State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2020	12/31/2020
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000000943A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113300

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/1/1928

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 9,996,762
   (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 07/01/2019 - 06/30/2020**
   (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 Services07/01/2019 - 06/30/2020** — $ 9,996,762

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	SVP & CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Ruth Fowler	404-785-7006	ruth.fowler@choa.org

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

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

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

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HOSPITAL ATL AT EGLESTON

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	$ 1,688.70		11,132		16,149		173		3,138		884		30,592		72.51%
2	03100 INTENSIVE CARE UNIT	$ 2,975.02		4,883		11,831		18		1,751		188		18,483		92.29%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,374.82		1,704		7,454				2,672		7		11,830		97.24%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	17,719		35,434		191		7,561		1,079		60,905		74.82%
19	Total Days per PS&R or Exhibit Detail			17,719		35,434		191		7,561		1,079				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 81,458,095		$ 146,516,097		$ 551,156		$ 41,187,875		$ 3,827,777		$ 269,713,223		74.49%
21.01	Calculated Routine Charge Per Diem			$ 4,597.22		$ 4,134.90		$ 2,885.63		$ 5,447.41		$ 3,547.52		$ 4,428.42		
	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)		0.378264	1,615,822	3,525,186	2,957,007	9,846,340	15,438	99,324	360,941	1,290,099	204,757	578,709	$ 4,949,208	$ 14,760,949	65.28%
23	5000 OPERATING ROOM		0.134603	46,212,447	18,223,971	75,477,938	41,055,855	836,513	462,644	16,478,565	6,764,277	2,353,779	872,524	$ 139,005,463	$ 66,506,747	66.24%
24	5100 RECOVERY ROOM		-											$ -	$ -	
25	5300 ANESTHESIOLOGY		0.070506	10,473,538	7,752,593	17,343,847	13,718,741	203,340	67,236	3,852,572	2,780,329	509,587	227,859	$ 31,873,297	$ 24,318,899	64.84%
26	5400 RADIOLOGY-DIAGNOSTIC		0.111816	8,583,553	8,640,756	20,462,482	23,477,151	67,903	124,144	3,247,518	4,745,599	695,508	1,144,234	$ 32,361,456	$ 36,987,650	59.72%
27	5500 RADIOLOGY-THERAPEUTIC		0.667966	2,172,063	492,337	2,482,600	2,790,641			479,565	1,189,196	2,380	94,961	$ 5,134,228	$ 4,472,174	49.96%
28	5600 RADIOISOTOPE		0.268920	174,933	203,845	196,534	203,565			60,732	280,671	37,014	2,505	$ 432,199	$ 688,081	49.69%
29	6000 LABORATORY		0.203353	25,497,926	16,275,488	45,085,619	27,940,232	462,309	1,440,661	8,900,928	5,981,097	2,498,524	1,929,688	$ 79,946,782	$ 51,637,478	69.04%
30	6400 IV THERAPY		0.310320	700,631	2,240,074	11,056	658,788		29,788	14,607	257,389	2,965	57,142	$ 726,294	$ 3,186,039	78.46%
31	6500 RESPIRATORY THERAPY		0.398053	18,434,172	816,547	26,868,685	999,724	25,863	10,133	10,688,262	285,046	627,927	49,143	$ 56,016,982	$ 2,111,450	75.67%
32	6600 PHYSICAL THERAPY		0.469808	2,564,786	465,232	4,884,618	963,998	16,341		1,252,771	139,003	98,585	18,211	$ 8,718,516	$ 1,568,233	73.96%
33	6900 EKG		0.185624	6,794,357	5,614,901	13,022,009	10,181,218	17,424	82,475	2,161,152	2,567,791	266,856	110,814	$ 21,994,942	$ 18,446,385	51.86%
34	7000 ELECTROENCEPHALOGRAPHY		0.155643	2,486,016	1,052,079	5,290,218	2,432,173	23,483	27,470	1,173,829	601,787	228,094	228,323	$ 8,973,546	$ 4,113,509	73.88%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.519503	6,154,822	4,606,980	7,389,756	5,240,293	58,305	43,839	1,982,440	1,394,895	251,479	35,790	$ 15,585,323	$ 11,286,007	63.99%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.534874	7,064,254	2,564,261	11,014,572	3,592,313			4,066,315	723,967	222,859	59,140	$ 22,145,141	$ 6,880,541	60.68%
37	7300 DRUGS CHARGED TO PATIENTS		0.212538	50,356,685	22,916,994	78,876,669	16,361,266	679,114	1,003,984	17,094,287	9,143,727	3,897,605	1,142,890	$ 147,006,755	$ 49,425,971	61.82%
38	7400 Renal		0.415466	124,720		536,123	2,924	118,872	1,462	186,048	737	111,797	2,924	$ 965,763	$ 5,123	83.49%
39	9000 CLINIC		2.083691	1,265	1,452,318	38,380	1,176,833		74,437	79,076	363,469	10,593	80,939	$ 118,721	$ 3,067,057	69.30%
40	9100 EMERGENCY		0.302652	2,844,290	4,967,797	6,111,270	31,514,056	65,734	67,952	817,282	1,806,644	282,863	3,338,632	$ 9,838,576	$ 38,356,449	67.37%
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HOSPITAL ATL AT EGLESTON

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
67				-											$ -	$ -
68				-											$ -	$ -
69				-											$ -	$ -
70				-											$ -	$ -
71				-											$ -	$ -
72				-											$ -	$ -
73				-											$ -	$ -
74				-											$ -	$ -
75				-											$ -	$ -
76				-											$ -	$ -
77				-											$ -	$ -
78				-											$ -	$ -
79				-											$ -	$ -
80				-											$ -	$ -
81				-											$ -	$ -
82				-											$ -	$ -
83				-											$ -	$ -
84				-											$ -	$ -
85				-											$ -	$ -
86				-											$ -	$ -
87				-											$ -	$ -
88				-											$ -	$ -
89				-											$ -	$ -
90				-											$ -	$ -
91				-											$ -	$ -
92				-											$ -	$ -
93				-											$ -	$ -
94				-											$ -	$ -
95				-											$ -	$ -
96				-											$ -	$ -
97				-											$ -	$ -
98				-											$ -	$ -
99				-											$ -	$ -
100				-											$ -	$ -
101				-											$ -	$ -
102				-											$ -	$ -
103				-											$ -	$ -
104				-											$ -	$ -
105				-											$ -	$ -
106				-											$ -	$ -
107				-											$ -	$ -
108				-											$ -	$ -
109				-											$ -	$ -
110				-											$ -	$ -
111				-											$ -	$ -
112				-											$ -	$ -
113				-											$ -	$ -
114				-											$ -	$ -
115				-											$ -	$ -
116				-											$ -	$ -
117				-											$ -	$ -
118				-											$ -	$ -
119				-											$ -	$ -
120				-											$ -	$ -
121				-											$ -	$ -
122				-											$ -	$ -
123				-											$ -	$ -
124				-											$ -	$ -
125				-											$ -	$ -
126				-											$ -	$ -
127				-											$ -	$ -
					$ 192,256,280	$ 101,811,359	$ 318,049,383	$ 192,156,111	$ 2,590,639	$ 3,535,549	$ 72,896,890	$ 40,315,723	$ 12,303,172	$ 9,974,428		

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HOSPITAL ATL AT EGLESTON

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 275,077,543	$ 101,811,359	$ 466,753,107	$ 192,156,111	$ 3,653,779	$ 3,535,549	$ 114,157,905	$ 40,315,723	$ 16,204,089 (Agrees to Exhibit A)	$ 9,974,428 (Agrees to Exhibit A)	$ 859,642,334	$ 337,818,742	66.76%
129	Total Charges per PS&R or Exhibit Detail	$ 275,077,543	$ 101,811,359	$ 466,753,107	$ 192,156,111	$ 3,653,779	$ 3,535,549	$ 114,157,905	$ 40,315,723	$ 16,204,089	$ 9,974,428			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 80,954,014	$ 24,602,655	$ 145,093,175	$ 43,879,696	$ 1,130,193	$ 856,727	$ 32,117,060	$ 9,399,917	$ 4,744,117	$ 2,512,270	$ 259,294,442	$ 78,738,995	71.18%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 75,995,233	$ 19,457,131	$ 143,213,963	$ 57,652,578							$ 219,209,196	$ 77,109,709	
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)							$ 67,132,031	$ 22,553,967			$ 67,132,031	$ 22,553,967	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 2,043,211	$ 967,188	$ 2,996,494	$ 3,030,475							$ 5,039,705	$ 3,997,663	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 78,038,444	$ 20,424,319	$ 146,210,457	$ 60,683,053									
137	Medicaid Cost Settlement Payments (See Note B)		$ 130,750									$ -	$ 130,750	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments					$ 13,413	$ 25,053			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 13,413	$ 25,053	
142	Other Medicare Cross-Over Payments (See Note D)					$ 629,842	$ 441,391					$ 629,842	$ 441,391	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 708,687	$ 708,361			
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)**	$ 2,915,570	$ 4,047,586	$ (1,117,282)	$ (16,803,357)	$ 486,938	$ 390,283	$ (35,014,971)	$ (13,154,050)	$ 4,035,430	$ 1,803,909	$ (32,729,745)	$ (25,519,538)	
146	**Calculated Payments as a Percentage of Cost**	96%	84%	101%	138%	57%	54%	209%	240%	15%	28%	113%	132%	
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)**					474								
148	**Percent of cross-over days to total Medicare days from the cost report**					40%								

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.

State of Georgia
Disproportionate Share Hospital (DSH) Examination Survey Part I
For State DSH Year 2020

DSH Version 6.00 2/17/2021

A. General DSH Year Information

	Begin	End
1. DSH Year:	07/01/2019	06/30/2020

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	01/01/2020	12/31/2020
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000001636A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	113301

B. DSH OB Qualifying Information

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

During the DSH Examination Year:

	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	No
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	Yes
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	6/1/1915

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 727,676
   (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 07/01/2019 - 06/30/2020**
   (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 Services07/01/2019 - 06/30/2020** — $ 727,676

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	Title	Date
	SVP & CFO	

Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail
Ruth Fowler	404-785-7006	ruth.fowler@choa.org

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

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

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

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HEALTHCARE-SCOTTISH RITE

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	$ 1,578.29		9,316		12,839		13		3,805		503		25,973		61.31%
2	03100 INTENSIVE CARE UNIT	$ 2,611.73		3,217		6,783		4		1,528		169		11,532		99.31%
3	03200 CORONARY CARE UNIT	$ -												-		
4	03300 BURN INTENSIVE CARE UNIT	$ -												-		
5	03400 SURGICAL INTENSIVE CARE UNIT	$ -												-		
6	03500 OTHER SPECIAL CARE UNIT	$ -												-		
7	04000 SUBPROVIDER I	$ -												-		
8	04100 SUBPROVIDER II	$ -												-		
9	04200 OTHER SUBPROVIDER	$ -												-		
10	04300 NURSERY	$ 1,448.72		2,218		4,766				1,469		229		8,453		76.86%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	14,751		24,388		17		6,802		901		45,958		61.70%
19	Total Days per PS&R or Exhibit Detail			14,751		24,388		17		6,802		901				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 60,070,748		$ 89,469,308		$ 59,674		$ 30,513,876		$ 4,246,668		$ 180,113,606		69.49%
21.01	Calculated Routine Charge Per Diem			$ 4,072.32		$ 3,668.58		$ 3,510.24		$ 4,486.02		$ 4,713.28		$ 3,919.09		
	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)		0.352461	1,636,258	2,736,469	3,182,318	11,823,189		4,464	686,348	2,157,183	225,362	760,180	$ 5,504,924	$ 16,721,305	53.51%
23	5000 OPERATING ROOM		0.181557	18,670,066	11,844,499	25,696,529	38,385,789	23,356	5,487	9,657,243	7,310,882	894,324	1,291,398	$ 54,047,194	$ 57,546,657	52.03%
24	5100 RECOVERY ROOM		0.490644	665,102	973,582	832,544	2,773,386			289,691	562,678	34,002	82,059	$ 1,787,537	$ 4,309,646	66.69%
25	5300 ANESTHESIOLOGY		0.104218	5,960,432	4,727,904	7,891,939	13,257,662	4,519	5,677	2,979,142	2,841,000	233,572	372,673	$ 16,836,032	$ 20,832,243	61.48%
26	5400 RADIOLOGY-DIAGNOSTIC		0.133647	4,108,502	4,633,248	6,646,376	16,526,479	9,824	41,171	1,960,602	2,611,908	285,938	1,072,533	$ 12,725,304	$ 23,812,806	46.24%
27	5500 RADIOLOGY-THERAPEUTIC		0.637673	293,175	916,405	387,952	2,020,508			179,845	2,265,667	2,168	149,570	$ 860,972	$ 5,202,580	52.21%
28	5600 RADIOISOTOPE		0.446449	28,046	91,187	68,886	301,579			17,720	327,152	3,733	10,032	$ 114,652	$ 719,918	49.73%
29	5800 MRI		0.133693	1,875,433	5,596,839	4,025,868	14,067,046			1,112,528	4,413,910	127,298	443,103	$ 7,013,829	$ 24,077,795	47.04%
30	6000 LABORATORY		0.192777	14,225,432	12,148,655	21,167,669	27,685,651	14,579	19,146	7,428,596	5,741,322	846,983	1,966,940	$ 42,836,276	$ 45,594,774	60.13%
31	6500 RESPIRATORY THERAPY		0.365354	18,516,689	297,736	13,630,904	456,620	18,681	718	7,614,942	252,982	510,038	29,511	$ 39,781,216	$ 1,008,056	77.11%
32	6600 PHYSICAL THERAPY		0.735370	1,548,806	1,786,266	2,317,060	5,522,599	2,346	886	696,381	2,114,233	78,924	193,865	$ 4,564,593	$ 9,423,984	38.69%
33	6800 SPEECH PATHOLOGY		0.553958	361,679	664,937	480,121	1,360,543			207,253	1,061,077	35,159	138,578	$ 1,049,053	$ 3,086,557	31.38%
34	7000 ELECTROENCEPHALOGRAPHY		0.196434	5,087,724	2,651,985	7,862,669	7,808,266	11,314	10,593	2,415,107	1,699,301	277,636	354,889	$ 15,376,814	$ 12,170,145	63.81%
35	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1.119207	2,940,248	1,656,769	1,995,135	1,200,207	2,453	180	1,345,926	751,909	40,291	41,640	$ 6,283,762	$ 3,609,065	71.39%
36	7200 IMPL. DEV. CHARGED TO PATIENTS		0.467060	6,647,178	2,431,994	8,436,001	3,193,349			2,742,666	1,492,130	113,063	58,675	$ 17,825,845	$ 7,117,473	48.88%
37	7300 DRUGS CHARGED TO PATIENTS		0.261481	28,614,892	12,449,493	31,447,496	9,400,309	34,770	2,977	18,823,059	9,730,802	1,463,526	1,567,593	$ 78,920,217	$ 31,583,581	66.30%
38	9000 CLINIC		2.142816	171	1,198,860	53,353	1,349,621	866	4,437	105,923	466,199	34,593	97,599	$ 160,313	$ 3,019,117	55.40%
39	9100 EMERGENCY		0.261559	3,480,043	5,126,231	6,831,744	33,824,695	8,998	2,995	1,407,970	2,371,709	446,092	4,129,367	$ 11,728,755	$ 41,325,630	53.76%
40			-											$ -	$ -	
41			-											$ -	$ -	
42			-											$ -	$ -	
43			-											$ -	$ -	
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
48			-											$ -	$ -	
49			-											$ -	$ -	
50			-											$ -	$ -	
51			-											$ -	$ -	
52			-											$ -	$ -	
53			-											$ -	$ -	
54			-											$ -	$ -	
55			-											$ -	$ -	
56			-											$ -	$ -	
57			-											$ -	$ -	
58			-											$ -	$ -	
59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HEALTHCARE-SCOTTISH RITE

					In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid	%
61				-											$ -	$ -
62				-											$ -	$ -
63				-											$ -	$ -
64				-											$ -	$ -
65				-											$ -	$ -
66				-											$ -	$ -
67				-											$ -	$ -
68				-											$ -	$ -
69				-											$ -	$ -
70				-											$ -	$ -
71				-											$ -	$ -
72				-											$ -	$ -
73				-											$ -	$ -
74				-											$ -	$ -
75				-											$ -	$ -
76				-											$ -	$ -
77				-											$ -	$ -
78				-											$ -	$ -
79				-											$ -	$ -
80				-											$ -	$ -
81				-											$ -	$ -
82				-											$ -	$ -
83				-											$ -	$ -
84				-											$ -	$ -
85				-											$ -	$ -
86				-											$ -	$ -
87				-											$ -	$ -
88				-											$ -	$ -
89				-											$ -	$ -
90				-											$ -	$ -
91				-											$ -	$ -
92				-											$ -	$ -
93				-											$ -	$ -
94				-											$ -	$ -
95				-											$ -	$ -
96				-											$ -	$ -
97				-											$ -	$ -
98				-											$ -	$ -
99				-											$ -	$ -
100				-											$ -	$ -
101				-											$ -	$ -
102				-											$ -	$ -
103				-											$ -	$ -
104				-											$ -	$ -
105				-											$ -	$ -
106				-											$ -	$ -
107				-											$ -	$ -
108				-											$ -	$ -
109				-											$ -	$ -
110				-											$ -	$ -
111				-											$ -	$ -
112				-											$ -	$ -
113				-											$ -	$ -
114				-											$ -	$ -
115				-											$ -	$ -
116				-											$ -	$ -
117				-											$ -	$ -
118				-											$ -	$ -
119				-											$ -	$ -
120				-											$ -	$ -
121				-											$ -	$ -
122				-											$ -	$ -
123				-											$ -	$ -
124				-											$ -	$ -
125				-											$ -	$ -
126				-											$ -	$ -
127				-											$ -	$ -
					$ 114,659,876	$ 71,933,059	$ 142,954,564	$ 190,957,498	$ 131,706	$ 98,731	$ 59,671,142	$ 48,172,044	$ 5,652,702	$ 12,760,205		

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

Cost Report Year (01/01/2020-12/31/2020) CHILDREN'S HEALTHCARE-SCOTTISH RITE

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges *(includes organ acquisition from Section J)***	$ 174,730,624	$ 71,933,059	$ 232,423,872	$ 190,957,498	$ 191,380	$ 98,731	$ 90,185,018	$ 48,172,044	$ 9,899,370 (Agrees to Exhibit A)	$ 12,760,205 (Agrees to Exhibit A)	$ 497,530,894	$ 311,161,332	58.89%
129	Total Charges per PS&R or Exhibit Detail	$ 174,730,624	$ 71,933,059	$ 232,423,872	$ 190,957,498	$ 191,380	$ 98,731	$ 90,185,018	$ 48,172,044	$ 9,899,370	$ 12,760,205			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 58,866,165	$ 20,886,743	$ 82,478,605	$ 48,275,839	$ 66,619	$ 26,620	$ 28,725,611	$ 14,567,572	$ 3,061,196	$ 3,336,051	$ 170,137,000	$ 83,756,774	60.94%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 46,952,296	$ 17,786,729	$ 73,144,506	$ 60,678,692							$ 120,096,802	$ 78,465,421	
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)							$ 57,091,118	$ 28,711,284			$ 57,091,118	$ 28,711,284	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 1,438,269	$ 1,263,215	$ 2,398,870	$ 3,128,789							$ 3,837,139	$ 4,392,004	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 48,390,565	$ 19,049,944	$ 75,543,376	$ 63,807,481									
137	Medicaid Cost Settlement Payments (See Note B)		$ 1,491,903									$ -	$ 1,491,903	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)											$ -	$ -	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)											$ -	$ -	
141	Medicare Cross-Over Bad Debt Payments									(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ -	$ -	
142	Other Medicare Cross-Over Payments (See Note D)					$ 73,605	$ 95,354					$ 73,605	$ 95,354	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 955,264	$ 2,204,504			
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)**	$ 10,475,600	$ 344,896	$ 6,935,229	$ (15,531,642)	$ (6,986)	$ (68,734)	$ (28,365,507)	$ (14,143,712)	$ 2,105,932	$ 1,131,547	$ (10,961,664)	$ (29,399,192)	
146	**Calculated Payments as a Percentage of Cost**	82%	98%	92%	132%	110%	358%	199%	197%	31%	66%	106%	135%	
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)**					25								
148	**Percent of cross-over days to total Medicare days from the cost report**					68%								

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

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