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

DSH Version 6.01 2/10/2022

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: 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	01/01/2021	12/31/2021
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	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 Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/20 - 06/30/21)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** — $ 95,179,160
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2020 - 06/30/2021** — $ 95,179,160

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	CFO Title	11-18-22 Date
Anthony Saul Hospital CEO or CFO Printed Name	404-616-1767 Hospital CEO or CFO Telephone Number	asaul@gmh.edu Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	Felicia Wofford
Title	Executive 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

DSH Required Fields (A-R)																		
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 1/1/2021 - 12/31/2021

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

	1/1/2021 through 12/31/2021		
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: 6/9/2022

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	GRADY MEMORIAL HOSPITAL		
5. Medicaid Provider Number:	000000855A		
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0		
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0		
8. Medicare Provider Number:	110079		
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.		
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	ALABAMA	1992799050
10. State Name & Number	ARKANSAS	206845105
11. State Name & Number	CONNECTICUT	1992799050
12. State Name & Number	DELAWARE	1992799050
13. State Name & Number	FLORIDA	913008000
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: (01/01/2021 - 12/31/2021)

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)	$ 14,090,111	$ 6,612,437	$20,702,548
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 1,076,126	$ 2,705,257	$3,781,383
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)	$15,166,237	$9,317,694	$24,483,931
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	92.90%	70.97%	84.56%

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.

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 (01/01/2021 - 12/31/2021)

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)	230,295 **(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	57,868,775
5.	Non-Hospital Subsidies	
6.	Total Hospital Subsidies	$ 57,868,775
7.	Inpatient Hospital Charity Care Charges	476,914,575
8.	Outpatient Hospital Charity Care Charges	554,077,143
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 1,030,991,718

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	$879,014,541.00			$ 753,842,799	$ -	$ -	$ 125,171,742
12.	Subprovider I (Psych or Rehab)	$20,688,025.00			$ 17,742,048	$ -	$ -	$ 2,945,977
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$44,678,705.00			$ 19,874,350	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$3,115,657,647.00	$1,932,294,868.00		$ 2,671,987,742	$ 1,657,135,920	$ -	$ 718,828,853
20.	Outpatient Services		$262,641,179.00			$ 225,241,054	$ -	$ 37,400,125
21.	Home Health Agency			$0.00			$ -	
22.	Ambulance	-	-	$ 239,837,137	-	-	$ 185,168,670	-
23.	Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24.	ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25.	Hospice			$0.00			$ -	
26.	Other	$0.00	$0.00	$367,429,418.00	$ -	$ -	$ 214,917,634	$ -
27.	Total	$ 4,015,360,213	$ 2,194,936,047	$ 651,945,260	$ 3,443,572,589	$ 1,882,376,974	$ 419,960,654	$ 884,346,697
28.	Total Hospital and Non Hospital		Total from Above	$ 6,862,241,520		Total from Above	$ 5,745,910,217	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	6,862,241,520	Total Contractual Adj. (G-3 Line 2)	5,745,910,217
30.	Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31.	Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32.	Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33.	Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34.	Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35.	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				5,745,910,217
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2021-12/31/2021) 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	$ 169,882,817	$ 47,138,415	$ 1,536,776	$0.00	$ 218,558,008	162,581	$411,475,429.00		$ 1,344.30
2	03100 INTENSIVE CARE UNIT	$ 89,889,626	$ 15,416,978	$ -		$ 105,306,604	43,741	$275,534,966.00		$ 2,407.50
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 43,774,549	$ 5,394,602	$ 141,928		$ 49,311,079	17,142	$164,821,843.00		$ 2,876.62
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	$ 7,782,024	$ 1,329,882	$ -		$ 9,111,906	4,230	$5,287,276.00		$ 2,154.11
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 15,827,566	$ 3,112,889	$ 11,660		$ 18,952,115	9,899	$45,060,061.00		$ 1,914.55
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 327,156,582	$ 72,392,766	$ 1,690,364	$ -	$ 401,239,712	237,593	$ 902,179,575		
19	Weighted Average									$ 1,688.77

		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)	5,733	-	-	$ 7,706,872	$3,563,353.00	$14,590,374.00	$ 18,153,727	0.424534

		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	$58,052,925.00	$ 8,059,727	$ 641,425		$ 66,754,077	$849,569,386.00	$273,770,646.00	$ 1,123,340,032	0.059425
22	5200 DELIVERY ROOM & LABOR ROOM	$17,774,748.00	$ 959,874	$ -		$ 18,734,622	$45,354,846.00	$7,569,772.00	$ 52,924,618	0.353987
23	5300 ANESTHESIOLOGY	$7,008,708.00	$ 5,040,681	$ 210,077		$ 12,259,466	$151,008,500.00	$56,356,125.00	$ 207,364,625	0.059120
24	5400 RADIOLOGY-DIAGNOSTIC	$28,124,414.00	$ 367,326	$ 25,921		$ 28,517,661	$136,070,345.00	$134,978,792.00	$ 271,049,137	0.105212
25	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
26	5600 RADIOISOTOPE	$7,771,786.00	$ 139,423	$ 10,192		$ 7,921,401	$34,755,669.00	$75,346,022.00	$ 110,101,691	0.071946
27	5700 CT SCAN	$8,016,868.00	$ 756,102	$ 52,008		$ 8,824,978	$318,595,119.00	$277,108,274.00	$ 595,703,393	0.014814
28	5800 MRI	$3,987,844.00	$ 112,611	$ 7,776		$ 4,108,231	$45,393,415.00	$43,262,692.00	$ 88,656,107	0.046339
29	6000 LABORATORY	$47,982,386.00	$ 2,372,874	$ 60,623		$ 50,415,883	$401,496,332.00	$354,251,398.00	$ 755,747,730	0.066710
30	6001 LABORATORY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2021-12/31/2021) 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 CELL	$13,921,506.00	$ -	$ -		$ 13,921,506	$65,969,421.00	$22,247,442.00	$ 88,216,863	0.157810
32	6500	RESPIRATORY THERAPY	$16,448,611.00	$ -	$ -		$ 16,448,611	$237,887,138.00	$11,847,981.00	$ 249,735,119	0.065864
33	6501	RESPIRATORY THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
34	6600	PHYSICAL THERAPY	$14,773,849.00	$ 536,242	$ 39,924		$ 15,350,015	$71,616,146.00	$22,277,471.00	$ 93,893,617	0.163483
35	6601	PHYSICAL THERAPY-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
36	6900	ELECTROCARDIOLOGY	$5,336,935.00	$ -	$ -		$ 5,336,935	$100,706,303.00	$48,354,386.00	$ 149,060,689	0.035804
37	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$36,278,781.00	$ -	$ -		$ 36,278,781	$77,689,742.00	$18,015,206.00	$ 95,704,948	0.379069
38	7101	MEDICAL SUPPLIES CHARGED CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
39	7200	IMPL. DEV. CHARGED TO PATIENTS	$30,450,455.00	$ -	$ -		$ 30,450,455	$48,077,459.00	$10,186,792.00	$ 58,264,251	0.522627
40	7300	DRUGS CHARGED TO PATIENTS	$72,419,452.00	$ -	$ -		$ 72,419,452	$200,065,039.00	$145,945,872.00	$ 346,010,911	0.209298
41	7301	DRUGS CHARGED TO PATIENTS-CRESTVIEW	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
42	7302	OUTPATIENT PHARMACY	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
43	7400	RENAL DIALYSIS	$6,478,830.00	$ -	$ -		$ 6,478,830	$21,875,537.00	$39,703,509.00	$ 61,579,046	0.105212
44	7601	PULMONARY FUNCTION TESTING	$1,795,797.00	$ -	$ 167,262		$ 1,963,059	$4,477,175.00	$9,833,550.00	$ 14,310,725	0.137174
45	7602	CARDIOVASCULAR LAB	$8,560,357.00	$ 1,378,144	$ 322,779		$ 10,261,280	$39,779,720.00	$13,260,485.00	$ 53,040,205	0.193462
46	9000	CLINIC	$95,237,713.00	$ 14,974,577	$ 418,569		$ 110,630,859	$29,813,768.00	$232,979,856.00	$ 262,793,624	0.420980
47	9001	SATELLITE CLINICS	$33,492,825.00	$ -	$ 53,050		$ 33,545,875	$259,510.00	$47,896,689.00	$ 48,156,199	0.696606
48	9100	EMERGENCY	$85,297,736.00	$ 13,778,756	$ 901,418		$ 99,977,910	$244,338,730.00	$493,484,563.00	$ 737,823,293	0.135504
49	9201	OBSERVATION BEDS (DISTINCT PART)	$5,125,854.00	$ -	$ -		$ 5,125,854	$1,708,005.00	$15,614,052.00	$ 17,322,057	0.295915
50		HUGES SPALDING COST- SEE SUPPORT	$ (49,263,204)	$ -	$ -		$ (49,263,204)	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
52		NOTE: CRESTVIEW & RETAIL PHARMACY	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
53		COSTS REMOVED SINCE NOT APPLICABLE	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
54		TO ACUTE CARE SERVICES.	$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2021-12/31/2021) 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	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 555,075,176	$ 48,476,337	$ 2,911,024		$ 606,462,537	$ 3,130,070,658	$ 2,368,881,949	$ 5,498,952,607	
127		**Weighted Average**									0.120647
128		**Sub Totals**	$ 882,231,758	$ 120,869,103	$ 4,601,388		$ 1,007,702,249	$ 4,032,250,233	$ 2,368,881,949	$ 6,401,132,182	
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)*					$224,601.00				
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**					$ 1,007,477,648				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					13.63%				

* 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 (01/01/2021-12/31/2021) 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	$ 1,344.30		35,349		7,476		5,131		27,222		34,585		75,178		71.21%
2	03100 INTENSIVE CARE UNIT	$ 2,407.50		10,584		1,413		1,733		8,201		8,901		21,931		71.17%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,876.62		3,693		1,199		406		2,093		4,423		7,391		70.71%
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 2,154.11		1,257		2,773				101		83		4,131		100.00%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 1,914.55		2,743		6,351				604		45		9,698		98.44%
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	53,626		19,212		7,270		38,221		48,037		118,329		71.10%
19	Total Days per PS&R or Exhibit Detail			53,626		19,212		7,270		38,221		48,037				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 186,007,644		$ 71,652,083		$ 26,966,857		$ 136,536,275		$ 171,346,143		$ 421,162,859		66.72%
21.01	Calculated Routine Charge Per Diem			$ 3,468.61		$ 3,729.55		$ 3,709.33		$ 3,572.28		$ 3,566.96		$ 3,559.25		
	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)		0.424534	640,468	1,228,602	99,132	391,908	193,804	950,268	803,480	2,726,856	726,660	3,138,580	$ 1,736,884	$ 5,297,634	60.61%
23	5000 OPERATING ROOM		0.059425	131,217,418	24,273,146	55,114,750	19,763,854	13,683,620	6,863,648	88,179,372	23,943,177	269,011,914	108,534,860	$ 288,195,160	$ 74,843,825	66.93%
24	5200 DELIVERY ROOM & LABOR ROOM		0.353987	10,440,142	871,088	26,705,931	3,760,809	196,337	10,826	2,836,317	423,829	1,348,553	1,319,018	$ 40,178,727	$ 5,066,552	91.39%
25	5300 ANESTHESIOLOGY		0.059120	24,800,433	5,103,705	16,279,362	3,689,497	2,467,618	1,559,515	16,003,614	5,444,155	42,454,408	22,513,810	$ 59,551,027	$ 15,796,872	68.54%
26	5400 RADIOLOGY-DIAGNOSTIC		0.105212	23,274,182	10,896,590	7,540,480	8,381,679	3,619,771	3,197,889	18,363,662	10,722,321	31,257,786	53,374,469	$ 52,798,095	$ 33,198,479	63.62%
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-											$ -	$ -	
28	5600 RADIOISOTOPE		0.071946	7,815,639	13,305,171	1,474,547	6,263,313	1,048,303	2,509,119	5,852,203	11,774,471	8,896,310	19,025,215	$ 16,190,692	$ 33,852,074	70.98%
29	5700 CT SCAN		0.014814	49,003,018	22,906,563	13,585,770	17,753,203	8,595,375	7,773,976	45,492,577	24,680,091	82,556,201	114,346,194	$ 116,676,740	$ 73,113,833	65.72%
30	5800 MRI		0.046339	8,337,176	5,034,862	1,713,044	1,832,193	1,465,639	1,570,184	7,387,706	4,803,218	9,880,443	16,524,884	$ 18,903,565	$ 13,240,457	66.54%
31	6000 LABORATORY		0.066710	84,187,355	44,880,417	20,898,919	31,711,819	13,502,987	9,389,742	68,451,509	34,262,767	88,139,309	138,011,102	$ 187,040,770	$ 120,244,746	71.27%
32	6001 LABORATORY-CRESTVIEW		-											$ -	$ -	
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.157810	17,728,811	4,162,038	7,073,030	2,219,225	2,591,670	446,777	12,265,198	3,030,821	21,559,408	4,499,739	$ 39,658,709	$ 9,858,861	87.02%
34	6500 RESPIRATORY THERAPY		0.065864	49,077,828	244,531	15,308,520	74,797	8,742,289	94,064	38,575,363	304,813	38,142,534	1,093,923	$ 111,704,000	$ 718,205	61.65%
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-											$ -	$ -	
36	6600 PHYSICAL THERAPY		0.163483	13,253,801	3,422,629	4,004,254	732,915	1,902,556	1,074,085	10,572,757	1,598,033	14,463,073	9,531,908	$ 29,733,368	$ 6,827,662	66.02%
37	6601 PHYSICAL THERAPY-CRESTVIEW		-											$ -	$ -	
38	6900 ELECTROCARDIOLOGY		0.035804	19,418,269	5,348,315	3,368,842	2,302,147	3,887,760	1,719,871	17,695,389	5,985,635	20,013,987	18,743,004	$ 44,370,260	$ 15,355,968	66.75%
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.379069	15,279,003	1,447,467	4,465,698	627,128	2,080,357	550,771	11,017,418	1,534,342	16,856,702	5,205,786	$ 32,842,476	$ 4,159,709	62.53%
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-											$ -	$ -	
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.522627	7,670,492	904,594	2,273,762	402,671	1,039,341	274,383	5,329,776	1,067,316	11,332,771	2,838,197	$ 16,313,371	$ 2,648,964	57.76%
42	7300 DRUGS CHARGED TO PATIENTS		0.209298	44,878,659	21,869,133	10,771,477	10,047,883	5,827,507	8,386,801	30,564,481	23,867,145	41,810,557	20,904,371	$ 92,042,123	$ 64,170,961	64.04%
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-											$ -	$ -	
44	7302 OUTPATIENT PHARMACY		-											$ -	$ -	
45	7400 RENAL DIALYSIS		0.105212	6,129,352	2,409,767	140,068	320,239	1,437,139	147,344	5,950,755	567,309	2,486,405	34,362,623	$ 13,657,314	$ 3,444,659	87.77%
46	7601 PULMONARY FUNCTION TESTING		0.137174	1,465,730	2,195,515	75,514	263,456	92,023	302,666	669,484	1,460,043	887,749	2,629,186	$ 2,302,751	$ 4,221,680	70.43%
47	7602 CARDIOVASCULAR LAB		0.193462	7,157,659	1,593,388	599,183	252,318	1,350,325	491,176	6,455,005	1,275,727	10,438,713	3,926,643	$ 15,562,172	$ 3,612,609	63.55%
48	9000 CLINIC		0.420980	6,689,192	30,194,848	1,331,309	17,908,237	1,249,736	7,493,468	5,247,913	25,442,150	5,816,279	66,979,098	$ 14,518,150	$ 81,038,703	64.43%
49	9001 SATELLITE CLINICS		0.696606	80,751	5,254,211	11,549	4,037,658	7,218	1,664,838	62,990	4,760,109	41,174	20,092,145	$ 162,508	$ 15,716,816	74.83%
50	9100 EMERGENCY		0.135504	37,077,141	34,767,713	12,855,109	28,656,884	5,965,592	8,777,152	32,195,187	26,509,838	73,416,686	187,605,323	$ 88,093,029	$ 98,711,587	61.54%

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

Cost Report Year (01/01/2021-12/31/2021) 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		%
51	9201	OBSERVATION BEDS (DISTINCT PART)		0.295915	415,040	1,289,244	65,736	596,460	54,764	124,468	285,964	1,408,908	452,864	8,749,372	$ 821,504	$ 3,419,080	78.46%
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				-											$ -	$ -	
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116				-											$ -	$ -	

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

Cost Report Year (01/01/2021-12/31/2021) 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		%
117			-											$ -	$ -	
118			-											$ -	$ -	
119			-											$ -	$ -	
120			-											$ -	$ -	
121			-											$ -	$ -	
122			-											$ -	$ -	
123			-											$ -	$ -	
124			-											$ -	$ -	
125			-											$ -	$ -	
126			-											$ -	$ -	
127			-											$ -	$ -	
				$ 566,037,559	$ 243,603,537	$ 205,755,986	$ 161,990,292	$ 81,001,731	$ 65,373,032	$ 430,258,118	$ 217,593,075	$ 791,990,486	$ 863,949,449			

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

Cost Report Year (01/01/2021-12/31/2021) GRADY MEMORIAL HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 752,045,203	$ 243,603,537	$ 277,408,069	$ 161,990,292	$ 107,968,588	$ 65,373,032	$ 566,794,393	$ 217,593,075	$ 963,336,629 (Agrees to Exhibit A)	$ 863,949,449 (Agrees to Exhibit A)	$ 1,704,216,253	$ 688,559,936	66.76%
129	Total Charges per PS&R or Exhibit Detail	$ 752,045,203	$ 243,603,537	$ 277,408,069	$ 161,990,292	$ 107,968,588	$ 65,373,032	$ 566,794,393	$ 217,593,075	$ 963,336,629	$ 863,949,449			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 152,889,876	$ 37,594,174	$ 61,847,208	$ 24,324,610	$ 20,668,089	$ 10,352,562	$ 108,064,594	$ 33,552,596	$ 156,702,609	$ 114,013,495	$ 343,469,767	$ 105,823,942	72.35%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 97,722,840	$ 29,096,305		$ 10,127	$ 247,943	$ 1,036,438	$ 1,156,580	$ 2,099,169			$ 99,127,363	$ 32,242,039	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ 48	$ 9	$ 45,738,034	$ 18,317,127	$ 31,606	$ 46	$ 910,925	$ 176,588			$ 46,680,613	$ 18,493,770	
134	Private Insurance (including primary and third party liability)	$ 975,577	$ 43,225	$ 47,699	$ 122,059		$ 6,232	$ 19,674,901	$ 3,933,201			$ 20,698,177	$ 4,104,717	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 6,277	$ 24,546	$ 33	$ 4,083	$ 530	$ 595	$ 18,518	$ 14,478			$ 25,358	$ 43,702	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 98,704,742	$ 29,164,085	$ 45,785,766	$ 18,453,396									
137	Medicaid Cost Settlement Payments (See Note B)		$ (3,034,254)									$ -	$ (3,034,254)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 24,245,967	$ 5,332,540	$ 35,099,205	$ 2,512,761			$ 59,345,172	$ 7,845,301	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 65,278,549	$ 15,204,967			$ 65,278,549	$ 15,204,967	
141	Medicare Cross-Over Bad Debt Payments					$ 1,157,252	$ 444,738					$ 1,157,252	$ 444,738	
142	Other Medicare Cross-Over Payments (See Note D)					$ 4,806,383	$ 629,506	$ 1,737,389	$ 654,507	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 6,543,772	$ 1,284,013	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 14,090,111	$ 6,612,437			
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)**	$ 54,185,134	$ 11,464,344	$ 16,061,442	$ 5,871,214	$ (9,821,592)	$ 2,902,466	$ (15,811,473)	$ 8,956,925	$ 142,612,498	$ 107,401,058	$ 44,613,511	$ 29,194,949	
146	**Calculated Payments as a Percentage of Cost**	65%	70%	74%	76%	148%	72%	115%	73%	9%	6%	87%	72%	

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)**	73,086
148	**Percent of cross-over days to total Medicare days from the cost report**	10%

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2021-12/31/2021) 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	$ 1,344.30		1,242		19		44		631		1,936	
2	03100 INTENSIVE CARE UNIT	$ 2,407.50		141		2		-		155		298	
3	03200 CORONARY CARE UNIT	$ -										-	
4	03300 BURN INTENSIVE CARE UNIT	$ -										-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 2,876.62		235				1		71		307	
6	03500 OTHER SPECIAL CARE UNIT	$ -										-	
7	04000 SUBPROVIDER I	$ -										-	
8	04100 SUBPROVIDER II	$ -										-	
9	04200 OTHER SUBPROVIDER	$ -										-	
10	04300 NURSERY	$ 2,154.11		16								16	
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 1,914.55		2								2	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	1,636		21		45		857		2,559	
19	Total Days per PS&R or Exhibit Detail			1,636		21		45		857			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ 6,020,038		$ 63,105		$ 143,984		$ 3,238,577		$ 9,465,704	
21.01	Calculated Routine Charge Per Diem			$ 3,679.73		$ 3,005.00		$ 3,199.64		$ 3,778.97		$ 3,698.99	
	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)		0.424534	25,476	33,924			-	-	2,904	41,448	$ 28,380	$ 75,372
23	5000 OPERATING ROOM		0.059425	7,534,390	766,066	-		640,547	-	2,030,942	243,225	$ 10,205,879	$ 1,009,291
24	5200 DELIVERY ROOM & LABOR ROOM		0.353987	372,800	39,992	-		-	-	32,829	10,961	$ 405,629	$ 50,953
25	5300 ANESTHESIOLOGY		0.059120	1,223,006	141,084	-		89,727	-	330,818	37,254	$ 1,643,551	$ 178,338
26	5400 RADIOLOGY-DIAGNOSTIC		0.105212	917,987	301,179	635		29,378	7,570	342,918	223,241	$ 1,290,918	$ 531,990
27	5401 RADIOLOGY-DIAGNOSTIC-CRESTVIEW		-									$ -	$ -
28	5600 RADIOISOTOPE		0.071946	111,276	41,737	-		-	-	18,798	10,092	$ 130,074	$ 51,829
29	5700 CT SCAN		0.014814	2,198,018	745,743	8,386		71,591	13,908	978,134	807,181	$ 3,256,129	$ 1,566,832
30	5800 MRI		0.046339	207,058	30,643	-		24,263	-	119,376	56,824	$ 350,697	$ 87,467
31	6000 LABORATORY		0.066710	2,385,440	739,054	29,208		92,410	20,141	1,327,484	564,951	$ 3,834,542	$ 1,324,146
32	6001 LABORATORY-CRESTVIEW		-									$ -	$ -
33	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.157810	924,749	21,582	7,761		39,389	-	179,637	13,478	$ 1,151,536	$ 35,060
34	6500 RESPIRATORY THERAPY		0.065864	1,410,570	1,066	8,560		59,733	-	825,473	835	$ 2,304,336	$ 1,901
35	6501 RESPIRATORY THERAPY-CRESTVIEW		-									$ -	$ -
36	6600 PHYSICAL THERAPY		0.163483	1,185,224	21,016			18,918	-	197,168	12,577	$ 1,401,310	$ 33,593
37	6601 PHYSICAL THERAPY-CRESTVIEW		-									$ -	$ -
38	6900 ELECTROCARDIOLOGY		0.035804	428,227	109,614	1,220		34,968	6,791	338,437	93,851	$ 802,852	$ 210,256
39	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.379069	414,790	30,768	3,256		24,256	215	294,542	8,425	$ 736,844	$ 39,408
40	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		-									$ -	$ -
41	7200 IMPL. DEV. CHARGED TO PATIENTS		0.522627	382,748	31,649	-		42,089	-	50,502	15,923	$ 475,338	$ 47,572
42	7300 DRUGS CHARGED TO PATIENTS		0.209298	1,883,160	142,925	11,900		30,448	288	520,449	61,300	$ 2,445,957	$ 204,514
43	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		-									$ -	$ -
44	7302 OUTPATIENT PHARMACY		-									$ -	$ -
45	7400 RENAL DIALYSIS		0.105212		16,556			-	3,300	50,596	25,762	$ 50,596	$ 45,618

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2021-12/31/2021) 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	
46	7601	PULMONARY FUNCTION TESTING	0.137174	19,394	-	-		-	2,323	16,292	-	$ 35,686	$ 2,323
47	7602	CARDIOVASCULAR LAB	0.193462	154,585	-	-		-	-	11,107	-	$ 165,692	$ -
48	9000	CLINIC	0.420980	288,540	350,595	-		313	4,358	128,430	201,940	$ 417,283	$ 556,893
49	9001	SATELLITE CLINICS	0.696606	223	14,669	-		-	939	-	5,694	$ 223	$ 21,302
50	9100	EMERGENCY	0.135504	2,383,971	1,567,925	12,814		67,858	33,100	815,965	1,316,683	$ 3,280,608	$ 2,917,708
51	9201	OBSERVATION BEDS (DISTINCT PART)	0.295915	25,140	68,772	1,188		-	396	7,128	44,880	$ 33,456	$ 114,048
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			-									$ -	$ -
64			-									$ -	$ -
65			-									$ -	$ -
66			-									$ -	$ -
67			-									$ -	$ -
68			-									$ -	$ -
69			-									$ -	$ -
70			-									$ -	$ -
71			-									$ -	$ -
72			-									$ -	$ -
73			-									$ -	$ -
74			-									$ -	$ -
75			-									$ -	$ -
76			-									$ -	$ -
77			-									$ -	$ -
78			-									$ -	$ -
79			-									$ -	$ -
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81			-									$ -	$ -
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102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2021-12/31/2021) 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	
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ 24,476,772	$ 5,216,558	$ 84,928	$ -	$ 1,265,888	$ 93,329	$ 8,619,929	$ 3,796,526		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ 30,496,810	$ 5,216,558	$ 148,033	$ -	$ 1,409,872	$ 93,329	$ 11,858,506	$ 3,796,526	$ 43,913,221	$ 9,106,414
129	Total Charges per PS&R or Exhibit Detail	$ 30,496,810	$ 5,216,558	$ 148,033	$ -	$ 1,409,872	$ 93,329	$ 11,858,506	$ 3,796,526		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ 5,376,089	$ 640,202	$ 40,141	$ -	$ 178,221	$ 10,488	$ 2,275,258	$ 429,955	$ 7,869,709	$ 1,080,645
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,438,323	$ 64,318			$ 9,728	$ 1,771	$ 13,938	$ 6,368	$ 1,461,989	$ 72,457
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 29,200		$ -	$ -	$ 18,557	$ 25,009	$ 47,757	$ 25,009
134	Private Insurance (including primary and third party liability)	$ 284,356	$ 7,418			$ -	$ -	$ 784,521	$ 210,901	$ 1,068,877	$ 218,319
135	Self-Pay (including Co-Pay and Spend-Down)	$ 25	$ 80			$ 200	$ 50	$ 136	$ 259	$ 361	$ 389
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,722,704	$ 71,816	$ 29,200	$ -						
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)					$ 238,726	$ 4,516	$ 991,365	$ 23,681	$ 1,230,091	$ 28,197
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ 620,715	$ 55,554	$ 620,715	$ 55,554
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)**	$ 3,653,385	$ 568,386	$ 10,941	$ -	$ (70,433)	$ 4,151	$ (153,974)	$ 108,183	$ 3,439,919	$ 680,720
144	**Calculated Payments as a Percentage of Cost**	32%	11%	73%	0%	140%	60%	107%	75%	56%	37%

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 (01/01/2021-12/31/2021) 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 (01/01/2021-12/31/2021) 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 (01/01/2021-12/31/2021) 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)*		$ 11,013,571		
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)		$ 11,013,571		*(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	$ (11,013,571)	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		$ 11,013,571
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	2,445,795,824
19	Uninsured Hospital	**Charges Sec. G**	1,827,286,078
20	Total Hospital	**Charges Sec. G**	6,401,132,182
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		38.21%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		28.55%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 4,208,153
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 3,143,966
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 7,352,119**

** 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.*