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

DSH Version 6.00 2/17/2021

A. General DSH Year Information

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

2. Select Your Facility from the Drop-Down Menu Provided: CANDLER 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	07/01/2019	06/30/2020
4. Cost Report Year 2 (if applicable)		
5. Cost Report Year 3 (if applicable)		

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

	Data
6. Medicaid Provider Number:	000000327A
7. Medicaid Subprovider Number 1 (Psychiatric or Rehab):	0
8. Medicaid Subprovider Number 2 (Psychiatric or Rehab):	0
9. Medicare Provider Number:	110024

B. DSH OB Qualifying Information

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

During the DSH Examination Year:	DSH Examination Year (07/01/19 - 06/30/20)
1. Did the hospital have at least two obstetricians who had staff privileges at the hospital that agreed to provide obstetric services to Medicaid-eligible individuals during the DSH year? (In the case of a hospital located in a rural area, the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.)	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?	7/26/1934

C. Disclosure of Other Medicaid Payments Received:

1. **Medicaid Supplemental Payments for Hospital Services DSH Year 07/01/2019 - 06/30/2020** — $ 1,082,887
   (Should include UPL and non-claim specific payments paid based on the state fiscal year. However, DSH payments should NOT be included.)

2. **Medicaid Managed Care Supplemental Payments for hospital services for DSH Year 07/01/2019 - 06/30/2020**
   (Should include all non-claim specific payments for hospital services such as lump sum payments for full Medicaid pricing (FMP), supplementals, quality payments, bonus payments, capitation payments received by the hospital (not by the MCO), or other incentive payments.
   NOTE: Hospital portion of supplemental payments reported on DSH Survey Part II, Section E, Question 14 should be reported here if paid on a SFY basis.

3. **Total Medicaid and Medicaid Managed Care Non-Claims Payments for Hospital Services07/01/2019 - 06/30/2020** — $ 1,082,887

Certification:

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

Explanation for "No" answers:

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

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

Hospital CEO or CFO Signature	CFO Title	11/9/21 Date
Greg Schaack Hospital CEO or CFO Printed Name	912-819-6162 Hospital CEO or CFO Telephone Number	schaackg@sjchs.org Hospital CEO or CFO E-Mail

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

Hospital Contact:

Name	Greg Schaack
Title	CFO
Telephone Number	912-819-6162
E-Mail Address	schaackg@sjchs.org
Mailing Street Address	5353 Reynolds St.,
Mailing City, State, Zip	Savannah, GA 31405

Outside Preparer:

Name	Bert Bennett
Title	Partner
Firm Name	Draffin & Tucker, LLP
Telephone Number	229-883-7878
E-Mail Address	bbennett@draffin-tucker.com

DSH Version 8.00 1/28/2021

D. General Cost Report Year Information 7/1/2019 - 6/30/2020

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: CANDLER HOSPITAL

	7/1/2019 through 6/30/2020		
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:	12/3/2020		

	Data	Correct?	If Incorrect, Proper Information
4. Hospital Name:	CANDLER HOSPITAL	Yes	
5. Medicaid Provider Number:	000000327A	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:	110024	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		
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: (07/01/2019 - 06/30/2020)

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)	$ 156,854	$ 846,122	$1,002,976
10. Total Cash Basis Patient Payments from All Other Patients (On Exhibit B)	$ 2,672,660	$ 12,027,829	$14,700,489
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)	$2,829,514	$12,873,951	$15,703,465
12. Uninsured Cash Basis Patient Payments as a Percentage of Total Cash Basis Patient Payments:	5.54%	6.57%	6.39%

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 (07/01/2019 - 06/30/2020)

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)	62,251	**(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	28,617,752
8.	Outpatient Hospital Charity Care Charges	57,800,410
9.	Non-Hospital Charity Care Charges	
10.	Total Charity Care Charges	$ 86,418,162

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	$93,371,464.00			$ 72,885,746	$ -	$ -	$ 20,485,718
12.	Subprovider I (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
13.	Subprovider II (Psych or Rehab)	$0.00			$ -	$ -	$ -	$ -
14.	Swing Bed - SNF			$0.00			$ -	
15.	Swing Bed - NF			$0.00			$ -	
16.	Skilled Nursing Facility			$9,244,278.00			$ 7,216,082	
17.	Nursing Facility			$0.00			$ -	
18.	Other Long-Term Care			$0.00			$ -	
19.	Ancillary Services	$286,234,333.00	$983,586,432.00		$ 223,434,463	$ 767,787,372	$ -	$ 278,598,930
20.	Outpatient Services		$114,301,156.00			$ 89,223,459	$ -	$ 25,077,697
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	$ 379,605,797	$ 1,097,887,588	$ 9,244,278	$ 296,320,209	$ 857,010,831	$ 7,216,082	$ 324,162,345
28.	Total Hospital and Non Hospital		Total from Above	$ 1,486,737,663		Total from Above	$ 1,160,547,122	

29.	Total Per Cost Report	Total Patient Revenues (G-3 Line 1)	1,486,737,663	Total Contractual Adj. (G-3 Line 2)		1,163,828,487
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)				-	3,281,365
35.	Adjusted Contractual Adjustments					1,160,547,122
36.	Unreconciled Difference	Unreconciled Difference (Should be $0)	$ -	Unreconciled Difference (Should be $0)		$ -

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) CANDLER 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	$ 35,777,338	$ -	$ -	$0.00	$ 35,777,338	51,367	$56,494,409.00		$ 696.50
2	03100 INTENSIVE CARE UNIT	$ 8,284,936	$ -	$ 2,078		$ 8,287,014	5,769	$21,505,608.00		$ 1,436.47
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	$ 3,287,485	$ -	$ -		$ 3,287,485	8,543	$9,101,739.00		$ 384.82
11		$ -	$ -	$ -		$ -	-	$0.00		$ -
12		$ -	$ -	$ -		$ -	-	$0.00		$ -
13		$ -	$ -	$ -		$ -	-	$0.00		$ -
14		$ -	$ -	$ -		$ -	-	$0.00		$ -
15		$ -	$ -	$ -		$ -	-	$0.00		$ -
16		$ -	$ -	$ -		$ -	-	$0.00		$ -
17		$ -	$ -	$ -		$ -	-	$0.00		$ -
18	Total Routine	$ 47,349,759	$ -	$ 2,078	$ -	$ 47,351,837	65,679	$ 87,101,756		
19	Weighted Average									$ 720.96

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)	3,428	-	-	$ 2,387,602	$71,348.00	$2,510,592.00	$ 2,581,940	0.924732

Line #	Ancillary Cost Centers (from W/S C excluding Observation) (list below)	Cost Report Worksheet B, Part I, Col. 26	Cost Report Worksheet B, Part I, Col. 25 (Intern & Resident Offset ONLY)*	Cost Report Worksheet C, Part I, Col.2 and Col. 4		Calculated	Inpatient Charges - Cost Report Worksheet C, Pt. I, Col. 6	Outpatient Charges - Cost Report Worksheet C, Pt. I, Col. 7	Total Charges - Cost Report Worksheet C, Pt. I, Col. 8	Medicaid Calculated Cost-to-Charge Ratio
21	5000 OPERATING ROOM	$25,072,621.00	$ -	$0.00		$ 25,072,621	$45,716,818.00	$149,762,079.00	$ 195,478,897	0.128263
22	5100 RECOVERY ROOM	$2,616,074.00	$ -	$0.00		$ 2,616,074	$10,913,488.00	$23,377,189.00	$ 34,290,677	0.076291
23	5200 DELIVERY ROOM & LABOR ROOM	$9,054,663.00	$ -	$0.00		$ 9,054,663	$18,403,441.00	$2,088,679.00	$ 20,492,120	0.441861
24	5300 ANESTHESIOLOGY	$1,069,121.00	$ -	$0.00		$ 1,069,121	$14,301,018.00	$32,473,635.00	$ 46,774,653	0.022857
25	5400 RADIOLOGY-DIAGNOSTIC	$13,616,994.00	$ -	$1,562.00		$ 13,618,556	$17,148,057.00	$86,913,472.00	$ 104,061,529	0.130870
26	5500 RADIOLOGY-THERAPEUTIC	$28,520,184.00	$ -	$7,615.00		$ 28,527,799	$8,228,619.00	$140,952,363.00	$ 149,180,982	0.191229
27	5700 CT SCAN	$2,294,736.00	$ -	$0.00		$ 2,294,736	$19,680,204.00	$72,359,485.00	$ 92,039,689	0.024932
28	5800 MRI	$1,174,736.00	$ -	$0.00		$ 1,174,736	$3,975,536.00	$15,628,835.00	$ 19,604,371	0.059922
29	6000 LABORATORY	$16,069,584.00	$ -	$15,133.00		$ 16,084,717	$43,006,842.00	$80,703,857.00	$ 123,710,699	0.130019

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) CANDLER 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	6500	RESPIRATORY THERAPY	$3,603,165.00	$ -	$0.00		$ 3,603,165	$13,503,716.00	$1,312,764.00	$ 14,816,480	0.243186
31	6600	PHYSICAL THERAPY	$2,922,394.00	$ -	$0.00		$ 2,922,394	$9,366,958.00	$7,824,994.00	$ 17,191,952	0.169986
32	6700	OCCUPATIONAL THERAPY	$1,073,090.00	$ -	$0.00		$ 1,073,090	$6,003,949.00	$1,679,982.00	$ 7,683,931	0.139654
33	6800	SPEECH PATHOLOGY	$371,431.00	$ -	$0.00		$ 371,431	$1,656,049.00	$621,351.00	$ 2,277,400	0.163094
34	6900	ELECTROCARDIOLOGY	$2,837,251.00	$ -	$5,895.00		$ 2,843,146	$3,808,743.00	$9,402,720.00	$ 13,211,463	0.215203
35	7000	ELECTROENCEPHALOGRAPHY	$238,924.00	$ -	$0.00		$ 238,924	$207,763.00	$281,347.00	$ 489,110	0.488487
36	7100	MEDICAL SUPPLIES CHARGED TO PATIENT	$17,905,383.00	$ -	$0.00		$ 17,905,383	$8,694,581.00	$18,551,001.00	$ 27,245,582	0.657185
37	7200	IMPL. DEV. CHARGED TO PATIENTS	$7,338,838.00	$ -	$0.00		$ 7,338,838	$4,189,846.00	$20,158,366.00	$ 24,348,212	0.301412
38	7300	DRUGS CHARGED TO PATIENTS	$83,388,076.00	$ -	$2,793.00		$ 83,390,869	$62,504,022.00	$341,330,628.00	$ 403,834,650	0.206498
39	7400	RENAL DIALYSIS	$1,242,845.00	$ -	$0.00		$ 1,242,845	$5,043,193.00	$526,236.00	$ 5,569,429	0.223155
40	9100	EMERGENCY	$11,505,651.00	$ -	$0.00		$ 11,505,651	$10,991,546.00	$46,030,495.00	$ 57,022,041	0.201776
41	9300	WOUND CARE	$5,066,849.00	$ -	$4,338.00		$ 5,071,187	$959,089.00	$25,475,056.00	$ 26,434,145	0.191842
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	$ -	-

G. Cost Report - Cost / Days / Charges

Cost Report Year (07/01/2019-06/30/2020) CANDLER 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	$0.00	$ -	-
91			$0.00	$ -	$0.00		$ -	$0.00	$0.00	$ -	-
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**	$ 236,982,610	$ -	$ 37,336		$ 237,019,946	$ 308,374,826	$ 1,079,965,126	$ 1,388,339,952	
127		**Weighted Average**									0.172442
128		**Sub Totals**	$ 284,332,369	$ -	$ 39,414		$ 284,371,783	$ 395,476,582	$ 1,079,965,126	$ 1,475,441,708	
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)*					$311,177.00				
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**					$ 284,060,606				
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 (07/01/2019-06/30/2020) CANDLER 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	$ 696.50		3,500		3,604		3,804		3,217		3,081		14,125		36.06%
2	03100 INTENSIVE CARE UNIT	$ 1,436.47		739		78		617		395		279		1,829		37.79%
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	$ 384.82		411		4,222		-		271		175		4,904		59.51%
11		$ -												-		
12		$ -												-		
13		$ -												-		
14		$ -												-		
15		$ -												-		
16		$ -												-		
17		$ -												-		
18			**Total Days**	4,650		7,904		4,421		3,883		3,535		20,858		37.38%
19	Total Days per PS&R or Exhibit Detail			4,650		7,904		4,421		3,883		3,535				
20	Unreconciled Days (Explain Variance)			-		-		-		-		-				
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**		
21	Routine Charges			$ 6,818,719		$ 9,368,705		$ 7,280,111		$ 5,848,083		$ 5,138,838		$ 29,315,618		40.01%
21.01	Calculated Routine Charge Per Diem			$ 1,466.39		$ 1,185.31		$ 1,646.71		$ 1,506.07		$ 1,453.70		$ 1,405.49		
	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)		0.924732	103,311	338,727	8,235	425,433	809	369,328	-	154,369	1,725	303,197	$ 112,355	$ 1,287,857	66.70%
23	5000 OPERATING ROOM		0.128263	3,216,096	3,813,287	1,277,721	15,466,212	3,817,911	5,716,514	2,087,738	2,717,418	2,941,465	9,159,899	$ 10,399,466	$ 27,713,431	25.86%
24	5100 RECOVERY ROOM		0.076291	367,640	536,435	2,347,276	3,493,360	360,480	681,855	932,204	463,285	546,567	1,157,012	$ 4,007,600	$ 5,174,935	31.89%
25	5200 DELIVERY ROOM & LABOR ROOM		0.441861	265,006	4,972	7,561,089	151,301	9,944	-	1,990,125	24,225	434,498	4,845	$ 9,826,164	$ 180,498	51.11%
26	5300 ANESTHESIOLOGY		0.022857	562,088	710,580	2,239,926	3,763,126	683,893	998,262	1,005,183	580,314	740,167	1,700,367	$ 4,491,090	$ 6,052,282	27.88%
27	5400 RADIOLOGY-DIAGNOSTIC		0.130870	1,036,272	1,679,873	590,543	3,838,045	1,547,221	4,166,908	975,699	1,518,865	1,145,108	8,133,752	$ 4,149,735	$ 11,203,691	23.94%
28	5500 RADIOLOGY-THERAPEUTIC		0.191229	139,613	3,817,795	290,389	4,733,762	698,920	9,330,423	478,247	2,293,288	863,031	7,909,575	$ 1,607,169	$ 20,175,268	20.70%
29	5700 CT SCAN		0.024932	1,476,889	2,214,589	456,269	2,907,425	1,851,142	4,840,353	925,321	1,359,231	1,944,583	10,278,402	$ 4,709,621	$ 11,321,598	31.06%
30	5800 MRI		0.059922	351,826	402,154	98,842	526,262	281,498	928,401	191,303	237,550	349,374	859,243	$ 923,469	$ 2,094,367	21.65%
31	6000 LABORATORY		0.130019	3,675,573	2,244,076	3,935,007	5,413,507	3,472,424	2,983,349	2,784,804	3,068,195	3,181,183	14,363,753	$ 13,867,809	$ 13,709,127	36.78%
32	6500 RESPIRATORY THERAPY		0.243186	817,308	172,421	200,891	153,787	1,540,186	340,857	1,009,409	54,795	679,592	292,042	$ 3,567,794	$ 721,860	36.58%
33	6600 PHYSICAL THERAPY		0.169986	295,549	63,048	42,150	389,221	505,384	370,591	240,029	668,131	176,802	238,199	$ 1,083,112	$ 1,490,991	17.41%
34	6700 OCCUPATIONAL THERAPY		0.139654	83,527	17,416	12,282	43,109	163,045	105,678	71,535	169,129	36,803	67,863	$ 330,389	$ 335,332	10.06%
35	6800 SPEECH PATHOLOGY		0.163094	61,135	10,381	68,268	6,680	159,316	29,434	74,852	37,980	39,864	80,169	$ 363,571	$ 84,475	25.10%
36	6900 ELECTROCARDIOLOGY		0.215203	285,798	151,609	140,624	230,541	395,516	608,427	205,399	227,165	434,006	718,836	$ 1,027,337	$ 1,217,742	25.93%
37	7000 ELECTROENCEPHALOGRAPHY		0.488487	14,643	12,460	7,221	39,821	9,569	2,268	34,692	4,572	22,877	37,948	$ 66,125	$ 59,121	38.04%
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.657185	500,025	295,154	207,390	924,117	762,072	715,164	430,508	275,547	587,197	1,198,269	$ 1,899,995	$ 2,209,982	21.79%
39	7200 IMPL. DEV. CHARGED TO PATIENTS		0.301412	216,789	159,417	198,827	533,917	453,648	976,800	197,035	258,290	219,940	673,696	$ 1,066,299	$ 1,928,424	15.99%
40	7300 DRUGS CHARGED TO PATIENTS		0.206498	5,135,155	5,471,983	2,791,418	6,963,127	4,338,109	17,918,202	3,254,281	5,422,290	3,260,994	4,256,008	$ 15,518,963	$ 35,775,602	14.72%
41	7400 RENAL DIALYSIS		0.223155	133,763	-	91,273	413	641,422	132,060	522,818	36,953	48,692	2,478	$ 1,389,276	$ 169,426	29.63%
42	9100 EMERGENCY		0.201776	995,302	2,520,447	242,166	6,158,690	1,092,358	3,263,264	602,534	1,161,324	1,151,791	9,954,635	$ 2,932,360	$ 13,103,725	48.22%
43	9300 WOUND CARE		0.191842	-	-	177,797	785,211	540,005	1,915,739	458,255	1,188,328	361,089	932,527	$ 1,176,057	$ 3,889,278	24.22%
44			-											$ -	$ -	
45			-											$ -	$ -	
46			-											$ -	$ -	
47			-											$ -	$ -	
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59			-											$ -	$ -	
60			-											$ -	$ -	

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

Cost Report Year (07/01/2019-06/30/2020) CANDLER 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	%
61			-											$ -	$ -
62			-											$ -	$ -
63			-											$ -	$ -
64			-											$ -	$ -
65			-											$ -	$ -
66			-											$ -	$ -
67			-											$ -	$ -
68			-											$ -	$ -
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124			-											$ -	$ -
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126			-											$ -	$ -
127			-											$ -	$ -
				$ 19,733,308	$ 24,636,823	$ 22,985,604	$ 56,947,067	$ 23,324,872	$ 56,393,878	$ 18,471,971	$ 21,921,244	$ 19,167,348	$ 72,322,715		

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

Cost Report Year (07/01/2019-06/30/2020) CANDLER HOSPITAL

	Totals / Payments	In-State Medicaid FFS Primary		In-State Medicaid Managed Care Primary		In-State Medicare FFS Cross-Overs (with Medicaid Secondary)		In-State Other Medicaid Eligibles (Not Included Elsewhere)		Uninsured		Total In-State Medicaid		%
128	**Total Charges** ***(includes organ acquisition from Section J)***	$ 26,552,027	$ 24,636,823	$ 32,354,309	$ 56,947,067	$ 30,604,983	$ 56,393,878	$ 24,320,054	$ 21,921,244	$ 24,306,186 (Agrees to Exhibit A)	$ 72,322,715 (Agrees to Exhibit A)	$ 113,831,373	$ 159,899,012	25.34%
129	Total Charges per PS&R or Exhibit Detail	$ 26,552,027	$ 24,636,823	$ 32,354,309	$ 56,947,067	$ 30,604,983	$ 56,393,878	$ 24,320,054	$ 21,921,244	$ 24,306,186	$ 72,322,715			
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-			
131	**Total Calculated Cost (includes organ acquisition from Section J)**	$ 7,045,927	$ 4,158,728	$ 9,630,047	$ 8,791,190	$ 7,523,916	$ 9,860,771	$ 6,479,416	$ 3,691,976	$ 5,791,101	$ 10,701,597	$ 30,679,306	$ 26,502,665	26.18%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)	$ 5,734,993	$ 3,640,169		$ 241	$ 196,318	$ 777,514	$ 129,501	$ 86,254			$ 6,060,812	$ 4,504,178	
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)			$ 9,256,426	$ 7,943,748		$ -	$ 329,912	$ 118,944			$ 9,586,338	$ 8,062,692	
134	Private Insurance (including primary and third party liability)	$ 91,889	$ 17,248		$ 17,071	$ 1,424	$ 5,000	$ 2,784,146	$ 1,503,138			$ 2,877,459	$ 1,542,457	
135	Self-Pay (including Co-Pay and Spend-Down)	$ 75	$ 9,267	$ 78	$ 13,615	$ 12	$ 8,450	$ 3,522	$ 12,391			$ 3,687	$ 43,723	
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ 5,826,957	$ 3,666,684	$ 9,256,504	$ 7,974,675									
137	Medicaid Cost Settlement Payments (See Note B)		$ 110,914									$ -	$ 110,914	
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)				$ 1,399							$ -	$ 1,399	
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)					$ 6,532,876	$ 7,093,815	$ 2,203,829	$ 1,006,956			$ 8,736,705	$ 8,100,771	
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)							$ 1,331,999	$ 925,355			$ 1,331,999	$ 925,355	
141	Medicare Cross-Over Bad Debt Payments					$ 147,499	$ 163,854			(Agrees to Exhibit B and B-1)	(Agrees to Exhibit B and B-1)	$ 147,499	$ 163,854	
142	Other Medicare Cross-Over Payments (See Note D)					$ 528,844	$ 63,025	$ 138,000	$ 3,777			$ 666,844	$ 66,802	
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)									$ 156,854	$ 846,122			
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)**	$ 1,218,970	$ 381,130	$ 373,543	$ 815,116	$ 116,943	$ 1,749,113	$ (441,493)	$ 35,161	$ 5,634,247	$ 9,855,475	$ 1,267,963	$ 2,980,520	
146	**Calculated Payments as a Percentage of Cost**	83%	91%	96%	91%	98%	82%	107%	99%	3%	8%	96%	89%	
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)**					28,228								
148	**Percent of cross-over days to total Medicare days from the cost report**					16%								

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 (07/01/2019-06/30/2020) CANDLER HOSPITAL

Line #	Cost Center Description	Medicaid Per Diem Cost for Routine Cost Centers	Medicaid Cost to Charge Ratio for Ancillary Cost Centers	Out-of-State Medicaid FFS Primary		Out-of-State Medicaid Managed Care Primary		Out-of-State Medicare FFS Cross-Overs (with Medicaid Secondary)		Out-of-State Other Medicaid Eligibles (Not Included Elsewhere)		Total Out-Of-State Medicaid	
				Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient
		From Section G	*From Section G*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*	*From PS&R Summary (Note A)*		
	Routine Cost Centers (list below):			**Days**		**Days**		**Days**		**Days**		**Days**	
1	03000 ADULTS & PEDIATRICS	$ 696.50								81		81	
2	03100 INTENSIVE CARE UNIT	$ 1,436.47								72		72	
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	$ 384.82								5		5	
11		$ -										-	
12		$ -										-	
13		$ -										-	
14		$ -										-	
15		$ -										-	
16		$ -										-	
17		$ -										-	
18			**Total Days**	-		-		-		158		158	
19	Total Days per PS&R or Exhibit Detail			-		-		-		158			
20	Unreconciled Days (Explain Variance)			-		-		-		-			
				Routine Charges		**Routine Charges**		**Routine Charges**		**Routine Charges**		**Routine Charges**	
21	Routine Charges									$ 391,762		$ 391,762	
21.01	Calculated Routine Charge Per Diem			$ -		$ -		$ -		$ 2,479.51		$ 2,479.51	
	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)		0.924732							-	17,070	$ -	$ 17,070
23	5000 OPERATING ROOM		0.128263							126,864	208,726	$ 126,864	$ 208,726
24	5100 RECOVERY ROOM		0.076291							9,685	38,855	$ 9,685	$ 38,855
25	5200 DELIVERY ROOM & LABOR ROOM		0.441861							22,906	4,845	$ 22,906	$ 4,845
26	5300 ANESTHESIOLOGY		0.022857							14,932	43,120	$ 14,932	$ 43,120
27	5400 RADIOLOGY-DIAGNOSTIC		0.130870							98,831	181,155	$ 98,831	$ 181,155
28	5500 RADIOLOGY-THERAPEUTIC		0.191229							21,932	303,563	$ 21,932	$ 303,563
29	5700 CT SCAN		0.024932							44,756	292,171	$ 44,756	$ 292,171
30	5800 MRI		0.059922							7,401	10,546	$ 7,401	$ 10,546
31	6000 LABORATORY		0.130019							188,602	194,108	$ 188,602	$ 194,108
32	6500 RESPIRATORY THERAPY		0.243186							147,160	11,844	$ 147,160	$ 11,844
33	6600 PHYSICAL THERAPY		0.169986							4,026	718	$ 4,026	$ 718
34	6700 OCCUPATIONAL THERAPY		0.139654							1,492	998	$ 1,492	$ 998
35	6800 SPEECH PATHOLOGY		0.163094							2,751	858	$ 2,751	$ 858
36	6900 ELECTROCARDIOLOGY		0.215203							9,888	17,354	$ 9,888	$ 17,354
37	7000 ELECTROENCEPHALOGRAPHY		0.488487							-	-	$ -	$ -
38	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.657185							28,223	13,684	$ 28,223	$ 13,684
39	7200 IMPL. DEV. CHARGED TO PATIENTS		0.301412							4,125	-	$ 4,125	$ -
40	7300 DRUGS CHARGED TO PATIENTS		0.206498							280,187	344,676	$ 280,187	$ 344,676
41	7400 RENAL DIALYSIS		0.223155							40,609	-	$ 40,609	$ -
42	9100 EMERGENCY		0.201776							33,245	322,302	$ 33,245	$ 322,302
43	9300 WOUND CARE		0.191842							22,956	21,009	$ 22,956	$ 21,009
44			-									$ -	$ -
45			-									$ -	$ -
46			-									$ -	$ -
47			-									$ -	$ -

I. Out-of-State Medicaid Data:

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				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			-									$ -	$ -
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102			-									$ -	$ -
103			-									$ -	$ -
104			-									$ -	$ -
105			-									$ -	$ -
106			-									$ -	$ -
107			-									$ -	$ -
108			-									$ -	$ -
109			-									$ -	$ -

I. Out-of-State Medicaid Data:

Cost Report Year (07/01/2019-06/30/2020) CANDLER 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	
110			-									$ -	$ -
111			-									$ -	$ -
112			-									$ -	$ -
113			-									$ -	$ -
114			-									$ -	$ -
115			-									$ -	$ -
116			-									$ -	$ -
117			-									$ -	$ -
118			-									$ -	$ -
119			-									$ -	$ -
120			-									$ -	$ -
121			-									$ -	$ -
122			-									$ -	$ -
123			-									$ -	$ -
124			-									$ -	$ -
125			-									$ -	$ -
126			-									$ -	$ -
127			-									$ -	$ -
				$ -	$ -	$ -	$ -	$ -	$ -	$ 1,110,571	$ 2,027,602		

Totals / Payments

128	**Total Charges (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,502,333	$ 2,027,602	$ 1,502,333	$ 2,027,602
129	Total Charges per PS&R or Exhibit Detail	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,502,333	$ 2,027,602		
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-		
131	**Total Calculated Cost (includes organ acquisition from Section K)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 369,529	$ 319,807	$ 369,529	$ 319,807
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)							$ 235,550	$ 164,048	$ 235,550	$ 164,048
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)									$ -	$ -
134	Private Insurance (including primary and third party liability)								$ (554)	$ -	$ (554)
135	Self-Pay (including Co-Pay and Spend-Down)							$ 25	$ 3,607	$ 25	$ 3,607
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	$ -	$ -	$ -	$ -						
137	Medicaid Cost Settlement Payments (See Note B)									$ -	$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)									$ -	$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)									$ -	$ -
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)**	$ -	$ -	$ -	$ -	$ -	$ -	$ 133,954	$ 152,706	$ 133,954	$ 152,706
144	**Calculated Payments as a Percentage of Cost**	0%	0%	0%	0%	0%	0%	64%	52%	64%	52%

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.

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 (07/01/2019-06/30/2020) CANDLER HOSPITAL

Worksheet A Provider Tax Assessment Reconciliation:

			Dollar Amount	W/S A Cost Center Line	
1	Hospital Gross Provider Tax Assessment (from general ledger)*		$ 3,281,365		
1a	*Working Trial Balance Account Type and Account # that includes Gross Provider Tax Assessment*		Contractual Adjustment	001.5515.4000	*(WTB Account #)*
2	Hospital Gross Provider Tax Assessment Included in Expense on the Cost Report (W/S A, Col. 2)				*(Where is the cost included on w/s A?)*
3	Difference (Explain Here ---------->)		$ 3,281,365		
	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*	Addback	$ 3,281,365		*(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		$ 3,281,365		

DSH UCC Provider Tax Assessment Adjustment:

17	Gross Allowable Assessment Not Included in the Cost Report		$ -
	Apportionment of Provider Tax Assessment Adjustment to Medicaid & Uninsured:		
18	Medicaid Hospital	**Charges Sec. G**	277,260,320
19	Uninsured Hospital	**Charges Sec. G**	96,628,901
20	Total Hospital	**Charges Sec. G**	1,475,441,708
21	Percentage of Provider Tax Assessment Adjustment to include in DSH Medicaid UCC		18.79%
22	Percentage of Provider Tax Assessment Adjustment to include in DSH Uninsured UCC		6.55%
23	Medicaid Provider Tax Assessment Adjustment to DSH UCC		$ -
24	Uninsured Provider Tax Assessment Adjustment to DSH UCC		$ -
25	Provider Tax Assessment Adjustment to DSH UCC		**$ -**

** 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.*