

A. General DSH Year Information

1. DSH Year:

Begin	End
07/01/2016	06/30/2017

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

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	10/01/2016	09/30/2017
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 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:

- 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.)
- 2. Was the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 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?
- 3a. Was the hospital open as of December 22, 1987?
- 3b. What date did the hospital open?

Questions 4-6, below, should be answered in the accordance with Sec. 1923(d) of the Social Security Act.

During the Interim DSH Payment Year:

- 4. Does the hospital have at least two obstetricians who have staff privileges at the hospital who have 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.)
- List the Names of the two Obstetricians (or case of rural hospital, Physicians) who have agreed to perform OB services:
- 5. Is the hospital exempt from the requirement listed under #1 above because the hospital's inpatients are predominantly under 18 years of age?
- 6. Is 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?

C. Disclosure of Other Medicaid Payments Received:

1. Medicaid Supplemental Payments for DSH Year 07/01/2016 - 06/30/2017

(Should include UPL and Non-Claim Specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

\$ 233,290

Certification:

Answer

Yes

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.

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

Senior Vice President and CFO

 Title

11/6/2018

 Date

Greg Hembree

 Hospital CEO or CFO Printed Name

(229) 228-2880

 Hospital CEO or CFO Telephone Number

gshembree@archbold.org

 Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Patricia L. Barrett
Title	Director of Reimbursement/GGH
Telephone Number	(229) 228-8857
E-Mail Address	pbarrett@archbold.org
Mailing Street Address	920 Cairo Rd
Mailing City, State, Zip	Thomasville, GA 31792-4255

Outside Preparer:

Name	
Title	
Firm Name	
Telephone Number	
E-Mail Address	

D. General Cost Report Year Information 10/1/2016 - 9/30/2017

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

10/1/2016 through 9/30/2017		
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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:

3/19/2018

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	GRADY GENERAL HOSPITAL	Yes	
5. Medicaid Provider Number:	00000844A	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	
8a. Owner/Operator (Private, State Govt., Non-State Govt., HIS/Tribal):	Non-State Govt.	Yes	
8b. 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:

- 9. State Name & Number
- 10. State Name & Number
- 11. State Name & Number
- 12. State Name & Number
- 13. State Name & Number
- 14. State Name & Number
- 15. State Name & Number

State Name	Provider No.
Florida	0102121

(List additional states on a separate attachment)

E. Disclosure of Medicaid / Uninsured Payments Received: (10/01/2016 - 09/30/2017)

- 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)

\$ -

- 9. Total Cash Basis Patient Payments from Uninsured (On Exhibit B)
- 10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)
- 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)
- 12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:

	Inpatient	Outpatient	Total
\$	22,971	316,722	\$339,693
\$	170,969	1,555,308	\$1,726,277
	\$193,940	\$1,872,030	\$2,065,970
	11.84%	16.92%	16.44%

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 (10/01/2016 - 09/30/2017)

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)

3,722 (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	826,295
8. Outpatient Hospital Charity Care Charges	1,713,465
9. Non-Hospital Charity Care Charges	-
10. Total Charity Care Charges	\$ 2,539,760

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)			Net Hospital Revenue
	Inpatient Hospital	Outpatient Hospital	Non-Hospital	Inpatient Hospital	Outpatient Hospital	Non-Hospital	
11. Hospital	\$2,828,690.00			\$ 1,800,366	\$ -	\$ -	\$ 1,028,324
12. Subprovider I (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
13. Subprovider II (Psych or Rehab)	\$0.00			\$ -	\$ -	\$ -	\$ -
14. Swing Bed - SNF			\$1,370,784.00			\$ 872,458	
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	\$19,192,084.00	\$43,413,459.00		\$ 12,215,113	\$ 27,631,201	\$ -	\$ 22,759,229
20. Outpatient Services		\$6,636,639.00			\$ 4,223,997	\$ -	\$ 2,412,642
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	\$0.00	\$0.00	\$0.00	\$ -	\$ -	\$ -	\$ -
27. Total	\$ 22,020,774	\$ 50,050,098	\$ 1,370,784	\$ 14,015,479	\$ 31,855,197	\$ 872,458	\$ 26,200,196
28. Total Hospital and Non Hospital		Total from Above	\$ 73,441,656		Total from Above	\$ 46,743,134	

29. Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	73,441,656	Total Contractual Adj. (G-3 Line 2)	46,743,134
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. 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)				
34. 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				46,743,134

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
		<i>Cost Report Worksheet B, Part I, Col. 26</i>	<i>Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*</i>	<i>Cost Report Worksheet C, Part I, Col.2 and Col. 4</i>	<i>Swing-Bed Carve Out - Cost Report Worksheet D-1, Part I, Line 26</i>	<i>Calculated</i>	<i>Days - Cost Report W/S D-1, Pt. 1, Line 2 for Adults & Peds; W/S D-1, Pt. 2, Lines 42-47 for others</i>	<i>Inpatient Routine Charges - Cost Report Worksheet C, Pt. 1, Col. 6 (Informational only unless used in Section L charges allocation)</i>	<i>Calculated Per Diem</i>

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.

Routine Cost Centers (list below):

1	03000	ADULTS & PEDIATRICS	\$ 4,048,166	\$ -	\$ -	\$572,073.00	\$ 3,476,093	3,396	\$3,508,074.00	\$ 1,023.58
2	03100	INTENSIVE CARE UNIT	\$ 682,961	\$ -	\$ -		\$ 682,961	391	\$584,667.00	\$ 1,746.70
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	\$ 693,619	\$ -	\$ -		\$ 693,619	416	\$212,992.00	\$ 1,667.35
11			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
12			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
13			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
14			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
15			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
16			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
17			\$ -	\$ -	\$ -		\$ -	-	\$0.00	\$ -
18		Total Routine	\$ 5,424,746	\$ -	\$ -	\$ 572,073	\$ 4,852,673	4,203	\$ 4,305,733	
19		Weighted Average								\$ 1,154.57

Observation Data (Non-Distinct)	Hospital Observation Days - Cost Report W/S S-3, Pt. 1, Line 28, Col. 8	Subprovider I Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.01, Col. 8	Subprovider II Observation Days - Cost Report W/S S-3, Pt. 1, Line 28.02, Col. 8	Calculated (Per Diems Above Multiplied by Days)	Inpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
20	09200 Observation (Non-Distinct)	481	-	\$ 492,342	\$57,885.00	\$1,625,394.00	\$ 1,683,279	0.292490

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. 1, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. 1, Col. 7	Total Charges - Cost Report Worksheet C, Pt. 1, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
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Ancillary Cost Centers (from W/S C excluding Observation) (list below):

21	5000	OPERATING ROOM	\$2,157,900.00	\$ -	\$0.00	\$ 2,157,900	\$1,841,850.00	\$7,257,029.00	\$ 9,098,879	0.237161
22	5200	DELIVERY ROOM & LABOR ROOM	\$624,524.00	\$ -	\$0.00	\$ 624,524	\$796,489.00	\$106,603.00	\$ 903,092	0.691540
23	5300	ANESTHESIOLOGY	\$4,338.00	\$ -	\$0.00	\$ 4,338	\$127,418.00	\$480,308.00	\$ 607,726	0.007138
24	5400	RADIOLOGY-DIAGNOSTIC	\$1,963,552.00	\$ -	\$0.00	\$ 1,963,552	\$1,953,929.00	\$11,970,145.00	\$ 13,924,074	0.141018
25	6000	LABORATORY	\$1,548,718.00	\$ -	\$0.00	\$ 1,548,718	\$3,585,373.00	\$7,634,131.00	\$ 11,219,504	0.138038
26	6500	RESPIRATORY THERAPY	\$702,946.00	\$ -	\$0.00	\$ 702,946	\$953,070.00	\$199,428.00	\$ 1,152,498	0.609933
27	6600	PHYSICAL THERAPY	\$3,115,395.00	\$ -	\$102.00	\$ 3,115,497	\$3,033,392.00	\$4,284,677.00	\$ 7,318,069	0.425727
28	6900	ELECTROCARDIOLOGY	\$88,667.00	\$ -	\$0.00	\$ 88,667	\$388,213.00	\$1,294,181.00	\$ 1,682,394	0.052703
29	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	\$1,528,349.00	\$ -	\$0.00	\$ 1,528,349	\$1,765,585.00	\$2,569,333.00	\$ 4,334,918	0.352567
30	7200	IMPL. DEV. CHARGED TO PATIENTS	\$162,630.00	\$ -	\$0.00	\$ 162,630	\$39,737.00	\$668,354.00	\$ 708,091	0.229674
31	7300	DRUGS CHARGED TO PATIENTS	\$1,313,054.00	\$ -	\$0.00	\$ 1,313,054	\$4,064,026.00	\$2,253,940.00	\$ 6,317,966	0.207829

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
32	9100 EMERGENCY	\$2,135,525.00	\$ -	\$0.00	\$ 2,135,525	\$798,778.00	\$5,788,147.00	\$ 6,586,925	0.324207
33		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
34		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
35		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
36		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
37		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
38		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
39		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
40		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
41		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
42		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
43		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
44		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
45		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
46		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
47		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
48		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
49		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
50		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
51		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
52		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
53		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
54		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
55		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
56		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
57		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
58		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
59		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
60		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
61		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
62		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
63		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
64		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
65		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
66		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
67		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
68		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
69		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
70		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
71		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
72		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
73		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
74		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
75		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
76		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
77		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
78		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
79		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
80		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
81		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
82		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
83		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
84		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
85		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
86		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
87		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
88		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
89		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
90		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
91		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (10/01/2016-09/30/2017) 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
92		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
93		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
94		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
95		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
96		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
97		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
98		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
99		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
100		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
101		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
102		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
103		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
104		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
105		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
106		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
107		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
108		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
109		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
110		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
111		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
112		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
113		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
114		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
115		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
116		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
117		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
118		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
119		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
120		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
121		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
122		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
123		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
124		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
125		\$0.00	\$ -	\$0.00	\$ -	\$0.00	\$0.00	\$ -	-
126	Total Ancillary	\$ 15,345,598	\$ -	\$ 102	\$ 15,345,700	\$ 19,405,745	\$ 46,131,670	\$ 65,537,415	
127	Weighted Average								0.241664
128	Sub Totals	\$ 20,770,344	\$ -	\$ 102	\$ 20,198,373	\$ 23,711,478	\$ 46,131,670	\$ 69,843,148	
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)				\$745,326.00				
131	NF, SNF, and Swing Bed Cost for Other Payors (Hospital must calculate. Submit support for calculation of cost.)								
131.01	Other Cost Adjustments (support must be submitted)								
132	Grand Total				\$ 19,453,047				
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 (10/01/2016-09/30/2017) GRADY GENERAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost	Medicaid Cost to Charge Ratio for Ancillary Cost	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 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	Inpatient	Outpatient		
Routine Cost Centers (from Section G):				Days		Days		Days		Days		Days		Days			
1	03000 ADULTS & PEDIATRICS	\$ 1,023.58		391		286		469		330		240		1,476		59.01%	
2	03100 INTENSIVE CARE UNIT	\$ 1,746.70		41		9		58		25		38		133		43.73%	
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	\$ 1,667.35		137		214				7		5		358		87.26%	
11		\$ -															
12		\$ -															
13		\$ -															
14		\$ -															
15		\$ -															
16		\$ -															
17		\$ -															
	Total Days			569		509		527		362		283		1,967		53.63%	
19	Total Days per PS&R or Exhibit Detail			569		509		527		362		283					
20	Unreconciled Days (Explain Variance)			-		-		-		-		-		-			
21	Routine Charges			\$ 371,139		\$ 305,719		\$ 427,698		\$ 251,449		\$ 212,490		\$ 1,356,005		36.49%	
21.01	Calculated Routine Charge Per Diem			\$ 652.27		\$ 600.63		\$ 811.57		\$ 694.61		\$ 750.85		\$ 689.38			
22	Ancillary Cost Centers (from W/S C) (from Section G):				Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		Ancillary Charges		
22	09200 Observation (Non-Distinct)		0.292490	21,248	33,992	32,924	176,437	194,063	676	176,344	657	10,772	\$ 55,048	\$ 580,836		38.46%	
23	5000 OPERATING ROOM		0.237161	211,343	371,216	265,090	1,308,938	144,089	438,053	138,205	351,228	160,493	454,725	\$ 758,727	\$ 2,466,435		42.21%
24	5200 DELIVERY ROOM & LABOR ROOM		0.691540	155,372	10,896	425,061	68,420	13,037	754	28,704	7,015	11,468	\$ 5,953	\$ 87,085		80.51%	
25	5300 ANESTHESIOLOGY		0.007138	16,348	30,922	17,884	129,271	10,780	23,250	10,904	21,364	28,136	\$ 55,916	\$ 204,807		49.15%	
26	5400 RADIOLOGY-DIAGNOSTIC		0.141018	143,592	559,928	80,220	1,015,447	1,262,132	170,253	666,632	71,655	1,829,090	\$ 719,825	\$ 3,504,139		44.15%	
27	6000 LABORATORY		0.138038	349,132	550,706	272,521	919,910	461,721	570,581	257,866	429,719	229,836	1,108,676	\$ 1,341,240	\$ 2,470,916		46.14%
28	6500 RESPIRATORY THERAPY		0.609933	60,802	9,612	33,117	33,117	111,221	36,138	30,799	17,643	37,297	\$ 36,611	\$ 212,434		34.27%	
29	6600 PHYSICAL THERAPY		0.428727	49,849	72,640	41,650	150,307	49,910	463,024	42,176	285,175	3,338	105,485	\$ 183,585	\$ 971,146		17.27%
30	6900 ELECTROCARDIOLOGY		0.052703	27,404	48,579	2,620	39,320	61,580	159,172	33,363	62,834	20,713	83,515	\$ 124,967	\$ 309,905		32.20%
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.352567	162,907	151,805	172,733	278,466	203,431	165,440	125,590	118,147	114,268	248,558	\$ 664,661	\$ 713,858		40.23%
32	7200 IMPL_DEV_CHARGED TO PATIENTS		0.229674	5,244	39,943	2,209	56,731	912	52,921	1,536	32,105	7,743	63,618	\$ 9,903	\$ 181,700		37.14%
33	7300 DRUGS CHARGED TO PATIENTS		0.207829	424,419	320,283	210,707	290,191	479,704	172,522	258,162	123,397	261,422	343,407	\$ 1,372,992	\$ 906,393		45.74%
34	9100 EMERGENCY		0.324207	49,994	353,568	11,164	975,368	108,806	534,151	51,032	294,310	1,465	1,401,861	\$ 220,996	\$ 2,157,397		57.79%
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H. In-State Medicaid and All Uninsured Inpatient and Outpatient Hospital Data:

Cost Report Year (10/01/2016-09/30/2017) GRADY GENERAL HOSPITAL

	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		% Survey
82													
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Totals / Payments		\$ 1,677,654	\$ 2,562,994	\$ 1,544,395	\$ 5,441,923	\$ 1,970,951	\$ 4,069,201	\$ 1,149,468	\$ 2,585,913	\$ 924,670	\$ 5,725,922		
128 Total Charges (includes organ acquisition from Section J)	\$ 2,048,793	\$ 2,562,994	\$ 1,850,114	\$ 5,441,923	\$ 2,398,649	\$ 4,069,201	\$ 1,400,917	\$ 2,585,913	\$ 1,137,160	\$ 5,725,922	\$ 7,698,473	\$ 14,660,031	41.97%
129 Total Charges per PS&R or Exhibit Detail	\$ 2,048,793	\$ 2,562,994	\$ 1,850,114	\$ 5,441,923	\$ 2,398,649	\$ 4,069,201	\$ 1,400,917	\$ 2,585,913	\$ 1,137,160	\$ 5,725,922			
130 Unreconciled Charges (Explain Variance)													
131 Total Calculated Cost (includes organ acquisition from Section J)	\$ 1,155,410	\$ 549,382	\$ 1,213,331	\$ 1,254,452	\$ 1,033,541	\$ 924,438	\$ 659,015	\$ 598,775	\$ 526,776	\$ 1,229,847	\$ 4,061,297	\$ 3,327,047	47.13%
132 Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	\$ 959,214	\$ 572,510	\$ -	\$ -	\$ 111,285	\$ 90,158	\$ 635,198	\$ 464,681			\$ 1,705,697	\$ 1,127,349	
133 Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)	\$ -	\$ -	\$ 766,150	\$ 1,260,661	\$ -	\$ -	\$ 125,913	\$ 233,725			\$ 892,063	\$ 1,494,386	
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)	\$ 959,214	\$ 572,510	\$ 766,150	\$ 1,260,661									
137 Medicaid Cost Settlement Payments (See Note B)	\$ -	\$ (50,758)	\$ -	\$ -							\$ -	\$ (50,758)	
138 Other Medicaid Payments Reported on Cost Report Year (See Note C)	\$ -	\$ -	\$ -	\$ -							\$ -	\$ -	
139 Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					\$ 1,039,326	\$ 619,514	\$ -	\$ -			\$ 1,039,326	\$ 619,514	
140 Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
141 Medicare Cross-Over Bad Debt Payments					\$ 42,257	\$ 30,977	\$ -	\$ -			\$ 42,257	\$ 30,977	
142 Other Medicare Cross-Over Payments (See Note D)					\$ -	\$ -	\$ -	\$ -			\$ -	\$ -	
143 Payment from Hospital Uninsured During Cost Report Year (Cash Basis)											\$ 22,971	\$ 316,722	
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)	\$ 196,196	\$ 27,630	\$ 447,181	\$ (6,209)	\$ (159,327)	\$ 183,789	\$ (102,096)	\$ (99,631)	\$ 503,805	\$ 913,125	\$ 381,954	\$ 105,579	
146 Calculated Payments as a Percentage of Cost	83%	95%	63%	100%	115%	80%	115%	117%	4%	26%	91%	97%	
147 Total Medicare Days from WS S-3 of the Cost Report Excluding Swing-Bed (CR, WS S-3, Pl. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)					2,042								
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.

I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) GRADY GENERAL HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost From Section G	Medicaid Cost to Charge Ratio for Ancillary Cost From Section G	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 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)
Routine Cost Centers (list below):				Days	Days	Days	Days	Days	Days	Days	Days	Days	Days
1	03000 ADULTS & PEDIATRICS	\$ 1,023.58								4		4	
2	03100 INTENSIVE CARE UNIT	\$ 1,746.70											
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	\$ 1,667.35											
11		\$ -											
12		\$ -											
13		\$ -											
14		\$ -											
15		\$ -											
16		\$ -											
17		\$ -											
18		\$ -											
			Total Days							4		4	
19	Total Days per PS&R or Exhibit Detail									4		4	
20	Unreconciled Days (Explain Variance)												
21													
21.01	Routine Charges									\$ 2,560		\$ 2,560	
	Calculated Routine Charge Per Diem									\$ 640.00		\$ 640.00	
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)		0.292490										
23	5000 OPERATING ROOM		0.237161										
24	5200 DELIVERY ROOM & LABOR ROOM		0.691540				377						377
25	5300 ANESTHESIOLOGY		0.007138										
26	5400 RADIOLOGY-DIAGNOSTIC		0.141018				12,278			4,120	6,458	4,120	18,736
27	6000 LABORATORY		0.138038				15,509			4,384	9,749	4,384	21,258
28	6500 RESPIRATORY THERAPY		0.609933				839			1,388	926	1,388	1,765
29	6800 PHYSICAL THERAPY		0.425727										
30	6900 ELECTROCARDIOLOGY		0.052703				531			1,735	354	1,735	885
31	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.352567				641			1,764	294	1,764	935
32	7200 IMPL. DEV. CHARGED TO PATIENTS		0.229674										
33	7300 DRUGS CHARGED TO PATIENTS		0.207829				1,446			3,845	572	3,845	2,018
34	9100 EMERGENCY		0.324207				18,067			808	6,097	808	24,164
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I. Out-of-State Medicaid Data:

Cost Report Year (10/01/2016-09/30/2017) GRADY GENERAL HOSPITAL

				Out-of-State Medicaid FFS Primary	Out-of-State Medicaid Managed Care Primary	Out-of-State Medicare FFS Cross-Over (with Medicaid Secondary)	Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)	Total Out-Of-State Medicaid													
79									\$	-											
80									\$	-											
81									\$	-											
82									\$	-											
83									\$	-											
84									\$	-											
85									\$	-											
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127									\$	-											
				\$	-	\$	-	\$	49,688	\$	-	\$	-	\$	18,044	\$	20,450	\$	20,604	\$	70,138

Totals / Payments

128	Total Charges (includes organ acquisition from Section K)	\$	-	\$	-	\$	-	\$	49,688	\$	-	\$	-	\$	20,604	\$	20,450	\$	20,604	\$	70,138
129	Total Charges per PS&R or Exhibit Detail	\$	-	\$	-	\$	-	\$	49,688	\$	-	\$	-	\$	20,604	\$	20,450	\$	20,604	\$	70,138
130	Unreconciled Charges (Explain Variance)																				
131	Total Calculated Cost (includes organ acquisition from Section K)	\$	-	\$	-	\$	-	\$	11,057	\$	-	\$	-	\$	7,901	\$	4,487	\$	7,901	\$	15,544
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)							\$	6,979					\$	5,737			\$	5,737		\$ 9,774
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)	\$	-	\$	-	\$	-	\$	6,979					\$	-			\$	-		
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)	\$	-	\$	-	\$	-	\$	4,078	\$	-	\$	-	\$	2,164	\$	1,692	\$	2,164	\$	5,770
144	Calculated Payments as a Percentage of Cost		0%		0%		0%		63%		0%		0%		73%		62%		73%		63%

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 (10/01/2016-09/30/2017)

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-Over (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)	
						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):																
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 (10/01/2016-09/30/2017)

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 Primary		Out-of-State Medicare FFS Cross-Over (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)	
						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 (10/01/2016-09/30/2017) GRADY GENERAL HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

	Dollar Amount	W/S A Cost Center Line
1 Hospital Gross Provider Tax Assessment (from general ledger)*	\$ 299,802	
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 ----->)	\$ 299,802	
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:

17 Gross Allowable Assessment Not Included in the Cost Report	\$ 299,802
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* Assessment must exclude any non-hospital assessment such as Nursing Facility.