospital's Medicaid shortfall or longfall. By federal Medicaid DSH regulations, the shortfall/longfall must be calculated using Medicare cost report costing methodologies.

2. The routine per diem cost per day for each hospital routine cost center present on the Medicaid cost report will automatically populate in Section H after DSH Survey "Sec. G - CR Data" has been completed. These amounts are calculated on Worksheet D-1 of the cost report. The ancillary cost-to-charge ratio for each ancillary cost center on your cost report will also automatically be populated in Section H after DSH Survey "Sec. G - CR Data" has been completed.

3. Record your routine days of care, routine charges and I/P and O/P ancillary charges in the next several columns. This information, when combined with cost information from the cost report, will calculate the total cost of hospital services provided to Medicaid and uninsured individuals.

In-State Medicaid FFS Primary

Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
In these two columns, record your in-state Medicaid fee-for-services days and charges. The days and charges should reconcile to your Medicaid provider statistics and reimbursement (PS&R) report, or your state version generated from the MMIS. Record in the box labeled "Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)," the total (gross) payments, prior to reductions for third party liability (TPL), your hospital received for these services. Reconcile your responses on the survey with the PS&R total at the bottom of each column. Provide an explanation for any unreconciled amounts.

In-State Medicaid Managed Care Primary

Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)
Same requirements as above, except payments received from the Medicaid Managed Care entity should be reported on the line titled "Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down)". If your hospital does business with more than one in-state Medicaid managed care entity, your combined results should be reported in these two columns (inpatient and outpatient). NOTE: 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.

In-State Medicare FFS Cross-Overs (with Medicaid Secondary)

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary
Each hospital must report its Medicare/Medicaid cross-over claims summary data on the survey. Total cross-over days and routine and ancillary charges must be reported and grouped in the same cost centers as reported on the hospital's cost report. Report payments as instructed on each line. In total, payments must include all amounts collected from the Medicare program, patient co-pays and deductible payments, Medicare bad debt payments, and any Medicaid payments and other third party payments.

N/A

In-State Other Medicaid Eligibles (Not Included Elsewhere)

In-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Enter claim charges, days, and payments for any other Medicaid-Eligible patients that have not been reported anywhere else in the survey. The patients must be Medicaid-eligible for the dates of service and they must be supported by Exhibit C and include the patient's Medicaid ID number. This would include Medicare Part C cross-overs not reported elsewhere on the survey.

N/A

N/A

N/A

N/A

N/A

N/A

N/A

N/A

Uninsured
Federal requirements mandate the uninsured services must be costed using Medicare cost reporting methodologies. As such, a hospital will need to report the uninsured days of care they provided each cost reporting period, by routine cost center, as well as inpatient and outpatient ancillary service revenue by cost report cost center. Exhibit A has been prepared to assist hospitals in developing the data needed to support responses on the survey. This data must be maintained in a reviewable format. It must also only include charges for inpatient and outpatient hospital services, excluding physician charges and other non-hospital charges. Per federal guidelines uninsured patients are individuals with no source of third party healthcare coverage (insurance) or third party liability for the specific service provided. See "Uninsured Definitions" tab for additional details.

4. Federal requirements mandate the hospital cost of providing services to the uninsured during the DSH year must be reduced by uninsured self-pay payments received during the DSH year. Exhibit B will assist hospitals in developing the data necessary to support uninsured payments received during each cost reporting period. The data must be maintained in a reviewable format and made available upon request.

Section I - Calculation of Out-of-State Medicaid Costs:

1. This schedule is formatted similar to Schedule H. It should be prepared to capture all out-of-state Medicaid FFS, managed care, FFS cross-over and managed care cross-over services the hospital provided during the cost reporting year. Like Schedule H, a separate schedule is required for each cost reporting period needed to completely cover the DSH year. Amounts reported on this schedule should reconcile to the out-of-state PS&R (or equivalent schedule) produced by the Medicaid program or managed care entity.

Out-of-State Medicaid FFS Primary
Traditional Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicaid Managed Care Primary
Managed Care Medicaid Primary (should exclude non-Title 19 programs such as CHIP/SCHIP)

Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)
Traditional Medicare Primary with Traditional Medicaid or Managed Care Medicaid Secondary

Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)
Out-of-State Other Medicaid Eligibles (Not Included Elsewhere) (should exclude non-Title 19 programs such as CHIP/SCHIP)

Section J - Calculation of In-State Medicaid and Uninsured Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred in-state Medicaid or uninsured organ acquisition costs only. Information is collected in a format similar to Section H.**

2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.

Section K - Calculation of Out-of-State Medicaid Organ Acquisition Costs:

1. **This section is to be completed by hospitals that have incurred out-of-state Medicaid organ acquisition costs only. Information is collected in a format similar to Section I.**
2. Total Medicaid and uninsured organ acquisition cost is calculated based on the ratio of Medicaid and uninsured useable organs to total organs.
3. The following columns will **NOT** need to be entered by the provider as they will automatically populate after Section J has been completed: "Total Organ Acquisition Cost", "Revenue for Medicaid/Uninsured Organs Sold", and "Total Useable Organs (Count)".

Section L. Provider Tax Assessment Reconciliation / Adjustment

1. **This section is to be completed by all hospitals in states that assess a provider tax on hospitals. Complete all lines as instructed below.**

   The objective of this form is to determine the state-assessed total hospital provider tax not included in your cost-to-charge ratios and per diem cost on the cost report.
2. Line 1 should be the total hospital Provider Tax Assessment from the general ledger, whether it is included as an expense, a revenue offset, etc..

   It should exclude non-hospital assessments such as a nursing facility tax unless an adjustment is made on W/S A-8 to remove the non-hospital expense.
3. Line 2 should be the total amount of the Provider Tax Assessment from line 1 that is included in Expense on Worksheet A, Column 2 of the cost report. Please report the cost report line number in which the expense is included in the box provided.
4. If there is a difference in the values you are reporting in lines 1 and 2, please explain that difference in the box provided (or attach separate explanation if it won't fit).
5. Lines 4-7 should identify any amount of the Provider Tax expense that was reclassified on Worksheet A-6 of the cost report. Please report the reasons for the reclassifications and the cost report line numbers affected in the boxes provided.
6. Lines 8-11 should identify any amount of the hospital allowable Provider Tax expense (assessed by the state) that was adjusted on Worksheet A-8 of the cost report.

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.
7. Lines 12-15 should identify Provider Tax expense adjustments on Worksheet A-8 of the cost report that are not related to the actual tax assessed by the state (e.g., association fees, other funding arrangments outside of the state's assessed tax).

   Please report the reasons for the adjustments and the affected cost report line numbers in the boxes provided.
8. Line 16 calculates the net Provider tax expense included in the cost report after all reclassifications and adjustments.
9. Line 17 calculates the total Provider Tax expense that has been excluded from the cost report - this amount is used to determine the amount that will be added back to your hospital's DSH UCC.
10. The amount on Line 25 may NOT be the final amount added into your DSH UCC. The examination will review the various adjustments and reconciliations and make a final determination.

Please submit your completed cost report year surveys (Part II), along with your Part I DSH Year Survey, and uninsured data analyses (exhibits A and B) electronically to Myers and Stauffer LC. This information contains protected health information (PHI), and as such, should be sent on CD or DVD via U.S. mail, or via other carrier authorized to transfer PHI.

Submit To:

Myers and Stauffer LC
Attention: DSH Examinations
700 W. 47th Street, Suite 1100
Kansas City, MO 64112
Fax: (816) 945-5301
Phone: (800) 374-6858
e-mail:

Include In Hospital Uninsured Charges:

To the extent hospital charges pertain to services that are medically necessary under applicable Medicaid standards and the services are defined as inpatient or outpatient hospital services under the Medicaid state plan the following charges are generally considered to be "uninsured":

Hospital inpatient and outpatient charges for services to patients who have no source of third party coverage for a specific inpatient hospital or outpatient hospital service (reported based on date of service). (*42 CFR 447.295 (b))*

- Include facility fee charges generated for hospital provider based sub-provider services to uninsured patients. Such services are identified as psychiatric or rehabilitation services, as identified on the facility cost report, Worksheet S-2, Line 3. The costs of these services are included on the provider's cost report.
- Include hospital charges for undocumented aliens with no source of third party coverage for hospital services. (73 FR dated 12/19/08, page 77916 / 42 CFR 447.299 (13))
- Include lab and therapy outpatient hospital services.
- Include services paid for by religious charities with no legal obligation to pay.

Include In Hospital Uninsured Payments:

Include all payments provided for hospital patients that met the uninsured definition for the specific inpatient or outpatient hospital service provided. The payments must be reported on a cash basis (report in the year provided, regardless of the year of service). (73 FR dated 12/19/08, pages 77913 & 77927)

- Include uninsured liens and uninsured accounts sold, when the cash is collected. (73 FR dated 12/19/08, pages 77942 & 77927)
- Include Section 1011 payments for hospital services without insurance or other third party coverage (undocumented aliens). (42 CFR 447.299 (13))
- Include other waiver payments for uninsured such as Hurricane Katrina/Rita payments. (73 FR dated 12/19/08, pages 77942 & 77927)

Do NOT Include In Hospital Uninsured Charges:

Exclude charges for patients who had hospital health insurance or other legally liable third party coverage for the specific inpatient or outpatient hospital service provided. Exclude charges for all non-hospital services. (42 CFR 447.295 (b))

- Exclude professional fees for hospital services to uninsured patients, such as Emergency Room (ER) physician charges and provider-based outpatient services. Exclude all physician professional services fees and CRNA charges. (42 CFR 447.299 (15) / 73 FR dated 12/19/08, pages 77924-77926)
- Exclude bad debts and charity care associated with patients that have insurance or other third party coverage for the specific inpatient or outpatient hospital service provided. (42 CFR 447.299 (15) and 42 CFR 447.295 (b))
- Exclude claims denied by an active health insurance carrier unless the entire claim was denied due to exhaustion of benefits or due to the benefit package not covering the specific inpatient or outpatient hospital service provided. *(73 FR dated 12/19/08, pages 77910-77911, 77913 and 42 CFR 447.295 (b))*
- Exclude uninsured charges for services that are not medically necessary (including elective procedures), under applicable Medicaid standards (if the service does not meet definition of a hospital service covered under the Medicaid state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77930)*
- Exclude charges for services to prisoners (wards of the state). *(73 FR dated 12/19/08, page 77915 / State Medicaid Director letter dated August 16, 2002)*
- Exclude Medicaid eligible patient charges (even if claim was not paid or denied). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77916)*
- Exclude patient charges covered under an automobile or liability policy that actually covers the hospital service (insured). *(45 CFR 146.113, 45 CFR 146.145, 73 FR dated 12/19/08, pages 77911 & 77916)*
- Exclude contractual adjustments required by law or contract with respect to services provided to patients covered by Medicare, Medicaid or other government or private third party payers (insured). (*42 CFR 447.299 (15), 73 FR dated 12/19/08, page 77922)*
- Exclude charges for services to patients where coverage has been denied by the patient's public or private payer on the basis of lack of medical necessity, regardless as to whether they met Medicaid's medical necessity and coverage criteria (still insured). *(73 FR dated 12/19/08, page 77916)*
- Exclude charges related to accounts with unpaid Medicaid or Medicare deductible or co-payment amounts (patient has coverage). *(42 CFR 447.299 (15))*
- Exclude charges associated with the provision of durable medical equipment (DME) or prescribed drugs that are for "at home use", because the goods or services upon which these charges are based are not hospital services. *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

- Exclude charges associated with services not billed under the hospital's provider numbers, as identified on the facility cost report, Worksheet S-2, Lines 2 and 3. These include non-hospital services offered by provider owned or provider based nursing facilities (SNF) and home health agencies (HHA). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude facility fees generated in provider based rural health clinic outpatient facilities (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, pages 77913 & 77926)*
- Exclude charges for provider's swing bed SNF services (not a hospital service in state plan). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*
- Exclude non-Title XIX charges including stand-alone Supplemental Children's Hospital Insurance Programs (SCHIP / CHIP).
- Exclude Independent Clinical ("Reference") Laboratory Charges (not a hospital service). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

Do NOT Include In Hospital Uninsured Payments:

- Exclude State, county or other municipal subsidy payments made to hospitals for indigent care. *(42 CFR 447.299 (12))*
- Exclude any individual payments or third party payments on deductibles and co-insurance on Commercial and Medicare accounts (cost not included so neither is payment). *(42 CFR 447.299 (15))*
- Exclude collections for non-hospital services: Skilled Nursing Facility, Nursing Facility, Rural Health Clinic, Federally Qualified Health Clinic, and non-hospital clinics (i.e. clinics not reported on Worksheet "C" Part I) (not hospital services). *(42 CFR 447.299 (14) / 73 FR dated 12/19/08, page 77913)*

December 3, 2014 Final Rule Highlights:

- **Medicaid Eligible Individuals:**

  • If an individual is Medicaid eligible for any day during a single inpatient stay for a particular service, states must classify the individual as Medicaid eligible.

  • If an individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, states cannot include any costs and revenues associated with that particular service when calculating the hospital-specific DSH limit.

  • If an individual has no source of third-party coverage for the specific inpatient hospital or outpatient hospital service, states should classify the individual as uninsured and include all costs and revenues associated with the particular service when calculating the hospital-specific DSH limit.

- **Uninsured and Underinsured:**

  • Individuals who have exhausted benefits before obtaining services will be considered uninsured.

  • Individuals who exhaust covered benefits during the course of a service will not be considered uninsured for the particular service. If the individual is not Medicaid eligible and has a source of third party coverage for all or a portion of the single inpatient stay for a particular service, the costs and revenues of the service cannot be included in the hospital-specific DSH limit.

  • Individuals with high deductible or catastrophic plans are considered insured for the service even in instances when the policy requires the individual to satisfy a deductible and/or share in the overall cost of the hospital service. The cost and revenues associated with these claims cannot be included in the hospital-specific DSH limit.

  • The costs and revenues, including the payments from private insurance for Medicaid eligible individuals, should be included in the calculation of the hospital-specific DSH limit.

- **Scope of Inpatient and Outpatient Hospital Services:**

  • To be considered as an inpatient or outpatient hospital service for purposes of Medicaid DSH, the service must meet the federal and state definitions of inpatient or outpatient hospital services and must be included in the state's definition of an inpatient or outpatient hospital service under the approved state plan.

  • FQHC services are not inpatient or outpatient hospital services and cannot be included in the hospital-specific DSH limit.

  • Example: If transplant services are not covered under the approved state plan, costs associated with transplants cannot be included in calculating the hospital-specific DSH limit.

  • Example: NF, HHA, employed physicians or other licensed practitioners are not recognized as inpatient or outpatient hospital services and are not covered under the inpatient or outpatient hospital Medicaid benefit service categories and cannot be included in the hospital-specific DSH limit.

  • Administratively necessary days (days awaiting placement) are recognized as inpatient hospital services and should be included in the hospital-specific DSH limit.

- **Timing of Service Specific Determination:**

  • The determination of an individual's status as having a source of third party coverage can occur only once per individual per service provided and applies to the entire claim's services.

• When benefits have been exhausted for individuals with a source of third party coverage, only costs associated with separate services provided after the exhaustion of covered benefits are permitted for inclusion in the calculation of the hospital-specific limit. These services must be a separate service based on the definition of a service for Medicaid (e.g., separate inpatient stay or separate outpatient billing period).

• Uncompensated care costs incurred by hospitals due to unpaid co-pays, co-insurance, or deductibles associated with a non-Medicaid eligible individual cannot be included in the calculation of the hospital-specific DSH limit.

■ **Physician Services:**

• Services that are not inpatient or outpatient hospital services, including physician services, must be excluded when calculating the hospital-specific DSH limit.

• Exception: Costs where insurance pays an all inclusive rate are allowable.

• Physician costs under Section 1115 waivers are still excluded from the DSH limit calculation.

■ **Prisoners:**

• Individuals who are inmates in a public institution or are otherwise involuntarily in secure custody as a result of criminal charges are considered to have a source of third party coverage.

■ **Indian Health Services:**

• For Medicaid DSH purposes, American Indians/Alaska Natives are considered to have third party coverage for inpatient and outpatient hospital services received directly from IHS or tribal health programs (direct health care services) and for services specifically authorized under CHS.

• Determining factor in deciding whether an American Indian or Alaska Native has health insurance for I/P or O/P hospital service is if the providing entity is an IHS facility or tribal health program.

• Contract Services (Non-IHS provider): if the service is specifically authorized via a purchase order or equivalent document, it is considered to be insured. If it does not have an authorization, it is considered an uninsured service.

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Code (PCN) (E)	Patient's Birth Date (F)	Patient's Social Security Number (G)	Patient's Gender (H)	Name (I)	Admit Date (J)	Discharge Date (K)	Service Indicator (Inpatient / Outpatient) (L)	Revenue Code (M)	Total Charges for Services Provided (N) *	Routine Days of Care (O)	Total Patient Payments for Services Provided (P) **	Total Private Insurance Payments for Services Provided (Q) **	Claim Status (Exhausted or Non-Covered Service ***, if applicable) (R)
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	110	$ 4,000.00	7		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	200	$ 4,500.00	3		$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	250	$ 5,200.25			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	300	$ 2,700.00			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	360	$ 15,000.75			$ -	
Uninsured Charges	Charity	Self-Pay	12345	2222222	1/1/1960	999-99-999	Female	Doe, Jane	3/1/2010	3/11/2010	Inpatient	450	$ 1,000.25			$ -	
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	250	$ 150.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Medicare		12345	4444444	7/12/1985	999-99-999	Male	Jones, James	6/15/2010	6/15/2010	Outpatient	450	$ 750.00		$ 500.00	$ -	Exhausted
Uninsured Charges	Blue Cross		12345	1111111	3/5/2000	999-99-999	Male	Smith, Mike	8/10/2010	8/10/2010	Outpatient	450	$ 1,100.00			$ -	Non-Covered Service

Notes for Completing Exhibit A:

* All charges for non-hospital services should be excluded.

** Payments reported in Columns P & Q are not reported in the survey. These amounts are used for examination purposes only. Amount should include all payments received to date on the account.

*** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B - Self Pay Collections

Claim Type (A)	Primary Payor Plan (B)	Secondary Payor Plan (C)	Transaction Code (D)	Hospital's Medicaid Provider # (E)	Patient Identifier Code (PCN) (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Date of Cash Collection (M)	Amount of Cash Collections (N)	Indicate if Collection is a 1011 Payment (O) ***	Service Indicator (Inpatient / Outpatient) (P)	Total Hospital Charges for Services Provided (Q) *	Total Physician Charges for Services Provided (R)	Total Other Non-Hospital Charges for Services Provided (S) **	Insurance Status When Services Were Provided (Insured or Uninsured) (T) *	Claim Status (Exhausted or Non-Covered Service****, if applicable) (U)	Calculated Hospital Uninsured Collections If (T)="Uninsured" or (U)="Exhausted" or (U)="Non-Covered Service",-(Q)/(Q+R+S)*(N), 0) *****
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	45695	999-99-999	Male	Jones, Anthony	34892	34894	40179	50	No	Inpatient	10000	900	0	Insured		=IF(ORT2="Uninsured", U2="Exhausted",U2=
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	45695	999-99-999	Male	Jones, Anthony	34892	34894	40210	50	No	Inpatient	10000	900	0	Insured		=IF(ORT3="Uninsured", U3="Exhausted",U3=
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	45695	999-99-999	Male	Jones, Anthony	34892	34894	40238	50	No	Inpatient	10000	900	0	Insured		=IF(ORT4="Uninsured", U4="Exhausted",U4=
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	45695	999-99-999	Male	Jones, Anthony	34892	34894	40269	50	No	Inpatient	10000	900	0	Insured		=IF(ORT5="Uninsured", U5="Exhausted",U5=
Self Pay Payments	Blue Cross	150	12345	9999999	29123	999-99-999	Male	Smith, John	36790	36790	40086	150	No	Outpatient	2000	0	50	Insured	Exhausted	=IF(ORT6="Uninsured", U6="Exhausted",U6=
Self Pay Payments	Blue Cross	150	12345	9999999	29123	999-99-999	Male	Smith, John	36790	36790	40117	150	No	Outpatient	2000	0	50	Insured	Exhausted	=IF(ORT7="Uninsured", U7="Exhausted",U7=
Self Pay Payments	Blue Cross	150	12345	9999999	29123	999-99-999	Male	Smith, John	36790	36790	40147	150	No	Outpatient	2000	0	50	Insured	Exhausted	=IF(ORT8="Uninsured", U8="Exhausted",U8=
Self Pay Payments	Self-Pay	500	12345	7777777	36716	999-99-999	Male	Cliff, Heath	40178	40179	40313	90	No	Inpatient	15000	1000	0	Uninsured		=IF(ORT9="Uninsured", U9="Exhausted",U9=
Self Pay Payments	Self-Pay	500	12345	7777777	36716	999-99-999	Male	Cliff, Heath	40178	40179	40329	90	No	Inpatient	15000	1000	0	Uninsured		=IF(ORT10="Uninsured", U10="Exhausted",U
Self Pay Payments	United Healthcare	500	12345	5555555	21961	999-99-999	Male	Johnson, Joe	38596	38598	40494	130	No	Inpatient	14000	400	50	Insured	Non-Covered Service	=IF(ORT11="Uninsured", U11="Exhausted",U

Notes for Completing Exhibit B:

* Charges and insurance status will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** Report services not covered under the patient's insurance package as a "Non-Covered Service". **Note - the service must be covered under the state Medicaid plan.**

***** The total Calculated Hospital Uninsured Collections (column V) should tie to the total Inpatient and Outpatient payments reported in Section H, Line 143 of the DSH Survey.

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

Example of Exhibit B-1

Summary of Self Pay Cash Collections During the Cost Report Year (Unknown Insurance Status)

NOTE: This is NOT intended for DOS prior to the cost report period. It is intended to be used for claims that are too old to determine the patient's true insurance status. Claims with DOS prior to the cost report period should be included in Exhibit B unless the patient's insurance status cannot be determined.

Patient Identifier Code (PCN) (A)	Name (B)	Admit Date (C)	Discharge Date (D)	Date of Cash Collection (E)	Amount of Cash Collections (F)	Indicate if Collection is a 1011 Payment (G) ***	Total Hospital Charges for Services Provided (H) *	Total Physician Charges for Services Provided (I)	Total Other Non-Hospital Charges for Services Provided (J) **	Calculated Uninsured Percentage (K) ****	Calculated Hospital Uninsured Collections (= (H)/((H)+(I)+(J))*(F)*(K))
8888888	Johnson, Joe	5/12/1999	5/25/1999	5/1/2010	$ 500	No	$ 55,000	$ 1,100	$ -	7%	$ 33
8888888	Johnson, Joe	5/12/1999	5/25/1999	3/1/2010	$ 250	Yes	$ 55,000	$ 1,100	$ -	7%	$ 16
8888888	Johnson, Joe	5/12/1999	5/25/1999	5/15/2010	$ 100	No	$ 55,000	$ 1,100	$ -	7%	$ 7
8888888	Johnson, Joe	5/12/1999	5/25/1999	6/15/2010	$ 300	No	$ 55,000	$ 1,100	$ -	7%	$ 20
5555555	Smith, Scott	7/1/2004	7/15/2004	2/18/2010	$ 800	No	$ 35,000	$ 550	$ 330	7%	$ 52
5555555	Smith, Scott	7/1/2004	7/15/2004	3/25/2010	$ 500	No	$ 35,000	$ 550	$ 330	7%	$ 33
5555555	Smith, Scott	7/1/2004	7/15/2004	4/28/2010	$ 200	No	$ 35,000	$ 550	$ 330	7%	$ 13
5555555	Smith, Scott	7/1/2004	7/15/2004	6/15/2010	$ 100	No	$ 35,000	$ 550	$ 330	7%	$ 7

Notes for Completing Exhibit B-1:

* Charges will be the same when listing multiple payments for the same patient and dates of service.

** Other Non-Hospital Charges should include RHC, FQHC, Pharmacy, etc...

*** If Section 1011 (Undocumented Alien) payments are applied at a patient level, include those payments in the cash collection column. If they are not applied at patient level, include them in Section E of the survey document.

**** The uninsured percentage should be calculated based on the total uninsured payments as a percentage of the self pay payments shown on Exhibit B. This percentage will be the same for all of the older service date collections since documentation is not available to support the insurance status.

Please submit the above data in an electronic file with this survey document. The electronic file must be submitted in Excel (.xls, .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key).

Example of Exhibit C (Other Medicaid Eligible example)

Claim Type (A) **	Primary Payor Plan (B)	Secondary Payor Plan (C)	Hospital's Medicaid Provider # (D)	Patient Identifier Number (PCN) (E)	Patient's Medicaid Recipient # (F)	Patient's Birth Date (G)	Patient's Social Security Number (H)	Patient's Gender (I)	Name (J)	Admit Date (K)	Discharge Date (L)	Service Indicator (Inpatient / Outpatient) (M)	Revenue Code (N)	Total Charges for Services Provided (O) *	Routine Days of Care (P)	Total Medicare Payments for Services Provided (Q)	Total Medicare HMO Payments for Services Provided (R)	Total Medicaid Payments for Services Provided (S)	Total Medicaid MCO Payments for Services	Total Private Insurance Payments for Services Provided (U)	Self-Pay Payments (V)	Sum of All Payments Received on Claim (Q)+(R)+(S)+(T)+(U)+(V)
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	120	$ 1,200	3	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	206	$ 1,500	1	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	250	$ 100	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	300	$ 375	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Blue Cross	Medicaid	12345	888888	123456789	1/1/1960	999-99-999	Male	James, Samuel	9/1/2009	9/4/2009	Inpatient	450	$ 1,500	-	$ -	$ -	$ 50	$ -	$ 1,500	$ -	$ 1,550
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	250	$ 100	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	300	$ 375	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Aetna	Medicaid	12345	666666	978654321	7/12/1985	999-99-999	Female	Johnson, Sandy	6/30/2010	6/30/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ -	$ -	$ 900	$ 75	$ 975
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	300	$ 375	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100
Other Medicaid Eligibles	Cigna	Medicaid	12345	555555	654321978	3/5/2000	999-99-999	Female	Jeffery, Susan	2/28/2010	2/28/2010	Outpatient	450	$ 1,500	-	$ -	$ -	$ 100	$ -	$ 1,000	$ -	$ 1,100

Notes for Completing Exhibit C:

* All charges for non-hospital services should be excluded.

**** A separate Exhibit C file should be submitted for each claim type reported (e.g. Medicaid Managed Care, Other Medicaid Eligibles, Out-of-State Medicaid, etc.). The format above should be used for each Exhibit C.**

Please submit the above data in the electronic file included with this survey document. The electronic file must be submitted in Excel (.xls or .xlsx). If this is not possible, the data must be submitted as a CSV (.csv) file using either the TAB or | (pipe symbol above the ENTER key). The data may not be accepted if not in one of these formats. Please do not alter column headings! These column headings will be used to input patient detail into a database from which Myers and Stauffer will generate reports.

DSH Version 7.25 5/3/2018

D. General Cost Report Year Information 1/1/2017 - 12/31/2017

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 HLTHCRE-HUGHES SPALDING		
		1/1/2017 through 12/31/2017		
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:	6/20/2018		

		Data	Correct?	If Incorrect, Proper Information
4.	Hospital Name:	CHILDREN'S HLTHCRE-HUGHES SPALDING		
5.	Medicaid Provider Number:	000679808A		
6.	Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7.	Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8.	Medicare Provider Number:	110079		
8a.	Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
8b.	DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban		

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: (01/01/2017 - 12/31/2017)

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)	$ 150	$ 114,447	$114,597
10.	Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 22,476	$ 424,493	$446,969
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)	$22,626	$538,940	$561,566
12.	Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	0.66%	21.24%	20.41%

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 (01/01/2017 - 12/31/2017)

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)	211,774	**(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	
8.	Outpatient Hospital Charity Care Charges	
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ -

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

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	$581,331,826.00			$ 476,541,473	$ -	$ -	$ 104,790,353
12.	Subprovider I (Psych or Rehab)	$15,686,059.00			$ 12,858,504	$ -	$ -	$ 2,827,555
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$18,070,407.00			$ 14,813,052	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$2,128,211,223.00	$1,415,901,576.00		$ 1,744,581,778	$ 1,160,672,428	$ -	$ 638,858,593
20.	Outpatient Services		$343,879,048.00			$ 281,891,719	$ -	$ 61,987,329
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance			$ 194,374,643	-	-	$ 159,336,844	
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$5,154.00	$7,418,494.00	$0.00	$ 4,225	$ 6,081,243	$ -	$ 1,338,180
27.	Total	$ 2,725,234,262	$ 1,767,199,118	$ 212,445,050	$ 2,233,985,979	$ 1,448,645,391	$ 174,149,896	$ 809,802,010
28.	Total Hospital and Non Hospital		Total from Above	$ 4,704,878,430		Total from Above	$ 3,856,781,266	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	4,704,878,430	Total Contractual Adj. (G-3 Line 2)	3,856,781,266
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)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35.	Adjusted Contractual Adjustments				3,856,781,266

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) | CHILDREN'S HLTHCRE-HUGHES SPALDING

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	$ 106,649,337	$ 27,812,902	$ 1,318,866	$0.00	$ 135,781,105	131,763	$247,224,658.00		$ 1,030.49
2	03100 INTENSIVE CARE UNIT	$ 57,599,027	$ 9,007,663	$ -		$ 66,606,690	41,729	$187,590,244.00		$ 1,596.17
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 31,903,333	$ 3,510,418	$ 184,038		$ 35,597,789	16,282	$96,362,927.00		$ 2,186.33
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000 SUBPROVIDER I	$ 7,301,545	$ 2,053,768	$ 124,614		$ 9,479,927	8,730	$15,686,059.00		$ 1,085.90
8	04100 SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300 NURSERY	$ 4,542,890	$ 1,154,073	$ -		$ 5,696,963	5,353	$4,734,806.00		$ 1,064.26
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 13,248,589	$ 2,380,443	$ -		$ 15,629,032	11,041	$40,061,545.00		$ 1,415.54
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 221,244,721	$ 45,919,267	$ 1,627,518	$ -	$ 268,791,506	214,898	$ 591,660,239		
19	Weighted Average									$ 1,250.78

		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)	3,124	-	-	$ 3,219,251	$1,923,252.00	$5,890,922.00	$ 7,814,174	0.411976

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) | CHILDREN'S HLTHCRE-HUGHES SPALDING

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*		*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	$48,482,105.00	$ 8,466,775	$880,349.00		$ 57,829,229	$577,977,586.00	$161,723,284.00	$ 739,700,870	0.078179
22	5200 DELIVERY ROOM & LABOR ROOM	$12,376,611.00	$ 498,046	$0.00		$ 12,874,657	$18,804,699.00	$4,156,552.00	$ 22,961,251	0.560712
23	5300 ANESTHESIOLOGY	$5,645,584.00	$ 4,758,209	$395,536.00		$ 10,799,329	$113,180,108.00	$30,404,350.00	$ 143,584,458	0.075212
24	5400 RADIOLOGY-DIAGNOSTIC	$20,478,198.00	$ 1,732,448	$100,580.00		$ 22,311,226	$78,961,134.00	$99,475,314.00	$ 178,436,448	0.125037
25	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW	$33,057.00	$ -	$0.00		$ 33,057	$321,087.00	$0.00	$ 321,087	0.102953
26	5600 RADIOISOTOPE	$8,525,994.00	$ 1,154,073	$78,179.00		$ 9,758,246	$52,811,353.00	$66,143,075.00	$ 118,954,428	0.082033
27	5700 CT SCAN	$6,389,144.00	$ 3,510,418	$202,298.00		$ 10,101,860	$186,535,144.00	$175,248,007.00	$ 361,783,151	0.027922
28	5800 MRI	$3,328,305.00	$ 669,416	$35,859.00		$ 4,033,580	$32,505,640.00	$36,599,411.00	$ 69,105,051	0.058369
29	6000 LABORATORY	$40,391,068.00	$ 2,658,920	$0.00		$ 43,049,988	$285,404,307.00	$281,687,599.00	$ 567,091,906	0.075914
30	6001 LABORATORY-CRESTVIEW	$41,778.00	$ -	$0.00		$ 41,778	$421,937.00	$0.00	$ 421,937	0.099015
31	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	$11,573,347.00	$ -	$0.00		$ 11,573,347	$45,503,964.00	$13,392,319.00	$ 58,896,283	0.196504
32	6500 RESPIRATORY THERAPY	$12,675,099.00	$ -	$0.00		$ 12,675,099	$156,778,779.00	$7,477,024.00	$ 164,255,803	0.077167
33	6501 RESPIRATORY THERAPY-CRESTVIEW	$771,492.00	$ -	$0.00		$ 771,492	$15,656,084.00	$0.00	$ 15,656,084	0.049277
34	6600 PHYSICAL THERAPY	$10,191,595.00	$ 535,532	$24,964.00		$ 10,752,091	$60,063,307.00	$13,963,400.00	$ 74,026,707	0.145246
35	6601 PHYSICAL THERAPY-CRESTVIEW	$1,274,141.00	$ -	$0.00		$ 1,274,141	$19,492,813.00	$0.00	$ 19,492,813	0.065365
36	6900 ELECTROCARDIOLOGY	$4,080,466.00	$ -	$0.00		$ 4,080,466	$51,556,277.00	$34,849,133.00	$ 86,405,410	0.047225
37	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	$26,084,060.00	$ -	$0.00		$ 26,084,060	$64,075,269.00	$19,489,400.00	$ 83,564,669	0.312142
38	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW	$284,487.00	$ -	$0.00		$ 284,487	$1,441,265.00	$0.00	$ 1,441,265	0.197387
39	7200 IMPL. DEV. CHARGED TO PATIENTS	$24,742,451.00	$ -	$0.00		$ 24,742,451	$42,938,682.00	$8,055,982.00	$ 50,994,664	0.485197
40	7300 DRUGS CHARGED TO PATIENTS	$53,813,294.00	$ -	$0.00		$ 53,813,294	$141,203,415.00	$71,065,881.00	$ 212,269,296	0.253514
41	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW	$735,471.00	$ -	$0.00		$ 735,471	$865,691.00	$0.00	$ 865,691	0.849577
42	7302 OUTPATIENT PHARMACY	$65,338,043.00	$ -	$0.00		$ 65,338,043	$54,581.00	$112,764,609.00	$ 112,819,190	0.579139
43	7400 RENAL DIALYSIS	$6,680,618.00	$ -	$0.00		$ 6,680,618	$18,068,165.00	$20,087,375.00	$ 38,155,540	0.175089
44	7601 PULMONARY FUNCTION TESTING	$1,629,847.00	$ -	$308,884.00		$ 1,938,731	$4,771,829.00	$8,526,901.00	$ 13,298,730	0.145783
45	7602 CARDIOVASCULAR LAB	$6,633,622.00	$ 267,766	$132,644.00		$ 7,034,032	$27,996,634.00	$9,811,387.00	$ 37,808,021	0.186046
46	9000 CLINIC	$58,205,959.00	$ 17,444,983	$628,668.00		$ 76,279,610	$12,962,659.00	$182,400,441.00	$ 195,363,100	0.390450
47	9001 SATELLITE CLINICS	$26,684,983.00	$ -	$78,141.00		$ 26,763,124	$459,320.00	$34,921,925.00	$ 35,381,245	0.756421
48	9100 EMERGENCY	$71,232,549.00	$ 15,045,795	$1,513,476.00		$ 87,791,820	$133,130,359.00	$334,085,818.00	$ 467,216,177	0.187904
49	9201 OBSERVATION BEDS (DISTINCT PART)	$3,702,756.00	$ -	$0.00		$ 3,702,756	$1,148,311.00	$13,109,082.00	$ 14,257,393	0.259708
50		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
51		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
55		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
56		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
57		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
58		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
59		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
60		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
61		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
62		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
63		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
64		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
65		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
66		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
67		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
68		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
69		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
70		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
71		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
72		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
73		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
74		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
75		$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) | CHILDREN'S HLTHCRE-HUGHES SPALDING

	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
76			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

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
126	**Total Ancillary**	$ 532,026,124	$ 56,742,381	$ 4,379,578	$ 593,148,083	$ 2,147,013,651	$ 1,745,329,191	$ 3,892,342,842	
127	**Weighted Average**								0.153215
128	**Sub Totals**	$ 753,270,845	$ 102,661,648	$ 6,007,096	$ 861,939,589	$ 2,738,673,890	$ 1,745,329,191	$ 4,484,003,081	
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)*				$481,333.00				
131	NF, SNF, and Swing Bed Cost for Other Payors *(Hospital must calculate. Submit support for calculation of cost.)*								
131.01	Other Cost Adjustments (support must be submitted)								
132	**Grand Total**				$ 861,458,256				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost				13.52%				

* 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 (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From Hospital's Own Internal Analysis	From Hospital's Own Internal Analysis			
	Routine Cost Centers (from Section G):			Days		Days		Days		Days		Days		Days		
1	03000 ADULTS & PEDIATRICS	$ 1,030.49		771		1,521				5		52		2,297		1.83%
2	03100 INTENSIVE CARE UNIT	$ 1,596.17												-		0.00%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,186.33												-		0.00%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ 1,085.90												-		0.00%
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,064.26												-		0.00%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 1,415.54												-		0.00%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			Total Days	771		1,521		-		5		52		2,297		1.09%
19	Total Days per PS&R or Exhibit Detail			771		1,521		-		5		52				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges		
21	Routine Charges			$ 982,254		$ 1,815,450		$ -		$ 11,239		$ 70,577		$ 2,808,943		0.49%
21.01	Calculated Routine Charge Per Diem			$ 1,274.00		$ 1,193.59		$ -		$ 2,247.80		$ 1,357.25		$ 1,222.87		
	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)		0.411976	5,756	136,867	54,252	575,881			2,735	8,791		22,392	$ 62,743	$ 721,539	10.32%
23	5000 OPERATING ROOM		0.078179		1,242	2,484	1,631				228		326	$ 2,484	$ 3,101	0.00%
24	5200 DELIVERY ROOM & LABOR ROOM		0.560712											$ -	$ -	0.00%
25	5300 ANESTHESIOLOGY		0.075212											$ -	$ -	0.00%
26	5400 RADIOLOGY-DIAGNOSTIC		0.125037	234,639	879,535	1,030,701	4,441,280			3,677	26,396	11,078	343,164	$ 1,269,017	$ 5,347,211	3.91%
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		0.102953											$ -	$ -	0.00%
28	5600 RADIOISOTOPE		0.082033											$ -	$ -	0.00%
29	5700 CT SCAN		0.027922											$ -	$ -	0.00%
30	5800 MRI		0.058369											$ -	$ -	0.00%
31	6000 LABORATORY		0.075914	696,578	3,961,659	950,275	6,420,483			11,288	68,299	31,567	647,279	$ 1,658,141	$ 10,450,441	2.25%
32	6001 LABORATORY-CRESTVIEW		0.099015											$ -	$ -	0.00%
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.196504											$ -	$ -	0.00%
34	6500 RESPIRATORY THERAPY		0.077167	4,203,520	979,131	5,792,520	3,827,038			26,817	57,675	278,903	484,397	$ 10,022,857	$ 4,863,844	9.53%
35	6501 RESPIRATORY THERAPY-CRESTVIEW		0.049277											$ -	$ -	0.00%
36	6600 PHYSICAL THERAPY		0.145246	4,847	1,854	30,077	54,199				33		264	$ 34,924	$ 56,086	0.12%
37	6601 PHYSICAL THERAPY-CRESTVIEW		0.065365											$ -	$ -	0.00%
38	6900 ELECTROCARDIOLOGY		0.047225	11,102	79,872	46,525	153,292				7,379	555	63,638	$ 57,627	$ 240,543	0.42%
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.312142	219,329	566,447	441,135	2,901,345			2,843	20,468	22,317	290,335	$ 663,307	$ 3,488,260	5.34%
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		0.197387											$ -	$ -	0.00%
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.485197	200	800						8			$ 200	$ 808	0.00%
42	7300 DRUGS CHARGED TO PATIENTS		0.253514	540,624	1,400,716	879,477	2,561,761			8,244	101,612	35,022	294,889	$ 1,428,345	$ 4,064,089	2.74%
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		0.849577											$ -	$ -	0.00%
44	7302 OUTPATIENT PHARMACY		0.579139											$ -	$ -	0.00%
45	7400 RENAL DIALYSIS		0.175089											$ -	$ -	0.00%
46	7601 PULMONARY FUNCTION TESTING		0.145783											$ -	$ -	0.00%
47	7602 CARDIOVASCULAR LAB		0.186046											$ -	$ -	0.00%
48	9000 CLINIC		0.390450	562	2,877,144	45,911	8,740,715			491	98,042	3,161	309,513	$ 46,964	$ 11,715,901	6.18%
49	9001 SATELLITE CLINICS		0.756421											$ -	$ -	0.00%
50	9100 EMERGENCY		0.187904	915,132	10,078,339	2,001,996	59,118,081			16,670	171,440	94,757	6,207,514	2,933,798	69,367,860	16.82%
51	9201 OBSERVATION BEDS (DISTINCT PART)		0.259708											$ -	$ -	0.00%
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
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89			-											$ -	$ -	
90			-											$ -	$ -	

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

Cost Report Year (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

					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		%
91				-											$ -	$ -	-
92				-											$ -	$ -	
93				-											$ -	$ -	
94				-											$ -	$ -	
95				-											$ -	$ -	
96				-											$ -	$ -	
97				-											$ -	$ -	
98				-											$ -	$ -	
99				-											$ -	$ -	
100				-											$ -	$ -	
101				-											$ -	$ -	
102				-											$ -	$ -	
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117				-											$ -	$ -	
118				-											$ -	$ -	
119				-											$ -	$ -	
120				-											$ -	$ -	
121				-											$ -	$ -	
122				-											$ -	$ -	
123				-											$ -	$ -	
124				-											$ -	$ -	

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

Cost Report Year (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

				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		%
125			-											$ -	$ -	-
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 6,832,289	$ 20,963,606	$ 11,275,353	$ 88,795,706	$ -	$ -	$ 72,765	$ 560,371	$ 477,360	$ 8,663,711			
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***			$ 7,814,543	$ 20,963,606	$ 13,090,803	$ 88,795,706	$ -	$ -	$ 84,004	$ 560,371	$ 547,937 (Agrees to Exhibit A)	$ 8,663,711 (Agrees to Exhibit A)	$ 20,989,350	$ 110,319,683	3.13%
129	Total Charges per PS&R or Exhibit Detail			$ 7,814,543	$ 20,963,606	$ 13,090,803	$ 88,795,706	$ -	$ -	$ 84,004	$ 560,371	$ 547,937	$ 8,663,711			
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**			$ 1,582,490	$ 4,096,243	$ 2,999,258	$ 17,666,948	$ -	$ -	$ 15,967	$ 119,576	$ 113,799	$ 1,594,370	$ 4,597,715	$ 21,882,767	3.27%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)			$ 1,970,759	$ 3,932,839	$ 3,467,506	$ 21,960,126							$ 5,438,265	$ 25,892,965	
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)			$ 8,250	$ 41,727	$ 63,677	$ 234,776							$ 71,927	$ 276,503	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)			$ 1,979,009	$ 3,974,566	$ 3,531,183	$ 22,194,902									
137	Medicaid Cost Settlement Payments (See Note B)				$ (169,334)									$ -	$ (169,334)	
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)											(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 150	$ 114,447			
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)**			$ (396,519)	$ 291,011	$ (531,925)	$ (4,527,954)	$ -	$ -	$ 15,967	$ 119,576	$ 113,649	$ 1,479,923	$ (912,477)	$ (4,117,367)	
146	**Calculated Payments as a Percentage of Cost**			125%	93%	118%	126%	0%	0%	0%	0%	0%	7%	120%	119%	
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)**							57,044								
148	**Percent of cross-over days to total Medicare days from the cost report**							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.

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

L Out-of-State Medicaid Data:

Cost Report Year (01/01/2017-12/31/2017) CHILDRENS H,THCRE-HUGHES SPALDING

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
	Routing Cost Centers (list below):			Days		Days		Days		Days		Days	
1	0200 NICU,TR,SI & PEDIATRICS	$ 1,530.48										-	
2	0210 INTENSIVE CARE UNIT	$ 1,596.17										-	
3	0220 CORONARY CARE UNIT	$ -										-	
4	0230 BURN INTENSIVE CARE UNIT	$ -										-	
5	0240 SURGICAL INTENSIVE CARE UNIT	$ 2,186.15										-	
6	0250 OTHER SPECIAL CARE UNIT	$ -										-	
7	0600 NURSERY	$ 1,085.99										-	
8	0610 SUBPROVIDER I	$ -										-	
9	0620 OTHER SUBPROVIDER	$ -										-	
10	0630 NURSERY	$ 1,064.28										-	
11	0901 NEONATAL INTENSIVE CARE UNIT	$ 1,415.56										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			Total Days	-	-	-	-	-	-	-	-	-	-
19	Total Days per PS&R or Exhibit Detail			-	-	-	-	-	-	-	-		
20	Unreconciled Days (Explain Variance)			-	-	-	-	-	-	-	-		
21	Routine Charges			Routine Charges		Routine Charges		Routine Charges		Routine Charges		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	
22	0230 Observation (Non-Distinct)		0.411976									$ -	$ -
23	0500 OPERATING ROOM		0.078179									$ -	$ -
24	0300 DELIVERY ROOM & LABOR ROOM		0.569212									$ -	$ -
25	0360 ANESTHESIOLOGY		0.075212									$ -	$ -
26	0400 RADIOLOGY-DIAGNOSTIC		0.129357									$ -	$ -
27	0401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		0.102853									$ -	$ -
28	0600 RADIOISOTOPE		0.082933									$ -	$ -
29	0700 CT SCAN		0.057992									$ -	$ -
30	0800 MRI		0.058369									$ -	$ -
31	0930 LABORATORY		0.075814									$ -	$ -
32	0931 LABORATORY-CRESTVIEW		0.099015									$ -	$ -
33	0936 WHOLE BLOOD & PACKED RED BLOOD CELL		0.186564									$ -	$ -
34	0940 RESPIRATORY THERAPY		0.077167									$ -	$ -
35	0941 RESPIRATORY THERAPY-CRESTVIEW		0.049277									$ -	$ -
36	0950 PHYSICAL THERAPY		0.145246									$ -	$ -
37	0951 PHYSICAL THERAPY-CRESTVIEW		0.063365									$ -	$ -
38	0960 ELECTROCARDIOLOGY		0.047320									$ -	$ -
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.301742									$ -	$ -
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		0.197387									$ -	$ -
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.464197									$ -	$ -
42	7300 DRUGS CHARGED TO PATIENTS		0.243514									$ -	$ -
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		0.203017									$ -	$ -
44	7302 OUTPATIENT PHARMACY		0.579139									$ -	$ -
45	7400 RENAL DIALYSIS		0.179089									$ -	$ -
46	7601 PULMONARY FUNCTION TESTING		0.143763									$ -	$ -
47	7602 CARDIOVASCULAR LAB		0.186946									$ -	$ -
48	9000 CLINIC		0.360450									$ -	$ -
49	9001 SATELLITE CLINICS		0.756421									$ -	$ -
50	9100 EMERGENCY		0.167004									$ -	$ -
51	9201 OBSERVATION BEDS (DISTINCT PART)		0.259706									$ -	$ -
52			-									$ -	$ -
53			-									$ -	$ -
54			-									$ -	$ -
55			-									$ -	$ -
56			-									$ -	$ -
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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)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
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 (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

		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 Acquistion 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 (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

		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 Acquistion 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 (01/01/2017-12/31/2017) CHILDREN'S HLTHCRE-HUGHES SPALDING

Worksheet A Provider Tax Assessment Reconciliation:

		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*	$ 426,772		
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 ---------->)	$ 426,772		
	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	$ 426,772

** Assessment must exclude any non-hospital assessment such as Nursing Facility.*