State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2026

DSH Version 6.02 2/10/2023

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2025	06/30/2026

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2024	12/31/2024
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000679808A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110079

B. DSH 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 (07/01/25 - 06/30/26)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	7/7/1952

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2025 - 06/30/2026** — $ 3,014,285
   (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 07/01/2025 - 06/30/2026**
   (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 Services07/01/2025 - 06/30/2026** — $ 3,014,285

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	SVP & CFO Title	11/10/25 Date
Ruth Fowler Hospital CEO or CFO Printed Name	404-785-7006 Hospital CEO or CFO Telephone Number	ruth.fowler@choa.org Hospital CEO or CFO E-Mail

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

Hospital Contact:	
Name	SherryCarneron
Title	Reimbursement Manager
Telephone Number	404-785-7964
E-Mail Address	sherry.cameron@choa.org
Mailing Street Address	1575 Northeast Expressway
Mailing City, State, Zip	Atlanta, GA 30329

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

GA DSH Payment Results for SFY 2026 - Pool 2 5/7/2026 15:39

DSH Uncompensated Care Cost & Allocation Factor Summary

Preliminary Results

Provider Name	CHILDREN'S HLTHCRE-HUGHES SPALDING
Mcaid Provider Number	000679808A
Mcare Provider Number	110079

Below is the preliminary uncompensated care cost (UCC) and allocation factor used as a basis for the 2026 Georgia Disproportionate Share Hospital (DSH) Payment. An initial review of the provider submitted survey and detailed information was performed and adjustments made, as appropriate. Please review the proposed adjustments and adjusted survey included with the preliminary results and respond with concerns within 5 business days. Hospital specific preliminary results are subject to change based on revisions needed after initial results are reviewed and possible additional validation work.

NOTE: These are initial results only.

GA Medicaid DSH Payment Uncompensated Care Cost (UCC) For State Fiscal Year: 7/1/2025 - 6/30/2026

	(A) Cost Report Year Begin		(B) Cost Report Year End	(C) As-Filed DSH Uncompensated Care Cost (UCC)	(D) Total Adjustments	(E) Adjusted DSH Uncompensated Care Cost (UCC)
Cost Report Year UCC:	1/1/2024	-	12/31/2024	$ (12,995,279)	$ -	$ (12,995,279)

Less: 2024 Net UPL Payments	$ 282,745
Less: 2026 Net DPP Payments	$ 105,777,609
Less: GME Payments	$ 2,588,464
Add: Net OP Settlement (Difference between provider submitted and estimated)	$ (59,918)
Add: Provider tax excluded from the cost report (Medicaid primary & uninsured portion)	$ 16,027
Uncompensated Care Allocation Factor	$ (121,687,988)
Hospital Specific DSH Limit	$ (175,357,083)
2026 Eligibility	**Not Eligible**

Note: If the Hospital Specific DSH Limit (i.e. UCC) is negative, the hospital does not qualify for a DSH payment even if the Uncompensated Care Allocation Factor is positive.

DSH Year Low Income Utilization Ratio (LIUR):	350.86%
DSH Year Medicaid Inpatient Utilization Ratio (MIUR):	60.43%

If you disagree with the findings presented above please respond within five days of receipt with additional supporting documentation.

All inquiries and additional documentation should be sent to the following:

e-mail:	gadsh@mslc.com
Fax:	816-945-5301
Web Portal Address:	https://DSH.MSLC.com
Phone Inquiries:	800-374-6858

EXAMINER ADJUSTED SURVEY

Workpaper #:		Reviewer:
Examiner:		
Date:		
DSH Version	9.02	4/22/2025

D. General Cost Report Year Information 1/1/2024 - 12/31/2024

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

1. Select Your Facility from the Drop-Down Menu Provided:	CHILDREN'S HLTHCRE-HUGHES SPALDING		
	1/1/2024 through 12/31/2024		
2. Select Cost Report Year Covered by this Survey:	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:	5/29/2025		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	CHILDREN'S HLTHCRE-HUGHES SPALDING	-	
5. Medicaid Provider Number:	000679808A	-	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	-	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	-	
8. Medicare Provider Number:	110079	-	
9. Ownership Type (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	-	
10. PY Pool (Pool 1: All CAHs & rural hosp. w/ <100 beds or Pool 2: all others)	Pool 2	-	
11. Rural Referral Center (Yes or No)	No	-	

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.
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		
16. State Name & Number		
17. State Name & Number		
18. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (01/01/2024 - 12/31/2024)

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)	$ 2,464	$ 183,896	$186,360
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 15,059	$ 400,825	$415,884
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B)	$17,523	$584,721	$602,244
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	14.06%	31.45%	30.94%

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 (01/01/2024 - 12/31/2024)

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)	2,959

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

2.	Inpatient Hospital Subsidies	-
3.	Outpatient Hospital Subsidies	-
4.	Unspecified I/P and O/P Hospital Subsidies	-
5.	Non-Hospital Subsidies	-
6.	Total Hospital Subsidies	$ -
7.	Inpatient Hospital Charity Care Charges	950,491
8.	Outpatient Hospital Charity Care Charges	11,389,159
9.	Non-Hospital Charity Care Charges	-
10.	Total Charity Care Charges	$ 12,339,650

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

		Total Patient Revenues (Charges)			Contractual Adjustments			
		Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11.	Hospital	$ 9,619,554	$ -	$ -	$ 7,462,979	$ -	$ -	$ 2,156,575
12.	Psych Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
13.	Rehab. Subprovider	$ -	$ -	$ -	$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$ -			$ -	
15.	Swing Bed - NF			$ -			$ -	
16.	Skilled Nursing Facility			$ -			$ -	
17.	Nursing Facility			$ -			$ -	
18.	Other Long-Term Care			$ -			$ -	
19.	Ancillary Services	$ 14,076,381	$ 59,975,457	$ -	$ 10,920,645	$ 46,529,762	$ -	$ 16,601,431
20.	Outpatient Services		$ 184,874,094	$ -		$ 143,427,796	$ -	$ 41,446,298
21.	Home Health Agency			$ -			$ -	
22.	Ambulance	$ -	$ -	$ -	$ -	$ -	$ -	
23.	Outpatient Rehab Providers	$ -	$ -	$ -	$ -	$ -	$ -	$ -
24.	ASC	$ -	$ -	$ -	$ -	$ -	$ -	$ -
25.	Hospice			$ -			$ -	
26.	Other	$ -	$ -	$ 3,815,425	$ -	$ -	$ 2,960,058	$ -
27.	Total	$ 23,695,935	$ 244,849,551	$ 3,815,425	$ 18,383,623	$ 189,957,558	$ 2,960,058	$ 60,204,305
28.	Total Hospital and Non Hospital		Total from Above	$ 272,360,911		Total from Above	$ 211,301,239	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	$ 272,360,911	Total Contractual Adj. (G-3 Line 2)	$ 211,301,239
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)"			-	$ -
36.	Adjusted Contractual Adjustments				211,301,239
37.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) | CHILDREN'S HLTHCRE-HUGHES SPALDING

Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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	$ 250,844,100	$ 49,230,018	$ 1,801,593	-	**$ 301,875,711**	177,894	$ 572,053,768		**$ 1,696.94**
2	03100 INTENSIVE CARE UNIT	$ 126,538,641	$ 7,584,205	$ -		**$ 134,122,846**	60,489	$ 421,720,764		**$ 2,217.31**
3	03200 CORONARY CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
4	03300 BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 69,616,097	$ 2,872,125	$ 130,152		**$ 72,618,374**	19,181	$ 227,806,506		**$ 3,785.95**
6	03500 OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
7	04000 SUBPROVIDER I	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
8	04100 SUBPROVIDER II	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
9	04200 OTHER SUBPROVIDER	$ -	$ -	$ -		**$ -**	-	$ -		**$ -**
10	04300 NURSERY	$ 10,550,492	$ 1,209,184	$ -		**$ 11,759,676**	7,053	$ 11,445,106		**$ 1,667.33**
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 30,296,279	$ 2,375,985	$ 80,537		**$ 32,752,801**	13,872	$ 84,158,357		**$ 2,361.07**
18	Total Routine	$ 487,845,609	$ 63,271,517	$ 2,012,282	$ -	$ 553,129,408	278,489	$ 1,317,184,501		
19	Weighted Average									$ 1,986.18

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)	6,119	-	-	**$ 10,383,576**	4,853,131	15,772,196	$ 20,625,327	**0.503438**

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	$ 97,346,289	$ 7,242,641	$ 722,503		**$ 105,311,433**	$ 1,172,654,282	$ 481,323,334	$ 1,653,977,616	**0.063672**
22	5200 DELIVERY ROOM & LABOR ROOM	$ 29,217,487	$ 1,104,471	$ -		**$ 30,321,958**	$ 111,350,887	$ 29,927,011	$ 141,277,898	**0.214626**
23	5300 ANESTHESIOLOGY	$ 8,525,299	$ 3,792,103	$ 210,677		**$ 12,528,079**	$ 221,991,202	$ 93,627,653	$ 315,618,855	**0.039694**
24	5400 RADIOLOGY-DIAGNOSTIC	$ 43,044,054	$ 5,230,658	$ 72,085		**$ 48,346,797**	$ 167,239,612	$ 167,424,598	$ 334,664,210	**0.144464**
25	5600 RADIOISOTOPE	$ 11,104,950	$ 137,124	$ 35,950		**$ 11,278,024**	$ 51,957,110	$ 124,934,982	$ 176,892,092	**0.063757**
26	5700 CT SCAN	$ 10,637,434	$ 645,730	$ 170,276		**$ 11,453,440**	$ 491,476,097	$ 371,780,855	$ 863,256,952	**0.013268**
27	5800 MRI	$ 5,671,208	$ 94,740	$ 25,749		**$ 5,791,697**	$ 68,621,393	$ 56,879,505	$ 125,500,898	**0.046149**
28	6000 LABORATORY	$ 72,599,047	$ 2,031,929	$ 435,151		**$ 75,066,127**	$ 561,146,751	$ 459,181,815	$ 1,020,328,566	**0.073571**
29	6001 LABORATORY-CRESTVIEW	$ 49,730	$ -	$ -		**$ 49,730**	$ 376,016	$ -	$ 376,016	**0.132255**
30	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	$ 15,555,728	$ -	$ -		**$ 15,555,728**	$ 88,208,166	$ 34,237,652	$ 122,445,818	**0.127042**
31	6500 RESPIRATORY THERAPY	$ 26,966,990	$ -	$ -		**$ 26,966,990**	$ 359,499,736	$ 11,632,946	$ 371,132,682	**0.072661**
32	6501 RESPIRATORY THERAPY-CRESTVIEW	$ 934,806	$ -	$ -		**$ 934,806**	$ 7,713,686	$ -	$ 7,713,686	**0.121188**
33	6600 PHYSICAL THERAPY	$ 24,577,904	$ 461,235	$ 37,175		**$ 25,076,314**	$ 97,122,707	$ 35,497,817	$ 132,620,524	**0.189083**

G. Cost Report - Cost / Days / Charges

Cost Report Year (01/01/2024-12/31/2024) | CHILDREN'S HLTHCRE-HUGHES SPALDING

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable		Net 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
34	6601	PHYSICAL THERAPY-CRESTVIEW	$ 1,424,736	$ -	$ -		**$ 1,424,736**	$ 6,159,598	$ -	$ 6,159,598	**0.231303**
35	6900	ELECTROCARDIOLOGY	$ 7,349,936	$ -	$ -		**$ 7,349,936**	$ 146,525,398	$ 55,534,925	$ 202,060,323	**0.036375**
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 49,612,865	$ -	$ -		**$ 49,612,865**	$ 97,968,031	$ 23,663,134	$ 121,631,165	**0.407896**
37	7101	MEDICAL SUPPLIES CHARGED CRESTVIEW	$ 518,255	$ -	$ -		**$ 518,255**	$ 799,583	$ -	$ 799,583	**0.648157**
38	7200	IMPL. DEV. CHARGED TO PATIENTS	$ 43,571,070	$ -	$ -		**$ 43,571,070**	$ 67,815,408	$ 14,074,635	$ 81,890,043	**0.532068**
39	7300	DRUGS CHARGED TO PATIENTS	$ 117,379,592	$ -	$ -		**$ 117,379,592**	$ 234,923,809	$ 272,069,870	$ 506,993,679	**0.231521**
40	7301	DRUGS CHARGED TO PATIENTS-CRESTVIEW	$ 775,529	$ -	$ -		**$ 775,529**	$ 999,263	$ -	$ 999,263	**0.776101**
41	7302	OUTPATIENT PHARMACY	$ 134,821,362	$ -	$ -		**$ 134,821,362**	$ 14,509	$ 240,467,885	$ 240,482,394	**0.560629**
42	7400	RENAL DIALYSIS	$ 8,953,874	$ -	$ -		**$ 8,953,874**	$ 22,370,149	$ 30,616,906	$ 52,987,055	**0.168982**
43	7601	PULMONARY FUNCTION TESTING	$ 1,379,567	$ -	$ 320,489		**$ 1,700,056**	$ 5,011,886	$ 14,156,557	$ 19,168,443	**0.088690**
44	7602	CARDIOVASCULAR LAB	$ 11,330,351	$ 1,131,896	$ 420,296		**$ 12,882,543**	$ 40,011,868	$ 10,648,014	$ 50,659,882	**0.254295**
45	9000	CLINIC	$ 167,064,520	$ 12,540,615	$ 759,333		**$ 180,364,468**	$ 67,051,604	$ 349,264,680	$ 416,316,284	**0.433239**
46	9001	SATELLITE CLINICS	$ 47,311,050	$ -	$ 81,208		**$ 47,392,258**	$ 142,697	$ 94,508,227	$ 94,650,924	**0.500706**
47	9100	EMERGENCY	$ 117,845,854	$ 10,254,384	$ 1,174,081		**$ 129,274,319**	$ 454,897,227	$ 767,068,835	$ 1,221,966,062	**0.105792**
48	9201	OBSERVATION BEDS (DISTINCT PART)	$ 6,616,446	$ -	$ -		**$ 6,616,446**	$ 2,211,672	$ 17,791,497	$ 20,003,169	**0.330770**
126		**Total Ancillary**	$ 1,062,185,933	$ 44,667,526	$ 4,464,973		$ 1,111,318,432	$ 4,551,113,478	$ 3,772,085,529	$ 8,323,199,007	
127		**Weighted Average**									**0.134768**
128		**Sub Totals**	$ 1,550,031,542	$ 107,939,043	$ 6,477,255		$ 1,664,447,840	$ 5,868,297,979	$ 3,772,085,529	$ 9,640,383,508	
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)					$ -				
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)					$ 48,684				
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**					**$ 1,664,399,156**				
133		Total Intern/Resident Cost as a Percent of Other Allowable Cost					**6.93%**				

* 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 (01/01/2024-12/31/2024) | CHILDREN'S HLTHCRE-HUGHES SPALDING

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		% Survey to Cost Report Totals (Includes all payers)
				Inpatient	Outpatient	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 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**		**Days**		
1	03000 ADULTS & PEDIATRICS	$ 1,696.94		692		1,007		-		74		15		51		1,788		1.07%
2	03100 INTENSIVE CARE UNIT	$ 2,217.31		-		-		-		-		-		-		-		0.00%
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-		-		-		
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-		-		-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,785.95		-		-		-		-		-		-		-		0.00%
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-		-		-		
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-		-		-		
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-		-		-		
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-		-		-		
10	04300 NURSERY	$ 1,667.33		-		-		-		-		-		-		-		0.00%
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,361.07		-		-		-		-		-		-		-		0.00%
18			**Total Days**	692		1,007		-		74		15		51		1,788		0.68%
19	Total Days per PS&R or Exhibit Detail			692		1,007		-		74		15		51				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 1,301,434		$ 1,876,618		$ -		$ 137,936		$ 27,896		$ 96,742		**$ 3,315,988**		0.26%
21.01	Calculated Routine Charge Per Diem			$ 1,880.68		$ 1,863.57		$ -		$ 1,864.00		$ 1,859.73		$ 1,896.90		$ 1,854.58		
	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**	**Ancillary Charges**	**Ancillary Charges**	
22	09200 Observation (Non-Distinct)		0.503438	$ 26,800	$ 94,475	$ 64,144	$ 921,018	$ -	$ -	$ 10,921	$ 22,445	$ -	$ -	$ 6,737	$ 33,335	$ 101,865	$ 1,037,938	5.72%
23	5000 OPERATING ROOM		0.063672	$ -	$ 47,570	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 47,570	0.00%
24	5200 DELIVERY ROOM & LABOR ROOM		0.214626	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
25	5300 ANESTHESIOLOGY		0.039694	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
26	5400 RADIOLOGY-DIAGNOSTIC		0.144464	$ 298,242	$ 1,574,160	$ 520,408	$ 11,170,275	$ -	$ -	$ 51,889	$ 452,453	$ 3,251	$ 42,150	$ 24,424	$ 991,713	$ 870,539	$ 13,196,888	4.52%
27	5600 RADIOISOTOPE		0.063757	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
28	5700 CT SCAN		0.013268	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
29	5800 MRI		0.046149	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
30	6000 LABORATORY		0.073571	$ 1,034,612	$ 3,691,528	$ 1,310,418	$ 18,432,331	$ -	$ -	$ 151,069	$ 818,705	$ 14,815	$ 51,249	$ 67,192	$ 1,304,482	$ 2,496,099	$ 22,942,564	2.63%
31	6001 LABORATORY-CRESTVIEW		0.132255	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.127042	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
33	6500 RESPIRATORY THERAPY		0.072661	$ 1,932,464	$ 401,669	$ 4,056,088	$ 4,148,074	$ -	$ -	$ 440,877	$ 193,693	$ 31,246	$ 3,016	$ 241,415	$ 310,099	$ 6,429,429	$ 4,743,436	3.17%
34	6501 RESPIRATORY THERAPY-CRESTVIEW		0.121188	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
35	6600 PHYSICAL THERAPY		0.189083	$ 48,131	$ -	$ 49,514	$ 54,251	$ -	$ -	$ 2,306	$ 925	$ 835	$ 142	$ 2,325	$ 1,270	$ 99,951	$ 55,176	0.12%
36	6601 PHYSICAL THERAPY-CRESTVIEW		0.231303	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
37	6900 ELECTROCARDIOLOGY		0.036375	$ 49,438	$ 83,985	$ 110,210	$ 1,326,884	$ -	$ -	$ 1,935	$ 68,425	$ 4,016	$ 23,211	$ 1,387	$ 107,234	$ 161,583	$ 1,479,294	0.88%
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.407896	$ 97,973	$ 442,432	$ 212,197	$ 3,316,142	$ -	$ 250	$ 24,192	$ 149,317	$ 3,595	$ 4,758	$ 14,392	$ 278,185	$ 334,362	$ 3,908,141	3.74%
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		0.648157	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.532068	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
41	7300 DRUGS CHARGED TO PATIENTS		0.231521	$ 1,023,879	$ 1,563,279	$ 901,391	$ 6,867,359	$ -	$ 262	$ 81,751	$ 388,717	$ 16,898	$ 49,600	$ 45,129	$ 412,638	$ 2,007,021	$ 8,819,617	2.24%
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		0.776101	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
43	7302 OUTPATIENT PHARMACY		0.560629	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
44	7400 RENAL DIALYSIS		0.168982	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
45	7601 PULMONARY FUNCTION TESTING		0.088690	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
46	7602 CARDIOVASCULAR LAB		0.254295	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
47	9000 CLINIC		0.433239	$ -	$ 3,319,761	$ 52,021	$ 12,621,745	$ -	$ 2,728	$ 1,088	$ 425,352	$ 1,351	$ 94,132	$ -	$ 551,193	$ 53,109	$ 16,369,586	4.10%
48	9001 SATELLITE CLINICS		0.500706	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
49	9100 EMERGENCY		0.105792	$ 859,427	$ 12,438,888	$ 2,446,055	$ 102,568,751	$ -	$ -	$ 175,029	$ 3,938,958	$ 14,773	$ 189,991	$ 133,051	$ 8,909,994	$ 3,480,511	$ 118,946,597	10.78%
50	9201 OBSERVATION BEDS (DISTINCT PART)		0.330770	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	0.00%
				5,370,964	23,657,745	9,722,446	161,426,830	-	3,240	941,057	6,458,990	90,780	458,249	536,052	12,900,143			

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

Cost Report Year (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

		In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured		Total In-State Medicaid (Days Include Medicaid FFS & MCO Exhausted and Non-Covered)		
	Totals / Payments															
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 6,672,398	$ 23,657,745	$ 11,599,064	$ 161,426,830	$ -	$ 3,240	$ 1,078,993	$ 6,458,990	$ 118,676	$ 458,249	$ 632,794 (Agrees to Exhibit A)	$ 12,900,143 (Agrees to Exhibit A)	$ 19,350,455	$ 191,546,805	2.33%
129	Total Charges per PS&R or Exhibit Detail	$ 6,672,398	$ 23,657,745	$ 11,599,064	$ 161,426,830	$ -	$ 3,240	$ 1,078,993	$ 6,458,990	$ 118,676	$ 458,249	$ 632,794	$ 12,900,143			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	-	-			
131.01	**Sampling Cost Adjustment (if applicable)**													$ -	$ -	
131.02	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 1,826,223	$ 3,878,413	$ 2,797,346	$ 23,055,154	$ -	$ 1,345	$ 230,006	$ 905,525	$ 37,115	$ 85,255	$ 146,833	$ 1,673,103	$ 4,853,575	$ 27,840,437	2.07%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 1,369,221	$ 4,091,698	$ -	$ -	$ -	$ 100	$ -	$ -					$ 1,369,221	$ 4,091,798	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ 3,217,615	$ 38,558,419	$ -	$ -	$ 12,337	$ 182,736					$ 3,229,952	$ 38,741,155	
134	Private Insurance (including primary and third party liability)	$ 5,492	$ 12,709	$ -	$ 199	$ -	$ -	$ 281,892	$ 1,684,068					$ 287,384	$ 1,696,976	
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ 864	$ -	$ -	$ 50	$ 863	$ -	$ 150			$ 50	$ 1,727	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 1,374,713	$ 4,104,407	$ 3,217,615	$ 38,559,482											
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ (948,006)	$ -	$ -									$ -	$ (948,006)	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -									$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ -		$ -		$ -	$ -	$ -	$ -	$ -		$ -		$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -					$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -					$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ 311	$ -	$ -			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ 311	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											$ 2,464	$ 183,896			
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)**	$ 451,510	$ 722,012	$ (420,269)	$ (15,504,328)	$ -	$ 934	$ (64,273)	$ (962,142)	$ 37,115	$ 85,105	$ 144,369	$ 1,489,207	$ (33,032)	$ (15,743,524)	
146	**Calculated Payments as a Percentage of Cost**	75%	81%	115%	167%	0%	31%	128%	206%	0%	0%	2%	11%	101%	157%	
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)**					94,602										
148	**Percent of cross-over days to total Medicare days from the cost report**					0%										

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

Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	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 & with Medicaid Secondary)		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	$ 1,696.94		-		-		-		-		-	
2	03100 INTENSIVE CARE UNIT	$ 2,217.31		-		-		-		-		-	
3	03200 CORONARY CARE UNIT	$ -		-		-		-		-		-	
4	03300 BURN INTENSIVE CARE UNIT	$ -		-		-		-		-		-	
5	03400 SURGICAL INTENSIVE CARE UNIT	$ 3,785.95		-		-		-		-		-	
6	03500 OTHER SPECIAL CARE UNIT	$ -		-		-		-		-		-	
7	04000 SUBPROVIDER I	$ -		-		-		-		-		-	
8	04100 SUBPROVIDER II	$ -		-		-		-		-		-	
9	04200 OTHER SUBPROVIDER	$ -		-		-		-		-		-	
10	04300 NURSERY	$ 1,667.33		-		-		-		-		-	
11	3501 NEONATAL INTENSIVE CARE UNIT	$ 2,361.07		-		-		-		-		-	
18			**Total Days**	-		-		-		-		-	
19	Total Days per PS&R or Exhibit Detail			-		-		-		-			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges			$ -		$ -		$ -		$ -		$ -	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ -		$ -	
	Ancillary Cost Centers (from W/S C) (list below):			**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**	**Ancillary Charges**
22	09200 Observation (Non-Distinct)		0.503438	-	-	-	-	-	-	-	-	$ -	$ -
23	5000 OPERATING ROOM		0.063672	-	-	-	-	-	-	-	-	$ -	$ -
24	5200 DELIVERY ROOM & LABOR ROOM		0.214626	-	-	-	-	-	-	-	-	$ -	$ -
25	5300 ANESTHESIOLOGY		0.039694	-	-	-	-	-	-	-	-	$ -	$ -
26	5400 RADIOLOGY-DIAGNOSTIC		0.144464	-	-	-	-	-	-	-	-	$ -	$ -
27	5600 RADIOISOTOPE		0.063757	-	-	-	-	-	-	-	-	$ -	$ -
28	5700 CT SCAN		0.013268	-	-	-	-	-	-	-	-	$ -	$ -
29	5800 MRI		0.046149	-	-	-	-	-	-	-	-	$ -	$ -
30	6000 LABORATORY		0.073571	-	-	-	-	-	-	-	-	$ -	$ -
31	6001 LABORATORY-CRESTVIEW		0.132255	-	-	-	-	-	-	-	-	$ -	$ -
32	6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.127042	-	-	-	-	-	-	-	-	$ -	$ -
33	6500 RESPIRATORY THERAPY		0.072661	-	-	-	-	-	-	-	-	$ -	$ -
34	6501 RESPIRATORY THERAPY-CRESTVIEW		0.121188	-	-	-	-	-	-	-	-	$ -	$ -
35	6600 PHYSICAL THERAPY		0.189083	-	-	-	-	-	-	-	-	$ -	$ -
36	6601 PHYSICAL THERAPY-CRESTVIEW		0.231303	-	-	-	-	-	-	-	-	$ -	$ -
37	6900 ELECTROCARDIOLOGY		0.036375	-	-	-	-	-	-	-	-	$ -	$ -
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.407896	-	-	-	-	-	-	-	-	$ -	$ -
39	7101 MEDICAL SUPPLIES CHARGED CRESTVIEW		0.648157	-	-	-	-	-	-	-	-	$ -	$ -
40	7200 IMPL. DEV. CHARGED TO PATIENTS		0.532068	-	-	-	-	-	-	-	-	$ -	$ -
41	7300 DRUGS CHARGED TO PATIENTS		0.231521	-	-	-	-	-	-	-	-	$ -	$ -
42	7301 DRUGS CHARGED TO PATIENTS-CRESTVIEW		0.776101	-	-	-	-	-	-	-	-	$ -	$ -
43	7302 OUTPATIENT PHARMACY		0.560629	-	-	-	-	-	-	-	-	$ -	$ -
44	7400 RENAL DIALYSIS		0.168982	-	-	-	-	-	-	-	-	$ -	$ -
45	7601 PULMONARY FUNCTION TESTING		0.088690	-	-	-	-	-	-	-	-	$ -	$ -
46	7602 CARDIOVASCULAR LAB		0.254295	-	-	-	-	-	-	-	-	$ -	$ -
47	9000 CLINIC		0.433239	-	-	-	-	-	-	-	-	$ -	$ -
48	9001 SATELLITE CLINICS		0.500706	-	-	-	-	-	-	-	-	$ -	$ -
49	9100 EMERGENCY		0.105792	-	-	-	-	-	-	-	-	$ -	$ -
50	9201 OBSERVATION BEDS (DISTINCT PART)		0.330770	-	-	-	-	-	-	-	-	$ -	$ -
				-	-	-	-	-	-	-	-		
	Totals / Payments												
128	**Total Charges (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
129	Total Charges per PS&R or Exhibit Detail			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)			-	-	-	-	-	-	-	-		
131.01	Sampling Cost Adjustment (if applicable)											$ -	$ -
131.02	**Total Calculated Cost (includes organ acquisition from Section K)**			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

		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 & with Medicaid Secondary)		Total Out-Of-State Medicaid	
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
134	Private Insurance (including primary and third party liability)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
135	Self-Pay (including Co-Pay and Spend-Down)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)	$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles) (See Note F)	$ -		$ -		$ -	$ -	$ -	$ -	$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					$ -	$ -	$ -	$ -	$ -	$ -
141	Medicare Cross-Over Bad Debt Payments					$ -	$ -	$ -	$ -	$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)					$ -	$ -	$ -	$ -	$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.
Note F - Medicare payments reported in FFS, MCO, MCD Exhausted/Non-covered, and uninsured payor buckets should only include Medicare Part B payments for inpatient, Medicaid primary claims with Medicare Part B only coverage for Medicaid covered ancillary services. Such claims should not have Medicare Part A benefits (due to no coverage or exhausted benefits).

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

Cost Report Year (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary - Exclude Medicaid Exhausted and Non-Covered)		Medicaid FFS & MCO Exhausted and Non-Covered (Not to be Included Elsewhere)		Uninsured	
							Charges	Useable Organs (Count)	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 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	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
2	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
3	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
4	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
5	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
6	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
7	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
8		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 D 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 (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

		Total Organ Acquisition Cost	Additional Add-In Intern/Resident Cost	Total Adjusted Organ Acquisition Cost	Revenue for Medicaid/ Cross-Over / Uninsured Organs Sold	Total Useable Organs (Count)	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere & with Medicaid Secondary)	
							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	$ -	0	$ -	0	$ -	0	$ -	0
12	Kidney Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
13	Liver Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
14	Heart Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
15	Pancreas Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
16	Intestinal Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
17	Islet Acquisition	$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	0
18		$ -	$ -	$ -	$ -	0	$ -	0	$ -	0	$ -	0	$ -	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 E 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 (01/01/2024-12/31/2024) CHILDREN'S HLTHCRE-HUGHES SPALDING

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 710,483		
1a	Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment		$ -	0	***(WTB Account #)***
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)		$ -	-	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)	0	$ 710,483		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
5	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
6	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
7	*Reclassification Code*	0	$ -	-	*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
9	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
10	*Reason for adjustment*	0	$ -	-	*(Adjusted to / (from))*
11	*Reason for adjustment*	0	$ -	-	*(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*	0	$ -	-	
13	*Reason for adjustment*	0	$ -	-	
14	*Reason for adjustment*	0	$ -	-	
15	*Reason for adjustment*	0	$ -	-	
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		$ 710,483
	Apportionment of Provider Tax Assessment Adjustment to All Medicaid Eligible & Uninsured:		
18	Medicaid Eligible***	**Charges Sec. G**	211,474,185
19	Uninsured Hospital	**Charges Sec. G**	13,532,937
20	Total Hospital	**Charges Sec. G**	9,640,383,508
21	Medicaid Eligible Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		2.19%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		0.14%
23	Medicaid Eligible Provider Tax Assessment Adjustment to DSH UCC***		$ 15,585
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 997
25	Provider Tax Assessment Adjustment to DSH UCC Including all Medicaid eligibles***		**$ 16,582**
	Apportionment of Provider Tax Assessment Adjustment to Medicaid Primary & Uninsured:		
26	Medicaid Primary***	**Charges Sec. G**	203,356,037
27	Uninsured Hospital	**Charges Sec. G**	14,109,862
28	Total Hospital	**Charges Sec. G**	9,640,383,508
29	Medicaid Primary Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC***		2.11%
30	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		0.15%
31	Medicaid Primary Provider Tax Assessment Adjustment to DSH UCC***		$ 14,987
32	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 1,040
33	Medicaid Primary Tax Assessment Adjustment to DSH UCC***		**$ 16,027**

** 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.*

****For state plan rate years (SPRY) beginning on or after October 1, 2021, Medicaid UCC includes only Medicaid primary cost and payments, unless a provider qualifies for 97th percentile exception and it benefits them. The exception is based on SPRY. For cost report periods overlapping SPRYs beginning on or after effective date, the Medicaid primary tax assessment adjustment to DSH UCC (line 33, above) will be utilized unless the provider qualifies for the 97th percentile exception and the SPRY UCC is greater utilizing total Medicaid eligible population. In which case, the provider tax assessment adjustment to DSH UCC including all Medicaid eligibles (line 25, above) will be utilized.*

DSH Examination Eligibility Summary

Hospital Name	**CHILDREN'S HLTHCRE-HUGHES SPALDING**
Hospital Medicaid Number	**000679808A**
Cost Report Period	From **1/1/2024** To **12/31/2024**

			As-Reported	Adjustments	As-Adjusted
	LIUR				
1	Medicaid Hospital Net Revenue	Survey H & I (Sum all In-State & Out-of-State Medicaid Payments)	$ 46,503,384	$ -	$ 46,503,384
2	Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
3	Total		$ 46,503,384	$ -	$ 46,503,384
4	Net Hospital Patient Revenue	Survey F-3	$ 60,204,305	$ -	$ 60,204,305
5	Medicaid Fraction		77.24%	0.00%	77.24%
6	Inpatient Charity Care Charges	Survey F-2	$ 950,491	$ -	$ 950,491
7	Inpatient Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
8	Unspecified Hospital Cash Subsidies	Survey F-2	$ -	$ -	$ -
9	Adjusted Inpatient Charity Care		$ 950,491	$ -	$ 950,491
10	Inpatient Hospital Charges	Survey F-3	$ 23,695,935	$ -	$ 23,695,935
11	Inpatient Charity Fraction		4.01%	0.00%	4.01%
12	LIUR		81.25%	0.00%	81.25%
	MIUR				
13	In-State Medicaid Eligible Days	Survey H	1,788	-	1,788
14	Out-of-State Medicaid Eligible Days	Survey I	-	-	-
15	Total Medicaid Eligible Days		1,788	-	1,788
16	Total Hospital Days (excludes swing-bed)	Survey F-1	2,959	-	2,959
17	MIUR		60.43%	0.00%	60.43%

NOTE: LIUR calculated above does not include other Medicaid or supplemental payments reported on DSH Survey Part I and may not reconcile to DSH results letter as a result.

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: CHILDREN'S HLTHCRE-HUGHES SPALDING
Hospital Medicaid Number: 000679808A
Cost Report Period: From 1/1/2024 To 12/31/2024

As-Reported:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	1,826,223	1,369,221	-	5,492	-	-	-	-	-	-	-			1,374,713	451,510	75.28%
2	Medicaid Fee for Service	Outpatient	3,878,413	4,091,698	-	12,709	-	(948,006)	-	-	-	-	-			3,156,401	722,012	81.38%
3	Medicaid Managed Care	Inpatient	2,797,346	-	3,217,615	-	-	-	-	-						3,217,615	(420,269)	115.02%
4	Medicaid Managed Care	Outpatient	23,055,154	-	38,558,419	199	864	-	-							38,559,482	(15,504,328)	167.25%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	1,345	100	-	-	-		-	-	-	-	311			411	934	30.56%
7	Other Medicaid Eligibles	Inpatient	230,006	-	12,337	281,892	50			-	-	-	-			294,279	(64,273)	127.94%
8	Other Medicaid Eligibles	Outpatient	905,525	-	182,736	1,684,068	863			-	-	-	-			1,867,667	(962,142)	206.25%
9	Uninsured	Inpatient	183,948	-	-	-	-	-	-	-	-	-	-	2,464	-	2,464	181,484	1.34%
10	Uninsured	Outpatient	1,758,358	-	-	-	150	-	-	-	-	-	-	183,896	-	184,046	1,574,312	10.47%
11	In-State Sub-total	Inpatient	5,037,523	1,369,221	3,229,952	287,384	50	-	-	-	-	-	-	2,464	-	4,889,071	148,452	97.05%
12	In-State Sub-total	Outpatient	29,598,795	4,091,798	38,741,155	1,696,976	1,877	(948,006)	-	-	-	-	311	183,896	-	43,768,007	(14,169,212)	147.87%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Sub-Total	I/P and O/P	34,636,318	5,461,019	41,971,107	1,984,360	1,927	(948,006)	-	-	-	-	311	186,360	-	48,657,078	(14,020,760)	140.48%
15.01	Provider Tax Assessment Adjustment to UCC																16,582	

Adjustments:

	Service Type		A Total Costs	B Medicaid Basic Rate Payments	C Medicaid Managed Care Payments	D Private Insurance Payments	E Self-Pay Payments (Includes Co-Pay and Spenddown)	F Medicaid Cost Settlement Payments	G Other Medicaid Payments (Outliers, etc..) **	H Medicare Traditional (non-HMO) Payments	I Medicare Managed Care (HMO) Payments	J Medicare Cross-over Bad Debt	K Other Medicare Cross-over Payments (GME, etc.)	L Uninsured Payments	M Uninsured Payments Not On Exhibit B (1011 Payments)	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
2	Medicaid Fee for Service	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
3	Medicaid Managed Care	Inpatient	-	-	-	-	-	-	-	-						-	-	0.00%
4	Medicaid Managed Care	Outpatient	-	-	-	-	-	-	-							-	-	0.00%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
6	Medicare Cross-over (FFS)	Outpatient	-	-	-	-	-		-	-	-	-	-			-	-	0.00%
7	Other Medicaid Eligibles	Inpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
8	Other Medicaid Eligibles	Outpatient	-	-	-	-	-			-	-	-	-			-	-	0.00%
9	Uninsured	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
10	Uninsured	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
11	In-State Sub-total	Inpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
12	In-State Sub-total	Outpatient	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	0.00%
15	Sub-Total	I/P and O/P	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.00%
15.01	Provider Tax Assessment Adjustment to UCC																	

DSH Examination UCC Cost & Payment Summary — Georgia

Hospital Name: CHILDREN'S HLTHCRE-HUGHES SPALDING
Hospital Medicaid Number: 000679808A
Cost Report Period: From 1/1/2024 To 12/31/2024
As-Adjusted:

	Service Type		A Total Costs Survey H & I	B Medicaid Basic Rate Payments Survey H & I	C Medicaid Managed Care Payments Survey H & I	D Private Insurance Payments Survey H & I	E Self-Pay Payments (Includes Co-Pay and Spenddown) Survey H & I	F Medicaid Cost Settlement Payments Survey H & I	G Other Medicaid Payments (Outliers, etc..) ** Survey H & I	H Medicare Traditional (non-HMO) Payments Survey H & I	I Medicare Managed Care (HMO) Payments Survey H & I	J Medicare Cross-over Bad Debt Survey H & I	K Other Medicare Cross-over Payments (GME, etc.) Survey H & I	L Uninsured Payments Survey H & I	M Uninsured Payments Not On Exhibit B (1011 Payments) Survey E	N Total Payments (Col. B through Col. M)	O Uncomp. Care Costs (Col. A - Col. N)	P Payment to Cost Ratio (Col. N / Col. A)
1	Medicaid Fee for Service	Inpatient	1,826,223	1,369,221	-	5,492	-	-	-	-	-	-	-			1,374,713	451,510	75.28%
2	Medicaid Fee for Service	Outpatient	3,878,413	4,091,698	-	12,709	-	(948,006)	-	-	-	-	-			3,156,401	722,012	81.38%
3	Medicaid Managed Care	Inpatient	2,797,346	-	3,217,615	-	-	-	-	-						3,217,615	(420,269)	115.02%
4	Medicaid Managed Care	Outpatient	23,055,154	-	38,558,419	199	864	-	-							38,559,482	(15,504,328)	167.25%
5	Medicare Cross-over (FFS)	Inpatient	-	-	-	-	-		-	-	-	-	-			-	-	n/a
6	Medicare Cross-over (FFS)	Outpatient	1,345	100	-	-	-		-	-	-	-	311			411	934	30.56%
7	Other Medicaid Eligibles	Inpatient	230,006	-	12,337	281,892	50			-	-	-	-			294,279	(64,273)	127.94%
8	Other Medicaid Eligibles	Outpatient	905,525	-	182,736	1,684,068	863			-	-	-	-			1,867,667	(962,142)	206.25%
9	Uninsured	Inpatient	183,948	-	-	-	-	-	-	-	-	-	-	2,464	-	2,464	181,484	1.34%
10	Uninsured	Outpatient	1,758,358	-	-	-	150	-	-	-	-	-	-	183,896	-	184,046	1,574,312	10.47%
11	In-State Sub-total	Inpatient	5,037,523	1,369,221	3,229,952	287,384	50	-	-	-	-	-	-	2,464	-	4,889,071	148,452	97.05%
12	In-State Sub-total	Outpatient	29,598,795	4,091,798	38,741,155	1,696,976	1,877	(948,006)	-	-	-	-	311	183,896	-	43,768,007	(14,169,212)	147.87%
13	Out-of-State Medicaid	Inpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
14	Out-of-State Medicaid	Outpatient	-	-	-	-	-	-	-	-	-	-	-			-	-	n/a
15	Cost Report Year Sub-Total	I/P and O/P	34,636,318	5,461,019	41,971,107	1,984,360	1,927	(948,006)	-	-	-	-	311	186,360	-	48,657,078	(14,020,760)	140.48%
15.01																	16,582	
16																	-	
17																	(14,004,178)	
18																	555	
19																	(1,025,481)	
20																	(12,979,252)	

Provider Tax Assessment Adjustment to UCC Including all Medicaid Eligibles
Less: Out of State DSH Payments from Adjusted Survey
Adjusted Sub-Total UCC Including All Medicaid Eligibles and Uninsured Prior to Supplemental Medicaid Payments
Less: Non-Medicaid Primary Provider Tax Assessment Adjustment to UCC
Less: Non-Medicaid Primary UCC Prior to Supplemental Medicaid Payments
Adjusted Sub-Total UCC Including Only Medicaid-Primary Payors and Uninsured Prior to Supplemental Medicaid Payments

Medicaid DSH Survey Adjustments

PROVIDER: CHILDREN'S HLTHCRE-HUGHES SPALDING
Mcaid Number: 000679808A
FROM: 1/1/2024 TO: 12/31/2024
Mcare Number: 110079

Myers and Stauffer DSH Survey Adjustments

Adj. #	Schedule	Line #	Line Description	Column	Column Description	Explanation for Adjustment	Original Amount	Adjustment	Adjusted Total	W/P Ref.

Medicaid DSH Report Notes

PROVIDER: CHILDREN'S HLTHCRE-HUGHES SPALDING Mcaid Number: 000679808A
FROM: 1/1/2024 TO: 12/31/2024 Mcare Number: 110079

Myers and Stauffer DSH Report Notes

Note #	Note for Report	Amounts
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