DSH Version 6.01 2/10/2022

A. General DSH Year Information

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

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

Identification of cost reports needed to cover the DSH Year:

	Cost Report Begin Date(s)	Cost Report End Date(s)
3. Cost Report Year 1	10/01/2020	09/30/2021
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000000844A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110121

B. DSH Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/20 - 06/30/21)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	Yes
2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?	No
3. Was the hospital exempt from the requirement listed under #1 above because it did not offer non-emergency obstetric services to the general population when federal Medicaid DSH regulations were enacted on December 22, 1987?	No
3a. Was the hospital open as of December 22, 1987?	Yes
3b. What date did the hospital open?	10/1/1960

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2020 - 06/30/2021** — $ 410,080

   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2020 - 06/30/2021** — $ -

   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.

   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2020 - 06/30/2021** — $ 410,080

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.

	Senior Vice President and CFO	11/14/2022
Hospital CEO or CFO Signature	Title	Date
Greg Hembree	(229) 228-2880	
Hospital CEO or CFO Printed Name	Hospital CEO or CFO Telephone Number	Hospital CEO or CFO E-Mail

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

Hospital Contact:		**Outside Preparer:**	
Name	Patricia L. Barrett	Name	
Title	Director of Reimbursement	Title	
Telephone Number		Firm Name	
E-Mail Address		Telephone Number	
Mailing Street Address	920 Cairo Rd	E-Mail Address	
Mailing City, State, Zip	Thomasville, GA 31792-4255		

DSH Version 8.10 7/5/2022

D. General Cost Report Year Information 10/1/2020 - 9/30/2021

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

1. Select Your Facility from the Drop-Down Menu Provided: GRADY GENERAL HOSPITAL

	10/1/2020 through 9/30/2021		
2. Select Cost Report Year Covered by this Survey (enter "X"):	X		
3. Status of Cost Report Used for this Survey (Should be audited if available):	1 - As Submitted		
3a. Date CMS processed the HCRIS file into the HCRIS database:	3/7/2022		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	GRADY GENERAL HOSPITAL	Yes	
5. Medicaid Provider Number:	000000844A	Yes	
6. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0	Yes	
7. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0	Yes	
8. Medicare Provider Number:	110121	Yes	
Owner/Operator (Private State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
DSH Pool Classification (Small Rural, Non-Small Rural, Urban):	Small Rural	Yes	

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

	State Name	Provider No.
9. State Name & Number	FL	0102121
10. State Name & Number		
11. State Name & Number		
12. State Name & Number		
13. State Name & Number		
14. State Name & Number		
15. State Name & Number		

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2020 - 09/30/2021)

1. Section 1011 Payment Related to Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
2. Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
3. Section 1011 Payment Related to Outpatient Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
4. **Total Section 1011 Payments Related to Hospital Services (See Note 1)**	$-
5. Section 1011 Payment Related to Non-Hospital Services Included in Exhibits B & B-1 (See Note 1)	$ -
6. Section 1011 Payment Related to Non-Hospital Services NOT Included in Exhibits B & B-1 (See Note 1)	$ -
7. **Total Section 1011 Payments Related to Non-Hospital Services (See Note 1)**	$-
8. **Out-of-State DSH Payments (See Note 2)**	$ -

	Inpatient	Outpatient	Total
9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)	$ 9,742	$ 199,165	$208,907
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 130,030	$ 1,190,988	$1,321,018
11. Total Cash Basis Patient Payments Reported on Exhibit B (Agrees to Column (N) on Exhibit B, less physician and non-hospital portion of payments)	$139,772	$1,390,153	$1,529,925
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	6.97%	14.33%	13.65%

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 (10/01/2020 - 09/30/2021)

F-1. Total Hospital Days Used in Medicaid Inpatient Utilization Ratio (MIUR)

1. Total Hospital Days Per Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 8, Sum of Lns. 14, 16, 17, 18.00-18.03, 30, 31 less lines 5 & 6)	2,812	**(See Note in Section F-3, below)**

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

2. Inpatient Hospital Subsidies	-
3. Outpatient Hospital Subsidies	-
4. Unspecified I/P and O/P Hospital Subsidies	-
5. Non-Hospital Subsidies	-
6. Total Hospital Subsidies	$ -
7. Inpatient Hospital Charity Care Charges	1,441,675
8. Outpatient Hospital Charity Care Charges	8,209,207
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	$ 9,650,882

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

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

	Total Patient Revenues (Charges)			Contractual Adjustments (formulas below can be overwritten if amounts are known)			
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Net Hospital Revenue
11. Hospital	$3,211,031.00			$ 1,965,458	$ -	$ -	$ 1,245,573
12. Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13. Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14. Swing Bed - SNF			$1,028,456.00			$ 629,513	
15. Swing Bed - NF			$0.00			$ -	
16. Skilled Nursing Facility			$0.00			$ -	
17. Nursing Facility			$0.00			$ -	
18. Other Long-Term Care			$0.00			$ -	
19. Ancillary Services	$17,499,767.00	$45,626,155.00		$ 10,711,530	$ 27,927,568	$ -	$ 24,486,824
20. Outpatient Services		$9,212,554.00			$ 5,638,964	$ -	$ 3,573,590
21. Home Health Agency			$0.00			$ -	
22. Ambulance		-	$ -	-	-	$ -	
23. Outpatient Rehab Providers			$0.00	$ -	$ -	$ -	$ -
24. ASC	$0.00	$0.00		$ -	$ -	$ -	$ -
25. Hospice			$0.00			$ -	
26. Other	$210,220.00	$3,221,521.00	$0.00	$ 128,675	$ 1,971,879	$ -	$ 1,331,188
27. Total	$ 20,921,018	$ 58,060,230	$ 1,028,456	$ 12,805,663	$ 35,538,410	$ 629,513	$ 30,637,175
28. Total Hospital and Non Hospital		Total from Above	$ 80,009,704		Total from Above	$ 48,973,586	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	80,009,704	Total Contractual Adj. (G-3 Line 2)	48,973,586
30. Increase worksheet G-3, Line 2 for Bad Debts NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
31. Increase worksheet G-3, Line 2 for Charity Care Write-Offs NOT INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
32. Increase worksheet G-3, Line 2 to reverse offset of Medicaid DSH Revenue INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
33. Increase worksheet G-3, Line 2 to reverse offset of State and Local Patient Care Cash Subsidies INCLUDED on worksheet G-3, Line 2 (impact is a decrease in net patient revenue)			+	
34. Decrease worksheet G-3, Line 2 to remove Medicaid Provider Taxes INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)			-	
35. Blank Recon Line OR "Decrease worksheet G-3, Line 2 to remove Charity Care Charges related to insured patients INCLUDED on worksheet G-3, Line 2 (impact is an increase in net patient revenue)"			-	
35. Adjusted Contractual Adjustments				48,973,586
36. Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)	$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

NOTE: All data in this section must be verified by the hospital. If data is already present in this section, it was completed using CMS HCRIS cost report data. If the hospital has a more recent version of the cost report, the data should be updated to the hospital's version of the cost report. Formulas can be overwritten as needed with actual data.

Line #		Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
			Cost Report Worksheet B, Part I, Col. 26	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*	*Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26*	*Calculated*	*Days - Cost Report W/S D-1, Pt. I, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others*	*Inpatient Routine Charges - Cost Report Worksheet C, Pt. I, Col. 6 (Informational only unless used in Section L charges allocation)*		*Calculated Per Diem*
	Routine Cost Centers (list below):										
1	03000	ADULTS & PEDIATRICS	$ 4,580,585	$ -	$ -	$350,330.00	$ 4,230,255	2,398	$2,768,562.00		$ 1,764.08
2	03100	INTENSIVE CARE UNIT	$ 1,178,493	$ -	$ -		$ 1,178,493	520	$1,142,272.00		$ 2,266.33
3	03200	CORONARY CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
4	03300	BURN INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
5	03400	SURGICAL INTENSIVE CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
6	03500	OTHER SPECIAL CARE UNIT	$ -	$ -	$ -		$ -	-	$0.00		$ -
7	04000	SUBPROVIDER I	$ -	$ -	$ -		$ -	-	$0.00		$ -
8	04100	SUBPROVIDER II	$ -	$ -	$ -		$ -	-	$0.00		$ -
9	04200	OTHER SUBPROVIDER	$ -	$ -	$ -		$ -	-	$0.00		$ -
10	04300	NURSERY	$ 875,687	$ -	$ -		$ 875,687	374	$425,246.00		$ 2,341.41
11			$ -	$ -	$ -		$ -	-	$0.00		$ -
12			$ -	$ -	$ -		$ -	-	$0.00		$ -
13			$ -	$ -	$ -		$ -	-	$0.00		$ -
14			$ -	$ -	$ -		$ -	-	$0.00		$ -
15			$ -	$ -	$ -		$ -	-	$0.00		$ -
16			$ -	$ -	$ -		$ -	-	$0.00		$ -
17			$ -	$ -	$ -		$ -	-	$0.00		$ -
18		Total Routine	$ 6,634,765	$ -	$ -	$ 350,330	$ 6,284,435	3,292	$ 4,336,080		
19		Weighted Average									$ 1,909.00

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)		480	-	-	$ 846,758	$176,084.00	$1,717,550.00	$ 1,893,634	0.447160

Line #		Cost Center Description	*Cost Report Worksheet B, Part I, Col. 26*	*Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY*	*Cost Report Worksheet C, Part I, Col.2 and Col. 4*		*Calculated*	*Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6*	*Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7*	*Total Charges - Cost Report Worksheet C, Pt. I, Col. 8*	*Medicaid Calculated Cost-to-Charge Ratio*
	Ancillary Cost Centers (from W/S C excluding Observation) (list below):										
21	5000	OPERATING ROOM	$1,997,615.00	$ -	$ -		$ 1,997,615	$847,082.00	$7,466,594.00	$ 8,313,676	0.240281
22	5200	DELIVERY ROOM & LABOR ROOM	$655,190.00	$ -	$ -		$ 655,190	$1,372,893.00	$120,142.00	$ 1,493,035	0.438831
23	5300	ANESTHESIOLOGY	$4,025.00	$ -	$ -		$ 4,025	$48,093.00	$548,521.00	$ 596,614	0.006746
24	5400	RADIOLOGY-DIAGNOSTIC	$1,527,796.00	$ -	$ -		$ 1,527,796	$1,641,455.00	$12,978,447.00	$ 14,619,902	0.104501
25	6000	LABORATORY	$2,190,517.00	$ -	$ -		$ 2,190,517	$4,175,846.00	$11,936,508.00	$ 16,112,354	0.135953
26	6500	RESPIRATORY THERAPY	$1,039,598.00	$ -	$ -		$ 1,039,598	$698,836.00	$333,620.00	$ 1,032,456	1.006917
27	6600	PHYSICAL THERAPY	$3,775,929.00	$ -	$ 1,865		$ 3,777,794	$1,554,174.00	$4,224,660.00	$ 5,778,834	0.653729
28	6900	ELECTROCARDIOLOGY	$120,386.00	$ -	$ -		$ 120,386	$329,727.00	$1,505,684.00	$ 1,835,411	0.065591
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$1,354,028.00	$ -	$ -		$ 1,354,028	$1,135,775.00	$2,290,092.00	$ 3,425,867	0.395237

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable	Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
30	7200	IMPL. DEV. CHARGED TO PATIENTS	$436,949.00	$ -	$ -	$ 436,949	$5,393.00	$900,990.00	$ 906,383	0.482080
31	7300	DRUGS CHARGED TO PATIENTS	$1,798,787.00	$ -	$ -	$ 1,798,787	$5,490,437.00	$2,262,911.00	$ 7,753,348	0.232001
32	9100	EMERGENCY	$3,231,947.00	$ -	$ -	$ 3,231,947	$911,259.00	$7,569,110.00	$ 8,480,369	0.381109
33			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
34			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
35			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
36			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
37			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
38			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
39			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
40			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
41			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
42			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
43			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
44			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
45			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
46			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
47			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
48			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
49			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
50			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
51			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
52			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
53			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
54			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
55			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
56			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
57			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
58			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
59			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
60			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
61			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
62			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
63			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
64			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
65			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
66			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
67			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
68			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
69			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
70			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
71			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
72			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
73			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
74			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
75			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
76			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
77			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
78			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
79			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
80			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
81			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
82			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
83			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
84			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
85			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
86			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
87			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
88			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-
89			$0.00	$ -	$ -	$ -	$0.00	$0.00	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

	Line #	Cost Center Description	Total Allowable Cost	Intern & Resident Costs Removed on Cost Report *	RCE and Therapy Add-Back (If Applicable)		Total Cost	I/P Days and I/P Ancillary Charges	I/P Routine Charges and O/P Ancillary Charges	Total Charges	Medicaid Per Diem / Cost or Other Ratios
90			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
91			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
92			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
93			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
94			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
95			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
96			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
97			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
98			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
99			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
100			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
101			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
102			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
103			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
104			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
105			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
106			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
107			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
108			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
109			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
110			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
111			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
112			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
113			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
114			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
115			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
116			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
117			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
118			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
119			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
120			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
121			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
122			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
123			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
124			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
125			$0.00	$ -	$ -		$ -	$0.00	$0.00	$ -	-
126		**Total Ancillary**	$ 18,132,767	$ -	$ 1,865		$ 18,134,632	$ 18,387,054	$ 53,854,829	$ 72,241,883	
127		**Weighted Average**									0.262748
128		**Sub Totals**	$ 24,767,532	$ -	$ 1,865		$ 24,419,067	$ 22,723,134	$ 53,854,829	$ 76,577,963	

Line	Description	Amount
129	NF, SNF, and Swing Bed Cost for Medicaid *(Sum of applicable Cost Report Worksheet D-3, Title 19, Column 3, Line 200 and Worksheet D, Part V, Title 19, Column 5-7, Line 200)*	$0.00
130	NF, SNF, and Swing Bed Cost for Medicare *(Sum of applicable Cost Report Worksheet D-3, Title 18, Column 3, Line 200 and Worksheet D, Part V, Title 18, Column 5-7, Line 200)*	$325,147.00
131	NF, SNF, and Swing Bed Cost for Other Payers *(Hospital must calculate. Submit support for calculation of cost.)*	
131.01	Other Cost Adjustments (support must be submitted)	
132	**Grand Total**	$ 24,093,920
133	Total Intern/Resident Cost as a Percent of Other Allowable Cost	0.00%

* 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 (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Line #		Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey to Cost Report Totals
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient (See Exhibit A)	Outpatient (See Exhibit A)	Inpatient	Outpatient	
			From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From Hospital's Own Internal Analysis*	*From Hospital's Own Internal Analysis*			
	Routine Cost Centers (from Section G):				**Days**		**Days**		**Days**		**Days**		**Days**		**Days**		
1	03000	ADULTS & PEDIATRICS	$ 1,764.08		231		278		277		71		189		857		54.74%
2	03100	INTENSIVE CARE UNIT	$ 2,266.33		28		19		72		31		42		150		36.92%
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	$ 2,341.41		92		213		1		2		17		308		86.90%
11			$ -												-		
12			$ -												-		
13			$ -												-		
14			$ -												-		
15			$ -												-		
16			$ -												-		
17			$ -												-		
18				**Total Days**	351		510		350		104		248		1,315		47.60%
19		Total Days per PS&R or Exhibit Detail			351		510		350		104		248				
20		Unreconciled Days (Explain Variance)			-		-		-		-		-				
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21		Routine Charges			$ 331,619		$ 443,658		$ 410,897		$ 135,174		$ 272,032		$ 1,321,348		36.83%
21.01		Calculated Routine Charge Per Diem			$ 944.78		$ 869.92		$ 1,173.99		$ 1,299.75		$ 1,096.90		$ 1,004.83		
	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)		0.447160	14,174	56,548	37,767	178,062	17,893	96,267	1,262	62,828	1,532	12,013	$ 71,096	$ 393,705	25.26%
23	5000	OPERATING ROOM		0.240281	116,735	216,780	393,739	1,675,292	20,082	291,678	18,412	144,323	32,066	487,309	$ 548,968	$ 2,328,073	40.85%
24	5200	DELIVERY ROOM & LABOR ROOM		0.438831	226,262	6,484	485,282	77,646	713	-	8,710	1,164	30,004	10,949	$ 720,967	$ 85,294	56.74%
25	5300	ANESTHESIOLOGY		0.006746	5,866	21,742	21,532	125,246	1,456	19,012	938	14,224	1,855	29,960	$ 29,792	$ 180,224	40.53%
26	5400	RADIOLOGY-DIAGNOSTIC		0.104501	96,928	560,484	70,223	1,201,060	179,312	1,290,545	27,642	226,096	79,371	1,979,086	$ 374,105	$ 3,278,185	39.19%
27	6000	LABORATORY		0.135953	346,632	715,412	464,505	1,948,936	397,013	601,360	130,550	494,188	271,692	1,477,987	$ 1,338,700	$ 3,759,896	42.69%
28	6500	RESPIRATORY THERAPY		1.006917	32,444	25,145	7,506	41,056	83,259	37,096	28,410	10,713	50,803	61,546	$ 151,619	$ 114,010	36.78%
29	6600	PHYSICAL THERAPY		0.653729	59,125	79,255	74,097	197,824	50,964	327,947	6,385	293,175	22,236	65,485	$ 190,571	$ 898,201	20.36%
30	6900	ELECTROCARDIOLOGY		0.065591	21,340	59,922	5,328	65,346	81,635	181,974	40,632	14,068	13,977	114,912	$ 148,935	$ 321,310	32.68%
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.395237	90,005	114,262	162,514	350,639	107,570	136,507	45,071	39,757	45,599	290,174	$ 405,160	$ 641,165	40.44%
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.482080	-	22,441	3,845	34,476	3,610	60,102	3,610	42,703	779	81,653	$ 11,065	$ 159,722	27.94%
33	7300	DRUGS CHARGED TO PATIENTS		0.232001	290,027	284,523	388,549	338,167	459,308	144,374	300,061	59,233	247,884	339,666	$ 1,437,945	$ 826,297	37.38%
34	9100	EMERGENCY		0.381109	50,241	423,072	24,810	1,319,994	105,063	622,634	21,680	112,016	-	1,788,823	$ 201,794	$ 2,477,716	53.06%
35				-											$ -	$ -	
36				-											$ -	$ -	
37				-											$ -	$ -	
38				-											$ -	$ -	
39				-											$ -	$ -	
40				-											$ -	$ -	
41				-											$ -	$ -	
42				-											$ -	$ -	
43				-											$ -	$ -	
44				-											$ -	$ -	
45				-											$ -	$ -	
46				-											$ -	$ -	
47				-											$ -	$ -	
48				-											$ -	$ -	
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58				-											$ -	$ -	
59				-											$ -	$ -	
60				-											$ -	$ -	

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

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Line					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				-											$ -	$ -	
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82				-											$ -	$ -	
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123				-											$ -	$ -	
124				-											$ -	$ -	
125				-											$ -	$ -	
126				-											$ -	$ -	
127				-											$ -	$ -	
					$ 1,349,779	$ 2,586,070	$ 2,139,697	$ 7,553,744	$ 1,507,878	$ 3,809,496	$ 633,363	$ 1,514,488	$ 797,798	$ 6,739,563			

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

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Line	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)***	1,681,398	2,586,070	2,583,355	7,553,744	1,918,775	3,809,496	768,537	1,514,488	1,069,830 **(Agrees to Exhibit A)**	6,739,563 **(Agrees to Exhibit A)**	6,952,065	15,463,798	39.65%
129	Total Charges per PS&R or Exhibit Detail	1,681,398	2,586,070	2,583,355	7,553,744	1,918,775	3,809,496	768,537	1,514,488	1,069,830	6,739,563			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	1,072,069	600,485	1,649,313	1,819,229	1,053,392	947,269	362,520	450,292	677,717	1,562,131	4,137,294	3,817,275	42.47%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	639,654	489,008	-	-	1,122	70,156	1,062	6,532			641,838	565,696	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	-	-	1,011,812	1,853,477	-	-	-	3,970			1,011,812	1,857,447	
134	Private Insurance (including primary and third party liability)	-	-	-	-	-	34	72,586	145,989			72,586	146,023	
135	Self-Pay (including Co-Pay and Spend-Down)	-	-	-	3	-	-	2,250	786			2,250	789	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	639,654	489,008	1,011,812	1,853,480									
137	Medicaid Cost Settlement Payments (See Note B)	-	2,133	-	-							-	2,133	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)	-	-	-	-							-	-	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					1,178,746	530,777	-	-			1,178,746	530,777	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					-	-	391,030	201,754			391,030	201,754	
141	Medicare Cross-Over Bad Debt Payments					28,259	11,795	-	-	(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	28,259	11,795	
142	Other Medicare Cross-Over Payments (See Note D)					-	-	-	-			-	-	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									9,742	199,165			
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)**	432,415	109,344	637,501	(34,251)	(154,735)	334,507	(104,408)	91,261	667,975	1,362,966	810,773	500,861	
146	**Calculated Payments as a Percentage of Cost**	60%	82%	61%	102%	115%	65%	129%	80%	1%	13%	80%	87%	
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)**					1,335								
148	**Percent of cross-over days to total Medicare days from the cost report**					26%								

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

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

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Line #	Code	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
					Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
			From Section G	From Section G	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)	From PS&R Summary (Note A)		
		Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000	ADULTS & PEDIATRICS	$ 1,764.08		3		1						4	
2	03100	INTENSIVE CARE UNIT	$ 2,266.33										-	
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	$ 2,341.41										-	
11			$ -										-	
12			$ -										-	
13			$ -										-	
14			$ -										-	
15			$ -										-	
16			$ -										-	
17			$ -										-	
18				Total Days	3		1		-		-		4	
19		Total Days per PS&R or Exhibit Detail			3		1		-		-			
20		Unreconciled Days (Explain Variance)			-		-		-		-			
					Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21		Routine Charges			$ 2,691		$ 897						$ 3,588	
21.01		Calculated Routine Charge Per Diem			$ 897.00		$ 897.00		$ -		$ -		$ 897.00	
		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)		0.447160									$ -	$ -
23	5000	OPERATING ROOM		0.240281									$ -	$ -
24	5200	DELIVERY ROOM & LABOR ROOM		0.438831									$ -	$ -
25	5300	ANESTHESIOLOGY		0.006746									$ -	$ -
26	5400	RADIOLOGY-DIAGNOSTIC		0.104501	146	8,773		10,429					$ 146	$ 19,202
27	6000	LABORATORY		0.135953	4,435	11,101	1,604	12,162					$ 6,039	$ 23,263
28	6500	RESPIRATORY THERAPY		1.006917	225	448	865	224					$ 1,090	$ 672
29	6600	PHYSICAL THERAPY		0.653729									$ -	$ -
30	6900	ELECTROCARDIOLOGY		0.065591	117	585							$ 117	$ 585
31	7100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.395237	769	1,091	711	792					$ 1,480	$ 1,883
32	7200	IMPL. DEV. CHARGED TO PATIENTS		0.482080									$ -	$ -
33	7300	DRUGS CHARGED TO PATIENTS		0.232001	23,761	20,703	642	1,231					$ 24,403	$ 21,934
34	9100	EMERGENCY		0.381109	1,113	16,635		13,979					$ 1,113	$ 30,614
35				-									$ -	$ -
36				-									$ -	$ -
37				-									$ -	$ -
38				-									$ -	$ -
39				-									$ -	$ -
40				-									$ -	$ -
41				-									$ -	$ -
42				-									$ -	$ -
43				-									$ -	$ -
44				-									$ -	$ -
45				-									$ -	$ -
46				-									$ -	$ -
47				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

					Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
48				-									$ -	$ -
49				-									$ -	$ -
50				-									$ -	$ -
51				-									$ -	$ -
52				-									$ -	$ -
53				-									$ -	$ -
54				-									$ -	$ -
55				-									$ -	$ -
56				-									$ -	$ -
57				-									$ -	$ -
58				-									$ -	$ -
59				-									$ -	$ -
60				-									$ -	$ -
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				-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Line	Description		Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
110		-									$ -	$ -
111		-									$ -	$ -
112		-									$ -	$ -
113		-									$ -	$ -
114		-									$ -	$ -
115		-									$ -	$ -
116		-									$ -	$ -
117		-									$ -	$ -
118		-									$ -	$ -
119		-									$ -	$ -
120		-									$ -	$ -
121		-									$ -	$ -
122		-									$ -	$ -
123		-									$ -	$ -
124		-									$ -	$ -
125		-									$ -	$ -
126		-									$ -	$ -
127		-									$ -	$ -
			$ 30,566	$ 59,336	$ 3,822	$ 38,817	$ -	$ -	$ -	$ -		
	Totals / Payments											
128	**Total Charges (includes organ acquisition from Section K)**		$ 33,257	$ 59,336	$ 4,719	$ 38,817	$ -	$ -	$ -	$ -	$ 37,976	$ 98,153
129	Total Charges per PS&R or Exhibit Detail		$ 33,257	$ 59,336	$ 4,719	$ 38,817	$ -	$ -	$ -	$ -		
130	Unreconciled Charges (Explain Variance)		-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**		$ 12,385	$ 14,490	$ 3,283	$ 8,895	$ -	$ -	$ -	$ -	$ 15,668	$ 23,385
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)		$ 6,836	$ 4,777	$ -	$ -					$ 6,836	$ 4,777
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)		$ -	$ -	$ 2,533	$ 5,272					$ 2,533	$ 5,272
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)		$ 6,836	$ 4,777	$ 2,533	$ 5,272						
137	Medicaid Cost Settlement Payments (See Note B)		$ -	$ -							$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)		$ -	$ -	$ -	$ -					$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										$ -	$ -
141	Medicare Cross-Over Bad Debt Payments										$ -	$ -
142	Other Medicare Cross-Over Payments (See Note D)										$ -	$ -
143	**Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)**		$ 5,549	$ 9,713	$ 750	$ 3,623	$ -	$ -	$ -	$ -	$ 6,299	$ 13,336
144	**Calculated Payments as a Percentage of Cost**		55%	33%	77%	59%	0%	0%	0%	0%	60%	43%

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

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

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

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

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

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

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

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

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

L. Provider Tax Assessment Reconciliation / Adjustment

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

Cost Report Year (10/01/2020-09/30/2021) GRADY GENERAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

Line	Description		Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 384,158		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Expense	28700-711478	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)			5.00	*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 384,158		
	Provider Tax Assessment Reclassifications (from w/s A-6 of the Medicare cost report)				
4	*Reclassification Code*				*(Reclassified to / (from))*
5	*Reclassification Code*				*(Reclassified to / (from))*
6	*Reclassification Code*				*(Reclassified to / (from))*
7	*Reclassification Code*				*(Reclassified to / (from))*
	DSH UCC ALLOWABLE - Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
8	*Reason for adjustment*				*(Adjusted to / (from))*
9	*Reason for adjustment*				*(Adjusted to / (from))*
10	*Reason for adjustment*				*(Adjusted to / (from))*
11	*Reason for adjustment*				*(Adjusted to / (from))*
	DSH UCC NON-ALLOWABLE Provider Tax Assessment Adjustments (from w/s A-8 of the Medicare cost report)				
12	*Reason for adjustment*				
13	*Reason for adjustment*				
14	*Reason for adjustment*				
15	*Reason for adjustment*				
16	Total Net Provider Tax Assessment Expense Included in the Cost Report		$ -		

DSH UCC Provider Tax Assessment Adjustment:

Line	Description		Amount
17	Gross Allowable Assessment Not Included in the Cost Report		$ 384,158
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	22,551,992
19	Uninsured Hospital	**Charges Sec. G**	7,809,393
20	Total Hospital	**Charges Sec. G**	76,577,963
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		29.45%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		10.20%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ 113,133
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ 39,176
25	Provider Tax Assessment Adjustment to DSH UCC		**$ 152,309**

** 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.*