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

DSH Version 6.00 2/21/2020

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: GRADY MEMORIAL HOSPITAL

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2019	12/31/2019
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000000855A
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 (07/01/18 - 06/30/19)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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?	No
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?	06/02/1892

State of Georgia
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C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2018 - 06/30/2019** — $ 70,102,287
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2018 - 06/30/2019**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2018 - 06/30/2019** — $ 70,102,287

Certification:

	Answer
1. **Was your hospital allowed to retain 100% of the DSH payment it received for this DSH year? Matching the federal share with an IGT/CPE is not a basis for answering this question "no". If your hospital was not allowed to retain 100% of its DSH payments, please explain what circumstances were present that prevented the hospital from retaining its payments.**	Yes

Explanation for "No" answers:

The following certification is to be completed by the hospital's CEO or CFO:

I hereby certify that the information in Sections A, B, C, D, E, F, G, H, I, J, K and L of the DSH Survey files are true and accurate to the best of our ability, and supported by the financial and other records of the hospital. All Medicaid eligible patients, including those who have private insurance coverage, have been reported on the DSH survey regardless of whether the hospital received payment on the claim. I understand that this information will be used to determine the Medicaid program's compliance with federal Disproportionate Share Hospital (DSH) eligibility and payments provisions. Detailed support exists for all amounts reported in the survey. These records will be retained for a period of not less than 5 years following the due date of the survey, and will be made available for inspection when requested.

Hospital CEO or CFO Signature	Title	Date
	CFO	10.26.20

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Richard Rhine	404-616-3504	rrhine@gmh.edu

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

Hospital Contact:	
Name	Felicia Sims
Title	Director of Reimbursement
Telephone Number	404-616-0606
E-Mail Address	fasims@gmh.edu
Mailing Street Address	80 Jesse Hill Jr. Dr.
Mailing City, State, Zip	Atlanta, GA 30303

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

Example of Exhibit A - Uninsured Charges

Claim Type (A)	Primary Payer Plan (B)	Secondary Payer 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 Payer Plan (B)	Secondary Payer 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	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	1/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	2/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	3/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Medicare	Medicaid	500	12345	3333333	2/7/2025	999-99-999	Male	Jones, Anthony	7/12/1995	7/14/1995	4/1/2010	$ 50	No	Inpatient	$ 10,000	$ 900	$ -	Insured		$ -
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	9/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	10/31/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Blue Cross		150	12345	9999999	9/25/1979	999-99-999	Male	Smith, John	9/21/2000	9/21/2000	11/30/2009	$ 150	No	Outpatient	$ 2,000	$ -	$ 50	Insured	Exhausted	$ 146
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/15/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	Self-Pay		500	12345	7777777	7/9/2000	999-99-999	Male	Cliff, Heath	12/31/2009	1/1/2010	5/31/2010	$ 90	No	Inpatient	$ 15,000	$ 1,000	$ -	Uninsured		$ 84
Self Pay Payments	United Healthcare		500	12345	5555555	2/15/1960	999-99-999	Male	Johnson, Joe	9/1/2005	9/3/2005	11/12/2010	$ 130	No	Inpatient	$ 14,000	$ 400	$ 50	Insured	Non-Covered Service	$ 126

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 C (Other Medicaid Eligible example)

Claim Type (A) **	Primary Payer Plan (B)	Secondary Payer 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)	Medicaid MCO Payments for Services Provided (T)	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.

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D. General Cost Report Year Information 1/1/2019 - 12/31/2019

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:	GRADY MEMORIAL HOSPITAL		
	1/1/2019 through 12/31/2019		
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:			

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	GRADY MEMORIAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000855A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110079	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Urban	Yes	

Out-of-State Medicaid Provider Number. List all states where you had a Medicaid provider agreement during the cost report year:

	State Name	Provider No.
9. State Name & Number	ALABAMA	1992799050
10. State Name & Number	ARKANSAS	206845105
11. State Name & Number	CONNECTICUT	1992799050
12. State Name & Number	DELAWARE	1992799050
14. State Name & Number	HAWAII	1992799050
15. State Name & Number	ILLINOIS	262037695-001

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2019 - 12/31/2019)

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)	$ 839,566	$ 4,607,314	$5,446,881
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,241,756	$ 3,514,707	$4,756,462
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)	$2,081,322	$8,122,021	$10,203,343
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	40.34%	56.73%	53.38%

NOTE: According to the payment data entered above, uninsured patient payments account for more than half of all patient payments. Please verify this is correct.

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 (01/01/2019 - 12/31/2019)

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)	240,452	**(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	62,762,444
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 62,762,444
7.	Inpatient Hospital Charity Care Charges	361,457,749
8.	Outpatient Hospital Charity Care Charges	526,208,082
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 887,665,831

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)			
11.	Hospital	$816,032,744.00			$ 690,586,210	$ -	$ -	$ 125,446,534
12.	Subprovider I (Psych or Rehab)	$20,123,708.00			$ 17,030,144	$ -	$ -	$ 3,093,564
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$43,609,499.00			$ 18,781,912	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$2,591,563,515.00	$1,655,924,226.00		$ 2,193,169,378	$ 1,401,363,418	$ -	$ 652,954,945
20.	Outpatient Services		$281,521,642.00			$ 238,244,072	$ -	$ 43,277,570
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 269,943,210	-	-	$ 213,212,967	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$369,510,209.00	$ -	$ -	$ 223,914,047	$ -
27.	Total	$ 3,427,719,967	$ 1,937,445,868	$ 683,062,918	$ 2,900,785,732	$ 1,639,607,490	$ 455,908,926	$ 824,772,613

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	6,048,228,753	Total Contractual Adj. (G-3 Line 2)	4,996,302,148
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				4,996,302,148
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) | GRADY MEMORIAL HOSPITAL

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	$ 136,472,107	$ 34,087,502	$ 1,171,457	$0.00	$ 171,731,066	158,794	$385,547,086.00		$ 1,081.47
2	03100	INTENSIVE CARE UNIT	$ 79,489,319	$ 10,969,388	$ -		$ 90,458,707	52,001	$258,953,122.00		$ 1,739.56
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ 34,993,303	$ 3,271,518	$ 141,566		$ 38,406,387	15,504	$143,474,810.00		$ 2,477.19
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 5,941,850	$ 1,127,264	$ -		$ 7,069,114	5,337	$5,464,610.00		$ 1,324.55
11	35.01	NICU	$ 15,768,040	$ 2,260,656	$ 23,037		$ 18,051,733	10,715	$45,707,172.00		$ 1,684.72
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 272,664,619	$ 51,716,328	$ 1,336,060	$ -	$ 325,717,007	242,351	$ 839,146,800		
19		Weighted Average									$ 1,343.99

Line #		Observation Data (Non-Distinct)	*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*
20	09200	Observation (Non-Distinct)	3,018	-	-	$ 3,263,876	$1,480,329.00	$5,777,242.00	$ 7,257,571	0.449720

Line #		Ancillary Cost Centers (from W/S C excluding Observation) (list below):	*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*
21	5000	OPERATING ROOM	$50,774,779.00	$ 9,232,543	$153,151.00		$ 60,160,473	$665,048,080.00	$189,574,745.00	$ 854,622,825	0.070394
22	5200	DELIVERY ROOM & LABOR ROOM	$13,868,772.00	$ 572,822	$0.00		$ 14,441,594	$23,692,428.00	$6,210,746.00	$ 29,903,174	0.482945
23	5300	ANESTHESIOLOGY	$7,241,651.00	$ 5,535,237	$111,341.00		$ 12,888,229	$128,404,999.00	$39,849,304.00	$ 168,254,303	0.076600
24	5400	RADIOLOGY-DIAGNOSTIC	$22,270,519.00	$ 2,524,092	$0.00		$ 24,794,611	$110,969,669.00	$129,848,572.00	$ 240,818,241	0.102960
25	5401	RADIOLOGY-DIAGNOSTIC-CRESTVIEW	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
26	5600	RADIOISOTOPE	$8,163,022.00	$ 1,050,684	$0.00		$ 9,213,706	$39,238,219.00	$70,675,381.00	$ 109,913,600	0.083827
27	5700	CT SCAN	$6,978,995.00	$ 4,649,967	$0.00		$ 11,628,962	$252,137,754.00	$234,749,607.00	$ 486,887,361	0.023884
28	5800	MRI	$3,626,520.00	$ 805,626	$0.00		$ 4,432,146	$36,431,821.00	$47,860,919.00	$ 84,292,740	0.052580
29	6000	LABORATORY	$43,912,429.00	$ 3,201,064	$0.00		$ 47,113,493	$349,913,073.00	$368,747,684.00	$ 718,660,757	0.065557
30	6001	LABORATORY-CRESTVIEW	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

	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
31	6200	WHOLE BLOOD & PACKED RED BLOOD	$13,596,915.00	$ -	$0.00		$ 13,596,915	$62,832,614.00	$22,418,906.00	$ 85,251,520	0.159492
32	6500	RESPIRATORY THERAPY	$14,840,075.00	$ -	$0.00		$ 14,840,075	$230,309,529.00	$12,905,837.00	$ 243,215,366	0.061016
33	6501	RESPIRATORY THERAPY-CRESTVIEW	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
34	6600	PHYSICAL THERAPY	$13,332,670.00	$ 563,633	$43,679.00		$ 13,939,982	$69,787,699.00	$20,535,254.00	$ 90,322,953	0.154335
35	6601	PHYSICAL THERAPY-CRESTVIEW	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
36	6900	ELECTROCARDIOLOGY	$5,917,437.00	$ -	$0.00		$ 5,917,437	$78,781,207.00	$46,640,165.00	$ 125,421,372	0.047180
37	7100	MEDICAL SUPPLIES CHARGED TO PAT	$31,933,584.00	$ -	$0.00		$ 31,933,584	$79,723,017.00	$15,179,408.00	$ 94,902,425	0.336489
38	7101	MEDICAL SUPPLIES CHARGED CRESTV	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$27,476,978.00	$ -	$0.00		$ 27,476,978	$47,238,583.00	$7,930,514.00	$ 55,169,097	0.498050
40	7300	DRUGS CHARGED TO PATIENTS	$70,671,973.00	$ -	$0.00		$ 70,671,973	$175,444,588.00	$110,620,026.00	$ 286,064,614	0.247049
41	7301	DRUGS CHARGED TO PATIENTS-CREST	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
42	7302	OUTPATIENT PHARMACY	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
43	7400	RENAL DIALYSIS	$8,085,400.00	$ -	$0.00		$ 8,085,400	$20,650,013.00	$26,105,712.00	$ 46,755,725	0.172929
44	7601	PULMONARY FUNCTION TESTING	$1,630,806.00	$ -	$153,869.00		$ 1,784,675	$4,936,703.00	$8,957,900.00	$ 13,894,603	0.128444
45	7602	CARDIOVASCULAR LAB	$7,688,669.00	$ 673,909	$100,552.00		$ 8,463,130	$36,154,107.00	$12,903,892.00	$ 49,057,999	0.172513
46	9000	CLINIC	$72,844,309.00	$ 18,553,918	$412,729.00		$ 91,810,956	$19,608,242.00	$246,448,910.00	$ 266,057,152	0.345080
47	9001	SATELLITE CLINICS	$29,306,037.00	$ -	$50,202.00		$ 29,356,239	$516,841.00	$53,194,660.00	$ 53,711,501	0.546554
48	9100	EMERGENCY	$73,172,778.00	$ 16,415,792	$592,487.00		$ 90,181,057	$174,765,632.00	$438,186,390.00	$ 612,952,022	0.147126
49	9201	OBSERVATION BEDS (DISTINCT PART	$4,162,687.00	$ -	$0.00		$ 4,162,687	$1,864,347.00	$12,768,570.00	$ 14,632,917	0.284474
50		HUGES SPALDING COST- SEE SUPPORT	($50,090,217.00)	$ -	$0.00		$ (50,090,217)	$0.00	$0.00	$ -	-
51			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
52		NOTE: CRESTVIEW & RETAIL PHARMACY	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
53		COSTS REMOVED SINCE NOT APPLICABLE	$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
54		TO ACUTE CARE SERVICES.	$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	$ -	-
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

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
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	$ -	-
126	**Total Ancillary**	$ 481,406,788	$ 63,779,287	$ 1,618,010		$ 546,804,085	$ 2,609,929,494	$ 2,128,090,344	$ 4,738,019,838	
127	**Weighted Average**									0.126668
128	**Sub Totals**	$ 754,071,407	$ 115,495,615	$ 2,954,070		$ 872,521,092	$ 3,449,076,294	$ 2,128,090,344	$ 5,577,166,638	
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)*					$687,798.00				
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*									
131.01	Other Cost Adjustments (support must be submitted)									
132	**Grand Total**					$ 871,833,294				
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost					15.26%				

* 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 (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

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	$ 1,081.47		35,268		5,969		7,119		31,780		32,592		80,136		73.00%
2	03100 INTENSIVE CARE UNIT	$ 1,739.56		13,127		919		2,711		9,937		7,569		26,694		66.28%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,477.19		4,035		854		364		3,240		3,430		8,493		77.70%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,324.55		1,874		3,060		20		231		132		5,185		100.00%
11	35.01 NICU	$ 1,684.72		3,378		6,180				474		64		10,032		94.24%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	57,682		16,982		10,214		45,662		43,787		130,540		72.48%
19	Total Days per PS&R or Exhibit Detail			57,682		16,982		10,214		45,662		43,787				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 159,175,522		$ 56,139,460		$ 34,101,914		$ 151,764,595		$ 140,808,404		$ 401,181,491		65.11%
21.01	Calculated Routine Charge Per Diem			$ 2.759.54		$ 3,305.82		$ 3,338.74		$ 3,323.65		$ 3,215.76		$ 3,073.25		
	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)		0.449720	356,983	311,892	10,292	175,956	63,860	277,264	326,244	1,012,336	204,104	859,196	$ 757,379	$ 1,777,448	50.02%
23	5000 OPERATING ROOM		0.070394	88,578,630	11,875,666	30,526,293	10,890,277	14,460,148	7,882,070	88,953,032	18,758,368	212,976,375	80,682,216	$ 222,518,103	$ 49,406,381	66.62%
24	5200 DELIVERY ROOM & LABOR ROOM		0.482945	5,722,337	536,487	12,278,208	2,848,621	121,301	35,730	2,980,263	688,440	959,477	1,323,870	$ 21,102,109	$ 4,109,278	92.42%
25	5300 ANESTHESIOLOGY		0.076600	18,516,100	2,763,635	10,550,764	2,115,922	2,784,128	1,601,226	17,884,084	4,208,433	36,531,314	16,923,185	$ 49,735,076	$ 10,689,216	68.04%
26	5400 RADIOLOGY-DIAGNOSTIC		0.102960	17,845,041	8,651,059	4,472,548	6,048,052	3,894,147	3,725,028	17,766,919	10,809,894	21,933,311	53,504,866	$ 43,978,655	$ 29,234,033	62.11%
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-											$ -	$ -	
28	5600 RADIOISOTOPE		0.083827	7,240,092	8,684,459	625,057	5,321,355	1,522,010	3,501,364	7,281,739	11,591,294	7,952,845	19,856,528	$ 16,668,898	$ 29,098,472	67.09%
29	5700 CT SCAN		0.023884	35,821,258	18,519,944	5,444,624	10,319,242	10,289,553	8,401,432	37,517,561	21,014,399	64,536,662	102,822,748	$ 89,072,996	$ 58,255,017	65.13%
30	5800 MRI		0.052580	6,536,978	3,444,113	1,034,472	1,618,349	1,493,908	2,280,017	6,403,408	8,053,839	7,308,511	19,550,432	$ 15,468,766	$ 15,396,318	68.71%
31	6000 LABORATORY		0.065557	73,480,788	45,320,866	15,088,898	27,735,812	16,584,170	13,388,432	66,650,703	38,511,759	69,692,978	147,046,398	$ 171,804,559	$ 124,956,869	71.88%
32	6001 LABORATORY-CRESTVIEW		-											$ -	$ -	
33	6200 WHOLE BLOOD & PACKED RED BLOOD		0.159492	16,851,266	3,899,525	6,094,059	2,088,860	2,865,489	1,049,591	14,766,144	1,864,978	17,909,329	4,195,506	$ 40,576,958	$ 8,902,954	84.52%
34	6500 RESPIRATORY THERAPY		0.061016	53,355,332	124,112	11,804,361	54,643	10,477,658	76,993	40,629,148	181,628	28,239,480	486,228	$ 116,266,499	$ 437,376	60.28%
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-											$ -	$ -	
36	6600 PHYSICAL THERAPY		0.154335	15,127,371	3,893,075	2,918,176	457,627	2,665,926	558,687	13,326,379	2,809,468	10,343,062	6,951,929	$ 34,037,852	$ 7,718,857	65.74%
37	6601 PHYSICAL THERAPY-CRESTVIEW		-											$ -	$ -	
38	6900 ELECTROCARDIOLOGY		0.047180	14,346,096	4,472,540	1,744,272	1,495,686	4,385,670	2,184,774	15,148,688	6,197,752	14,312,993	18,453,208	$ 35,624,726	$ 14,350,752	66.41%
39	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.336489	15,612,239	958,798	3,001,000	408,238	2,757,897	608,462	14,271,179	1,453,415	15,346,805	4,725,513	$ 35,642,316	$ 3,428,913	62.69%
40	7101 MEDICAL SUPPLIES CHARGED CRESTV		-											$ -	$ -	
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.498050	6,917,072	766,900	1,585,832	238,476	942,234	405,420	6,604,937	913,243	11,231,235	2,492,703	$ 16,050,075	$ 2,324,039	58.64%
42	7300 DRUGS CHARGED TO PATIENTS		0.247049	36,771,572	13,854,522	10,024,323	8,787,237	6,142,909	7,729,297	31,637,801	16,440,604	29,401,637	20,888,325	$ 84,576,605	$ 46,811,660	63.97%
43	7301 DRUGS CHARGED TO PATIENTS-CREST		-											$ -	$ -	
44	7302 OUTPATIENT PHARMACY		-											$ -	$ -	
45	7400 RENAL DIALYSIS		0.172929	4,563,304	987,453	120,662	98,307	1,698,865	212,047	4,045,788	1,510,989	1,597,436	21,961,552	$ 10,428,619	$ 2,808,796	78.90%
46	7601 PULMONARY FUNCTION TESTING		0.128444	1,417,886	1,293,184	19,466	198,940	215,535	669,980	1,071,781	1,775,371	1,173,092	2,134,125	$ 2,724,668	$ 3,937,475	71.75%
47	7602 CARDIOVASCULAR LAB		0.172513	6,357,490	1,615,738	316,538	364,430	1,442,384	920,536	5,956,744	2,188,952	8,561,970	3,790,999	$ 14,073,156	$ 5,089,656	64.61%
48	9000 CLINIC		0.345080	4,459,058	21,637,900	861,900	16,769,085	873,883	8,190,231	4,040,708	37,476,712	3,850,216	71,791,799	$ 10,235,548	$ 84,073,927	64.09%
49	9001 SATELLITE CLINICS		0.546554	162,353	4,620,469	27,708	4,217,228	35,622	1,698,215	87,204	6,407,637	69,731	22,820,170	$ 312,887	$ 16,943,549	74.82%
50	9100 EMERGENCY		0.147126	24,552,391	29,253,862	4,385,706	16,689,774	6,593,443	9,714,941	22,749,003	24,941,193	52,048,379	161,474,579	$ 58,280,542	$ 80,599,770	58.01%
51	9201 OBSERVATION BEDS (DISTINCT PART		0.284474	301,331	966,769	25,048	313,596	51,832	347,944	218,736	1,291,708	271,312	4,657,936	$ 596,947	$ 2,920,017	58.16%
52	HUGES SPALDING COST- SEE SUPPORT		-											$ -	$ -	
53			-											$ -	$ -	
54	NOTE: CRESTVIEW & RETAIL PHARMACY		-											$ -	$ -	
55	COSTS REMOVED SINCE NOT APPLICABLE		-											$ -	$ -	
56	TO ACUTE CARE SERVICES.		-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
61				-											$ -	$ -	-
62				-											$ -	$ -	
63				-											$ -	$ -	
64				-											$ -	$ -	
65				-											$ -	$ -	
66				-											$ -	$ -	
67				-											$ -	$ -	
68				-											$ -	$ -	
69				-											$ -	$ -	
70				-											$ -	$ -	
71				-											$ -	$ -	
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74				-											$ -	$ -	
75				-											$ -	$ -	
76				-											$ -	$ -	
77				-											$ -	$ -	
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121				-											$ -	$ -	
122				-											$ -	$ -	
123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 454,892,967	$ 188,452,967	$ 122,960,207	$ 119,255,713	$ 92,362,571	$ 75,459,680	$ 420,318,194	$ 220,102,412	$ 616,452,253	$ 789,394,010			

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

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

		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		%
	Totals / Payments													
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 614,068,489	$ 188,452,967	$ 179,099,668	$ 119,255,713	$ 126,464,485	$ 75,459,680	$ 572,082,788	$ 220,102,412	$ 757,260,658 (Agrees to Exhibit A)	$ 789,394,010 (Agrees to Exhibit A)	$ 1,491,715,430	$ 603,270,772	65.73%
129	Total Charges per PS&R or Exhibit Detail	$ 614,068,489	$ 188,452,967	$ 179,099,668	$ 119,255,713	$ 126,464,485	$ 75,459,680	$ 572,082,788	$ 220,102,412	$ 757,260,658	$ 789,394,010			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 132,314,640	$ 27,415,711	$ 42,755,977	$ 19,248,616	$ 23,107,342	$ 10,936,595	$ 108,274,779	$ 35,343,898	$ 120,836,597	$ 105,987,509	$ 306,452,738	$ 92,944,820	72.30%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 103,865,267	$ 27,567,281		$ 1,302	$ 298,126	$ 1,098,994	$ 158,350	$ 1,246,927			$ 104,321,743	$ 29,914,504	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 35,254,387	$ 13,795,968	$ 6,334	$ 13	$ 246,260	$ 73,912			$ 35,506,981	$ 13,869,893	
134	Private Insurance (including primary and third party liability)	$ 648,649	$ 75,350	$ 21,303	$ 102,502	$ 85,890	$ 6,792	$ 17,458,504	$ 3,376,425			$ 18,214,346	$ 3,561,069	
135	Self-Pay (including Co-Pay and Spend-Down)		$ 164,329	$ 1,240	$ 11,455	$ 1,393	$ 13,201	$ 36,868	$ 117,248			$ 39,501	$ 306,233	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 104,513,916	$ 27,806,960	$ 35,276,930	$ 13,911,227									
137	Medicaid Cost Settlement Payments (See Note B)		$ (3,979,747)									$ -	$ (3,979,747)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 31,841,614	$ 6,750,936	$ 32,201,934	$ 3,335,841			$ 64,043,548	$ 10,086,777	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 39,140,134	$ 12,195,900			$ 39,140,134	$ 12,195,900	
141	Medicare Cross-Over Bad Debt Payments					$ 1,125,880	$ 600,347					$ 1,125,880	$ 600,347	
142	Other Medicare Cross-Over Payments (See Note D)					$ (176,380)	$ 676,016	$ 924,984	$ 738,654	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 748,604	$ 1,414,670	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 839,566	$ 4,607,314			
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)**	$ 27,800,724	$ 3,588,498	$ 7,479,047	$ 5,337,389	$ (10,075,515)	$ 1,790,296	$ 18,107,745	$ 14,258,992	$ 119,997,031	$ 101,380,195	$ 43,312,000	$ 24,975,176	
146	**Calculated Payments as a Percentage of Cost**	79%	87%	83%	72%	144%	84%	83%	60%	1%	4%	86%	73%	
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)**					35,225								
148	**Percent of cross-over days to total Medicare days from the cost report**					29%								

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include *all* Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

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)		
	Routine Cost Centers (list below):			Days		Days		Days		Days		Days	
1	03000 ADULTS & PEDIATRICS	$ 1,081.47		72		5		21		887		985	
2	03100 INTENSIVE CARE UNIT	$ 1,739.56		20		2		5		177		204	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,477.19		28						95		123	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 1,324.55								20		20	
11	35.01 NICU	$ 1,684.72								2		2	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	120		7		26		1,181		1,334	
19	Total Days per PS&R or Exhibit Detail			120		7		26		1,181			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		Routine Charges		Routine Charges		Routine Charges		Routine Charges	
21	Routine Charges			$ 440,892		$ 22,922		$ 66,420		$ 3,840,579		$ 4,370,813	
21.01	Calculated Routine Charge Per Diem			$ 3,674.10		$ 3,274.57		$ 2,554.62		$ 3,251.97		$ 3,276.47	
	Ancillary Cost Centers (from W/S C) (list below):			Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges	Ancillary Charges
22	09200 Observation (Non-Distinct)		0.449720							18,848	13,516	$ 18,848	$ 13,516
23	5000 OPERATING ROOM		0.070394	617,113	-	-		-		2,875,225	260,318	$ 3,492,338	$ 260,318
24	5200 DELIVERY ROOM & LABOR ROOM		0.482945	-	2,739	-		-		116,918	20,640	$ 116,918	$ 23,379
25	5300 ANESTHESIOLOGY		0.076600	108,625	-	-		-		454,570	42,081	$ 563,195	$ 42,081
26	5400 RADIOLOGY-DIAGNOSTIC		0.102960	68,734	33,478	6,367		2,607		428,269	388,662	$ 505,977	$ 422,140
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-									$ -	$ -
28	5600 RADIOISOTOPE		0.083827	11,273	15,234	-		-		89,675	50,855	$ 100,948	$ 66,089
29	5700 CT SCAN		0.023884	209,316	62,552	6,815		3,714		1,302,774	825,111	$ 1,522,619	$ 887,663
30	5800 MRI		0.052580	18,901	-	5,025		-		103,613	69,502	$ 127,539	$ 69,502
31	6000 LABORATORY		0.065557	194,717	99,761	12,101		22,725		1,711,150	1,022,415	$ 1,940,693	$ 1,122,176
32	6001 LABORATORY-CRESTVIEW		-									$ -	$ -
33	6200 WHOLE BLOOD & PACKED RED BLOOD		0.159492	40,556	5,505	5,742		-		391,587	23,811	$ 437,885	$ 29,316
34	6500 RESPIRATORY THERAPY		0.061016	202,886	-	-		11,592		969,443	2,118	$ 1,183,921	$ 2,118
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-									$ -	$ -
36	6600 PHYSICAL THERAPY		0.154335	37,126	1,499			675		274,812	9,513	$ 312,613	$ 11,012
37	6601 PHYSICAL THERAPY-CRESTVIEW		-									$ -	$ -
38	6900 ELECTROCARDIOLOGY		0.047180	46,398	27,748	4,863		4,863		324,423	143,505	$ 380,547	$ 171,253
39	7100 MEDICAL SUPPLIES CHARGED TO PAT		0.336489	57,357	217	-		1,184		277,494	11,899	$ 336,034	$ 12,116
40	7101 MEDICAL SUPPLIES CHARGED CRESTV		-									$ -	$ -
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.498050	111,688		356				141,763	1,637	$ 253,808	$ 1,637
42	7300 DRUGS CHARGED TO PATIENTS		0.247049	92,084	7,065	1,171		8,935		1,102,590	97,160	$ 1,204,781	$ 104,225
43	7301 DRUGS CHARGED TO PATIENTS-CREST		-									$ -	$ -
44	7302 OUTPATIENT PHARMACY		-									$ -	$ -
45	7400 RENAL DIALYSIS		0.172929							95,496		$ 95,496	$ -
46	7601 PULMONARY FUNCTION TESTING		0.128444	-	-					-	-	$ -	$ -
47	7602 CARDIOVASCULAR LAB		0.172513	34,326	-					145,031	-	$ 179,357	$ -
48	9000 CLINIC		0.345080	13,929	23,062					103,284	431,077	$ 117,213	$ 454,139

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

					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	
49	9001	SATELLITE CLINICS		0.546554	-	516					439	38,055	$ 439	$ 38,571
50	9100	EMERGENCY		0.147126	116,386	249,343	3,311		14,493		974,788	1,840,680	$ 1,108,978	$ 2,090,023
51	9201	OBSERVATION BEDS (DISTINCT PART		0.284474	1,240	14,136			992		8,432	40,052	$ 10,664	$ 54,188
52		HUGES SPALDING COST- SEE SUPPORT		-									$ -	$ -
53				-									$ -	$ -
54		NOTE: CRESTVIEW & RETAIL PHARMACY		-									$ -	$ -
55		COSTS REMOVED SINCE NOT APPLICABLE		-									$ -	$ -
56		TO ACUTE CARE SERVICES.		-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
61				-									$ -	$ -
62				-									$ -	$ -
63				-									$ -	$ -
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105				-									$ -	$ -
106				-									$ -	$ -
107				-									$ -	$ -
108				-									$ -	$ -
109				-									$ -	$ -
110				-									$ -	$ -
111				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

				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	
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 1,982,655	$ 542,855	$ 45,751	$ -	$ 71,780	$ -	$ 11,910,625	$ 5,332,607		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 2,423,547	$ 542,855	$ 68,673	$ -	$ 138,200	$ -	$ 15,751,204	$ 5,332,607	$ 18,381,624	$ 5,875,462
129	Total Charges per PS&R or Exhibit Detail	$ 2,423,547	$ 542,855	$ 68,673	$ -	$ 138,200	$ -	$ 15,751,204	$ 5,332,607		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 413,207	$ 67,264	$ 12,861	$ -	$ 39,317	$ -	$ 2,873,801	$ 665,011	$ 3,339,186	$ 732,275
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 363,829	$ 46,765			$ 4,641		$ 6,059	$ 1,621	$ 374,529	$ 48,386
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 68,673				$ 23,493	$ 2,386	$ 92,166	$ 2,386
134	Private Insurance (including primary and third party liability)	$ 13,772	$ 750					$ 222,735	$ 53,324	$ 236,507	$ 54,074
135	Self-Pay (including Co-Pay and Spend-Down)							$ 400	$ 803	$ 400	$ 803
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 377,601	$ 47,515	$ 68,673	$ -						
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)					$ 51,222		$ 119,348		$ 170,570	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 108,314	$ 7,683	$ 108,314	$ 7,683
141	Medicare Cross-Over Bad Debt Payments									$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)									$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ 35,606	$ 19,749	$ (55,812)	$ -	$ (16,546)	$ -	$ 2,393,452	$ 599,194	$ 2,356,700	$ 618,943
144	**Calculated Payments as a Percentage of Cost**	91%	71%	534%	0%	142%	0%	17%	10%	29%	15%

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 (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

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

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

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

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (01/01/2019-12/31/2019) GRADY MEMORIAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 8,662,790		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	60534.00	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ 8,662,790		*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ -		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	Removed from Medicare, allowable on Medicaid DSH	$ (8,662,790)	5.00	*(Adjusted to / (from))*
9	*Reason for adjustment*	Account number 60534, Dept 16108			*(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		$ 8,662,790
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	2,119,243,288
19	Uninsured Hospital	**Charges Sec. G**	1,546,654,668
20	Total Hospital	**Charges Sec. G**	5,577,166,638
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		38.00%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		27.73%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 3,291,736
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 2,402,357
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 5,694,093**

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

*** The Gross Allowable Assessment Not Included in the Cost Report (line 17, above) will be apportioned to Medicaid and uninsured based on charges sec. g unless the hospital provides a revised cost report to include the amount in the cost-to-charge ratios and per diems used in the survey.*